Alternative Benefit Plan

State Name: Nevada

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: NV - 19 - 004

OMB Expiration date: 10/31/2014

Alternative Benefit Plan Populations — ABP1

Identify and define the population that will participate in the Alternative Benefit Plan.

Alternative Benefit Plan Population Name: Nevada Medicaid Newly Eligibles

Identify eligibility groups that are included in the Alternative Benefit Plan's population, and which may contain individuals that meet any targeting criteria used to further define the population.

Eligibility Groups Included in the Alternative Benefit Plan Population:

	Eligibility Group:	Enrollment is mandatory or voluntary?	
+	Adult Group	Mandatory	X

Enrollment is available for all individuals in these eligibility group(s). Yes

Geographic Area

The Alternative Benefit Plan population will include individuals from the entire state/territory. Yes

Any other information the state/territory wishes to provide about the population (optional)

PRA Disclosure Statement

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V.20140415

Alternative Benefit Plan

State Name: Nevada

Attachment 3.1-L-

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Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act

ABP2a

The state/territory has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements. Therefore the state/territory is deemed to have met the requirements for voluntary choice of benefit package for individuals exempt from mandatory participation in a section 1937 Alternative Benefit Plan.

Yes

Explain how the state has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements.

The state is using FEHB as the Base Benchmark and Secretary Approved Coverage as the 1937 Benchmark. Adding Habilitation-Maintenance Therapy as the EHB for both newly eligibles and existing Medicaid State Plan. The Medicaid State Plan will be modified under state plan to align the existing State Medicaid Plan and the Alternative Benefit Plan.

PRA Disclosure Statement

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Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package — ABP3

Select one of the following:

- ○ The state/territory is amending one existing benefit package for the population defined in Section 1.
- ◉ The state/territory is creating a single new benefit package for the population defined in Section 1.

Name of benefit package: Nevada Medicaid Newly Eligible Benefits

Selection of the Section 1937 Coverage Option

The state/territory selects as its Section 1937 Coverage option the following type of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package under this Alternative Benefit Plan (check one):

- ◉ Benchmark Benefit Package.
- ○ Benchmark-Equivalent Benefit Package.

The state/territory will provide the following Benchmark Benefit Package (check one that applies):

- ○ The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employee Health Benefit Program (FEHBP).
- ○ State employee coverage that is offered and generally available to state employees (State Employee Coverage):
- ○ A commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state/territory (Commercial HMO):
- ◉ Secretary-Approved Coverage.
  - ◉ The state/territory offers benefits based on the approved state plan.
  - ○ The state/territory offers an array of benefits from the section 1937 coverage option and/or base benchmark plan benefit packages, or the approved state plan, or from a combination of these benefit packages.
    - ◉ The state/territory offers the benefits provided in the approved state plan.
    - ○ Benefits include all those provided in the approved state plan plus additional benefits.
    - ○ Benefits are the same as provided in the approved state plan but in a different amount, duration and/or scope.
    - ○ The state/territory offers only a partial list of benefits provided in the approved state plan.
    - ○ The state/territory offers a partial list of benefits provided in the approved state plan plus additional benefits.

Please briefly identify the benefits, the source of benefits and any limitations:

Selection of Base Benchmark Plan

Alternative Benefit Plan

The state/territory must select a Base Benchmark Plan as the basis for providing Essential Health Benefits in its Benchmark or Benchmark-Equivalent Package.

The Base Benchmark Plan is the same as the Section 1937 Coverage option. No

Indicate which Benchmark Plan described at 45 CFR 156.100(a) the state/territory will use as its Base Benchmark Plan:

- ○ Largest plan by enrollment of the three largest small group insurance products in the state's small group market.
- ○ Any of the largest three state employee health benefit plans by enrollment.
- ◉ Any of the largest three national FEHBP plan options open to Federal employees in all geographies by enrollment.
- ○ Largest insured commercial non-Medicaid HMO.

Plan name:

Other Information Related to Selection of the Section 1937 Coverage Option and the Base Benchmark Plan (optional):

1. The state assures that all services in the base benchmark have been accounted for throughout the benefit chart found in ABP5.
2. The state assures the accuracy of all information in the ABP5 depicting amount, duration and scope parameters of services authroized in the currently approved Medicaid state plan.

PRA Disclosure Statement

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Alternative Benefit Plan Cost-Sharing — ABP4

☑ Any cost sharing described in Attachment 4.18-A applies to the Alternative Benefit Plan.

Attachment 4.18-A may be revised to include cost sharing for ABP services that are not otherwise described in the state plan. Any such cost sharing must comply with Section 1916 of the Social Security Act.

The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than that described in Attachment 4.18-A. No

Other Information Related to Cost Sharing Requirements (optional):

PRA Disclosure Statement

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Benefits Description ABP5

The state/territory proposes a "Benchmark-Equivalent" benefit package. No

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

Federal Employees Health Benefit Plan BCBS Basic/Standard Option 2012 Benefit Plan

Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."

Secretary Approved

Alternative Benefit Plan

1. Essential Health Benefit: Ambulatory patient services

Collapse All

Remove

Benefit Provided: Physician Services

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: n/a

Scope Limit: Within state licensing requirements

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: n/a

Remove

Benefit Provided: Hospice care

Source: State Plan 1905(a)

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Initial increment six months. Re-evaluate every three months

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: n/a

Remove

Benefit Provided: Home Health Care

Source: State Plan 1905(a)

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: n/a

Scope Limit: Skill nursing, PT, OT, PT, ST, RT, dietitians, HH Aids, Must be intermittent services.

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Physician order and plan of care determine tx hours

Remove

Benefit Provided: Family Planning Services

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Must be FDA approved

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

n/a

Remove

Benefit Provided: Personal Care Services

Source: State Plan 1905(a)

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: Reassessment process

Scope Limit: PCS include a range of human assistance provided to a person with disabilities and chronic conditions of all ages. Assistance with IADLs and ADLs.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

The assessment is conducted by licensed physical and/or occupational therapist. Authorizations are dependent upon assessment process and will not exceed one year. Reassessments are required 30 days prior to expiration of authorization.

Remove

Benefit Provided: Private Duty Nursing

Source: State Plan 1905(a)

Authorization: Authorization required in excess of limitation

Provider Qualifications: Medicaid State Plan

Amount Limit: see below

Duration Limit: none

Alternative Benefit Plan

Scope Limit:

The intent of private duty nursing is to assist the non-institutionalized recipient with complex direct skilled nursing care, to develop caregiver competencies through training and education, and to optimize recipient health status and outcomes.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Hourly service limitations are dependent upon diagnosis, caregiver availability, age and medical necessity. Hourly services may be exceeded with authorization.

Remove

Benefit Provided: Outpatient Hospital Services

Source: State Plan 1905(a)

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: n/a

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services require authorization dependent upon service being provided. Services provided include emergency room, radiology, laboratory, diagnostic, therapy, ambulatory surgery and observation.

Remove

Benefit Provided: Clinics (1905 Clinics Under the Direction of Phys)

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Within licensure requirements

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services provided under the direction of a physician.

Remove

Benefit Provided: Podiatry

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Alternative Benefit Plan

Amount Limit:

None

Duration Limit:

n/a

Scope Limit:

Within state licensing requirements

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

n/a

Add

Alternative Benefit Plan

2. Essential Health Benefit: Emergency services

Collapse All

Remove

Benefit Provided: Clinic: Urgent Care Clinics

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: n/a

Scope Limit: Within state licensing requirements

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: n/a

Remove

Benefit Provided: Outpatient Hospital: Emergency Room Coverage

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: n/a

Scope Limit: Within state licensing requirements

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: n/a

Remove

Benefit Provided: Transportation: Emergency

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: nNne

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Emergent transports requiring "911" to acute facility and scheduled specialty care transports for hospital-to-

hospital transports of a critically ill or ill recipient by a ground or air ambulance vehicle needing medically necessary supplies and services at a level beyond scope of EMT-intermediate or paramedic

Add

Alternative Benefit Plan

3. Essential Health Benefit: Hospitalization

Collapse All

Remove

Benefit Provided: Inpatient hospital

Source: State Plan 1905(a)

Authorization: Concurrent Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Med/surg tx; diagnostic testing; psychiatric/substance abuse/detox in a general acute care hospital; trauma; ICU medical rehab.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Admission, concurrent and retrospective authorization requirements. Medicare certified.

Remove

Benefit Provided: Inpatient Hospital: psychiatric

Source: State Plan 1905(a)

Authorization: Concurrent Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: Dependent upon concurrent authorization

Duration Limit: Dependent upon authorization and recipient age

Scope Limit: Free-standing psychiatric hospital, or general med/surg hospital with a dedicated psychiatric unit. Services not covered for recipient ages 22-64 in a free-standing psychiatric hospital due to Institute of Mental Disease (IMD) exclusion regulation.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

n/a

Remove

Benefit Provided: Inpatient Hospital: Substance Abuse (detox/tx)

Source: State Plan 1905(a)

Authorization: Concurrent Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: Detox 5 days Treatment 21 hospital days

Duration Limit: Unlimited lifetime admissions

Scope Limit: Free-standing substance abuse tx hospitals or general hospital with a specialized substance abuse tx unit

which includes a secure, structured enrivonment, 24 hr observation and supervision by mental health substance abuse professionals

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

All ages require results of urine drug screen or blood alcohol test at the time of the request for authorization. May exceed limits with authorization. Services not covered for recipients ages 22-64 in a free-standing psychiatric hospital due to Institute for Mental Disease (IMD) exclusion regulations.

Remove

Benefit Provided: Inpatient hospital: Transplants

Source: State Plan 1905(a)

Authorization: Concurrent Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Covered adult transplants: bone marrow/stem cell, corneal, kidney and liver

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Admission, concurrent and retrospective authorization requirements. Medicare certified.

Remove

Benefit Provided: Inpatient hospital: Skill/Admin Days

Source: State Plan 1905(a)

Authorization: Concurrent Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Provides for ongoing hospital svs for those who don't require acute care but can't be discharged due to waiting for alternate placement. Not for convenience of caregiver. Must be due to medical intervention.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Admission, concurrent and retrospective authorization requirements. Medicare certified.

Remove

Benefit Provided: RTC: Psychiatric Residential Treatment Facility

Source: State Plan 1905(a)

Authorization: Concurrent Authorization

Provider Qualifications: Medicaid State Plan

Alternative Benefit Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Psychiatric, medical-model facility accredited by Joint Commission, CARF, COA for recipients under age 21. providing active treatment, psychiatric services, psychological services therapeutic and behavioral modification, therapy & nursing services.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Dependent upon concurrent authorization.

Add

Alternative Benefit Plan

4. Essential Health Benefit: Maternity and newborn care

Collapse All

Remove

Benefit Provided: Free Standing Birthing Centers

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: Labor, delivery, postpartum care

Duration Limit: Labor, delivery, postpartum care only

Scope Limit: Natural childbirth procedures for labor, delivery, postpartum care and immediate newborn care.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Uncomplicated low-risk prenatal course is reasonably expected to result in a normal uncomplicated vaginal birth.

Remove

Benefit Provided: Physician: Maternity Services

Source: State Plan 1905(a)

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Obstetric/maternity/family planning procedures at time of delivery; newborn/neonatal/pediatric/postpartum

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

No authorization required for less than 48 hour normal vaginal delivery and/or 96 hour cesarean section delivery. C-section less than 39 weeks gestation and elective C-sections require prior authorization.

Remove

Benefit Provided: Inpatient hospital-maternity

Source: State Plan 1905(a)

Authorization: Concurrent Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Obstetric/maternity/family planning procedures at time of delivery, newborn/neonatal pediatric

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Admission, concurrent and retrospective authorization requirements. Medicare certified. No authorization

required for less than 48 hour vaginal delivery and/or 96 hour cesarean section delivery. C-section less than 39 weeks gestation and elective C-section requires prior authorization. Inpatient and physician maternity services.

Add

Alternative Benefit Plan

5. Essential Health Benefit: Mental health and substance use disorder services including behavioral health treatment

Collapse All

Remove

Benefit Provided: Partial Hospitalization (BH/SA): PHP 1905(a)

Source: State Plan 1905(a)

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: Dependent upon authorization and intensity of need

Duration Limit: none

Scope Limit:

Medical model by a hospital, in an outpatient setting which encompasses a variety of psychiatric modalities to coordinate intensive, comprehensive and multidisciplinary tx not generally provided in an outpatient setting.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Mental health rehab service based upon the assessed needs of the recipient based upon standardized assessments. The service has been standardized to a utilization system based upon a level of care placement system specific to children and adults.

Remove

Benefit Provided: Intensive Outpatient Program (BH/SA): IOP 1905(a)

Source: State Plan 1905(a)

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: Dependent upon authorization and intensity of need

Duration Limit: none

Scope Limit:

Comprehensive interdisciplinary program of array of direct mental health/substance abuse & rehabilitative services which are expected to improve or maintain an individual's condition and functioning level for prevention of relapse or hospitalization.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Mental health rehab services based upon the assessed need of the recipient based upon standardized assessments. The service has been standardized to a utilization system based upon a level of care placement system specific to children and adults.

Remove

Benefit Provided: BH/SA Outpatient Services: Rehab(1905)

Source: State Plan 1905(a)

Authorization: Authorization required in excess of limitation

Provider Qualifications: Medicaid State Plan

Alternative Benefit Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Services recommended by physician/licensed practitioner of the healing arts, within their scope of practice under State law for the maximum reduction of a physical or mental disability and to restore the individual to the best function level.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

n/a

Add

☒ 6. Essential Health Benefit: Prescription drugs

Benefit Provided:

Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

Prescription Drug Limits (Check all that apply.):	Authorization:	Provider Qualifications:
☒ Limit on days supply	Yes	State licensed
☐ Limit on number of prescriptions		
☐ Limit on brand drugs		
☒ Other coverage limits		
☒ Preferred drug list		

Coverage that exceeds the minimum requirements or other:

Follows all requirements under Section 1927 of the Social Security Act. Implementing the Nevada Medicaid State Plan Pharmacy Coverage 3.1a in its entirety. Nevada ABP prescription drug benefit plan is the same as under the approved Medicaid state plan for prescribed drugs.

Alternative Benefit Plan

7. Essential Health Benefit: Rehabilitative and habilitative services and devices

Collapse All

Remove

Benefit Provided: Physical Therapy and Related Services

Source: State Plan 1905(a)

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: Medically necessary therapy services for an illness or injury resulting in functional limitations which can respond or improve as a result of the prescribed therapy treatment plan in a reasonable, predictable period of time.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: n/a

Remove

Benefit Provided: Maintenance Therapy:Physical Therapy & Related Svs

Source: State Plan 1905(a)

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: Ten visits every three years

Scope Limit: Design or establish a maintenance plan, assure patient safety, train the patient, family members and/or unskilled personnel and make infrequent but periodic reevaluations of the plan.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan: Service cannot be exceeded through prior authorization. The goals of a maintenance program are to maintain functional status at a level consistent with the patient's physical or mental limitations or to prevent decline in function.

Remove

Benefit Provided: Durable Medical Equipment : Home Health Care

Source: State Plan 1905(a)

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: Authorization dependent upon the service

Duration Limit: Dependent upon the service

Scope Limit: Items must have received approval by FDA and be consistent with approved use. Products for

experimental or investigational purposes are non-covered. Consideration may be given to items classified by FDA as Humanitarian Device Exemptions (HDE).

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

n/a

Remove

Benefit Provided: Medical Supplies: Home Health Care

Source: State Plan 1905(a)

Authorization: Authorization required in excess of limitation

Provider Qualifications: Medicaid State Plan

Amount Limit: Quantity limitation dependent upon service

Duration Limit: Lifetime limit dependent upon service

Scope Limit:

Items must have received approval by FDA and be consistent with approved use. Product for experimental or investigational purposed are non-covered. Consideration may be given to items classified by FDA as Humanitarian Device Exemptions (HDE).

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

n/a

Remove

Benefit Provided: Orthotics and Prosthetics: Prosthetic Devices

Source: State Plan 1905(a)

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: Authorization dependent upon the service

Duration Limit: Lifetime limit dependent on service

Scope Limit:

Items must have received approval by FDA and be consistent with approved use. Product for experimental or investigational purposed are non-covered. Consideration may be given to items classified by FDA as Humanitarian Device Exemptions (HDE).

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

n/a

Remove

Benefit Provided: Ocular - hardware : eyeglasses

Source: State Plan 1905(a)

Alternative Benefit Plan

Authorization:
Authorization required in excess of limitation

Provider Qualifications:
Medicaid State Plan

Amount Limit:
1/12 months

Duration Limit:
n/a

Scope Limit:
Change in refractive error must exceed plus or minus 0.5 diopter or 10 degrees in axis deviation in order to qualify within 12 mo limitation or EPSDT.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
n/a

Benefit Provided:
Occupational Therapy-Physical Therapy &Related Svs

Source:
State Plan 1905(a)

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
n/a

Scope Limit:
Medically necessary therapy services for an illness or injury resulting in functional limitations which can respond or improve as a result of the prescribed therapy treatment plan in a reasonable, predictable period of time.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
n/a

Benefit Provided:
Speech, hearing and language -Physical Therapy & R

Source:
State Plan 1905(a)

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
n/a

Scope Limit:
Medically necessary therapy services for an illness or injury resulting in functional limitations which can respond or improve as a result of the prescribed therapy treatment plan in a reasonable, predictable period of time.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
n/a

Alternative Benefit Plan

Benefit Provided: Adult Day Health Care

Source: State Plan 1915(i)

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: Universal Needs Assessment & Physician Eval

Duration Limit: none

Scope Limit:

Services include health and social services needed to ensure the optimal functioning of the participant. Services are generally furnished within four or more hours per day on a regularly scheduled basis. Recipient must be at least 18 years of age.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

n/a

Benefit Provided: Home Based Habilitation Services

Source: State Plan 1915(i)

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: Universal Needs Assessment Tool

Duration Limit: None

Scope Limit:

Pt. must have endurance for three hours of habilitative services per day, five days a week.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Day tx program for individuals to assist in acquiring, retaining, and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community setting. Habilitation services are prescribed by a physician, and provided by the appropriate qualified staff.

Add

Alternative Benefit Plan

8. Essential Health Benefit: Laboratory services

Collapse All

Remove

Benefit Provided: Laboratory and x-ray services

Source: State Plan 1905(a)

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: none

Duration Limit: none

Scope Limit:

These services include, but not limited to microbiology, serology, immunohemotology, cytology, histology, chemical, hematology, toxicology, or other methods of "in-vitro" exam of tissues, secretions, excretions or other human body parts.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Gentoype and phenotype are covered and require PA. Clinic and facility based services.

Remove

Benefit Provided: Laboratory and X-ray services: diagnostics

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: none

Duration Limit: none

Scope Limit:

X-ray and diagnostic testing

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Medically necessary services for diagnosis and treatment of a specific illness, symptom, complaint or injury or to improve the function of a malformed body part. The investigational use for any radiological test is not covered. Clinic and facility based services.

Add

Alternative Benefit Plan

■ 9. Essential Health Benefit: Preventive and wellness services and chronic disease management Collapse All ☐

The state/territory must provide, at a minimum, a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Remove

Benefit Provided: Preventive Services

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: none

Duration Limit: none

Scope Limit: U.S. Preventive Services Task Force A & B recommendations, ACIP and Bright Future, and IOM Women's Health

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Nevada State Plan Preventive services are exclusive to the USPSTF/ACIP/Bright Futures/IOM EHB requirements.

Remove

Benefit Provided: Medical Nutrition Therapy

Source: State Plan 1905(a)

Authorization: Authorization required in excess of limitation

Provider Qualifications: Medicaid State Plan

Amount Limit: Four hours - 1st year; two hours - subsequent years

Duration Limit: none

Scope Limit: Medical nutrition therapy (MNT) is provided for recipients with nutritionally related chronic disease states. MNT can only be provided by registered dietitians working under state licensing requirements.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

Alternative Benefit Plan

10. Essential Health Benefit: Pediatric services including oral and vision care

Collapse All

Remove

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Source:
State Plan 1905(a)

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
none

Duration Limit:
none

Scope Limit:
Medically Necessary services for children under the age of 21

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
n/a

Add

☐ 11. Other Covered Benefits from Base Benchmark Collapse All ☐

Alternative Benefit Plan

☒ 12. Base Benchmark Benefits Not Covered due to Substitution or Duplication — Collapse All ☐

Base Benchmark Benefit that was Substituted: Heart, heart/lung transplant adults
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Substituted for (hospital) Residential Treatment Center benefit for adolescents 19-20, up to 22 if in facility on birthday and Skilled Inpatient Administrative Days are mapped to EBH3

Base Benchmark Benefit that was Substituted: pancreas, pancreas/liver transplant adults
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Substituted for (hospital) Residential Treatment Center benefit for adolescents 19-20, up to 22 if in facility on birthday and Skilled Inpatient Administrative Days are mapped to EHB3

Base Benchmark Benefit that was Substituted: Fertility, Accupuncture, Chiropractic
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Substituted for personal care services and Private Duty Nursing Services are mapped to EHB1.

Base Benchmark Benefit that was Substituted: Physicians and other healthcare professionals
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under the Nevada Medicaid State Plan as EHB 1(physician, family planning, clinic benefit). Base benchmark: covers services by physicians and other health care professionals determined to be medically necessary. Services include consultations, second surgical opinions, clinic visits, office visits, home visits, initial exam of newborns, and nutritional counseling. No service limitation.

Base Benchmark Benefit that was Substituted: Lab, X-ray, and other diagnostic services
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under the Nevada Medicaid State Plan as EHB 8(lab and x-ray benefit). Services ordered by a physician. Billed, by physician, independent laboratory, and/or outpatient hospital department. Base benchmark does not cover genetic screening, requires cancer diagnosis for BRCA testing. No service limitations.

Alternative Benefit Plan

Base Benchmark Benefit that was Substituted: Preventive care, adult

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the Nevada Medicaid State Plan as EHB9. Base benchmark: Services recommended under PPACA. Services have quantity limitations, one per year. FDA approved immunizations. Group counseling not covered.

Base Benchmark Benefit that was Substituted: Preventive care, children

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the Nevada Medicaid State Plan as EHB9 (preventive benefit). Nevada Medicaid does not limit STI. Base benchmark: Services recommended under the PPACA and AAP. Newborn visits and screens, lab tests, hearing and vision screenings, FDA approved immunizations, screenings for STI, HPV, HIV, STI limited to one per year.

Base Benchmark Benefit that was Substituted: Maternity Care

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the Nevada Medicaid State Plan as EHB4 (free-standing birth centers, physician-maternity, inpatient-maternity benefit), and EHB5 (BH/SA Outpatient Services benefit). Base benchmark : Prenatal care, tocolytic therapy, delivery postpartum care, surgery, anesthesia, and mental health tx for postpartum depression. No service limitations.

Base Benchmark Benefit that was Substituted: Family Planning

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the Nevada Medicaid State Plan as EHB6 (prescripton benefit), EHB1 (physician, family planning, clinic, urgent care, outpatient hospital, emergency room benefit), EHB7 (HH: medical supplies). Base benchmark: Contraceptive counseling, contraceptive supplies (oral, injectable, implants, transdermal, condoms), fitting, insertion, implantation, or removal of the contraception, voluntary sterilization. Non-covered reversal of voluntary sterilization. No service limitations

Base Benchmark Benefit that was Substituted: Allergy care

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the Nevada Medicaid State Plan as EHB1 (physician services, clinics benefit). Base benchmark: no service limitations.

Alternative Benefit Plan

Base Benchmark Benefit that was Substituted: Treatment Therapies

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the Nevada Medicaid State Plan as EHB1 (physicians, clinics, outpatient hospital benefit) and EHB8 (laboratory/x-ray benefits). Base benchmark : no service limitations.

Base Benchmark Benefit that was Substituted: PT, ST, OT, Cognitive therapy

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the Nevada Medicaid State Plan as EHB7 (physical therapy & related services; PT/ST/OT/Cognitive therapy benefit) EHB1 (Outpatient Hospital benefit), EHB5 (BH/SA Outpatient Services benefit). Nevada Medicaid State Plan provides a greater benefit for therapy services due to a lesser service limitations. Cognitive therapy covered under both medical and behavioral therapy. Base benchmark: covers licensed therapist or physician. Non-covers; Maintenance, recreation, education, exercise, and hippotherapy non-covered. Limited to 50 visits per calendar year for, combination of PT, OT, ST.

Base Benchmark Benefit that was Substituted: Hearing svs (testing, tx, supplies)

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the Nevada Medicaid State Plan as EHB1 (physicians, clinics benefit), EHB7 (physical therapy & related services benefit, orthotics and prosthetics: prosthetic devices), EHB8 (laboratory, x-ray benefit). Nevada Medicaid State Plan provides a greater benefit for Hearing Aid services due to no annual expenditure limit. Base benchmark: Annual expenditure amount on hearing aids.

Base Benchmark Benefit that was Substituted: Vision services

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the Nevada Medicaid State Plan as EHB1 (physician services and clinic benefits) EHB 7 (ocular-hardware: eyeglasses benefit). Nevada Medicaid State Plan provides for all medically necessary conditions. Service limitation exceeded through EPSDT. Base benchmark: covers exam related to amblyopia and strabismus for children under age 18. non-covered-routine eye exam and hardware.

Base Benchmark Benefit that was Substituted: Orthopedic and prosthetic devices

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the Nevada Medicaid State Plan as EHB7 (orthotics and prosthetic: prosthetic

device benefit). Nevada Medicaid State Plan provides coverage of orthotics and prosthetics by licensed and Medicare certified/bonded providers. Base benchmark: lifetime limit on wigs as a result of cancer. non-cover over-the-counter orthotics, shoes, arch supports, heal pads/supports.

Base Benchmark Benefit that was Substituted: Durable medical equipment (DME)

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the Nevada Medicaid State Plan as EHB7 (Durable medical equipment: home health care benefit). Nevada Medicaid State Plan provides a greater benefit for DME services due to coverage of bathroom equipment. Providers must be licensed, bonded and Medicare Certified. base benchmark: Annual expenditure amounts on SGD, non-cover bathroom equipment.

Base Benchmark Benefit that was Substituted: Medical Supplies

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the Nevada Medicaid State Plan as EHB7 (medical supplies: home health care benefit). Base benchmark: no limitation.

Base Benchmark Benefit that was Substituted: Home health services

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the Nevada Medicaid State Plan as EHB1 (home health care benefit). Nevada Medicaid State Plan provides a greater benefit for Home health services due to coverage of PT, OT, ST, RT services under home health benefits and lesser service limitations. Base benchmark: service limitations up to 25 visits per calendar year, provider qualifications of RN/LPN, and skilled visit coverage only.

Base Benchmark Benefit that was Substituted: Educational classes and programs

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the Nevada Medicaid State Plan as EHB1 (physician and clinic benefits) and EHB9 (Preventive benefit) as physician services and other practitioners as preventive services, smoking and tobacco cessation, diabetic education, medical nutritional therapy. Base benchmark: non-cover educational classes not listed above.

Base Benchmark Benefit that was Substituted: Surgical Procedures

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the Nevada Medicaid State Plan as EHB3 (inpatient hospital, inpatient hospital: transplant benefit), EHB 1 (physician services, outpatient hospital services, 1905 clinics: under the direction of benefit) and EHB2 (outpatient hospital emergency room services and urgent care clinics benefit). Base benchmark: non covers reversal of voluntary sterilization, standby physician, routine tx of conditions of foot, cosmetic surgery and refractive surgery.

Base Benchmark Benefit that was Substituted: Reconstructive surgery

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the Nevada Medicaid State Plan as EHB3 (inpatient hospital, inpatient hospital: transplant benefit), EHB1 (physician services, outpatient hospital services, 1905 clinics: under the direction of benefit) and EHB2 (outpatient hospital emergency room services and urgent care clinics benefit). Base benchmark: non-covered: cosmetic surgery unless in the case of post mastectomy due to cancer and surgery to correct sexual dysfunction and/or inadequacy.

Base Benchmark Benefit that was Substituted: Oral and maxillofacial surgery

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the Nevada Medicaid State Plan as EHB3 (inpatient hospital), EHB1 (physician services, outpatient hospital services, 1905 clinics: under the direction of benefit) and EHB2 (outpatient hospital emergency room services and urgent care clinics benefit). Covered in physician office, hospital, hospital outpatient, SNF, ASC center. Base benchmark: dental/orthodontic care only covered for accidental injuries.

Base Benchmark Benefit that was Substituted: Anesthesia

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the Nevada Medicaid State Plan as EHB3 (inpatient hospital, inpatient hospital: transplant benefit) EHB1 (physician services, outpatient hospital services, 1905 clinics: under the direction of benefit) and EHB2 (outpatient hospital emergency room services benefit). Base benchmark: Covered by qualified healthcare professionals in hospital (inpatient, outpatient), skilled nursing facility, ambulatory surgical center and office. No service limitations.

Base Benchmark Benefit that was Substituted: Inpatient hospital

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the Nevada Medicaid State Plan as EHB3 (inpatient hospital, inpatient hospital: transplant, inpatient hospital: skilled/admin days benefit) and EHB4 (inpatient hospital: maternity

and free-standing birthing center benefit) as inpatient hospital services. Base benchmark services covers operating, recover, maternity, and other treatment rooms. Prescribed drugs, Diagnostic studies, radiology, lab, pathology and supplies. : non-covered - nursing homes, extended care facilities, schools, residential treatment centers, private duty nursing.

Base Benchmark Benefit that was Substituted: Outpatient hospital and ambulatory surgical center

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the Nevada Medicaid State Plan as EHB1 (Outpatient hospital services benefit) ambulatory services and EHB4 (free-standing birthing center benefit) maternity/newborn care. Base benchmark services covers operating, recovery, and other treatment rooms, free-standing birthing centers, pre-surgical testing performed within one day of surgery. Observation, radiology, diagnostic, supplies, therapies, treatment therapies, and free-standing ASC services. No service limitations.

Base Benchmark Benefit that was Substituted: Hospice Care

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the Nevada Medicaid State Plan as EHB1 (hospice benefit) ambulatory and EHB3 (inpatient hospital benefit) hospitalization. Base benchmark covers home and facility services. Service limited to seven consecutive days for home and 30 consecutive days in facility. Episodes may be reauthorized. Non-covered- homemaker, home health aide.

Base Benchmark Benefit that was Substituted: Ambulance-Emergency

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the Nevada Medicaid State Plan as EHB2 (transportation: emergency benefit) emergency services. Base benchmark covers emergency transport/ambulance with covered hospital inpatient care related to medical emergency and/or covered hospice care. Non-covered: non-emergency transport.

Base Benchmark Benefit that was Substituted: Accidental injury (ER) Medical emergency

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the Nevada Medicaid State Plan as EHB2 (outpatient hospital: emergency room benefit) emergency services. Base benchmark covers inpatient and physician benefits under emergency services. No limitations.

Base Benchmark Benefit that was Substituted: MH/SA professional services

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the Nevada Medicaid State Plan as EHB1 (physician services benefit) EHB5 (MH/SA: partial hospitalization; Intensive outpatient program; outpatient services benefit). Nevada Medicaid State Plan provides a greater benefit for MH/SA rehab services including, day treatment (medical model), BST, PSR and peer support. Base benchmark covers professional services for individual, group therapy, office visits, pharmacotherpy, and psychological testing. Covered in outpatient hospital dept. and inpatient visit. Must be licensed professional. Non-covered: non-licensed professional, marital, family, educational or other counseling services, testing and tx for learning disabilities and mental retardation, applied behavior analysis (ABA) or ABA therapy, services performed or billed by residential treatment centers, schools, halfway houses, residential camps, and light boxes.

Base Benchmark Benefit that was Substituted: MH/SA inpatient hospital or other covered facility

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the Nevada Medicaid State Plan as EHB3 (MH/SA inpatient hospital: substance abuse, inpatient hospital: psychiatric, inpatient hospital: Skilled/Admin days, RTC/Psychiatric Residential Treatment Facilities benefit). Services for individuals age 22-64 are non-covered by Nevada Medicaid in an IMD. Base benchmark covers MH/SA inpatient services. Non-covered: non-licensed professionals, marital, family, educational or other counseling/training services, testing and tx for learning disabilities and mental retardation, applied behavior analysis (ABA) or ABA therapy, services performed or billed by residential treatment centers, schools, halfway houses, residential camps, and light boxes.

Base Benchmark Benefit that was Substituted: MH/SA outpatient hospital or covered facility

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the Nevada Medicaid State Plan as EHB5 (MH/SA: partial hospitalization; intensive outpatient program; outpatient services benefit). Services for individuals age 22-64 are non-covered by Nevada Medicaid in an IMD. Base benchmark covers outpatient hospital, partial hospitalization, facility-based intensive outpatient treatment, diagnostic testing, and psychological testing. Non-covered: non-licensed professionals, marital, family, educational or other counseling/training services, testing and tx for learning disabilities and mental retardation, applied behavior analysis (ABA) or ABA therapy, services performed or billed by residential treatment centers, schools, halfway houses, residential camps, and light boxes.

Base Benchmark Benefit that was Substituted: Prescribed drug benefits

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the Nevada Medicaid State Plan as EHB6 (prescription drug benefit) Pharmacy services. Nevada Medicaid is required to comply with all regulatory requirements of Section 1927 of the Social Security Act. Base benchmark covers a four-tier system to categorize their payment levels for drugs; Tier 1: generic drugs, Tier 2: Preferred brand-name drugs, Tier 3: non-preferred brand-name drugs, and Tier 4: specialty drugs.

Alternative Benefit Plan

Base Benchmark Benefit that was Substituted: Dental benefits

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the Nevada Medicaid State Plan as EHB10 (EPSDT benefit) Pediatric oral services. Nevada Medicaid covers under EPSDT and Dental services. Base benchmark: covers eval, xray, preventive, palliative and extractions. Service limitations- preventive (1/yr), xray (1/3yr)

Base Benchmark Benefit that was Substituted: Transplant benefits

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Covered under the Nevada Medicaid State Plan as EHB2 (hospitalization benefits) and EHB1 (ambulatory benefit). Base benchmark covers bone marrow, stem cell, liver, cornea transplants. Reference Substitution section for additional transplants.

Base Benchmark Benefit that was Substituted: Podiatry

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: covered under the Nevada State Medicaid Plan as EHB1 (podiatry).

Add

Alternative Benefit Plan

☒ 13. Other Base Benchmark Benefits Not Covered

Collapse All ☐

Base Benchmark Benefit not Included in the Alternative Benefit Plan: Adult Dental

Source: Base Benchmark

Remove

Explain why the state/territory chose not to include this benefit:

Adult dental benifit from the base benchmark plan (FEHBP) will not be covered in the ABP.

Add

Alternative Benefit Plan

☒ 14. Other 1937 Covered Benefits that are not Essential Health Benefits — Collapse All ☐

Other 1937 Benefit Provided: Targeted Case Mangement

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Authorization required in excess of limitation

Provider Qualifications: Medicaid State Plan

Amount Limit: 30 hours per month

Duration Limit: n/a

Scope Limit: Seven covered target groups. Seriously Mentally Ill, Emotional Disturbance, Axis I (non SED non SMI), Juvenile Protective Services, Child Welfare, Developmentally Delayed ages 0-3, Mental Retardation and Related Conditions.

Other: n/a

Other 1937 Benefit Provided: Inst. Facility for Individuals w/Intellectual w/D

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: Based upon authorization determination

Duration Limit: none

Scope Limit: Must be certified and comply with all Federal Cond of Participation in 8 areas, including mngt, client protections, facility staffing, active tx services, client behavior and facility practices, healthcare services, physical enviro & dietetic svs.

Other: Institutional Facility for Individuals with Intellectual with Disabilities
Formally ICF/MR

Other 1937 Benefit Provided: Transportation (non-emergency)

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: Dependent upon services

Duration Limit: None

Scope Limit:

NET includes: charter air flight, commercial air, rotary wing, fixed wing, ground ambulance, bus (local and out-of-town), paratransit (private and public), private vehicle and taxi.

Other:

Non-emergency Transportation (NET) services are provided to all Medicaid recipients through the contracted NET broker and must be authorized by the broker.

Remove

Other 1937 Benefit Provided: Dental

Source: Section 1937 Coverage Option Benchmark Benefit Package

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: See below

Duration Limit: None

Scope Limit:

Individuals under the age of 21 Medicaid-eligible for EPSDT benefits receive comprehensive dental care such as periodic and routine dental services needed for restoration of teeth, prevention, and maintenance of dental health.

Other:

Individuals over age 21, Dental services for Medicaid-eligible adults who qualify for full benefits receive emergency extractions, palliative care, and may also be eligible to receive prosthetic care (dentures/partials) under certain guidelines and limitations.

Remove

Other 1937 Benefit Provided: Nursing Facility

Source: Section 1937 Coverage Option Benchmark Benefit Package

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: Based upon level of care screens

Duration Limit: n/a

Scope Limit:

Level of Care assessment to determine appropriateness of NF placement. Options include; NF standard, NF ventilator dependent, Pediatric specialty I/II, and Behaviorally Complex, PASRR I/II screens completed for behavioral health rule out procedures.

Other:

Provide health related care and services on a 24-hour basis to individuals, due to medical disorders, injuries, developmental disabilities, and/or related cognitive and behavioral impairments, exhibit the need for medical, nursing, rehab, psychosocial, management.

Other 1937 Benefit Provided: Optometrist

Alternative Benefit Plan

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Authorization required in excess of limitation

Provider Qualifications:
Medicaid State Plan

Amount Limit:
One exam per 12 months

Duration Limit:
n/a

Scope Limit:
n/a

Other:
Ophthalmologist no limit for medical condition, no PA under physician visit. Ocular exam for medical exam by optometrist do not require PA, ICD9 required. (glaucoma, diabetes, follow up from cataract surgery, EPSDT referral)

Other 1937 Benefit Provided:
Peer Support Services: Rehab (1905)

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Authorization required in excess of limitation

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Rehab interventions to restore recipient to highest level of functioning through peer supporters.

Other:
Mental health rehab service based upon an the assessed needs of the recipient based upon standardized assessments. The service has been standardized to a utilization system based upon a level of care placement system specific to children and adults.

Other 1937 Benefit Provided:
Basic Skills/Psychosocial Rehab: Rehab (1905)

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Authorization required in excess of limitation

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
BST services help recipients acquire (learn) constructive cognitive and behavioral skills through positive reinforcement modeling, operant condition and other techniques. PSR target psychological functioning within a variety of social settings.

Other:

Mental health rehab services based upon an the assessed needs of the recipient based upon standardized assessments. The service has been standardized to a utilization system based upon a level of care placement system specific to children and adults.

Remove

Other 1937 Benefit Provided: Respiratory Therapy

Source: Section 1937 Coverage Option Benchmark Benefit Package

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Medically necessary therapy services for an illness or injury resulting in functional limitations which can respond or improve as a result of the prescribed therapy treatment plan in a reasonable, predictable period of time.

Other:

n/a

Remove

Other 1937 Benefit Provided: Tobacco-cessation for Pregnant Women

Source: Section 1937 Coverage Option Benchmark Benefit Package

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

Services provided according to the USPSTF.

Other:

No prior authorization required.

Remove

Other 1937 Benefit Provided: OLP - Community Paramedicine

Source: Section 1937 Coverage Option Benchmark Benefit Package

Authorization: Other

Provider Qualifications: Medicaid State Plan

Alternative Benefit Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Community paramedicine services are delivered according to a recipient-specific plan of care under the supervision of a Nevada-licensed primary care provider's care plan.

Other:

No prior authorization required.

Add

Alternative Benefit Plan

☐ 15. Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.)

Collapse All ☐

PRA Disclosure Statement

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 0938-1148. The time required to complete this information collection is estimated to average 5 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.

V.20160722

Alternative Benefit Plan

State Name: Nevada

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: NV - 19 - 004

OMB Expiration date: 10/31/2014

Benefits Assurances — ABP7

EPSDT Assurances

If the target population includes persons under 21, please complete the following assurances regarding EPSDT. Otherwise, skip to the Prescription Drug Coverage Assurances below.

The alternative benefit plan includes beneficiaries under 21 years of age. Yes

☑ The state/territory assures that the notice to an individual includes a description of the method for ensuring access to EPSDT services (42 CFR 440.345).

☑ The state/territory assures EPSDT services will be provided to individuals under 21 years of age who are covered under the state/territory plan under section 1902(a)(10)(A) of the Act.

Indicate whether EPSDT services will be provided only through an Alternative Benefit Plan or whether the state/territory will provide additional benefits to ensure EPSDT services:

- (●) Through an Alternative Benefit Plan.
- ( ) Through an Alternative Benefit Plan with additional benefits to ensure EPSDT services as defined in 1905(r).

Other Information regarding how ESPDT benefits will be provided to participants under 21 years of age (optional):

The benefit plan is identical to the State Medicaid Plan which includes EPSDT.

Prescription Drug Coverage Assurances

☑ The state/territory assures that it meets the minimum requirements for prescription drug coverage in section 1937 of the Act and implementing regulations at 42 CFR 440.347. Coverage is at least the greater of one drug in each United States Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

☑ The state/territory assures that procedures are in place to allow a beneficiary to request and gain access to clinically appropriate prescription drugs when not covered.

☑ The state/territory assures that when it pays for outpatient prescription drugs covered under an Alternative Benefit Plan, it meets the requirements of section 1927 of the Act and implementing regulations at 42 CFR 440.345, except for those requirements that are directly contrary to amount, duration and scope of coverage permitted under section 1937 of the Act.

☑ The state/territory assures that when conducting prior authorization of prescription drugs under an Alternative Benefit Plan, it complies with prior authorization program requirements in section 1927(d)(5) of the Act.

Other Benefit Assurances

☑ The state/territory assures that substituted benefits are actuarially equivalent to the benefits they replaced from the base benchmark plan, and that the state/territory has actuarial certification for substituted benefits available for CMS inspection if requested by CMS.

☑ The state/territory assures that individuals will have access to services in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Security Act.

Alternative Benefit Plan

- ☑ The state/territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Social Security Act.
- ☑ The state/territory assures that it will comply with the requirement of section 1937(b)(5) of the Act by providing, effective January 1, 2014, to all Alternative Benefit Plan participants at least Essential Health Benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.
- ☑ The state/territory assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.
- ☑ The state/territory assures that it will comply with section 1937(b)(7) of the Act by ensuring that benefits provided to Alternative Benefit Plan participants include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.
- ☑ The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR 431.53.
- ☑ The state/territory assures, in accordance with 45 CFR 156.115(a)(4) and 45 CFR 147.130, that it will provide as Essential Health Benefits a broad range of preventive services including: “A” and “B” services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

PRA Disclosure Statement

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V.20140415

Alternative Benefit Plan

State Name: Nevada

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: NV19 - 004

Service Delivery Systems — ABP8

Provide detail on the type of delivery system(s) the state/territory will use for the Alternative Benefit Plan's benchmark benefit package or benchmark-equivalent benefit package, including any variation by the participants' geographic area.

Type of service delivery system(s) the state/territory will use for this Alternative Benefit Plan(s).

Select one or more service delivery systems:

- [x] Managed care.
  - [x] Managed Care Organizations (MCO).
  - [ ] Prepaid Inpatient Health Plans (PIHP).
  - [x] Prepaid Ambulatory Health Plans (PAHP).
  - [ ] Primary Care Case Management (PCCM).
- [x] Fee-for-service.
- [ ] Other service delivery system.

Managed Care Options

Managed Care Assurance

- [✓] The state/territory certifies that it will comply with all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, in providing managed care services through this Alternative Benefit Plan. This includes the requirement for CMS approval of contracts and rates pursuant to 42 CFR 438.6.

Managed Care Implementation

Please describe the implementation plan for the Alternative Benefit Plan under managed care including member, stakeholder, and provider outreach efforts.

The State's managed care organizations (MCO) are modifying their systems edits to allow for the payment of claims based on the ABP. The plans are using a combination of USPS mail, email; web announcements and FAX blasts to confirm for providers that they will provide these benefits. Recipients and stakeholders are being notified by those same methods as well as personal contact at meetings and health fairs. MCO implementation will follow the same time lines as fee for service.

MCO: Managed Care Organization

The managed care delivery system is the same as an already approved managed care program. Yes

The managed care program is operating under (select one):

- ○ Section 1915(a) voluntary managed care program.
- ○ Section 1915(b) managed care waiver.
- ◉ Section 1932(a) mandatory managed care state plan amendment.
- ○ Section 1115 demonstration.
- ○ Section 1937 Alternative (Benchmark) Benefit Plan state plan amendment.

Alternative Benefit Plan

Identify the date the managed care program was approved by CMS: June 12, 2012

Describe program below:

The DHCFP's managed care program currently offers a risk-based capitation rate program operated through contracts with Managed Care Organizations (Vendors). DHCFP contracts with Vendors to provider covered medically necessary services for eligible recipients at an established risk-based capitation rate.
Enrollment in a managed care organization is mandatory for FMC/TANF/CHAP recipients as well as the new Medicaid Adult Group (effective January 1, 2014, when there is more than one managed care option from which to choose in a particular geographic service area. Managed care enrollment is mandatory for all CHIP recipients when an option is available in their service area.
Recipients who are SED/SMI or Indian Health may opt out of managed care.

Additional Information: MCO (Optional)

Provide any additional details regarding this service delivery system (optional):

PAHP: Prepaid Ambulatory Health Plan

The managed care delivery system is the same as an already approved managed care program. Yes

The managed care program is operating under (select one):

- ○ Section 1915(a) voluntary managed care program.
- ◉ Section 1915(b) managed care waiver.
- ○ Section 1115 demonstration.
- ○ Section 1937 Alternative (Benchmark) Benefit Plan state plan amendment.

Identify the date the managed care program was approved by CMS: January 1, 2018

Describe program below:

The Dental Benefits Administrator (DBA) is intended to strengthen Nevada's dental program by enhancing network access to quality dental and specialty providers, monitoring and encouraging appropriate dental utilization and to promote effective dental program integrity activities. The DBA is designed as a single PAHP provider serving urban Washoe and Clark counties. The PAHP will be paid on a risk basis.

Additional Information: PAHP (Optional)

Provide any additional details regarding this service delivery system (optional):

Fee-For-Service Options

Indicate whether the state/territory offers traditional fee-for-service and/or services managed under an administrative services organization:

- ◉ Traditional state-managed fee-for-service
- ○ Services managed under an administrative services organization (ASO) arrangement

Please describe this fee-for-service delivery system, including any bundled payment arrangements, pay for performance, fee-for-service care management models/non-risk, contractual incentives as well as the population served via this delivery system.

The FFS delivery are is in the rural region of the state for New Eligibles, TANF/CHAP, and MABD. MABD is in the urban areas of

Washoe County and Clark County. The services covered for the FFS will be identical to the Medicaid State Plan.

Additional Information: Fee-For-Service (Optional)

Provide any additional details regarding this service delivery system (optional):

PRA Disclosure Statement

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V.20160722

Alternative Benefit Plan

State Name: Nevada

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: NV - 19 - 004

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.)

PRA Disclosure Statement

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V.20160722

Alternative Benefit Plan

State Name: Nevada

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: NV - 19 - 004

OMB Expiration date: 10/31/2014

General Assurances — ABP10

Economy and Efficiency of Plans

☑ The state/territory assures that Alternative Benefit Plan coverage is provided in accordance with Federal upper payment limit requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

Economy and efficiency will be achieved using the same approach as used for Medicaid state plan services. Yes

Compliance with the Law

☑ The state/territory will continue to comply with all other provisions of the Social Security Act in the administration of the state/ territory plan under this title.

☑ The state/territory assures that Alternative Benefit Plan benefits designs shall conform to the non-discrimination requirements at 42 CFR 430.2 and 42 CFR 440.347(e).

☑ The state/territory assures that all providers of Alternative Benefit Plan benefits shall meet the provider qualification requirements of the Base Benchmark Plan and/or the Medicaid state plan.

PRA Disclosure Statement

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V.20140415

Alternative Benefit Plan

State Name: Nevada

Attachment 3.1-L-

OMB Control Number: 0938-1148

Transmittal Number: NV - 19 - 004

OMB Expiration date: 10/31/2014

Payment Methodology — ABP11

Alternative Benefit Plans - Payment Methodologies

☑ The state/territory provides assurance that, for each benefit provided under an Alternative Benefit Plan that is not provided through managed care, it will use the payment methodology in its approved state plan or hereby submits state plan amendment Attachment 4.19a, 4.19b or 4.19d, as appropriate, describing the payment methodology for the benefit.

An attachment is submitted.

PRA Disclosure Statement

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V.20140415

Medicaid Administration

State Name: Nevada

OMB Control Number: 0938-1148

Transmittal Number: NV - 14 - 0006

Expiration date: 10/31/2014

State Plan Administration Designation and Authority — A1

42 CFR 431.10

Designation and Authority

State Name: Nevada

As a condition for receipt of Federal funds under title XIX of the Social Security Act, the single state agency named below submits the following state plan for the medical assistance program, and hereby agrees to administer the program in accordance with the provisions of this state plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Department.

Name of single state agency: The Department of Health and Human Services (DHHS)

Type of Agency:

- ○ Title IV-A Agency
- ○ Health
- ○ Human Resources
- ◉ Other

Type of Agency: Health and Title IV-A Agency

The above named agency is the single state agency designated to administer or supervise the administration of the Medicaid program under title XIX of the Social Security Act. (All references in this plan to "the Medicaid agency" mean the agency named as the single state agency.)

The state statutory citation for the legal authority under which the single state agency administers the state plan is:

Chapter 422 of the Nevada Revised Statutes, as amended

The single state agency supervises the administration of the state plan by local political subdivisions.

○ Yes ◉ No

☑ The certification signed by the state Attorney General identifying the single state agency and citing the legal authority under which it administers or supervises administration of the program has been provided.

An attachment is submitted.

The state plan may be administered solely by the single state agency, or some portions may be administered by other agencies.

The single state agency administers the entire state plan under title XIX (i.e., no other agency or organization administers any portion of it).

○ Yes ◉ No

☒ Waivers of the single state agency requirement have been granted under authority of the Intergovernmental Cooperation Act of 1968.

The waivers are still in effect.

◉ Yes ○ No

Enter the following information for each waiver:

Remove

Date waiver granted (MM/DD/YY): 04/23/15

The type of responsibility delegated is (check all that apply):

☐ Determining eligibility

☒ Conducting fair hearings

☐ Other

Name of state agency to which responsibility is delegated:

Department of Administration (DOA)

Describe the organizational arrangement authorized, the nature and extent of responsibility for program administration delegated to the above named agency, and the resources and/or services of such agency to be utilized in administration of the plan:

The DHHS, through an interlocal contract between its Division of Health Care Financing and Policy (DHCFP) and the Department of Administration Appeals Office (DOA), delegates its authority to conduct beneficiary fair hearings and issue final fair hearing decisions for Medicaid covered services and provider fair hearings for claims, re-coupments and enrollment issues to the DOA. The Interlocal Contract also defines the respective relationship between the DHCFP and the DOA including implementation of 42 CFR section 431, subpart E; Chapter 3100 of the Nevada Medicaid Services Manual, all other applicable provisions and any quality control and oversight that is planned.

The DOA agrees to conduct scheduled impartial administrative hearings for individuals who request a fair hearing and for whom DHCFP is not able to resolve their issue during an informal resolution process. Generally fair hearing requests are received by DHCFP and DHCFP informs DOA of the cases that should be scheduled for a hearing. A beneficiary has 90 calendar days from the date of the notice of decision to request a fair hearing.

The methods for coordinating responsibilities among the agencies involved in administration of the plan under the alternate organizational arrangement are as follows:

The DHHS through the DHCFP will ensure that every applicant and beneficiary is informed, in writing, of the fair hearing process and how to contact both the DHCFP and the DOA. The DHHS retains oversight of the State Plan, the development and issuance of policies, rules, and regulations on program matters; and will establish a process to monitor the entire appeals process, including the quality and accuracy of the final decisions made by the DOA. DHHS will ensure that the Department of Administration complies with all Medicaid related federal and state laws, regulations and policies in the completion of the fair hearing.

Add

☐ The agency that administers or supervises the administration of the plan under Title X of the Act as of January 1, 1965, has been separately designated to administer or supervise the administration of that portion of this plan related to blind individuals.

The entity or entities that have responsibility for determinations of eligibility for families, adults, and for individuals under 21 are:

- [x] The Medicaid agency
- [ ] Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- [ ] An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act

The entity that has responsibility for determinations of eligibility for the aged, blind, and disabled are:

- [x] The Medicaid agency
- [ ] Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- [ ] An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- [ ] The Federal agency administering the SSI program

The entity or entities that have responsibility for conducting fair hearings with respect to denials of eligibility based on the applicable modified adjusted gross income standard are:

- [x] Medicaid agency
- [ ] An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- [ ] An Exchange appeals entity, including an entity established under section 1411(f) of the Affordable Care Act

The agency has established a review process whereby the agency reviews appeals decisions made by the Exchange or Exchange appeals entity or other state agency, but only with respect to conclusions of law, including interpretations of state or federal policies.

○ Yes ◉ No

State Plan Administration
Organization and Administration

A2

42 CFR 431.10
42 CFR 431.11

Organization and Administration

Provide a description of the organization and functions of the Medicaid agency.

The Nevada Department of Health and Human Services (DHHS) is the single state agency responsible for administering or supervising the administration of the Medicaid program under title XIX of the Social Security Act. The DHHS, through its Divisions, is responsible for all the Medicaid (title XIX) and Nevada Check Up (title XXI, the Children's Health Insurance Program) eligibility decisions and the fair hearings for eligibility. The Division of Health Care Financing and Policy (DHCFP), a Division of DHHS administers the Medicaid and Nevada Check Up state plans, including the rates and medical benefit plans, the 1915 (c) and 1115 waiver programs. The DHCFP manages the Fee for Service Benefit plan, the Managed Care Organizations, program compliance activities and the program's budget and fiscal operations. The Division of Welfare and Supportive Services (DWSS) a Division of DHHS completes the eligibility functions, including the fair hearings for eligibility for the following groups: Parents and other caretaker relatives, Pregnant women, Infants and children under age 19, Adult group, Former foster care children, Breast and cervical cancer, Targeted low income children, Emergency assistance for non-qualified non-citizens, Aged, blind and disabled, SSI, State institutional, Public law, Disabled children cared for at home, Home and community based waivers, Health insurance for work advancement, Medicare savings program. These two functions, though completed by the same agency, fall under two distinct program units and program chiefs. The eligibility determination function is located in the Program and Field Operations Unit

within the Eligibility and Payments section and the fair hearing function is located in the Program Review and Evaluation Unit, which reports directly to the Administrator. The Division of Child and Family Services (DCFS), Nevada's child welfare agency and also a division of DHHS completes the eligibility functions, including the fair hearings for eligibility for the following groups:Title IV-E Eligible Foster Care Children, Non-Title IV-E Eligible Foster Care Children, Foster Care Children Receiving Supplemental Security Income (SSI), Children born to a Medicaid eligible minor parent in foster care, Title IV-E Eligible Children for whom there is a Nevada adoption assistance agreement, Title IV-E Eligible Children for whom there is an adoption assistance agreement from another state, Non-Title IV-E Children for whom there is an Adoption Assistance Agreement, Children born to a Medicaid Eligible adopted minor parent and Children who have Aged Out of Foster Care. The eligibility determination function is located in the Fiscal Unit which is part of the Agency's Administrative Unit, reporting the agency deputy administrator and the fair hearing function completed by the Systems Advocate reports directly to the Agency Administrator. The Aging and Disability Service Division (ADSD) operates two of Nevada's Three 1915 (c) waiver programs, The Home and Community Based Waiver for the Frail Elderly, and the Home and Community Based Waiver for Individuals with Intellectual Disabilities and Related Conditions. The DHCFP operates the third 1915 (c) waiver, the Home and Community Based Waiver for Individuals with Physical Disabilities. All Divisions, including the Division of Public and Behavioral Health work closely with the DHCFP in the development and utilization of Medicaid and Nevada Check Up benefit policy.

The DHHS divisions in addition to the functions they complete for the Medicaid or Nevada Check Up programs also complete other health and human services for the state of Nevada. The Division of Aging and Disability Services operates the State funded Regional Centers, serving the intellectually disabled population, the state funded home and community based services for the elderly and the disabled, elder rights services, early intervention services and the Senior and Disability RX program. The Child and Family Service Division operates the State's Child Welfare Services, Juvenile Justice services and facilities and Children's Behavioral Health services and facilities. The Division of Public and Behavioral health completes the public health services including biostatistics and epidemiology, health statics, planning and emergency response, Consumer Health Protection, service and facility licensing (Health Care Quality and Compliance) and adult and rural mental health services. The Division of Welfare and Supportive Services completes the eligibility and payment for Nevada's public assistance programs as well as child support enforcement and child care programs.

Upload an organizational chart of the Medicaid agency.

An attachment is submitted.

Provide a description of the structure of the state's executive branch which includes how the Medicaid agency fits in with other health, human service and public assistance agencies.

The Department of Health and Human Services (DHHS) is the single state agency responsible for administering or supervising the administration of the Medicaid program under title XIX of the Social Security Act. DHHS is a Cabinet Level Agency that administers Nevada's health and human services and public assistance agencies. The DHHS and the Department of Administration (DOA) are two separate departments under the Nevada State Executive Branch of the Government. The Hearings Division is a division of the Nevada Department of Administration and was established to provide an independent appeals process for workers compensations, Victims of Crime Program appeal, and a variety of state agency administrative hearings, including Medicaid and Nevada Check Up.

Entities that determine eligibility other than the Medicaid Agency (if entities are described under Designation and Authority)

Remove

Type of entity that determines eligibility:

- ○ Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- ○ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- ○ The Federal agency administering the SSI program

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

Add

Entities that conduct fair hearings other than the Medicaid Agency (if are described under Designation and Authority)

Remove

Type of entity that conducts fair hearings:

- ○ An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- ○ An Exchange appeals entity, including an entity established under section 1411(f) of the Affordable Care Act

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

Add

Supervision of state plan administration by local political subdivisions (if described under Designation and Authority)

Is the supervision of the administration done through a state-wide agency which uses local political subdivisions?

○ Yes ○ No

State Plan Administration Assurances | A3

42 CFR 431.10
42 CFR 431.12
42 CFR 431.50

Assurances

- [x] The state plan is in operation on a statewide basis, in accordance with all the requirements of 42 CFR 431.50.
- [x] All requirements of 42 CFR 431.10 are met.
- [x] There is a Medical Care Advisory Committee to the agency director on health and medical services established in accordance with meeting all the requirements of 42 CFR 431.12.
- [x] The Medicaid agency does not delegate, to other than its own officials, the authority to supervise the plan or to develop or issue policies, rules, and regulations on program matters.

Assurance for states that have delegated authority to determine eligibility:

- [ ] There is a written agreement between the Medicaid agency and the Exchange or any other state or local agency that has been delegated authority to determine eligibility for Medicaid eligibility in compliance with 42 CFR 431.10(d).

Assurances for states that have delegated authority to conduct fair hearings:

- ☐ There is a written agreement between the Medicaid agency and the Exchange or Exchange appeals entity that has been delegated authority to conduct Medicaid fair hearings in compliance with 42 CFR 431.10(d).
- ☐ When authority is delegated to the Exchange or an Exchange appeals entity, individuals who have requested a fair hearing are given the option to have their fair hearing conducted instead by the Medicaid agency.

Assurance for states that have delegated authority to determine eligibility and/or to conduct fair hearings:

- ☐ The Medicaid agency does not delegate authority to make eligibility determinations or to conduct fair hearings to entities other than government agencies which maintain personnel standards on a merit basis.

PRA Disclosure Statement

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V.20141203

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Attachment 1.1-A

MEDICAL ASSISTANCE PROGRAM

State of Nevada

ATTORNEY GENERAL'S CERTIFICATION

I certify that:

The Nevada Department of Health and Human Services (DHHS) is the single State agency responsible for:

☒ Administering the Plan

The legal authority under which the agency administers the plan on a Statewide basis is:

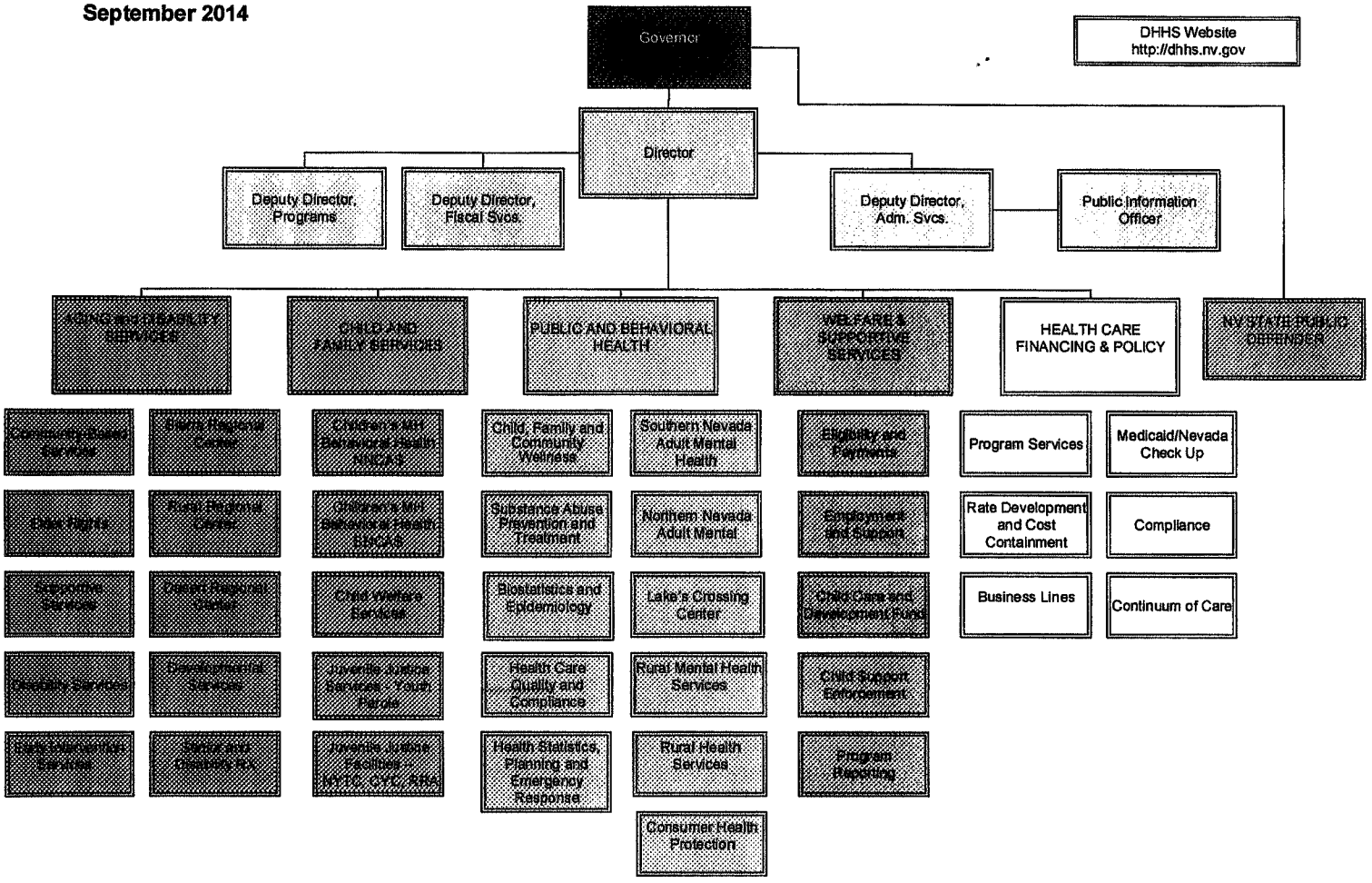
Chapter 422 of the Nevada Revised Statues, as amended
(statutory citation)

Adam Laxalt, Attorney General

9/29/15
Date

DEPARTMENT OF HEALTH AND HUMAN SERVICES

September 2014



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SUPERSEDING PAGES OF STATE PLAN MATERIAL		
TRANSMITTAL NUMBER: NV 14-0006	**STATE:** Nevada	
PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	**COMPLETE PAGES SUPERSEDED:**	**PARTIAL PAGES SUPERSEDED:**
A1 – A3	Page 1 Section 1.1 (pages 2-6) Section 1.2 (page 7) Section 1.3 (page 8) Attachment 1.1-A (Attorney General certification) Attachment 1.2-A Attachment 1.2-B (Description of the functions of the single state agency) Attachment 1.2-C (Description of professional medical and supporting staff)	Section 1.4 (page 9)(State Medical Care Advisory Committee only. Tribal consultation will remain in the state plan.)

State: NEVADA

Citation	1.4 State Medical Care Advisory Committee
42 CFR 431.12(b) AT-78-90	There is an advisory committee to the Medicaid agency director on health and medical care services established in accordance with and meeting all the requirements of 42 CFR 431.12.
42 CFR	☒ The State enrolls recipients in MCO, PIHP, PAHP and/or 438.104 PCCM programs. The State assures that it complies with 42 CFR 438.104(c) to consult with the Medical Care Advisory Committee in the review of marketing materials.

Tribal Consultation Requirements

Section 1902(a)(73) of the Social Security Act (the Act) requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular, ongoing bases from designees of Indian health programs, whether operated by the Indian Health Service (IHS), Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), or Urban Indian Organizations under the Indian Health Care Improvement Act (IHCIA). Section 2107(e)(I) of the Act was also amended to apply these requirements to the Children's Health Insurance Program (CHIP). Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

Nevada Consultation Process

The Department of Health and Human Services (DHHS), Tribes, Indian Health Service, Tribal and Urban Indian Organizations (I/T/U) residing within of the State of Nevada created a Tribal Consultation Process. The Tribal Consultation Process was signed and became effective March 2010. Below is a summary of the process for the Tribal Consultation Process:

Purpose - The purpose of the agreement is to establish an open and meaningful consultation process between the Nevada Department of Health and Human Services and the Indian Tribes in the State of Nevada to facilitate better communication and collaboration between the entities.

Agreement - The guiding principle of the agreement is to ensure that open and meaningful communication occurs in a timely manner for consultation between the parties regarding high-level policy changes that significantly impact Indian Tribes in the State of Nevada. Policy changes that significantly impact Indian Tribes refer to actions that have substantial Tribal implications with direct effects on one or more Indian Tribes, on relationship between the State of Nevada and Indian Tribes, or on the distribution of roles on and responsibilities between the State of Nevada and Indian Tribes.

A copy of the tribe-state consultation process can be requested from the Division of Health Care Financing and Policy (DHCFP).

1. *Please describe the process the State uses to seek advice on a regular ongoing basis from federally-recognized tribes, Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects prior to submission to CMS. Please include information about the frequency, inclusiveness and process for seeking such advice.*

Notification Process

In addition to the tribe-state consultation process set forth between DHHS, Tribes, and I/T/Us;

DHCFP will consult with all federally recognized Tribes and I/T/Us within the State of Nevada on all Medicaid state plan amendments, waiver requests, waiver renewals, demonstration project proposals and/or on all matters that relate to Medicaid and CHIP programs.

a. The notification will describe the purpose of the state plan amendment, waiver request, waiver renewal, demonstration project proposal and/or on matter relating to Medicaid and CHIP programs and will include the anticipated impact on Tribal members, Tribes and/or I/T/Us. The description of the impact will not be Tribal member, Tribe and/or I/T/U specific if the impact is similar on all Tribal members, Tribes and/or I/T/Us.
b. The notification will also describe a method for Tribes and/or I/T/Us to provide official written comments and questions within a time-frame that allows adequate time for State analysis, consideration of any issues that are raised and the time for discussion between the State and entities responding to the notification.
c. Tribes and I/T/Us will be provided a reasonable amount of time to respond to the notification. Whereof, thirty (30) days is considered reasonable.
d. In all cases where Tribes and/or I/T/Us request in-person consultation meetings, DHCFP will make these meetings available.
e. The tribe-state consultation process allows for an expedited process for notification of policy changes due to budget cuts prior to changes being implemented. The Centers for Medicare and Medicaid Services (CMS) requires Medicaid state plan amendments, waiver requests and waiver renewals, which fall within this category to have a notification process prior to these documents being submitted to CMS. Due to this, the State is instituting an expedited process which allows for notification to the tribes of at least one-week notice prior to the changes being implemented as agreed upon in the tribe-state consultation process or two weeks prior to the submission of the state plan amendments, waiver requests and/or waiver renewals, whichever date precedes.

2. *Please describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.*

State of Nevada, Department of Health and Human Services (DHHS) Tribal Consultation Process: On August 13, 2009, Michael J. Willden (Director, DHHS), Charles Duarte (Administrator, DHCFP) and John Liveratti (Chief of Compliance, DHCFP) met with representatives from the Indian Health Board of Nevada (IHBN) to begin tribal-state collaboration process discussions. To help facilitate this discussion, IHBN presented a draft of the State of Arizona's tribal-state consultation policy. Based on the outcome of this discussion and Arizona's draft policy, Mary Liveratti (Deputy Director, DHHS) created a draft tribal-state consultation policy. The draft policy was completed on September 15, 2009. Subsequently, the Deputy Director presented the draft policy to the IHBN and DHHS division administrators. On October 7, 2009, a follow-up meeting was convened to discuss the draft policy. Those in attendance were Mary Liveratti, Diane Comeaux (Administrator, Division of Child and Family Services), Romaine Gilliland (Administrator, Division of Welfare

and Supportive Services), Carol Sala (Administrator, Division of Aging and Disability Services), Dr. Luana Ritch (Health Division) and Larry Curley (Indian Health Board Nevada). Resulting from the discussion and input during this meeting, a revised draft was created. On November 10, 2009, a subsequent meeting was convened. Those in attendance were Mary Liveratti, Diane Comeaux, Romaine Gilliland, Carol Sala, Dr. Luana Ritch, Larry Curley, Sherry Rupert (Executive Director, Nevada Indian Commission)[1,] and Darryl Crawford (Executive Director, Inter-Tribal Council of Nevada). Based on agreements established during this meeting, in December 2009, DHHS mailed an explanatory letter (viz., requesting their input) and the draft tribal-state consultation policy to all Federally Recognized Tribes, Inter-Tribal Council of Nevada, Indian Health Services and Tribal and Urban organizations residing within the State of Nevada. Based on feedback from the chairpersons, DHHS developed a final policy. In January 2010, DHHS mailed policy agreement letters, along with the final policy, to all the tribal chairpersons. Tribes were asked to sign and return the letters to DHHS. As of March 31, 2010, DHHS received 11 responses. On March 31, 2010, the Director sent out a memorandum to all of the division administrators, along with the policy, requesting they sign and return the policy agreement letters to DHHS.

Note[1]: The Nevada Indian Commission is codified into the Nevada Revised Statute (NRS 233A – Indian Affairs).

SECTION 2 – COVERAGE AND ELIGIBILITY

Citation		
42 CFR 435.10 and Subpart J	2.1	Application, Determination of Eligibility and Furnishing Medicaid
		(a) The Medicaid agency meets all requirements of 42 CFR Part 435, Subpart J for processing applications, determining eligibility and furnishing Medicaid.

State: Nevada

Citation			
42 CFR 435.914 1902(a)(34) of the Act	2.1(b)	(1)	Except as provided in Items 2.1(b)(2) and (3) below, individuals are entitled to Medicaid services under the plan during the three months preceding the month of application, if they were, or on application would have been, eligible. The effective date of prospective and retroactive eligibility is specified in Attachment 2.6-A.
1902(e)(8) and 1905(a) of the Act		(2)	For individuals who are eligible for Medicare cost-sharing expenses as qualified Medicare beneficiaries under Section 1902(a)(10)(E)(i) of the Act, coverage is available for services furnished after the end of the month which the individual is first determined to be a qualified Medicare beneficiary. Attachment 2.6-A specifies the requirements for determination of eligibility for this group.
1902(a)(47) and		(3)	Pregnant women are entitled to ambulatory prenatal care under the plan during a presumptive eligibility period in accordance with Section 1920 of the Act. Attachment 2.6-A specifies the requirements for determination of eligibility for this group.

State: Nevada

Citation		
1902(a)(55) of the Act	2.1(d)	The Medicaid agency has procedures to take applications, assist applicants and perform initial processing of applications from those low income pregnant women, infants and children under age 19, described in Section 1902(a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII) and (a)(10)(A)(ii)(IX) at locations other than those used by the title IV-A program including FQHCs and disproportionate share hospitals. Such application forms do not include the ADC from except as permitted by HCFA instructions.

A State qualified Health maintenance Organization (HMO) is an organization which:

(a) Is organized under the laws of the State of Nevada, and is in good standing with the Secretary of State of Nevada;

(b) Is authorized by the Commissioner of Insurance to operate as an HMO in Nevada, and is in good standing with the Commissioner of Insurance;

(c) Is operated primarily for the purpose of providing health care services as defined by 42 CFR 434.20(c)(1);

(d) Meets the requirements of Section 1903(m)(2)(A)(i)-(xi) of Title XIX of the Social Security Act;

(e) Ensures all providers and facilities employed by it will be properly licensed or certified by the appropriate agency(ies) and will be in good standing with the Medicaid and Medicare programs where appropriate;

(f) Is in conformance with 42 CFR 434.20(c)(2), assures the services it provides to its Medicaid participants are as accessible to them as those services are to the non-enrolled Medicaid recipients within the services area;

(g) Makes provisions, satisfactory to the State Medicaid agency, against risk of insolvency and assures that Medicaid participants will not be liable for the Health Maintenance Organizations debt if it becomes insolvent in conformance with 42 CFR 434.20(c)(3); and

(h) Is in conformance with 42 CFR 434.26.

State: Nevada

Citation
42 CFR
435.10

2.2 Coverage and Conditions of Eligibility

Medicaid is available to the groups specified in ATTACHMENT 2.2-A.

___ Mandatory categorically needy and other required special groups only.

___ Mandatory categorically needy, other required special groups, and the medically needy, but no other optional groups.

XX_ Mandatory categorically needy, other required special groups, and specified optional groups.

___ Mandatory categorically needy, other required special groups, specified optional groups, and the medically needy.

The conditions of eligibility that must be met are specified in ATTACHMENT 2.6-A.

All applicable requirements of 42 CFR Part 435 and Sections 1902(a)(10)(A)(i)(IV), (V), and (VI), 1902(a)(10)(A)(ii)(XI), 1902(a)(10)(E), 1902(l) and (m), 1905(p), (q) and (s), 1920, and 1925 of the Act are met.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEVADA

GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

Agency*	Citation(s)	Groups Covered

The following groups are covered under this plan.

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups

42 CFR 435.110 1. Recipients of AFDC

The approved State AFDC plan includes:

XX Families with an unemployed parent for the mandatory six-month period and an optional extension of 0 months.

XX Pregnant women with no other eligible children.

XX AFDC children age 18 who are full-time students in a secondary school or in the equivalent level of vocational or technical training.

The standard for AFDC payments is listed in Supplement 1 of ATTACHMENT 2.6-A.

42 CFR 435.115 2. Deemed Recipients of AFDC

a. Individuals denied a title IV-A cash payment solely because the amount would be less than $10.

*Agency that determines eligibility for coverage. If you do not have sufficient space allotted under "Agency" designation column for the States to specify the name of the agency designated to determine eligibility, specify the name of the agency under the citation.

State: NEVADA

Agency* Citation(s)	Groups Covered
	A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
	2. Deemed Recipients of AFDC.
42 CFR 435.115, 408(a)(11)(B), 1931(c)(1), and 1902(a)(10)(A)(i)(l) of the Act	d. An assistance unit deemed to be receiving AFDC for a period of four calendar months because the family becomes ineligible for AFDC as a result of collection or increased collection of support and meets the requirements of Section 408(a)(11)(B) and 1931(c)(1) of the Act.
42 CFR 435.145, 1902(a)(10)(A)(i)(l) 473(b)of the Act	e. Individuals deemed to be receiving AFDC who meet the requirements of Section 473(b) of the Act for whom an adoption assistance agreement is in effect and or foster care maintenance payments or kinship guardianship assistance payments are being made under title IV-E of the Act.

*Agency that determines eligibility for coverage.

State: NEVADA

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
	407(b), 1902 (a)(10)(A)(i) and 1905(m)(1) of the Act	3. Qualified Family Members Effective October 1, 1990, qualified family members who would be eligible to receive AFDC under Section 407 of the Act because the principal wage earner is unemployed. ___ Qualified family members are not included because cash assistance payments may be made to families with unemployed parents for 12 months per calendar year.
	1902(a)(52) and 1925 of the Act	4. Families terminated from AFDC solely because of earnings, hours of employment, or loss of earned income disregards entitled up to twelve months of extended benefits in accordance with Section 1925 of the Act. (This provision expires on September 30, 1998.)

*Agency that determines eligibility for coverage.

State: NEVADA

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
	42 CFR 435.113	5. Individuals who are ineligible for AFDC solely because of eligibility requirements that are specifically prohibited under Medicaid. Included are:
		a. Families denied AFDC solely because of income and resources deemed to be available from--
		(1) Stepparents who are not legally liable for support of stepchildren under a State law of general applicability;
		(2) Grandparents;
		(3) Legal guardians; and
		(4) Individual alien sponsors (who are not spouses of the individual or the individual's parent);
		b. Families denied AFDC solely because of the involuntary inclusion of siblings who have income and resources of their own in the filing unit.
		c. Families denied AFDC because the family transferred a resource without receiving adequate compensation.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

42 CFR 435.114

6. Individuals who would be eligible for AFDC except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972.

X Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan).

X Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State's August 1972 plan).

N/A ___ Not applicable with respect to intermediate care facilities; State did or does not cover this service.

1902(a)(10)(A)(i)(III) and 1905(n) of the Act

7. Qualified Pregnant Women and Children.

a. A pregnant woman whose pregnancy has been medically verified who--

(1) Would be eligible for an AFDC cash payment or who would be eligible if the State had an AFDC-unemployed parents' program if the child had been born and was living with her;

*Agency that determines eligibility for coverage.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEVADA

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)	Groups Covered
	A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
	7.a. (2) Is a member of a family that would be eligible for aid to families with dependent children of unemployed parents if the State had an AFDC-unemployed parents' program; or
	(3) Would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.
1902(a)(10)(A)(i)(III) and 1905(n) of the Act	b. Children born after September 30, 1983 who are under age 19 and who would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.
	___ Children born after (specify optional earlier date) who are under age 19 and who would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEVADA

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)	Groups Covered
	A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
1902(a)(10)(A)(i)(IV) and 1902(l)(l)(A) and (B) of the Act	8. Pregnant women and infants under 1 year of age with family incomes up to 133% of the Federal poverty level who are described in Section 1902(a)(10)(A)(i)(IV) and 1902(l)(l)(A) and (B) of the Act. The income level for this group is specified in Supplement 1 to ATTACHMENT 2.6-A. N/A The State uses a percentage greater than 133 but not more than 185% of the Federal poverty level, as established in its State plan, State legislation, or State appropriations as of December 19, 1989.
	9. Children:
1902(a)(10)(A)(i)(VI) 1902(l)(1)(C) of the Act	a. who have attained 1 year of age but have and not attained 6 years of age, with family incomes at or below 133% of the Federal poverty levels.
1902(a)(10)(A)(i)(VII) and 1902(l)(1)(D) of the Act	b. born after September 30, 1983, who have attained 6 years of age but have not attained 19 years of age, with family incomes at or below 100% of the Federal poverty levels.
	Income levels for these groups are specified in Supplement 1 to ATTACHMENT 2.6A.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEVADA

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)	Groups Covered
	A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
1902(a)(10)(A)(i)(V) and 1905(m) of the Act	10. Individuals other than qualified pregnant women and children under item A.7. above who are members of a family that would be receiving AFDC under Section 407 of the Act if the State had not exercised the option under Section 407(b)(2)(B)(i) of the Act to limit the number of months for which a family may receive AFDC.
1902(e)(5) of the Act	11. a. A woman who, while pregnant, was eligible for, applied for and receives Medicaid under the approved State plan on the day her pregnancy ends. The woman continues to be eligible, as though she were pregnant, for all pregnancy-related and postpartum medical assistance under the plan for a 60-day period (beginning on the last day of her pregnancy) and for any remaining days in the month in which the 60th day falls.
1902(e)(6) of the Act	b. A pregnant woman who would otherwise lose eligibility because of an increase in income (of the family in which she is a member) during the pregnancy or the postpartum period which extends through the end of the month in which the 60-day period (beginning on the last day of pregnancy) ends.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEVADA

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)	Groups Covered
	A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
1902(e)(4) of the Act	12. A child born to a woman who is eligible for and receiving Medicaid as categorically needy on the date of the child's birth. The child is deemed eligible for one year from birth as long as the mother remains eligible or would remain eligible if still pregnant and the child remains in the same household as the mother.
42 CFR 435.120	13. Aged, Blind and Disabled Individuals Receiving Cash Assistance
	XX a. Individuals receiving SSI.
	This includes beneficiaries' eligible spouses and persons receiving SSI benefits pending a final determination of blindness or disability or pending disposal of excess resources under an agreement with the Social Security Administration; and beginning January 1, 1981 persons receiving SSI under Section 1619(a) of the Act or considered to be receiving SSI under Section 1619(b) of the Act.
	X Aged X Blind X Disabled

Agency*	Citation(s)			Groups Covered
		A.		Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
435.121 1619(b)(1) of the Act		13. N/A	b.	Individuals who meet more restrictive requirements for Medicaid than the SSI requirements. (This includes persons who qualify for benefits under Section 1619(a) of the Act or who meet the requirements for SSI status under Section 1619(b)(1) of the Act and who met the State's more restrictive requirements for Medicaid in the month before the month they qualified for SSI under Section 1619(a) or met the requirements under Section 1619(b)(1) of the Act. Medicaid eligibility for these individuals continues as long as they continue to meet the 1619(a) Eligibility Standard or the requirements of Section 1619(b) of the Act.) ___ Aged ___ Blind ___ Disabled The more restrictive categorical eligibility criteria are described below:

(Financial criteria are described in ATTACHMENT 2.6-A).

*Agency that determines eligibility for coverage.

State: NEVADA

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
	1902(a)(10)(A)(i)(II) and 1905(q) of the Act	14. Qualified severely impaired blind and disabled individuals under age 65, who--
		a. For the month preceding the first month of eligibility under the requirements of Section 1905(q)(2) of the Act, received SSI, a State supplemental payment under Section 1616 of the Act or under Section 212 of P.L. 93-66 or benefits under Section 1619(a) of the Act and were eligible for Medicaid; or
		b. For the month of June 1987, were considered to be receiving SSI under Section 1619(b) of the Act and were eligible for Medicaid. These individuals must--
		(1) Continue to meet the criteria for blindness or have the disabling physical or mental impairment under which the individual was found to be disabled;
		(2) Except for earnings, continue to meet all nondisability-related requirements for eligibility for SSI benefits;
		(3) Have unearned income in amounts that would not cause them to be ineligible for a payment under Section 1611(b) of the Act;

*Agency that determines eligibility for coverage.

Agency* Citation(s) Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

(4) Be seriously inhibited by the lack of Medicaid coverage in their ability to continue to work or obtain employment; and

(5) Have earnings that are not sufficient to provide for himself or herself a reasonable equivalent of the Medicaid, SSI (including any Federally administered SSP), or public funded attendant care services that would be available if he or she did have such earnings.

N/A Not applicable with respect to individuals receiving only SSP because the State either does not make SSP payments or does not provide Medicaid to SSP-only recipients.

*Agency that determines eligibility for coverage.

State: NEVADA

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
	1619(b)(3) of the Act	N/A The State applies more restrictive eligibility requirements for Medicaid than under SSI and under 42 CFR 435.121. Individuals who qualify for benefits under Section 1619(a) of the Act or individuals described above who meet the eligibility requirements for SSI benefits under Section 1619(b)(1) of the Act and who met the State's more restrictive requirements in the month before the month they qualified for SSI under Section 1619(a) or met the requirements of Section 1619(b)(1) of the Act are covered. Eligibility for these individuals continues as long as they continue to qualify for benefits under Section 1619(a) of the Act or meet the SSI requirements under Section 1619(b)(1) of the Act.

*Agency that determines eligibility for coverage.

State: NEVADA

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
	1634(c) of the Act	15. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, blind or disabled individuals who-- a. Are at least 18 years of age; b. Lose SSI eligibility because they become entitled to OASDI child's benefits under Section 202(d) of the Act or an increase in these benefits based on their disability. Medicaid eligibility for these individuals continues for as long as they would be eligible for SSI, absent their OASDI eligibility. N/A c. The State applies more restrictive eligibility requirements than those under SSI, and part or all of the amount of the OASDI benefit that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility. N/A d. The State applies more restrictive requirements than those under SSI, and none of the OASDI benefit is deducted in determining the amount of countable income for categorically needy eligibility.
	42 CFR 435.122	16. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, individuals who are ineligible for SSI or optional State supplements (if the agency provides Medicaid under '435.230), because of requirements that do not apply under title XIX of the Act.
	42 CFR 435.130	17. Individuals receiving mandatory State supplements.

*Agency that determines eligibility for coverage.

State: NEVADA

Agency*	Citation(s)	Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

42 CFR 435.131

18. Individuals who in December 1973 were eligible for Medicaid as an essential spouse and who have continued, as spouse, to live with and be essential to the well-being of a recipient of cash assistance. The recipient with whom the essential spouse is living continues to meet the December 1973 eligibility requirements of the State's approved plan for OAA, AB, APTD, or AABD and the spouse continues to meet the December 1973 requirements for having his or her needs included in computing the cash payment.

N/A In December 1973, Medicaid coverage of the essential spouse was limited to the following group(s):

___ Aged ___ Blind ___ Disabled

N/A Not applicable. In December 1973, the essential spouse was not eligible for Medicaid.

Agency that determines eligibility for coverage.

State: NEVADA

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
	42 CFR 435.132	19. Institutionalized individuals who were eligible for Medicaid in December 1973 as inpatients of title XIX medical institutions or residents of title XIX intermediate care facilities, if, for each consecutive month after December 1973, they-- a. Continue to meet the December 1973 Medicaid State plan eligibility requirements; and b. Remain institutionalized; and c. Continue to need institutional care.
	42 CFR 435.133	20. Blind and disabled individuals who-- a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria; and b. Were eligible for Medicaid in December 1973 as blind or disabled; and c. For each consecutive month after December 1973 continue to meet December 1973 eligibility criteria.

*Agency that determines eligibility for coverage.

State: NEVADA

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
	42 CFR 435.134	21. Individuals who would be SSI/SSP eligible except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972.
		XX Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan).
		XX Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State's August 1972 plan).
		N/A Not applicable with respect to intermediate care facilities; the State did or does not cover this service.

*Agency that determines eligibility for coverage.

Agency*	Citation(s)	Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

42 CFR 435.135 22. Individuals who --

a. Are receiving OASDI and were receiving SSI/SSP but became ineligible for SSI/SSP after April 1977; and

b. Would still be eligible for SSI or SSP if cost-of-living increases in OASDI paid under Section 215(i) of the Act received after the last month for which the individual was eligible for and received SSI/SSP and OASDI, concurrently, were deducted from income.

N/A Not applicable with respect to individuals receiving only SSP because the State either does not make such payments or does not provide Medicaid to SSP-only recipients.

N/A Not applicable because the State applies more restrictive eligibility requirements than those under SSI.

N/A The State applies more restrictive eligibility requirements than those under SSI and the amount of increase that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.

*Agency that determines eligibility for coverage.

State: NEVADA

Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
	1634 of the Act	23. Disabled widows and widowers who would be eligible for SSI or SSP except for the increase in their OASDI benefits as a result of the elimination of the reduction factor required by Section 134 of Pub. L. 98-21 and who are deemed, for purposes of title XIX, to be SSI beneficiaries or SSP beneficiaries for individuals who would be eligible for SSP only, under Section 1634(b) of the Act.
		N/A Not applicable with respect to individuals receiving only SSP because the State either does not make these payments or does not provide Medicaid to SSP-only recipients.
		N/A The State applies more restrictive eligibility standards than those under SSI and considers these individuals to have income equaling the SSI Federal benefit rate, or the SSP benefit rate for individuals who would be eligible for SSP only, when determining countable income for Medicaid categorically needy eligibility.

*Agency that determines eligibility for coverage.

State/Territory: NEVADA

Agency*	Citation(s)	Groups Covered
	1634(d) of the Act	A. Mandatory Coverage - Categorically Needy and Required Special Groups (Continued)

24. Disabled widows and widowers who would be eligible for SSI except for receipt of early social security disability benefits, who are not entitled to hospital insurance under Medicare Part A and who are deemed, for purposes of title XIX, to be SSI beneficiaries under Section 1634(d)of the Act.

N/A _____ Not applicable with respect to individuals receiving only SSP because the State either does not make these payments or does not provide Medicaid to SSP-only recipients.

N/A ____ Not applicable because the State applies more restrictive eligibility than those under SSI and the State chooses not to deduct any of the benefit that caused SSI/SSP ineligibility subsequent cost-of-living increases.

N/A ____ The State applies more restrictive eligibility requirements than those under SSI and part or all of the amount of the benefit that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.

*Agency that determines eligibility for coverage.

State: NEVADA

Agency*	Citation(s)	Groups Covered
Nevada State Division of Health Care Financing and Policy	A.	Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
l902(a)(l0(E)(i) and 1905(p) of the Act	25.	Qualified Medicare beneficiaries-- a. Who are entitled to hospital insurance benefits under Medicare Part A, (but not pursuant to an enrollment under Section 1818A of the Act); b. Whose income does not exceed 100% of the Federal poverty level; and c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index. (Medical assistance for this group is limited to Medicare cost-sharing as defined in Item 3.2 of this plan.)
1902(a)(10)(E)(ii), 1905(s) and 1905(p)(3)(A)(i) of the Act	26.	Qualified disabled and working individuals-- a. Who are entitled to hospital insurance benefits under Medicare Part A under Section 1818A of the Act; b. Whose income does not exceed 200% of the Federal poverty level; and c. Whose resources do not exceed twice the maximum standard under SSI. d. Who are not otherwise eligible for medical assistance under Title XIX of the Act. (Medical assistance for this group is limited to Medicare Part A premiums under Section 1818A of the Act.)

*Agency that determines eligibility for coverage.

State: NEVADA

Agency*	Citation(s)	Groups Covered
Nevada State Division of Health Care Financing & Policy		
	A.	Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
l902 (a) (l0) (E) (iii) and 1905 (p) (3) (A) (ii) of the Act		27. Specified low-income Medicare beneficiaries-- a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under Section 1818A of the Act); b. Whose income is at least 100% but does not exceed 120% of the Federal Poverty Level; and c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index. (Medical assistance for this group is limited to Medicare Part B premiums under Section 1839 of the Act.)

*Agency that determines eligibility for coverage.

Agency* Citation(s)	Groups Covered
	A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
1902(a)(10)(E)(iv) And 1905(p)(3)(A)(ii) And 1860D-14(a)(3)(D) of the Act.	28. Qualifying Individuals a. Who are entitled to hospital benefits under Medicare Part A (but not pursuant to an enrollment under Section 1818A of the Act); b. Whose income is at least 120% but less than 135% of the Federal Poverty level; c. Whose resources do not exceed three items the SSI resource limit, adjusted annually by the increase in the consumer price index.
1634(e) of the Act	29.a. Each person to whom SSI benefits by reason of disability are not payable for any month solely by reason of clause (i) of (v) of Section 1611(e)(3)(A) shall be treated, for purposes of Title XIX, as receiving SSI benefits for the month. b. The State applies more restrictive eligibility standards than those under SSI. Individuals whose eligibility for SSI benefits are based solely on disability who are not payable for any months solely by reason of clause (i) or (v) of Section 1611(e)(3)(A), and who continue to meet the more restrictive requirements for Medicaid eligibility under the State plan, are eligible for Medicaid as categorically needy.

Agency that determines eligibility for coverage.

Agency*	Citation(s)			Groups Covered
	B. Optional Groups Other Than the Medically Needy			
	42 CFR 435.210 1902(a)(10)(A)(ii) and 1905(a) of the Act	N/A	___ 1.	Individuals described below who meet the income and resource requirements of AFDC, SSI, or an optional State supplement as specified in 42 (10)(A)(ii) and 42 CFR 435.230, but who do not receive cash assistance.
			___	The plan covers all individuals as described above.
			___	The plan covers only the following group or groups of individuals:
				___ Aged ___ Blind ___ Disabled ___ Caretaker relatives ___ Pregnant women
	42 CFR 435.211	XX	2.	Individuals who would be eligible for AFDC, SSI or an optional State supplement as specified in 42 CFR 435.230, if they were not in a medical institution.
			XX	The plan covers only the following group or groups of individuals:
				X Aged X Blind X Disabled

*Agency that determines eligibility for coverage.

State: NEVADA

Agency*	Citation(s)		Groups Covered
		B.	Optional Groups Other Than the Medically Needy (Continued)
42 CFR 435.212 & 1902(e)(2) Act, P.L. 99-272 (Section 9517) P.L.101-508 (Section 4732)	[**N/A**]	3.	The State deems as of the eligible those individuals who became otherwise ineligible for Medicaid while enrolled in an HMO qualified under Title XIII of the Public Health Service Act, or a managed care organization (MCO) or a primary care case management (PCCM) program, but who have been enrolled in the entity for less than the minimum enrollment period listed below. Coverage under this Section is limited to MCO or PCCM services and family planning services described in Section 1905(a)(4)(C) of the Act.
		_**X**_	The State elects not to guarantee eligibility.
		___	The State elects to guarantee eligibility. The minimum enrollment period is _____ months (not to exceed six).
			The State measures the minimum enrollment period from:
			[**N/A**] The date beginning the period of enrollment in the MCO or PCCM, without any intervening disenrollment, regardless of Medicaid eligibility.
			[**N/A**] The date beginning the period of enrollment in the MCO or PCCM as a Medicaid patient (including periods when payment is made under this Section), without any intervening disenrollment.
			[**N/A**] The date beginning the last period of enrollment in the MCO or PCCM as a Medicaid patient (not including periods when payment is made under this section) without any intervening disenrollment or periods of enrollment as a privately paying patient. (A new minimum enrollment period begins each time the individual becomes Medicaid eligible other than under this section).

*Agency that determines eligibility for coverage.

State: NEVADA

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than Medically Needy (Continued)

1932(a)(4) of Act

The Medicaid Agency may elect to restrict the disenrollment of Medicaid enrollees of MCOs, PIHPs, PAHPs, and PCCMs in accordance with the regulations at 42 CFR 438.56. This requirement applies unless a recipient can demonstrate good cause for disenrolling or if he/she moves out of the entity's service area or becomes ineligible.

[**N/A**] Disenrollment rights are restricted for a period of _____months (not to exceed 12 months).

During the first three months of each enrollment period the recipient may disenroll without cause. The State will provide notification, at least once per year, to recipients enrolled with such organization of their right to and restrictions of terminating such enrollment.

[**X**] No restrictions upon disenrollment rights.

1903(m)(2)(H), 1902(a)(52) of the Act
P.L. 101-508
42 CFR 438.56(g)

In the case of individuals who have become ineligible for Medicaid for the brief period described in Section 1903(m)(2)(H) and who were enrolled with an MCO, PIHP, PAHP, or PCCM when they became ineligible, the Medicaid agency may elect to reenroll those individuals in the same entity if that entity still has a contract.

[**X**] The agency elects to reenroll the above individuals who are ineligible in a month but in the succeeding two months become eligible, into the same entity in which they were enrolled at the time eligibility was lost.

[**N/A**] The agency elects not to reenroll above individuals into the same entity in which they were previously enrolled.

* Agency that determines eligibility for coverage.

State/Territory:

Agency*	Citation(s)		Groups Covered
		B.	Optional Groups Other Than the Medically Needy (Continued)
		N/A ____	The date beginning the last period of enrollment in the HMO as a Medicaid patient (not including periods when payment is made under this section), without any intervening disenrollment or periods of enrollment as a privately paying patient. (A new minimum enrollment period begins each time the individual becomes Medicaid eligible other than under this section).
42 CFR 435.217	X	4.	A group or groups of individuals who would be eligible for Medicaid under the plan if they were in a NF or an ICF/MR, who but for the provision of home and community-based services under a waiver granted under 42 CFR Part 441, Subpart G would require institutionalization, and who will receive home and community-based services under the waiver. The group or groups covered are listed in the waiver request. This option is effective on the effective date of the State's Section 1915(c) waiver under which this group(s) is covered. In the event an existing 1915(c) waiver is amended to cover this group(s), this option is effective on the effective date of the amendment.

*Agency that determines eligibility for coverage.

State: NEVADA

Agency*	Citation(s)	Groups Covered
		B. Optional Groups Other Than the Medically Needy (Continued)
	1902(a)(10)(A)(ii)(VII) of the Act	N/A 5. Individuals who would be eligible for Medicaid under the plan if they were in a medical institution, who are terminally ill, and who receive hospice care in accordance with a voluntary election described in Section 1905(o) of the Act. ___ The State covers all individuals as described above. ___ The State covers only the following group or groups of individuals: ___ Aged ___ Blind ___ Disabled ___ Individuals under the age of-- ___ 21 ___ 20 ___ 19 ___ 18 ___ Caretaker relatives ___ Pregnant women

*Agency that determines eligibility for coverage.

State: NEVADA

Agency*	Citation(s)		Groups Covered
			B. Optional Groups Other Than the Medically Needy (Continued)
42 CFR 435.220		N/A	6. Individuals who would be eligible for AFDC if their work-related child care costs were paid from earnings rather than by a State agency as a service expenditure. The State's AFDC plan deducts work-related child care costs from income to determine the amount of AFDC.
		___	The State covers all individuals as described above.
1902(a)(10)(A)(ii) and 1905(a) of the Act		___	The State covers only the following group or groups of individuals: ___ Individuals under the age of-- ___ 21 ___ 20 ___ 19 ___ 18 ___ Caretaker relatives ___ Pregnant women
42 CFR 435.222 1902(a)(10)(A)(ii) and 1905(a)(i) of the Act			7. N/A a. All individuals who are not described in Section 1902(a)(10)(A)(i) of the Act, who meet the income and resource requirements of the AFDC State plan, and who are 21 years of age or younger as indicated below. ___ 20 ___ 19 ___ 18

*Agency that determines eligibility for coverage.

State: NEVADA

Agency*	Citation(s)	Groups Covered
Nevada State Welfare Division	B.	Optional Groups Other Than the Medically Needy (Continued)
42 CFR 435.222	XX b.	Reasonable classifications of individuals described in (a) above, as follows:
	X	(1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are:
	* X	(a) In foster homes (and are under the age of 19).
	* X	(b) In private institutions or psychiatric facilities (and are under the age of 19).
	N/A	(c) In addition to the group under b.(1)(a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies (and are under the age of).
	* X	(2) Individuals in adoptions subsidized in full or part by a public agency (who are under the age of 19).
	* X	(3) Individuals in NFs (who are under the age of 19). NF services are provided under this plan.
	* X	(4) In addition to the group under (b)(3), individuals in ICFs/MR (who are under the age of 19).

*Children who are age 18 must be a full-time student in a secondary school or in the equivalent level of vocational or technical training and must be reasonably expected to complete the program before reaching age 19.

State: NEVADA

Agency*	Citation(s)	Groups Covered
		B. Optional Groups Other Than the Medically Needy (Continued)
	N/A	(5) Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of _____). Inpatient psychiatric services for individuals under age 21 are provided under this plan.
	N/A	(6) Other defined groups (and ages), as specified in Supplement 1 of ATTACHMENT 2.2-A.

*Agency that determines eligibility for coverage.

State: NEVADA

Agency*	Citation(s)	Groups Covered
		B. Optional Groups Other Than the Medically Needy (Continued)
	1902(a)(10)(A)(ii)(VIII) of the Act	XX 8. A child for whom there is in effect a State adoption assistance agreement (other than under title IV-E of the Act), who, as determined by the State adoption agency, cannot be placed for adoption without medical assistance because the child has special needs for medical or rehabilitative care, and who before execution of the agreement-- a. Was eligible for Medicaid under the State's approved Medicaid plan; or b. Would have been eligible for Medicaid if the standards and methodologies of the title IV-E foster care program were applied rather than the AFDC standards and methodologies. The State covers individuals under the age of-- ___ 21 ___ 20 XX 19 ___ 18

*Agency that determines eligibility for coverage.

State: NEVADA

Agency*	Citation(s)		Groups Covered
		B.	Optional Groups Other Than the Medically Needy (Continued)
	42 CFR 435.223	N/A	9. Individuals described below who would be eligible for AFDC if coverage under the State's AFDC plan were as broad as allowed under title IV-A:
	1902(a)(10)(A)(ii) and 1905(a) of the Act	___	Individuals under the age of--
		___	21
		___	20
		___	19
		___	18
		___	Caretaker relatives
		___	Pregnant women

*Agency that determines eligibility for coverage.

State: NEVADA

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.230 XX 10. States using SSI criteria with agreements under Sections 1616 and 1634 of the Act.

The following groups of individuals who receive only a State supplementary payment (but no SSI payment) under an approved optional State supplementary payment program that meets the following conditions. The supplement is--

a. Based on need and paid in cash on a regular basis.

b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.

c. Available to all individuals in the State.

d. Paid to one or more of the classifications of individuals listed below, who would be eligible for SSI except for the level of their income.

X (1) All aged individuals.

X (2) All blind individuals.

N/A (3) All disabled individuals.

*Agency that determines eligibility for coverage.

State: NEVADA

Agency*	Citation(s)		Groups Covered
		B.	Optional Groups Other Than the Medically Needy (Continued)
		N/A	(4) Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.
42 CFR 435.230		N/A	(5) Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.
		N/A	(6) Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.
		XX	(7) Individuals receiving a Federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230.
		N/A	(8) Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230.
		N/A	(9) Individuals in additional classifications approved by the Secretary as follows:

*Agency that determines eligibility for coverage.

State: NEVADA

Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

___ Yes.

XX No.

The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.6-A.

*Agency that determines eligibility for coverage.

State: NEVADA

Agency*	Citation(s)	Groups Covered
		B. Optional Groups Other Than the Medically Needy (Continued)
42 CFR 435.230 435.121, 1902(a)(10) (A)(ii)(XI) of the Act	N/A	11. Section 1902(f) States and SSI criteria States without agreements under Section 1616 or 1634 of the Act. The following groups of individuals who receive a State supplementary payment under an approved optional State supplementary payment program that meets the following conditions. The supplement is-- a. Based on need and paid in cash on a regular basis. b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement. c. Available to all individuals in each classification and available on a Statewide basis. d. Paid to one or more of the classifications of individuals listed below: ___ (1) All aged individuals. ___ (2) All blind individuals. ___ (3) All disabled individuals.

State: NEVADA

Agency*	Citation(s)	Groups Covered
N/A	B.	Optional Groups Other Than the Medically Needy (Continued)

___ (4) Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.

___ (5) Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.

___ (6) Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.

___ (7) Individuals receiving federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230.

___ (8) Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230.

___ (9) Individuals in additional classifications approved by the Secretary as follows:

*Agency that determines eligibility for coverage.

State: NEVADA

Agency* Citation(s) Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

___ Yes

XX No

The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.6-A.

*Agency that determines eligibility for coverage.

State: NEVADA

Agency*	Citation(s)	Groups Covered
		B. Optional Groups Other Than the Medically Needy (Continued)
42 CFR 435.231 1902(a)(10) (A)(ii)(V) of the Act		XX 12. Individuals who are in institutions for at least 30 consecutive days and who are eligible under a special income level. Eligibility begins on the first day of the 30-day period. These individuals meet the income standards specified in Supplement 1 to ATTACHMENT 2.6-A. ___ The State covers all individuals as described above. XX The State covers only the following group or groups of individuals:
1902(a)(10)(A) (ii) and 1905(a) of the Act		X Aged X Blind X Disabled ___ Individuals under the age of-- ___ 21 ___ 20 ___ 19 ___ 18 ___ Caretaker relatives ___ Pregnant women

State: NEVADA

Agency*	Citation(s)	Groups Covered
		B. Optional Groups Other Than the Medically Needy (Continued)
1902(e)(3) of the Act		XX 13. Certain disabled children age 18 or under who are living at home, who would be eligible for Medicaid under the plan if they were in a medical institution, and for whom the State has made a determination as required under Section 1902(e)(3)(B) of the Act. Supplement 3 to ATTACHMENT 2.2-A describes the method that is used to determine the cost effectiveness of caring for this group of disabled children at home.
1902(a)(10)(A)(ii)(IX) and 1902(l) of the Act		N/A 14. The following individuals who are not mandatory categorically needy whose income does not exceed the income level (established at an amount above the mandatory level and not more than 185% of the Federal poverty income level) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size, including the woman and unborn child or infant and who meet the resource standards specified in Supplement 2 to ATTACHMENT 2.6-A: a. Women during pregnancy (and during the 60-day period beginning on the last day of pregnancy); and b. Infants under one year of age.

*Agency that determines eligibility for coverage.

State: NEVADA

Agency*	Citation(s)	Groups Covered
		B. Optional Groups Other Than the Medically Needy (Continued)
1902(a)(10)(A)(ii)(IX) and 1902(1)(1)(D) of the Act		N/A 15. The following individuals who are not mandatory categorically needy, who have income that does not exceed the income level (established at an amount up to 100% of the Federal poverty level) specified in Supplement 1 of ATTACHMENT 2.6-A for a family of the same size. Children who are born after September 30, 1983 and who have attained 6 years of age but have not attained-- ___ 7 years of age; or ___ 8 years of age.

*Agency that determines eligibility for coverage.

State: NEVADA

Agency*	Citation(s)	Groups Covered
		B. Optional Groups Other Than the Medically Needy (Continued)
	1902(a)(ii)(X) and 1902(m)(1) and (3) of the Act	N/A 16. Individuals-- a. Who are 65 years of age or older or are disabled, as determined under Section 1614(a)(3) of the Act. Both aged and disabled individuals are covered under this eligibility group. b. Whose income does not exceed the income level (established at an amount up to 100% of the Federal income poverty level) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size; and c. Whose resources do not exceed the maximum amount allowed under SSI; under the State's more restrictive financial criteria; or under the State's medically needy program as specified in ATTACHMENT 2.6-A.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEVADA

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)	Groups Covered
	B. Optional Groups Other Than the Medically Needy (Continued)
1902(a)(47) and 1920 of the Act	N/A 17. Pregnant women who are determined by a "qualified provider" (as defined in '1920(b)(2) of the Act) based on preliminary information, to meet the highest applicable income criteria specified in this plan under ATTACHMENT 2.6-A and are therefore determined to be presumptively eligible during a presumptive eligibility period in accordance with '1920 of the Act.

State/Territory: NEVADA

Citation	Groups Covered
	B. Optional Groups Other Than the Medically Needy (Continued)
1906 of the Act	N/A 18. Individuals required to enroll in cost-effective employer-based group health plans remain eligible for a minimum enrollment period of _____ months.
1902(a)(10)(F) and 1902(u)(1) of the Act	N/A 19. Individuals entitled to elect COBRA continuation coverage and whose income as determined under Section 1612 of the Act for purposes of the SSI program, is no more than 100% of the Federal poverty level, whose resources are no more than twice the SSI resource limit for an individual, and for whom the State determines that the cost of COBRA premiums is likely to be less than the Medicaid expenditures for an equivalent set of services. See Supplement 11 to Attachment 2.6-A.

STATE: Nevada

Citation		Group Covered
	B.	Optional Coverage Other Than the Medically Needy (Continued)
1902 (a) (10) (A) (ii) (XVIII) of the Act	X [24].	Women who:
	a.	have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under title XV of the Public Health Service Act in accordance with the requirements of Section 1504 of that Act and need treatment for breast or cervical cancer, including a pre-cancerous condition of the breast or cervix;
	b.	are not otherwise covered under creditable coverage, as defined in Section 2701 (c) of the Public Health Service Act;
	c.	are not eligible for Medicaid under any mandatory categorically needy eligibility group; and
	d.	have not attained age 65.
1920B of the Act	X [25].	Women who are determined by a "qualified entity" (as defined in 1920B (b) based on preliminary information, to be a woman described in 1902 (aa) of the Act related to certain breast and cervical cancer patients.

The presumptive period begins on the day that the determination is made. The period ends on the date that the State makes a determination with respect to the woman's eligibility for Medicaid, or if the woman does not apply for Medicaid (or a Medicaid application was not made on her behalf) the last day of the month following the month in

which the determination of presumptive eligibility was made, the presumptive period ends on that last day.

State/Territory:

Citation	Groups Covered

B. Optional Groups Other Than the Medically Needy
(Continued)

1902(a)(10)(A)(ii)(XVII) of the Act and 1905(w)(1) of the Act

☒21. All "Independent foster care adolescents" (as defined in §1905(w)(1) of the Social Security Act)

a) Reasonable classifications of individuals described in (21) above, as follows:

___1) Individuals under the age of
___ 19
___ 20

___2) Individuals to whom foster care maintenance payments or independent living services were furnished under a program funded under part E of title IV before the date the individuals attained 18 years of age.

___ 3) Other (please describe):
_____
_____

b) Financial requirements
1) Income test
_X_ There is no income test for this group.
___ The income test for this group is
_____.
2) Resource test
_X_ There is no resource test for this group.
___ The resource test for this group is
_____.

NOTE:
If there is an income or resource test, then the standards and methodologies used cannot be more restrictive than those used for the State's low-income

families with children eligible under Section 1931 of the Act as specified in Supplement 12 of Attachment 2.6-A.

B. Optional Groups Other Than the Medically Needy

1902(a)(10)(A) (ii) (XIII)of the Act	☐	23.	BBA Work Incentives Eligibility Group – Individuals with a disability whose net family income is below 250% of the Federal poverty level for a family of the size involved and who, except for earned income, meet all criteria for receiving benefits under the SSI program. See page 12c of Attachment 2.6-A.
1902(a)(10)(A) (ii)(XV) of the Act	☒	24.	TWII Basic Coverage Group – Individuals with a disability at least 16 but less than 65 years of age whose income and resources do not exceed a standard established by the state. See page 12d of Attachment 2.6-A.
1902(a)(10)(A) (ii)(XVI) of the Act	☐	25.	TWIIA Medical Improvement Group – Employed individuals at least 16 but less than 65 years of age with a medically improved disability whose income and resources do not exceed a standard established by the State. See page 12h of Attachment 2.16-A. Note: If the State elects to cover this group, it MUST also cover the Basic Coverage Group described in no. 24 above.

State: NEVADA

Agency*	Citation(s)	Groups Covered

C. Optional Coverage of the Medically Needy

42 CFR 435.301

This plan includes the medically needy.

XX No.

____ Yes. This plan covers:

1. Pregnant women who, except for income and/or resources, would be eligible as categorically needy under title XIX of the Act.

1902(e) of the Act

2. Women who, while pregnant, were eligible for and have applied for Medicaid and receive Medicaid as medically needy under the approved State plan on the date the pregnancy ends. These women continue to be eligible, as though they were pregnant, for all pregnancy-related and postpartum services under the plan for a 60-day period, beginning with the date the pregnancy ends, and any remaining days in the month in which the 60th day falls.

1902(a)(10)(C)(ii)(I) of the Act

3. Individuals under age 18 who, but for income and/or resources, would be eligible under Section 1902(a)(10)(A)(i) of the Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nevada

REQUIREMENTS RELATING TO DETERMINING ELIGIBILITY FOR MEDICARE PRESCRIPTION DRUG LOW-INCOME SUBSIDIES

Agency	Citation (s)	Groups Covered

(Reserved for Future Use)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nevada

REQUIREMENTS RELATING TO DETERMINING ELIGIBILITY FOR MEDICARE PRESCRIPTION DRUG LOW-INCOME SUBSIDIES

Agency	Citation (s)	Groups Covered

(Reserved for Future Use)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: _Nevada _____

REQUIREMENTS RELATING TO DETERMINING ELIGIBILITY FOR MEDICARE PRESCRIPTION DRUG LOW-INCOME SUBSIDIES

Agency	Citation (s)	Groups Covered
1935(a) and 1902(a)(66) 42 CFR 423.774 and 423.904	The agency provides for making Medicare prescription drug Low Income Subsidy determinations under Section 1935(a) of the Social Security Act. 1. The agency makes determinations of eligibility for premium and cost-sharing subsidies under and in accordance with Section 1860D-14 of the Social Security Act; 2. The agency provides for informing the Secretary of such determinations in cases in which such eligibility is established or redetermined; 3. The agency provides for screening of individuals for Medicare cost-sharing described in Section 1905(p)(3) of the Act and offering enrollment to eligible individuals under the State plan or under a waiver of the State plan.	

Groups Covered

Optional Groups other than the Medically Needy

In addition to providing State plan HCBS to individuals described in 1915(i)(1), the state may **also** cover the optional categorically needy eligibility group of individuals described in 1902(a)(10)(A)(ii)(XXII) who are eligible for HCBS under the needs-based criteria established under 1915(i)(1)(A) and have income that does not exceed 150% of the FPL, or who are eligible for HCBS under a waiver approved for the state under Section 1915(c), (d) or (e) or Section 1115 (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate. See 42 CFR § 435.219. (*Select one*):

☑ No. Does not apply. State does not cover optional categorically needy groups.

☐ Yes. State covers the following optional categorically needy groups. *(Select all that apply):*

(a) ☐ Individuals not otherwise eligible for Medicaid who meet the needs-based criteria of the 1915(i) benefit, have income that does not exceed 150% of the federal poverty level, and will receive 1915(i) services. There is no resource test for this group. Methodology used: *(Select one):*

☐ SSI. The state uses the following less restrictive 1902(r)(2) income disregards for this group. (*Describe, if any*):

☐ OTHER (*describe*):

(b) ☐ Individuals who are eligible for home and community-based services under a waiver approved for the State under section 1915(c), (d) or (e) (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate.
Income limit: (*Select one):*

☐ 300% of the SSI/FBR

☐ Less than 300% of the SSI/FBR (*Specify):* _____%

Specify the applicable 1915(c), (d), or (e) waiver or waivers for which these individuals would be eligible: *(Specify waiver name(s) and number(s)):*

(c) ☐ Individuals eligible for 1915(c), (d) or (e) -like services under an approved 1115 waiver. The income and resource standards and methodologies are the same as the applicable approved 1115 waiver.

Specify the 1115 waiver demonstration or demonstrations for which these individuals would be eligible. *(Specify demonstration name(s) and number(s)):*

PRA Disclosure Statement

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 0938-1188. The time required to complete this information collection is estimated to average 114 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nevada

REASONABLE CLASSIFICIATIONS OF INDIVIDUALS UNDER
THE AGE OF 21, 20, 19, AND 18

Refer to Item B-7-b on page 12 of Attachment 2.2-A

STATE/TERRITORY: NEVADA

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

METHOD FOR DETERMINING COST EFFECTIVENESS OF CARING FOR CERTAIN DISABLED CHILDREN AT HOME (KATIE BECKETT)

At the end of each calendar quarter, a computerized list of approved Katie Beckett Eligibility Option cases is generated by the Division of Health Care Financing and Policy (DHCFP) staff. The list shows the total Medicaid expenditure amount incurred quarterly which is compared to the maximum allowable costs. The maximum allowable costs are the costs of institutionalization in either a Skilled Nursing Facility (SNF), or an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID), which is determined by a level of care assessment. If the amount exceeds the maximum allowable, the Case Manager at the appropriate DHCFP office notifies the participant and advises him/her: 1) of the requirement to keep costs at or below the maximum allowable amount; and 2) that failure to keep costs to allowable amounts will result in termination from the program. If the participant's incurred costs exceed the maximum allowable amount for two consecutive quarters, he/she will be terminated from the program effective the first day of the month following the date of the determination for non-compliance with program requirements.

A level of care assessment is conducted annually; therefore, allowable costs may fluctuate annually based on the individual recipient's Level of Care (LOC).

State: Nevada

Citation	2.4	Blindness
42 CFR 435.530 (b) 42 CFR 435.531 AT-78-90 AT-79-29		All of the requirements of 42 CFR 435.530 and 42 CFR 435.531 are met. The more restrictive definition of blindness in terms of ophthalmic measurement used in this plan is specified in ATTACHMENT 2.2-A. .

Citation	2.5 Disability
42 CFR 435.121, 435.540 (b) 435.541	All of the requirements of 42 CFR 435.540 and 435.541 are met. The State uses the same definition of disability used under the SSI program unless a more restrictive definition of disability is specified in Item A.14.b of ATTACHMENT 2.2-A of this plan.

Citation(s)

42 CFR
435.10 and
Subparts G & H
1902(a)(10)(A)(i)
(III), (IV), (V),
(VI), and (VII),
1902(a)(10)(A)(ii)
(IX), 1902(a)(10)
(A)(ii)(X), 1902
(a)(10)(C),
1902(f), 1902(l)
and (m),
1905(p) and (s),
1902(r)(2),
and 1920

2.6 Financial Eligibility

(a) The financial eligibility conditions for Medicaid-only eligibility groups and for persons deemed to be cash assistance recipients are described in ATTACHMENT 2.6-A.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEVADA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
	A. General Conditions of Eligibility
	Each individual covered under the plan:
42 CFR Part 435, Subpart G	1. Is financially eligible (using the methods and standards described in Parts B and C of this Attachment) to receive services.
42 CFR Part 435, Subpart F	2. Meets the applicable non-financial eligibility conditions.
	a. For the categorically needy:
	(i) Except as specified under items A.2.a.(ii) and (iii) below, for AFDC-related individuals, meets the non-financial eligibility conditions of the AFDC program.
	(ii) For SSI-related individuals, meets the non-financial criteria of the SSI program or more restrictive SSI-related categorically needy criteria.
1902(l) of the Act	(iii) For financially eligible pregnant women, infants or children covered under Sections 1902(a)(10)(A)(i)(IV), 1902(a)(10)(A)(i)(VI), 1902(a)(10)(A)(i)(VII), and 1902(a)(10)(A)(ii)(IX) of the Act, meets the non-financial criteria of Section 1902(l) of the Act.
1902(m) of the Act	(iv) For financially eligible aged and disabled individuals covered under Section 1902(a)(10)(A)(ii)(X) of the Act, meets the non-financial criteria of Section 1902(m) of the Act.

Citation	Condition or Requirement
	b. For the medically needy, meets the non-financial eligibility conditions of 42 CFR Part 435.
1905(p) of the Act	c. For financially eligible qualified Medicare beneficiaries covered under Section 1902(a)(10)(E)(i) of the Act, meets the non-financial criteria of Section 1905(p) of the Act.
1905(s) of the Act	d. For financially eligible qualified disabled and working individuals covered under Section 1902(a)(10)(E)(ii) of the Act, meets the non-financial criteria of Section 1905(s).

State: NEVADA

Citation	Condition or Requirement
	Reserved

Citation	Condition or Requirement
42 CFR 435.1008	5. a. Is not an inmate of a public institution. Public institutions do not include medical institutions, nursing facilities, or publicly operated community residences that serve no more than 16 residents, or certain child care institutions.
42 CFR 435.1008 1905(a) of the Act	b. Is not a patient under age 65 in an institution for mental diseases except as an inpatient under age 22 receiving active treatment in an accredited psychiatric facility or program. N/A Not applicable with respect to individuals under age 22 in psychiatric facilities or programs. Such services are not provided under the plan.
42 CFR 433.145 1912 of the	6. Is required, as a condition of eligibility, to assign rights to medical support and to payments for medical care from any third party, to cooperate in obtaining such support and payments, and to cooperate in identifying and providing information to assist in pursuing any liable third party. The assignment of rights obtained from an applicant or recipient is effective only for services that are reimbursed by Medicaid. The requirements of 42 CFR 433.146 through 433.148 are met. N/A Assignment of rights is automatic because of State law.
42 CFR 435.910	7. Is required, as a condition of eligibility, to furnish his/her social security account number (or numbers, if he/she has more than one number).

Citation	Condition or Requirement
	An applicant or recipient must also cooperate in establishing the paternity of any eligible child and in obtaining medical support and payments for himself or herself and any other person who is eligible for Medicaid and on whose behalf the individual can make an assignment; except that individuals described in 1902(l)(1)(A) of the Social Security Act (pregnant women and women in the post-partum period) are exempt from these requirements involving paternity and obtaining support. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate.
	An applicant or recipient must also cooperate in identifying any third party who may be liable to pay for care that is covered under the State plan and providing information to assist in pursuing these third parties. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate.
	___ Assignment of rights is automatic because of State law.
42 CFR 435.910	7. Is required, as a condition of eligibility, to furnish his/her social security account number (or numbers, if he/she has more than one number).

Citation	Condition or Requirement
1902(c)(2)	8. Is not required to apply for AFDC benefits under title IV-A as a condition of applying for, or receiving, Medicaid if the individual is a pregnant woman, infant, or child that the State elects to cover under Sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act.
1902(e)(10)(A) and (B) of the Act	9. Is not required, as an individual child or pregnant woman, to meet requirements under Section 402(a)(43) of the Act to be in certain living arrangements. (Prior to terminating AFDC individuals who do not meet such requirements under a State's AFDC plan, the agency determines if they are otherwise eligible under the State's Medicaid plan.)

Citation	Condition or Requirement
1906 of the Act	10. Is required to apply for enrollment in an employer-based cost-effective group health plan, if such plan is available to the individual. Enrollment is a condition of eligibility except for the individual who is unable to enroll on his/her own behalf (failure of a parent to enroll a child does not affect a child's eligibility).

Citation	Condition or Requirement
B.	Post eligibility Treatment of Institutionalized Individuals' Incomes
	1. The following items are not considered in the post eligibility process:
1902(o) of the Act	a. SSI and SSP benefits paid under §1611(e)(1)(E) and (G) of the Act to individuals who receive care in a hospital, nursing home, SNF, or ICF.
Bondi v. Sullivan (SSI)	b. Austrian Reparation Payments (pension (reparation) payments made under §500 - 506 of the Austrian General Social Insurance Act). Applies only if State follows SSI program rules with respect to the payments.
1902(r)(1) of the Act	c. German Reparations Payments (reparation payments made by the Federal Republic of Germany).
105/206 of P. L. 100-383	d. Japanese and Aleutian Restitution Payments.
1. (a) of P.L. 103-286	e. Netherlands Reparation Payments based on Nazi, but not Japanese, persecution (during World War II).
10405 of P.L. 101-239	f. Payments from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In re Agent orange product liability litigation, M.D.L. No.381 (E.D.N.Y.)
6(h)(2) of P.L. 101-426	g. Radiation Exposure Compensation.
12005 of P. L. 103-66	h. VA pensions limited to $90 per month under 38 U.S.C. 5503.

Citation	Condition or Requirement
1924 of the Act 435.725 435.733 435.832	2. The following monthly amounts for personal needs are deducted from total monthly income in the application of an institutionalized individual's or couple's income to the cost of institutionalized care: Personal Needs Allowance (PNA) of not less than $30 For Individuals and $60 For Couples for All Institutionalized Persons. a. Aged, blind, disabled: Individuals $ 35 Couples $ N/A For the following persons with greater need: Institutionalized individuals with no community spouse living in the home but with other dependant family members in the home as described in Attachment 2.6.A page 5. Supplement 12 to Attachment 2.6-A page 1 describes the Greater need, describes the basis or formula for determining the deductible amount when a specific amount is not listed above; and lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met. b. AFDC related: Children $ 35. Adults $ 35. For the following persons with greater need: Supplement 12 to Attachment 2.6-A describes the greater need describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met. c. Individual under age 21 covered in the plan as specified in Item B. 7. of Attachment 2.2 -A. $ 35.

Citation	Condition or Requirement
	For the following persons with greater need: Supplement 12 to Attachment 2.6-A describes the greater need describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met.
1924 of the Act	3. In addition to the amounts under item 2, the following monthly amounts are deducted from the remaining income of an institutionalized individual with a community spouse: a. The monthly income allowance for the community spouse, calculated using the formula in §1924(d)(2), is the amount by which the maintenance needs standard exceeds the community spouse's income. The maintenance needs standard cannot exceed the maximum prescribed in §1924 (d)(3)(C). The maintenance needs standard consists of a poverty level component plus an excess shelter allowance. __x__ The poverty level component is calculated using the applicable percentage (set out §1924(d)(3)(B) of the Act) of the official poverty level. ____ The poverty level component is calculated using a percentage greater than the applicable percentage, equal to _____%, of the official poverty level (still subject to maximum maintenance needs standard). _____ The maintenance needs standard for all community spouses are set at the maximum permitted by §1924(d)(3)(C). Except that, when applicable, the State will set the community spouse's monthly income allowance at the amount by which exceptional maintenance needs, established at a fair hearing, exceed the community spouse's income, or at the amount of any court-ordered support.

Citation	Condition or Requirement

In determining any excess shelter allowance, utility expenses are calculated using:

__x__ the standard utility allowance under §5(e) of the Food Stamp Act of 1977 or

____ the actual unreimbursable amount of the community spouse's utility expenses less any portion of such amount included in condominium or cooperative charges.

b. The monthly income allowance for other dependent family members living with the community spouse is:

__x__ one-third of the amount by which the poverty level component (calculated under §1924(d)(3)(A)(i) of the Act, using the applicable percentage specified in §1924 (d)(3)(B)) exceeds the dependent family member's monthly income.

_____ a greater amounted calculated as follows:

The following definition is used in lieu of the definition provided by the Secretary to determine the dependency of family members under §1924 (d)(1):

c. Amounts for health care expenses described below that are incurred by and for the institutionalized individual and are not subject to payments by a third party:

(i) Medicaid, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or copayments.

(ii) Necessary medical or remedial care recognized under State law but not covered under the State plan. (Reasonable limits on amounts are described in Supplement 3 to ATTACHMENT 2.6-A.)

Citation	Condition or Requirement
435.725 435.733 435.832	4. In addition to any amounts deductible under the items above, the following monthly amounts are deducted from the remaining monthly income of an institutionalized individual or an institutionalized couple: a. An amount for the maintenance needs of each member of a family living in the institutionalized individual's home with no company spouse living in the home. The amount must be based on a reasonable assessment of need but must not exceed the higher of the: AFDC level, or Medically needy level: (Check one) _x_ AFDC levels in Supplement 1 to Attachment 2.6.A page 1 __ Medically needy level in Supplement 1 b. Amounts for health care expenses described below that have not been deducted under 3.c. above (i.e., for an institutionalized individual with a community spouse), are incurred by and for the institutionalized individual or institutionalized couple and are not subject to the payment by a third party. (I) Medicaid, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or copayments. (ii) Necessary medical or remedial care recognized under State law but not covered under the State plan. (Reasonable limits on amount are described in Supplement 3 to ATTACHMENT 2.6-A)
435.725 435.733 435.832	5. At the option of the State, as specified below, the following is deducted from any remaining monthly income of an institutionalized individual or an institutionalized couple: A monthly amount for the maintenance of the home of the individual or couple for not longer than 6 months if a physician has certified that the individual, or one member of the institutionalized couple, is likely to return to the home within that period: __x__ No. _____ Yes (the applicable amount is shown on page 5a.)

Citation	Condition or Requirement
N/A	Amount for maintenance of home is: $_____.
N/A	Amount for maintenance of home is the actual maintenance costs not to exceed $_____.
N/A	Amount for maintenance of home is deductible when countable income is determined under §1924(d)(1) of the Act only if the individual's home and the community spouse's home is different.
N/A	Amount for maintenance of home is not deductible when countable income is determined under §1924 (d)(1) of the Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEVADA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
42 CFR 435.711 435.721, 435.831	C. Financial Eligibility For individuals who are AFDC or SSI recipients, the income and resource levels and methods for determining countable income and resources of the AFDC and SSI program apply, unless the plan provides for more restrictive levels and methods than SSI for SSI recipients under Section 1902(f) of the Act, or more liberal methods under Section 1902(r)(2) of the Act, as specified below. For individuals who are not AFDC or SSI recipients in a non-Section 1902(f) State and those who are deemed to be cash assistance recipients, the financial eligibility requirements specified in this Section C apply. Supplement 1 to ATTACHMENT 2.6-A specifies the income levels for mandatory and optional categorically needy groups of individuals, including individuals with incomes related to the Federal income poverty level--pregnant women and infants or children covered under Sections 1902(a)(10)(A)(i)(IV), 1902(a)(10)(A)(i)(VI), 1902(a)(10)(A)(i)(VII), and 1902(a)(10)(A)(ii)(IX) of the Act and aged and disabled individuals covered under Section 1902(a)(10)(A)(ii)(X) of the Act--and for mandatory groups of qualified Medicare beneficiaries covered under Section 1902(a)(10)(E)(i) of the Act.

"EXCEPT AS PROVIDED UNDER SECTION 1924 OF THE ACT, THE POLICIES REFLECTED IN `C' APPLY. SEE SUPPLEMENT 13 FOR ADDITIONAL POLICIES RELATIVE TO SECTION 1924."

Citation | Condition or Requirement

XX Supplement 2 to ATTACHMENT 2.6-A specifies the resource levels for mandatory and optional categorically needy poverty level related groups, and for medically needy groups.

N/A Supplement 7 to ATTACHMENT 2.6-A specifies the income levels for categorically needy aged, blind and disabled persons who are covered under requirements more restrictive than SSI.

N/A Supplement 4 to ATTACHMENT 2.6-A specifies the methods for determining income eligibility used by States that have more restrictive methods than SSI, permitted under Section 1902(f) of the Act.

N/A Supplement 5 to ATTACHMENT 2.6-A specifies the methods for determining resource eligibility used by States that have more restrictive methods than SSI, permitted under Section 1902(f) of the Act.

XX Supplement 8a to ATTACHMENT 2.6-A specifies the methods for determining income eligibility used by States that are more liberal than the methods of the cash assistance programs, permitted under Section 1902(r)(2) of the Act.

XX Supplement 8b to ATTACHMENT 2.6-A specifies the methods for determining resource eligibility used by States that are more liberal than the methods of the cash assistance programs, permitted under Section 1902(r)(2) of the Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEVADA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(r)(2) of the Act	1. Methods of Determining Income
	a. AFDC-related individuals (except for poverty level related pregnant women, infants, and children).
	(1) In determining countable income for AFDC-related individuals, the following methods are used:
	___ (a) The methods under the State's approved AFDC plan only; or
	XX (b) The methods under the State's approved AFDC plan and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.
	(2) In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.
1902(e)(6) the Act	(3) Agency continues to treat women eligible under the provisions of Sections 1902(a)(10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends and any remaining days in the month in which the 60th day falls.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEVADA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
42 CFR 435.721 435.831, and 1902(m)(1)(B)(m)(4) and 1902(r)(2) of the Act	b. Aged individuals. In determining countable income for aged individuals, including aged individuals with incomes up to the Federal poverty level described in Section 1902(m)(1) of the Act, the following methods are used: ___ The methods of the SSI program only. XXX The methods of the SSI program and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.

Citation | Condition or Requirement

N/A For individuals other than optional State supplement recipients, more restrictive methods than SSI, applied under the provisions of Section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A; and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.

N/A For institutional couples, the methods specified under Section 1611(e)(5) of the Act.

N/A For Optional State supplement recipients under '435.230, income methods more liberal than SSI, as specified in Supplement 4 to ATTACHMENT 2.6-A.

N/A For Optional State supplement recipients in Section 1902(f) States and SSI criteria States without Section 1616 or 1634 agreements--

___ SSI methods only.

___ SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A.

___ Methods more restrictive and/or more liberal than SSI. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are described in Supplement 8a to ATTACHMENT 2.6-A.

In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses.

Citation	Condition or Requirement
CFR 435.721 and 435.831 1902(m)(l)(B), (m)(4), and 1902(r)(2) of the Act	c. Blind individuals. In determining countable income for blind individuals, the following methods are used: ___ The methods of the SSI program only. XX SSI methods and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A. N/A For individuals other than optional State supplement recipients, more restrictive methods than SSI, applied under the provisions of Section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A, and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A. N/A For institutional couples, the methods specified under Section 1611(e)(5) of the Act. N/A For Optional State supplement recipients under '435.230, income methods more liberal than SSI, as specified in Supplement 4 to ATTACHMENT 2.6-A. N/A For Optional State supplement recipients in Section 1902(f) States and SSI criteria States without Section 1616 or 1634 agreements-- ___ SSI methods only. ___ SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A. ___ Methods more restrictive and/ or more liberal than SSI. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are described in Supplement 8a to ATTACHMENT 2.6-A.

Citation	Condition or Requirement
	In determining relative responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.
42 CFR 435.721, and 435.831 1902(m)(1)(B), (m)(4), and 1902(r)(2) of the Act	d. Disabled individuals. In determining countable income of disabled individuals, including individuals with incomes up to the Federal poverty level described in Section 1902(m) of the Act the following methods are used: ___ The methods of the SSI program. XX SSI methods and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A. N/A For institutional couples: the methods specified under Section 1611(e)(5) of the Act. ___ For optional State supplement recipients under '435.230: income methods more liberal than SSI, as specified in Supplement 4 to ATTACHMENT 2.6-A. ___ For individuals other than optional State supplement recipients (except aged and disabled individuals described in Section 1903(m)(1) of the Act): more restrictive methods than SSI, applied under the provisions of Section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A; and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.

Citation | Condition or Requirement

N/A For Optional State supplement recipients in Section 1902(f) States and SSI criteria States without Section 1616 or 1634 agreements--

___ SSI methods only.

___ SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A.

___ Methods more restrictive and/or more liberal than SSI, except for aged and disabled individuals described in Section 1902(m)(1) of the Act. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are specified in Supplement 8a to ATTACHMENT 2.6-A.

In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEVADA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(l)(3)(E) and 1902(r)(2) of the Act	e. Poverty level pregnant women, infants, and children. For pregnant women and infants or children covered under the provisions of Sections 1902(a)(10)(A)(i)(IV), (VI), and (VII), and 1902(a)(10)(A)(ii)(IX) of the Act-- (1) The following methods are used in determining countable income: ___ The methods of the State's approved AFDC plan. ___ The methods of the approved title IV-E plan. XX The methods of the approved AFDC State plan and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A. ___ The methods of the approved title IV-E plan and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEVADA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
	(2) In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.
1902(e)(6) of the Act	(3) The agency continues to treat women eligible under the provisions of Sections 1902(a)(10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends and any remaining days in the month in which the 60th day falls.
1905(p)(1), 1902(m)(4), and l902(r)(2) of the Act	f. Qualified Medicare beneficiaries. In determining countable income for qualified Medicare beneficiaries covered under Section 1902(a)(10)(E)(i) of the Act, the following methods are used: ___ The methods of the SSI program only. XX SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A. ___ For institutional couples, the methods specified under Section 1611(e)(5) of the Act.

Citation	Condition or Requirement
	If an individual receives a title II benefit, any amounts attributable to the most recent increase in the monthly insurance benefit as a result of a title II COLA is not counted as income during a "transition period" beginning with January, when the title II benefit for December is received, and ending with the last day of the month following the month of publication of the revised annual Federal poverty level. For individuals with title II income, the revised poverty levels are not effective until the first day of the month following the end of the transition period. For individuals not receiving title II income, the revised poverty levels are effective no later than the date of publication.
1905(s) of the Act	g. (1) Qualified disabled and working individuals. In determining countable income for qualified disabled and working individuals covered under 1902(a)(10)(E)(ii) of the Act, the methods of the SSI program are used.
1905(p) of the Act	(2) Specified low-income Medicare beneficiaries. In determining countable income for specified low-income Medicare beneficiaries covered under 1902(a)(10)(E)(iii) of the Act, the same method as in f. is used.

Citation	Condition or Requirement
1902(u) of the Act	(h) COBRA Continuation Beneficiaries

N/A In determining countable income for COBRA continuation beneficiaries, the following disregards are applied:

_____ The disregards of the SSI program;

_____ The agency uses methodologies for treatment of income more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 to Attachment 2.6-A.

NOTE: For COBRA continuation beneficiaries specified at 1902(u)(4), costs incurred from medical care or for any other type of remedial care shall not be taken into account in determining income, except as provided in Section 1612(b)(4)(B)(ii).

1902(a)(10)(A)
(ii)(XV) of the Act

(ii) Working Individuals with Disabilities – Basic Coverage Group - TWWIIA

In determining financial eligibility for working individuals with disabilities under this provision, the following standards and methodologies are applied:

_____ The agency does not apply any income or resource standard.

NOTE: If the above option is chosen, no further eligibility-related options should be elected.

__X___ The agency applies the following income and/or resource standard(s):

The agency applies the following income and or resource standard(s):

1. The maximum Gross Unearned Income standard is $699.00.

2. The maximum Net Income standard is 250% of the Federal Poverty Level (FPL).

3. The resource standard is $15,000.00 in non-excluded resources.

1902(a)(10)(A)
(ii)(XV) of the Act (cont.)

Income Methodologies

In determining whether an individual meets the income standard described above, the agency uses the following methodologies.

____ The income methodologies of the SSI program.

____ The agency uses methodologies for treatment of income that are more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 to Attachment 2.6-A.

_X_ The agency uses more liberal income methodologies than the SSI program. More liberal income methodologies are described in Supplement 8a to Attachment 2.6-A.

1902(a)(10)(A)
(ii)(XV) of the Act (cont.)

Resource Methodologies

In determining whether the individual meets the resource standard described above, the agency uses the following methodologies.

Unless one of the following items is checked the agency, under the authority of Section 1902(r)(2) of the Act, disregards all funds held in retirement funds and accounts, including private retirement accounts such IRAs and other individual accounts, and employer-sponsored retirement plans such as 401(k) plans, Keogh plans, and employer pension plans. Any disregard involving retirement accounts is separately described in Supplement 8b to Attachment 2.6-A.

____ The agency disregards funds held in employer-sponsored retirement plans, but not private retirement plans.

____ The agency disregards funds in retirement accounts in a manner other than those described above. The agency's disregards are specified in Supplement 8b to Attachment 2.6-A.

1902(a)(10)(A)
the Act (cont.)

____ The agency does not disregard funds in retirement (ii)(XV) of accounts.

__X_ The agency uses resource methodologies in addition to any indicated above that are more liberal than those used by the SSI program. More liberal resource methodologies are described in Supplement 8b to Attachment 2.6A

_____ The agency uses the resource methodologies of the SSI program.

_____ The agency uses methodologies for treatment of resources that are more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 5 to Attachment 2.6-A.

1902(a)(10)(A)(ii)(XIII), (XVI), and 1916(g) of the Act (cont.)

For individuals eligible under the Basic Coverage (XV), Group described in No. 2y on Page 23d of Attachment 2.2-A:

NOTE: Regardless of the option selected below, the agency MUST require that individuals whose annual adjusted gross income, as defined under IRS statute, exceeds $75,000 pay 100% of premiums.

__X__ The agency requires individuals to pay premiums or other cost-sharing charges on a sliding scale based on income below 450% of the Federal poverty level for a family of the size involved, the amount of premiums cannot exceed 7.5% of the individual's income.

The premiums or other cost-sharing charges, and how they are applied, are described on Page 12o.

Sections 1902(a)(10)(A)
(ii)(XV), (XVI), and 1916(g)
of the Act (cont.)

Premiums and Other Cost-Sharing Charges

For the Basic Coverage Group and the Medical Improvement Group, the agency's premium or other cost-sharing charges, and how they are applied, are described below.

Payment of a premium applies to an individual who has Combined Net Income greater than 0% FPL but less than or equal to 250% FPL. The premium calculation is determined as follows:

1. An individual with Combined Net Income of greater than 0% FPL and less than 200% FPL pays a premium of 5% of the individual's Combined Net Income.

2. An individual with Combined Net Income between 200% FPL and 250% FPL pays a premium of 7.5% of the individual's Combined Net Income.

3. No other cost sharing charges apply.

Citation	Condition or Requirement
1902(k) of the Act	2. Medicaid Qualifying Trusts In the case of a Medicaid qualifying trust described in Section 1902(k)(2) of the Act, the amount from the trust that is deemed available to the individual who established the trust (or whose spouse established the trust) is the maximum amount that the trustee(s) is permitted under the trust to distribute to the individual. This amount is deemed available to the individual, whether or not the distribution is actually made. This provision does not apply to any trust or initial trust decree established before April 7, 1986, solely for the benefit of a mentally retarded individual who resides in an intermediate care facility for the mentally retarded. N/A The agency does not count the funds in a trust as described above in any instance where the State determines that it would work an undue hardship. Supplement 10 of ATTACHMENT 2.6-A specifies what constitutes an undue hardship.
1902(a)(10) of the Act N/A	3. Medically needy income levels (MNILs) are based on family size. Supplement 1 to ATTACHMENT 2.6-A specifies the MNILs for all covered medically needy groups. If the agency chooses more restrictive levels under Section 1902(f) of the Act, Supplement 1 so indicates.

Citation	Condition or Requirement
435.831	42 CFR 435.732, 4. Handling of Excess Income - Spend-down for the Medically Needy in All States and the Categorically Needy in 1902(f) States Only

a. Medically Needy

(1) Income in excess of the MNIL is considered as available for payment of medical care and services. The Medicaid agency measures available income for periods of either or ____ month(s) (not to exceed six months) to determine the amount of excess countable income applicable to the cost of medical care and services.

(2) If countable income exceeds the MNIL standard, the agency deducts the following incurred expenses in the following order:

(a) Health insurance premiums, deductibles and coinsurance charges.

(b) Expenses for necessary medical and remedial care not included in the plan.

(c) Expenses for necessary medical and remedial care included in the plan.

___ Reasonable limits on amounts of expenses deducted from income under a.(2)(a) and (b) above are listed below.

1902(a)(17) of the Act

Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government.

Citation	Condition or Requirement
	b. Categorically Needy - Section 1902 (f) States
42 CFR 435.732 N/A	The agency applies the following policy under the provisions of Section 1902(f) of the Act. The following amounts are deducted from income to determine the individual's countable income: (1) Any SSI benefit received. (2) Any State supplement received that is within the scope of an agreement described in Sections 1616 or 1634 of the Act, or a State supplement within the scope of Section 1902(a)(10)(A)(ii)(XI) of the Act. (3) Increases in OASDI that are deducted under 435.134 and 435.135 for individuals specified in that section, in the manner elected by the State under that section. (4) Other deductions from income described in this plan at Attachment 2.6-A, Supplement 4. (5) Incurred expenses for necessary medical and remedial services recognized under State law.
1902(a)(17) of the Act, P.L. 100-203	Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government.

Citation | Condition or Requirement

5. Methods for Determining Resources

a. AFDC-related individuals (except for poverty level related pregnant women, infants, and children).

(1) In determining countable resources for AFDC-related individuals, the following methods are used:

(a) The methods under the State's approved AFDC plan; and

XX (b) The methods under the State's approved AFDC plan and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A.

(2) In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

Citation	Condition or Requirement
	5. Methods for Determining Resources
1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B) and (C), and 1902(r) of the Act	b. Aged individuals. For aged individuals covered under Section 1902(a)(10)(A)(ii)(X) of the Act, the agency used the following methods for treatment of resources: ___ The methods of the SSI program. XX SSI methods and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A. ___ Methods that are more restrictive (except for individuals described in Section 1902(m)(1) of the Act) and/or more liberal than those of the SSI program. Supplement 5 to ATTACHMENT 2.6-A describes the more restrictive methods and Supplement 8b to ATTACHMENT 2.6-A specifies the more liberal methods.

Citation	Condition or Requirement
	In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses.
1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B), and 1902(r) of the Act	c. Blind individuals. For blind individuals the agency uses the following methods for treatment of resources: ___ The methods of the SSI program. XX SSI methods and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A. ___ Methods that are more restrictive and/or more liberal than those of the SSI program. Supplement 5 to ATTACHMENT 2.6-A describe the more restrictive methods and Supplement 8b to ATTACHMENT 2.6-A specify the more liberal methods. In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

Citation	Condition or Requirement
1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B) and (C), and 1902(r)(2) of the Act	d. Disabled individuals, including individuals covered under Section 1902(a)(10)(A)(ii)(X) of the Act. The agency uses the following methods for the treatment of resources: ___ The methods of the SSI program. XX SSI methods and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A. ___ Methods that are more restrictive (except for individuals described in Section 1902(m)(1) of the Act) and/or more liberal that those under the SSI program. More restrictive methods are described in Supplement 5 to ATTACHMENT 2.6-A and more liberal methods are specified in Supplement 8b to ATTACHMENT 2.6-A. In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.
1902(l)(3) and 1902(r)(2) of the Act	e. Poverty level pregnant women covered under Sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX)(A) of the Act. The agency uses the following methods in the treatment of resources. ___ The methods of the SSI program only. ___ The methods of the SSI program and/or any more liberal methods described in Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.

Citation	Condition or Requirement
	___ Methods that are more liberal than those of SSI. The more liberal methods are specified in Supplement 5a or Supplement 8b to ATTACHMENT 2.6-A.
	_X_ Not applicable. The agency does not consider resources in determining eligibility.
1902(1)(3) and 1902(r)(2) of the Act	f. Poverty level infants covered under Section 1902(a)(10)(A)(i)(IV) of the Act.
	The agency uses the following methods for the treatment of resources:
	___ The methods of the State's approved AFDC plan.
1902(1)(3)(C) of the Act	___ Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), in accordance with Section 1902(1)(3)(C) of the Act, as specified in Supplement 5a to ATTACHMENT 2.6-A.
1902(r)(2) of the Act	___ Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in Supplement 5a or Supplement 8b to Attachment 2.6-A.
	_X_ Not applicable. The agency does not consider resources in determining eligibility.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEVADA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(l)(3) and 1902(r)(2) of the Act	g. 1. Poverty level children covered under Section 1902(a)(10)(A)(i)(VI) of the Act. The agency uses the following methods for the treatment of resources: ___ The methods of the State's approved AFDC plan. ___ Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), in accordance with Section 1902(l)(3)(C) of the Act, as specified in Supplement 5a of ATTACHMENT 2.6-A.
1902(l)(3)(C) of the Act	
1902(r)(2) of the Act	___ Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in Supplement 8b to ATTACHMENT 2.6-A. _X_ Not applicable. The agency does not consider resources in determining eligibility.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEVADA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(l)(3) and 1902(r)(2) of the Act	g. 2. Poverty level children under Section 1902(a)(10)(A)(i)(VII) The agency uses the following methods for the treatment of resources: ___ The methods of the State's approved AFDC plan.
1902(l)(3)(C) the Act	___ Methods more liberal than those in the State's approved AFDC plan (but not more restrictive) as specified in Supplement 5a of ATTACHMENT 2.6-A.
1902(r)(2) of the Act	___ Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in Supplement 8a to ATTACHMENT 2.6-A.
	_X_ Not applicable. The agency does not consider resources in determining eligibility.

Citation	Condition or Requirement
1905(p)(1) (C) and (D) and 1902(r)(2) of the Act	5. h. For Qualified Medicare beneficiaries covered under Section 1902(a)(10)(E)(i) of the Act the agency uses the following methods for treatment of resources: ___ The methods of the SSI program only. _X_ The methods of the SSI program and/or more liberal methods as described in Supplement 8b to ATTACHMENT 2.6-A.
1905(s) of the Act	i. For qualified disabled and working individuals covered under Section 1902(a)(10)(E)(ii) of the Act, the agency uses SSI program methods for the treatment of resources.
1902(u) of the	N/A j. For COBRA continuation beneficiaries, the agency Actuses the following methods for treatment of resources: ___ The methods of the SSI program only. ___ More restrictive methods applied under Section 1902(f) of the Act as described in Supplement 5 to Attachment 2.6-A.

Citation	Condition or Requirement
1902(a)(10)(E)(iii) of the Act	k. Specified low-income Medicare beneficiaries covered under Section 1902(a)(10)(E)(iii) of the Act-- The agency uses the same method as in 5.h. of Attachment 2.6-A.

6. Resource Standard - Categorically Needy

a. 1902(f) States (except as specified under items 6.c. and d. below) for aged, blind and disabled individuals:

___ Same as SSI resource standards.

N/A

___ More restrictive.

The resource standards for other individuals are the same as those in the related cash assistance program.

b. Non-1902(f) States (except as specified under items 6.c. and d. below)

The resource standards are the same as those in the related cash assistance program.

Supplement 8 to ATTACHMENT 2.6-A specifies for 1902(f) States the categorically needy resource levels for all covered categorically needy groups.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEVADA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1902(l)(3)(A), (B) and (C) of the Act	c. For pregnant women and infants covered under the provisions of Section 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act, the agency applies a resource standard. ___ Yes. Supplement 2 to ATTACHMENT 2.6-A specifies the standard which, for pregnant women, is no more restrictive than the standard under the SSI program; and for infants is no more restrictive than the standard applied in the State's approved AFDC plan. _X_ No. The agency does not apply a resource standard to these individuals.
1902(l)(3)(A) and (C) of the Act	d. For children covered under the provisions of Section 1902(a)(10)(A)(i)(VI) of the Act, the agency applies a resource standard. ___ Yes. Supplement 2 to ATTACHMENT 2.6-A specifies the standard which is no more restrictive than the standard applied in the State's approved AFDC plan. _X_ No. The agency does not apply a resource standard to these individuals.

Citation	Condition or Requirement
1902(m)(1)(C) and (m)(2)(B) of the Act	e. For aged and disabled individuals described in Section 1902(m)(1) of the Act who are covered under Section 1902(a)(10)(A)(ii)(X) of the Act, the resource standard is: ___ Same as SSI resource standards. ___ Same as the medically needy resource standards, which are higher than the SSI resource standards (if the State covers the medically needy). Supplement 2 to ATTACHMENT 2.6-A specifies the resource levels for these individuals.

Citation	Condition or Requirement
	7. Resource Standard - Medically Needy
	a. Resource standards are based on family size.
1902(a)(10)(C)(i) of the Act	b. A single standard is employed in determining resource eligibility for all groups.
	___ c. In 1902(f) States, the resource standards are more restrictive than in 7.b. above for-- ___ Aged ___ Blind ___ Disabled Supplement 2 to ATTACHMENT 2.6-A specifies the resource standards for all covered medically needy groups. If the agency chooses more restrictive levels under 7.c., Supplement 2 so indicates.
1905(p)(1)(D) and (p)(2)(B) of the Act	8. Resource Standard - Qualified Medicare Beneficiaries and Specified Low-Income Medicare Beneficiaries For qualified Medicare beneficiaries covered under Section 1902(a)(10)(E)(i) of the Act and specified low-income Medicare beneficiaries covered under Section 1902(a)(10)(E)(iii) of the Act, the resource standard is twice the SSI standard.
1905(s) of the Act	9. Resource Standard - Qualified Disabled and Working Individuals For qualified disabled and working individuals covered under Section 1902(a)(10)(E)(ii) of the Act, the resource standard for an individual or a couple (in the case of an individual with a spouse) is twice the SSI resource standard.

Citation		Condition or Requirement
1902(u) of the Act	9.1 N/A	For COBRA continuation beneficiaries, the resource standard is: ___ Twice the SSI resource standard for an individual. ___ More restrictive standard as applied under Section 1902(f) of the Act as described in Supplement 8 to Attachment 2.6-A.

State: NEVADA

Citation	Condition or Requirement
1902(u) of the Act	10. Excess Resources a. Categorically Needy, Qualified Medicare Beneficiaries, Qualified Disabled and Working Individuals, and Specified Low-Income Medicare Beneficiaries Any excess resources make the individual ineligible. b. Categorically Needy Only N/A This State has a Section 1634 agreement with SSI. Receipt of SSI is provided for individuals while disposing of excess resources. c. Medically Needy Any excess resources make the individual ineligible.

Citation	Condition or Requirement
42 CFR 435.914	11. Effective Date of Eligibility

a. Groups Other Than Qualified Medicare Beneficiaries

(1) For the prospective period.

Coverage is available for the full month if the following individuals are eligible at any time during the month.

_X_ Aged, blind, disabled.
_X_ AFDC-related.

Coverage is available only for the period during the month for which the following individuals meet the eligibility requirements.

N/A ___ Aged, blind, disabled.
___ AFDC-related.

(2) For the retroactive period.

Coverage is available for three months before the date of application if the following individuals would have been eligible had they applied:

N/A ___ Aged, blind, disabled.
___ AFDC-related.

Coverage is available beginning the first day of the third month before the date of application if the following individuals would have been eligible at any time during that month, had they applied.

_X_ Aged, blind, disabled.
_X_ AFDC-related.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEVADA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
1920(b)(1) of the Act	N/A (3) For a presumptive eligibility for pregnant women only. Coverage is available for ambulatory prenatal care for the period that begins on the day a qualified provider determines that a woman meets any of the income eligibility levels specified in ATTACHMENT 2.6-A of this approved plan. If the woman files an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination of presumptive eligibility, the period ends on the day that the State agency makes the determination of eligibility based on that application. If the woman does not file an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination, the period ends on that last day.
1902(e)(8) and 1905(a) of the Act	XX b. For qualified Medicare beneficiaries defined in Section 1905(p)(1) of the Act coverage is available beginning with the first day of the month after the month in which the individual is first determined to be a qualified Medicare beneficiary under Section 1905(p)(1). The eligibility determination is valid for-- XX 12 months ___ 6 months ___ ___ months (no less than 6 months and no more than 12 months)

Citation		Condition or Requirement
1902(a)(18) and 1902(f) of the Act	12.	Pre-OBRA '93 Transfer of Resources - Categorically and Medically Needy, Qualified Medicare Beneficiaries, and Qualified Disabled and Working Individuals The agency complies with the provisions of Section 1917 of the Act, with respect to the transfer of resources Disposal of resources at less than fair market value affects eligibility for certain services as detailed in SUPPLEMENT 9 TO ATTACHMENT 2.6-A.
1917(c)	13.	Transfer of Assets - All eligibility groups The agency complies with the provisions of Section 1917(c) of the Act, as enacted by OBRA '93, with regard to the transfer of assets. Disposal of assets at less than fair market value affects eligibility for certain services as detailed in SUPPLEMENT 9(a) and ATTACHMENT 2.6-A, except in instances where the agency determines that the transfer rules would work an undue hardship.
1917(d)	14.	Treatment of Trusts - All eligibility groups The agency complies with the provisions of Section 1917(d) of the Act, as amended by OBRA '93, with regard to trusts. ___ The agency uses more restrictive methodologies under Section 1902(f) of the Act, and applies those methodologies in dealing with trusts; _X_ The agency meets the requirements in Section 1917(d)(f)(B) of the Act for use of Miller trusts. The agency does not count the funds in a trust in any instance where the agency determines that the transfer would work an undue hardship, as described in SUPPLEMENT 10 TO ATTACHMENT 2.6-A.

Citation		Condition or Requirement
1924 of the Act	15.	The agency complies with the provisions of §1924 with respect to income and resource eligibility determinations for individuals who are expected to be institutionalized for at least 30 consecutive days and who have a spouse living in the community. When applying the formula used to determine the amount of resources in initial eligibility determinations, the State standard for community spouses is: ___ the maximum standard permitted by law; _X_ the minimum standard permitted by law; or $__ a standard that is an amount between the minimum and the maximum.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Nevada

INCOME ELIGIBILITY LEVELS

A. MANDATORY CATEGORICALLY NEEDY

1. AFDC-Related Groups Other Thank Poverty Level Pregnant Women and Infants:

Family Size	Need Standard	Payment Standard	Maximum Payment Amounts
1	$459	$229	N/A
2	579	288	N/A
3	699	348	N/A
4	819	408	N/A
5	939	468	N/A
6	1,059	527	N/A
7	1,179	587	N/A
8	1,299	647	N/A

2. Pregnant Women and Infants under Section 1902(a)(10)(i)(IV) of the Act:

Effective April 1, 1990, based on the following percent of the official Federal income poverty level –

__X__ 133% (no more than 185%)

State: Nevada

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

INCOME ELIGIBILITY LEVELS

A. MANDATORY CATEGORICALLY NEEDY (Continued)

3. For children under Section 1902 (a) (10) (i) (IV) of the Act (children who have attained age 1 but have not attained age 6), the income eligibility level is 133 percent of the Federal poverty level (as revised annually in the Federal Register) for the size family involved.

4. For children under Section 1902 (a) (10) (i) (VII) of the Act (children who were born after September 30, 1983 and have attained age 6 but have not attained age 19), the income eligibility level is 100 percent of the Federal poverty level (as revised annually in the Federal Register for the size family involved.

State: Nevada

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

INCOME ELIGIBILITY LEVELS (Continued)

B. OPTIONAL CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

N/A

1. Pregnant Women and Infants

The levels for determining income eligibility for optional groups of pregnant women and infants under the provisions of Sections 1902 (a) (1) (A) (ii) (IX) and 1902 (1) (2) of the Act are as follows:

Based on _____ percent of the official Federal income poverty level (no less than 133% and no more than 185%).

Family Size	Income Level
1	$
2	$
3	$
4	$
5	$

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nevada

INCOME ELIGIBILITY LEVELS (Continued)

B. OPTIONAL CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

N/A 2. Children Between Ages 6 and 8

The levels for determining income eligibility for groups of children who are born after September 30, 1983 and who have attained six years of age but are under eight years of age under the provisions of Section 1902 (1) (2) of the Act are as follows:

Based on _____% (no more than 100%) of the official Federal income poverty line.

Family Size	Income Level
1	$
2	$
3	$
4	$
5	$
6	$
7	$
8	$
9	$
10	$

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nevada

INCOME ELIGIBILITY LEVELS (Continued)

N/A 3. Aged and Disabled Individuals

The levels for determining income eligibility for groups of aged and disabled individuals under the provision of Section 1902 (m) (1) of the Act are as follows:

Based on _____% of the official Federal income poverty line.

Family Size	Income Level
1	$
2	$
3	$
4	$
5	$

If an individual receives a title II benefit, any amount attributable to the most recent increase in the monthly insurance benefit as a result of a title II COLA is not counted as income during a "transition period" beginning with January, when the title II benefit for December is received, and ending with the last day of the month following the month of publication of the revised annual Federal poverty level.

For individuals with title II income, the revised poverty levels are not effective until the first day of the month following the end of the transition period.

For individuals not receiving title II income, the revised poverty levels are effective no later than the beginning of the month following the date of publication.

4. Income Standards in Institutions for at least 30 Consecutive Days

The income standards used in determining eligibility for individuals who are in institutions for at least 30 consecutive days is 300% of the SSI federal benefit rate.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nevada

INCOME ELIGIBILITY LEVELS (Continued)

C. QUALIFIED MEDICARE BENEFICIARIES WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

The levels for determining income eligibility for groups of qualified Medicare beneficiaries under the provisions of Section 1905 (p)(2)(A) of the Act are as follows:

1. NON-SECTION 1902(f) STATES

a. Based on the following percent of the official federal income poverty level:

Eff. Jan 1, 1989: _____85% _____% (no more than 100)

Eff. Jan 1, 1990: _____90% _____ % (no more than 100)

Eff. Jan 1, 1991: 100%

Eff. Jan 1, 1992: 100%

b. Levels:

Family Size	Income Level
1	100%
2	100%

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nevada

INCOME ELIGIBILITY LEVELS (Continued)

C. QUALIFIED MEDICARE BENEFICIARIES WITH INCOMES RELATED TO FEDERAL POVERTY LINE

N/A 2. SECTION 1902 (f) STATES WHICH AS OF JANUARY 1, 1989 USED INCOME STANDARDS MORE RESTRICTIVE THAN SSI

a. Based on the following percent of the official Federal income poverty level:

Eff. Jan 1, 1989: _____80% _____% (no more than 100)

Eff. Jan 1, 1990: _____85% _____% (no more than 100)

Eff. Jan 1, 1991: _____95% _____% (no more than 100)

Eff. Jan 1, 1992: 100%

b. Levels:

Family Size	Income Level
1	$
2	$

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nevada

INCOME LEVELS (Continued)

D. MEDICALLY NEEDY
N/A

_____ Applicable to all groups.

_____ Applicable to allow groups except those specified below. Excepted group income levels are also listed on an attached Page 3.

(1) Family Size	(2) Net income level protected for maintenance for _____ months	(3) Amount by which Column (2) exceeds limits specified in 42 CFR 435.1007[1]	(4) Net income level for persons living in rural areas for ____ months	(5) Amount by which Column (4) exceeds limits specified In 42 CFR 435.1007[1]
_____urban only				
_____urban & rural				
1	$	$	$	$
2	$	$	$	$
3	$	$	$	$
4	$	$	$	$
For each additional person, add:	$	$	$	$

[1] The agency has methods for excluding from its claim for FFP payments made on behalf of individuals whose income exceeds these limits.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nevada

INCOME LEVELS (Continued)

D. MEDICALLY NEEDY
N/A

(1) Family Size	(2) Net income level protected for maintenance for _____ months	(3) Amount by which Column (2) exceeds limits specified in 42 CFR 435.1007[1]	(4) Net income level for persons living in rural areas for ____ months	(5) Amount by which Column (4) exceeds limits specified In 42 CFR 435.1007[1]
_____urban only				
_____urban & rural				
5	$	$	$	$
6	$	$	$	$
7	$	$	$	$
8	$	$	$	$
9	$	$	$	$
10	$	$	$	$
For each additional person, add:	$	$	$	$

[1] The agency has methods for excluding from its claim for FFP payments made on behalf of individuals whose income exceeds these limits.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nevada

RESOURCE LEVELS

A. CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

1. Pregnant Women

a. Mandatory Groups

_____ Same as SSI resource levels.

__X__ Less restrictive than SSI resource levels and is as follows:

Family Size	Resource Level
1	
2	

b. Optional Groups

_____ Same as SSI resource levels.

_____ Less restrictive than SSI resource levels and is as follows:

Family Size	Resource Level
1	
2	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nevada

2. Infants

a. Mandatory Group of Infants

_____ Same as resource levels in the State's approved AFDC plan.

__X__ Less restrictive than the AFDC levels and are as follows:

Family Size	Resource Level
Any	No Limit Imposed

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nevada

b. Optional Group of Infants

_____ Same as resource levels in the State's approved AFDC plan.

_____ Less restrictive than the AFDC levels and are as follows:

Family Size	Resource Level
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nevada

3. Children

a. Mandatory Group of Children under Section 1902 (a) (10) (i) (VI) of the Act. Children who have attained age one but have not attained age six.

_____ Same as resource levels in the State's approved AFDC plan.

__X_ Less restrictive than the AFDC levels and are as follows:

Family Size	Resource Level
Any	No Limit Imposed

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nevada

b. Mandatory Group of Children under Section 1902 (a) (10) (i) (VII) of the Act. (Children born after September 30, 1983 who have attained age six but have not attained age 19.)

_____ Same as resource levels in the State's approved AFDC plan.

__X__ Less restrictive than the AFDC levels and are as follows:

Family Size	Resource Level
Any	No Limit Imposed

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nevada

N/A 4. Aged and Disabled Individuals

_____ Same as SSI resource levels.

_____ More restrictive than SSI levels and are as follows:

Family Size	Resource Level
1	
2	
3	
4	
5	

_____ Same as medically needy resource levels (applicable only if State has a medically needy program)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nevada

RESOURCE LEVELS (Continued)

B. MEDICALLY NEEDY

Applicable to all groups –

N/A _____ Except those specified below under the provisions of Section 1902 (f) of the Act.

Family Size	Resource Level
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

For each additional person

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEVADA

REASONABLE LIMITS ON AMOUNTS FOR NECESSARY MEDICAL
OR REMEDIAL CARE NOT COVERED UNDER MEDICAID

The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty is limited to zero.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nevada

METHODS FOR TREATMENT OF INCOME THAT DIFFER FROM THOSE OF THE SSI PROGRAM

(Section 1902(f) more restrictive methods and criteria and State supplement criteria in SSI criteria States without Section 1634 agreements and in Section 1902(f) States. Use to reflect more liberal methods only if you limit to State supplement recipients. DO NOT USE this supplement to reflect more liberal policies that you elect under the authority of Section 1902(r)(2) of the Act. Use Supplement 8a for Section 1902(r)(2) methods.)

N/A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nevada

MORE RESTRICTIVE METHODS OF TREATING RESOURCES
THAN THOSE OF THE SSI PROGRAM – Section 1902(f) States only.

N/A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nevada

METHODS FOR TREATMENT OF RESOURCES FOR INDIVIDUALS
WITH INCOMES RELATED TO FEDERAL POVERTY LEVELS

(Do not complete if you are electing more liberal methods under the authority of Section 1902(r)(2) of the Act instead of the authority specific to Federal poverty levels. Use Supplement 8b for Section 1902(r)(2) methods.)

The resource methodology of the Supplemental Security Income (SSI) Program is used except as follows:

Poverty Level Pregnant Women, Infants and Children described in Section 1902(l) of the Act.

Nevada no longer applies a resource limitation to these groups.

State: Nevada

Standards for Optional State Supplementary Payments

Payment Category Reasonable Classification	Administered by Federal/State	Income Level Gross 1 per Couple			Income Level NET 1 per		Income Disregards Employed
Independent Living							
(1)	(2)	(3)			(4)		(4)
Aged	X	1656.00	N/A		588.40		N/A
Blind	X	1656.00	N/A		661.30		N/A
Disabled			N/A		552.00		N/A
Both Aged	X	N/A	2487.00	(not to	N/A		903.46
Aged/Blind	X	N/A	2487.00	exceed	N/A		1053.53
Both Blind	X	N/A	2487.00	$1656.00	N/A		1203.60
Aged/Disabled	X	N/A	2487.00	per	N/A		866.23
Blind/Disabled	X	N/A	2487.00	person)	N/A		1016.30
Both Disabled		N/A	2487.00		N/A		829.00
Home of Another:							
Aged	X	1104.00			392.27		
Blind	X	1104.00	N/A		581.96		N/A
Diabled*		1104.00	N/A		368.00		N/A
Both Aged	X	N/A	1658.01	(Not to	N/A		602.31
Aged/Blind	X	N/A	1658.01	exceed	N/A		843.46
Both Blind	X	N/A	1658.01	1,104.00	N/A		1084.61
Aged/Disabled	X	N/A	1658.01	per	N/A		577.49
Blind Disabled	X	N/A	1658.01	person)	N/A		818.64
Both Disabled		N/A	1658.01		N/A		552.67

State:
Nevada

Standards for Optional State Supplementary Payments
Income Level

Payment Category Reasonable Classification	Administered by Federal/State	Gross 1 per Couple			NET 1 per	Income Disregards Employed
(1)	(2)	(3)			(4)	(4)
In Congregate Care (FCH/AGFC)						
Aged	X	$1,656.00	N/A		$902.00	N/A
Blind	X	1,656.00	N/A		902.00	N/A
Disabled*		1,656.00	N/A		552.00	N/A
Both Aged	X	N/A	$2,487	(not to	N/A	$1,710.00
Aged/Blind	X	N/A	2,487	exceed	N/A	1,710.00
Both Blind	X	N/A	2,487	$1,656	N/A	1,710.00
Aged/Disabled	X	N/A	2,487	per	N/A	$1,269.50
Blind/Disabled	X	N/A	2,487	person)	N/A	1,269.50
Both Disabled	X	N/A	2,487		N/A	829.00

* There is neither mandatory nor optional supplementary payment for the disabled in Nevada.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEVADA

INCOME LEVELS FOR 1902(f) STATES – CATEGORICALLY NEEDY
WHO ARE COVERED UNDER REQUIREMENTS MORE RESTRICTIVE THAN SSI

N/A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nevada

RESOURCE STANDARDS FOR 1902(f) STATES – CATEGORICALLY NEEDY

N/A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEVADA

MORE LIBERAL METHODS OF TREATING INCOME
UNDER SECTION 1902(r)(2) OF THE ACT*
Section 1902(f) State Non ☒Section 1902(f) State

METHODS FOR THE TREATMENT OF INCOME FOR INDIVIDUALS WITH INCOME RELATED TO FEDERAL POVERTY LEVEL

For poverty level pregnant women, infants and children eligible under 1902(a)(10)(A)(i)(IV), VI & VII of the Social Security Act. The agency uses the less restrictive methods for treating income:

For all individuals under this group whose net income without application of disregards does not exceed the 100% need standard:

1. Disregard 100% earned income for three months;

   Disregard 85% of earned income for a second three months;

   Disregard 75% of earned income for a third three months;

   Disregard 65% of earned income for a fourth three months:

   Disregard $90 or 20% of gross earning (whichever is greater) for month 13 and ongoing; and

2. Disregard the full cost of child care.

   The $30 + 1/3 / $30 earnings disregards as applicable and $90 work expense, whichever is more advantageous to the applicant/recipient.

   The income and/or resource methodologies that the less restrictive methodologies replace are as follows:

   1. No resource methodology is replaced.

      Replaced income methodology is:

      1. $30 + 1/3 earned income disregard allowed for applicants/recipients who received Medicaid in one of the immediately preceding four months or whose net income without application of the disregards does not exceed the 100% need standard. $30 + 1/3 allowed for four consecutive months followed by $30 disregard for eight consecutive months; and

2. $90 work expense; and

3. Child care deductions limited to $200 per month per child under age 2, and $175 per month per child age 2 and older.

Income Exclusion for Children in the Custody of a Public Agency

The income of children will be excluded when:

- The child is in the custody of a state, county or tribal public agency,

AND

- The child is placed in an approved living arrangement.

Determining Countable Lump Sum Income

Lump sum income received once a year or less frequently, will be considered a resource only in the month received. Lump sum income received more than one time per year is counted as unearned income in the month received. (1902(a)(10)(A)(i)(IV) & (ii)(IX) and 1902(I)(1)(A)(D) of the Social Security Act.

* More liberal methods may not result in exceeding gross income limitations under section 1903(f).

Wages paid by the Census Bureau for temporary employment related to census activities; When the Governor declares an economic crisis, Unemployment Insurance Benefits (UIB) will be excluded from income until the month following the month the Governor declares the economic crisis is over.

These incomes will be excluded for the following eligibility groups:

X Qualified children and pregnant women under 1902(a)(10)(A)(i)(III).

X Poverty level pregnant women and infants (133 –185% FPL) under 1902(a)(10)(A)(i)(IV).

X Poverty level children under age six (133% FPL) under 1902(a)(10)(A)(i)(VI).

X Poverty level children under age 19 (100% FPL) under 1902(a)(10)(A)(i)(VII).

X Optional categorically needy groups under 1902(a)(10)(A)(ii) as listed below:

NOTE: The Special Income Level Group under 1902(a)(10)(A)(ii)(V), the Individuals Who Would be Eligible if In an Institution Group under 1902(a)(10)(A)(ii)(VI) and the Hospice Group under 1902(a)(10)(A)(ii)(Vii) cannot be included in this disregard.

1. Individuals who would be eligible for cash assistance (AFDC or SSSI) if they were not in a medical institution under 1902(a)(10)(A)(ii)(IV).
2. Individuals who are under State adoption agreements under 1902(a)(10)(A)(ii)(VIII)
3. Individuals receiving only an option State supplement which is more restrictive that the criteria for an optional State supplement under title XVI, under 1902(a)(10)(A)(ii)(XI)
4. Working disabled individuals who buy into Medicaid under TWWIIA Basic Coverage Group under 1902(a)(10)(A)(ii)(XV)
5. Children under age 21 who were in foster care on their 18th birthday, under 1902(a)(10)(A)(ii)(XVII)
6. Individuals screened for breast or cervical cancer under CDC program, under 1902(a)(10)(A)(ii)(XVIII)

_ Medically Needy under 1902(a)(10)(C)(i)(III).

_ All aged, blind or disabled groups in 209(b) states under 1902(f).

X QMBs, SLMBs and QIs under 1905(p),

The State follows the SSI rules. The agency uses income and income deduction methodologies of the SSI program as well as more liberal income deduction methodologies than the SSI program.

The following are the more liberal income methodology deductions allowed by the agency:

1. Educational Expenses to Enhance Employability.
2. Employment Related Interpreting Services Expenses

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State: Nevada

MORE LIBERAL METHODS OF TREATING RESOURCES
UNDER SECTION 1902(r)(2) OF THE ACT

___ Section 1902(f) State X Non-Section 1902(f) State

Splitting of Resources Between Spouses (NON-SPOUSAL IMPOVERISHMENT CASES)
(42 CFR Part 435.211, 435.231 & 435.217)

The State defines a non-spousal impoverishment case as those where the institutionalized spouse began a continuous period of institutionalization PRIOR to September 30, 1989 and where the institutionalized spouse's medical facility stay is less than 30 consecutive days.

Married persons who are living separate and apart from each other may enter into a written agreement between themselves dividing the total resources of both spouses equally between them. Only the portion the agreement specified as the applicant/recipient's will be counted in determining eligibility for Medicaid, UNLESS the spouse makes a portion of his/her resources available to the applicant/recipient. The portion made available to the applicant/recipient will be counted in determining eligibility for Medicaid. The regular SSI joint bank account procedures apply to the months of requested coverage prior to the effective date of the agreement.

Married persons who are living separate and apart from each other may petition the court to equally divide their total community resources, excluding income, between them. Only the portion the court order specifies as the applicant/recipient's will be counted in determining eligibility for Medicaid, UNLESS the spouse makes a portion of his/her resources available to the applicant/recipient. The portion made available to the applicant/recipient will be counted in determining eligibility for Medicaid. The regular SSI joint back account procedures apply to the months of requested coverage prior to the effective date of the agreement.

Property Exclusion
(42 CFR Part 435.221, 435.231 & 435.217; and 1902(a)(10)(E) & 1905(p) of the Social Security Act)

Nevada allows a property exclusion when the property is for sale at market value and no offers to purchase have been received (the property must remain for sale while the client receives assistance), OR the property has been sold and escrow has not been completed. Good faith efforts to sell the property must be made by or on behalf of the client in order for property to qualify under this exclusion. These efforts must also be made on an ongoing basis in order for the exclusion to remain in effect.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nevada

MORE LIBERAL METHODS OF TREATING RESOURCES
UNDER SECTION 1902(r)(2) OF THE ACT

___ Section 1902(f) State X Non-Section 1902(f) State

Parent to Child Deeming

Nevada does not impose SSI deeming provisions (parent to child) when determining eligibility for Qualified Medicare Beneficiaries (QMB). Only the child's resources are considered. (1902(a)(10)(E) and 1905(p) of the Social Security Act.)

First Day of the Month Resources Rule

An applicant/recipient may be eligible for assistance in a month if their resources are under the resource limits on any day of that month (42 CFR Part 435.211, 435.231 and 435.217: and 1902(a)(10)(E) and 1905(p) of the Social Security Act).

Household Goods and Personal Effects

Nevada does not impose a value limitation on an applicant/recipient's household goods and personal effects (42 CFR Part 435.211, 435.231 & 435.217; and 1902(a)(10)(E) and 1905(p) of the Social Security Act).

Resource Test for Pregnant Women and Children Described in 1905(n) of the Act

Nevada no longer applies a resource limit.

Resources Exclusion for Children in the Custody of a Public Agency

The resources of children will be excluded when:

- The child is in the custody of a state, county or tribal public agency,
  AND
- The child is placed in an approved living arrangement.

The agency uses more liberal methods for the treatment of resources under Section 1902(r)(2) of the Act than is used by SSI.

The following are the more liberal methods for the treatment of resources:

1. Approved Accounts of $15,000.00 or less
2. Special needs trusts
3. IRS recognized retirement accounts
4. SSA death benefit payments
5. Medical savings accounts
6. Tax refunds
7. Life insurance policies with cash surrender values of less than $50,000.00
8. Funeral/burial policies

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nevada

TRANSFER OF RESOURCES

1902(f) and 1917 of the Act

The agency provides for the denial of eligibility by reason of disposal of resources for less than fair market value.

A. Except as noted below, the criteria for determining the period of ineligibility are the same as criteria specified in Section 1623 (c) of the Social Security Act (Act).

1. Transfer of resources other than the home of an individual who is an inpatient in a medical institution.

a. xx The agency uses a procedure which provides for a total period of ineligibility greater than 24 months for individuals who have transferred resources for less than fair market value when the uncompensated value of disposed of resources exceeds $12,000. This period bears a reasonable relationship to the uncompensated value of the transfer. The computation of the period and the reasonable relationship of this period to the uncompensated value is described as follows:

The uncompensated value of such transferred resources is counted for a period of time which is measured at a rate of one month for each $500 of the uncompensated value of the transferred property. Eligibility will be re-evaluated 1) if the individual secures the return of the transferred property; 2) if the individual receives further compensation or; 3) if the individual incurs medical expenses equal to the sum of the uncompensated value of the transferred property. The incurred medical expenses cannot be paid or subject to payment by a third party.

** TRANSFERS OCCURRING 10/01/89 AND LATER, SEE ADDENDUM TO SUPPLEMENT 9 TO ATTACHMENT 2.6-A.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nevada

b. xx The period of ineligibility is less than 24 months, as specified below:

The uncompensated value of such transferred resources is counted for a period of time which is measured at a rate of one month for each $500 of the uncompensated value of the transferred property. If the transfer is $500 or less, the period of ineligibility will be for the month of transfer only.

c. N/A The agency has provisions for waiver of denial of eligibility in any instance where the State determines that a denial would work an undue hardship.

** TRANSFERS OCCURRING 10/01/89 AND LATER, SEE ADDENDUM TO SUPPLEMENT 9 TO ATTACHMENT 2.6-A.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nevada

N/A 2. Transfer of the home of an individual who is an inpatient in a medical institution.

___ A period of ineligibility applies to inpatients in an SNF, ICF or other medical institution as permitted under section 1917 (c) (2) (B) (i).

a. Subject to the exceptions on Page 2 of this supplement, an individual is ineligible for 24 months after the date on which he disposed of the home. However, if the uncompensated value of the home is less than the average amount payable under this plan for 24 months of care in an SNF, a period of ineligibility is a shorter time, bearing a reasonable relationship (based on the average amount payable under this plan as medical assistance for care in an SNF) to the uncompensated value of the home as follows:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nevada

b. N/A Subject to the exceptions on Page 2 of this supplement, if the uncompensated value of the home is more than the average amount payable under this plan as medical assistance for 24 months of care in an SNF, the period of ineligibility is more than 24 months after the date on which he disposed of the home. The period of ineligibility bears a reasonable relationship (based upon the average amount payable under this plan as medical assistance for care in an SNF) to the uncompensated value of the home as follows:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nevada

N/A No individual is ineligible by reason of Item A.2 if -

(i) A satisfactory showing is made to the agency (in accordance with any regulations of the Secretary of Health and Human Services) that the individual can reasonably be expected to be discharged from the medical institution and to return to that home;

(ii) Title to the home was transferred to the individual's spouse or child who is under age 21, or (for States eligible to participate in the State program under title XVI of the Social Security Act) is blind or permanently and totally disabled or (for States not eligible to participate in the State program under title XVI of the Social Security Act) is blind or disabled as defined in section 1614 of the Act;

(iii) A satisfactory showing is made to the agency (in accordance with any regulations of the Secretary of Health and human Services) that the individual intended to dispose of the home either at fair market value or for other valuable consideration; or

(iv) The agency determines that denial of eligibility would work an undue hardship.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nevada

3. 1902 (f) States

N/A Under the provisions of Section 1902 (f) of the Social Security Act, the following transfer of resource criteria more restrictive than those established under Section 1917 (c) of the Act, apply:

B. Other than those procedures specified elsewhere in the supplement, the procedures for implementing denial of eligibility by reason of disposal of resources for less than fair market value are as follows:

1. If the uncompensated value of the transfer is $12,000 or less:

The uncompensated value of such transferred resources is counted for a period of time which is measured at a rate of one month for each $500 of the uncompensated value of the transferred property. If the transfer is $500 or less the period of ineligibility will be for the month of transfer only.

2. If the uncompensated value of the transfer is more than $12,000:

The uncompensated value of such transferred resources is counted for a period of time which is measured at a rate of one month for each $500 of the uncompensated value of the transferred property.

** TRANSFERS OCCURRING 10/01/89 AND LATER SEE SUPPLEMENT 9 TO ATTACHMENT 2.6-A.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nevada

N/A 3. If the agency sets a period of ineligibility of less than 24 months and applies it to all transfers of resources (regardless of uncompensated value):

4. Other procedures:

a. If spouses who are living separate and apart from each other obtain a court order which equally divides their community assets, excluding income, only those assets designated as the applicant/ recipients will be considered for eligibility purposes. If the spouse makes a portion of his/her assets available to the applicant/recipient, that portion will be considered when determining eligibility.

b. If spouses who are living separate and apart from each other enter into a written agreement, which equally divides their community assets, only those assets designated as the applicant/recipient will be considered for eligibility purposes. If the spouse makes a portion of his/her assets available to the applicant/recipient, that portion will be considered when determining eligibility.

If both of the above instances, the transfer of resource policy will not apply.

** TRANSFERS OCCURRING 10/01/89 AND LATER SEE ADDENDUM TO SUPPLEMENT 9 TO ATTACHMENT 2.6-A.

APPENDIX 1 TO SUPPLEMENT 9 OF ATTACHMENT 2.6-A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nevada

SECTION 1917 (c)(2)(D)

Transfer of Resources

An institutionalized spouse who (or whose spouse) transferred resources for less than fair market value shall not be found ineligible for nursing facility services, for a level of care in a medical institution equivalent to that of nursing facility services, or for home and community-based services where the States determine that denial of eligibility would work an undue hardship under the provision of Section 1917 (c)(2)(D) of the Social Security Act.

ADDENDUM TO SUPPLEMENT 9 TO ATTACHMENT 2.6-A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: NEVADA

1902 (f) AND 1917 (c) OF THE SOCIAL SECURITY ACT

Transfer of Resources

The agency provides for a period of ineligibility for nursing facility services, a level of care in a medical institution equivalent to that of nursing facility services, and for Home Based Waiver services when it is determined an institutionalized individual or their spouse disposed of resources for less than fair market value to become or remain eligible for Medicaid.

Transfers occurring within 36 months before or after application (or institutionalization, if later) or assets placed in an irrevocable trust within 60 months are evaluated.

The period of ineligibility shall begin with the month in which the transfer took place and continue for a period of time which is the number of months determined by dividing the uncompensated value by $4,583 (the statewide average monthly cost of care in a nursing facility for a private patient).

Eligibility can be re-evaluated if the individual secures the return of the transferred resource or if the individual receives further compensation. The uncompensated value will be reduced by the amount of additional compensation received.

An institutionalized individual is defined as an individual who is an inpatient in a nursing facility, who is an inpatient in a medical institution, for whom payment is made based on a level of care provided in a nursing facility or who is a Home and Community Based Service recipient.

For purposes of Section 1917 (c) of the Act, the term “resources” has the meaning given such term in Section 1613 of the Act, without regard to the exclusion described in Subsection (a) (1) thereof.

An individual shall not be determined ineligible for medical assistance if:

1. the resources transferred was a home and title to the home was transferred to:

    a. the spouse of such individual;

b. a child of such individual who is under age 21 or is blind or permanently and totally disabled;

c. a sibling of such individual who has an equity interest in such home and who was residing in the individual's home for a period of at least one year immediately before the date the individual becomes institutionalized;

d. a child of such individual (other than a child described in item "b" above) who was residing in the individual's home for a period of at least two years immediately before the date the individual becomes institutionalized and who provided care to the individual which permitted the individual to reside at home rather than an institution or facility;

2. the resources were transferred to or from (or to another for the sole benefit of) the individual's spouse, or to the individual's blind/disabled child;

3. a satisfactory showing is made the individual intended to dispose of the resources either at fair market value or for other valuable consideration or the resources were transferred exclusively for a purpose other than to qualify for medical assistance;

4. it has been determined a denial of eligibility would work an undue hardship against the individual.

Undue hardship is when there is no means, legal or otherwise, by which the individual is able to have the resource returned to his/her ownership or receive further compensation. The individual is otherwise eligible for Medicaid, and without Medicaid, the individual would be forced to go without life-sustaining medical care as determined by an individual licensed to practice medicine in the State of Nevada.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nevada

TRANSFER OF ASSETS

1917(c) The agency provides for the denial of certain Medicaid services by reason of disposal of assets for less than fair market value.

1. Institutional individuals may be denied certain Medicaid services upon disposing of assets for less than fair market value on or after the look-back date.

The agency withholds payment to institutionalized individuals for the following services:

Payments based on a level of care in a nursing facility;

Payments based on a nursing facility level of care in a medical institution;

Home and community-based services under a 1915 waiver.

2. Non-institutionalized individuals:

N/A The agency applies these provisions to the following non-institutionalized eligibility groups. These groups can be no more restrictive than those set forth in section 1905(a) of the Social Security Act:

Agency withholds payment to non-institutionalized individuals for the following services:

N/A Home health services (section 1905(a)(7));

N/A Home and community care for functionally disabled and elderly adults (section 1905(a)(22));

N/A Personal care services furnished to individuals who are not inpatients in certain medical institutions, as recognized under agency law and specified in section (1905(a)(24).

N/A The following other long-term care services for which medical assistance is otherwise under the agency plan:

3. Penalty Date --
The beginning date of each penalty period imposed for an uncompensated transfer of assets is:

X the first day of the month in which the asset was transferred;

___ the first day of the month following the month of transfer.

4. Penalty Period – Institutionalized Individuals--
In determining the penalty for an institutionalized individual, the agency uses:

X the average monthly cost to a private patient of nursing facility services in the agency;

___ the average monthly cost to a private patient of nursing facility services in the community in which the individual is institutionalized.

5. Penalty Period - Non-institutionalized Individuals --
The agency imposes a penalty period determined by using the same method as is used for an institutionalized individual, including the use of the average monthly cost of nursing facility services;

N/A Imposes a shorter penalty period than would be imposed for institutionalized individuals, as outlined below:

6. Penalty period for amounts of transfer less than cost of nursing facility care --

a. Where the amount of the transfer is less than the monthly cost of nursing facility care, the agency:

_X_ does not impose a penalty;

____ imposes a penalty for less than a full month, based on the proportion of the agency's private nursing facility rate that was transferred.

b. Where an individual makes a series of transfers, each less than the private nursing facility rate for a month, the agency:

_X_ does not impose a penalty;

____ imposes a series of penalties, each for less than a full month.

7. Transfers made so that penalty periods would overlap --
The agency:

___ totals the value of all assets transferred to produce a single penalty period.

_X_ calculates the individual penalty periods and imposes them sequentially.

8. Transfers made so that penalty periods would not overlap --

_X_ assigns each transfer its own penalty period;

___ uses the method outlined below:

9. Penalty periods – transfer by a spouse that results in a penalty period for the individual --

   a. The agency apportions any existing penalty period between the spouses using the method outlined below, provided the spouse is eligible for Medicaid. A penalty can be assessed against the spouse, and some portion of the penalty against the individual remains.

      The remaining penalty period existing for the individual, at the time the spouse is determined eligible for Medicaid, will be divided in one-half and that one-half period of time will apply to the individual and the spouse.

   b. If one spouse is no longer subject to a penalty, the remaining penalty period must be served by the remaining spouse.

10. Treatment of income as an asset --
When income has been transferred as a lump sum, the agency will calculate the penalty period on the lump sum value.

___ The agency will impose partial month penalty periods.

When a stream of income or the right to a stream of income has been transferred, the agency will impose a penalty period for each income payment.

___ For transfer of individual income payments, the agency will impose partial month penalty periods.

_X_ For transfers of the right to an income stream, the agency will use the actuarial value of all payments transferred.

___ The agency uses an alternate method to calculate penalty periods, as described below:

11. Imposition of a penalty would work an undue hardship --
The agency does not apply the transfer of assets provisions in any case in which the agency determines that such an application would work an undue hardship. The agency will use the following procedures in making undue hardship determinations:

Notice to applicant/recipient an undue hardship exception exists will be given at the point when the opportunity to rebut the presumption a transfer of assets occurred.

If undue hardship is claimed, the applicant/recipient will be responsible for providing convincing evidence the disqualification would cause an undue hardship. The evidence must include:

a. A written statement from the client/authorized representative stating the reason they feel undue hardship applies.

b. Verification, if possible, there is no means, legal or otherwise, by which the client is able to have the resource transferred back to his ownership or receive further compensation.

c. The client's relationship, if any, to the person(s) to who the resource was transferred.

Once the rebuttal and all the necessary information to substantiate the claim is received, the ECS must send the information to the Chief of Eligibility and Payments requesting a decision on whether undue hardship exists. The request must be accompanied by the following:

- The name and case number of the applicant/recipient;

- The application date;

- The date the client entered the institution; and

- A brief description of the circumstances of the transfer and why it would be an undue hardship if the penalty were imposed.

A decision whether an undue hardship waiver will be granted will be made within 45 days from the date the undue hardship request is received by the Chief of Eligibility and Payments, unless extenuating circumstances exist. An adverse determination may be appealed if received by a hearing officer within 90 days from the date of the undue hardship decision.

The following criteria will be used to determine whether the agency will not count assets transferred because the penalty would work an undue hardship:

> Undue hardship is when there is no means, legal or otherwise, by which the individual is able to have the resource returned to his/her ownership or receive further compensation. The individual is otherwise eligible for Medicaid and without Medicaid the individual would be forced to go without life-sustaining medical care as determined by an individual licensed to practice medicine in the State of Nevada.

TRANSFER OF ASSETS

1917(c) **FOR TRANSFERS OF ASSETS FOR LESS THAN FAIR MARKET VALUE MADE ON OR AFTER FEBRUARY 8, 2006,** the agency provides for the denial of certain Medicaid services.

1. Institutionalized individuals are denied coverage of certain Medicaid services upon disposing of assets for less than fair market value on or after the look-back date.

   The agency does not provide medical assistance coverage for institutionalized individuals for the following services:

   - Nursing facility services;
   - Nursing facility level of care provided in a medical institution;
   - Home and community-based services under a 1915 (c) or (d) waiver.

2. Non-institutionalized individuals

   ☒ The agency applies theses provisions to the following non-institutionalized eligibility groups. These groups can be no more restrictive than those set forth in Section 1905(a) of the Social Security Act:

   - The aged, blind or disabled

   The agency withholds payment to non-institutionalized individuals for the following services:

   - Home health services (Section 1905(a)(7));
   - Home and community care for functionally disabled elderly adults (Section 1905(a)(22));
   - Personal care services furnished to individuals who are not inpatients in certain medical institutions, as recognized under agency law and specified in Section 1905(a)(24).

   ☒ The following other long-term care services for which payment for medical assistance is otherwise made under the agency plan:

   - Home and Community Based Waiver Services

TRANSFER OF ASSETS

3. Penalty Date – The beginning date of each penalty period imposed for an uncompensated transfer of assets is the later of:

- the first day of a month during or after which assets have been transferred for less than fair market value;

☐ The State uses the first day of the month in which the assets were transferred

☒ The State uses the first day of the month after the month in which the assets were transferred

Or

- the date on which the individual is eligible for medical assistance under the State plan and is receiving institutional level care services described in Paragraphs 1 and 2 that, were it not for the imposition of the penalty period, would be covered by Medicaid;

AND

which does not occur during any other period of ineligibility for services by reason of a transfer of assets penalty.

4. Penalty Period – Institutionalized Individuals – In determining the penalty for an institutionalized individual, the agency uses:

☒ the average monthly cost to a private patient of nursing facility services in the State at the time of application;

☐ the average monthly cost to a private patient of nursing facility services in the community in which the individual is institutionalized at the time of application.

5. Penalty Period – Non-institutionalized Individuals – The agency imposes a penalty period determined by using the same method as is used for an institutionalized individual, including the use of the average monthly cost of nursing facility services;

☐ imposes a shorter penalty period than would be imposed for institutionalized individuals, as outlined below:

6. Penalty period for amounts of transfer less than cost of nursing facility care

Where the amount of the transfer is less than the monthly cost of nursing facility care, the agency imposes a penalty for less than a full month, based on the option selected in Item 4.

TRANSFER OF ASSETS

☒ The state adds together all transfers for less than fair market value made during the look-back period in more than one month and calculates a single period of ineligibility that begins on the earliest date that would otherwise apply if the transfer had been made in a single lump sum.

7. Penalty periods – transfer by a spouse that results in a penalty period for the individual

a. The agency apportions any existing penalty period between the spouses using the method outlined below, provided the spouse is eligible for Medicaid. A penalty can be assessed against the spouse, and some portion of the penalty against the individual remains.

b. If one spouse is no longer subject to a penalty, the remaining penalty period must be served by the remaining spouse.

8. Treatment of a transfer of income

When income has been transferred as a lump sum, the agency will calculate the penalty period on the lump sum value.

When a stream of income or the right to a stream of income has been transferred, the agency will impose a penalty period for each income payment.

For transfers of individual income payments, the agency will impose partial month penalty periods using the methodology selected in 6. above.

☒ For transfers of the right to an income stream, the agency will base the penalty period on the combined actuarial value of all payments transferred.

9. Imposition of a penalty would work an undue hardship – The agency does not impose a penalty for transferring assets for less than fair market value in any case in which the agency determines that such imposition would work an undue hardship. The agency will use the following criteria in making undue hardship determinations:

Application of a transfer of assets penalty would deprive the individual:

a. Of medical care such that the individual's health or life would be endangered; or

b. Of food, clothing, shelter, or other necessities of life.

10. Procedures for Undue Hardship Waivers

The agency has established a process under which hardship waivers may be requested that provides for:

TRANSFER OF ASSETS

a. Notice to a recipient subject to a penalty that an undue hardship exception exists.

b. A timely process for determining whether an undue hardship waiver will be granted; and

c. A process, which is described in the notice, under which an adverse determination can be appealed.

These procedures shall permit the facility in which the institutionalized individual is residing to file an undue hardship waiver application on behalf of the individual with the consent of the individual or the individual's personal representative.

11. Bed Hold Waivers for Hardship Applicants

The agency provides that while an application for an undue hardship waiver is pending in the case of an individual who is a resident of a nursing facility:

N/A Payments to the nursing facility to hold the bed for the individual will be made for a period not to exceed _____ days (may not be greater than 30).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: Nevada

The agency does not apply the trust provisions in any case in which the agency determines that such application would work an undue hardship.

The following criteria will be used to determine whether the agency will not apply the trust provisions because doing so would work an undue hardship:

Notice to applicant/recipient an undue hardship exception exists and the opportunity to appeal the decision will be given on the denial notice.

If undue hardship is claimed, the applicant/recipient will be responsible for providing convincing evidence application of the trust provisions would cause an undue hardship. The evidence must include:

1. A written statement from the client/authorized representative stating the reason they feel undue hardship applies.

2. Verification, if possible, there is no means. Legal or otherwise, by which the client is able to recover and/or access assets held in the trust.

3. The client's relationship, if any, to the person(s) who are trustees of the trust.

Denial of eligibility would work an undue hardship against the individual when ALL of the following conditions exist:

1. The individual is otherwise eligible for Medicaid: AND

2. The Trustee has refused to make such income/resources available to the individual: AND

3. The individual has sufficient funds to cover the cost of institutionalized care: AND

4. Without Medicaid, the individual would be forced to go without life sustaining medical care as determined by an individual licensed to practice medicine in the State of Nevada: AND

5. Where the individual has the ability to amend the trust so it contains the provision, upon death of the individual the State receives and amount equal to the total amount of medical assistance paid on behalf of the individual under the State Plan: AND

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: Nevada

6. The applicant/recipient has exercised all reasonable efforts and all possible avenues to recover and/or access to the assets held in the trust.

A decision whether an undue hardship waiver will be granted should be made within 45 days from the date the undue hardship request is received by the Chief of Eligibility and Payments.

Under the agency's undue hardship provisions, the agency takes the option to exempt the funds in an irrevocable burial trust is $N/A.

State/Territory: Nevada

Citation		Condition or Requirement
		COST EFFECTIVENESS METHODOLOGY FOR COBRA CONTINUATION BENEFICIARIES
1902(u) of the Act	N/A	Premium payments are made by the agency only if such payments are likely to be cost-effective. The agency specifies the guidelines used in determining cost effectiveness by selecting one of the following methods: ___ The methodology as described in SMM section 3598. ___ Another cost-effective methodology as described below.

VARIATIONS FROM THE BASIC PERSONAL NEEDS ALLOWANCE

In addition to the $35.00 PNA allowed in Attachment 2.6.A Page 4a, persons with greater need identified in Attachment 2.6.A Page 4a, Institutionalized individuals with no Community Spouse at home, as described in Attachment 2.6.A Page 5 #4.a, for Post Eligibility Determinations are allowed an additional Personal Needs Allowance based on household size.

HOUSEHOLD SIZE	ADDITIONAL PNA ALLOWED
1 Family Member	$239
2 Family Members	$367
3 Family Members	$494
4 Family Members	$622
5 Family Members	$749
6 Family Members	$877
7 Family Members	$1004
8 Family Members	$1132

For households greater than eight, add $128.00 for each additional person.

The greater PNA deduction is to allow the difference between the 1996 AFDC 100% Need Standard Amount used in the Maintenance Needs Allowance, which is frozen at the 1996 rate, and the current TANF 100% Need Standard Amount.

The AFDC amount used in the Maintenance Need Standard is stated in Supplement 1 to Attachment 2.6.A Page 1.

Disclosure Statement for Post-Eligibility Preprint

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 #0938-0673. The time required to complete this information collection is estimated at 3 hours per response, including the time to review instructions, searching existing data resources, gathering the data needed and completing and reviewing the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland, 21244-1850 and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C., 20503.

ELIGIBILITY UNDER SECTION 1931 OF THE ACT

The State covers low-income families and children under Section 1931 of the Act. The following groups were included in the AFDC state plan effective July 16, 1996:

_X_ Pregnant women with no other eligible children.

_X_ AFDC children age 18 who are full-time students in a secondary school or in the equivalent level of vocational or technical training.

___ In determining eligibility for Medicaid, the agency uses the AFDC standards and methodologies in effect as of July 16, 1996, without modification.

_X_ In determining eligibility for Medicaid, the agency uses the AFDC standards and methodologies in effect as of July 16, 1996, with the following modifications:

___ The agency applies lower income standards which are no lower than the AFDC standards in effect on May 1, 1988, as follows:

___ The agency applies higher income standards than those in effect as of July 16, 1996, increased by no more than the percentage increases in the CPI-U since July 16, 1996, as follows:

___ The agency applies higher resource standards than those in effect as of July 16, 1996, increase by no more than the percentage increases in the CPI-U since July 16, 1996, as follows:

X The agency uses less restrictive income and/or resource methodologies than those in effect as of July 16, 1996, as follows:

- Disregard an additional $1,000 in resources.
- Disregard the full cost of child care.
- Time limited Earned Income Disregard test:

1. For families whose gross income does not exceed the current 130% Federal Poverty Level (FPL) (which is no more than the July 1996 AFDC 185% need standard increased by CPI) apply the disregard test to determine if Earned Income Disregards are allowed.

2. For households with earned income apply the earned Income Disregard Test either a. or b. (whichever is more advantageous) to identify if the wage earners qualify for the time limited Earned Income Disregards:

a. Gross earned income minus $90.00 or 20% work expense, whichever is greater, plus countable unearned income is compared to the 100% TANF Need Standard. (Need Standards are the 1996 AFDC need standards increased annually by CPI). If the family passes the 100% Need Standard test, or was eligible in immediately preceding month apply earned income disregards as indicated below.

Current TANF earned income disregards:

1. Disregard 100% earned income for three months;
2. Disregard 85% of earned income for a second 3 months;
3. Disregard 75% of earned income for a third 3 months;
4. Disregard 65% of earned income for a fourth 3 months.
5. Disregard $90 or 20% of gross earnings (whichever is greater) for month 13 and ongoing (Work Expense).

b. 7/16/1996 AFDC earned income disregards:

1. The $30 + 1/3 / $30 earnings disregards as applicable;
2. $90 work expense; and
3. Determine eligibility based on whether total net countable earned and unearned income is no more than the current TANF payment standard.

The income and/or resource methodologies that the less restrictive methodologies replace are as follows:

- No resource methodology is replaced.
- Replaced income methodology is:

  1. $30 + 1/3 earned income disregard allowed for applicants/recipients who received a cash grant in one of the immediately preceding 4 months or whose net income without application of the disregards does not exceed the 100% need standard. $30 + 1/3 allowed for 4 consecutive months followed by $30 disregard for 8 consecutive months; and

  2. $175/$200 disregard of child care expenses; and

  3. $90 work expense.

___ The agency terminates medical assistance (except for certain pregnant women and children) for individuals who fail to meet TANF work requirements.

___ The agency continues to apply the following waivers of provisions of Part A of Title IV in effect as of July 1 1996, or submitted prior to August 22, 1996 and approved by the Secretary on or before July 1, 1997.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
TRANSITIONAL MEDICAL ASSISTANCE

The State covers low-income families and children for Transitional Medical Assistance (TMA) under Section 1925 of the Social Security Act (the Act). This coverage is provided for families who no longer qualify under Section 1931 of the Act due to increased earned income, or working hours, from the caretaker relative's employment, or due to the loss of a time-limited earned income disregard. **(1902(a)(52), 1902(e)(1)(B), and 1925 of the Act)**

The amount, duration, and scope of services for this coverage are specified in Section 3.5 of this State plan.

For Medicaid eligibility to be extended through TMA, families must have been Medicaid eligible under section 1931 (months of retroactive eligibility may be used to meet this requirement):

_X_ During at least three of the six months immediately preceding the month in which the family became ineligible under section 1931.

___ For fewer than three of the six previous months immediately preceding the month in which the family became ineligible under Section 1931. Specify:

The State extends Medicaid eligibility under TMA for an initial period of:

___ Six months. For TMA eligibility to continue into a second six-month extension period, the family must meet the reporting, technical, and income eligibility requirements specified at section the Act.

_X_ Twelve months. Section 1925(b) does not apply for a second six-month extension period.

The State collects and reports participation information to the Department of Health and Human Services as required by Section 1925(g) of the Act, in accordance with the format, timing, and frequency specified by the Secretary and makes such information publicly available.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nevada

ELIGIBILITY UNDER SECTION 1931 OF THE ACT

The State covers low-income families and children under Section 1931 of the Act.

X The agency uses less restrictive income and/or resources methodologies than those in effect as July 16, 1996 as follows:

All wages paid by the Census Bureau for temporary employment related to Census activities are excluded.

Monies received from blood donations, panhandling and Jury Duty are excluded as income.

Monies received to cover shelter costs in Homeless Transitional Housing are excluded as income.

The value of in-kind income which is not in the form of money payable to the household is excluded.

Monies in a 401K plan or Vested Retirement Account are excluded even if accessible with a penalty.

Exempt the value of prepaid burial funds, funeral plans and insurance policies earmarked for burial.

The amount of money in a retirement account which is not an IRA or Keogh plan will be considered exempt as a resource until such time as distributions are made from the account.

Exempt payments for relocation provided from Public Law 93-531.

When the Governor declares an economic crisis, Unemployment Insurance Benefits (UIB) will be excluded from income until the month following the month the Governor declares the economic crisis is over.

All otherwise countable income deposited in an IDA account funded under the Assets for Independent Act is excluded from income.

All interest earned on an IDA account funded under the Asset for Independence Act is excluded from income.

All funds in IDA accounts funded under the Assets for Independence Act are excluded from resources.

All otherwise countable income deposited in an IDA account funded under Section 404 of the Social Security Act is excluded from income.

___ The income and/or resource methodologies that the less restrictive methodologies replace are as follows:

"SECTION 1924 PROVISIONS"

A. Income and resource eligibility policies used to determine eligibility for institutionalized individuals who have spouses living in the community are consistent with Section 1924.

B. In the determination of resource eligibility, the State resource standard is the minimum standard permitted by law.

C. The definition of undue hardship for purposes of determining if institutionalized spouses receive Medicaid in spite of having excess countable resources is described below:

Denial of eligibility would work an undue hardship against an institutionalized spouse (as defined in MAABD Program Manual Section 350) when ALL of the following conditions exist:

1. The institutionalized spouse is otherwise eligible for Medicaid; AND

2. The community spouse (as defined in MAABD Program Manual Section 350) is the sole owner of liquid resources OR non-liquid joint resources valued in excess of the maximum standard permitted by law; AND

3. The community spouse has refused to make such resources available to the institutionalized spouse; AND

4. The institutionalized spouse has insufficient funds to cover the cost of institutionalized care; AND

5. Without Medicaid, the institutionalized spouse would be forced to go without life sustaining medical care as determined by an individual licensed to practice medicine in the State of Nevada.

APPENDIX 1 TO SUPPLEMENT 13 OF ATTACHMENT 2.6-A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nevada

SECTION 1924(c)(3)(C)

Spousal Impoverishment

An institutionalized spouse who (or whose spouse) has excess resources shall not be found ineligible under Title XIX of the Social Security Act, per Section 1924(c)(3)(C), where the State determines that denial of eligibility on the basis of having excess resources would work an undue hardship.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: Nevada

METHODOLOGIES FOR TREATMENT OF INCOME UNDER
THE AUTHORITY OF WASHINGTON V. BOWEN NINTH
CIRCUIT COURT RULING

Splitting of Income Between Spouses
(42 CFR Part 435.21, 435.231 & 435.217)

In cases where it is in the institutionalized spouse's best interest for financial eligibility, Nevada Welfare Division will consider one-half of the total community income of the couple when determining initial an ongoing Medicaid eligibility of the applicant/recipient. This policy applies to all months for which an application for assistance is requested.

DISQUALIFICATION FOR LONG-TERM CARE ASSISTANCE FOR INDIVIDUALS WITH SUBSTANTIAL HOME EQUITY

1917(f) The State agency denies reimbursement for nursing facility services and other long-term care services covered under the State plan for an individual who does not have a spouse, child under 21 or adult disabled child residing in the individual's home, when the individual's equity interest in the home exceeds the following amount:

☒ $500,000 (increased by the annual percentage increase in the urban component of the consumer price index beginning with 2011, rounded to the nearest $1,000).

☐ An amount that exceeds $500,000 but does not exceed $750,000 (increased by the annual percentage increase in the urban component of the consumer price index beginning with 2011, rounded to the nearest $1,000).

The amount chosen by the State is $_____.

☐ This higher standard applies statewide.

☐ This higher standard does not apply statewide. It only applies in the following areas of the State:

☐ This higher standard applies to all eligibility groups.

☐ This higher standard only applies to the following eligibility groups:

The State has a process under which this limitation will be waived in cases of undue hardship.

ASSET VERIFICATION SYSTEM

1940(a) Of the Act

1. The agency will provide verification of assets for the purpose of of determining Medicaid eligibility for aged, blind and disabled Medicaid applicants and recipients using an Asset Verification System (AVS) that meets the following minimum requirements.

A. The request and response system must be electronic:

(1) Verification inquiries must be sent electronically via the internet or similar means from the agency to the financial institution (FI).
(2) The system cannot be based on mailing paper-based requests.
(3) The system must have the capability to accept responses electronically.

B. The system must be secure, based on a recognized industry standard of security (e.g., as defined by the U.S. Commerce Department's National Institute of Standards and Technology, or NIST).

C. The system must establish and maintain a database of FIs that participate in the agency's AVS.

D. Verification requests also must be sent to FIs other than those identified by applicants and recipients, based on some logic such as geographic proximity to the applicant's home address, or other reasonable factors whenever the agency determines that such requests are needed to determine or redetermine the individual's eligibility.

E. The verification requests must include a request for information on both open and closed accounts, going back up to 5 years as determined by the State.

ASSET VERIFICATION SYSTEM

2. System Development

_____ A. The agency itself will develop an AVS.

In 3 below, provide any additional information the agency wants to include.

__x__ B. The agency will hire a contractor to develop an AVS

In 3 below, provide any additional information the agency wants to include.

_____ C. The agency will be joining a consortium to develop an AVS.

In 3 below, identify the States participating in the consortium. Also, provide any other information the agency wants to include pertaining to how the consortium will implement the AVS requirements.

_____ D. The agency already has a system in place that meets the requirements for an acceptable AVS.

In 3 below, describe how the existing system meets the requirements in Section 1.

_____ E. Other alternative not included in A. – D. above.

In 3 below, describe this alternative approach and how it will meet the requirements in Section 1.

ASSET VERIFICATION SYSTEM

3. Provide the AVS implementation information requested for the implementation approach checked in Section 2, and any other information the agency may want to include.

State Plan Under Title XIX of the Social Security Act

State: Nevada

METHODOLOGY FOR IDENTIFICATION OF APPLICABLE FMAP RATES

The State will determine the appropriate FMAP rate for expenditures for individuals enrolled in the adult group described in 42 CFR 435.119 and receiving benefits in accordance with 42 CFR Part 440 Subpart C. The adult group FMAP methodology consists of two parts: an individual-based determination related to enrolled individuals, and as applicable, appropriate population-based adjustments.

Part 1 – Adult Group Individual Income-Based Determinations

For individuals eligible in the adult group, the state will make an individual income-based determination for purposes of the adult group FMAP methodology by comparing individual income to the relevant converted income eligibility standards in effect on December 1, 2009, and included in the MAGI Conversion Plan (Part 2) approved by CMS on 04/08/2014. In general, and subject to any adjustments described in this SPA, under the adult group FMAP methodology, the expenditures of individuals with incomes below the relevant converted income standards for the applicable subgroup are considered as those for which the newly eligible FMAP is not available. The relevant MAGI-converted standards for each population group in the new adult group are described in Table 1.

Table 1: Adult Group Eligibility Standards and FMAP Methodology Features

Covered Populations Within New Adult Group		Applicable Population Adjustment			
Population Group	**Relevant Population Group Income Standard** For each population group, indicate the lower of: • The reference in the MAGI Conversion Plan (Part 2) to the relevant income standard and the appropriate cross-reference, or • 133% FPL. If a population group was not covered as of 12/1/09, enter "Not covered".	**Resource Proxy**	**Enrollment Cap**	**Special Circumstances**	**Other Adjustments**
		Enter "Y" (Yes), "N" (No), or "NA" in the appropriate column to indicate if the population adjustment will apply to each population group. Provide additional information in corresponding attachments.			
A	B	C	D	E	F
Parents/Caretaker Relatives	Attachment A,Table 1,ColumnG,Line 1 of Part 2 of the CMS approved MAGI conversion plan, including any subsequent CMS approved modification to the MAGI Conversion Plan.	No	No	No	No
Disabled Persons, non-institutionalized	Attachment A,Table 1,ColumnG,Line 2 of Part 2 of the CMS approved MAGI conversion plan, including any subsequent CMS approved modification to the MAGI Conversion Plan.	N/A	N/A	N/A	N/A
Disabled Persons, institutionalized	Attachment A,Table 1,ColumnG,Line 3 of Part 2 of the CMS approved MAGI conversion plan, including any subsequent CMS approved modification to the MAGI Conversion Plan.	No	No	No	No
Children Age 19 or 20	Attachment A,Table 1,ColumnG,Line 4 of Part 2 of the CMS approved MAGI conversion plan, including any subsequent CMS approved modification to the MAGI Conversion Plan.	N/A	N/A	N/A	N/A
Childless Adults	Attachment A,Table 1,ColumnG,Line 5 of Part 2 of the CMS approved MAGI conversion plan, including any subsequent CMS approved modification to the MAGI Conversion Plan.	N/A	N/A	N/A	N/A

APR 23 2014

Part 2 – Population-based Adjustments to the Newly Eligible Population Based on Resource Test, Enrollment Cap or Special Circumstances

A. Optional Resource Criteria Proxy Adjustment (42 CFR 433.206(d))

1. The state:

   ☐ Applies a resource proxy adjustment to a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

   ■ Does NOT apply a resource proxy adjustment (Skip items 2 through 3 and go to Section B).

   Table 1 indicates the group or groups for which the state applies a resource proxy adjustment to the expenditures applicable for individuals eligible and enrolled under 42 CFR 435.119. A resource proxy adjustment is only permitted for a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

   The effective date(s) for application of the resource proxy adjustment is specified and described in Attachment B.

2. Data source used for resource proxy adjustments:

   The state:

   ☐ Applies existing state data from periods before January 1, 2014.

   ☐ Applies data obtained through a post-eligibility statistically valid sample of individuals.

   Data used in resource proxy adjustments is described in Attachment B.

3. Resource Proxy Methodology: Attachment B describes the sampling approach or other methodology used for calculating the adjustment.

B. Enrollment Cap Adjustment (42 CFR 433.206(e))

1. ☐ An enrollment cap adjustment is applied by the state (complete items 2 through 4).

   ■ An enrollment cap adjustment is not applied by the state (skip items 2 through 4 and go to Section C).

2. Attachment C describes any enrollment caps authorized in section 1115 demonstrations as of December 1, 2009 that are applicable to populations that the state covers in the eligibility group described at 42 CFR 435.119 and received full benefits, benchmark benefits, or benchmark equivalent benefits as determined by CMS. The enrollment cap or caps are as specified in the applicable section 1115 demonstration special terms and conditions as confirmed by CMS, or in alternative authorized cap or caps as confirmed by CMS. Attach CMS correspondence confirming the applicable enrollment cap(s).

3. The state applies a combined enrollment cap adjustment for purposes of claiming FMAP in the adult group:

   ☐ Yes. The combined enrollment cap adjustment is described in Attachment C

   ☐ No.

4. Enrollment Cap Methodology: Attachment C describes the methodology for calculating the enrollment cap adjustment, including the use of combined enrollment caps, if applicable.

C. Special Circumstances (42 CFR 433.206(g)) and Other Adjustments to the Adult Group FMAP Methodology

1. The state:

   ☐ Applies a special circumstances adjustment(s).

   ■ Does not apply a special circumstances adjustment.

2. The state:

   ☐ Applies additional adjustment(s) to the adult group FMAP methodology (complete item 3).

   ■ Does not apply any additional adjustment(s) to the adult group FMAP methodology (skip item 3 and go to Part 3).

3. Attachment D describes the special circumstances and other proxy adjustment(s) that are applied, including the population groups to which the adjustments apply and the methodology for calculating the adjustments.

Part 3 – One-Time Transitions of Previously Covered Populations into the New Adult Group

A. Transitioning Previous Section 1115 and State Plan Populations to the New Adult Group

☐ Individuals previously eligible for Medicaid coverage through a section 1115 demonstration program or a mandatory or optional state plan eligibility category will be transitioned to the new adult group described in 42 CFR 435.119 in accordance with a CMS-approved transition plan and/or a section 1902(e)(14)(A) waiver. For purposes of claiming federal funding at the appropriate FMAP for the populations transitioned to new adult group, the adult group FMAP methodology is applied pursuant to and as described in Attachment E, and where applicable, is subject to any special circumstances or other adjustments described in Attachment D.

☒ The state does not have any relevant populations requiring such transitions.

Part 4 - Applicability of Special FMAP Rates

A. Expansion State Designation

The state:

☒ Does NOT meet the definition of expansion state in 42 CFR 433.204(b). (Skip section B and go to Part 5)

☐ Meets the definition of expansion state as defined in 42 CFR 433.204(b), determined in accordance with the CMS letter confirming expansion state status, dated _____.

B. Qualification for Temporary 2.2 Percentage Point Increase in FMAP.

The state:

☒ Does NOT qualify for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7).

☐ Qualifies for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7), determined in accordance with the CMS letter confirming eligibility for the temporary FMAP increase, dated _____ . The state will not claim any federal funding for individuals determined eligible under 42 CFR 435.119 at the FMAP rate described in 42 CFR 433.10(c)(6).

Part 5 - State Attestations

The State attests to the following:

A. The application of the adult group FMAP methodology will not affect the timing or approval of any individual's eligibility for Medicaid.

B. The application of the adult group FMAP methodology will not be biased in such a manner as to inappropriately establish the numbers of, or medical assistance expenditures for, individuals determined to be newly or not newly eligible.

ATTACHMENTS

Not all of the attachments indicated below will apply to all states; some attachments may describe methodologies for multiple population groups within the new adult group. Indicate those of the following attachments which are included with this SPA:

- ■ Attachment A – Conversion Plan Standards Referenced in Table 1
- ☐ Attachment B – Resource Criteria Proxy Methodology
- ☐ Attachment C – Enrollment Cap Methodology
- ☐ Attachment D – Special Circumstances Adjustment and Other Adjustments to the Adult Group FMAP Methodology
- ☐ Attachment E – Transition Methodologies

PRA Disclosure Statement

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 0938-1148. The time required to complete this information collection is estimated to average 4 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.

Attachment A – Most Recent Table 1 for Part 2 of the Modified Adjusted Gross Income(MAGI) Conversion Plan*

Table 1

Part 2 of MAGI Conversion Plan Using State Data

	Population Group	SIPP results used? (Yes/No)	Time Period selected	Sampling (Yes/No)	Net Income Standard	Income band used in conversion	Converted Standard
	A	B	C	D	E	F	G
Conversions for FMAP Claiming							
1	Parents/Caretaker Relatives (Expand number of rows for family size as needed for larger family size standards defined by the state)	Yes	April 2010 – SIPP results		% FPL _____ **or** Fixed dollar standards Family size 1_253_____ 2_318_____ 3_383_____ 4_448_____ 5_513_____ 6_578_____ 7_643_____ Add-on for additional family members if relevant__65___	% FPL _____ **or** Fixed dollar standards Family size 1_____ 2_____ 3_____ 4_____ 5_____ 6_____ 7_____ Add-on for additional family members if relevant_____	% FPL _____ **or** Fixed dollar standards Family size 1_319_____ 2_407_____ 3_495_____ 4_582_____ 5_670_____ 6_758_____ 7_846_____ Add-on for additional family members if relevant__88___

	Population Group	SIPP results used? (Yes/No)	Time Period selected	Sampling (Yes/No)	Net Income Standard	Income band used in conversion	Converted Standard
	A	B	C	D	E	F	G
2	Non-institutionalized disabled adults	N/A	N/A	N/A	% FPL _____ N/A _____ % SSI FBR _____ **or** Dollar Standards Single_____ Couple_____	%FPL _____ N/A ____ % SSI FBR _____ **or** Dollar Standards Single_____ Couple_____	% FPL ___ N/A _____ % SSI FBR _____ **or** Dollar Standards Single_____ Couple_____ Conversion based on: __ Average disregard __ Median disregard

	Population Group	SIPP results used? (Yes/No)	Time Period selected	Sampling (Yes/No)	Net Income Standard	Income band used in conversion	Converted Standard
	A	B	C	D	E	F	G
3	Institutionalized disabled adults (This is a gross income category: fill in column G **only**)						% FPL _____ % SSI FBR 300____ **or** Dollar Standards Single_____ Couple_____

	Population Group	SIPP results used? (Yes/No)	Time Period selected	Sampling (Yes/No)	Net Income Standard	Income band used in conversion	Converted Standard
	A	B	C	D	E	F	G
4	Children age 19 and/or 20 **Specify age limit as of 12/1/09** **(19 or 20):** _____	N/A	N/A	N/A	% FPL _____ N/A ___ or Fixed dollar standards Family size 1_____ 2_____ 3_____ 4_____ 5_____ 6_____ 7_____ Add-on for additional family members if relevant_____	% FPL _____ N/A __ or Fixed dollar standards Family size 1_____ 2_____ 3_____ 4_____ 5_____ 6_____ 7_____ Add-on for additional family members if relevant_____	% FPL _____ N/A _____ or Fixed dollar standards Family size 1_____ 2_____ 3_____ 4_____ 5_____ 6_____ 7_____ Add-on for additional family members if relevant_____
5	Childless Adults	N/A	N/A	N/A	% FPL _____ N/A ____	% FPL ____ N/A ____	% FPL _____ N/A _____

*the contents of this table will be updated automatically in the case of modifications in the CMS approved MAGI Conversion Plan.

State: Nevada

Citation(s)	2.7 Medicaid Furnished Out of State
431.52 and (b) of the Act, P.L. 99-272 (Section 9529)	Medicaid is furnished under the conditions specific in 42 CFR 431.52 to an eligible individual who is a resident of the State while the individual is in another State, to the same extent that Medicaid is furnished to residents in the State.

State/Territory: Nevada

SECTION 3 – SERVICES: GENERAL PROVISIONS

Citation

3.1 Amount, Duration and Scope of Services

42CFR Part 440, Subpart B 1902(a), 1902(e), 1905(a), 1905 (p), 1915, 1920 and 1925 of the Act

(a) Medicaid is provided in accordance with the requirements of 42 CFR Part 440, Subpart B and Sections 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920 and 1925 of the Act.

(1) Categorically needy.

Services for the categorically needy are described below and in Attachment 3.1-A. These services include:

1902(a)(10)(A) and 1905(a) of the Act

(i) Each item or service listed in section 1905(a)(1) through (5) and (21) of the Act, is provided as defined in 42 CFR Part 440, Subpart A, or for EPSDT services, Section 1905(r) and 42 CFR Part 441, Subpart B.

(ii) Nurse-midwife services listed in Section 1905(a)(17) of the Act, as defined in 42 CFR 440.165 are provided to the extent that nurse-midwives are authorized to practice under State Law or regulation.
Nurse-midwives are permitted to enter into independent provider agreements with the Medicaid agency without regard to whether the nurse-midwife is under the supervision of, or associated with, a physician or other health care provider.

___ Not applicable. Nurse-midwives are not authorized to practice in this State.

State/Territory: Nevada

Citation	3.1(a)(1)	Amount, Duration and Scope of Services: Categorically Needy (Continued)		
1902(e)(5) of the Act			(iii)	Pregnancy-related, including family planning services, and postpartum services for a 60-day period (beginning on the day pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for, and received medical assistance on the day the pregnancy ends.
		X	(iv)	Services for medical conditions that may complicate the pregnancy (other than pregnancy-related or postpartum services) are provided to pregnant women.
1902(a)(10)(F)(VII)			(v)	Services related to pregnancy (including prenatal, delivery, postpartum and family planning services) and to other conditions that may complicate pregnancy are the same services provided to poverty level pregnant women eligible under the provision of Sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act.

Revision: HCFA-PM-91-4 (BPD) OMB No.: 0938-
August 1991

State/Territory: Nevada

Citation	3.1(a)(1)	Amount, Duration and Scope of Services: Categorically Needy (Continued)
1902(a)(10)(d) of the Act	(vi)	Home health services are provided to individuals entitled to nursing facility services as indicated in Item 3.1(b) of this plan.
1902(e)(7) of the Act	(vii)	Inpatient services that are being furnished to infants and children described in Section 1902(1)(1)(B) through (D), or Section 1905(n)(2) of the Act on the date the infant or child attains the maximum age for coverage under the approved State plan will continue until the end of the stay for which the inpatient services are furnished.
1902(e)(9) of the Act	(viii)	Respiratory care services are provided to ventilator dependent individuals as indicated in Item 3.1(h) of this plan.
1902(a)(52) and 1925 of the	(ix)	Services are provided to families eligible under Section 1925 of the Act as indicated in Item 3.5 of this plan.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy, specifies all limitations on the amount, duration and scope of those services, and lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.

Citation 3.1 Amount, Duration and Scope of Services: (Continued)

42 CFR Part 440, Subpart B

(a)(2) Medically needy.

___ This State plan covers the medically needy. The services described below and in ATTACHMENT 3.1-B are provided.

Services for the medically needy include:

1902(a)(10)(C)(iv) of the Act
42 CFR 440.220

(i) If services in an institution for mental diseases (42 CFR 440.140 and 440.160) or an intermediate care facility for the mentally retarded (or both) are provided to any medically needy group, then each medically needy group is provided either the services listed in Section 1905(a)(1) through (5) and (17) of the Act, or seven of the services listed in section 1905(a)(1) through (20). The services are provided as defined in 42 CFR Part 440, Subpart A and in Sections 1902, 1905 and 1915 of the Act.

___ Not applicable with respect to nurse-midwife services under Section 1902(a)(17).
Nurse-midwives are not authorized to practice in this State.

1902(e)(5) of the Act

(ii) Prenatal care and delivery services for pregnant women.

State/Territory: Nevada

Citation	3.1(a)(2)		Amount, Duration and Scope of Services: Medically Needy (Continued)
		(iii)	Pregnancy-related, including family planning services and postpartum services for a 60-day period (beginning on the day the pregnancy ends) and any remaining days in the month in which the 60th day falls are provided to women who, while pregnant, were eligible for, applied for and received medical assistance on the day the pregnancy ends.
	___	(iv)	Services for any other medical condition that may complicate the pregnancy (other than pregnancy-related and postpartum services) are provided to pregnant women.
		(v)	Ambulatory services, as defined in ATTACHMENT 3.1-B, for recipients under age 18 and recipients entitled to institutional services.
		___	Not applicable with respect to recipients entitled to institutional services; the plan does not cover those services for the medically needy.
		(vi)	Home health services to recipients entitled to nursing facility services as indicated in Item 3.1(b) of this plan.
42 CFR 440.140, 440.150, 440.160 Subpart B, 442.441, Subpart C 1902(a)(20) and (21) of the Act	___	(vii)	Services in an institution for mental diseases for individuals over age 65.
	___	(viii)	Services in an intermediate care facility for the mentally retarded.
1902(a)(10)(c) of the Act	___	(ix)	Inpatient psychiatric services for individuals under age 21.

Revision: HCFA-PM-93-5 (MB)
May 1993

State/Territory: Nevada

Citation	3.1(a)(2)		Amount, Duration and Scope of Services: Medically Needy (Continued)
1902(e)(9) of Act	___	(x)	Respiratory care services are provided to ventilator dependent individuals as indicated in Item 3.1(h) of this plan.
1905(a)(23) and 1929 of the Act	___	(xi)	Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A and Appendices A-G to Supplement 2 to Attachment 3.1-A.

ATTACHMENT 3.1-B identifies the services provided to each covered group of the medically needy; specifies all limitations on the amount, duration and scope of those items; and specifies the ambulatory services provided under this plan and any limitations on them. It also lists the additional coverage (that is in excess of established service limits) for pregnancy-related services and services for conditions that may complicate the pregnancy.

Revision: HCFA-PM-97-3 (CMSO)

State/Territory: Nevada

Citation	3.1	Amount, Duration and Scope of Services: (Continued)
	(a)(3)	Other Required Special Groups: Qualified Medicare Beneficiaries
1902(a)(10)(E)(i) and clause (VIII) of the matter following (F), and 1905(p)(3) of the Act		Medicare cost sharing for qualified Medicare beneficiaries described in Section 1905(p) of the Act is provide only as indicated in Item 3.2 of this plan.
1902(a)(10) (E)(ii) and 1905(s) of the Act	(a)(4)(i)	Other Required Special Groups: Qualified Disabled and Working Individuals Medicare Part A premiums for qualified disabled and working individuals described in Section 1902(a)(10)(E)(ii) of the Act are provided as indicated in item 3.2 of this plan.
1902(a)(10) (E)(iii) and 1905(p)(3)(A)(ii) of the Act	(ii)	Other Required Special Groups: Specified Low-Income Medicare Beneficiaries Medicare Part B premiums for specified low-income Medicare beneficiaries described in Section 1902(a)(10)(E)(iii) of the Act are provided as indicated in Item 3.2 of this plan.
1902(a)(10) (E)(iv)(I),1905(p)(3) (A)(ii) and 1933 of the Act	(iii)	Other Required Special Groups: Qualifying Individuals – 1 Medicare Part B premiums for qualifying individuals described in 1902(a)(10)(E)(iv)(I) and subject to 1933 of the Act are provided as indicated in Item 3.2 of this plan.

1902(a)(10) (E)(iv)(II), 1905(p)(3) (A)(iv)(II), 1905(p)(3) the Act	(iv)	Other Required Special Groups: Qualifying Individuals – 2 The portion of the amount of increase to the Medicare Part B premium attributable to the Home Health provisions for qualifying individuals described in 1902(A)(10)(E)(iv)(II) and subject to 1933 of the Act are provided as indicated in Item 3.2 of this plan.
1925 of the Act	(a)(5)	Other Required Special Groups: Families Receiving Extended Medicaid Benefits Extended Medicaid benefits for families described in Section 1925 of the Act are provided as indicated in Item 3.5 of this plan.

State/Territory: Nevada

Citation 3.1 Amount, Duration and Scope of Services (Continued)

Sec. 245A(h) Of the Immigration and Nationality Act

(a)(6) Limited Coverage for Certain Aliens

(1) Aliens granted lawful temporary resident status under Section 245A of the Immigration and Nationality Act who meet the financial and categorical eligibility requirements under the approved State Medicaid plan are provided the services covered under the plan if they:

(A) Are aged, blind or disabled individuals as defined in Section 1614(a)(1) of the Act.

(B) Are children under 18 years of age; or

(C) Are Cuban or Haitian entrants as defined in Section 501(e)(1) and (2)(A) of P.L. 96-422 in effect on April 1, 1983.

(ii) Except for emergency services and pregnancy-related services, as defined in 42 CFR 447.53(b) aliens granted lawful temporary resident status under Section 245A of the Immigration and Nationally Act who are not identified in Item 3.1(a)(6)(i)(A) through (C) above, and who meet the financial categorical eligibility requirements under the approved State plan are provided services under the plan no earlier than five years from the date the plan the alien is granted lawful temporary resident status.

State/Territory: Nevada

Citation	3.1(a)(6)	Amount, Duration and Scope of Services: Limited Coverage for Certain Aliens (Continued)
1902(a) and 1903 (v) of the Act		(iii) Aliens who are not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law who meet the eligibility conditions under this plan, except for the requirement for receipt of AFDC, SSI or a State supplementary payment, are provided Medicaid only for care and services necessary for the treatment of an emergency medical condition (including emergency labor and delivery) as defined in Section 1903(v)(3) of the Act.
1905(a)(9) of the Act	(a)(7)	Homeless Individuals. Clinic services furnished to eligible individuals who do not reside in a permanent dwelling or do not have a fixed home or mailing address are provided without restrictions regarding the site at which the services are furnished.
1902(a)(47) and 1920 of the Act	(a)(8)	Presumptively Eligible Pregnant Women. Ambulatory prenatal care for pregnant women is provided during a presumptive eligibility period if the care is furnished by a provider that is eligible for payment under the State plan.
42 CFR 441.55 50 FR 43654 1902(a)(43), 1905(a)(4)(B), and 1905 (r) of the Act	(a)(9)	EPSDT Services. The Medicaid agency meets the requirements of Sections 1902(a)(43), 1905 (a)(4)(B) and 1905(r) of the Act with respect to early and periodic screening, diagnostic and treatment (EPSDT) services.

State/Territory: Nevada

Citation	3.1(a)(9)	Amount, Duration and Scope of Services: EPSDT Services (Continued)
42 CFR 441.60	[N/A]	The Medicaid agency has in effect agreements with continuing care providers. Described below are the methods employed to assure the providers' compliance with their agreements. **
42 CFR 440.240 and 440.250	(a)(10)	Comparability of Services
1902(a) and 1902 (a)(10), 1902(a)(52), 1903(v), 1915(g) and 1925(b)(4) and 1932 of the Act		Except for those items or services for which Sections 1902(a), 1902(a)(10), 1903(v), 1915, 1925 and 1932 of the Act, 42 CFR 440.250 and Section 245A of the Immigration and Nationality Act, permit exceptions:
		(i) Services made available to the categorically needy are equal in amount, duration and scope for each categorically needy person.
		(ii) The amount, duration and scope of services made available to the categorically needy are equal to or greater than those made available to the medically needy.
		(iii) Services made available to the medically needy are equal in amount, duration and scope for each person in a medically needy coverage group.
	[N/A]	(iv) Additional coverage for pregnancy-related service and services for conditions that may complicate the pregnancy are equal for categorically and medically needy.

**Describe here.

The continuing care provider submits monthly encounter data reflecting the number of examinations completed the number of examinations where a referable condition was identified, and the number of follow-up treatment encounters. Medicaid staff makes periodic on-site reviews to monitor the provider's record of case management.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State/Territory: Nevada

Citation
42 CFR Part
440, Subpart B
42 CFR 441.15
AT-78-90
AT 80-34

3.1(b) Home health services are provided in accordance with the requirements of 42 CFR 441.15.

(1) Home health services are provided to all categorically needy individuals 21 years of age or over.

(2) Home health services are provided to all categorically needy individuals under 21 years of age.

X Yes.

___ Not applicable. The State plan does not provide for skilled nursing facility services for such individuals.

(3) Home health services are provided to the medically needy:

___ Yes, to all.

___ Yes, to individuals age 21 or over; SNF services are provided.

___ Yes, to individuals under age 21; SNF services are provided.

___ No; SNF services are not provided.

X Not applicable; the medically needy are not included under this plan.

Revision: HCFA-PM-93 (BPD)

State/Territory: Nevada

Citation 3.1 Amount, Duration and Scope of Services (Continued)

42 CFR 431.53 (c)(1) Assurance of Transportation

Provision is made for assuring necessary transportation of recipients to and from providers. Methods used to assure such transportation are described in ATTACHMENT 3.1-D.

42 CFR 483.10 (C)(2) Payment for Nursing Facility Services

The State includes in nursing facility services at least the items and services specified in 42 CFR 483.10(c)(8)(i).

State/Territory: Nevada

Citation	3.1(d) Methods and Standards to Assure Quality of Services
42 CFR 440.260 AT-78-90	The standards established and the methods used to assure high quality care are described in ATTACHMENT 3.1-C.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State/Territory: Nevada

Citation	3.1(e) Family Planning Services
42 CFR 441.20 AT-78-90	The requirements of 42 CFR 441.20 are met regarding freedom from coercion or pressure of mind and conscience, and freedom of choice of method to be used for family planning.

State/Territory: Nevada

Citation 3.1(f)(1) Optometric Services

42 CFR 441.30
AT-78-90

Optometric services (other than those provided under 435.531 and 436.531) are not now but were previously provided under the plan. Services of the type an optometrist is legally authorized to perform are specifically included in the term "physicians' services" under this plan and are reimbursed whether furnished by a physician or an optometrist.

___ Yes

___ No. The conditions described in the first sentence apply but the term "physicians' services" does not specifically include services of the type an optometrist is legally authorized to perform.

X Not applicable. The conditions in the first sentence do not apply.

1903(i)(1) (2) Organ Transplant Procedures
of the Act,
P.L. 99-272
(Section 9507)

Organ transplant procedures are provided.

___ No.

X Yes. Similarly situated individuals are treated alike and any restriction on the facilities that may, or practitioners who may, provide those procedures is consistent with the accessibility of high quality care to individuals eligible for the procedures under this plan. Standards for the coverage of organ transplant procedures are described at ATTACHMENT 3.1-E.

State/Territory: Nevada

AMOUNT, DURATION, AND SCOPE OF MEDICALAND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1. Inpatient hospital services other than those provided in an institution for mental diseases.

   Provided: ___ No limitations X With limitations*

2. a. Outpatient hospital services.

   ___ Provided: ___ No limitations X With limitations*

   b. Rural health clinic services and other ambulatory services furnished by a rural health clinic (which are otherwise included in the State plan).

   X Provided: ___ No limitations X With limitations*

   ___ Not provided.

   c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with Section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

   X Provided: ___ No limitations X With limitations*

3. Other laboratory and x-ray services.

   Provided: X No limitations ___ With limitations*

*Description provided on Attachment.

1. Inpatient hospital services are limited to admissions certified for payment by Nevada Peer Review Organization.

2.a. Outpatient hospital services are limited to the same extent as physicians' services, prescribed drugs, therapy and other specific services listed in this Attachment (see 2.c.).

2.b. Rural health clinic services are subject to the same limitations listed for specific services elsewhere in this Attachment.

Rural Health Clinic (RHC) Services are defined in Section 1905(a)(2)(B) of the Social Security Act (the Act). RHC services include services provided by physicians (MD/DO), dentist, advanced practice registered nurse, physician assistants, nurse anesthetist, nurse midwives, psychologist, licensed clinical social workers, dental hygienist, podiatrist, radiology, optometrist, opticians (including eyeglasses dispensed), visiting nurses, clinical laboratory and other ambulatory services included in the state plan. RHC services also include services and supplies that are furnished as an incident to professional services furnished by a physician, physician assistant, nurse practitioner or nurse midwife, and related medical supplies other than drugs and biologicals. Limitations on other ambulatory services furnished in the RHC are the same limitations as defined for those services in the State Plan.

2.c. Federally qualified health center services are subject to the same limitation as those of rural health clinics.

Federally Qualified Health Center (FQHC) Services as defined in Section 1905(a)(2)(C) of the Act. FQHC services include services provided by physicians (MD/DO), dentist, advanced practice registered nurse, physician assistants, nurse anesthetist, nurse midwives, psychologist, licensed clinical social workers, dental hygienist, podiatrist, radiology, optometrist, opticians (including eyeglasses dispensed), visiting nurses, clinical laboratory and other ambulatory services included in the state plan. FQHC services also include services and supplies that are furnished as an incident to professional services furnished by a physician, physician assistant, nurse practitioner or nurse midwife, and related medical supplies other than drugs and biologicals. Limitations on other ambulatory services furnished in the FQHC are the same limitations as defined for those services in the State Plan.

State/Territory: Nevada

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Provided: __ No limitations X With limitations*

4.b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*

4.c. Family planning services and supplies for individuals of child-bearing age.

Provided: __No limitations X With limitations*

4.d Face-to-face tobacco cessation counseling services for pregnant women.

1. Provided:

(i) X By or under supervision of a physician;

(ii) X By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services other than tobacco cessation services; or

(iii) Any other health care professional legally authorized to provide tobacco cessation services under State law *and* who is specifically *designated* by the Secretary in regulations. (none are designated at this time)

2. Provided: X No limitations __ With limitations*

*Any benefit package that consists of less than four counseling sessions per quit attempt, with a minimum of two quit attempts per 12-month period should be explained below.

Please describe any limitations

5. a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

Provided: X No limitations __With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with Section 1905(a)(5)(B) of the Act).

Provided: __ No limitations X With limitations*

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' services are available for all eligible recipients.

Provided: X No limitations __ With limitations*

*Description provided on Attachment.

4.a. Nursing facility services require prior authorization from the Nevada Medicaid Office.

4.b. Early Periodic Screening, Diagnostic, and Treatment (EPSDT) services as defined in 42 CFR 440.40(b). All medically necessary diagnostic and treatment services will be provided to EPSDT recipients to treat conditions detected by periodic and interperiodic screening services, even if the services are not included in the "State Plan."

Services in a school-based setting must be performed by qualified providers as set forth in the State Plan for the services they are providing and shall meet applicable qualifications under 42 CFR Part 440.

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Applied Behavior Analysis (ABA) Services

Services:

The ABA services must be medically necessary to develop, maintain, or restore to the maximum extent practical the functions of an individual with a diagnosis of Autism Spectrum Disorder (ASD) or other condition for which ABA is recognized as medically necessary. All services must be provided under a treatment plan based on evidence-based assessment criteria and include realistic and obtainable treatment goals.

Services must be rendered according to the written orders of the Physician, Physician's Assistant or an Advanced Practitioner Registered Nurse (APRN) and be directly related to the active treatment regimen designed by the healthcare professional that is clinically responsible for the treatment plan. Treatment services must be delivered by a qualified healthcare professional as defined in provider qualifications and acting within their scope of practice according to state law. The services are to be provided in the least restrictive, most normative setting possible and may be delivered in a medical professional clinic/office, within a community environment, or in the recipient's home.

Prior authorization and service limits are applicable for treatment services based on the individual's treatment needs as determined through and medical necessity in accordance with EPSDT. Service limits may be exceeded based upon medical necessity.

Service Limitations:

a. Services which do not meet medical necessity requirements.

b. Educational services being provided under an Individualized Education Program (IEP) pursuant to the federal Individuals with Disabilities Education Act (IDEA).

c. Custodial care, child care, and/or respite care services.

d. Treatment whose purpose is vocational or recreational.

e. Services, supplies or procedures performed in a non-conventional setting including but not limited to Resorts, Spa and Camps.

f. Care coordination and treatment planning.

g. Duplicative services.

Provider Qualifications

To be recognized and reimbursed for ABA, the provider must be one of the following:

a. Licensure as a Physician by the Nevada State Board of Medical Examiners and acting within their scope of practice.

b. A doctoral degree in psychology obtained from an approved doctoral program in psychology edited by the American Psychological Association (APA) or a doctoral program in psychology accredited individually or as part of an institutional accreditation by another private or governmental accrediting agency, when the association's or agency's standards and procedures have been approved by the Nevada State Board of Psychologist Examiners. Licensed in the state in which they perform the functions or actions and acting within their scope of practice.

a. A qualified Behavior Analyst (BCBA/D) is an individual who has earned a master's degree level and/or doctorate from an accredited college or university in a field of social science or special education and holds a current certification as a Board-Certified Behavior Analyst by the Behavior Analyst Certification Board, Inc., and licensed by the appropriate Nevada State Board or qualifying state agency per Nevada Revised Statute (NRS) 437.200 – 437.335, and acting within their scope of practice as defined by state law.

b. A qualified Assistant Behavior Analyst (BCaBA) is an individual who has earned a bachelor's degree from an accredited college or university in a field of social science or special education approved by the Board and holds a current certification as a Board Certified Assistant Behavior Analyst by the Behavior Analyst Certification Board, Inc., and licensed by the appropriate Nevada State Board or qualifying state agency per NRS 437.200 – 437.335, and acting within their scope of practice. All BCaBAs must practice under the supervision of a Licensed Psychologist or BCBA/D. The Physician, Psychologist, BCBA/D will be the billing provider (they are licensed) and the BCaBA and RBT will be the servicing provider on the claim.

c. A Registered Behavior Technician (RBT) is an individual who has earned a high school diploma or equivalent, completed training and testing as approved and credentialed by the Behavior Analyst Certification Board, and registered by the appropriate Nevada State Board or qualifying state agency per NRS 437.200 – 437.335, and acting within their scope of practice. All RBTs must practice under the supervision of a Licensed Psychologist, BCBA/D, or BCaBA. The Physician, Psychologist, BCBA/D will be the billing provider (they are licensed) and the BCaBA and RBT will be the servicing provider on the claim.

4.c. Family planning services are not covered for individuals whose age or physical condition precludes reproduction. Tubal ligations and vasectomies to permanently prevent conception are not covered for anyone under the age of 21 who is adjudged mentally incompetent or who is institutionalized.

5.b. Medical and surgical services provided by a dentist are limited to providers who are a Doctor of Dental Medicine or dental surgery. Reference 42 CFR 440.50 (b) for further information.

State/Territory: Nevada

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Optometrists' services.

XX Provided: ___ No limitations X With limitations*

___ Not provided.

c. Chiropractors' services.

XX Provided: ___ No limitations X With limitations*

___ Not provided.

d. Other practitioners' services.

XX Provided: Identified on attached sheet with description of limitations, if any.

___ Not provided.

7. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Provided: ___ No limitations X With limitations*

b. Home health aide services provided by a home health agency.

Provided: ___ No limitations X With limitations*

c. Medical supplies, equipment, and appliances.

___ Provided: ___ No limitations X With limitations*

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

XX Provided: ___ No limitations X With limitations*

___ Not Provided.

8. Private duty nursing services.

XX Provided: ___ No limitations X With limitations*

___ Not Provided.

*Description provided on Attachment 3a.

6.b. Optometrist services require prior authorization from the Nevada Medicaid Office. Refractions are limited to one in 24 months except for those required as a result of an EPSDT examination.

6.c. Chiropractor services are limited to individuals under the age of 21 and referred as a result of a Healthy Kids (EPSDT) screening.

6.d. Other practitioner services

Services of a licensed Physician Assistant.

Services of a licensed Advanced Practice Registered Nurse

Services of a licensed Psychologist

Services of a licensed Registered Nurse within their scope of practice according to Nevada State Law.

Community Paramedicine services:

1. Services must be part of the care plan ordered by the recipient's primary care provider. The primary care provider consults with the ambulance service's Medical Director to ensure there is no duplication of services.

   A) The following services are covered under the supervision of the Medical Director:

      a. Evaluation/health assessment.
      b. Chronic disease prevention, monitoring and education.
      c. Medication compliance.
      d. Immunizations and vaccinations.
      e. Laboratory specimen collection and point of care lab tests.
      f. Hospital discharge follow-up care.
      g. Minor medical procedures and treatments within their scope of practice as approved by the Community Paramedicine Agency's Medical Director.
      h. A home safety assessment.
      i. Telehealth originating site.

Form
2.06"

B) The following are non-covered services:

a. Travel time.
b. Mileage.
c. Services related to hospital-acquired conditions or complications resulting from treatment provided in a hospital.
d. Emergency response; for recipients requiring emergency response, the EMS transport will be billed under the ambulance medical emergency code.
e. Duplication of services.
f. Personal care services.

7. Home health care services

Services: As regulated under 42 CFR 484, 42 CFR 440.70 and other applicable state and federal law or regulation.

Home health services are certified by a physician and provided under a physician approved Plan of Care. These services may be provided in any setting where normal life activities occur. The provider must be enrolled as a Medicare Certified Home Health Agency licensed and authorized by state and federal laws to provide health care services in the home. Home health services include the following services and items:

a. Physical therapy.
(Reference Section 11 “a” of Attachment 3.1-A)

b. Occupational therapy.
(Reference Section 11 “b” of Attachment 3.1-A)

c. Speech therapy.
(Reference Section 11 “c” of Attachment 3.1-A)

Provider Qualifications:

(Reference Section 7 “e” of Attachment 3.1-A)

d. Skilled nursing services (RN/LPN visits)

Services of a registered or licensed practical nurse that may be provided to recipients in a home setting include:

"Skilled nursing" means assessments, judgments, interventions, and evaluations of intervention, which require the training, and experience of a licensed nurse. Skilled nursing care includes but is not limited to performing assessments to determine the basis for action or a need for action; monitoring fluid and electrolyte balance; suctioning of the airway; central venous catheter care; mechanical ventilation; and tracheotomy care.

Provider Qualifications:

A "qualified registered nurse" is an individual who has met the requirements outlined in NAC 632.150 and NRS 632.

1. In addition to those requirements contained in NRS 632, an applicant for a license to practice as a registered nurse must:
   a. Have graduated from a nursing program approved by the Board.
   b. Have successfully completed courses on the theory of and have clinical experience in medical-surgical nursing, maternal and child nursing and psychiatric nursing if the applicant graduated from an accredited school of professional nursing after January 1, 1952.
   c. On or after July 1, 1982, obtain a passing score as determined by the Board on the examination for licensure.

   A "qualified licensed practical nurse" is an individual who has met the requirements outlined in NAC 632.150 and NRS 632.

2. An applicant for a license to practice as a licensed practical nurse must:
   a. Have graduated from high school or passed the general educational development test.
   b. Have graduated or received a certificate of completion from a program for registered nurses or practical nurses approved by the Board.
   c. Have successfully completed a course of study on the theory of and have clinical practice in medical-surgical nursing, maternal and child health nursing and principles of mental health if the applicant graduated from an accredited school of practical or vocational nursing after January 1, 1952.
   d. Obtain a passing score as determined by the Board on the examination for licensure.

f. Home health aide services.

Home health aides may provide assistance with:

1. Personal care services, such as bathing
2. Simple dressing changes that do not require the skills of a licensed nurse
3. Assistance with medications that are self-administered
4. Assistance with activities that are directly supported of skilled therapy services but do not require the skills of a therapist, such as, routine maintenance exercise
5. Routine care of prosthetic and orthotic device

6. Monitoring of vital signs
7. Reporting of changes in recipient condition and needs
8. Any task allowed under NRS 632 and directed in the physician's approved plan of care.

Provider Qualifications:
A person who:

- has successfully completed a state-established or other training program that meets the requirements of 42 CFR 484.36(a); and
- a competency evaluation program or state licensure program that meets the requirements of 42 CFR 484.36(b), or
- a competency evaluation program or state licensure program that meets the requirements of 42 CFR 484.36(b) or (e).

An individual is not considered to have completed a training and competency evaluation program, or a competency evaluation program if, since the individuals most recent completion of this program(s), there has been a continuous period of 24 consecutive months during none of which the individual furnished services described in 42 CFR 409.40 for compensation.

g. Medical supplies, equipment and appliances.

Services:
Equipment and appliances are defined as items which are primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of disability, illness or injury, can withstand repeated use and can be reusable and removable.

Medical supplies are those health care related items which are consumable or disposable or cannot withstand repeated use by more than one individual, that are required to address an individual medical disability, illness or injury.

Service limitations:
Nevada Medicaid covers standard medical equipment that meets the basic medical need of the recipient. Deluxe equipment will not be authorized when it is determined a standard model will meet the basic medical needs of the recipient. Items classified as educational or rehabilitative by nature are not covered under this benefit. The DME provider is required to have documentation of physician's orders prior to the dispensing of any equipment or supplies.

DME services are typically not covered under this program benefit for recipients in an inpatient setting. Customized seating systems may be covered under this benefit to a recipient in a nursing facility if the item is unique to their medical needs. Disposable services are not covered in an inpatient setting under this benefit.

Prior authorization and service limitations are applicable for some equipment and supplies. Specific limitations can be found in Chapter 1300 of the Medicaid Services Manual.

Provider Qualifications:
Providers are required to have a Medical Device Equipment and Gas licensure from the Nevada Board of Pharmacy

8. Private duty nursing services
Private duty nursing services means nursing services provided by a registered nurse or licensed practical nurse under the direction of the recipient's physician. These services may be provided in the recipient's home and other settings where normal life activities occur. To qualify for these services, a recipient must require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility. These services are provided in accordance with 42 CFR 440.80 and other applicable state and federal law or regulation. These services are offered through a home health provider that is enrolled as a Medicare Certified Home Health Agency licensed and authorized by state and federal laws to provide health care services in the home.
Provider Qualifications:
(Reference Section 7 "e" of Attachment 3.1-A)

AMOUNT, DURATION, AND SCOPE OF MEDICAL
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9. Clinic services.

_X_ Provided: __ No limitations _X_ With limitations*

__ Not provided.

10. Dental services.

_X_ Provided: __ No limitations _X_ With limitations*

__ Not provided.

11. Physical therapy and related services.

a. Physical therapy.

_X_ Provided: __ No limitations _X_ With limitations*

__ Not provided.

b. Occupational therapy.

_X_ Provided: __ No limitations _X_ With limitations*

__ Not provided.

c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

_X_ Provided: __ No limitations _X_ With limitations*

__ Not provided.

*Description provided on Attachment.

9. Clinic services are subject to the same limitations listed elsewhere in this Attachment, e.g., limits on prescriptions and physician office visits.

10. Dental services are limited to emergency care only. Requirements for prior authorization for oral surgery are specified in the Medicaid Services Manual, Chapter 1000, Addendum A. For those individuals referred for diagnosis/treatment under the Early Periodic Screening, Diagnosis and Treatment Program dental services are not so limited, and the full range of dental care is provided without authorization. Orthodontics through EPSDT require prior authorization.

11a. Physical therapy provided in an outpatient setting

Services: As regulated under 42 CFR §440.110(a) and other applicable state and federal law or regulation.

Physical therapy means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of practice under state law and provided to a recipient by or under the direction of a qualified physical therapist to ameliorate/improve neuromuscular, musculoskeletal and cardiopulmonary disabilities which can respond or improve as a result of the prescribed treatment plan in a reasonable, predicable period of time. Services related to the general health and welfare of recipients, such as general exercises and play/recreational therapy to promote overall fitness and flexibility and activities to provide diversion or general motivation is not covered. Service limits may be exceeded based on medical necessity.

Physical Therapy Evaluations and Treatments: includes assessing, preventing or alleviating movement dysfunction and related functional problems; obtaining and interpreting information; and coordinating care and integrating services relative to the recipient receiving treatment such as:

a. Evaluation and diagnosis to determine the existence and extent of motor delays, disabilities and/or physical impairments affecting areas such as tone, coordination, movement, strength, and balance;
b. Therapeutic exercise;
c. Application of heat, cold, water, air, sound, massage, and electricity;
d. Measurements of strength, balance, endurance, range of motion;
e. Individual or group therapy.

Maintenance Therapy means services provided by or under the direction of a qualified therapist to develop and safely implement a maintenance program to maintain functional status at a level consistent with the patient's physical or mental limitations or to prevent decline in function. Services must be established during the last rehabilitative treatment visit. Services must be medically necessary and require the management of a qualified therapist.

Maintenance Therapy Evaluations and Treatments: includes establishing a plan, assuring patient safety, training the patient, family members and/or unskilled personnel to maintain functional status or prevent decline in function, and making necessary reevaluations of the plan such as:

a. Ongoing evaluation of patient performance;
b. Adjustment to the maintenance program to achieve appropriate functional goals;
c. Prevent decline of function;
d. Provide interventions, in the case of a chronic or progressive limitation, to improve the likelihood of independent living and quality of life; and
e. Provide treatment interventions for recipients who are making progress, but not at a rate comparable to the expectations of restorative care.

Provider Qualifications:

A "qualified physical therapist" is an individual who is a graduate of a program of physical therapy approved by both the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Physical Therapy Association or its equivalent; and where applicable, licensed by the State.

Physical therapy assistant is a person who is licensed as a physical therapist assistant, if applicable, by the State in which practicing (NRS 640.260), and has graduated from a 2-year college-level program approved by the American Physical Therapy Association; or has 2 years of appropriate experience as a physical therapist assistant, and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service, except that these determinations of proficiency do not apply with respect to persons initially licensed by a State or seeking initial qualification as a physical therapy assistant after December 31, 1977. PTA works under the direct supervision of the PT and is not receiving direct reimbursement.

All personnel who are involved in the furnishing of outpatient physical therapy services directly by or under arrangements with an organization must be legally authorized (licensed or, if applicable, certified or registered) to practice by the State in which they perform the functions or actions and must act only within the scope of their State license or State certification or registration.

The physical therapist must be present or readily available to supervise a physical therapist assistant for prescribed supervised CPT modalities that do not require direct (one-on-one), patient contact by the licensed therapist.

11b. Occupational therapy services provided in an outpatient setting

Services: As regulated under 42 CFR §440.110(b) and other applicable state and federal law or regulation.

Occupational therapy means services prescribed by a physician or other licensed practitioner of the healing arts within the scope of practice under state law and provided to a recipient by or under the direction of a qualified occupational therapist to ameliorate/improve functional disabilities which can respond or improve as a result of the prescribed treatment plan in a reasonable, predicable period of time. Services related to the general health and welfare of recipients, such as general exercises and play/recreational therapy to promote overall fitness and flexibility and activities to provide diversion or general motivation is not covered. Service limits may be exceeded based on medical necessity.

Occupational Therapy Evaluations and Treatments: Include assessing, improving, developing, or restoring functions impaired or lost through illness, injury or deprivation, improving ability to perform tasks for independent functioning when functions are lost or impaired, preventing through early intervention, initial or further impairment or loss of function; and obtaining and interpreting information; and coordinating care and integrating services, such as:

a. Evaluation and diagnosis to determine the extent of disabilities in areas such as sensorimotor skills, self-care, daily living skills, play and leisure skills, and use of adaptive or corrective equipment;
b. Task-oriented activities to prevent or correct physical or emotional deficits to minimize the disabling effect of these deficits;
c. Exercise to enhance functional performance;

d. Individual and group therapy.

Maintenance Therapy means services provided by or under the direction of a qualified therapist to develop and safely implement a maintenance program to maintain functional status at a level consistent with the patient's physical or mental limitations or to prevent decline in function. Services must be established during the last rehabilitative treatment visit. Services must be medically necessary and require the management of a qualified therapist.

Maintenance Therapy Evaluations and Treatments: includes establishing a plan, assuring patient safety, training the patient, family members and/or unskilled personnel to maintain functional status or prevent decline in function, and making necessary reevaluations of the plan such as:

a. Ongoing evaluation of patient performance;
b. Adjustment to the maintenance program to achieve appropriate functional goals;
c. Prevent decline of function;
d. Provide interventions, in the case of a chronic or progressive limitation, to improve the likelihood of independent living and quality of life; and
e. Provide treatment interventions for recipients who are making progress, but not at a rate comparable to the expectations of restorative care.

Provider Qualifications:

A "qualified occupational therapist" is an individual who is a graduate of a program in occupational therapy approved by the Committee on Allied Health Education and Accreditation of the American Medical Association and engaged in the supplemental clinical experience required before registration by the American Occupational Therapy Association.

Occupational therapy assistant is a person who has satisfied the academic requirement of an educational program approved by the Board of Occupational Therapy and the American Occupational Therapy Association and is authorized (licensed or certified) to practice by the State in which they perform the functions or actions and must act only within the scope of their State license or State certification or registration. OTA works under the direct supervision of the OT and is not receiving direct reimbursement.

All personnel who are involved in the furnishing of outpatient occupational therapy services directly by or under arrangements with an organization must be legally authorized (licensed or, if applicable, certified or registered) to practice by the State in which they perform the functions or actions and must act only within the scope of their State license or State certification or registration.

The occupational therapist must be present or readily available to supervise an occupational therapist assistant for prescribed supervised CPT modalities that do not require direct (one-on-one), patient contact by the licensed therapist.

11c. Services for individuals with speech, hearing, and language disorders provided in an outpatient setting

Services: as regulated under 42 CFR §440.110(c) and other applicable state and federal law or regulation.

Speech and language pathology services are those services necessary for the diagnosis and treatment of speech and language disorders that result in communication disabilities and for the diagnosis and treatment of swallowing disorders with or without the presence of a communication disability. The services must be of such a level of complexity and sophistication or the condition of the patient must be such that the services required can be safely and effectively performed only by a qualified therapist. Services are provided to a recipient to ameliorate/improve functional disabilities which can respond or improve as a result of the prescribed treatment plan in a reasonable, predicable period of time. Service limits may be exceeded based on medical necessity.

The practice of audiology consists of rendering services for the measurement, testing, appraisal, prediction, consultation, counseling, research or treatment of hearing and hearing impairment for the purpose of modifying disorders in communication involving speech, language and hearing. Audiology services must be performed by a certified and licensed audiologist. Treatment services such as:

a. Speech and language evaluations and diagnosis of delay and/or disabilities to include voice, communication, fluency, articulation, or language development;
b. Individual treatment and therapeutic modalities and/or group treatment (therapy);
c. Audiological evaluation and diagnosis to determine the presence or extent of hearing impairments;
d. Complete hearing and/or hearing aid evaluation, hearing aid fittings or re-evaluations, and audiograms.

Maintenance Therapy means services provided by or under the direction of a qualified therapist to develop and safely implement a maintenance program to maintain functional status at a level consistent with the patient's physical or mental limitations or to prevent decline in function. Services must be established during the last rehabilitative treatment visit. Services must be medically necessary and require the management of a qualified therapist.

Maintenance Therapy Evaluations and Treatments: includes establishing a plan, assuring patient safety, training the patient, family members and/or unskilled personnel to maintain functional status or prevent decline in function, and making necessary reevaluations of the plan such as:

a. Ongoing evaluation of patient performance;
b. Adjustment to the maintenance program to achieve appropriate functional goals;
c. Prevent decline of function;
d. Provide interventions, in the case of a chronic or progressive limitation, to improve the likelihood of independent living and quality of life; and
e. Provide treatment interventions for recipients who are making progress, but not at a rate comparable to the expectations of restorative care.

Provider Qualifications:

Speech and language pathologists are required to have a State license or State certification or registration and have a certificate of clinical competence from the American Speech and Hearing Association (ASHA); have completed the equivalent educational requirements and work experience necessary for the certificate; or has completed the academic program and is acquiring supervised work experience to qualify for the certificate;

A qualified audiologist has a master's or doctoral degree in audiology which meets State licensure requirements. Per NRS 637B.160 they are licensed by the Board of Examiners for Audiology and Speech Pathology.

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12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

_X_ Provided __ No limitations _X_ With limitations*

___ Not Provided

b. Dentures.

_X_ Provided __ No limitations _X_ With limitations*

___ Not Provided

c. Prosthetic devices.

_X_ Provided __ No limitations _X_ With limitations*

___ Not Provided

d. Eyeglasses.

_X_ Provided __ No limitations _X_ With limitations*

___ Not Provided

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

_X_ Provided __ No limitations _X_ With limitations*

___ Not Provided

*Description provided on Attachment.

12.a.

1. Nevada Medicaid will meet all reporting and provision of information requirements of Section 1927(b)(2) and the requirements of Subsections (d) and (g) of Section 1927.

2. Covered outpatient drugs are those of any manufacturer who has entered into and complies with an agreement under Section 1927(a), which are prescribed for a medically accepted indication (as defined in Subsection 1927(k)(6)) of Title XIX of the Social Security Act.

1935(d)(1) 3. Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.

1927(d)(2)
1935(d)(2) a. Other Drugs Not Covered:

1) Pharmaceuticals designated "ineffective" or "less than effective" (including identical, related, or similar drugs) by the Food and Drug Administration (FDA) as to substance or diagnosis for which prescribed.
2) Pharmaceuticals considered "experimental" as to substance or diagnosis for which prescribed.
3) Pharmaceuticals manufactured by companies not participating in the Medicaid Drug Rebate Program unless rated "1-A" by the FDA.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency

MEDICAID PROGRAM: REQUIREMENTS RELATING TO COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

12.a. Prescribed Drugs: Description of Service Limitation

Citation(s)	Provision(s)
1935(d)(1)	Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.
1927(d)(2) and 1935(d)(2)	The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare prescription Drug Benefit – Part D.

☐ **The following excluded drugs are covered:**

("All" drugs categories covered under the drug class) ☐

("Some" drugs categories covered under the drug class ☐
-List the covered common drug categories not individual drug products directly under the appropriate drug class)

("None" of the drugs under this drug class are covered) ☐

☐ (a) agents when used for anorexia, weight loss, weight gain

☐ (b) agents when used to promote fertility

☐ (c) agents when used for cosmetic purposes or hair growth

☒ (d) agents when used for the symptomatic relief of cough and colds

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency _____

MEDICAID PROGRAM: REQUIREMENTS RELATING TO COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

12.a. Prescribed Drugs: Description of Service Limitation

Citation(s)	Provision(s)
	☒ (e) prescription vitamins and mineral products, except prenatal vitamins and fluoride
	☒ (f) nonprescription drugs
	☐ (g) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee (see specific drug categories below)

3. The State will not pay for covered outpatients' drugs of a non-participating manufacturer, except for drugs rated "1-A" by the FDA. If such a medication is essential to the health of a recipient and a physician has obtained approval for use of the drugs in advance of its dispensing, it may be covered by the program pursuant to Section 1927(a)(3).

4. The Medicaid program restricts coverage of certain covered outpatient drugs through the operation of a prior authorization program. The prior authorization process provides for a turn-around response by either telephone or other telecommunications device within twenty-four hours of receipt of a prior authorization request. In emergency situations, providers may dispense at least a seventy-two-hour supply of medication in accordance with the provisions of §1927 (d)(5) of the (SSA).

5. Pursuant to 42 U.S.C. Section 1396r-8, the state is establishing a preferred drug list with prior authorization for drugs not included on the preferred drug list. The state, or the state in consultation with a contractor, may negotiate supplemental rebate agreements that will reclassify any drug not designated as preferred in the baseline listing for as long as the agreement is in effect.

6. Pursuant to Section 1927(d)(6), the State has established a maximum quantity of medication per prescription as a 34-day supply; maintenance drugs per prescription as a 100-day (three month) supply; and contraceptives per prescription as a 12-month supply.

   a) In those cases where less than a 30-day supply of maintenance drug is dispensed without reasonable medical justification, the professional fee may be disallowed.

   b) In nursing facilities if the prescriber fails to indicate the duration of therapy for maintenance drug, the pharmacy must estimate and provide at least a 30-day supply.

7. The state will meet the requirements of Section 1927 of the SSA. Based on the requirements for Section 1927 of the act, the state has the following policies for the supplemental rebate program for Medicaid recipients:

   a) CMS has authorized the State of Nevada to enter into direct agreements with pharmaceutical manufacturers for a supplemental drug rebate program. The supplemental rebate agreement effective July 1, 2014 amends the original, January 1, 2012 version, which is effective through their expiration dates.

   b) Supplemental rebates received by the State under these agreements by the State that are in excess of those required under the national drug rebate agreement will be shared with the federal government on the same percentage basis as applied under the national rebate agreement.

   c) All drugs covered by the program, irrespective of a supplemental agreement, will comply with provisions of the national drug rebate agreement.

d) The unit rebate amount is confidential and cannot be disclosed for purposes other than rebate invoicing and verification, in accordance with Section 1927 (b)(3)(D).

e) Acceptance of supplemental rebates for products covered in the Medicaid program does not exclude the manufacturers' product(s) from prior authorization or other utilization management requirements.

f) Rebates paid under CMS-approved Supplemental Rebate Agreement for the Nevada Medicaid population does not affect AMP or best price under the Medicaid program.

8. The Medicaid program restricts coverage of certain covered outpatient drugs through the operation of a prior authorization program. The prior authorization process provides for a turn-around response by either telephone or other telecommunications device within 24 hours of receipt of a prior authorization request. In emergency situations, providers may dispense at least a 72-hour supply of medication in accordance with the provisions of §1927 (d)(5) of the SSA.

9. Pursuant to Section 1927(d)(6), the State has established a maximum quantity of medication per prescription as a 34-day supply; maintenance drugs per prescription as a 100-day (three month) supply; and contraceptives per prescription as a 12-month supply.

   a) In those cases where less than a 30-day supply of maintenance drug is dispensed without reasonable medical justification, the professional fee may be disallowed.

   b) In nursing facilities if the prescriber fails to indicate the duration of therapy for maintenance drug, the pharmacy must estimate and provide at least a 30-day supply.

12. b. Dentures are allowed every five years.

c. Prosthetic devices must be prescribed by a physician or osteopath and must be prior authorized by the Nevada Medicaid Office on Form NMO-3.

d. Eyeglasses are limited to those prescribed to correct a visual defect of at least 0.5 diopters or 10 degrees in axis deviation for recipients for recipients of all ages once in 12 months, or with prior authorization if program limitations are exceeded. In addition, they are available on the periodicity schedule established for EPSDT.

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b. Screening services.

_X_ Provided ___ No limitations _X_ With limitations*

___ Not Provided

c. Preventive services.

_X_ Provided ___ No limitations _X_ With limitations*

___ Not Provided

d. Rehabilitative services.

_X_ Provided ___ No limitations _X_ With limitations*

___ Not Provided

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

_X_ Provided ___ No limitations _X_ With limitations*

___ Not Provided

b. Nursing facility services.

_X_ Provided ___ No limitations _X_ With limitations*

___ Not Provided

*Description provided on Attachment.

A. Diagnostic Services. Provided under the EPSDT program.

B. Screening Services. Annual mammography provided to women aged 40 and over. Screening services also provided under the EPSDT program.

C. Preventive Services. Services provided are according to the United States Preventive Services Task Force (USPSTF) A and B recommendations along with approved vaccines and their administration recommended by the Advisory Committee on Immunization Practices (ACIP). Documentation is available to support claiming of FMAP for such services. As changes are made to the USPSTF and/or ACIP, coverage and billing codes will be updated to comply with the changes. Cost sharing is not applied to any of these services.

Medical Nutrition Therapy (MNT): Medical nutrition therapy services are designed to provide medically necessary, diagnostic, therapy and counseling services for the management of nutrition related disease states. MNT involves the assessment of an individual's overall nutritional status followed by an individualized course of treatment to prevent or treat medical illness. Services must be provided under a treatment plan based on evidence-based assessment criteria and include realistic and obtainable goals.

Services:

The following services are covered when provided by a Licensed and Registered Dietician and must include coordination with the referring provider:

a. An initial nutrition and lifestyle assessment
b. One on one or group nutrition counseling
c. Follow-up intervention visits to monitor progress in managing diet
d. Subsequent visits in the following years
e. Services may be provided in a group setting with the same service limitations

Service limits may be exceeded based on medical necessity. Prior authorization is required

Service Limitations:

MNT services are rendered by a Licensed and Registered Dietitian (RD) working in a coordinated, multidisciplinary team effort with a Physician, Physician's Assistant (PA) or Advanced Practice Registered Nurse (APRN). Treatment services must be ordered by the recipient's referring provider and delivered by a Registered Dietitian as defined in provider qualifications and acting within the scope of their licensure.

Provider Qualifications:

a. Licensure as a Registered Dietitian by the Nevada State Board of Health.
b. The individual must hold a bachelor's degree or higher education from an accredited college or university in human nutrition, nutrition education or equivalent education and completed the required training.
c. Registered dietitians are not authorized to supervise any non-licensed practitioners to provide medical nutrition therapy services.

D. Rehabilitative Services:

1. Mental Health Rehabilitation Services

Mental health rehabilitation assists individuals to restore and/or retain psychiatric stability, social integration skills, personal adjustment and/or independent living competencies in order to experience success and satisfaction in environments of their choice and to function as independently as possible. Interventions occur concurrently with clinical treatment and begin as soon as clinically appropriate.

The services must be recommended by a physician or other licensed practitioner of the healing arts, within their scope of practice and prescribed on an individualized treatment plan to achieve maximum reduction of a mental disability and restore the recipient to their optimal level of functioning.

13D. Rehabilitative Services

The following Practitioners and Qualifications chart is applicable to each of the Mental Health Rehabilitation Services that follow in this section.

Licensed Professionals		
Provider Type/Qualifications	**Services Provided**	**Supervisions Requirements**
• Licensed Marriage and Family Therapist (LMFT) • 42 CFR 440.60 • Licensed Clinical Social Worker (LCSW) • 42 CFR 440.60 • Licensed Clinical Professional Counselor (CPC) • 42 CFR 440.60 • Licensed Clinical Alcohol and Drug Counselor (LCADC) • 42 CFR 440.60 • Licensed Alcohol and Drug Counselor (LADC) • 42 CFR 440.60	• Individual counseling • Group counseling • Medication Assisted Treatment • Family therapy • Behavioral Health Assessment • Basic Skills Training • Psychosocial Rehabilitation • Peer-to-Peer Support Services • Crisis Services •	Services must be within the scope of the providers licensure.
• Licensed Psychologist 42 CFR 440.60	• Individual counseling • Group counseling • Family Therapy • Behavioral Health Assessment • Psychological Testing	NA
• Licensed Psychiatrist 42 CFR 440.50	• Evaluation • Medication management • Individual counseling • Group counseling • Medication Assisted Treatment • Family therapy	NA

• Registered Nurse	• Behavioral Health Assessments • Crisis Services	NA
• Advanced Practice Registered Nurse (psychiatry)	• Medication Management • Behavioral Health Assessments • Crisis Services	N/A
• Certified Alcohol and Drug Counselor (CADC) NRS 641C.390	• Individual counseling • Group counseling • Medication Assisted Treatment • Behavioral Health Assessment • Basic Skills Training • Psychosocial Rehabilitation • Peer-to-Peer Support Services • Crisis Services	CADCs do not require supervision and can function on their own within their scope of practice as referenced in NRS 641C.390. They are not licensed, but certified.
Qualified Mental Health Professional (QMHP)		
Provider Type/Qualifications	**Services Provided**	**Supervision Requirements**
• Licensed Marriage and Family Therapist (LMFT) 42 CFR 440.60 • Licensed Clinical Social Worker (LCSW) 42 CFR 440.60 • Licensed Clinical Professional Counselor (CPC) 42 CFR 440.60 • Licensed Psychologist 42 CFR 440.60 • Advanced Practice Registered Nurse The following licensed interns are covered as a QMHP	• Individual counseling • Group counseling • Medication Assisted Treatment • Family therapy • Behavioral Health Assessment • Basic Skills Training • Psychosocial Rehabilitation • Peer-to-Peer Support Services • Crisis Services	Practitioners acting in the QMHP capacity must practice within the scope of their license. Interns or those not licensed independently must be supervised by a licensed clinician appropriate to their scope/board in accordance with State regulations. The DHCFP understand that the supervising licensed clinician assumes responsibility for licensed intern supervisees.

• Licensed Marriage and Family Therapist Intern (LMFT-Intern) 42 CFR 440.60 • Licensed Clinical Social Worker Intern (LCSW-Intern) 42 CFR 440.60 • Licensed Clinical Professional Counselor Intern (CPC-Intern) 42 CFR 440.60		
Qualified Mental Health Associates (QMHA)		
Provider Type/Qualification	**Services Provided**	**Supervisions Requirements**
• Registered nurse; or • A person who meets the following minimum documented qualifications; ○ Holds a bachelor's degree in a social services field with ○ Additional understanding of mental health rehabilitation services, and case file documentation requirements; AND ○ Education and experience demonstrate the competency under clinical supervision to direct and provide professional therapeutic interventions within the scope of their practice and limits of their expertise,	• Basic Skills Training • Psychosocial Rehabilitation • Crisis Services • Peer-to-Peer Support Services	Staff acting in the QMHA capacity must be supervised by a licensed clinician appropriate to their scope/board as listed under Licensed Professionals. The DHCFP understand that the supervising licensed clinician assumes responsibility for unlicensed supervisees.

identify presenting problems, participate in treatment plan development and implementation, coordinate treatment, provide parenting skills, training, facilitate discharge plans, and effectively provide verbal and written communication on behalf of the recipient to all involved parties, AND ○ FBI background check in accordance with the provider qualifications of a QBA.		
Qualified Behavioral Aide (QBA)		
Provider Type/Qualifications	**Services Provided**	**Supervisions Requirements**
• A person who has an educational background of a high-school diploma or GED equivalent. • A QBA must have the documented competencies to assist in the provision of individual and group rehabilitation services which are under the direct supervision of a QMHP or QMHA ○ Read, write and follow written or oral instructions ○ Perform mental health	• Basic Skills Training • Peer-to-Peer Support Services	Staff acting in the QBA capacity must be supervised by a licensed clinician appropriate to their scope/board as listed under Licensed Professionals. The DHCFP understand that the supervising licensed clinician assumes responsibility for unlicensed supervisees. QBAs are required to participate in and successfully complete an approved training program which includes basic training, periodic and continuing in service training. Training must be interactive and not solely based on self-study guides or

rehabilitation services as documented in the treatment plan ○ Identify emergency situations and respond accordingly, ○ Communicate effectively, ○ Document services provided ○ Maintain confidentiality, ○ Successfully complete approved training program ○ CPR certification, • FBI criminal background check to ensure no convictions of applicable offenses have been incurred.		videotapes and should ensure that a QBA will be able to interact appropriately with individuals with mental health disorders. Training must also include: ▪ Case file documentation; ▪ Recipient's rights; ▪ HIPAA compliance; ▪ Communication skills; ▪ Problem solving and conflict resolution skills; ▪ Communication techniques for individuals with communication or sensory impairments; and ▪ CPR certification The entity that is providing supervision over the QBA shall provide annually a minimum of eight hours of service training for each QBA. The purpose of the annual training is to facilitate the development of specialized skills or knowledge not included in the basic training and/or to review or expand skills or knowledge included in the basic training. Consideration must be given to topics suggested by recipients. Documentation of the completed training and achieved competencies meeting this requirement must be maintained by the entity. Training requirements may be waived if the QBA can provide written verification of comparable education and training. The entity must document this validation.

Peer Supporter		
Provider Type/Qualifications	Services Provided	Supervision Requirements
• A qualified individual currently or previously diagnosed with a mental health disorder who has the skills and abilities to work collaboratively with and under the direction of a QMHP; • Qualified Behavioral Aide (QBA);	• Peer-to-Peer Support Services	• Peer-to-Peer Support services are delivered under Clinical Supervision, provided by an independently licensed mental health professional QMHP-level mental health professional, Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), or Clinical Professional Counselor (CPC). Supervision by the QMHP, LCSW, LMFT, or CPC, that must be provided and documented at least monthly; and • Quarterly In-Service Training: i. Specific to Peer-to-Peer Support Service delivery, the training must include any single or any combination of the following competencies: 1. The ability to help stabilize the recipient; 2. The ability to help the recipient access community-based mental health and/or behavioral health services; 3. The ability to assist during crisis situations and interventions; 4. The ability to provide preventative care assistance; and 5. The ability to provide personal encouragement, peer mentoring, self-

		direction training, and self-advocacy; and ii. Includes two hours of training in any single or any combination of the following competencies: 1. Basic living and self-care skills; 2. Social skills; 3. Communication skills 4. Parental training; 5. Organizational and time management skills; and 6. Transitional living skills.

2. Mental Health Rehabilitation Services

Mental health rehabilitation assists individuals to restore and/or retain psychiatric stability, social integration skills, personal adjustment and/or independent living competencies in order to experience success and satisfaction in environments of their choice and to function as independently as possible. Interventions occur concurrently with clinical treatment and begin as soon as clinically appropriate.

The services must be recommended by a physician or other licensed practitioner of the healing arts, within their scope of practice and prescribed on an individualized treatment plan to achieve maximum reduction of a mental disability and restore the recipient to their optimal level of functioning.

Each individual service must be identified on a written rehabilitation plan. This is also referenced as the treatment plan. Providers are required to maintain case records. Components of the rehabilitation plan and case records must be consistent with the federal rehabilitation regulations. Rehabilitation services may only be covered by Medicaid if they are not the responsibility of other programs and if all applicable requirements of the Medicaid program are met. Services covered under the Title IV-E program are not covered under the rehabilitation program. Room and Board is not an allowable service under the mental health rehabilitative program. Services are not provided to recipients who are inmates of a public institution.

These services require utilization review according to the individual intensity of need and are time limited.

Rehabilitative mental health services may be provided in a community-based, outpatient services, home-based, and school-based environment. Depending on the specific services they may be provided in a group or individual setting. All collateral services that are delivered to a person that is an integral part of the recipient's environment such as medically necessary training, counseling and therapy, must directly support the recipient.

Services are based on an intensity of needs determination. The assessed level of need specifies the amount, scope and duration of mental health rehabilitation services required to improve, retain a recipient's level of functioning or prevent relapse. The determination cannot be based upon the habilitative needs of the recipient.

Intensity of needs determination is completed by a trained Qualified Mental Health Professional (QMHP) or Qualified Mental Health Associate (QMHA) and is based on several components related to person- and family-centered treatment planning. These components include:

- A comprehensive assessment of the recipient's level of functioning;
- The clinical judgment of the QMHP; or
- The clinical judgment of the case manager working under clinical supervision who is trained and qualified in mental health intensity of services determinations; and
- A proposed Treatment Plan.

A re-determination of the intensity of needs must be completed every 90 days or anytime there is a substantial change in the recipient's clinical status.

Nevada Medicaid utilizes an intensity of needs grid to determine the amount and scope of services based upon the clinical level of care of the recipient. The grid is based upon the current level of care assessments: Level of Care Utilization System (LOCUS) for adults and Child and Adolescent Services Intensity Instrument (CASII) for children. The determined level on the grid guides the interdisciplinary team in planning treatment.

Within each level there are utilization standards for the amount of services to be delivered. The six levels are broken out by the following categories in order from less intense to more intense;

Level of Care Utilization System (LOCUS)

- Level 1- Recovery maintenance and health management,
- Level 2- Low intensity community-based services,
- Level 3- High intensity community-based services,
- Level 4- Medically monitored non-residential services,
- Level 5- Medically monitored residential services, and
- Level 6 -Medically managed residential services.

Child and Adolescent Services Intensity Instrument (CASII)

- Level 1- Basic services, Recovery maintenance and health management,
- Level 2-Outpatient services,
- Level 3- Intensive outpatient services,
- Level 4- Intensive integrated services,
- Level 5- Non-secure, 24-hour services with psychiatric monitoring,
- Level 6- Secure, 24-hour services with psychiatric management.

All mental health rehabilitation services must meet the associated admission and continuing stay criteria and go through utilization management per the intensity of needs grid.

Service Array:

1. *Assessments: C*overed for problem identification (diagnosis) and to establish measurable treatment goals and objectives by a Qualified Mental Health Professional or designated Qualified Mental Health Associate in the case of a Mental Health Screen. An assessment is not intended for entry into each of the services. It is provided as an overall assessment of the recipient's needs. Assessments are limited to two per calendar year. Additional assessments may be prior authorized based upon medical necessity. Re-assessments utilizing the appropriate CPT codes are not subject to the initial assessment limitations.

2. *Mental Health Screens*: Determine eligibility for admission to treatment program. This is completed through a clinical determination of the intensity of need of the recipient. The objective of this service is to allow for the 90-day review for the intensity of needs determination and to determine either SED or SMI if it has not already been determined. The provider must meet the requirements of a QMHA.

3. *Neuro-cognitive/psychological and mental status testing:* This service is performed by a QMHP. Examples of testing are defined in the CPT; neuropsychological testing, neurobehavioral testing, and psychological testing. Each service includes both interpretation and reporting of the tests. This service requires prior authorization.

4. *Basic Skills Training*: Services in this category are rehabilitative interventions that target concrete skills training such as: monitoring for safety, basic living skills, household management, self-care, social skills, communication skills, parent education, organization skills, time management, and transitional living skills. This service is provided in a variety of settings including community-based, outpatient services, and the home environment. The level of professional providing the services is dependent upon the needs of the recipient and the utilization management criteria. This service is provided by a QMHP or QMHA, under the direction of a QMHP, or provided by a QBA under the direct supervision of a QMHP or QMHA. This may be provided in a group (four or more individuals) or in an individual setting. These services require utilization review according to the individual intensity of need and are time limited.

5. *Psycho-social Rehabilitation*: Services in this category are rehabilitative interventions that target specific behaviors. These services may include: behavioral management and counseling, conflict and anger management, interpersonal skills, collateral interventions with schools and social service systems, parent and family training and counseling, community transition and integration, and self-management. This service is provided in a variety of settings including, community-based, outpatient services, and the home environment. The level of professional providing the services is dependent upon the needs of the recipient and the utilization management criteria. This is provided on an individual basis or in a group consisting of at least four individuals. Service is provided by a QMHP or a QMHA. The services provided may be directly attributable to an individual provider. Recipients must either be severely emotionally disturbed or seriously mentally ill. The level of care of the recipient is consistent with the high intensity community-based services. These services require utilization review according to the individual intensity of need and are time limited. This service is reimbursed in 15-minute increments.

6. *Crisis Intervention*: A service provided by a QMHP to recipients who are experiencing a psychiatric crisis and a high level of personal distress. Crisis intervention services are brief, immediate and intensive interventions to reduce symptoms, stabilize the recipient, restore the recipient to his/her previous level of functioning, and to assist the recipient in returning to the community as rapidly as possible, if the recipient has been removed from their natural setting. The individual demonstrates an acute change in mood or thought that is reflected in the recipient's behavior and necessitates crisis intervention to stabilize and prevent hospitalization. The Individual is a danger to himself, others or property or is unable to care for self as a result of personal illness. These services may be mobile and may be provided in a variety of settings, including, but not limited to, psychiatric emergency departments, homes, hospital emergency rooms, schools, child protective custody and homeless shelters. Crisis intervention services include follow-up and de-briefing sessions to ensure stabilization and continuity of care.

The service may be provided telephonically, as long as the service meets the definition of crisis intervention. Face to face crisis intervention is reimbursable for either one QMHP or a team that is composed of at least one QMHP and another QMHP or QMHA. This service is allowable for all levels of care. These services require utilization review according to the individual intensity of need and are time limited. All service limitations may be exceeded with a prior authorization demonstrating medical necessity.

7. Intentionally left blank.

8. *Mental Health Therapy:* Provided by a QMHP for individual, group, and/or family therapy with the recipient present and for family therapy without the recipient present. Therapy delivered must be of a direct benefit to the recipient. Minimum size for group therapy is three individuals and a maximum therapist to participant ratio is one to ten. Mental health therapy is available at all levels of care. The intensity of the service increases based on the need of the recipient. These services require utilization review according to the individual intensity of need and are time limited. All service limitations may be exceeded with a prior authorization demonstrating medical necessity.

Level of Care	**Child & Adolescent**	**Adult**
Level 1	10 Total Sessions; Individual, Group and Family	6 Total Sessions; Individual, Group and Family
Level II	26 Total Sessions; Individual, Group and Family	12 Total Sessions; Individual, Group and Family
Level III	26 Total Sessions; Individual, Group and Family	12 Total Sessions; Individual, Group and Family
Level IV	26 Total Sessions; Individual, Group and Family	16 Total Sessions; Individual, Group and Family
Level V	26 Total Sessions; Individual, Group and Family	18 Total Sessions; Individual, Group and Family
Level VI	26 Total Sessions; Individual, Group and Family	18 Total Sessions; Individual, Group and Family

9. *Day Treatment Services*: A community-based psycho-social package of rehabilitative services designed to improve individual and group functioning for effective community integration. This is not an Institution for Mental Illness (IMD), a Residential Treatment Facility, nor is it an institution as defined under federal regulation. Admission to this program requires: severe emotional disturbance or serious mental illness and recipient's clinical and behavioral issues require intensive, coordinated, multi-disciplinary intervention within a therapeutic milieu. Day treatment is provided in a structured therapeutic environment which has programmatic objectives such as but not limited to: development of skills to promote health relationships and learn to identify ingredients that contribute to healthy relationships, development of coping skills and strategies, development of aggression prevention plans, problem identification and resolution, ability to learn respectful behaviors in social situations, development of the ability to demonstrate

self-regulation on impulsive behaviors, development of empathy for peers and family and develop a clear understanding of recipients cycles of relapse and a relapse prevention plan. Services must be provided by a QMHP or by a QMHA under the direct supervision of a QMHP. The services provided may be directly attributable to an individual provider. The staff ratio is one to five participants. The average time per day this program is offered is three hours per day. All service limitations may be exceeded with a prior authorization meeting medical necessity.

Level of Care	**Ages 3-6**	**Ages 7-18**	**Ages 19 and older**
Level I and II	No Services Authorized	No Services Authorized	No Services Authorized
Level III	Max. of 3 hrs per day	Max. of 4 hrs per day	No Services Authorized
Level IV	Max. of 3 hrs per day	Max. of 5 hrs per day	Max. of 5 hrs per day
Level V	Max. of 3 hrs per day	Max. of 6 hrs per day	Max. of 6 hrs per day
Level VI	Max. of 3 hrs per day	Max. of 6 hrs per day	Max. of 6 hrs per day

Mental health therapy and day treatment cannot be billed for the same time period. This service is consistent with intensive integrated outpatient services. These services require utilization review according to the individual intensity of need and are time limited.

10. *Peer-to-Peer Support Services*:

These services provide scheduled activities that encourage recovery, self-advocacy, developments of natural supports, and maintenance of community living skills. They promote skills for self-determination, community inclusion/participation, independence, and productivity. Peer Supporters model skills to help individuals meet their rehabilitative goals. Peer-to-Peer Support Services are for the direct benefit of the beneficiary and assist individuals and their families in the use of strategies for coping, resiliency, self-advocacy, symptom management, crisis support, and recovery.

Service Limitations – Services may be provided in an individual or group (requires five or more individuals) setting. The services are identified in the recipient's treatment plan and must be provided by a Peer Supporter working collaboratively with the case manager or child and family team/interdisciplinary team. The selection of a Peer Supporter is based on the best interest of the recipient. A Peer Supporter cannot be the legal guardian or spouse of the recipient. Services are offered based on the intensity/frequency of needs and are time limited. Additional hours may be granted when services are clinically indicated based on a recipient-centered approach and when determined medically necessary by the state.

11. *Intensive Outpatient Services:*

Service Definition (Scope) – A comprehensive array of direct mental health and rehabilitative services which are expected to restore an individual's condition and functioning level for prevention of relapse or hospitalization. These services are provided to individuals who meet the state's medical necessity criteria for the services. Intensive outpatient group sizes are required to be within four to 15 recipients. Intensive outpatient services require the availability of 24/7 psychiatric and psychological services.

Intensive outpatient services include:

- Individual counseling
- Group counseling
- Medication management
- Medication Assisted Treatment
- Drug Testing
- Family therapy

- Occupational therapy
- Behavioral Health Assessment
- Basic Skills Training
- Psychosocial Rehabilitation
- Peer-to-Peer Support Services
- Crisis Services

Service Limitations – Intensive Outpatient services may exceed minimum hours when services are clinically indicated based on a patient centered approach. Intensive Outpatient services are direct services provided no less than three days a week, with a minimum of three hours a day and not to exceed six hours a day. Individuals needing services that exceed this time frame should be reevaluated for referral to a higher intensity/frequency of services.

Utilization management must include on-going patient assessments, including intensity of needs determinations using ASAM/LOCUS/CASII, to evaluate patient's response to treatment interventions and to monitor progress toward treatment plan goals. On-going patient assessments must be completed at regularly scheduled intervals and whenever clinically indicated. Patient assessments must document the individual patients response to the treatment plan, progress towards goals, changes in identified goals and objectives based on progress and substantiate continued stay at the current intensity/frequency of services, or of response to the treatment plan and resolution of issues necessitates transfer to a higher or lower intensity/frequency of services or discharge from treatment as no longer meeting medical necessity at any level. Transfer and discharge planning must reflect best practices recognized by professional and advocacy organizations that ensure coordination of needed services, follow-up care and recovery supports.

12. *Partial Hospitalization Services:*

Service Definition (Scope) - Services furnished in an outpatient setting, at a hospital or an enrolled federally qualified health center (FQHC) that assumes clinical liability and meets the criteria of a Certified Mental Health Clinic (CMHC). Partial hospitalization services encompass a variety of psychiatric treatment services designed for recipients who require a higher intensity of coordinated, comprehensive and multidisciplinary treatment. These services are expected to restore the individual's condition and functional level and to prevent relapse or admission to a hospital. The services are intended to be an alternative to inpatient psychiatric care and are generally provided to recipients experiencing an

exacerbation of a severe and persistent mental illness. Partial hospitalization services include active therapeutic treatment and must be targeted to meet the goals of alleviating impairments and restoring functioning.

Partial hospitalization services include:

- Individual counseling
- Group counseling
- Medication management
- Medication Assisted Treatment
- Drug Testing
- Family therapy
- Occupational therapy
- Behavioral Health Assessment
- Basic Skills Training
- Psychosocial Rehabilitation
- Peer-to-Peer Support Services
- Crisis Services

Direct services are face-to-face interactive services spent with licensed staff. Interns and assistants enrolled as a QMHP can provide partial hospitalization services while under the direct and clinical supervision of a licensed clinician. Direct supervision requires the licensed clinical supervisor to be onsite where services are rendered.

Service Limitations – Partial hospitalization may exceed minimum hours when services are clinically indicated based on a patient centered approach. PHP services are direct services provided no less than five days a week, with a minimum of four hours a day and not to exceed 23 hours a day. Individuals needing services that exceed this time frame should be reevaluated for referral to a higher intensity/frequency of services. Individuals who are not able to reside safely in the community with appropriate supports to actively engage in the PHP should not be considered appropriate for this intensity/frequency of services. Utilization management must include on-going patient assessments, including intensity of needs determinations using ASAM/LOCUS/CASII, to evaluate patient's response to treatment interventions and to monitor progress toward treatment plan goals. On-going patient assessments must be completed at regularly scheduled intervals and whenever clinically indicated. Patient assessments must document the individual patient response to the treatment plan, progress towards goals, changes in identified goals and objectives based on progress and substantiate continued stay at the current intensity/frequency of services, or of response to the treatment plan and resolution of issues necessitates transfer to a higher or lower intensity/frequency of services or discharge from treatment as no longer meeting medically necessity at any level. Transfer and discharge planning must reflect best practices recognized by professional and advocacy organizations that ensure coordination of needed services, follow-up care and recovery supports.

the following: a graduate degree in counseling and a license as a marriage and family therapist, or a clinical professional counselor, or is employed by the State of Nevada mental health agency and meets class specification qualifications of a Mental Health Counselor. The following licensed interns are covered as a QMHP: Licensed clinical social worker intern, licensed marriage and family therapist intern, licensed clinical professional counselor interns, or a Psychological Intern registered through the Psychological Board of Examiners defined in NAC 641.165. Interns must be supervised in accordance with state regulations and may only provide services within the scope of their licensure.

b. Qualified Mental Health Associate: A person who meets the following minimum documented qualifications; 1) Registered nurse OR 2) holds a bachelor's degree in a social services field with additional understanding of mental health rehabilitation services, and case file documentation requirements; AND 3) whose education and experience demonstrate the competency under clinical supervision to direct and provide professional therapeutic interventions within the scope of their practice and limits of their expertise, identify presenting problems, participate in treatment plan development and implementation, coordinate treatment, provide parenting skills, training, facilitate discharge plans, and effectively provide verbal and written communication on behalf of the recipient to all involved parties, AND 4) Has an FBI background check in accordance with the provider qualifications of a QBA.

c. Qualified Behavioral Aide: A person who has an educational background of a high-school diploma or GED equivalent. A QBA may only provide the following services: basic skills training and peer support services. A QBA must have the documented competencies to assist in the provision of individual and group rehabilitation services which are under the direct supervision of a QMHP or QMHA, read, write and follow written or oral instructions, perform mental health rehabilitation services as documented in the treatment plan, identify emergency situations and respond accordingly, communicate effectively, document services provided, maintain confidentiality, successfully complete approved training program, CPR certification, and have completed an FBI criminal background check to ensure no convictions of applicable offenses have been incurred. QBA's are required to participate in and successfully complete an approved training program which includes basic training, periodic and continuing in service training. Training must be interactive and not solely based on self-study guides or videotapes and should ensure that a QBA will be able to interact appropriately with individuals with mental health disorders. Training must also include:

- Case file documentation;
- Recipient's rights;
- HIPAA compliance;
- Communication skills;
- Problem solving and conflict resolution skills;
- Communication techniques for individuals with communication or sensory impairments; and
- CPR certification

The entity that is providing supervision over the QBA shall provide annually a minimum of eight hours of service training for each QBA. The purpose of the annual training is to facilitate the development of specialized skills or knowledge not included in the basic training and/or to review or expand skills or knowledge included in the basic training. Consideration must be given to topics suggested by recipients. Documentation of the completed training and achieved competencies meeting this requirement must be maintained by the entity. Training requirements may be waived if the QBA can provide written verification of comparable education and training. The entity must document this validation.

approved training program, CPR certification, and have completed an FBI criminal background check to ensure no convictions of applicable offenses have been incurred. QBA's are required to participate in and successfully complete an approved training program which includes basic training, periodic and continuing in service training. Training must be interactive and not solely based on self-study guides or videotapes and should ensure that a QBA will be able to interact appropriately with individuals with mental health disorders. Training must also include:

- Case file documentation;
- Recipient's rights;
- HIPAA compliance;
- Communication skills;
- Problem solving and conflict resolution skills;
- Communication techniques for individuals with communication or sensory impairments; and
- CPR certification

The entity that is providing supervision over the QBA shall provide annually a minimum of eight hours of service training for each QBA. The purpose of the annual training is to facilitate the development of specialized skills or knowledge not included in the basic training and/or to review or expand skills or knowledge included in the basic training. Consideration must be given to topics suggested by recipients. Documentation of the completed training and achieved competencies meeting this requirement must be maintained by the entity. Training requirements may be waived if the QBA can provide written verification of comparable education and training. The entity must document this validation.

Certified Community Behavioral Health Centers (CCBHC)

Certified Community Behavioral Health Center (CCBHC) is an entity that provides integrated, comprehensive health services with a focus on behavioral health. Certification indicates that the entity meets criteria as established by the State of Nevada, by the Division of Public and Behavioral Health's (DPBH) Health Care Quality and Compliance (HCQC) bureau. CCBHC's services must be provided under the philosophy of recovery and be informed by best practices for working with individuals from diverse cultural and linguistic backgrounds. Providers within the CCBHC model utilize pre-existing provider qualifications outlined under the current Rehabilitative section of the State Plan for behavioral health services and HCQC validates the appropriate policies and procedures are in place to operate as a CCBHC.

CCBHCs may also contract with Designated Collaborative Organization (DCO) that provide aspects of those services. Designated Collaborating Organization (DCO) is a distinct entity that is not under the direct supervision of a CCBHC but has a formal contractual relationship with a CCBHC to provide an authorized CCBHC service. The CCBHC must ensure the DCO provides the same quality of care as those required by the CCBHC certification. The CCBHC maintains ultimate clinical responsibility for the services provided to CCBHC recipients by the DCO under this agreement. To the extent that services are required that cannot be provided by either the CCBHC directly or by a DCO, referrals may be made to other providers or entities. The CCBHC retains responsibility for the overall coordination of a recipient's care including services provided by the DCO or those to which it refers a recipient. Providers within the DCO's utilize pre-existing provider qualifications outlined in the State Plan.

Service Array:

Nevada Medicaid offers the following services under a CCBHC delivery model. The services are currently covered services under the Rehabilitative Services benefit (13d.) of the State Plan.

- Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services and crisis stabilization;
- Screening, assessment and diagnosis, including risk assessment;
- Patient-centered treatment planning or similar processes, including risk assessment and crisis planning;
- Outpatient mental health and substance use services;
- Outpatient clinic primary care screening and monitoring of key health indicators and health risk; targeted case management;
- Psychiatric rehabilitation services;
- Peer support and counselor services and family supports.

Service Limitations:

There are no limitations on the amount, duration, and scope for services furnished under a CCBHC delivery model. An individual's treatment plan defines the services they will receive.
Practitioner/Provider Qualifications:
Please refer to the chart located at the beginning of the 13d. Rehabilitative Service section.

14. Services for individuals age 65 or older in institutions for mental diseases

A. Inpatient hospital services are limited to recipients 65 and older if the admission is prior authorized by Medicaid's Peer Review Organization (PRO). The only exception for the recipient to be admitted without a prior authorization would be in the event of an emergency in which the PRO must be notified for certification purposes within five business days after the admission.

Inpatient psychiatric services are limited to seven days. Additional services may be authorized if accompanied by daily documentation from the attending physician and determined medically necessary by the state.

An emergency psychiatric admission must meet at least one of the following three criteria:

1. Active suicidal ideation accompanied by a documented suicide attempt or documented history of a suicide attempt(s) within the past 90 days; or

2. Active suicidal ideation accompanied by physical evidence (e.g., a note) or means to carry out the suicide threat (e.g., gun, knife or another deadly weapon); or

3. Documented aggression within the 72-hour period before admission:

   a. Which resulted in harm to self, others, or property;

   b. Which manifests that control cannot be maintained outside inpatient hospitalization; and

   c. Which is expected to continue if no treatment is provided.

B. Nursing facility services require prior authorization from the Medicaid office on Form NMO-49.

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND
REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

15. a. Intermediate care facility services for MR (other than such services as in an institution for mental diseases) for persons determined, in accordance with Section 1902(a)(31)(A) of the Act, to be in need of such care.

X Provided __ No limitations X With limitations*

___ Not provided

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

X Provided __ No limitations X With limitations*

___ Not provided

16. Inpatient psychiatric facility services for individuals under 22 years of age.

X Provided X No limitations __With limitations*

___ Not provided

17. Nurse-midwife services.

X Provided ___ No limitations X With limitations*

___ Not provided

18. Hospice care (in accordance with Section 2302 of the Affordable Care Act).

X Provided X No limitations ___ With limitations*

___ Not provided

*Description provided on Attachment.

15. a. Intermediate care facility services require prior authorization from the Institutional Care Unit on Form NMO-49.

16. Intentionally left blank.

17. Nurse-midwife services are limited to the same extent as are physicians' services.

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State/Territory: NEVADA

**AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY**

19. Case management services and Tuberculosis related services

a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

_X_ Provided: _X_ With limitations

___ Not provided.

b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.

___ Provided: ___ With limitations

_X_ Not provided.

20. Extended services to pregnant women.

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

___ Additional coverage ++

b. Services for any other medical conditions that may complicate pregnancy.

_X_ Additional coverage ++

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

State/Territory: Nevada

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by an eligible provider (in accordance with Section 1920 of the Act).

__ Provided: __ No limitations __ With limitations*

_X_ Not provided.

22. Respiratory care services (in accordance with Section 1902(e)(9)(A) through (C) of the Act).

_X_ Provided: __ No limitations _X_ With limitations*

__ Not provided.

23. Certified pediatric or family nurse practitioners' services.

Provided: __ No limitations _X_ With limitations*

*Description provided on Attachment.

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

20. Extended services to pregnant women include all major categories of service provided for categorically needy recipients, except for services for individuals aged 65 or older in institutions for mental diseases, insofar as the services are medically necessary and related to the pregnancy. Services may require prior authorization from the Nevada Medicaid Office on Form NMO-3.

Expanded dental benefits are covered for pregnant women who are not normally covered for adult recipients ages 21 and older. In order to reduce the risk of premature birth due to periodontal disease, pregnant women will be allowed dental prophylaxes and certain periodontal services during pregnancy, as outlined within the Medicaid Services Manual, Chapter 1000, and the Provider Type 22 (Dentist) Fee Schedule, available on the Nevada Medicaid website, at http://dhcfp.nv.gov/.

21. All respiratory care services require prior authorization from the Medicaid Office on Form NMO-3.

22. Pediatric or family nurse practitioner services are limited to the same extent as physician services.

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a.1. Transportation

☐ Provided: ☐ No Limitations ☐ With Limitations
☒ Not Provided.

a.2. Brokered Transportation

☒ Provided: Under Section 1902(a)(70) ☐ No Limitations ☒ With Limitations*
☐ Not Provided.

a. Services provided in Religious Health Care Institutions

☐ Provided: ☐ No Limitations ☐ With Limitations
☒ Not Provided.

c. Reserved

d. Nursing facility services for patients under 21 years of age

☒ Provided: ☐ No Limitations ☒ With Limitations*
☐ Not Provided.

e. Emergency hospital services.

☒ Provided: ☒ No Limitations ☐ With Limitations
☐ Not Provided.

f. Personal care services in recipient home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

☐ Provided: ☐ No Limitations ☐ With Limitations
☒ Not Provided.

Covered under Item 26.

* Description provided on following pages

24.a.2 Brokered Transportation

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State/Territory: Nevada

SECTION 3 – SERVICES: GENERAL PROVISIONS

3.1 Amount, Duration, and Scope of Services

Medicaid is provided in accordance with the requirements of Sections 1902(a), 1902(e), 1903(i), 1905(a), 1905(p), 1905(r), 1905(s), 1906, 1915, 1916, 1920, 1925, 1929, and 1933 of the Act, Section 245A(h) of the Immigration and Nationality Act and 42 CFR Parts 431, 440, 441, 442, and 483.

A. Categorically Needy

28. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary (in accordance with Section 1905(a)(28) of the Social Security Act and 42 CFR 440.170).

a. Transportation (provided in accordance with 42 CFR 440.170 as an optional medical service) excluding "school-based" transportation.

☐ Not Provided:

☐ Provided without a broker as an optional medical service:
(**If** state attests "Provided without a broker as an optional medical service" **then insert** supplemental information.)

Describe below how the transportation program operates including types of transportation and transportation related services provided and any limitations.

Describe emergency and non-emergency transportation services separately. Include any interagency or cooperative agreements with other Agencies or programs.

☒ Non-emergency transportation is provided through a brokerage program as an optional medical service in accordance with 1902(a)(70) of the Social Security Act and 42 CFR 440.170(a)(4).

(**If** the State attests that non-emergency transportation is being provided through a brokerage program **then insert** information about the brokerage program.)

☒ The State assures it has established a non-emergency medical transportation program in accordance with 1902(a)(70) of the Social Security Act in order to more cost-effectively provide transportation, and can document, upon request from CMS, that the transportation broker was procured in compliance with the requirements of 45 CFR 92.36 (b)-(i).

(1) The State will operate the broker program without the requirements of the following paragraphs of Section 1902(a);

☐ (1) state-wideness (indicate areas of State that are covered)

☒ (10)(B) comparability (indicate participating beneficiary groups)

☒ (23) freedom of choice (indicate mandatory population groups)

(2) Transportation services provided will include:

☒ wheelchair van

☒ taxi

☒ stretcher car

☒ bus passes

☒ tickets

☒ secured transportation

☒ other transportation (if checked describe below other transportation).

- Charter air flight
- Commercial air
- Rotary Wing
- Fixed wing
- Ground ambulance
- Bus, local, city
- Bus, out of town

(3) The State assures that transportation services will be provided under a contract with a broker who:

(i) is selected through a competitive bidding process based on the State's evaluation of the broker's experience, performance, references, resources, qualifications, and costs:

(ii) has oversight procedures to monitor beneficiary access and complaints and ensures that transportation is timely and transport personnel are licensed qualified, competent and courteous:

(iii) is subject to regular auditing and oversight by the State in order to ensure the quality and timeliness of the transportation services provided and the adequacy of beneficiary access to medical care and services:

(iv) complies with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish (based on prohibitions on physician referrals under Section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate.)

(4) The broker contract will provide transportation to the following categorically needy mandatory populations:

☒ Low-income families with children (Section 1931)

☐ Deemed AFCD-related eligibles

☒ Poverty-level related pregnant women

☒ Poverty-level infants

☒ Poverty-level children 1 through 5

☒ Poverty-level children 6 – 18

☒ Qualified pregnant women AFDC – related

☒ Qualified children AFDC – related

☒ IV-E foster care and adoption assistance children

☒ TMA recipients (due to employment) (Section 1925)

☒ TMA recipients (due to child support)

☒ SSI recipients

(5) The broker contract will provide transportation to the following categorically needy optional populations:

☐ Optional poverty-level - related pregnant women
☐ Optional poverty-level - related infants
☐ Optional targeted low-income children

- ☒ Non-IV-E children who are under State adoption assistance agreements
- ☒ Non-IV-E independent foster care adolescents who were in foster care on their 18th birthday
- ☒ Individuals who meet income and resource requirements of AFDC or SSI
- ☐ Individuals who would meet the income & resource requirements of AFDC if child care costs were paid from earnings rather than by a State agency
- ☐ Individuals who would be eligible for AFDC if State plan had been as broad as allowed under Federal law
- ☐ Children aged 15-20 who meet AFDC income and resource requirements
- ☒ Individuals who would be eligible for AFDC or SSI if they were not in a medical institution
- ☐ Individuals infected with TB
- ☒ Individuals screened for breast or cervical cancer by CDC program
- ☐ Individuals receiving COBRA continuation benefit
- ☒ Individuals in special income level group, in a medical institution for at least 30 consecutive days, with gross income not exceeding 300% of SSI income standard
- ☒ Individuals receiving home and community-based waiver services who would only be eligible under State plan if in a medical institution
- ☒ Individuals terminally ill if in a medical institution and will receive hospice care
- ☐ Individuals aged or disabled with income not above 100% FPL
- ☐ Individuals receiving only an optional State supplement in a 209(b) State
- ☐ Individuals working disabled who buy into Medicaid (BBA working disabled group)
- ☒ Employed medically improved individuals who buy into Medicaid under TWWIIA Medical Improvement Group
- ☒ Individuals disabled age 18 or younger who would require an institutional level of care (TEFRA 134 kids).

(6) Payment Methodology

(A) The State will pay the contracted broker by the following method:

☒ (i) risk capitation

☐ (ii) non-risk capitation

☒ (iii) other (e.g., brokerage fee and direct payment to providers) (If checked describe any other payment methodology)

(B) Who will pay the transportation provider?

☒ (i) Broker

☐ (ii) State

☐ (iii) Other (if checked describe who will pay the transportation provider)

(C) What is the source of the non-Federal share of the transportation payments?

Describe below the source of the non-Federal share of the transportation payments proposed under the State plan amendment. If more than one source exists to fund the non-Federal share of the transportation payment, please separately identify each source of non-Federal share funding.

☒ (D) The State assures that no agreement (contractual or otherwise) exists between the State or any form of local government and the transportation broker to return or redirect any of the Medicaid payment to the State or form of local government (directly or indirectly). For instance, the NET broker will facilitate rides for recipients requiring door-to-door transport (Paratransit). The DHCFP will reimburse the Regional Transportation Commission (RTC) directly for any costs incurred for these services. This assurance is not intended to interfere with the ability of a transportation broker to contract for transportation services at a lesser rate and credit any savings to the program.

☒ (E) The State assures that payments proposed under this State plan amendment will be made directly to transportation providers and that the transportation provider payments are fully retained by the transportation providers and no agreement (contractual or otherwise) exists between the State or local government and the transportation provide to return or redirect any of the Medicaid payment to the State or form of local government (directly or indirectly).

☒ (7) The broker is a non-governmental entity:

☒ The broker is not itself a provider of transportation nor does it refer to or subcontract with any entity with which it has a prohibited financial relationship as described at 45 CFR 440.170(4)(ii).

☐ The broker is itself a provider of transportation or subcontracts with or refers to an entity with which it has a prohibited financial relationship; and

☐ Transportation is provided in a rural area as defined at 412.62(f) and there is no other available Medicaid participating provider or other provider determined by the State to be qualified except the non-governmental broker.

☐ Transportation is so specialized that there is no other available Medicaid participating provider or other provider determined by the State to be qualified except the non-governmental broker.

☐ The availability of other non-governmental Medicaid participating providers or other providers determined by the State to be qualified is insufficient to meet the need for transportation.

☐ (8) The broker is a governmental entity and provides transportation itself or refers to or subcontracts with another governmental entity for transportation. The governmental broker will:

☐ Maintain an accounting system such that all funds allocated to the Medicaid brokerage program and all costs charged to the Medicaid brokerage will be completely separate from any other program.

☐ Document that with respect to each individual beneficiary's specific transportation needs, the government provider is the most appropriate and lowest cost alternative.

☐ Document that the Medicaid program is paying no more for fixed route public transportation than the rate charged to the general public and no more for public para-transit services than the rate charged to other State human services agencies for the same service.

(9) Please describe below how the NEMT brokerage program operates. Include the services that will be provided by the broker. If applicable, describe any services that will not be provided by the broker and name the entity that will provide these services.

The NET broker provides transportation to and from medically necessary Nevada Medicaid covered services. Transportation is provided by the least expensive means available which is in accordance with the recipient's medical condition and needs and to the nearest appropriate Medicaid health care provider or medical facility. NET is available to all eligible Medicaid recipients with limitations.

Recipients call the NET broker for reservations. The NET broker verifies the recipient's eligibility and the existence of a medical services appointment. Recipients are screened for the most appropriate level of service. Recipients who use the system frequently or require high cost transportation may be further assessed by the Medicaid District Office to ensure appropriate utilization. The NET broker authorizes and schedules the rides with providers. The broker determines efficient routes.

The NET broker provides NET both statewide and out of state. Recipients traveling out of state may have the cost of meals and lodging en route to and from medical care, and while receiving medical care reimbursed. An attendant's costs may be covered if an attendant is required to ensure the recipient receives required medical services.

Medicaid does not reimburse the costs of non-emergency travel which had not been prior authorized or transportation to non-covered medical services. Ambulance charges for waiting time, stairs, plane loadings and in-town mileage and No shows, where a ride does not occur are also not reimbursable.

Full benefit dual eligible recipients may receive NET services to Access Medicaid only services.

Limitations:

Recipients whose eligibility is pending at the time of transport are not eligible for NET. QMBs and SLMBs for whom the State only pays their Medicare premiums are not eligible for NET. Emergency services only recipient may not receive NET for transport home from place of emergent services. Nursing facility NET for institutionalized recipients is included in NF rates. The NET broker may schedule rides for Paratransit services and the DHCFP will reimburse the RTC directly for any costs incurred.

Service Limitations

Recipients must contact the NET broker to obtain prior authorization for transportation in all but emergency situations. Medicaid does not reimburse the costs of: meals and lodging, transportation to non-covered medical services, ambulance charges for waiting time, stairs, plane loadings and in-town mileage, or non-emergency travel which had not been prior authorized. Medicaid does not reimburse the transportation of full benefit dual eligible Medicare Part D recipients for non-emergency travel which had not been authorized, transportation for non-covered prescription drugs, or non-emergency transportation for recipients whose eligibility is pending at the time of transport.

Provider Qualifications

To be a NET provider, a vendor must have a current provider agreement with Nevada Medicaid NET broker, a State issued exemption from TSA regulation, proof of a liability insurance policy, pursuant to NRS 706.291 for a similar situated motor carrier, a criminal background check and an alcohol and substance abuse testing program in place for the drivers, and vehicles adequately maintained to meet the requirements of the contract. Vehicles shall comply with the Americans with Disabilities Act (ADA) regulations.

24.d. Nursing facility services for patients under 21 years of age require prior authorization from the Nevada Medicaid Office on Form NMO-49.

Form
at 0"
2.92"
5.83"

24.f. Personal care services covered under Item 26, Page 10a.

State: NEVADA

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

___ Provided _X_ Not Provided

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for persons with mental retardation (ICF/MR), or institution for mental disease that are: (1) authorized for an individual in accordance with a service plan approved by the State; (2) provided by an individual who is qualified to provide such services and who is not a member of the individual's family; and (3) furnished in a home or other location.

___X___ Provided: ___X___ State Approved (Not Physician Service Plan Allowed)

_____ Not Provided: ___X___ Services Outside the Home Also Allowed

___X___ Limitations Described on Attachment

26a. Nevada Medicaid PERSONAL CARE SERVICES (PCS) assist, support, and maintain recipients living independently in their homes and in settings outside the home. These services are to be provided where appropriate, medically necessary, and consistent with program utilization control procedures. Personal Care Services may be an alternative to institutionalization. These services and hours are established based on medical necessity and must be prior authorized by Medicaid and established using a Medicaid defined functional assessment. Personal care services cannot exceed hours determined by a functional assessment conducted by State Medicaid staff or their designee. Services may be reassessed when a significant change in condition or circumstance occurs or annually as specified in policy.

Personal care services include a range of human assistance provided to persons with disabilities and chronic conditions of all ages, which enables them to accomplish tasks they would normally do for themselves if they did not have a disability. Assistance may be in the form of hands-on assistance (actually performing a personal care task for a person) or cuing so that the person performs the task by him/herself. Such assistance most often relates to performance of activities of daily living (ADLs) and instrumental activities of daily living (IADLs). ADLs include eating, bathing, dressing, toileting, transferring, and maintaining continence. IADLs capture more complex life activities and include light housework, laundry, meal preparation, transportation, and grocery shopping. Personal care services can be provided on a continuing basis or on episodic occasions. Skilled services that may be performed only by a health professional are not considered personal care services.

Personal care services may be provided by any willing and qualified provider through a Provider Agency (PA), Intermediary Service Organization (ISO), or by an Independent Contractor when a PA or ISO is not available in that area of the state. All providers must meet established qualifications of 16 hours of basic training, background checks, and TB testing. Legally responsible individuals (e.g. spouse, legal guardian, parent of minor child, legally responsible stepparent, or foster parent) may not be reimbursed for providing personal care services.

Coverage Template for Freestanding Birth Center Services

Attachment 3.1A: Freestanding Birth Center Services

28. (i) Licensed or Otherwise State-Approved Freestanding Birth Centers

Provided: ☐ No limitations ☒ With limitations ☐ None licensed or approved

Please describe any limitations:

1. Must meet applicable state licensing and/or certification requirements in the state in which the center is located. Services are limited to labor, delivery, post-partum, and immediate newborn care.

2. Accreditation by one of the following nationally recognized accreditation organizations:

   a. The Accreditation Association for Ambulatory Health Care, Inc.
   b. The Commission for the Accreditation of Birth Centers.
   c. The Joint Commission.

3. Service requirements are limited to care when the following pregnancy criteria are met:

   a. An uncomplicated low-risk prenatal course is reasonably expected to result in a normal and uncomplicated vaginal birth in agreement with licensed birth center protocol;
   b. Completion of at least 36 weeks' gestation and not more than 42 weeks' gestation.

28. (ii) Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center

Provided: ☐ No limitations ☒ With limitations (please describe below)

☐ Not Applicable (there are no licensed or State Approved Freestanding Birth Centers)

Please describe any limitations:

Childbirth procedures are limited to labor, delivery, postpartum care and immediate newborn care.

Please check all that apply:

☒ (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).

☐ (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs) and any other type of licensed midwife). *

☐ (c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*

*For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services: N/A

State: Nevada

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
TARGETED CASE MANAGEMENT SERVICES

1. General assurances for targeted case management services:

   A. Individuals have the free choice of any qualified Medicaid provider in accordance with 42 CFR § 431.51.

   B. Targeted Case Management services can not restrict an individual's access to other services under the plan.

   C. An individual cannot be compelled to receive targeted case management services, targeted case management services cannot be a condition of receipt of other Medicaid services, and other Medicaid covered services cannot be a condition to receive targeted case management services.

   D. Targeted case management services provided in accordance with Section §1915(g) of the Act will not duplicate payments made to public agencies or private entities under State plan and other program authorities. Interventions to be reimbursed for under the Targeted Case Management service must be considered a covered Medicaid service. Medicaid reviews appropriateness of service through medical documentation and claim level audits at least annually. Medicaid performs provider training meetings to review covered and non-covered services and the circumstances in which TCM may be reimbursed.

   E. Comprehensive targeted case management services are provided on a one-to-one (telephonic or face-to-face) basis. Requirements for a single-case manager are effective March 4, 2010.

   F. Targeted case management service can not authorize, approve or deny the provision of other services under the plan.

   G. Providers are to maintain case records in accordance with Medicaid policy:
      a. The name of the individual receiving services, the dates of case management services, the name of the provider agency and person chosen by the recipient to provide services.
      b. The nature, content, and units of case management services received.
      c. Whether the goals specified in the care plan have been achieved.
      d. If an individual declines services listed in the care plan, this must be documented in the individual's case record.
      e. Timelines for providing services and reassessment.
      f. The need for and occurrences of coordination with case managers of other programs.

2. Limitations:

   Targeted case management does not include the following:

A. Targeted case management activities that are an integral component of another covered Medicaid service.
B. The direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred.
C. Activities integral to the administration of foster care programs.
D. Activities, for which an individual may be eligible, that are integral to the administration of another non-medical program, except for targeted case management that is included in an individualized education program or individualized family service plan consistent with section 1903(c) of the Social Security Act.

Service: Targeted Case Management in accordance with 1915(g) of the Act.

1. Target Group: Non-SED/Non SMI
   A. Children, Adolescents and Adults who are Non-SED/SMI are persons who are not seriously mentally ill or severely emotionally disturbed, have a significant life stressor, and:
      i. A current International Classification of Diseases (ICD) diagnosis, diagnosis from the current Mental, Behavioral, Neurodevelopmental Disorders section including Z Codes 55-65, R45.850 and R45.851, which does not meet Seriously Mentally Ill or Severely Emotionally Disturbed criteria.
      ii. A Locus score of Level I or II, or
      iii. A CASII Level of 0, 1, 2, or above.

2. Geographic area to be serviced:

   ☒ Statewide

   ☐ Limited geographic area

3. Service:

   Services are not comparable in amount, duration and scope.

   Targeted case management services are services furnished to assist individuals, eligible under the State plan that reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, educational, and other services. The assistance provided through this service are:
   A. Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social, or other services.
   B. Development (and periodic revision) of a specific care plan based on the information collected through the assessment; specifies goals and actions to address services needed; activities insuring active participation of the individual and others in developing goals; and identifies a course of action to respond to the needs of the individual.
   C. Referral and related activities to help the eligible individual obtain needed services, including activities that help link the individual with medical, social, and educational providers or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.

D. Monitoring and follow-up activities, including activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual. Activities may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, including at least one annual monitoring, to help determine whether the following conditions are met:

i. Services are being furnished in accordance with the individual's care plan.
ii. Services in the care plan are adequate.
iii. There are changes in the needs or status of the eligible individual.

E. Targeted case management services may include contacts with non-eligible individuals that are directly related to the identification of the eligible individual's needs and care, for the purposes of helping the eligible individual access services, identifying needs and supports to assist the eligible individual in obtaining services, providing case managers with feedback, and alerting case managers to changes in the eligible individual's needs.

4. Frequency of Assessments and Monitoring:

A. Initial Assessment requires a face-to-face assessment.
B. Reassessment requires an annual face-to-face visit. A reassessment may occur more frequently if there is a change in the eligible individual's condition.
C. The assessment and reassessment are limited to no more than four per 365 days. This does not preclude qualified providers from adjusting the care plan and service arrangements more frequently through monitoring activities.

5. Provider Qualifications

A. Minimum qualifications of a case manager providing services for Non-SED/SMI are:

1. A Bachelor's degree in a health-related field, Registered Nurse (RN), master's level professional (LCSW or LMFT), APN in mental health, psychologist, LCSW or LMFT interns that are supervised within the scope of their license, or a mental health professional who works under the direct supervision of a person listed above. A mental health professional is an individual who is employed and determined by a state mental health agency to meet established class specifications and who has the established education and experience.

A mental health professional may work under the direct supervision of a licensed intern within their scope of practice.

6. Transitional Targeted Case Management

☒ Not provided to this target group

☐ Provided to this target group

Service: Targeted Case Management in accordance with 1915(g) of the Act.

1. Target Group: Children with a Severe Emotional Disturbance (SED)

   A. Children with SED are persons up to 18 years of age who currently or at any time during the past year (continuous 12-month period) have a:

      i. Diagnosable mental or behavioral disorder or diagnostic criteria that meets the coding and definition criteria specified in the current ICD (excluding substance abuse or addictive disorders, irreversible dementias, mental retardation, developmental disorders, and Z codes, unless they co-occur with a serious mental disorder that meets current ICD criteria); and have a:

      ii. Functional impairment which substantially interferes with or limits the child from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative or adaptive skill. Functional impairments of episodic, recurrent, and persistent features are included, however may vary in terms of severity and disabling effects unless they are temporary and an expected response to stressful events in the environment. Children who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are included in this definition.

2. Geographic area to be serviced:

   ☒ Statewide

   ☐ Limited geographic area

3. Service:

   Services are not comparable in amount, duration, and scope.

   Targeted case management services are services furnished to assist individuals, eligible under the State plan that reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, educational and other services. The assistance provided through this service are:

   A. Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social, or other services.
   B. Development (and periodic revision) of a specific care plan based on the information collected through the assessment;

9. Clinic services are subject to the same limitations listed elsewhere in this attachment, e.g., limits on prescription and physician office visits.

10. Dental services are limited to emergency care only. Requirements for prior authorization or oral surgery are specified in the Medicaid Services Manual, Chapter 1000, Addendum A. For those individuals referred for diagnosis/treatment under the Early Periodic Screening, Diagnosis and Treatment Program dental services are not so limited, and the full range of dental care is provided without authorization. Orthodontics through EPSDT require prior authorization.

11. Physical therapy and related services must be prescribed by a physician, and, are limited to services required for restitution and/or rehabilitation as contrasted with maintenance or palliation. Hospital inpatient therapy is limited to the same range of services that Medicare covers for its beneficiaries. Lon-term-care facility inpatient therapy and therapy provided outpatients, other than emergencies or initial evaluations, require prior authorization from the Nevada Medicaid Office on Form NMO-3.

C. Referral and related activities to help the eligible individual obtain needed services, including activities that help link the individual with medical, social, and educational providers or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.

D. Monitoring and follow-up activities, including activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual. Activities may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, including at least one annual monitoring, to help determine whether the following conditions are met:

i. Services are being furnished in accordance with the individual's care plan.

ii. Services in the care plan are adequate.

iii. There are changes in the needs or status of the eligible individual.

E. Targeted case management services may include contacts with non-eligible individuals that are directly related to the identification of the eligible individual's needs and care, for the purposes of helping the eligible individual access services, identifying needs and supports to assist the eligible individual in obtaining services, providing case managers with feedback, and alerting case managers to changes in the eligible individual's needs.

4. Frequency of Assessments and monitoring:

A. Initial Assessment requires a face-to-face assessment.

B. Reassessment requires an annual face-to-face visit. A reassessment may occur more frequently if there is a change in the eligible individual's condition.

C. The assessment and reassessment are limited to no more than four per 365 days. This does not preclude qualified providers from adjusting the care plan and service arrangements more frequently through monitoring activities.

5. Provider Qualifications: In accordance with §1915(g), these providers are limited based upon the target group of Chronic Mental Illness(CMI).

A. Minimum qualification of a case manager providing services for SED children and adolescents are:

i. Bachelor's degree in a health-related field, registered nurse (RN), Licensed Clinical Social Worker, Licensed Marriage and Family Therapist, Advanced Practitioner of Nursing (APN) – mental health, Psychologist or mental health professional who works under the direct supervision of a person listed above; and

ii. Provided by a State agency or the University Health System.

Limitations of targeted case management for CMI to the above listed professionals ensure needed services are received as they possess the knowledge and skills to fulfill the required elements of targeted case management, assessment and information gathering. These individuals also meet the education, work experience, training, and licensure and certification required to provide these comprehensive services to this target group. The individual is familiar with the general needs of the population and the programs that serve them.

6. Transitional Targeted Case Management

A Transitional Targeted Case Management services are provided to eligible recipients transitioning to a community setting after a period of time in a psychiatric facility or hospital for recipients under the age of 21.

☐ Not provided to this target group

☒ Provided to this target group

A. Transitional targeted case management services are provided 14 days prior to discharge for an institutional stay.

B. Transitional targeted case management activities are coordinated with and are not a duplication of institutional discharge planning services.

C. The amount, scope and duration of targeted case management activities are to be documented in an individual's plan of care which includes targeted case management activities prior to and post-discharge.

D. Transitional targeted case management is only provided by and reimbursed to community targeted case management providers.

E. Federal Financial Participation is only available to community providers and will not be claimed on behalf of an individual until discharge from the medical institution and enrollment in community services.

F. The State will monitor the compliance of transitional targeted case management through utilization management and utilization review criteria.

Service: Targeted Case Management in accordance with 1915(g) of the Act.

1. Target Group: Adults with a Serious Mental Illness (SMI)
   A. Adults with SMI are persons:
      i. 18 years of age and older; and
      ii. Who currently, or at any time during the past year (continuous 12-month period);
         a. Have a diagnosable mental, behavioral or emotional disorder that meets the coding and definition criteria specified within the current ICD, excluding substance abuse or addictive disorders, irreversible dementias as well as mental retardation, unless they co-occur with another serious mental illness that meets current ICD criteria;
         b. That resulted in functional impairment which substantially interferes with or limits one or more major life activities; and
      iii. Have a functional impairment addressing the ability to function successfully in several areas such as psychological, social, occupational or educational. It is seen on a hypothetical continuum of mental health-illness and is viewed from the individual's perspective within the environmental context. Functional impairment is defined as difficulties that substantially interfere with or limit an adult from achieving or maintaining housing, employment, education, relationships or safety.

2. Geographic area to be serviced:

   ☒ Statewide

   ☐ Limited geographic area

3. Service:

   Services are not comparable in amount, duration, and scope.

   Targeted case management services are services furnished to assist individuals, eligible under the State plan that reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, educational, and other services. The assistance provided through this service are:

   A. Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social, or other services.
   B. Development (and periodic revision) of a specific care plan based on the information collected through the assessment; specifies goals and actions to address services needed; activities insuring active participation of the individual and others in development goals; and identifies a course of action to respond to the needs of the individual.
   C. Referral and related activities to help the eligible individual obtain needed services, including activities that help link the individual with medical, social, and educational

providers or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.

D. Monitoring and follow-up activities, including activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual. Activities may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, including at least one annual monitoring, to help determine whether the following conditions are met:

i. Services are being furnished in accordance with the individual's care plan.

ii. Services in the care plan are adequate.

iii. There are changes in the needs or status of the eligible individual.

E. Targeted case management services may include contacts with non-eligible individuals that are directly related to the identification of the eligible individual's needs and care, for the purposes of helping the eligible individual access services, identifying needs and supports to assist the eligible individual in obtaining services, providing case managers with feedback, and alerting case managers to changes in the eligible individual's needs.

4. Frequency of Assessments and Monitoring:

A. Initial Assessment requires a face-to-face assessment.

B. Reassessment requires an annual face-to-face visit. A reassessment may occur more frequently if there is a change in the eligible individual's condition.

C. The assessment and reassessment are limited to no more than four per 365 days. This does not preclude qualified providers from adjusting the care plan and service arrangements more frequently through monitoring activities.

5. Provider Qualifications: In accordance with §1915(g), these providers are limited based upon the target group of Chronic Mental Illness(CMI).

a. Employee or contractor a State agency or University Health System and one of the following;

i. Bachelor's degree in a health-related field,

ii. registered nurse (RN),

iii. Licensed Clinical Social Worker,

iv. Licensed Marriage and Family Therapist,

v. Advanced Practitioner of Nursing (APN) – mental health,

vi. Psychologist,

vii. Mental health professional who works under the direct supervision of a person listed above.

viii. Limitations of targeted case management for CMI to the above listed professionals ensures needed services are received as they possess the knowledge and skills to fulfill the required elements of targeted case management, assessment and information gathering. These individuals also meet the education, work experience, training, and licensure and certification required to provide these comprehensive services to this target group. The individual is familiar with the general needs of the population and the programs that serve them.

6. Transitional Targeted Case Management

☒ Not provided to this target group

☐ Provided to this target group

Service: Targeted Case Management in accordance with 1915(g) of the Act.

1. Target Group: Persons with Mental Retardation and Related Conditions
   a. Persons with mental retardation are persons who:
      I. Are of significantly sub-average general intellectual functioning (IQ of 70 or below) and with concurrent related limitations in two or more adaptive skill areas, such as communication, self-care, social skills, community use, self-direction, health and safety, functional academics, leisure and work activities.
   b. Persons with related conditions to mental retardation are persons who have a severe, chronic disability that is attributable to cerebral palsy or epilepsy; or any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons. It is manifested before the person reaches age 22. It is likely to continue indefinitely. It results in substantial functional limitations in three or more of the following areas of major life activity:
      I. Taking care of oneself;
      II. Understanding and use of language;
      III. Learning;
      IV. Mobility;
      V. Self-direction;
      VI. Capacity for independent living.

2. Geographic area to be serviced:

☒ Statewide

☐ Limited geographic area

3. Service:

Services are not comparable in amount, duration, and scope.

Targeted case management services are services furnished to assist individuals, eligible under the State plan that reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, educational, and other services. The assistance provided through this service are:

A. Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social, or other services.
B. Development (and periodic revision) of a specific care plan based on the information collected through the assessment; specifies goals and actions to address services needed; activities
C. Insuring active participation of the individual and others in development goals; and identifies a course of action to respond to the needs of the individual.
D. Referral and related activities to help the eligible individual obtain needed services, including activities that help link the individual with medical, social, and educational providers or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.
E. Monitoring and follow-up activities, including activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual. Activities may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, including at least one annual monitoring, to help determine whether the following conditions are met:
   i. Services are being furnished in accordance with the individual's care plan.
   ii. Services in the care plan are adequate.
   iii. There are changes in the needs or status of the eligible individual.
F. Targeted case management services may include contacts with non-eligible individuals that are directly related to the identification of the eligible individual's needs and care, for the purposes of helping the eligible individual access services, identifying needs and supports to assist the eligible individual in obtaining services, providing case managers with feedback, and alerting case managers to changes in the eligible individual's needs.

4. Frequency of assessments and monitoring:
   A. Initial Assessment requires a face-to-face assessment.
   B. Reassessment requires an annual face-to-face visit. A reassessment may occur more frequent if there is a change in the eligible individual's condition.
   C. The assessment and reassessment are limited to no more than four per 365 days. This does not preclude qualified providers from adjusting the care plan and service arrangements more frequently through monitoring activities.

5. Provider Qualifications: In accordance with §1915(g), these providers are limited based upon the target group of Developmental Disability.

   a. Employee or contractor of the Division of Mental Health and Developmental Services (MHDS) and one of the following;

      I. Bachelor's level social worker licensed to practice in Nevada, or
      II. Registered Nurse licensed to practice in Nevada, or
      III. Disabilities specialist with at least a bachelor's degree in human sciences, or
      IV. Psychologist licensed to practice in Nevada, or
      V. Child Developmental Specialist and psychology, nursing, or social work caseworker who works under the direct supervision of a person above.

6. Transitional Targeted Case Management

A Transitional Targeted Case Management services are provided to eligible recipients transitioning to a community setting after a period of time in a psychiatric facility or hospital for recipients under the age of 21.

☐ Not provided to this target group

☒ Provided to this target group

A. Transitional keep targeted case management services are provided 180 days prior to discharge.

B. Transitional targeted case management activities are coordinated with and are not a duplication of institutional discharge planning services.

C. The amount, scope and duration of targeted case management activities are to be documented in an individual's plan of care which includes targeted activities prior to and post-discharge.

D. Transitional targeted case management is only provided by and reimbursed to community targeted case management providers.

E. Federal Financial Participation is only available to community providers and will not be claimed on behalf of an individual until discharge from the medical institution and enrollment in community services.

F. The State will monitor the compliance of transitional targeted case management through utilization management and utilization review criteria.

Service: Targeted Case Management in accordance with 1915(g) of the Act.

1. Target Group: Developmentally Delayed infants and toddlers
   a. Developmentally delayed infants and toddlers are children ages birth through two years and are determined eligible for early intervention services through the identification of a "developmental delay," a term which means:
      i. A child exhibits a minimum of 50% delay of the child's chronological age in any one of the areas listed below or a minimum of 25% delay of the child's chronological age in any two areas listed below. Delays for infants less than 36 weeks gestation shall be calculated according to their adjusted age.
      ii. The delay(s) must be defined in one or more of the following areas:
         a. Cognitive development;
         b. Physical development, including vision and hearing;
         c. Communication development;
         d. Social or emotional development; or
         e. Adaptive development.
      iii. Children also are eligible who have a diagnosed physical or mental condition which has a high probability of resulting in developmental delays.
      iv. Informed clinical opinion must be used in determining eligibility for services as a result of a development delay.

2. Geographic area to be serviced:

   ☒ Statewide

   ☐ Limited geographic area

3. Service:

   Services are not comparable in amount, duration, and scope.

   Targeted case management services are services furnished to assist individuals, eligible under the State plan that reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, educational and other services. The assistance provided through this service are:

   A. Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social, or other services.
   B. Development (and periodic revision) of a specific care plan based on the information collected through the assessment; specifies goals and actions to address services needed; activities insuring active participation of the individual and others in development goals; and identifies a course of action to respond to the needs of the individual. Referral and related activities to help the eligible individual obtain needed services, including activities that help link the individual with medical, social, and educational providers or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.

C. Monitoring and follow-up activities, including activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual. Activities may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, including at least one annual monitoring, to help determine whether the following conditions are met:

i. Services are being furnished in accordance with the individual's care plan.

ii. Services in the care plan are adequate.

iii. There are changes in the needs or status of the eligible individual.

D. Targeted case management services may include contacts with non-eligible individuals that are directly related to the identification of the eligible individual's needs and care, for the purposes of helping the eligible individual access services, identifying needs and supports to assist the eligible individual in obtaining services, providing case managers with feedback, and alerting case managers to changes in the eligible individual's needs.

4. Frequency of Assessments and monitoring:

A. Initial Assessment requires a face-to-face assessment.

B. Reassessment requires an annual face-to-face visit. A reassessment may occur more frequent if there is a change in the eligible individual's condition.

C. The assessment and reassessment is limited to no more than four per 365 days. This does not preclude qualified providers from adjusting the care plan and service arrangements more frequently through monitoring activities.

5. Provider Qualifications: In accordance with §1915(g), these providers are limited based upon the target group of Developmental Disability. Qualifications of a case manager providing services to an infant or toddler with developmental delays are an employee or contractor of the Department of Human Resources or one of its qualified Divisions; and

i. An individual with a master's degree from an accredited college or university in early childhood special education, childhood human growth and development, psychology, counseling, social work, or closely related field, or

ii. An individual with a Bachelor's degree from an accredited college or university with major work in early childhood growth and development, early childhood special education, psychology, counseling, social work or a closely related field, and one year of full-time professional experience in an early integrated preschool program, mental health facility, or a clinical setting providing developmental or special education or treatment-oriented services to preschool or school age children with physical or mental disabilities, or emotional or behavioral disorders.

6. Transitional Targeted Case Management

A Transitional Targeted Case Management services are provided to eligible recipients transitioning to a community setting after a period of time in a psychiatric facility or hospital for recipients under the age of 21.

☐ Not provided to this target group

☒ Provided to this target group

A. Transitional targeted case management services are provided 180 days prior to discharge for an institutional stay.

B. Transitional targeted case management activities are coordinated with and are not a duplication of institutional discharge planning.

C. The amount, scope and duration of targeted case management activities are to be documented in an individual's plan of care which includes targeted case management activities prior to and post-discharge.

D. Transitional targeted case management is only provided by and reimbursed to community targeted case management providers.

E. Federal Financial Participation is only available to community providers and will not be claimed on behalf of an individual until discharge from the medical institution and enrollment in community services.

F. The State will monitor the compliance of transitional targeted case management through utilization management and utilization review criteria.

Service: Targeted Case Management in accordance with 1915(g) of the Act.

1. Target Group: Juvenile Services

   A. Covered services will be provided to juveniles on probation (referred or under the supervision of juveniles' caseworkers).

   B. Covered services will be provided to family member who are Medicaid eligible whose children are on probation.

2. Geographic area to be serviced:

   ☒ Statewide

   ☐ Limited geographic area

3. Service:

   Services are not comparable in amount, duration, and scope.

   Targeted case management services are services furnished to assist individuals, eligible under the State plan that reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, educational, and other services. The assistance provided through this service are:

   A. Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social, or other services.
   B. Development (and periodic revision) of a specific care plan based on the information collected through the assessment; specifies goals and actions to address services needed; activities insuring active participation of the individual and others in developing goals; and identifies a course of action to respond to the needs of the individual.
   C. Referral and related activities to help the eligible individual obtain needed services, including activities that help link the individual with medical, social, and educational providers or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.
   D. Monitoring and follow-up activities, including activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual. Activities may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, including at least one annual monitoring, to help determine whether the following conditions are met:
      i. Services are being furnished in accordance with the individual's care plan.
      ii. Services in the care plan are adequate.
      iii. There are changes in the needs or status of the eligible individual.

E. Targeted case management services may include contacts with non-eligible individuals that are directly related to the identification of the eligible individual's needs and care, for the purposes of helping the eligible individual access services, identifying needs and supports to assist the eligible individual in obtaining services, providing case managers with feedback, and alerting case managers to changes in the eligible individual's needs.

4. Frequency of Assessments and Monitoring:
Initial Assessment requires a face-to-face assessment.

A. Reassessment requires an annual face-to-face visit. A reassessment may occur more frequently if there is a change in the eligible individual's condition.

B. The assessment and reassessment are limited to no more than four per 365 days. This does not preclude qualified providers from adjusting the care plan and service arrangements more frequently through monitoring activities.

5. Provider Qualifications:

A. Targeted case management services will be provided only through qualified provider agencies. Qualified targeted case management services provider agencies must meet the following criteria:

1. Have full access to all relevant records concerning the child's needs for services including records of the Nevada District Family and Juvenile Courts.

2. Have established referral systems and demonstrated linkages and referral ability with community resources required by the target population.

3. Have a minimum of five years' experience in providing all core elements of target services to the target populations.

4. Have an administrative capacity to ensure quality of services in accordance with State and Federal requirements.

5. Have a financial management capacity and system that provides documentation of services and costs in accordance with OMB A-87 principles.

6. Have a capacity to document and maintain individual case records in accordance with State and Federal requirements, and

7. Have a demonstrated ability to meet all State and Federal laws governing the participation of providers in the State Medicaid program, including the ability to meet Federal and State requirements for documentation, billing and audits.

B. Individual case managers working for provider agencies must meet the following minimum qualification.

1. meet the minimum qualifications for case managers as established by qualified provider agencies and

2. have a minimum of a bachelor's degree in social work, sociology, psychology, criminal justice or a related field and

3. have experience in working with youth and

4. Documented experience in a closely related youth services field may be substituted on a year-for-year basis.

6. Transitional Targeted Case Management

Transitional Targeted Case Management services are provided to eligible recipients transitioning to a community setting after a period of time in a psychiatric facility or hospital for recipients under the age of 21.

☐ Not provided to this target group

☒ Provided to this target group

A. Transitional targeted case management services are provided 180 days prior to discharge for an institutional stay.

B. Transitional targeted case management activities are coordinated with and are not a duplication of institutional discharge planning services.

C. The amount, scope and duration of targeted case management activities are to be documented in an individual's plan of care which includes targeted case management activities prior to and post-discharge.

D. Transitional targeted case management is only provided by and reimbursed to community targeted case management providers.

E. Federal Financial Participation is only available to community providers and will not be claimed on behalf of an individual until discharge from the medical institution and enrollment in community services.

F. The State will monitor the compliance of transitional targeted case management through utilization management and utilization review criteria.

Service: Targeted Case Management in accordance with 1915(g) of the Act.

1. Target Group: Child Protective Services

   1. This service will be reimbursed when provided to children and young adults who are Medicaid recipients who are abused or neglected or suspected to be at risk thereof as evidenced by being in the care of the Division of Child and Family Services, Clark County Department of Family Youth Services and Washoe County Department of Social Services.

   2. Covered services will be provided to families who are Medicaid recipients whose children are abused or neglected or suspected of to be at risk thereof as evidenced by being in the care of the Division of Child and Family Services, Clark County Department of Family Youth Services and Washoe County Department of Social Services.

2. Geographic area to be serviced:

   ☒ Statewide

   ☐ Limited geographic area

3. Service:

   Services are not comparable in amount, duration, and scope.

   Targeted case management services are services furnished to assist individuals, eligible under the State plan that reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, educational, and other services. The assistance provided through this service are:

   A. Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social, or other services.
   B. Development (and periodic revision) of a specific care plan based on the information collected through the assessment; specifies goals and actions to address services needed; activities insuring active participation of the individual and others in developing goals; and identifies a course of action to respond to the needs of the individual.
   C. Referral and related activities to help the eligible individual obtain needed services, including activities that help link the individual with medical, social, and educational providers or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan.
   D. Monitoring and follow-up activities, including activities and contacts that are necessary to ensure that the care plan is effectively implemented and adequately addresses the needs of the eligible individual. Activities may be with the individual, family members, service providers, or other

entities or individuals and conducted as frequently as necessary, including at least one annual monitoring, to help determine whether the following conditions are met:

i. Services are being furnished in accordance with the individual's care plan.
ii. Services in the care plan are adequate.
iii. There are changes in the needs or status of the eligible individual.

E. Targeted case management services may include contacts with non-eligible individuals that are directly related to the identification of the eligible individual's needs and care, for the purposes of helping the eligible individual access services, identifying needs and supports to assist the eligible individual in obtaining services, providing case managers with feedback, and alerting case managers to changes in the eligible individual's needs.

4. Frequency of Assessments and Monitoring: Initial Assessment requires a face-to-face assessment.

A. Reassessment requires an annual face-to-face visit. A reassessment may occur more frequently if there is a change in the eligible individual's condition.

B. The assessment and reassessment are limited to no more than four per 365 days. This does not preclude qualified providers from adjusting the care plan and service arrangements more frequently through monitoring activities.

5. Provider Qualifications:

Targeted case management services will be provided only through qualified provider agencies. Qualified provider agencies must have case managers which meet one of the following criteria:

1. Must have as a minimum the following education and/or experience: (a) Equivalent to completion of 60 semester units of college level course work with a minimum of 15 semester units of child development, psychology, social work or a closely related behavioral science field. (b) Experience in a field related to the work may be substituted for the education on a year-for-year basis.

2. Must have as a minimum the following education and/or experience: (a) Equivalent to a bachelor's degree in criminal justice, psychology, social service, sociology or a closely related field. (b) Experience in a field related to the work may be substituted for the education on a year-for-year basis.

3. Must have as a minimum the following education and/or experience: a) Equivalent to a bachelor's degree in child development, psychology, social work or a closely related field. (b) Experience in a field related to the work may be substituted for the education on a year-for-year basis.

4. Must have as a minimum the following education and/or experience: a) bachelor's degree from an accredited college or university in social work, guidance and counseling, education, gerontology, human services, marriage and family studies, psychology, social welfare or sociology. (b) Licensed to practice social work in the state of Nevada; or eligible for licensure at the time of appointment.

6. Transitional Targeted Case Management

Transitional Targeted Case Management services are provided to eligible recipients transitioning to a community setting after a period of time in a psychiatric facility or hospital for recipients under the age of 21.

☐ Not provided to this target group

☒ Provided to this target group

A. Transitional targeted case management services are provided 180 days prior to discharge for an institutional stay.

B. Transitional targeted case management activities are coordinated with and are not a duplication of institutional discharge planning services.

C. The amount, scope and duration of targeted case management activities are to be documented in an individual's plan of care which includes targeted case management activities prior to and post-discharge.

D. Transitional targeted case management is only provided by and reimbursed to community targeted case management providers.

E. Federal Financial Participation is only available to community providers and will not be claimed on behalf of an individual until discharge from the medical institution and enrollment in community services.

F. The State will monitor the compliance of transitional targeted case management through utilization management and utilization review criteria.

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Target Group (42 Code of Federal Regulations 441.18(a)(8)(i) and 441.18(a)(9)):

Nevada Medicaid eligible children on parole, under the age of 21 years old, who are:

1. At high risk for medical compromise due to one of the following conditions:
   a. Failure to take advantage of necessary health care services, or
   b. Noncompliance with their prescribed medical regime, or
   c. An inability to coordinate multiple medical, social and other services due to the existence of an unstable medical condition in need of stabilization, or
   d. An inability to understand medical directions because of comprehension barriers, or
   e. A lack of community support system to assist in appropriate follow-up care at home, or
   f. Substance abuse, or
   g. A victim of abuse, neglect or violence; and
2. In need of assistance in accessing necessary medical, social, educational, or other services, when comprehensive case management is not being provided elsewhere.

Target group includes individuals transitioning to a community setting. Case-management services will be made available for up to180 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions. (State Medicaid Directors Letter (SMDL), July 25, 2000)

Areas of State in which services will be provided (§1915(g)(1) of the Act):

X Entire State
__ Only in the following geographic areas:

Comparability of services (§§1902(a)(10)(B) and 1915(g)(1))

__ Services are provided in accordance with §1902(a)(10)(B) of the Act.
X Services are not comparable in amount duration and scope (§1915(g)(1)).

Definition of services (42 CFR 440.169): Targeted case management services are defined as services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational and other services. Targeted Case Management includes the following assistance:

1. Comprehensive assessment and periodic reassessment of individual needs, to determine the need for any medical, educational, social or other services. These assessment activities include:

   - taking client history;

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- identifying the individual's needs and completing related documentation; and
- gathering information from other sources such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the eligible individual;

Assessment and/or periodic reassessment to be conducted at a minimum of once every six months to determine if an individual's needs, conditions, and/or preferences have changed.

2. Development (and periodic revision) of a specific care plan that is based on the information collected through the assessment that:

   - specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
   - includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
   - identifies a course of action to respond to the assessed needs of the eligible individual;

3. Referral and related activities (such as scheduling appointments for the individual) to help the eligible individual obtain needed services including:

   - activities that help link the individual with medical, social, educational providers, or other programs and services that are capable of providing needed services to address identified needs and achieve goals specified in the care plan; and

4. Monitoring and follow-up activities:

   - activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs, and which may be with the individual, family members, service providers, or other entities or individuals and conducted as frequently as necessary, and including at least one annual monitoring, to determine whether the following conditions are met:
     - services are being furnished in accordance with the individual's care plan;
     - services in the care plan are adequate; and
     - changes in the needs or status of the individual are reflected in the care plan. Monitoring and follow-up activities include making necessary adjustments in the care plan and service arrangements with providers.

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- Periodic Reviews will be completed at least every six months. These activities may be conducted as specified in the care plan, or as frequently as necessary to ensure execution of the care plan.
- Monitoring does not include ongoing evaluation or check-in of an individual when all care plan goals have been met.

X Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e))

Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

TCM Provider Agency Qualifications:

The organization providing case management services for Juvenile Parole Services must meet the following provider qualification requirements:

1. A minimum of five years' experience of working successfully with children and families in the target population, including a demonstrated capacity to provide all components of case management.
2. Establish a system to coordinate services for individuals who may be covered under another program which offers components of case management or coordination similar to TCM including, but not limited to, the coordination of services with Managed Care providers, Division of Child and Family Services, as well as State waiver programs; and
3. Demonstrated programmatic and administrative experience in providing comprehensive case management services and the ability to increase their capability to provide their services to the target group; and
4. Must be an agency employing staff with case management qualifications; and
5. Establish referral systems and demonstrated linkages and referral ability with essential social and health service agencies; and
6. A minimum of five years' experience in responding successfully to the needs of children and families in the target population on a countywide 24 hours, seven days a week basis.
7. A minimum of five years' case management experience in coordinating and linking community medical, social, educational, or other resources needed by the target population on a countywide basis.

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8. A minimum of five years' experience in documenting and maintaining individual case records that is in accordance with all applicable state and federal requirements.
9. A minimum of five years' experience of demonstrated capacity in meeting the case management service needs of the target population.
10. Demonstrated capacity to provide training and supervision to individual case managers, including training pertaining to Medicaid-covered services.

Qualifications of individual case managers:

1. Bachelor's degree in criminal justice, psychology, social work or a closely related field; or equivalent college and two years of experience in the criminal justice system to include conducting casework services, making program eligibility determinations, investigating offenders, preparing detailed reports for the purposes of justifying criminal sanctions and/or prosecution, or coordinating with law enforcement agencies, the juvenile justice system, community-based placements, and related State agencies regarding the preparation of parole agreements, placement, program development, obtaining services and the legal process of assigned youth; and
2. Ability to work in and with legal systems, including the court system and law enforcement; and
3. Ability to learn state and federal rules, laws, and guidelines relating to the target population and to gain knowledge about community resources.

Freedom of choice (42 CFR 441.18(a)(1)):

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan. Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):

Access to Services (42 CFR 441.18(a)(2), 42 CFR 441.18(a)(3), 42 CFR 441.18(a)(6)):

The State assures the following:

- Case management (including targeted case management) services will not be used to restrict an individual's access to other services under the plan.

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- Individuals will not be compelled to receive case management services, condition receipt of case management (or targeted case management) services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management (or targeted case management) services; and
- Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

Payment (42 CFR 441.18(a)(4)):

Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

Case Records (42 CFR 441.18(a)(7)):
Providers maintain case records that document for all individuals receiving case management as follows: (i)The name of the individual; (ii) The dates of the case management services; (iii)The name of the provider agency (if relevant) and the person providing the case management service; (iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) Whether the individual has declined services in the care plan; (vi) The need for, and occurrences of, coordination with other case managers; (vii) A timeline for obtaining needed services; (viii) A timeline for reevaluation of the plan.

Limitations:
Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service (State Medicaid Manual (SMM) 4302.F).

Case management does not include, and Federal Financial Participation (FFP) is not available in expenditures for, services defined in §441.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c))

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FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act. (§§1902(a)(25) and 1905(c))

Limitations on translation: Arranging for translation activities and/or providing translation as part of the TCM service, including the costs of purchasing translation services from a vendor to enable communication between the client and case manager, is included in the TCM rate. When a case manager provides translation that is unrelated to providing the TCM service, the translation is not claimable as TCM.

Case Management Services Do Not Include:

1. Targeted case management activities that are an integral component of another covered Medicaid service.
2. The direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred.
3. Activities integral to the administration of foster care programs.
4. Activities, for which an individual may be eligible, that are integral to the administration of another non-medical program, except for targeted case management that is included in an individualized education program or individualized family service plan consistent with Section 1903(c) of the Social Security Act.

State: Nevada

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S):

The following ambulatory services are provided.

N/A

State: Nevada

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): N/A

1. Inpatient hospital services other than those provided in an institution for mental diseases.

___ Provided: ____ No limitations ___With limitations*

2.a. Outpatient hospital services.

___ Provided: ____ No limitations ___With limitations*

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.

___ Provided: ____ No limitations ___With limitations*

3. Other laboratory and X-ray services

___ Provided: ____ No limitations ___With limitations*

4.a. Skilled nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

___ Provided: ____ No limitations ___With limitations*

b. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.

___ Provided: ____ Limited to Federal requirements ___ In excess of Federal requirements

c. Family planning services and supplies for individuals of childbearing age.

___ Provided: ____ No limitations ___With limitations*

5. Physician's services, whether furnished in the office, or the patient's home, a hospital, a skilled nursing facility, or elsewhere.

___ Provided: ____ No limitations ___With limitations*

Description provided on attachment.

State: Nevada

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): N/A

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

   a. Podiatrists' Services

      ___ Provided: ____ No limitations ___With limitations*

   b. Optometrists' Services

      ___ Provided: ____ No limitations ___With limitations*

   c. Chiropractors' Services

      ___ Provided: ____ No limitations ___With limitations*

   d. Other Practitioners' Services

      ___ Provided: ____ No limitations ___With limitations*

7. Home Health Services

   a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

      ___ Provided: ____ No limitations ___With limitations*

   b. Home health aide services provided by a home health agency.

      ___ Provided: ____ No limitations ___With limitations*

   c. Medical supplies, equipment, and appliances suitable for use in the home.

      ___ Provided: ____ No limitations ___With limitations*

   d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

      ___ Provided: ____ No limitations ___With limitations*

* Description provided on attachment.

State: Nevada

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): N/A

8. Private duty nursing services.

___ Provided: ____ No limitations ___With limitations*

9. Clinic services.

___ Provided: ____ No limitations ___With limitations*

10. Dental services.

___ Provided: ____ No limitations ___With limitations*

11. Physical therapy and related services.

a. Physical therapy

___ Provided: ____ No limitations ___With limitations*

b. Occupational therapy.

___ Provided: ____ No limitations ___With limitations*

c. Services for individuals with speech, hearing and language disorders provided by or under supervision of a speech pathologist or audiologist.

___ Provided: ____ No limitations ___With limitations*

12. Prescribed drugs, dentures and prosthetic devices; and eyeglasses prescribed by a physician skilled in disease of the eye or by an optometrist.

a. Prescribed drugs.

___ Provided: ____ No limitations ___With limitations*

b. Dentures.

___ Provided: ____ No limitations ___With limitations*

* Description provided on attachment

State: Nevada

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): N/A

c. Prosthetic devices.

___ Provided: ____ No limitations ___With limitations*

d. Eyeglasses.

___ Provided: ____ No limitations ___With limitations*

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan.

a. Diagnostic services.

___ Provided: ____ No limitations ___With limitations*

b. Screening services.

___ Provided: ____ No limitations ___With limitations*

c. Preventive services.

___ Provided: ____ No limitations ___With limitations*

d. Rehabilitative services.

___ Provided: ____ No limitations ___With limitations*

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

___ Provided: ____ No limitations ___With limitations*

b. Skilled nursing facility services.

___ Provided: ____ No limitations ___With limitations*

* Description provided on attachment

State: Nevada

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): N/A

c. Intermediate care facility services.

___ Provided: ____ No limitations ___With limitations*

15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined in accordance with Section 1902 (a) (31) (a) of the Act, to be in need of such care.

___ Provided: ____ No limitations ___With limitations*

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

16. Inpatient psychiatric facility services for individuals under 22 years of age.

___ Provided: ____ No limitations ___With limitations*

17. Nurse-midwife services.

___ Provided: ____ No limitations ___With limitations*

18. Hospice care (in accordance with Section 2302 of the Affordable Care Act).

___ Provided: ____ No limitations ___With limitations*

* Description provided on attachment.

State: Nevada

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): N/A

19. Case management services as defined in and to the group specified in Supplement 1 to Attachment 3.1-A (in accordance with Section 1905 (a) (19) or Section 1915 (g) of the Act).

___ Provided: ___With limitations ___Not provided

20. Extended services for pregnant women.

a. Pregnancy-related and postpartum services for 60 days after the pregnancy ends.

___ Provided: + ____ Additional coverage ++

b. Services for any other medical conditions that may complicate pregnancy.

___ Provided: + ____ Additional coverage ++ ___Not provided

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a qualified provider (in accordance with Section 1920 of the Act).

___ Provided: ____ No limitations ___With limitations*

___Not provided

\+ Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment

State: Nevada

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

22. Respiratory care services (in accordance with Sections 1902(e)(9)(A) through (C) of the Act).

___ Provided: ____ No limitations ___With limitations*

___Not provided

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation

___ Provided: ____ No limitations ___With limitations*

b. Services provided in religious Non-Medical Health Care Institutions.

___ Provided: ____ No limitations ___With limitations*

c. Reserved

d. Skilled nursing facility services for patients under 21 years of age.

___ Provided: ____ No limitations ___With limitations*

e. Emergency hospital services.

___ Provided: ____ No limitations ___With limitations*

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

___ Provided: ____ No limitations ___With limitations*

* Description provided on attachment

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Attachment 3.1-C

STATE NEVADA

STANDARDS AND METHODS OF ASSURING HIGH QUALITY CARE

The standards demanded of all medical services are necessity, appropriateness and timelines.

Methods of assuring high quality care encompass the entire administration of the program. They include but are not limited to:

1. Use of professional medical and paramedical consultants.
2. Verification of the professional qualification of providers.
3. Public relations efforts and active use of the Medical Care Advisory Groups.
4. Payment of fees adequate to enlist a high percentage of each professional group.
5. Constant assessment of under and over-utilization followed by appropriate action.
6. Use of local medical societies to adjudicate professional problems.
7. Prompt payment of claims.
8. Use of Medical Social Teams at the local level to review care received and evaluate need for and use of medical services and supplies.
9. Nurse visits to each medical facility on weekly basis.
10. Toll-free statewide telephone to Medical Assistance Unit for providers with questions or problems.
11. Integration of medical and social services.

TRANSPORTATION

The State of Nevada Division of Health Care Financing and Policy (DHCFP) provides emergency medical transportation and non-emergency transportation (NET) of eligible recipients to and from Nevada Medicaid covered services in accordance with 42 CFR440.170, 42 CFR431.53, 45 CFR92.36.

Emergency medical transportation services are covered to the nearest, appropriate Medicaid health care provider or appropriate medical facility capable of meeting the recipient's medical needs, in an emergent situation, when other methods of transportation are contraindicated. Emergency medical transportation may be provided via ground or air ambulance transport. These services do not require prior authorization.

Ground ambulance emergency medical transportation claims for all Nevada Medicaid recipients, including Managed Care Organization (MCO) enrolled recipients, must be submitted to Nevada Medicaid's fiscal agent.

Air ambulance transportation claims for Nevada Medicaid recipients enrolled in Fee-for-Service Medicaid, must be submitted to Nevada Medicaid's fiscal agent. For recipients enrolled in MCO, claims for air ambulance transportation are to be submitted to the MCO in which the recipient is enrolled.

NET services are provided to all eligible Nevada Medicaid recipients under a contract with a broker who:

1. Is selected through a competitive bidding process based on the state's evaluation of the broker's experience, performance, references, resources, qualifications and costs;

2. Has oversight procedures to monitor recipient access and complaints and ensures the transportation personnel are licensed, qualified, competent and courteous;

3. Is subject to regular auditing and oversight by the state in order to ensure that quality of the transportation services provided and adequacy of recipient access to medical care and services;

4. Complies with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish.

The State assures that the NET Broker itself is not a provider of transportation. The NET broker may not hold ownership in any NET provider with whom the broker subcontracts or arranges NET through a non-contractual relationship. This prohibition applies to the corporation, if the broker is incorporated and to the owners, officers or employees of the broker.

The State of Nevada assures the availability of medically necessary transportation to and from medical providers for eligible Medicaid recipients in the following ways:

1. Eligible Medicaid program recipients are informed verbally and in writing of the availability of non-emergency transportation services by the Nevada Medicaid contracted Transportation Broker.

2. NET is contracted by a broker to provide transportation to medically necessary covered services statewide 24 hours a day, seven days per week, including weekends and holidays. The NET broker operates within all applicable Federal, State and local laws.
3. All NET services require prior authorization by DHCFP's NET broker with the exception of NET services provided by Indian Health Services (IHS) clinics. The NET broker is required to authorize the least expensive alternative conveyance available consistent with the recipient's medical condition and needs.

4. The NET broker will facilitate rides for recipients requiring door-to-door transport (Paratransit). The DHCFP will reimburse the Regional Transportation Commission (RTC) directly for any costs incurred for these services.

NET is not covered for recipients residing in a Nursing Facility (NF) setting requiring NET to and from Nevada Medicaid covered services. NET is the responsibility of the NF as NET is included in the NF all-inclusive per diem rates.

TRANSPORTATION

Transportation services must be:
1. Medically necessary;
2. Only to and from Nevada Medicaid covered services;
3. Provided by the least expensive means available which is in accordance with the recipient's medical condition and needs;
4. To the nearest appropriate Medicaid health care provider or medical facility.

Covered transportation services may be provided by:
1. Charter air flight;
2. Commercial air;
3. Rotary wing;
4. Fixed wing;
5. Ground ambulance;
6. Air ambulance;
7. Bus, local city;
8. Bus, out of town;
9. Para-transit – Public;
10. Para-transit – Private;
11. Private vehicle; and
12. Taxi.

Travel expenses include:
1. The cost of the ambulance, taxicab, common carrier, or other appropriate means;
2. The cost of meals and lodging en route to and from medical care, and while receiving medical care;
3. An attendant's costs may be covered if an attendant is required to ensure the recipient receives required medical services.

Medicaid does not reimburse the costs of:
1. Non-emergency travel which had not been prior authorized;
2. Transportation to non-covered medical services; or
3. Ambulance charges for waiting time, stairs, plane loadings and in-town mileage;
4. Non-emergency transportation for recipients whose eligibility is pending at the time of transport.
5. No shows, where a ride does not occur.

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

A. Transplants and associated fees to be reimbursed by Nevada Medicaid:

1. Corneal;
2. Kidney;
3. Liver; and
4. Bone marrow.

B. The following transplants are not covered by Nevada Medicaid and associated fees relating to the transplants are not to be reimbursed by Nevada Medicaid.

1. Heart;
2. Heart/Lung;
3. Heart/Liver
4. Pancreas; nor
5. Post surgical care, which directly and unequivocally relates to the transplant, will not be reimbursed. For example:
   a. Hospital admission for transplant;
   b. Physician fees for transplant;
   c. All other ancillary charges included for acute care related to the original admission for transplant; or
   d. Capture of live or cadaveric organ for any transplant.

C. The Quality Improvement Organization-like vendor under contract with Nevada Medicaid will be responsible for transplant approval for program eligibles based on written Medicare criteria when appropriate, the following Medicaid criteria, and on medical judgment of recipient appropriateness.

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

Transplants will not be approved if they are not medically necessary and if:

1. The procedure is specified as experimental by the National Institutes of Health;
2. Another procedure costing less or which is less risky will achieve the same result;
3. The transplant will not make a difference in the recipient's health and performing the transplant will merely serve an academic purpose.
4. The transplant is relatively unsafe given the age and prognosis of the recipient; and
5. The transplant does not meet appropriate Medicare criteria.

Determination of acceptability for transplants will not be made on the basis of race, color, sex, national origin, handicapping condition, or age except as given in the above criteria.

D. In the absence of a familial or unrelated organ donor, organs must be procured from an Organ Procurement Organization meeting the requirements of 42 CFR 486. Organ donor search and match services will be approved for payment by Nevada Medicaid or its vendor(s) at negotiated rates.

If transplant services are not available in Nevada, out-of-state services may be approved, including transportation, evaluation, transplant, and follow-up services.

Payment for transportation will be prior authorized by Nevada Medicaid or its vendor(s) to and from an approved transplant facility for all covered medically necessary transplant services.

State/Territory: Nevada

Citation 3.1 (g) Participation by Indian Health Service Facilities
42 CFR 431.110(b)
AT-78-90

Indian Health Service facilities are accepted as providers, in accordance with 42 CFR 431.110(b), on the same basis as other qualified providers.

1902 (e) (9) of the Act,
P.L. 99-509
(Section 9408)

(h) Respiratory Care Services for Ventilator-Dependent Individuals

Respiratory care services, as defined in section 1902 (e) (9) (C) of the Act, are provided under the plan to individuals who

(1) Are medically dependent on a ventilator for life support at least six hours per day;

(2) Have been so dependent as inpatients during a single stay or a continuous stay in one or more hospitals, SNFs or ICFs for the lesser of –

__X__ 30 consecutive days;

_____ days (the maximum number of inpatient days allowed under the State plan);

(3) Except for home respiratory care, would require respiratory care on an inpatient basis in a hospital, SNF or ICF for which Medicaid payments would be made;

(4) Have adequate social support services to be cared for at home; and

(5) Wish to be cared for at home.

__X__ Yes. The requirements of section 1902 (e) (9) of the Act are met.

_____ Not applicable. These services are not included in the plan.

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 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)

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) 438.6(c) 42 CFR 438.50(c)(6)	7.	X The state assures that all applicable requirements of 42 CFR 42 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)	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
Population	**M**	**Geographic Area**	V	**Geographic Area**	**Excluded**

Citation | Condition or Requirement

MCO					
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).

PCCM					
Population	**M**	**Geographic Area**	V	**Geographic Area**	**Excluded**

Citation Condition or Requirement

PCCM					
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					
Population	**M**	**Geographic Area**	V	**Geographic Area**	**Excluded**
Children under 19 receiving services funded under section					

Citation	Condition or Requirement				
PCCM					
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 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 Three 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):

Swing bed stays in acute hospitals over 45 days

Citation	Condition or Requirement

The MCO is required to cover the first 45 days of a swing bed. The MCO shall notify the DHCFP of any swing bed stay expected to exceed 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.

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 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.

Citation	Condition or Requirement
	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 two 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 lapse 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 two months or less for reasons other than a loss in Medicaid eligibility OR for more than two 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. 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

Citation | Condition or Requirement

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 two months or less.

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

1932(a)(4)
42 CFR 438.56

G. Disenrollment

1. X The state will limit disenrollment for managed care.

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

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

3. 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.

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.

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.

Citation		Condition or Requirement
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 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. **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.

Citation		Condition or Requirement
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. X The state will 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 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.

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, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850
CMS-10120 (exp. 3/31/2014)

§1915(i) Home and Community Based Services (HCBS) State Plan Services
ADMINISTRATION AND OPERATION

1. Program Title: **NEVADA 1915(i) STATE PLAN HOME AND COMMUNITY BASED SERVICES -** Including Adult Day Health and HCBS Home-Based Habilitation.

§1915(i) Home and Community Based Services (HCBS) State Plan Services
ADMINISTRATION AND OPERATION

2. State-wideness:

☒ The State implements this supplemental benefit package statewide, per §1902(a)(1) of the Act.

☐ The State implements this benefit without regard to the state wideness requirements in §1902(a)(1) of the Act.:

☐ Geographic Limitation. HCBS state plan services will only be available to individuals who reside in the following geographic areas or political subdivisions of the State.:

☐ Limited Implementation of Participant-Direction. HCBS state plan services will be implemented without regard to state-wideness requirements to allow for the limited implementation of participant-direction. Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the State. Individuals who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.:

§1915(i) Home and Community Based Services (HCBS) State Plan Services
ADMINISTRATION AND OPERATION

3. State Medicaid Agency (SMA) Line of Authority for Operating the HCBS State Plan Supplemental Benefit Package:

☒ The HCBS state plan supplemental benefit package is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*:

☒ The Medical Assistance Unit: **Division of Health Care Financing and Policy**

☐ Another division/unit within the SMA that is separate from the Medical Assistance Unit

☐ The HCBS state plan supplemental benefit package is operated by: a separate agency of the State that is not a division/unit of the Medicaid agency. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.

§1915(i) Home and Community Based Services (HCBS) State Plan Services
ADMINISTRATION AND OPERATION

§1915(i) Home and Community Based Services (HCBS) State Plan Services
ADMINISTRATION AND OPERATION

4. Distribution of State Plan HCBS Operational and Administrative Functions.

☒ The State assures that in accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration or supervision of the state plan. When a function is performed by other than the Medicaid agency, the entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities.:

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Disseminate information concerning the state plan HCBS to potential enrollees	☒	☒ Other divisions of the State Department of Health and Human Services	☒ QIO-like agency	☒ Providers
2 Assist individuals in state plan HCBS enrollment	☒	☒ Other divisions of the State Department of Health and Human Services	☐	☒ Providers
3 Manage state plan HCBS enrollment against approved limits, if any	☒	☐	☐	☐
4 Review participant service plans to ensure that state plan HCBS requirements are met	☒	☐	☒ QIO-like agency	☒ Providers
5 Recommend the prior authorization of state plan HCBS	☒	☐	☒ QIO-like agency	☒ Providers
6 Conduct utilization management functions	☒	☐	☒ QIO-like agency	☐
7 Recruit providers	☒	☐	☒ QIO-like agency	☐
8 Execute the Medicaid provider agreement	☒	☐	☒ QIO-like agency	☐
9 Conduct training and technical assistance concerning state plan HCBS requirements	☒	☐	☒ QIO-like agency	☐
10 Conduct quality monitoring of individual health and welfare and State plan HCBS program performance.	☒	☐	☒ QIO-like agency	☒ Providers

For items 1. and 2., the Nevada Divisions for Aging Services (DAS), Division of Child and Family Services (DCFS), and Mental Health and Developmental Services (MHDS) as well the office of Disability Services (ODS) will assist in disseminating information concerning the state plan HCBS and enrolling potential recipients.

§1915(i) Home and Community Based Services (HCBS) State Plan Services
ADMINISTRATION AND OPERATION

For Items 1., 4., 5., 6., 7., 8., 9. and 10., the Medicaid Fiscal Intermediary which is the QIO-like agency in Nevada will serve as the contracted entity.

For Item 10, the Nevada Divisions of Aging Services (DAS), Division of Child and Family Services (DCFS), and Mental Health and Developmental Services (MHDS) as well the Office of Disability Services (ODS) will assist in disseminating information concerning the state plan HCBS and enrolling potential recipients.

5. ☒ **Conflict of Interest Standards.** The State assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensures, at a minimum, that persons performing these functions are not:

- related by blood or marriage to the individual, or any paid caregiver of the individual
- financially responsible for the individual
- empowered to make financial or health-related decisions on behalf of the individual
- for assessments and plan of care
- providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except at the option of the State, when such individuals are the only willing and qualified provider in a geographic area, and the State devises conflict of interest protections. *(If the State chooses this option, specify the conflict of interest protections the State will implement):*

The individual performing assessment, eligibility, and plan of care must be an independent third party.

ADMINISTRATION AND OPERATION

6. ☒ **Appeals**. The State allows for appeals in accordance with 42 CFR 431 Subpart E.

7. ☒ **No FFP for Room and Board.** The State has methodology to prevent claims for Federal financial participation for room and board in HCBS state plan services.

§1915(i) Home and Community Based Services (HCBS) State Plan Services
NUMBER SERVED

8. ☒ **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, State, local, and private entities. For habilitation services, the State includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funder under §110 of the Rehabilitation Act of 1973.

§1915(i) Home and Community Based Services (HCBS) State Plan Services
NUMBER SERVED

1. **Projected Number of Unduplicated Individuals to Be Served Annually.** The first-year projection is based on current utilization of all services combined. Growth in succeeding years is projected at 6.5%, which reflects the average annual caseload growth rates experienced by the DHCFP.

Annual Period	From	To	Projected Number of Participants
Year 1	7/1/2007	6/30/2008	4655
Year 2	7/1/2008	6/30/2009	4958
Year 3	7/1/2009	6/30/2010	5280
Year 4	7/1/2010	6/30/2011	5623
Year 5	7/1/2011	6/30/2012	5989

§1915(i) Home and Community Based Services (HCBS) State Plan Services
NUMBER SERVED

2. Optional Annual Limit on Number Served.:

☒ The State does not limit the number of individuals served during the Year.

☐ The State chooses to limit the number of individuals served during the Year.:

Annual Period	From	To	Annual Maximum Number of Participants
Year 1			
Year 2			
Year 3			
Year 4			
Year 5			

☐ The State chooses to further schedule limits within the above annual period(s).:

§1915(i) Home and Community Based Services (HCBS) State Plan Services
NUMBER SERVED

3. Waiting List.

☒ The State will not maintain a waiting list.

☐ The State will maintain a single list for entrance to the HCBS state plan supplemental benefit package. State-established selection policies: are based on objective criteria; meet requirements of the Americans with Disabilities Act and all Medicaid regulations; ensure that otherwise eligible individuals have comparable access to all services offered in the package.

§1915(i) Home and Community Based Services (HCBS) State Plan Services
FINANCIAL ELIGIBILITY

1. **Income Limits.** The State assures that individuals receiving state plan HCBS are in an eligibility group covered under the State's Medicaid state plan, and who have income that does not exceed 150% of the Federal Poverty Level (FPL).

§1915(i) Home and Community Based Services (HCBS) State Plan Services
FINANCIAL ELIGIBILITY

2. Medically Needy.:

☒ The State does not provide HCBS state plan services to the medically needy.

☐ The State provides HCBS state plan services to the medically needy:

☐ The State elects to waive the requirements at Section 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy.

☐ The State does not elect to waive the requirements at Section 1902(a)(10)(C)(i)(III).

§1915(i) Home and Community Based Services (HCBS) State Plan Services
NEEDS-BASED EVALUATION/REEVALUATION

1. Responsibility for Performing Evaluations/Reevaluations. Independent evaluations /reevaluations to determine whether applicants are eligible for HCBS are performed:

☐ Directly by the Medicaid agency

☒ By Other: QIO-like agency

2. Qualifications of Individuals Performing Evaluation/Reevaluation. There are qualifications (that are reasonably related to performing evaluations) for persons responsible for evaluation/reevaluation for eligibility.:

a. The QIO-like agency employs licensed registered nurses and licensed social workers to evaluate/re-evaluate for eligibility.

b. All the individuals performing evaluations/reevaluations will have professional credentials and experience in evaluating an individual's needs for medical and social supports.

§1915(i) Home and Community Based Services (HCBS) State Plan Services
NEEDS-BASED EVALUATION/REEVALUATION

3. ☒ **Process for Performing Evaluation/Reevaluation.** Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

Prior authorization must be obtained through the QIO-like vendor using universal needs assessment tool. This same process is used to both evaluate and reevaluate whether an individual is eligible for the 1915(i) services.

4. Needs-based HCBS Eligibility Criteria. Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for HCBS state plan services. The criteria take into account the individual's support needs and capabilities and may take into account the individual's ability to perform two or more ADLs, the need for assistance, and other risk factors:

The "1915(i) Home and Community Based Services Universal Needs Assessment Tool" will be used to evaluate and reevaluate whether an individual is eligible for the Nevada 1915(i) HCBS state plan services. In order to qualify for services, the individual meets at least two of the following:

1. the inability to perform two or more ADLs;
2. the need for significant assistance to perform ADLs;
3. risk of harm;
4. the need for supervision;
5. functional deficits secondary to cognitive and /or behavioral impairments.

§1915(i) Home and Community Based Services (HCBS) State Plan Services
NEEDS-BASED EVALUATION/REEVALUATION

5. ☒ **Needs-based Institutional and Waiver Criteria.** There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of HCBS state plan services. Individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Include copies of the State's official documentation of the need-based criteria for each of the following):*

- *Applicable Hospital*
- *NF*
- *ICF/MR*

Differences Between Level Of Care Criteria

State Plan HCBS needs-based eligibility criteria	NF (& NF LoC waivers)	ICF/MR (& ICF/MR LoC waivers)	Long Term Care Hospital LoC
Individuals need at least two of the following: Functional Impairment in 1. ADL/IADLs, or 2. Cognitive behavior. Or Risk Factors of 3. Medical 4. Need for Supervision 5. Substance Abuse 6. Multiple Social System Involvement	The individual's condition requires services for three of the following: 1. Medication, 2. Treatments/Special Needs, 3. ADLs, 4. Supervision, 5. IADLs	The individual has a diagnosis of Mental retardation or related condition and requires active treatment due to substantial deficits in three of the following: 1. Mobility, 2. Self-Care, 3. Understanding and Use of Language, 4. Learning, 5. Self-Direction, and 6. Capacity for Independent Living	The individual has chronic mental illness and has at least three functional deficits: 1. Imminent risk of self harm, 2. Imminent risk of harm to others, 3. Risk of serious medical complications, 4. Need for 24-hour supervision

To qualify for the NF standard, a recipient must score three points on the NF Level of Care Determination. To qualify for State plan HCBS benefit, the recipient must score at least two points on the Universal Needs Based Assessment.

NEEDS-BASED EVALUATION/REEVALUATION

6. ☒ **Reevaluation Schedule.** The State assures that needs-based reevaluations are conducted at least annually.

§1915(i) Home and Community Based Services (HCBS) State Plan Services
NEEDS-BASED EVALUATION/REEVALUATION

7. ☒ **Adjustment Authority.** The State will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

§1915(i) Home and Community Based Services (HCBS) State Plan Services
NEEDS-BASED EVALUATION/REEVALUATION

8. ☒ **Residence in home or community.** The State plan HCBS benefit will be furnished to individuals who reside in their home or in the community, not an institution. *(Specify any residential settings, other than an individual's home or apartment, in which residents will be furnished State plan HCBS, if applicable. Describe the criteria by which the State determines that these settings are not institutional in character such as privacy and unscheduled access to food, activities, visitors, and community pursuits outside the facility):*

§1915(i) Home and Community Based Services (HCBS) State Plan Services
PERSON-CENTERED PLANNING & SERVICE DELIVERY

1. ☒ The State assures that there is an independent assessment of individuals determined to be eligible for HCBS. The assessment is based on:

- An objective face-to-face evaluation by an independent agent trained in assessment of need for home and community-based services and supports;
- Consultation with the individual and others as appropriate;
- An examination of the individual's relevant history, medical records, care and support needs, and preferences;
- Objective evaluation of the inability to perform, or need for significant assistance to perform 2 or more ADLs (as defined in §7702B(c)(2)(B) of the Internal Revenue Code of 1986);
- Where applicable, an evaluation of the support needs of the individual (or the individual's representative) to participant-direct; and
- A determination of need for at least one State plan home and community-based service before an individual is enrolled in the State plan HCBS benefit.

§1915(i) Home and Community Based Services (HCBS) State Plan Services
PERSON-CENTERED PLANNING & SERVICE DELIVERY

2. ☒ The State assures that, based on the independent assessment, the individualized plan of care:

- Is developed by a person-centered process in consultation with the individual, the individual's: treating physician, health care or supporting professional, or other appropriate individuals, as defined by the State, and where appropriate the individual's family, caregiver, or representative;
- Identifies the necessary HCBS to be furnished to the individual;
- Takes into account the extent of, and need for, any family or other supports for the individual;
- Prevents the provision of unnecessary or inappropriate care;
- Is guided by best practices and research on effective strategies for improved health and quality of life outcomes; and
- Is reviewed at least annually and as needed when there is significant change in the individual's circumstances.

3. Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities. There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with physical and mental needs for HCBS.:

A physician or other licensed practitioner of the healing arts within the scope of this professional practice as defined and limited by Federal and State law with experience in conducting assessments will be responsible for conducting the face-to-face independent assessments and reassessments of an individual's support needs and capabilities.

4. Responsibility for Service Plan Development. There are qualifications (that are reasonably related to developing plans of care) for persons responsible for the development of the individualized, person-centered plan of care.

The service plan is developed by the service provider. An interdisciplinary team will formulate the plan in conjunction with the recipient. The team must include staff trained in person-centered planning and must include a licensed health care professional and may include other individuals who can contribute to the plan development. Recipient and family involvement in service planning must be documented in the Service Plan.

The Conflict of Interest Standards specified in Administration and Operation, question #5 are applicable to service plan development.

5. Supporting the Participant in Service Plan Development. Supports and information are made available to the participant (and/or the additional parties specified, at the choice of the participant) to direct and be actively engaged in the service plan development process.:

Participants are provided by the service case manager or the DHCFP District Office staff with information about the person-centered planning process, their opportunity to select who participates in the planning, the services available and the available providers.

The provider will ensure the recipient, or the recipient's legal representative, is fully involved in the treatment planning process and choice of providers. The provider will also ensure the participant has an understanding of the needed services and the elements of the Service Plan. Participant's, family's (at the choice of the participant) and/or legal representative's participation in treatment planning must be documented on the Service Plan.

Providers will ensure the recipient or the recipient's legal representative is fully involved in the plan of care and ongoing day to day delivery of services, while promoting the rights of the client in regard to choice of services and providers.

6. Informed Choice of Providers:

A physician or other licensed practitioner of the healing arts conducts the needs-based assessment and refers the recipient to the local Medicaid District Office for a list of providers who meet Medicaid requirements and have a Medicaid contract to provide needed services. The Medicaid District Office will provide information and assistance in contacting Medicaid providers, including a list of providers and service descriptions. The recipient or the recipient's representative contacts the provider to select a provider of services. The provider of services is responsible for obtaining a written statement that the recipient was offered a choice of providers.

7. Process for Making Service Plan Subject to the Approval of the Medicaid Agency:

The quality improvement organization (QIO) selected by Nevada Medicaid will approve all service plans. Additionally, the DHCFP staff or designee will review a representative sample of participant service plans each year, with a confidence level of 95%.

8. **Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of three years as required by 45 CFR §74.53. Service plans are maintained by the following:

☐ Medicaid agency

☐ Case Manager

☒ Other: Service providers

1. Home and Community Based Services (HCBS) State Plan Services:

Service Specifications

Service Title: Home and Community Based (HCBS) Adult Day Health Care:

Service Definition (Scope): Adult Day Health Care services include health and social services needed to ensure the optimal functioning of the participant. Services are generally furnished in four or more hours per day on a regularly scheduled basis. The schedule may be modified as specified in the service plan (not to exceed six hours per day). Services must take place in a non-institutional or community-based setting.

Services provided by the appropriate professional staff include the following:

- Care coordination
- Supervision and assistance to the recipient, to ensure the recipient's well being and that care is appropriate to recipient's needs
- Nursing Services
  - Assessment
  - Care planning
  - Treatment
  - Medication administration
- Restorative therapy and care
- Nutritional assessment and planning
- Recipient training in activities of daily living
- Social activities to ensure the recipient's optimal functioning
- Meals (*Meals provided as a part of these services shall not constitute a "full nutritional regimen" (three meals per day)).*

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§1915(i) Home and Community Based Services (HCBS) State Plan Services
SERVICES

Specify limits (if any) on the amount, duration, or scope of this service for:

☒ Categorically needy: No more than 6 hours per day per recipient.

☐ Medically needy:

Specify whether the service may be provided by a:
☐ Relative
☐ Legal Guardian
☐ Legally Responsible Person

Provider Qualifications:

Provider Type:	License:	Certification:	Other Standard:
Home and Community Based Services (HCBS) Adult Day Health Care Facility	Licensed by the Health Division Bureau of Licensure and Certification, as an Adult Day Care Facility	Certified by the Division of Health Care Financing and Policy as an Adult Day Health Care provider that provides medical/nursing services in conjunction with adult day care activities.	Must maintain a Medicaid Services Provider Agreement and comply with the criteria set forth in the Medicaid Services Manual.

Verification of Provider Qualifications:

Provider Type:	Entity Responsible for Verification:	Frequency of Verification:
Home and Community Based Services (HCBS) Adult Day Health Care Facility	Division of Health Care Financing and Policy (DHCFP)	Annual

Service Delivery Method:

☐ Participant-directed

☒ Provider managed

Service Title: Habilitation

Service Definition (Scope): Habilitation Services include services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. Habilitation Services are prescribed by a physician, provided by the appropriate qualified staff, and include the following:

- Care Coordination
- Adaptive Skill Development
- Assistance with Activities of Daily Living
- Community Inclusion
- Transportation (not duplicative of State Plan non-emergency transportation)
- Adult Educational Supports
- Social and Leisure Skill Development
- Physical Therapy
- Speech Therapy
- Occupational Therapy

Habilitation services under Section 1915(i) do not include special education and related services defined in the Individuals with Disabilities Education Improvement Act of 2004 (IDEA), which otherwise are available to the individual through a local education agency, and vocational rehabilitation services, which otherwise are available to the individual through a program funded under Section 110 of the Rehabilitation Act of 1973. Documentation to this effect will be maintained in the file of each individual receiving habilitation services that may be duplicated through these specific authorities.

The professional provider must see a patient at least once, have some input as to the type of care provided, review the patient after treatment has begun, and assume legal responsibility for the services provided.

§1915(i) Home and Community Based Services (HCBS) State Plan Services
SERVICES

Additional needs-based criteria for receiving the service, if applicable:

Recipient must need Habilitation services as identified in the functional assessment as assessed by a Licensed Practitioner of the Healing Arts within the scope of professional practice as defined and limited by Federal and State law.

Specify limits (if any) on the amount, duration, or scope of this service for:

☒ Categorically needy: Each service is subject to Utilization Management.

☐ Medically needy:

Specify whether the service may be provided by a:

☐ Relative
☐ Legal Guardian
☐ Legally Responsible Person

Provider Qualifications:

Provider Type:	License:	Certification:	Other Standard:
Habilitation Services Provider Agency	No state license required for the agency.	Current accreditation with either the Commission on Accreditation of Rehabilitation Facilities or the Joint Commission on the Accreditation of Health Organizations.	Must maintain a Medicaid Services Provider Agreement and comply with criteria specified in the Medicaid Services Manual.
Care Coordinator	Must have current licensure as a Social Worker or Registered Nurse as defined in 42 CFR 440.60.		
Certified Care Coordinator	Must have current licensure as a Social Worker or Registered Nurse as defined in 42 CFR 440.60.	Current certification.	
Other Licensed Individual who provides Care coordination	Must have current licensure as a Social Worker or Registered Nurse as defined in 42 CFR 440.60.		Must be a licensed individual that is eligible to apply for certification as a care coordinator or who is working under the direct supervision of a Certificate of Clinical Competence (CCC).
Physical Therapist/ Occupational Therapist/ Speech Therapist	Must have current professional licensure as defined in 42 CFR 440.110.		

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Registered Nurse	Must have current licensure as a Registered Nurse as defined in 42 CFR 440.60.	Registered Nurse	Must have current licensure as a Registered Nurse as defined in 42 CFR 440.60.
Physician	Must have current licensure as a Physician as defined in the 42 CFR 440.50.		
Habilitation Technician			Possess high school diploma or GED; some post-secondary educational experience preferred; a minimum of two positive, verifiable employment experiences; two years of related experience; job experience that demonstrates the ability to teach, work independently of constant supervision, demonstrate regard and respect for recipients; have verbal and written communication skills; the ability to multi-task; the ability to follow through with designated tasks; knowledge of the philosophy and principles of independent living for people with disabilities. Habilitation Technicians must be directly supervised by a licensed/certified Therapy provider as defined in 42 CFR 440.110. Documentation will be kept supporting the supervision of service and ongoing involvement in the treatment by the supervising qualified provider.
Licensed Psychologist	Must have current licensure as a Psychologist as defined in 42 CFR 440.60.		

Verification of Provider Qualifications:

Provider Type:	Entity Responsible for Verification:	Frequency of Verification:
Habilitation Services Provider Agency	The designated QIO like-vendor for Nevada Medicaid.	Annual

Service Delivery Method:

☐ Participant-directed

☒ Provider managed

FIN REF: Attachment 4.19-B, Page 15-15a

RESERVED FOR FUTURE USE

2. Policies Concerning Payment for State Plan Home and Community Based Services (HCBS) Furnished by Legally Responsible Individuals, Other Relatives and Legal Guardians:

☒ The State does not make payment to legally responsible individuals, other relatives or legal guardians for furnishing state plan Home and Community Based Services (HCBS).

☐ The State makes payment to:

☐ **Legally Responsible Individuals.** The State makes payment to legally responsible individuals under specific circumstances and only when the relative is qualified to furnish services:

☐ **Relatives.** The State makes payment to relatives under specific circumstances and only when the relative is qualified to furnish services:

☐ **Legal Guardians.** The State makes payment to legal guardians under specific circumstances and only when the guardian is qualified to furnish services:

☐ **Other policy.**:

§1915(i) Home and Community Based Services (HCBS) State Plan Services
SERVICES

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. Election of Participant-Direction.:

☒ The State does not offer opportunity for participant-direction of state plan Home and community Based Services (HCBS).

☐ Every participant in HCBS state plan services (or the participant's representative) are afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.

☐ Participants in HCBS state plan services (or the participant's representative) are afforded the opportunity to direct some or all their services, subject to criteria specified by the State.

SERVICES

2. Description of Participant-Direction.:

§1915(i) Home and Community Based Services (HCBS) State Plan Services
SERVICES

3. Participant-Directed Services:

Participant-Directed Service	**Employer Authority**	**Budget Authority**
	☐	☐
	☐	☐

4. Financial Management:

☐ Financial Management is not furnished. Standard Medicaid payment mechanisms are used.

☐ Financial Management is furnished as an administrative function.

5. ☐ **Participant–Directed Service Plan.** The State assures that, based on the independent assessment, a person-centered process produces an individualized plan of care for participant-directed services that:

- Is directed by the individual or authorized representative and builds upon the individual's preferences and capacity to engage in activities that promote community life;
- Specifies the services to be participant-directed, and the role of family members or others whose participation is sought by the individual or representative;
- For employer authority, specifies the methods to be used to select, manage, and dismiss providers;
- For budget authority, specifies the method for determining and adjusting the budget amount, and a procedure to evaluate expenditures; and
- Includes appropriate risk management techniques.

6. Voluntary and Involuntary Termination of Participant-Direction:

7. Opportunities for Participant-Direction

a. Participant–Employer Authority (individual can hire and supervise staff).

☒ The State does not offer opportunity for participant-employer authority.

☐ Participants may elect participant-employer Authority.

☐ **Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

☐ **Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

b. Participant–Budget Authority (individual directs a budget).

☒ The State does not offer opportunity for participants to direct a budget.

☐ Participants may elect Participant–Budget Authority.

Participant-Directed Budget:

Expenditure Safeguards:

§1915(i) Home and Community Based Services (HCBS) State Plan Services
QUALITY MANAGEMENT STRATEGY

Requirement	**Monitoring Activity** *(What)*	**Monitoring Responsibilities** *(Who)*	**Evidence** *(Data Elements)*	**Management Reports** *(Yes/No)*	**Frequency** *(Mos/Yrs)*
Service plans address assessed needs of enrolled participants, are updated annually, and document choice of services and providers.	1. All person-centered service plans will be reviewed when initially submitted by the provider. 2. A representative sample of service plans for the entire population will be reviewed annually. 3. Participant Experience Survey (PES) that addresses access to care, choice and control, respect/dignity, community integration and inclusion. 4. A needs assessment will be done at least annually for all participants. A representative sample will be reviewed to determine changes in functioning levels within the sample and try to get a picture of the total population.	1. QIO-like vendor. 2. DHCFP 3. DHCFP 4. DHCFP	1. & 2. Current assessment is in the file. Current service plans exist in the file. Service plan addresses all the assessed needs. Service plan is person-centered. Choice of providers is documented in the case file. 3. Results of PES. 4. Results of representative sample review of changes in functioning level.	1 &2. Percent of compliance in each component; trends of changes in percent compliance. Serious problem areas defined. 3. Summary reports of PES. 4. Summary reports of sample review of changes in functioning level. Sample represents a 95% confidence level.	1. Ongoing as submitted. 2. Annual. 3. At least annually or at discharge. 4. Annual.
Providers meet required qualifications	Verify 100% providers meet requirements established for each service, such as licensure, accreditation, etc. Verify all providers have a current Medicaid contract.	DHCFP	The DHCFP records the documentation of provider meeting qualifications, such as copies of licenses, certifications and Medicaid contracts.	List of all providers, with reports of compliance in each area of qualification, with percentage compliance.	Review 100% of providers per year.
The SMA retains authority and responsibility for program operations and oversight.	The DHCFP conducts routine ongoing monitoring of 1915(i) HCBS.	DHCFP	Documentation of monitoring system. Management reports of monitoring results.	Summary reports of quality of HCB Services. Documentation of monitoring findings, remediation, analysis of effectiveness of remediation, and documentation of system improvement.	Ongoing.

The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to enrolled participants by qualified providers.	The DHCFP oversight exists through the MMIS system to assure claims are coded and paid in accordance with the state plan. State Plan HCB Services will be included in the population of paid claims subject to a PERM-like financial review. Additionally, a program review of a representative sample of claims will be conducted annually.	DHCFP	MMIS reports. PERM-like review reports. Documentation of sample selection process for program review, monitoring tools, monitoring findings reports and management reports.	Documentation of monitoring findings, remediation, analysis of effectiveness of remediation, documentation of system improvement.	Ongoing payment edits. Annual reviews.
The State identifies, addresses and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.	Service plans address health and welfare and are monitored by the DHCFP and the QIO-like vendor. Recipients may participate in Participant Experience Surveys (PES) that address access to care, choice and control, respect/dignity and community integration and inclusion. Providers of all services are required to ensure compliance with 42CFR483.374 to assure the health and welfare of recipients with regard to seclusion and restraints.	DHCFP, QIO-like vendor, Bureau of Licensure and Certification (BLC) when appropriate.	The DHCFP and QIO-like vendor Program review reports, PES Responses. Complaints received by the DHCFP, BLC, or incidents identified in program reviews.	Summary reports of BLC tracking results, program reviews and PES.	Ongoing.

QUALITY MANAGEMENT STRATEGY

Describe the process(es) for remediation and systems improvement.	Serious occurrence reports, Participant Experience Surveys and program review reports that identify issues related to a specific participant will be referred to the District Office case manager to assess and remediate immediately, if appropriate. Central Office program specialists will analyze all review findings, prepare reports as indicated above, make recommendations for remediation and submit to a management team or program chief. The report will include an executive summary that highlights important issues that require attention and remediation. Providers will be informed and educated when problems are identified. When necessary a plan of improvement will be required of specific providers that do not meet standards specified in the Medicaid Services Manual. If corrective action is determined by the DHCFP to not be adequate, appropriate actions will be taken and may include temporary suspension or full termination of provider Medicaid contracts. Program specialists will assess the effectiveness of remediations and report results to the management team or program chief. The Management Team or Program Chief will review and approve the report or return to the program specialist for additional information or action. When complete the program specialist and the management team or Program Chief will determine whether the monitoring system has been effective or needs improvement. The State plans to treat remediation and improvement activities for delegated functions by a similar methodology to the process described above. Once any issue is identified through management procedures or reports related to claims utilization, level of care determinations, notices of decision, fair hearing outcomes, audit findings, or utilization management trends, the DHCFP works directly with the responsible delegated entity to remediate the findings and prioritize in its systems improvement processes. The DHCFP is in the process of developing a meaningful, statewide monitoring, analysis and remediation system for these occurrences. The DCHFP will assess how best to distinguish and prioritize incident reports to identify trends and work with affected entities to effectively prioritize based on the impact to the recipient and the needs of all parties involved.

1915(i) State Plan Home and Community-Based Services

Administration and Operation

The state implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit *for elderly and disabled individuals as set forth below.*

1. **Services.** *(Specify the state's service title(s) for the HCBS defined under "Services" and listed in Attachment 4.19-B):*

NEVADA 1915(i) STATE PLAN HOME AND COMMUNITY BASED SERVICES–
Adult Day Health Care, Day Habilitation and Residential Habilitation.

2. **Concurrent Operation with Other Programs.** (*Indicate whether this benefit will operate concurrently with another Medicaid authority)*:

***Select one*:**

⦿	**Not applicable**
○	**Applicable**
	Check the applicable authority or authorities:
☐	**Services furnished under the provisions of §1915(a)(1)(a) of the Act.** The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of 1915(i) State plan HCBS. Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. *Specify:* *(a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1);* *(b) the geographic areas served by these plans;* *(c) the specific 1915(i) State plan HCBS furnished by these plans;* *(d) how payments are made to the health plans; and* *(e) whether the 1915(a) contract has been submitted or previously approved.*
☐	**Waiver(s) authorized under §1915(b) of the Act.** *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:*

Specify the §1915(b) authorities under which this program operates (*check each that applies*):

☐	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)
☐	§1915(b)(2) (central broker)	☐	§1915(b)(4) (selective contracting/limit number of providers)

☐	**A program operated under §1932(a) of the Act.** *Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:*
☐	**A program authorized under §1115 of the Act.** *Specify the program*:

3. State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS Benefit. *(Select one)*:

⦿	The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program *(select one)*:		
	⦿	The Medical Assistance Unit *(name of unit)*:	Division of Health Care Financing and Policy
	○	Another division/unit within the SMA that is separate from the Medical Assistance Unit	
		(name of division/unit) This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency.	
○	The State plan HCBS benefit is operated by *(name of agency)*		
	a separate agency of the state that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request.		

4. Distribution of State plan HCBS Operational and Administrative Functions.

☑ *(By checking this box, the state assures that):* When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (*check each that applies*):

(*Check all agencies and/or entities that perform each function*):

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
1 Individual State plan HCBS enrollment	☑	☐	☐	☐
2 Eligibility evaluation	☑	☐	☐	☐
3 Review of participant service plans	☑	☐	☐	☐
4 Prior authorization of State plan HCBS	☑	☐	☐	☐
5 Utilization management	☑	☐	☐	☐
6 Qualified provider enrollment	☑	☐	☑	☐
7 Execution of Medicaid provider agreement	☑	☐	☑	☐
8 Establishment of a consistent rate methodology for each State plan HCBS	☑	☐	☐	☐
9 Rules, policies, procedures, and information development governing the State plan HCBS benefit	☑	☐	☐	☐
10 Quality assurance and quality improvement activities	☑	☐		☐

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):

The Contracted Entity is the Nevada SMA Fiscal Agent.

(By checking the following boxes, the State assures that):

5. ☑ **Conflict of Interest Standards.** The state assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensures, at a minimum, that persons performing these functions are not:

- related by blood or marriage to the individual, or any paid caregiver of the individual
- financially responsible for the individual
- empowered to make financial or health-related decisions on behalf of the individual
- providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *(If the state chooses this option, specify the conflict of interest protections the state will implement):*

6. ☑ **Fair Hearings and Appeals.** The state assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

7. ☑ **No FFP for Room and Board.** The state has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.

8. ☑ **Non-duplication of services.** State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. For habilitation services, the state includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Education Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.

Number Served

1. **Projected Number of Unduplicated Individuals to Be Served Annually.**
(Specify for year one. Years 2-5 optional):

Annual Period	From	To	Projected Number of Participants
Year 1	03/1/2020	02/28/2021	1,898

2. ☑ **Annual Reporting.** *(By checking this box, the state agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

Financial Eligibility

1. ☑ **Medicaid Eligible.** *(By checking this box, the state assures that):* Individuals receiving State plan HCBS are included in an eligibility group that is covered under the State's Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Line (FPL). (This election does not include the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) of the Social Security Act. States that want to adopt the §1902(a)(10)(A)(ii)(XXII) eligibility category make the election in Attachment 2.2-A of the state Medicaid plan.)

2. **Medically Needy** (*Select one*):

☑ The State does not provide State plan HCBS to the medically needy.
☐ The State provides State plan HCBS to the medically needy. (*Select one*):
☐ The state elects to disregard the requirements section of 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a state makes this election, individuals who qualify as medically needy on the basis of this election receive only 1915(i) services. ☐ The state does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act.

Evaluation/Reevaluation of Eligibility

1. **Responsibility for Performing Evaluations / Reevaluations.** Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual). Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (*Select one*):

☑	Directly by the State Medicaid Agency

	By Other (*specify State agency or entity under contract with the State Medicaid agency*):

2. **Qualifications of Individuals Performing Evaluation/Reevaluation**. The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications):*

SMA Health Care Coordinator (HCC) must be licensed as a Social Worker by the State of Nevada Board of Examiners for Social Workers; licensure as a Registered Nurse by the Nevada State Board of Nursing; or have a professional license or certificate in a medical specialty applicable to the assignment. Additional Criteria includes valid driver's license to enable site and home visits, adhere to Health Insurance Portability and Accountability Act (HIPAA) requirements and FBI Criminal History Background Check (standard for all State employees).

3. **Process for Performing Evaluation/Reevaluation.** Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

SMA Health Care Coordinator (HCC) conducts a face-to-face visit with a potential recipient to determine whether the needs-based criteria will be met. The face-to-face assessment may be performed by telemedicine, when the following conditions are met:

- The agent performing the assessment is independent and qualified and meets the provider qualifications defined by the State, including any additional qualifications or training requirements for the operation of required information technology;
- The individual receives appropriate support during the assessment, including the use of any necessary on-site support staff; and
- The individual provides informed consent for this type of assessment.

The Health Care Coordinator uses the Comprehensive Social Health Assessment (CSHA) which is a tool to assess medical, social, and psychological condition of a potential recipient.

4. ☑ **Reevaluation Schedule**. *(By checking this box, the state assures that):* Needs-based eligibility reevaluations are conducted at least every twelve months.

5. ☑ **Needs-based HCBS Eligibility Criteria.** *(By checking this box, the state assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria consider the individual's support needs, and may include other risk factors: *(Specify the needs-based criteria):*

A recipient must need assistance or prompting in at least two Activities of Daily Living (bathing, dressing, grooming, toileting, transfer, mobility, eating) and must also have one of the following risk factors:

- At risk of social isolation due to lack of family or social supports.
- At risk of a chronic medical condition being exacerbated if not supervised by a registered nurse; or
- A history of aggressive behavior if not supervised or if medication is not administered by a registered nurse.

6. ☑ **Needs-based Institutional and Waiver Criteria.** *(By checking this box, the state assures that):* There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the state has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

State plan HCBS needs-based eligibility criteria	**NF (& NF LOC** waivers)**	**ICF/IID (& ICF/IID LOC waivers)**	**Applicable Hospital* (& Hospital LOC waivers)**
A recipient must need assistance or prompting in at least two Activities of Daily Living (bathing, dressing, grooming, toileting, transfer, mobility, eating) and must also have one of the following risk factors: • At risk of social isolation due to lack of family or social supports. • At risk of a chronic medical condition being exacerbated if not supervised	The individual's condition requires services for three of the following: 1. Medication, 2. Treatment/Special Needs, 3. ADLs, 4. Supervision, or 5. IADLs.	The individual has a diagnosis of intellectual disability or related condition and requires active treatment due to substantial deficits in three of the following: 1. Mobility, 2. Self-Care, 3. Understanding and Use of Language, 4. Learning, 5. Self-Direction, or 6. Capacity for Independent Living	The individual has chronic mental illness and has at least three functional deficits: 1. Imminent risk of self-harm, 2. Imminent risk of harm to others, 3. Risk of serious medical complications, or 4. Need for 24-hour supervision

by a registered nurse; or • A history of aggressive behavior if not supervised or if medication is not administered by a registered nurse.			

*Long Term Care/Chronic Care Hospital **LOC= level of care

7. ☑ **Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 90 days prior to the end of this 5-year period, the state may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C) and 42 CFR 441.710(e)(2). (*Specify target group(s)*):

Recipients 18 years and over. For Day and Residential Habilitation Services, individuals must have a Traumatic Brain Injury (TBI) or an Acquired Brain Injury (ABI).

☐ **Option for Phase-in of Services and Eligibility.** If the state elects to target this 1915(i) State plan HCBS benefit, it may limit the enrollment of individuals or the provision of services to enrolled individuals in accordance with 1915(i)(7)(B)(ii) and 42 CFR 441.745(a)(2)(ii) based upon criteria described in a phase-in plan, subject to CMS approval. At a minimum, the phase-in plan must describe: (1) the criteria used to limit enrollment or service delivery; (2) the rationale for phasing-in services and/or eligibility; and (3) timelines and benchmarks to ensure that the benefit is available statewide to all eligible individuals within the initial 5-year approval. (Specify the phase-in plan):

(By checking the following box, the State assures that):

8. ☑ **Adjustment Authority**. The state will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

9. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, and (b) the provision of 1915(i) services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the person-centered service plan. Specify the state's policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

i.	**Minimum number of services**. The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is*:* 1	
ii.	**Frequency of services**. The state requires (select one):	
	⊙	**The provision of 1915(i) services at least monthly**
	○	**Monthly monitoring of the individual when services are furnished on a less than monthly basis** If the state also requires a minimum frequency for the provision of 1915(i) services other than monthly (e.g., quarterly), specify the frequency:

Home and Community-Based Settings

(By checking the following box, the State assures that):

1. ☑ **Home and Community-Based Settings.** The State plan HCBS benefit will be furnished to individuals who reside and receive HCBS in their home or in the community, not in an institution. (*Explain how residential and non-residential settings in this SPA comply with Federal home and community-based settings requirements at 42 CFR 441.710(a)(1)-(2) and associated CMS guidance. Include a description of the settings where individuals will reside and where individuals will receive HCBS, and how these settings meet the Federal home and community-based settings requirements, at the time of submission and in the future):*

   (Note: In the Quality Improvement Strategy (QIS) portion of this SPA, the state will be prompted to include how the state Medicaid agency will monitor to ensure that all settings meet federal home and community-based settings requirements, at the time of this submission and ongoing.)

The state assures that this 1915(i) SPA will be subject to any provisions or requirements included in the state's most recent and/or approved home and community-based settings Statewide Transition Plan. The state will implement any required changes by the end of the transition period as outlined in the home and community-base settings Statewide Transition Plan.

The settings for 1915(i) include:

Adult Day Health Care center – A setting for elderly, physically disabled and intellectually and developmentally disabled recipients who are in need for supervision due to medical, behavioral and physical issues and require the presence of a RN to monitor behaviors and administer medication during the day.

Day Treatment facility – A setting that provides treatment to recipients with TBI or ABI outside their homes or residential facilities.

Residential Group Homes for TBI or ABI - This setting is for individuals with TBI or ABI, who require services 24 hours per day in a normalized living environment and are not ready to live independently due to their functional or cognitive impairments

Person-Centered Planning & Service Delivery

(By checking the following boxes, the state assures that):

1. ☑ There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment meets federal requirements at 42 CFR §441.720.

2. ☑ Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State plan HCBS benefit. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).

3. ☑ The person-centered service plan is reviewed and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

4. Responsibility for Face-to-Face Assessment of an Individual's Support Needs and Capabilities. There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with need for HCBS. *(Specify qualifications):*

> SMA Health Care Coordinator. All SMA Health Care Coordinators receive training on person-centered thinking.
>
> Qualifications:
>
> SMA Health Care Coordinator (HCC) must be licensed as a Social Worker by the State of Nevada Board of Examiners for Social Workers; licensure as a Registered Nurse by the Nevada State Board of Nursing; or have a professional license or certificate in a medical specialty applicable to the assignment. Additional Criteria includes valid driver's license to enable site and home visits, adhere to Health Insurance Portability and Accountability Act (HIPAA) requirements and FBI Criminal History Background Check (standard for all State employees).

5. Responsibility for Development of Person-Centered Service Plan. There are qualifications (that are reasonably related to developing service plans) for persons responsible for the development of the individualized, person-centered service plan. *(Specify qualifications):*

> SMA Health Care Coordinator
>
> Qualifications:
>
> SMA Health Care Coordinator (HCC) must be licensed as a Social Worker by the State of Nevada Board of Examiners for Social Workers; licensure as a Registered Nurse by the Nevada State Board of Nursing; or have a professional license or certificate in a medical specialty applicable to the assignment. Additional Criteria includes valid driver's license to enable site and home visits, adhere to Health Insurance Portability and Accountability Act (HIPAA) requirements and FBI Criminal History Background Check (standard for all State employees).

6. Supporting the Participant in Development of Person-Centered Service Plan. Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the person-centered service plan development process. *(Specify: (a) the supports and information made available, and (b) the participant's authority to determine who is included in the process):*

The SMA HCC is responsible for the development of Plan of Care (POC) using a person-centered plan.

During the initial assessment, and development of the person-centered POC, the potential recipient, family, support systems, and/or designated representatives are encouraged to participate in the development of the POC and to direct the process to the maximum extent possible. The person-centered planning process is driven by the individual, designated representative, legal guardian or other supports chosen by the individual and includes necessary information and support to ensure that the individual directs the process to the maximum extent possible.

Planning includes convenience to the recipient, cultural considerations, use of plain language, strategies for solving any disagreements, identification of what is important to and for the individual, personal preferences, choice of caregivers, strategies to facilitate health and welfare and remediate identified risks, identified goals, outcomes, preferences related to relationships, community integration and opportunities to participate in integrated settings/seek employment or volunteer activities, control over personal resources.

A POC form must be developed for all potential recipients. The POC includes, at a minimum, the individual's needs, goals to meet those needs, identified risks and services to be provided.

7. **Informed Choice of Providers.** *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the person-centered service plan):*

During the assessment process, and at any time during the authorization period, the SMA HCC informs and provides a printed list of qualified providers to the potential recipient so they may choose among enrolled providers. All potential recipients must read, or have the form read to them, and sign the Statement of Understanding in which the potential recipient acknowledges a selection from the qualified providers on either a printed list or via the SMA website.

The information reviewed with the recipient/personal representative include: process for development of the POC, services to be provided, and choice of service provider. The recipient may request a change in services or service provider at any time.

8. **Process for Making Person-Centered Service Plan Subject to the Approval of the Medicaid Agency**. *(Describe the process by which the person-centered service plan is made subject to the approval of the Medicaid agency):*

The POC is developed and implemented by the SMA HCC using a person-centered process. The HCC contacts all service providers to arrange for the agreed upon services.

9. **Maintenance of Person-Centered Service Plan Forms**. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies):*

☑	Medicaid agency	☐	Operating agency	☐	Case manager
☐	Other (*specify):*				

Services

- **State plan HCBS.** *(Complete the following table for each service. Copy table as needed):*

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*	
Service Title:	**Adult Day Health Care**
Service Definition (Scope)*:*	
Adult Day Health Care (ADHC) services provide assistance with the activities of daily living, medical equipment and medication administration. Services are generally furnished in four or more hours per day on a regularly scheduled basis, for one or more days per week. The schedule may be modified as specified in the plan of care. Services include care coordination, nursing services, restorative therapy and care, nutritional assessment, training or assistance in activities of daily living or instrumental activities of daily living, social activities and meals (*shall not constitute a "full nutritional regimen" (3 meals per day)*.	
Additional needs-based criteria for receiving the service, if applicable *(specify):*	
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*	
☑	Categorically needy *(specify limits):*
	No more than 6 hours per day per recipient.
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Another Standard *(Specify):*
Adult Day Health Care Center	Licensed by the Division of Public and Behavioral Health, Bureau of Health Care Quality and Compliance		Must maintain a Medicaid Services Provider Agreement and comply with the criteria set forth in the Medicaid Services Manual.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed)*:

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Adult Day Health Care Center	Nevada Medicaid Provider Enrollment Unit	Every five years.

	Division of Public and Behavioral Health, Bureau of Health Care Quality and Compliance	Every six years, unless compliant circumstances warrant provider review.

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: **Day Habilitation**

Service Definition (Scope)*:*

This service is targeted to individuals with a Traumatic Brain Injury (TBI) or Acquired Brain Injury (ABI). Day Habilitation services are regularly scheduled activities in a non-residential setting, separate from the recipient's private residence or other residential living arrangement. Services include assistance with the acquisition, retention, or improvement in self-help, socialization, and adaptive skills that enhance social development and develop skills in performing activities of daily living and community living.

Activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal competence, greater independent and personal choice. Services are identified in the recipient's POC according to recipient's need and individual choices. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

Day Habilitation services focus on enabling the participant to attain or maintain his or her maximum potential and shall be coordinated with any needed therapies in the recipient's POC such as physical, occupational, or speech therapy.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☑	Categorically needy *(specify limits):*
	Limited to 6 hours per day.
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify):*	Certification *(Specify):*	Another Standard *(Specify):*

Habilitation Services Agency		CARF, Commission on Accreditation of Rehabilitation Facilities	Must maintain a Medicaid Services Provider Agreement and comply with the criteria set forth in the Medicaid Services Manual.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify):*	Frequency of Verification *(Specify):*
Habilitation Services Agency	Nevada Medicaid Provider Enrollment Unit	Every five years

Service Delivery Method. *(Check each that applies)*:

☐	Participant-directed	☑	Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

Service Title: **Residential Habilitation**

Service Definition (Scope)*:*

This service is targeted to individuals with a Traumatic Brain Injury (TBI) or Acquired Brain Injury (ABI). Residential Habilitation means individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. These services include adaptive skill development, assistance with activities of daily living, community inclusion, adult educational supports, social and leisure skill development, that assist the recipient to reside in the most integrated setting appropriate to his/her needs. Residential Habilitation also includes personal care and protective oversight and supervision.

Payment for Room and Board is prohibited.

Additional needs-based criteria for receiving the service, if applicable *(specify):*

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☐	Categorically needy *(specify limits):*
☐	Medically needy *(specify limits):*

Provider Qualifications *(For each type of provider. Copy rows as needed)*:

Provider Type *(Specify)*:	License *(Specify)*:	Certification *(Specify)*:	Another Standard *(Specify)*:
Habilitation Services Agency		CARF, Commission on Accreditation of Rehabilitation Facilities	Must maintain a Medicaid Services Provider Agreement and comply with the criteria set forth in the Medicaid Services Manual.

Verification of Provider Qualifications (*For each provider type listed above. Copy rows as needed*):

Provider Type *(Specify)*:	Entity Responsible for Verification *(Specify)*:	Frequency of Verification *(Specify)*:
Habilitation Services Agency	Nevada Medicaid Provider Enrollment Unit	Every five years

Service Delivery Method. (*Check each that applies*):

☐	Participant-directed	☑	Provider managed

- ☐ **Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians.** *(By checking this box, the state assures that):* There are policies pertaining to payment the state makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the state makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. *(Specify (a) who may be paid to provide State plan HCBS; (b) the specific State plan HCBS that can be provided; (c) how the state ensures that the provision of services by such persons is in the best interest of the individual; (d) the state's strategies for ongoing monitoring of services provided by such persons; (e) the controls to ensure that payments are made only for services rendered; and (f) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):*

Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. Election of Participant-Direction. (S*elect one):*

⦿	The state does not offer opportunity for participant-direction of State plan HCBS.
○	Every participant in State plan HCBS (or the participant's representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
○	Participants in State plan HCBS (or the participant's representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the state. *(Specify criteria):*

2. Description of Participant-Direction. (Provide an overview of the opportunities for participant-*direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):*

3. Limited Implementation of Participant-Direction. (*Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to statewideness requirements. Select one):*

○	Participant direction is available in all geographic areas in which State plan HCBS are available.
○	Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the state. Individuals who reside in these areas may elect self-directed service delivery options offered by the state or may choose instead to receive comparable services through the benefit's standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. (*Specify the areas of the state affected by this option*):

4. Participant-Directed Services. *(Indicate the State plan HCBS that may be participant-directed, and the authority offered for each. Add lines as required):*

Participant-Directed Service	Employer Authority	Budget Authority
	☐	☐
	☐	☐

5. Financial Management. (*Select one)* :

○	Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
○	Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.

6. ☐ **Participant–Directed Person-Centered Service Plan.** *(By checking this box, the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and:

- Specifies the State plan HCBS that the individual will be responsible for directing;
- Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget;
- Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual;
- Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and
- Specifies the financial management supports to be provided.

7. **Voluntary and Involuntary Termination of Participant-Direction.** *(Describe how the state facilitates an individual's transition from participant-direction, and specify any circumstances when transition is involuntary):*

8. **Opportunities for Participant-Direction**

a. **Participant–Employer Authority** (individual can select, manage, and dismiss State plan HCBS providers). (*Select one):*

⦿	The state does not offer opportunity for participant-employer authority.	
○	Participants may elect participant-employer Authority *(Check each that applies):*	
	☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.
	☐	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

b. **Participant–Budget Authority** (individual directs a budget that does not result in payment for medical assistance to the individual). (*Select one):*

⦿	The state does not offer opportunity for participants to direct a budget.
○	Participants may elect Participant–Budget Authority.

	Participant-Directed Budget. *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including the method for calculating the dollar values in the budget based on reliable costs and service utilization, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the person-centered service plan.):*
	Expenditure Safeguards. *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards.*

Quality Improvement Strategy

Quality Measures

(Describe the state's quality improvement strategy. For each requirement, and lettered sub-requirement, complete the table below):

1. Plan of Care a) address assessed needs of 1915(i) participants; b) are updated annually; and (c document choice of services and providers.

2. Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.

3. Providers meet required qualifications.

4. Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).

5. The SMA retains authority and responsibility for program operations and oversight.

6. The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.

7. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation.

(Table repeats for each measure for each requirement and lettered sub-requirement above.)

Requirement	***1.a) Service plans address assessed needs of 1915(i) participants.***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of service plans reviewed that adequately address the assessed needs of 1915(i) participants. N = Number of service plans reviewed that adequately address the assessed needs of 1915(i) participants. D = Total number of service plans reviewed.
Discovery Activity *(Source of Data & sample size)*	Record reviews, on-site. Less than 100% review. The State will obtain a sample size that will produce a probability of 95% and confidence level of 5% using Raosoft Sample Size Calculator.

	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	State Medicaid Agency (SMA) Quality Assurance (QA) and 1915(i) Units.
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA will remediate any issue or non-compliance within 30 days. Deficiencies are remediated through the monthly quality improvement (QI) meeting. The QI team consists of SMA QA and 1915(i) Units.
	Frequency *(of Analysis and Aggregation)*	Monthly, Quarterly, Annually

Requirement		***1.b) Service plans are updated annually***
Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent of service plans that are updated at least once in the last 12 months. N = Number of service plans that are updated at least once in the last 12 months. D = Total number of service plans reviewed.
	Discovery Activity *(Source of Data & sample size)*	Record reviews, on-site. Less than 100% Review. The State will obtain a sample size that will produce a probability of 95% and confidence level of 5% using Raosoft Sample Size Calculator.
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA QA Unit

Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA will remediate any issue or non-compliance within 30 days. Deficiencies are remediated through the monthly quality improvement (QI) meeting. The QI team consists of SMA QA and 1915(i) Units.
Frequency *(of Analysis and Aggregation)*	Monthly, Quarterly, and Annually

Requirement	***1.c) Service plans document choice of services and providers***
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of service plans reviewed that indicate 1915(i) participants were given a choice when selecting services. N = Number of service plans reviewed that indicate 1915(i) participants were given a choice when selecting services. D = Total number of service plans reviewed
Discovery Activity *(Source of Data & sample size)*	Record reviews, on-site. Less than 100% Review. The State will obtain a sample size that will produce a probability of 95% and confidence level of 5% using Raosoft Sample Size Calculator.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA QA Unit
Frequency	Annually
Remediation	
Remediation Responsibilities	SMA will remediate any issue or non-compliance within 30 days.

	(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)	Deficiencies are remediated through the monthly quality improvement (QI) meeting. The QI team consists of SMA QA and 1915(i) Units.
	Frequency *(of Analysis and Aggregation)*	Monthly, Quarterly, and Annually

Discovery Evidence *(Performance Measure)*	Number and percent of service plans reviewed that indicate 1915(i) participants were given a choice when selecting providers. N = Number of service plans reviewed that indicate 1915(i) participants were given a choice when selecting providers. D = Total number of service plans reviewed
Discovery Activity *(Source of Data & sample size)*	Record reviews, on-site. Less than 100% Review. The State will obtain a sample size that will produce a probability of 95% and confidence level of 5% using Raosoft Sample Size Calculator.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA QA Unit
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA will remediate any issue or non-compliance within 30 days. Deficiencies are remediated through the monthly quality improvement (QI) meeting. The QI team consists of SMA QA and 1915(i) Units.
Frequency	Monthly, Quarterly, and Annually

(of Analysis and Aggregation)	

Requirement	**2. (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of new applicants who had an evaluation indicating the individual met the 1915(i) needs-based eligibility criteria prior to receiving services. N: Number of new applicants who had an evaluation indicating the individual met the 1915(i) needs-based eligibility criteria prior to receiving services. D: Number of new applicants receiving 1915(i) services reviewed.
Discovery Activity *(Source of Data & sample size)*	Record reviews, on-site. Less than 100% Review. The State will obtain a sample size that will produce a probability of 95% and confidence level of 5% using Raosoft Sample Size Calculator.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA 1915(i) Unit
Frequency	Monthly, Quarterly and Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA will remediate any issue or non-compliance within 30 days. Deficiencies are remediated through the monthly quality improvement (QI) meeting. The QI team consists of SMA QA and 1915(i) Units.
Frequency *(of Analysis and Aggregation)*	Quarterly, Annually

Discovery

	Discovery Evidence *(Performance Measure)*	Number and percent of applicants who receive an evaluation for 1915(i) State plan HCBS eligibility for whom there is reasonable indication that 1915(i) services may be needed in the future. N: Number of applicants who receive an evaluation for 1915(i) State plan HCBS eligibility for whom there is reasonable indication that 1915(i) services may be needed in the future. D: Number of 1915(i) applicants
	Discovery Activity *(Source of Data & sample size)*	Record reviews, on-site. Less than 100% Review. The State will obtain a sample size that will produce a probability of 95% and confidence level of 5% using Raosoft Sample Size Calculator.
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA 1915(i) Unit.
	Frequency	Monthly, Quarterly and Annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA will remediate any issue or non-compliance within 30 days. Deficiencies are remediated through the monthly quality improvement (QI) meeting. The QI team consists of SMA QA and 1915(i) Units.
	Frequency *(of Analysis and Aggregation)*	Quarterly, Annually

Requirement	**2. (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of reviewed 1915(i) evaluations that were completed using the processes and instruments approved in the 1915(i) HCBS state plan.

		N = Number of reviewed 1915(i) evaluations that were completed using the processes and instruments approved in the 1915(i) HCBS state plan. D = Total number of 1915(i) evaluations reviewed
	Discovery Activity *(Source of Data & sample size)*	Record reviews, on-site. Less than 100% Review. The State will obtain a sample size that will produce a probability of 95% and confidence level of 5% using Raosoft Sample Size Calculator.
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA Quality Assurance
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA is responsible for the collection of documentation of monitoring findings, remediation, analysis of effectiveness of remediation, documentation of system improvement. Documentation of sample selection process for program review, monitoring tools, monitoring findings reports and management reports. SMA will remediate any issue or non-compliance within 30 days. Deficiencies are remediated through the monthly quality improvement (QI) meeting. The QI team consists of SMA QA and 1915(i) Units.
	Frequency *(of Analysis and Aggregation)*	Monthly, Quarterly and Annually

Requirement	**2. (c) the 1915(i)-benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percentage of enrolled recipients whose 1915 (i) benefit Needs Based eligibility Criteria, was reevaluated annually. N: Number of enrolled recipients whose Needs Based Criteria was reevaluated annually; D: Number of enrolled recipients reviewed.
Discovery Activity	Record reviews, on-site. 100% Review

	(Source of Data & sample size)	
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA QA
	Frequency	Quarterly, Annually, Continuously and Ongoing
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA will remediate any issue or non-compliance within 30 days. Deficiencies are remediated through the monthly quality improvement (QI) meeting. The QI team consists of SMA QA and 1915(i) Units.
	Frequency *(of Analysis and Aggregation)*	Quarterly, Annually, Continuously and Ongoing

Requirement		**Providers meet required qualifications.**
Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent of 1915(i) providers who meet the State's certification standards, as required, prior to providing 1915(i) services. N: Number of 1915(i) providers who meet the State's certification standards, as required, prior to providing 1915(i) services. D:Total number of 1915(i) providers reviewed.
	Discovery Activity *(Source of Data & sample size)*	Record reviews. 100% Review
	Monitoring Responsibilities	SMA 1915(i) Unit, Provider Enrollment Unit and SMA Fiscal Agent.

(Agency or entity that conducts discovery activities)	
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA 1915(I), and Provider Enrollment Units and Fiscal Agent. State Medicaid Agency will remediate any issue or non-compliance within 30 days. All provider enrollment applications and revalidations are submitted electronically through the Interchange. The Fiscal Agent and SMA Provider Enrollment Unit monitor and review all applications and documents and make appropriate action as needed.
Frequency *(of Analysis and Aggregation)*	Ongoing and Annually or on re-validation schedule

Requirement	**4. Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of HCBS settings that meet Federal HCBS settings requirements. N: Number of HCBS settings that meet Federal HCBS settings requirements. D: Total # of HCBS settings providing 1915(i) services.
Discovery Activity *(Source of Data & sample size)*	Record reviews, on-site. 100% Review. The State will obtain a sample size that will produce a probability of 95% and confidence level of 5% using Raosoft Sample Size Calculator.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA QA

	Frequency	Annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	State Medicaid Agency will remediate any issue or non-compliance within 30 days. Deficiencies are remediated through the monthly quality improvement (QI) meeting. The QI team consists of SMA QA and 1915(i) Units.
	Frequency *(of Analysis and Aggregation)*	Annually

Requirement		**5. The SMA retains authority and responsibility for program operations and oversight.**
Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent of issues identified in contract monitoring reports that were remediated as required by the state. N = Number of issues identified in contract monitoring reports that were remediated as required by the State. D = Total number of issues identified.
	Discovery Activity *(Source of Data & sample size)*	Provider application. Less than 100% Review. The State will obtain a sample size that will produce a probability of 95% and confidence level of 5% using Raosoft Sample Size Calculator.
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA 1915(i) Unit.
	Frequency	Annually
Remediation		
	Remediation Responsibilities	SMA will remediate any issue or non-compliance within 30 days.

	(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)	On a monthly basis, HCC supervisor reviews random sample of case files and if deficiencies are found, will take action as needed such as one-on-one education with the HCC as well as remediation discussion during the monthly QI meeting.
	Frequency *(of Analysis and Aggregation)*	Annually

Requirement	**6. The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.**
Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of claims paid to 1915(i) service providers who are qualified to furnish 1915(i) services to 1915(i) recipients. N: Number of claims paid to 1915(i) service providers who are qualified to furnish 1915(i) services to 1915(i) recipients. D: Number of claims reviewed.
Discovery Activity *(Source of Data & sample size)*	Financial records (including expenditures); Less than 100% Review. The State will obtain a sample size that will produce a probability of 95% and confidence level of 5% using Raosoft Sample Size Calculator.
Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA QA
Frequency	Annually
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA will remediate any issue or non-compliance within 30 days. Deficiencies are remediated through the monthly quality improvement (QI) meeting. The QI team consists of SMA QA and 1915(i) units.

Frequency *(of Analysis and Aggregation)*	Monthly, Quarterly, Annually

Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent of claims verified through a review of provider documentation that have been paid in accordance with the individual's service plan. N: Number of claims verified through a review of provider documentation that have been paid in accordance with the individual's service plan. D: Total number of claims reviewed.
	Discovery Activity *(Source of Data & sample size)*	Financial records (including expenditures); Less than 100% Review. The State will obtain a sample size that will produce a probability of 95% and confidence level of 5% using Raosoft Sample Size Calculator.
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA QA
	Frequency	Annually
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA will remediate any issue or non-compliance within 30 days. Deficiencies are remediated through the monthly quality improvement (QI) meeting. The QI team consists of SMA QA and 1915(i) Units.
	Frequency *(of Analysis and Aggregation)*	Monthly, Quarterly, Annually

Requirement	**7. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation.**
Discovery	

	Discovery Evidence *(Performance Measure)*	Number and percent of 1915(i) recipients who receive information/education about how to report abuse, neglect, exploitation and other critical incidents. N: Number of recipients who received information or education about how to report abuse, neglect, exploitation and other critical incidents. D: Number of participants reviewed.
	Discovery Activity *(Source of Data & sample size)*	Records review on-site, 100% Review.
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA
	Frequency	Annually, Continuously and Ongoing
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA will remediate any issue or non-compliance within 30 days. During initial and annual assessment, potential recipient/recipient will be educated and sign the acknowledgement form indicating they were given information on how report and provided a list of contacts for reporting critical incidence. The form will be kept in the case file for 1915(i) supervisor review monthly and for SMA QA review annually.
	Frequency *(of Analysis and Aggregation)*	Monthly, Quarterly, Annually

Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent of incident reviews/investigations that were initiated regarding unexplained deaths, abuse, neglect, exploitation and unapproved restraints as required by the SMA. N: Number of incident reviews/investigations that were initiated regarding unexplained deaths, abuse, neglect, exploitation and unapproved restraints as required by the SMA. D: Number of incidents reviewed.
	Discovery Activity	Records review on-site, 100% Review.

	(Source of Data & sample size)	
	Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA
	Frequency	Annually, Continuously and Ongoing
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA will remediate any issue or non-compliance within 30 days. All Serious Occurrence Reports (SOR) must be reported within 24 hours of discovery. All SORs are entered into the database called Harmony, including follow-ups by HCCs. On a weekly basis or as needed, HCC supervisor reviews and approves follow-ups to ensure appropriate action is taken and the health and safety of the recipients have been addressed timely. Reports are generated upon request. Within 5 business days, HCC will conduct all necessary follow-ups to include plan of correction, report submitted to law enforcement, EPS or Health Care Quality and Compliance (HCQC) if applicable. The Harmony database monitors and tracks all incidents and generates reports upon request. The 1915(i) Supervisor will review SORs on a weekly or as needed basis.
	Frequency *(of Analysis and Aggregation)*	Monthly, Quarterly, Annually

Discovery		
	Discovery Evidence *(Performance Measure)*	Number and percent of incident reviews/investigations involving unexplained deaths, abuse, neglect, exploitation and unapproved restraints for recipients that were completed by the SMA. N: Number of incident reviews/investigations involving unexplained deaths, abuse, neglect, exploitation and unapproved restraints for recipients that were completed by the SMA. D: Number of incidents reviewed.
	Discovery Activity *(Source of Data & sample size)*	Records review on-site, 100% Review.

Monitoring Responsibilities *(Agency or entity that conducts discovery activities)*	SMA
Frequency	Annually, Continuously and Ongoing
Remediation	
Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA will remediate any issue or non-compliance within 30 days. All Serious Occurrence Reports (SOR) must be reported within 24 hours of discovery. All SORs are entered into the database called Harmony, including follow-ups by HCCs. On a weekly basis or as needed, HCC supervisor reviews and approves follow-ups to ensure appropriate action is taken and the health and safety of the recipients have been addressed timely. Reports are generated upon request. Within 5 business days, 1915(i) HCC will conduct all necessary follow-ups to include plan of correction, report submitted to law enforcement, EPS or Health Care Quality and Compliance (HCQC) if applicable. The Harmony database monitors and tracks all incidents and generates reports upon request. The 1915(i) Supervisor will review SORs on a weekly or as needed basis.
Frequency *(of Analysis and Aggregation)*	Monthly, Quarterly, Annually

Discovery	
Discovery Evidence *(Performance Measure)*	Number and percent of incidents reviewed involving abuse, neglect, exploitation, unexplained deaths, and unapproved restraints that had a plan of prevention/documentation of a plan developed as a result of the incident. N: Number of incidents reviewed involving abuse, neglect, exploitation, unexplained deaths, and unapproved restraints that had a plan of prevention/documentation of a plan developed as a result of the incident. D: Number of incidents reviewed.
Discovery Activity *(Source of Data & sample size)*	Records review on-site, 100% Review.
Monitoring Responsibilities	SMA

	(Agency or entity that conducts discovery activities)	
	Frequency	Annually, Continuously and Ongoing
Remediation		
	Remediation Responsibilities *(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)*	SMA will remediate any issue or non-compliance within 30 days. All Serious Occurrence Reports (SOR) must be reported within 24 hours of discovery. All SORs are entered into the database called Harmony, including follow-ups by HCCs. On a weekly basis or as needed, HCC supervisor reviews and approves follow-ups to ensure appropriate action is taken and the health and safety of the recipients have been addressed timely. Reports are generated upon request. Within 5 business days, the 1915(i) HCC will conduct all necessary follow-ups to include plan of correction, report submitted to law enforcement, EPS or Health Care Quality and Compliance (HCQC) if applicable. The Harmony database monitors and tracks all incidents and generates reports upon request. The 1915(i) Supervisor will review SORs on a weekly or as needed basis.
	Frequency *(of Analysis and Aggregation)*	Monthly, Quarterly, Annually

System Improvement
(Describe the process for systems improvement as a result of aggregated discovery and remediation activities.)

1. **Methods for Analyzing Data and Prioritizing Need for System Improvement**

On an ongoing basis, the 1915(i) and QA Units collaborate in a Quality Improvement Team to assess quality improvements needed to ensure required performance measures are met. Monthly Comprehensive QI meetings review performance measures below 86% to determine remediation and mitigation efforts using CMS guidelines. Such guidelines include, but are not limited to, identifying probable cause, development of interventions to improve performances, trend analysis on performance measures, etc. On an as needed basis, the QA Unit conducts educational trainings with the 1915(i) Unit regarding how to perform case file and provider reviews. Provider reviews are entered into the ALis database to be tracked and deficiencies flagged. Depending on the deficiency, referrals are sent to an appropriate state agency for review and corrective action plan as appropriate.

Case Management records are in a SAMS database which generates reports needed for QA case file reviews. Provider records are managed through the InterChange (Medicaid Management Information System) and reviewed by the SMA Fiscal Agent and Provider Enrollment Unit. Electronic submission of claims is also done through InterChange, which has a built-in edits to ensure claims are processed correctly and appropriately.

Serious Occurrence Reports (SORs) are tracked through a Harmony system which is monitored and reviewed by the 1915(i) Supervisor.

2. Roles and Responsibilities

The SMA QA complete annual reviews of the performance measures outlined above excluding provider reviews which are conducted by the 1915(i) Unit.

1915(i) and QA Unit participate in monthly and quarterly comprehensive QI meetings.

3. Frequency

QI Team meet monthly to discuss remediations on deficiencies found during the annual review. QI Team also meet quarterly to review remediations and discuss system improvement to determine changes as needed to the process. The QIS is evaluated in its entirety prior to the 5-year renewal.

4. Method for Evaluating Effectiveness of System Changes

Through QI Team meetings, trend analysis is conducted on remediation efforts to determine effectiveness of such efforts and those performance measures needing continual improvement. As potential trends develop, specific activities will be identified that may need changing and an evaluation is conducted to remedy the issue.

Revision: HCFA-PM-93-5 (MB)
May 1993

State: Nevada

Citation

3.2 Coordination of Medicaid with Medicare and Other Insurance

(a) Premiums

(1) Medicare Part A and Part B

1902 (a) (10) (E) (i) and

1905 (p) (1) of the Act

(i) Qualified Medicare Beneficiary (QMB)

The Medicaid agency pays Medicare Part A premiums (if applicable) and part B premiums for individuals in the QMB group defined in Item A.25 of ATTACHMENT 2.2-A, through the group premium payment arrangement, unless the agency has a Buy-in agreement, for such payment as indicated below.

Buy-In agreement for:

__X__ Part A __X__ Part B

_____ The Medicaid agency pays premiums for which the beneficiary would be liable, for enrollment in an HMO participating in Medicare.

Revision: HCFA-PM-93-2 (MB)
March 1993

State: Nevada

Citation

1902 (a) (10) (E) (ii) and 1905 (s) of the Act	(ii)	Qualified Disabled and Working Individual (QDWI) The Medicaid agency pays Medicare Part A premiums under a group premium payment arrangement, subject to any contribution required as described in Attachment 4.18-E, for individuals in the QDWI group defined in Item A.26 of Attachment 2.2-A of this plan.
1902 (a) (10) (E) (iii) and 1905 (p) (3) (A) (ii) of the Act	(iii)	Specified Low-Income Medicare Beneficiary SLMB The Medicaid agency pays Medicare Part B premiums under the State buy-in process for individuals in the SLMB group defined in Item A.27 of Attachment 2.2-A of this plan.

Revision: HCFA-PM-93-2 (MB)
March 1993

State: Nevada

Citation

1843 (b) and 1905 (a) of the Act and 42 CFR 431.625

(iv) Other Medicaid Recipients

The Medicaid agency pays Medicare Part B premiums to make Medicare Part B coverage available to the following individuals:

X All individuals who are: a) receiving benefits under Titles I, IV-A, X, XIV, or XVI (AABD or SSI); b) receiving State supplements under Title XVI; or c) within a group listed at 42 CFR 431.625 (d) (2).

X Individuals receiving Title II or Railroad Retirement benefits.

_ Medically needy individuals (FFP is not available for this group).

2. Other Health Insurance

1902(a)(30) And of the Act

_ The Medicaid agency pays insurance 1905(a) premiums for medical or any other type of remedial care to maintain a third party resource for Medicaid covered services provided to eligible individuals (except individuals 65 years or age or older and disabled individuals, entitled to Medicare Part A but not enrolled in Medicare Part B).*

*Only when cost effective.

Revision: HCFA-PM-93-2TC (MB)
March 1993

State: Nevada

Citation

(b) Deductibles/Coinsurance

(1) Medicare Part A and B

1902(a) (30), 1902 (n)
1905 (a) and 1916 of the Act

Supplement 1 to ATTACHMENT 4.19-B describes describes the methods and standards for establishing payment rates for services covered under Medicare, and/or the methodology for payment of Medicare deductible and coinsurance amounts, to the extent available for each of the following groups.

Section 1902
(a) (10) (E) (i) and

(i) Qualified Medicare Beneficiaries (QMBS)
The Medicaid agency pays Medicare Part A and Part B 1905 (p) (3) of the Act deductible and coinsurance amounts for QMBs (subject to any nominal Medicaid copayment) for all services available under Medicare.

1902 (a) (10), 1902 (a) (30),
And 1905 (a) of the Act

(ii) Other Medicaid Recipients
The Medicaid agency pays for Medicaid services also covered under Medicare and furnished to recipients entitled to Medicare (subject to any nominal Medicaid copayment). For services furnished to individuals who are described in Section 3.2 (a) (1) (iv), payment is made as follows:

42 CFR 431.625

X For the entire range of services available under Medicare Part B.

_ Only for the amount, duration and scope of services otherwise available under this plan.

1902 (a) (10), 1902 (a) (30),
1905 (a), and 1905 (p)
of the Act

(iii) Dual Eligible – QMB plus

The Medicaid agency pays Medicare Part A and Part B deductible and coinsurance amounts for all services available under Medicare and pays for all Medicaid services furnished to individuals or medically needy (subject to any nominal Medicaid copayment.)

Revision: HCFA-PM-91-8 (MB)
October 1991

State: Nevada

Citation			Condition or Requirement
1906 of the Act		(c)	Premiums, Deductibles, Coinsurance and Other Cost Sharing Obligations The Medicaid agency pays all premiums, deductibles, coinsurance and other cost sharing obligations for items and services covered under the State plan (subject to any nominal Medicaid copayment) for eligible individuals in employer-based cost-effective group health plans. When coverage for eligible family members is not possible unless ineligible family members enroll, the Medicaid agency pays premiums for enrollment of other family members when cost-effective. In addition, the eligible individual is entitled to services covered by the State plan which are not included in the group health plan. Guidelines for determining cost effectiveness are described in section 4.22 (h).
1902 (a) (10) (F) of the Act	N/A	(d)	_____ The Medicaid agency pays premiums for individuals described in Item 19 of Attachment 2.2-A.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nevada

COORDINATION OF TITLE XIX WITH SPECIAL SUPPLEMENTAL FOOD PROGRAM FOR WOMEN, INFANTS AND CHILDREN (WIC)

The following method is used to provide for the coordination between the Medicaid Agency and the Special Supplemental Food Program for Women, Infants and Children (WIC) for the dissemination of the program's benefits to Medicaid applicant/recipients.

A. Maintain communication with State's WIC operations to promote timely and accurate dissemination of WIC program benefits and modifications.

B. Generate a onetime informational mailing of the WIC program's benefits to all Medicaid applicants and recipients to insure notification of the target population, (i.e. all individuals who are determined to be eligible for medical assistance and who are pregnant women, breastfeeding or postpartum women… or children under the age of five).

C. Revise initial and redetermination applicant and recipient interview procedures to distribute written WIC information and to verbally describe the availability of the WIC program's benefits to insure dissemination of information whether or not the potential beneficiary can read.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: Nevada

Citation
42 CFR 441.101,
42 CFR 431.620(c)
and (d)
AT-79-29

3.3 Medicaid for Individuals Age 65 or Over in Institutions for Mental Diseases

Medicaid is provided for individuals 65 years of age or older who are patients in institutions for mental diseases.

X Yes. The requirements of 42 CFR Part 441, Subpart C and 42 CFR 431.620(c) and (d) are met.

___ Not applicable. Medicaid is not provided to aged individuals in such institutions under this plan.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: Nevada

Citation		
42 CFR 441.252 AT-78-99	3.3	Special Requirements Applicable to Sterilization Procedures All requirements of 42 CFR Part 441, Subpart F are met.

State: Nevada

Citation
1902(a)(52) and 1925 of the Act

3.5 Families Receiving Extended Medicaid Benefits

(a) Services provided to families during the first 6-month period of extended Medicaid benefits under Section 1925 of the Act are equal in amount, duration, and scope to services provided to categorically needy AFDC recipients as described in ATTACHMENT 3.1-A (or may be greater if provided through a caretaker relative employer's health insurance plan).

(b) Services provided to families during the second 6-month period of extended Medicaid benefits under section 1925 of the Act are--

X Equal in amount, duration, and scope to services provided to categorically needy AFDC recipients as described in ATTACHMENT 3.1-A (or may be greater if provided through a caretaker relative employer's health insurance plan).

_ Equal in amount, duration, and scope to services provided to categorically needy AFDC recipients, (or may be greater if provided through a caretaker relative employer's health insurance plan) minus any one or more of the following acute services:

_ Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

_ Medical or remedial care provided by licensed practitioners.

_ Home health services.

Citation 3.5 Families Receiving Extended Medicaid Benefits (Continued)

_ Private duty nursing services.

_ Physical therapy and related services.

_ Other diagnostic, screening, preventive, and rehabilitation services.

_ Inpatient hospital services and nursing facility services for individuals 65 years of age or over in an institution for mental diseases.

_ Intermediate care facility services for the mentally retarded.

_ Inpatient psychiatric services for individuals under age 21.

_ Hospice services.

_ Respiratory care services.

_ Any other medical care and any other type of remedial care recognized under State law and specified by the Secretary.

Citation 3.5 Families Receiving Extended Medicaid Benefits (Continued)

(c) _ The agency pays the family's premiums, enrollment fees, deductibles, coinsurance, and similar costs for health plans offered by the caretaker's employer as payments for medical assistance--

_ 1st 6 months _ 2nd 6 months

_ The agency requires caretakers to enroll in employers' health plans as a condition of eligibility.

_ 1st 6 mos. _ 2nd 6 mos.

(d) _ (1)The Medicaid agency provides assistance to families during the second 6-month period of extended Medicaid benefits through the following alternative methods:

_ Enrollment in the family option of an employer's health plan.

_ Enrollment in the family option of a State employee health plan.

_ Enrollment in the State health plan for the uninsured.

_ Enrollment in an eligible health maintenance organization (HMO) with a prepaid enrollment of less than 50 percent Medicaid recipients (except recipients of extended Medicaid).

Citation 3.5 Families Receiving Extended Medicaid Benefits (Continued)

Supplement 2 to ATTACHMENT 3.1-A specifies and describes the alternative health care plan(s) offered, including requirements for assuring that recipients have access to services of adequate quality.

(2) The agency--

(i) Pays all premiums and enrollment fees imposed on the family for such plan(s).

_ (ii) Pays all deductibles and coinsurance imposed on the family for such plan(s).

3.6 Unemployed Parent

For purposes of determining whether a child is deprived on the basis of the unemployment of a parent, the agency--

9 uses the standard for measuring unemployment which was in the AFDC state plan in effect on July 16, 1996.

: uses the following more liberal standard to measure unemployment :

A child will be considered deprived if family income is below the applicable income standard, regardless of the number of hours the parent/caretaker is employed.

STATE OF NEVADA
STATE PLAN AMENDMENT
MEDICAID MANDATORY MANAGED CARE PROGRAM

Under Section 1932(A)(1)(A)
Mandatory Managed Care Program

I. Eligibility

1. Eligible Categories
   The State of Nevada Mandatory Managed Care Program will include the following Medicaid eligibility categories:

   1. Temporary Assistance for Needy Families (TANF);
   2. Two parent TANF;
   3. TANF - Related Medical Only;
   4. TANF - Post Medical;
   5. TANF - Transitional Medical;
   6. TANF Related (Sneede vs. Kizer): and
   7. Child Health Assurance Program (CHAP).

2. Eligible Category Exemptions
   The State of Nevada Mandatory Managed Care Program assures the exclusion of the following Medicaid eligible individuals from mandatory enrollment:

   1. Adults diagnosed as seriously mentally ill (SMI) by the Nevada State Division of Mental Hygiene and Mental Retardation (MH/MR).
   2. Children diagnosed as seriously emotionally disturbed (SED) by the Nevada State Division of Child and Family Services (DCFS) or MH/MR in rural areas.
   3. Children who are inpatients of a Residential Treatment Center (RTC);
   4. Individuals with comprehensive health coverage from another organization or agency which cannot be billed by a managed care organization.
   5. Children with special health care needs.
      Children with special health care needs are defined as:
      1. Those who have, or are at risk for, chronic physical, developmental, behavioral, or emotional conditions; and
      2. Who also require health and related services of a type and amount beyond that required by children in general; and
      3. Receiving services through a family-centered, community-based, coordinated care system receiving grant funds, under Section 501(a)(1)(D) of Title V of the Social Security Act. There are two facilities in Nevada named Special Children's Clinics, one in Washoe County and one in Clark County; or
      4. Participants utilizing or obtaining services through the First Step or Happy programs or
      5. Participant/guardian self-identification of potential child with special health care needs.

C. Excluded Medicaid Eligible Categories
Individuals federally exempt from mandatory enrollment are:

1. Children under the age of 19:
   a. Children eligible for SSI under Title XIX;
   b. Children described in section 1902(e)(3) of the Social Security Act (Katie-Beckett):
   c. Children in foster care or another out-of-town placement;
   d. Children receiving foster care or adoption assistance; or
   e. Children as identified under I.B.5. above.
2. The Aged, Blind and Disabled eligible for SSI, as a state institutional case or through a Home- and Community-Based Waiver.
3. Dual Medicare-Medicaid eligibles.
4. American Indians who are members of a Federally-recognized tribe.

D. Voluntary Participants
The State will allow American Indians, participants diagnosed SED or SMI and children as identified in I.B.5., to voluntarily enroll in an HMO under the mandatory managed care program. These categories of enrollees are not subject to mandatory lock-in enrollment provisions.

II. Enrollment

A. Process
The State will conduct enrollment sessions with all Medicaid eligibles in groups of 10 - 30 at a time.

1. The sessions are scheduled in conjunction with the initial eligibility interview or the redetermination interview where third-party liability information is also collected.
2. Attendance at the enrollment sessions is voluntary.
3. The State assures the information will be presented to non-English speaking participants in a culturally competent manner.

B. Methodology
The content of the enrollment session is provided through:

1. A video;
2. State or State contract staff presentation following the video and responding to participant questions;
3. State written information; and
4. State approved HMO materials.

1. **Content**

The content of the enrollment sessions includes information as follows:

1. Rights and responsibilities of the participant;
2. Services and items covered by the HMO;
3. Benefits outside the managed care contract and how the recipients may access these services;
4. Grievance and appeal rights provided by the HMO and the State Fair Hearing process, and the procedures for using them;
5. Lists of providers participating with each HMO
6. Service areas covered by each HMO
7. When information is available, performance and quality of services provided by the HMOs, including a comparison chart regarding benefits, cost sharing, and service areas;
8. Assurances that recipients may disenroll with cause at any time and without cause within the first 90 days of enrollment in the HMO, and at least every 12 months. The total lock-in period is 12 months inclusive of the initial 90 days up front to disenroll without cause. The recipients will be notified of their option to change HMOs at least 60 days prior to the end of the lock-in period.
9. Instructions for disenrolling from one HMO and choosing another, including the caution that if another HMO is not chosen, the State will select one for the recipient.
10. Explanation of enrollment exemptions as given in I.B. above.
11. Attendees will be asked to complete their selections of HMOs and PCPs/PCSs at the end of the session or prior to the eligibility decision date. If none is chosen, the State will complete a default enrollment, in accordance with 1932(a)(4)(C) and 1932(a)(4)(D), maintaining existing provider-recipient relationships, or relationships with traditional Medicaid providers wherever possible. When these criteria is not possible, the default process will provide an equitable distribution of auto-enrollees among the HMOs. When an attendee does not select an HMO, the State will assign family unit cases to an HMO in the following order:
    1. Enroll the attendee in the HMO the attendee had previously chosen under the Nevada Medicaid voluntary enrollment managed care program, if applicable;
    2. Enroll a weighted number of enrollees based on the number of contracts each HMO has with Nevada Medicaid-defined traditional providers. These providers are:
        1) University of Nevada School of Medicine
        2) University Medical Center
        3) Federally Qualified Health Care Centers
        4) Other State-identified essential community providers.
    3. If no previous enrollment under the voluntary managed care program exists and there is no difference between the number of contracts with traditional providers between HMOs, a family case unit will be assigned to the HMOs by a consecutive rotation between the HMOs in the service area.

III. Geographic Areas

The State assures individuals will have a choice of at least two HMOs in each geographic area. Those geographic areas are limited to Clark and Washoe counties. In accordance with NAC 695C.160, Medicaid eligible recipients are exempt from mandatory participation if they live more than 25 miles from a managed care contracted physician and hospital. When fewer than two HMOs are available for choice in the geographic areas listed, the managed care program will be voluntary.

IV. Cost Sharing

There is no cost sharing for Medicaid services.

V. Program Administration

A. Exemption Process

Medicaid eligibles specified in I.C. above are identified by an aid category number, except for I.C.1.e. and I.C.4. individuals. First, these persons (aid category identified) will not be required to attend the enrollment session. Second, the computer system will not allow a Medicaid eligible with an exempt aid category number to enroll. If a Medicaid eligible given in category I.A. above becomes exempt under I.C. above, the computer system will identify the exempt aid category and require disenrollment. Medicaid eligibles listed in category I.B. and I.C.4. above will be excluded from mandatory enrollment by the following methods:

1. Medicaid will have data base matches with the State Division of MH/MR for SMI individuals, DCFS for SED and Division of Health which operates the two Special Children's Clinics for children with special health care needs. The participants will be identified through a data match of name, Social Security number and birth date. Matching recipients will not be enrolled in an HMO or will be disenrolled if enrollment has occurred after notification to the recipient, parent or guardian.
2. The above-mentioned agencies will notify Medicaid when:
   1. A client was erroneously enrolled and not identified by the data match, and
   2. New clients to their agencies, who were previously enrolled in an HMO, will be disenrolled after notification to the recipient, parent or guardian.
3. The recipient, parent or guardian may identify themselves or child as meeting the definition of an SMI, SED or child with special health care needs at any time, starting with the eligibility interview and/or orientation session. Medicaid will immediately verify their status and take appropriate action.
4. Exclusion of categories I.B.3. and 4 and I.C.4. will begin in the eligibility interview and/or orientation session. Recipients will be asked to identify themselves. Medicaid staff present in the orientation session will also assist clients based on questions and information given to determine if they are not required to enroll in the mandatory program.
5. Medicaid staff, dealing with the inpatient placement of children into Residential Treatment Centers, will provide the Medicaid Managed Care Unit (MCU) staff with additional identification for category I.B.3. above.
6. Once a person is identified as exempt, a computer record code is used for identification.

B. Provider Panel & Credentials

Any HMO, licensed by the Nevada Department of Business & Industry, Division of Insurance, able to provide services as outlined by the conditions of the Mandatory Managed Care contract, will be considered for participation. The State assures all contracts with HMOs will comply with all pertinent sections of 1932 and 1903(m) of the Social Security Act.

1. The State assures it will monitor the contracted HMOs to ensure sufficient numbers of medical providers, willing and open to accept Medicaid recipients, to meet the requirement of the contract. Services shall be provided at levels no less than those given by Medicaid under fee-for-service to all participants, as defined in the State Plan, Nevada State Medicaid Service Manuals and Provider Bulletins.
2. The Mandatory Managed Care contract contains specific provisions regarding primary care physicians. Each HMO must maintain a specified ratio of PCPs to participants (1 PCP/across board specialist: 1500 participants; 1 PCP with extender: 1800 participants) in each geographic service area; a specified percentage of each HMO=s provider panel (50% per geographic area) must be willing and currently open to Medicaid enrollees; and the State reserves the right to stop enrollment in an HMO when it is discovered that the HMO-PCP panel does not fall within the ratio or percentage requirements.
3. Prior to the effective date of any contract, MCU staff will conduct a readiness review, including review of PCP contracts. The HMO must have its contracts with providers in good order and signed. If an HMO lacks sufficient contracts, the state will not begin enrollment in the HMO. The effective date of the Medicaid contract with an HMO is dependent upon the HMO meeting all contract requirements.
4. The State will conduct reviews at least annually. Provider contracts will be reviewed again and, if the HMO is deficient, the State will suspend enrollment and request a plan of corrective action. Between readiness reviews and annual reviews, the State will review any information regarding access problems and conduct reviews and apply contract suspension of enrollment rules when necessary.

C. Compliance

The State further assures all requirements of sections 1903(m) and 1932 of the Social Security Act will be met. All relevant provisions are included in the contract with the HMOs, either as contractor or State responsibility. On site reviews will be conducted as both scheduled and unscheduled activities by MCU staff.

1. The MCU will monitor and oversee the operation of the mandatory managed care program, assuring compliance with all federal program requirements, federal and state laws and regulations, and the requirements of the contract agreed upon by Medicaid and the HMOs.
2. Compliance will be evaluated by review and analysis of reports prepared and sent to the MCU by the HMO contractors. Deficiencies in one or more areas will result in the HMO being required to prepare a corrective action plan, which will also be monitored by the MCU.
3. Reports from the grievance and complaint process will be analyzed and used for evaluation purposes.

4. MCU staff will provide technical assistance as necessary to ensure the HMOs have adequate information and resources to comply with all the requirements of law and their contract.
5. MCU staff will evaluate each HMO for financial viability/solvency, access and quality assurance.

D. Cultural & Linguistic Sensitivity

Specific, designated enrollment sessions with Hispanic interpretation services are, and will continue to be, provided. Additional translator services are available through the Language Bank, which covers a wide variety of languages and dialects. Primary care physicians and other providers are required to list the languages spoken in their practices. This information is included on the provider lists from which recipients make their health care choices. Appropriate methods for communicating with the visually and hearing-impaired participants and accommodations for the physically disabled participants are available and access provided through the Medicaid staff on a pre-identified, individual basis.

E. Coordination with Out-of-Plan and Excluded Services

The State assures the services provided within the managed care network, and out-of-plan and excluded services, will be coordinated. The required coordination is specified in the State contract with the HMOs and is specific to service type and/or service provider.

VI. Rates & Payments

Rates for the two geographic areas of Nevada, Clark and Washoe counties, are established through a consulting actuarial firm, Nevada Medicaid fee-for-service rates, as well as other health care cost data, were considered in the development of the fees. The contract with the Actuary requires that calculated rates shall be actuarially sound and consistent with the Upper Payment Limit requirement at 42 CFR 447.361. State payments to contractors will comply with the upper payment limit provisions in 42 CFR 447.361 or 447.362, as applicable.

DHCFP, via its title XIX State Plan Attachment 3.1.E, covers corneal, kidney, liver, and bone marrow transplants and associated fees for adult recipients. For children to the age of 21 any medically necessary transplant that is not experimental will be covered. The health plan may claim transplant case reimbursement from DHCFP for inpatient medical expenses above the threshold of $100,000 in a one-year period (State Fiscal Year). Seventy five percent (75%) of the expenses above $100,000 are reimbursed to the health plan.

At the discretion of DHCFP administration, a recipient enrolled in a health maintenance organization may elect to re-enroll in (or receive treatment from) another HMO at any time that is in the medical best interest of the recipient, or the financial best interest of DHCFP, so long as this is done with the recipient's full understanding of the reason for the reassignment and with the recipients complete agreement. For those same reasons, and within those same restrictions and guidelines stated above, DHCFP may also assign the management and payment of a fee for service recipient's transplant to an HMO, so long as the recipient has elected such assignment, that assignment is only for the purpose of the transplant and there is no disruption of the recipient's medical home other than what is absolutely necessary for the success of the transplant. In any case, as soon as the transplant is complete, the recipient will be returned to his original health care delivery model, including the return to the original HMO.

Revision: HCFA-AT-80-38 (BPP)
MAY 22, 1980

State: Nevada

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

Citation	4.1 Methods of Administration
42 CFR 431.15 AT-79-29	The Medicaid agency employs methods of administration found by the Secretary of Health, Education and Welfare to be necessary for the proper and efficient operation of the plan.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: Nevada

Citation		
42 CFR 431.202 AT-79-29 AT-80-34	4.2	Hearings for Applicants and Recipients The Medicaid agency has a system of hearings that meets all the requirements of 42 CFR Part 431, Subpart E.

State/Territory: Nevada

Citation		
42 CFR 431.301	4.3	Safeguarding Information on Applicants and Recipients
AT-79-29		Under State statute which imposes legal sanctions, safeguards are provided that restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan.
52 FR 5967		All other requirements of 42 CFR Part 431, Subpart F are met.

State/Territory: Nevada

Citation
42 CFR 431.800(c)
50 FR 21839
1903(u)(1)(D) of the Act,
P.L. 99-509
(Section 9407)

4.4 Medicaid Quality Control

(a) A system of quality control is implemented in accordance with 42 CFR Part 431, Subpart P.

(b) The State operates a claims processing assessment system that meets the requirements of 431.800(e), (g), (h), (j), and (k).

X Yes.

_ Not applicable. The State has an approved Medicaid Management Information System (MMIS).

State/Territory: Nevada

Citation		
42 CFR 455.12 AT-78-90 48 FR 3742 52 FR 48817	4.5	Medicaid Agency Fraud Detection and Investigation Program The Medicaid agency has established and will maintain methods, criteria, and procedures that meet all requirements of 42 CFR 455.13 through 455.21 and 455.23 for prevention and control of program fraud and abuse.

SECTION 4 - GENERAL PROGRAM ADMINISTRATION

4.5 Medicaid Recovery Audit Contractor Program

Citation	
Section 1902(a)(42)(B)(i) of the Social Security Act	__X__The State has established a program under which it will contract with one or more recovery audit contractors (RACs) for the purpose of identifying underpayments and overpayments of Medicaid claims under the State plan and under an0.y waiver of the State plan. __X_ The State is seeking an exception to establishing such program for the following reasons: The State is seeking an exception to the requirement of a 1.0 FTE CMD. Please refer to Page 36b.1 for additional information.
Section 1902(a)(42)(B)(ii)(I) of the Act	__X__The State/Medicaid agency has contracts of the type(s) listed in section 1902(a)(42)(B)(ii)(I) of the Act. All contracts meet the requirements of the statute. RACs are consistent with the statute. ***The State attests that when the RAC contract is implemented that it will meet the required statutes.*** Place a check mark to provide assurance of the following: __X__The State will make payments to the RAC(s) only from amounts recovered.
Section 1902 (a)(42)(B)(ii)(II)(aa) of the Act	__X__The State will make payments to the RAC(s) on a contingent Basis for collecting overpayments. The following payment methodology shall be used to determine State payments to Medicaid RACs for identification and recovery of overpayments (e.g., the percentage of the contingency fee): **The exact contingency fee percentage has not yet been determined for this contract.** __X__ The State attests that the contingency fee rate paid to the Medicaid RAC will not exceed the highest rate paid to Medicare RACs, as published in the Federal Register. _____ The State attests that the contingency fee rate paid to the Medicaid RAC will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will only submit for FFP up to the amount equivalent to that published rate.

Section 1902 (a)(42)(B)(ii)(II)(bb) of the Act	_____The contingency fee rate paid to the Medicaid RAC that will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will submit a justification for that rate and will submit for FFP for the full amount of the contingency fee. __X__The following payment methodology shall be used to determine State payments to Medicaid RACs for the identification of underpayments (e.g., amount of flat fee, the percentage of the contingency fee): **A market based rate will be determined via the request for proposal (RFP) process.**
Section 1902 (a)(42)(B)(ii)(III) of the Act	__X__ The State has an adequate appeal process in place for entities to appeal any adverse determination made by the Medicaid RAC(s).
Section 1902 (a)(42)(B)(ii)(IV)(aa) of the Act	__X__ The State assures that the amounts expended by the State to carry out the program will be amounts expended as necessary for the proper and efficient administration of the State plan or a waiver of the plan.
Section 1902(a)(42)(B)(ii)(IV(bb) of the Act	__X___ The State assures that the recovered amounts will be subject to a State's quarterly expenditure estimates and funding of the State's share.
Section 1902 (a)(42)(B)(ii)(IV)(cc) Of the Act	__X__ Efforts of the Medicaid RAC(s) will be coordinated with other contractors or entities performing audits of entities receiving payments under the State plan or waiver in the State, and/or State and Federal law enforcement entities and the CMS Medicaid Integrity Program.

BRIAN SANDOVAL
Governor

MICHAEL J. WILLDEN
Director

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February 8, 2013

Gloria Nagle
Associate Regional Administrator
Division of Medicaid and Children's Health Operations, CMS
90 7th Street, Suite 5-300 (5W)
San Francisco CA 94103

Dear Ms. Nagle:

Enclosed please find Nevada's State Plan Amendment (SPA) #12-009. This SPA amends Nevada's State Plan effective July 1, 2012.

On behalf of the State of Nevada Division of Health Care Financing and Policy, I would like to request an exception to 42 CFR 455.508(b) which requires States to have a minimum 1.0 FTE Contractor Medical Director for Nevada's Medicaid RAC. The Nevada Medicaid RAC contract was awarded to HMS Holdings Corp and continues through December 31, 2016. Due to the nature and level of clinical review work projected to be performed, it is reasonable to consider that a full time Contracted Medical Director is not warranted for this individual state RAC contract. The State proposes to hire a 0.5 FTE CMD and utilize our contractor's contracted physician review panel for specialty peer reviews as required. In addition to this approach, our contractor has a full time (FTE) National Medical Director who is licensed in another state that brings national knowledge and experience to our RAC program, while the NV licensed CMD, and NV licensed contract physician review panel brings local state perspective and understanding of state health policy and coverage issues. We believe this approach will work well for the State and minimize cost prohibitive concerns resulting from the requirement of hiring a FTE CMD under this contingency fee based contract. The DHCFP and HMS believe that the spirit and intent of the Medicaid rule for a full time Contract Medical Director is to follow the Medicare RAC guidelines. We are empathetic to the concerns posed by providers regarding the availability of a licensed physician Contracted Medical Director and we intend to ensure that a Contracted Medical Director is available. However, CMS requires *Medicare* RACs to employ *one full time Contract Medical Director to oversee each awarded 7 to 20-state Medicare region, not each state*. Because of this, the DHCFP would like to be granted the ability to determine the appropriate staffing level for our Contracted Medical Director.

Our RAC administrator, HMS, employs Contracted Medical Directors (CMDs) who are currently licensed, have extensive knowledge of state coverage and payment rules, and have appropriate clinical experience. The CMD selected for the RAC will work closely with HMS's

Corporate Medical Officer (CMO), Dr. David Sand. Dr. Sand has extensive RAC experience, including serving as a CMD in the Medicare RAC pilot program, and as a member of HMS's physician panel to oversee clinical activities and determinations. The CMD for the Nevada RAC will oversee the medical review process, assist review staff upon request or as required, oversee quality assurance procedures, and maintain relationships with provider associations.

All of the physicians used by HMS are subjected to rigorous credentialing, including primary verification of licensure and certification by an American Board of Medical Specialties or American Osteopathic Association recognized board, as well as queries of the National Practitioners' Data Bank and the Department of Health and Human Services Office of the Inspector General's List of Excluded Individuals and Entities. No physician with a significant entry or exclusion is permitted to serve on their panel.

As detailed above, we believe that the approach used by HMS exceeds CMS' Final Rule statement that the RAC must employ an FTE CMD. Under the RAC contract, HMS will provide:

1. A Nevada-licensed CMD, whose staffing hours would be correlated with the volume of the RAC contract clinical reviews;

2. A panel of Nevada-licensed physician reviewers as needed; and

3. A resource of 800 physician peer reviewers nationwide.

As demonstrated by HMS's current Program Integrity contracts, due to the deep and ongoing involvement of their Chief Medical Officer, Contracted Medical Directors, and physician panel, we are confident that HMS can achieve the highest levels of quality, accuracy, and objectivity required of the Nevada RAC without employing a separate full time Nevada CMD. This approach ensures that the CMD has adequate knowledge and experience working on RAC programs, rather than having to place individuals in this role that may not have experience serving as a RAC CMD. For these reasons, the State of Nevada DHCFP does not believe employing a FTE CMD is appropriate for our state RAC and would request that we be given the ability to determine the appropriate staffing levels for our CMD.

Thank you for your consideration and should you have any questions regarding this request, please contact Marta Stagliano, Chief, Compliance at (775) 684-3623 or Marta.Stagliano@dhcfp.nv.gov.

Sincerely,

Michael J. Willden, Director
Department of Health and Human Services

Enclosures

Cc: Elizabeth Aiello, Deputy Administrator, DHCFP
Leah Lamborn, ASO IV, DHCFP
Marta Stagliano, Chief, Compliance, DHCFP

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: Nevada

Citation		
42 CFR 431.16 AT-79-29	4.6	Reports The Medicaid agency will submit all reports in the form and with the content required by the Secretary, and will comply with any provisions that the Secretary finds necessary to verify and assure the correctness of the reports. All requirements of 42 CFR 431.16 are met.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: Nevada

Citation
42 CFR 431.17
AT-79-29

4.7 Maintenance of Records

The Medicaid agency maintains or supervises the maintenance of records necessary for the proper and efficient operation of the plan, including records regarding applications, determination of eligibility, the provision of medical assistance, and administrative costs, and statistical, fiscal and other records necessary for reporting and accountability, and retains these records in accordance with Federal requirements. All requirements of 42 CFR 431.17 are met.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: Nevada

Citation
42 CFR 431.18(b)
AT-79-29

4.8 Availability of Agency Program Manuals

Program manuals and other policy issuances that affect the public, including the Medicaid agency's rules and regulations governing eligibility, need and amount of assistance, recipient rights and responsibilities, and services offered by the agency are maintained in the State office and in each local and district office for examination, upon request, by individuals for review, study, or reproduction. All requirements of 42 CFR 431.18 are met.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: Nevada

Citation		
42 CFR 433.37 AT-78-90	4.9	Reporting Provider Payments to Internal Revenue Service There are procedures implemented in accordance with 42 CFR 433.37 for identification of providers of services by social security number or by employer identification number and for reporting the information required by the Internal Revenue Code (26 U.S.C. 604l) with respect to payment for services under the plan.

State: NEVADA

Citation
42 CFR 431.51
AT 78-90
46 FR 48524
48 FR 23212
1902(a)(23)
P.L. 100-93
(Section 8(f))
P.L. 100-203
(Section 4113)

4.10 Free Choice of Providers

(a) Except as provided in paragraph (b), the Medicaid agency assures that an individual eligible under the plan may obtain Medicaid services from any institution, agency, pharmacy person, or organization that is qualified to perform the services including of the Act an organization that provides these services or arranges for their availability on a prepayment basis.

(b) Paragraph (a) does not apply to services furnished to an individual –

(1) Under an exception allowed under 42 CFR 431.54, subject to the limitations in paragraph (c), or

(2) Under a waiver approved under 42 CFR 431.55, subject to the limitations in paragraph (c), or

(3) By an individual or entity excluded from participation in accordance with section 1902(p) of the Act,

Section
1902(a)(23)
Of the Social
Security Act

(4) By individuals or entities who have been convicted of a felony under Federal or State law and for which the State determines that the offense is inconsistent with the best interests of the individual eligible to obtain Medicaid services, or

Section 1932(a)(1)
Section 1905(t)

(5) Under an exception allowed under 42 CFR 438.50 or 42 CFR 440.168, Section 1905(t) subject to the limitations in paragraph (c).

(c) Enrollment of an individual eligible for medical assistance in a primary care case management system described in section 1905(t), 1915(a), 1915(b)(1), or 1932(a); or, managed care organization, prepaid inpatient health plan, a prepaid ambulatory health plan, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive emergency services or services under section 1905 (a)(4)(c).

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Revision: HCFA-AT-80-38 (BPP) OMB No.: 0938-0193
May 22, 1980

State: Nevada

Citation

4.11 Relations with Standard-Setting and Survey Agencies

42 CFR 431.610
AT-78-90

(a) The State agency utilized by the AT-80-34 Secretary to determine qualifications of institutions and suppliers of services to participate in Medicare is responsible for establishing and maintaining health standards for private or public institutions (exclusive of Christian Science sanatoria) that provide services to Medicaid recipients. This agency is Department of Human Resources, Health Division.

(b) The State authority(ies) responsible for establishing and maintaining standards, other than those relating to health, for public or private institutions that provide services to Medicaid recipients is (are): Department of Commerce, Office of State Fire Marshall.

(c) ATTACHMENT 4.11-A describes the standards specified in paragraphs (a) and (b) above, that are kept on file and made available to the Health Care Financing Administration on request.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: Nevada

Citation		
42 CFR 431.610 AT-78-90 AT-89-34	4.11(d)	The Bureau of Regulatory Health Services, Health Division (agency), which is the State agency responsible for licensing health institutions, determines if institutions and agencies meet the requirements for participation in the Medicaid program. The requirements in 42 CFR 431.610(e), (f) and (g) are met.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nevada

Citation
Sect 1919(e)(1)(A)
Social Security Act as
Amended by ORBA 87

4.11(e) The Bureau of Regulatory Health Services, State Health Division, is the State agency that determines if health institutions and agencies meet the requirements for participation in the Medicaid program.

Nevada Medicaid maintains an interagency agreement with the Bureau of Regulatory Health Services to carry out a program of onsite surveys of all Nursing Facilities to monitor and assure compliance with provisions of Public Law 100-203, and to monitor and assure compliance with provisions of Public Law 100-203 for all delegated responsibilities to the Nevada Board of Nursing. The current agreement is on file with the Nevada Medicaid Office.

Under provisions of that agreement, the Bureau of Regulatory Health Services monitors and assures compliance of the Nursing Facilities with provisions of Public Law 100-203 relating to the regulation of nursing assistants in Nursing Facilities to include training and competency evaluation, certification, maintenance of registry, investigation of complaints, and the imposition of appropriate disciplinary action.

I. Health Standards

The Nevada Medicaid Office maintains on file and will make available to HCFA the following health standards for institutions providing medical services to Medicaid recipients:

a. Construction Standards for Hospitals, Skilled Nursing Facilities and Intermediate Care Facilities;

b. Standards for Intermediate Care Facilities;

c. Standards for Mental Health Facilities;

d. Standards for Hospitals; Facilities for Long Term Care; Nursing Homes; Extended Care Facilities; and

e. Standards for Care of Adults During the Day (Adult Day Health Care).

A. The Construction Standards for facilities include the following areas:

1. Fees

2. Definitions

3. Review of Building Plan Requirements

4. Elevator Requirements

5. Electrical Requirements

6. Mechanical Requirements

7. Door, Ceiling, floor requirements

8. Lobby requirements

9. Ambulatory surgical center

10. Rooms for disturbed patients

11. Emergency Units

12. Hemodialysis facilities

13. Intensive Care Units

14. Isolation rooms
15. Nursery units
16. Obstetrical units
17. Outpatient facilities
18. Pediatric and adolescent units
19. Psychiatric care units
20. Surgical units
21. Central Stores
22. Dietary Units
23. Facilities for employees
24. Janitor's closets
25. Laboratory requirements
26. Linen service
27. Medical and surgical supply units
28. Medical records
29. Morgue and autopsy unit
30. Nursing Unit
31. Occupational therapy unit
32. Pharmacy
33. Physical therapy unit
34. Radiology unit
35. Service areas
36. Processing waste

37. Skilled nursing and Intermediate Care Facilities

38. Correction of deficiencies

B. Operational Standards for Intermediate Care Facilities include:

1. Fees

2. Definitions

3. Applications

4. Licenses; Investigation; expiration; posting

5. Provisional licenses

6. Denial, suspension, revocation of license

7. Financing, liability insurance

8. Administrator: Qualifications

9. Employees: Qualifications

10. Employees: Physical examinations

11. Physical environment: New Construction

12. Accommodations for handicapped persons

13. Sanitary requirements

14. Laundry requirements

15. Fire inspections; hazardous conditions; operation of other businesses.

16. Plan for Disasters

17. Admission, transfer, discharge

18. Money of residents

19. Inventory of resident's belongings

20. Program requirements

21. Dietary Services

22. Health Services

23. Pharmaceutical services

24. Records

25. Supervision of physician, volunteers; advertising

26. Facilities for the mentally retarded or persons with develop-mental disabilities:

27. Discrimination prohibited

    a. Personnel
    b. Plan of Care
    c. Use of restraints
    d. Records

C. Operational Standards for Mental Health Facilities include:

1. Fees

2. Definition

3. When licensing is required

4. Construction of facilities: Submission of plans

5. Construction standards

6. Evaluation of programs

7. Issuance of license, term of license

8. Inspection of facilities

9. Denial, suspension, revocation of license

10. Appeals

11. Injections

12. Governing body: Bylaws, duties and responsibilities

13. Administration and personnel

14. Physical environment: general requirements, rooms for patients, housekeeping practices, sanitary requirements

15. Diagnostic and therapeutic facilities

16. Contents of medical records

17. Medical Library

18. Medical staff

19. Types of programs: inpatient hospitalization, partial hospitalization, mental health centers, emergency services, specialized programs, consultation and education

20. Psychological services

21. Medical services: medical attendants and nursing services, pediatric department, emergency medical care

22. Patient care unit

23. Social services

24. Rehabilitation services: staffing, physical and occupational therapy, recreational areas

25. Educational service

26. Pharmaceutical services: general requirements, prescriptions and orders, storage, administration and control

27. Dietary services: management and personnel, facilities required, diets, manual

28. Radiology department

29. Laboratory

30. Laundry requirements

31. Discrimination prohibited

D. Operational Standards for Hospitals; Facilities for Long Term Care; Nursing Homes; Extended Care Facilities include:

1. Fees

2. Definitions

3. Licenses

4. Licensing requirements

5. Governing body; bylaws

6. Physical environment: buildings, ventilation; water supply, diagnostic and therapeutic areas, rooms for patients

7. Housekeeping services

8. Sanitary requirements

9. Fire Control; plans for disasters

10. First Aid; transfer agreements; restraint of patients

11. Gases for medical use

12. Dietary services

13. Pharmaceutical services and medication

14. Rehabilitation services

15. Emergency services

16. Discrimination prohibited

17. Hospitals

    a. Medical staff
    b. Nursing services
    c. Obstetrical units
    d. Nurseries
    e. Department for outpatients
    f. Laboratories
    g. Radiology department
    h. Medical records
    i. Medical library
    j. Operating rooms
    k. Department of Anesthesia
    l. Dental services
    m. Psychiatric services

18. Other facilities: medical staff, nursing services, medical records

19. Correction of deficiencies

E. Facilities for Care of Adults During the Day Standards include:

1. Definition
2. Application for license
3. Purchase or lease of facility; new construction or remodeling
4. Display of license; transfer of real property
5. Consultation with representative of Division; notice of non-conformity
6. Renewal of license
7. Operation in combination with other medical facility or facility for the dependent
8. Fees
9. Insurance
10. Advertising and promotional materials
11. Policies and procedures; accounting
12. Director and employees: qualifications and duties; physical and mental health
13. Supervision of clients; volunteers
14. Files concerning employees
15. Requirements of facility; health and sanitation; medications; exits
16. Plan for emergencies; drill for evacuation
17. First aid
18. Policy for admissions; retention of signed copy
19. Requirement for admission; designation of physician
20. Required services
21. Housekeeping and maintenance
22. Service of food; dietary consultants
23. Discrimination prohibited

24. Summary of client's care; referrals

25. Records

26. Medical and Ancillary services

    a. Contract for provision by another person
    b. Provision by facility authorized
    c. Evaluation of programs and policies
    d. Written assessments of clients
    e. Plan of care; periodic assessment
    f. Menus

II. Fire and Safety Standards

The Nevada Medicaid Office maintains on file and will make available to HCFA the Nevada State Fire Marshall Regulations (Nevada Administrative Code Chapter 477 effective September 1, 1986) which cover the regulations the Office of the Fire Marshall, Nevada Department of Commerce, use for institutions providing medical services to Medicaid recipients.

The Regulations cover the following areas:

1. Definitions

2. Licensing

3. Inspection of Systems

4. Protective Signaling Systems

5. Portable Fire Extinguishers and Fixed Hood Systems

6. Automatic Sprinkler Systems: Commercial, Residential, Institutional Buildings, Buildings Used for Child Care

7. Fireworks

8. Containers for Flammable or Combustible Liquids

9. Use of Explosives in Blasting

10. Review of Plans

11. Nevada Revised Statute, Chapter 477, State Fire Marshall

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: Nevada

Citation

42 CFR 431.105(b)
AT-78-90

4.12 Consultation to Medical Facilities

(a) Consultative services are provided by health and other appropriate State agencies to hospitals, nursing facilities, home health agencies, clinics and laboratories in accordance with 42 CFR 431.105(b).

(b) Similar services are provided to other types of facilities providing medical care to individuals receiving services under the programs specified in 42 CFR 431.105(b).

__ Yes, as listed below:

X Not applicable. Similar services are not provided to other types of medical facilities.

State/Territory: Nevada

Citation 4.13 Required Provider Agreement

With respect to agreements between the Medicaid agency and each provider furnishing services under the plan:

42 CFR 431.107	(a)	For all providers, the requirements of 42 CFR 431.107 and 42 CFR Part 442, Subparts A and B (if applicable) are met.
42 CFR Part 483 1919 of the Act	(b)	For providers of NF services, the requirements of 42 CFR Part 483, Subpart B, and section 1919 of the Act are also met.
42 CFR Part 483, Subpart D	(c)	For providers of ICF/MR services, the requirements of participation in 42 CFR Part 483, Subpart D are also met.
1920 of the Act	(d)	For each provider that is eligible under the plan to furnish ambulatory prenatal care to pregnant women during a presumptive eligibility period, all the requirements of section 1920(b)(2) and (c) are met.

/X/ Not applicable. Ambulatory prenatal care is not provided to pregnant women during a presumptive eligibility period.

State: NEVADA

Citation
1902 (a)(58)
1902(w)

4.13(e) For each provider receiving funds under the plan, all the requirements for advance directives of section 1902(w) are met:

(1) Hospitals, nursing facilities, providers of home health care or personal care services, hospice programs, managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans (unless the PAHP excludes providers in 42 CFR 489.102) and health insuring organizations are required to do the following:

(a) Maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization about their rights under State law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.

(b) Provide written information to all adult individuals on their policies concerning implementation of such rights;

(c) Document in the individual's medical records whether or not the individual has executed an advance directive;

(d) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(e) Ensure compliance with requirements of State Law (whether statutory or recognized by the courts) concerning advance directives; and

State: NEVADA

(f) Provide (individually or with others) for education for staff and the community on issues concerning advance directives.

(2) Providers will furnish the written information described in paragraph (1)(a) to all adult individuals at the time specified below:

(a) Hospitals at the time an individual is admitted as an inpatient;

(b) Nursing facilities when the individual is admitted as a resident;

(c) Providers of home health care or personal care services before the individual comes under the care of the provider;

(d) Hospice program at the time of initial receipt of hospice care by the individual from the program; and

(e) Managed care organizations, health insuring organizations, prepaid inpatient health plans, and prepaid ambulatory health plans (as applicable) at the time of enrollment of the individual with the organization.

(3) Attachment 4.34A describes law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives.

_____ Not applicable. No State law or court decisions exist regarding advance directives.

State: NEVADA

Citation
42 CFR 431.60
42 CFR 456.2
50 FR 15312
1902(a)(30)(C) and
1902(d) of the
Act, P.L. 99-509
(Section 9431)

4.14 Utilization/Quality Control

(a) A Statewide program of surveillance and utilization control has been implemented that safeguards against unnecessary or inappropriate use of Medicaid services available under this plan and against excess payments, and that assesses the quality of services. The requirements of 42 CFR Part 456 are met:

* **X** Directly

** **X** By undertaking medical and utilization review requirements through a contract with a Utilization and Quality Control Peer Review Organization (PRO) designated under 42 CFR Part 462. The contract with the PRO —

(1) Meets the requirements of §434.6(a):

(2) Includes a monitoring and evaluation plan to ensure satisfactory performance;

(3) Identifies the services and providers subject to PRO review;

(4) Ensures that PRO review activities are not inconsistent with the PRO review of Medicare services; and

(5) Includes a description of the extent to which PRO determinations are considered conclusive for payment purposes.

1932(c)(2)
And 1902(d) of the
ACT, P.L. 99-509
(Section 9431)

X A qualified External Quality Review Organization performs an annual External Quality Review that meets the requirements of 42 CFR 438 Subpart E each managed care organization, prepaid inpatient health plan, and health insuring organizations under contract, except where exempted by the regulation.

* Except inpatient hospital
** Inpatient hospital

Citation

42 CFR 456.2
50 FR 15312

4.14(b) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart C, for control of the utilization of inpatient hospital services.

X Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

__ Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart C for:

__ All hospitals (other than mental hospitals).

__ Those specified in the waiver.

X No waivers have been granted.

State/Territory: Nevada

Citation

42 CFR 456.2
50 FR 15312

4.14 (c) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart D, for control of utilization of inpatient services in mental hospitals.

X Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

___ Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart D for:

_ All mental hospitals.

_ Those specified in the waiver.

X No waivers have been granted.

___ Not applicable. Inpatient services in mental hospitals are not provided under this plan.

State: Nevada

Citation

42 CFR 456.2
50 FR 15312

4.14(d) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart E, for the control of utilization of skilled nursing facility services.

X Utilization and medical review are performed by a Utilization and Quality Control Peer Review Organization designated under 42 CFR Part 462 that has a contract with the agency to perform those reviews.

__ Utilization review is performed in accordance with 42 CFR Part 456, Subpart H, that specifies the conditions of a waiver of the requirements of Subpart E for:

__ All skilled nursing facilities.

__ Those specified in the waiver.

X No waivers have been granted.

X 4.14(e) The Medicaid agency meets the requirements of 42 CFR Part 456, Subpart F, for control of the utilization of intermediate care facility services. Utilization review in facilities is provided through:

Citation

42 CFR 456.2
50 FR 15312

__ Facility-based review.

X Direct review by personnel of the medical assistance unit of the State agency.

X Personnel under contract to the medical assistance unit of the State agency.

__ Utilization and Quality Control Peer Review Organizations.

__ Another method as described in ATTACHMENT 4.14-A.

X Two or more of the above methods. ATTACHMENT 4.14-B describes the circumstances under which each method is used.

___ Not applicable. Intermediate care facility services are not provided under this plan.

State: NEVADA

Citation 4.14 Utilization/Quality Control (Continued)

42 CFR 438.356(e)	For each contract, the State must follow an open, competitive procurement process that is in accordance with State law and regulations and consistent with 45 CFR part 74 as it applies to State procurement of Medicaid services.
42 CFR 438.354 42 CFR 438.356(b) and (d)	The State must ensure that an External Quality Review Organization and its subcontractors performing the External Quality Review or External Quality Review-related activities meets the competence and independence requirements.
	____ Not applicable.

The State agency requires that each intermediate care facility participating under the plan have in effect or be covered by a utilization review plan which meets the requirements of 42 CFR Part 456, Subpart F. Utilization review in such facilities is provided through:

1. Facility-based review for those ICFs operating in conjunction with acute or skilled nursing facilities, and

2. Direct review by Nevada Physician's Review Organization for free-standing ICFs.

Revision: HCFA-PM-92-2 (HSQB)
May 22, 1980

State: Nevada

Citation
42 CFR 456.2
AT-78-90

4.15 Inspection of Care in Skilled Nursing and Intermediate Care Facilities and Institutions for Mental Diseases

All applicable requirements of 42 CFR 456, Subpart I, are met with respect to periodic inspections of care and services.

___ Not applicable with respect to intermediate care facility services; such services are not provided under this plan.

___ Not applicable with respect to services for individuals age 65 or over in institutions for mental disease; such services are not provided under this plan.

___ Not applicable with respect to inpatient psychiatric services for individuals under age 22; such services are not provided under this plan.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: Nevada

Citation		
42 CFR 431.615(c) AT-78-90	4.16	Relations with State Health and Vocational Rehabilitation Agencies and Title V Grantees

The Medicaid agency has cooperative arrangements with State health and vocational rehabilitation agencies and with title V grantees, that meet the requirements of 42 CFR 431.615.

ATTACHMENT 4.16-A describes the cooperative arrangements with the health and vocational rehabilitation agencies.

Nevada Medicaid maintains interagency agreements with Nevada State Health Division and Rehabilitation Division. The Health Division provides family planning services, Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT), Special Children's Clinic Services, Crippled Children's Services, TB Control, Pre-screening for institutional care and Maternal and Child Health Services. The Rehabilitation Division administers the vocational rehabilitation program throughout the State. (The Health Division provides Maternal and Child Health Services and EPSDT services in all rural counties and Crippled Children's Services statewide.)

Nevada Medicaid also maintains interagency agreements with other Title V grantees, the Health Division, the Clark County Health District, Washoe County District Health Department and Economic Opportunity Board. In Clark County the Health District and Economic Opportunity Board provide EPSDT and Maternal and Child Health services; in Washoe County the Health Department provides them.

The above mentioned agreements meet all of the following requirements:

1. They specify:

    a. The mutual objectives and responsibilities of each party to the agreement;

    b. The services each party offers and under what circumstances;

    c. The cooperative and collaborative relationship at the State level;

    d. The kinds of services to be provided by local agencies; and

    e. The methods for:

        1) Early identification of individuals under age 21 in need of medical or remedial services;

        2) Reciprocal referrals;

        3) Coordinating plans for health services provided or arranged for recipients;

        4) Payment or reimbursement;

        5) Exchange of reports of services provided to recipients;

        6) Periodic review and joint planning for changes in the agreements;

7) Continuous liaison between the parties including designation of State and local liaison staff; and

8) Joint evaluation of policies which affect the cooperative work of the parties.

Nevada Medicaid, if requested by the Title V grantee, reimburses the grantee or the provider for the cost of services furnished to recipients by or through the grantee, in accordance with the Nevada Medicaid State Plan.

All of the current above mentioned agreements are on file at the Nevada Medicaid Office and are available for review.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Revision: HCFA-PM-95-3 (MB)
MAY 1995

State/Territory: Nevada

Citation

42 CFR 433.36(c)
1902(a)(18) and
1917(a) and (b)
of the Act

4.17 Liens and Recoveries

(a) Liens

__ The State imposes liens against an individual's real property on account of medical assistance paid or to be paid.

The State complies with the requirements of section 1917(a) of the Act and regulations at 42 CFR 433.36(c) (g) with respect to any lien imposed against the property of any individual prior to his or her death on account of medical assistance paid or to be paid on his or her behalf.

__ The State imposes liens on real property on account of benefits incorrectly paid.

__ The State imposes TEFRA liens 1917(a)(1)(B) on real property of an individual who is an inpatient of a nursing facility, ICF/MR, or other medical institution, where the individual is required to contribute toward the cost of institutional care all but a minimal amount of income required for personal needs.

The procedures by the State for determining that an institutionalized individual cannot reasonably be expected to be discharged are specified in Attachment 4.17-A. (NOTE: If the State indicates in its State Plan that it is imposing TEFRA liens, then the State is required to determine whether an institutionalized individual is permanently institutionalized and afford these individuals notice, hearing procedures, and due process requirements.

_X_ The State imposes liens on both real and personal property of an individual after the individual's death.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Revision: HCFA-PM-95-3 (MB)
MAY 1995

State/Territory: Nevada

Citation

4.17 (Cont'd)

42 CFR 433.36(c)
1902(a)(18) and
1917(a) and (b)
of the Act

(b) Adjustment or Recoveries

The State complies with the requirements of section 1917(b) of the Act and regulations at 42 CFR 433.36(h)-(i).

Adjustments or recoveries for Medicaid claims correctly paid are as follows:

(1) For permanently institutionalized individuals, adjustments or recoveries are made from the individual's estate or upon sale of the property subject to a lien imposed because of medical assistance paid on behalf of the individual for services provided in a nursing facility, ICF/MR, or other medical institution.

X Adjustments or recoveries are made for all other medical assistance paid on behalf of the individual.

(2) X The State determines "permanent institutional status" of individuals under the age of 55 other than those with respect to whom it imposes liens on real property under (ss)1917(a)(1)(B) (even if it does not impose those liens).

(3) For any individual who received medical assistance at age 55 or older, adjustments or recoveries of payments are made from the individual's estate for nursing facility services, and related hospital and prescription drug services.

X In addition to adjustment or recovery of payments for services listed above, payments are adjusted or recovered for other services under the State Plan as listed below:

All other Medicaid services currently covered under Nevada's State Plan for recipients age 55 and over, except for Medicare cast sharing as identified in Section 4.17(b)(3-Continued).

Revision: HCFA-PM-95-3 (MB)
May 1995

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nevada

4.17 (b) Adjustments or Recoveries

(3) (Continued)

Limitations on Estate Recovery – Medicare Cost Sharing:

i. Medical assistance for Medicare cost sharing is protected from estate recovery for the following categories of dual eligibles: QMB, SLMB, QI, QDWI, QMB+, SLMB+. This protection extends to medical assistance for four Medicare cost sharing benefits: (Part A and B premiums, deductibles, coinsurance, co-payments) with dates of service on or after January 1, 2010. The date of service for deductibles, coinsurance, and co-payments is the date the request for payment is received by the State Medicaid Agency. The date of service for premiums is the date the State Medicaid Agency paid the premium.

ii. In addition to being a qualified dual eligible the individual must also be age 55 or over. The above protection from estate recovery for Medicare cost sharing benefits (premiums, deductibles, coinsurance, co-payments) applies to approved mandatory (i.e., nursing facility, home and community-based services, and related prescription drugs and hospital services) as well as optional Medicaid services identified in the State plan, which are applicable to the categories of duals referenced above.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nevada

1917(b)1(C) (4) ☒ If an individual covered under a long-term care insurance policy received benefits for which assets or resources were disregarded as provided for in Attachment 2.6-A, Supplement 8c (State Long-Term Care Insurance Partnership), the State does not seek adjustment or recovery from the individual's estate for the amount of assets or resources disregarded.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Revision: HCFA-PM-95?3 (MB)
MAY 1995

State/Territory: Nevada

Citation

4.17 (Cont'd)

42 CFR 433.36(c)
1902(a)(18) and
1917(a) and (b)
of the Act

(c) Adjustment or Recoveries: Limitations

The State complies with the requirements of section 1917(b)(2) of the Act and regulations at 42 CFR ?433.36(h)?(i).

(1) Adjustment or recovery of medical assistance correctly paid will be made only after the death of the individual's surviving spouse, and only when the individual has no surviving child who is either under age 21, blind, or disabled.

(2) With respect to liens on the home of any individual who the State determines is permanently institutionalized and who must as a condition of receiving services in the institution apply their income to the cost of care, the State will not seek adjustment of recovery of medical assistance correctly paid on behalf of the individual until such time as none of the following individuals are residing in the individual's home:

(a) a sibling of the individual (who was residing in the individual's home for at least one year immediately before the date that the individual was institutionalized), or

(b) a child of the individual (who was residing in the individual's home for at least two years immediately before the date that the individual was institutionalized) who establishes to the satisfaction of the State that the care the child provided permitted the individual to reside at home rather than become institutionalized.

(3) No money payments under another program are reduced as a means of adjusting or recovering Medicaid claims incorrectly paid.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Revision: HCFA-PM-95-3 (MB)
MAY 1995

State/Territory: Nevada

Citation

42 CFR 433.36(c)
1902(a)(18) and
1917(a) and (b)
of the Act

4.17 (Cont'd)

(d) ATTACHMENT 4.17-A

(1) Specifies the procedures for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home. The description of the procedure meets the requirements of 42 CFR 433.36(d).

(2) Specifies the criteria by which a son or a daughter can establish that he or she has been providing care, as specified under 42 CFR 433.36(f).

(3) Defines the following terms:

- estate (at a minimum, estate as defined under State probate law). Except for the grandfathered States listed in section 4.17(b)(3), if the State provides a disregard for assets or resources for any individual who received or is entitled to receive benefits under a long term care insurance policy, the definition of estate must include all real, personal property, and assets of an individual (including any property or assets in which the individual had any legal title or interest at the time of death to the extent of the interest and also including the assets conveyed through devices such as joint tenancy, life estate, living trust, or other arrangement);
- individual's home;
- equity interest in the home;
- residing in the home for at least 1 or 2 years;
- on a continuous basis;
- discharge from the medical institution and return home; and
- lawfully residing

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

Revision: HCFA-PM?95?3 (MB)
MAY 1995

State/Territory: Nevada

Citation	4.17 (Cont'd)	
42 CFR 433.36(c) 1902(a)(18) and 1917(a) and (b) of the Act	(4)	Describes the standards and procedures for waiving estate recovery when it would cause undue hardship.
	(5)	Defines when adjustment or recovery is not cost-effective. Defines cost-effective and includes methodology or thresholds used to determine cost-effectiveness.
	(6)	Describes collection procedures. Includes advance notice requirements, specifies the method for applying for a waiver, hearing and appeals procedures, and the time frames involved.

State: NEVADA

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
LIENS AND ADJUSTMENT OR RECOVERIES

1. The State defines "estate" as follows:

   "ESTATE" - means all real and personal property and other assets included in the estate of a deceased recipient of Medicaid and any other assets in or to which he/she had an interest or legal title at the time of their death, to the extent of that interest or title. The term includes assets passing by reason of joint tenancy, *tenants-in-common*, life estate, survivorship, living trust, annuity, homestead or other arrangement.

2. The State uses the following notification procedures):

   a. Advance Notice Procedure

      1) All Medicaid applicants are notified of the Medicaid Estate Recovery program at their initial application process and annual redetermination, via the Signature and Affirmation (2920-EM (9/01) which they read and sign. Along with the application or redetermination, the applicant is provided with "Medicaid Estate Recovery Notification of Program Operation" (form 6160) which is signed and dated by the eligibility worker to confirm that a copy was provided to the applicant. The applicant keeps a copy of this form and a copy is filed in the permanent section of the client's case file.

   b. Recovery Notification Procedures

      Immediately following case identification, all known heirs, survivors and designated representatives are notified of:

      1) the State's interest in the decedent's estate and of the right to recovery,
      2) the amount of Medicaid assistance paid, to date, on behalf of the decedent,
      3) the priority of estate creditors as defined by Nevada State Law, and
      4) the method through which an undue hardship waiver may be pursued.

3. The State defines undue hardship as severe financial duress or a significant compromise to an individual's health care or shelter needs.

4. Application for Undue Hardship Waiver - Any heir or survivor may seek an undue hardship waiver by submitting a written request for a waiver by completing an "Application (Request) for a Hardship Waiver Regarding Recovery of Correctly Paid Medicaid Benefits" form, within thirty (30) days of notification of the Division's intent to recover. Documentary evidence that supports the applicant's claim should be attached. The written decision of the Administrator will be provided to the applicant 90-days from receipt of the request.

5. The State will waive enforcement of any estate recovery claim when the requesting party is able to show, through convincing evidence, the state's pursuit of estate recovery subjects them to undue hardship. A claim for emotional hardship is not considered sufficient to warrant waiver approval. No waiver will be granted if the Division finds the undue hardship was created by estate planning methods by which the waiver applicant or deceased client divested, transferred or otherwise encumbered assets, in whole or part, to avoid estate recovery. In determining whether undue hardship exists, the following criteria will be used:

   a. The asset to be recovered is the sole income-producing asset of the applicant; or,

   b. The recovery of the assets would result in the applicant becoming eligible for governmental public assistance based on need and/or medical assistance programs; or,

   c. A doctor's written verification of a medical condition that compromises the applicant's ability to repay the Medicaid claim.

6. If an undue hardship waiver is requested and the State determines that none of the above conditions apply, full payment of the claim may be ordered, recovery may be temporarily waived, compromised, or modified. The following factors shall be considered individually or in combination when making a decision to temporarily waive, modify, or compromise estate recovery:

   a. The gross annual income, property and other assets of the applicant and their immediate family;

   b. The type and level of care provided by the applicant (caregiver) to the decedent and the extent to which the care delayed or prevented the institutionalization of the decedent;

      1) The State uses the following process for determining if the applicants will be considered as caregivers when through clear evidence they substantiate:

         a) Maintained residency in the Medicaid recipient's home for at least two years immediately preceding the recipient's death or admission into a nursing facility, intermediate care facility for the mentally retarded or other medical institutions; and
         b) Provided care for the Medicaid recipient which meets or exceeds published state standard established for Intermediate Care Level (ICL 1), which includes as necessary, assisting the individual with ambulatory needs, feeding, grooming, personal hygiene, oral hygiene, nail care, bathing toilet activities, skin care and medical needs.

   c. The applicant continuously resided with the decedent for two years or more immediately prior to the decedent's death and continues to reside in the decedent's residence and the prior occupancy permitted the decedent to reside at home rather than in an institution;

   d. The estimated value of the real or personal property at issue. If the cost of recovering the asset(s) of the deceased Medicaid recipient is more than the value of the asset(s), it would not be cost effective to recover, and/or;

   e. The financial impact of recovery against immediate family members of the applicant.

f. Applicants who seek a recovery delay (i.e., temporary waiver) will be given the opportunity to provide written details or complete an "Application for a Hardship Waiver Regarding Recovery of Correctly Paid Medicaid Benefits" form, within 30-days of notification of the Division's intent to recover.

7. The following collection methods may be utilized when recovery is temporarily waived, compromised, or modified:

a. Reduction of recovery amount;
b. Reasonable payment schedule based on the asset to be recovered; and/or
c. Where not prohibited by law, imposition of a lien against the assets of the deceased Medicaid recipient.

1) Before imposition of a lien, the Division shall notify all persons having an interest in the estate of the deceased Medicaid recipient and petition the appropriate district court for the imposition of a lien per NRS 422.29355.

2) If a lien is placed on an individual's home, adjustment or recovery will only be made when:
a) there is no surviving spouse;
b) there is no child under the age of 21; or
c) there is no blind or disabled (as defined in Section 1614 of the Social Security Act) child of the Medicaid recipient.

3) The lien will become due and payable upon the sale, refinance, transfer or change in title to the real property; and /or escrow funding, but only when there is no surviving spouse, children under 21, blind or disabled children of the Medicaid recipient. Recovery is limited to the Medicaid recipient's interest in the property at the time of claim payment not to exceed the Medicaid claim or the percentage of interest of the Medicaid recipient in the asset.

4) Upon payment of the claim, or need of the statutory exemptions, the division will prepare a release of lien or subordinate the lien. This release will be provided to the appropriate entity; such as, an escrow company or the county recorder's office.

8. The following time frames are used by the State in considering the waiving of estate recoveries:

a. Any beneficiary, heir or family member claiming entitlement to receive the assets of the deceased Medicaid recipient may apply for a hardship waiver by submitting a written request for a waiver within 30-days of being notified of intent to recover to the Medicaid Estate Recovery unit.

b. The Division may request additional information or documentation from the waiver applicant. If some or all of the additional information or documentation is not provided within 30 days of the request, the hardship waiver request will be considered solely on the basis of the information and documentation provided.

c. Within 90-days of receipt of the undue hardship waiver request, the Division Administrator OR his appointed representative, will issue a written decision granting or denying the applicant's request for an undue hardship waiver.

9. The State defines cost-effective as follows (include methodology/thresholds used to determine cost effectiveness):

a. Cost-effective recovery is accomplished when the amount recovered exceeds the administrative (direct or indirect) expense associated with obtaining the recovery such as, but not limited to, legal fees and expenses.

b. Many of the estate recovery activities have been automated thereby minimizing correspondence costs. Individual case analysis and management is not required until a ninety (90) day delinquency has occurred.

c. Therefore, case costs would begin to accrue after this time. Costs such as, but not limited to, staff costs, document filing fees, legal costs, postage, copying, travel and indirect administrative costs would be considered.

10. The Division may elect not to recover a Medicaid Estate Recovery claim when the State determines that it is not cost-effective to do so.

a. Cost-effectiveness will be decided on a case-by-case basis.
b. If the Medicaid claim is $100 or less or the value of the asset to be recovered is $100 or less, recovery may not be pursued.

11. Hearing and Appeal Procedures

a. If the undue hardship waiver is denied, the decision may be appealed within 30 days through the appropriate district court (Administrative Procedure Act 233B.130).

12. Action to Enforce Recovery:

a. Actions to enforce recovery of Medicaid Estate Recovery claims are accomplished through legal means using, if necessary, the appropriate court of jurisdiction. Use of the court protects the due process right of all and guarantees safe protection of the law.

b. NRS. 150.220; "Priority of Creditors" list the order in which assets are to be distributed after death. Money owed to the Department of Human Resources as a result of benefits paid to the Medicaid recipient is listed as Number 6 in order of payment.

c. Time Frames Involved

1) Action to Enforce

Recovery Limitations of time to contest specific actions are detailed in Nevada State Law NRS 422.2785.

State: NEVADA

Citation
42 CFR 447.51 through 447.58

4.18 Recipient Cost Sharing and Similar Charges

(a) Unless a waiver under 42 CFR 431.55(g) applies, deductibles, coinsurance rates, and co-payments do not exceed the maximum allowable charges under 42 CFR 447.54.

1916(a) and (b) of the Act

(b) Except as specified in items 4.18(b)(4), (5), and (6) below, with respect to individuals covered as categorically needy or as qualified Medicare beneficiaries (as defined in section 1905(p)(1) of the Act) under the plan:

(1) No enrollment fee, premium, or similar charge is imposed under the plan.

(2) No deductible, coinsurance, co-payment, or similar charge is imposed under the plan for the following:

(i) Services to individuals under age 18, or under--

[ ] Age 19

[ ] Age 20

[ ] Age 21

Reasonable categories of individuals who are age 18 or older, but under age 21, to whom charges apply are listed below, if applicable.

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

State: NEVADA

Citation 4.18(b)(2) (Continued)

42 CFR 447.51
Through
447.58

(iii) All services furnished to pregnant women.

[ ] Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.

(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution to spend for medical care costs all but a minimal amount of his or her income required for personal needs.

(v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).

(vi) Family planning services and supplies furnished to individuals of childbearing age.

(vii) Services furnished by a managed care organization, health insuring organization, prepaid inpatient health plan, or prepaid ambulatory health plan in which the individual is enrolled, unless they meet the requirements of 42 CFR 447.60.

42 CFR 438.108
42 CFR 447.60

[ ] Managed care enrollees are charged deductibles, coinsurance rates, and co-payments in an amount equal to the State Plan service cost-sharing.

[X] Managed care enrollees are not charged deductibles, coinsurance rates and co-payments.

1916 of the Act
P.L. 99-272,
(Section 9505)

(viii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.

State/Territory: Nevada

Citation

4.18(b) (Continued)

42 CFR 447.51

(3) Unless a waiver under 42 CFR 431.55(g) applies, nominal deductible, coinsurance, copayment, or similar charges are imposed for services that are not excluded from such charges under item (b) (2) above.

☒ Not applicable. No such charges are imposed.

(i) For any service, no more than one type of charge is imposed.

(ii) Charges apply to services furnished to the following age groups:

☐ 18 or older

☐ 19 or older

☐ 20 or older

☐ 21 or older

☐ Charges apply to services furnished to the following reasonable categories of individuals listed below who are 18 years of age or older but not under age 21.

State/Territory: Nevada

Citation 4.18(b)(3) (Continued)

42 CFR 447.51
Through 447.58

(iii) For the categorically needy and qualified Medicare beneficiaries, ATTACHMENT 4.18-A specifies the:

(A) Service(s) for which a charge(s) is applied;

(B) Nature of the charge imposed on each service.

(C) Amount(s) of and basis for determining the charge(s).

(D) Method used to collect the charge(s)

(E) Basis for determining whether an individual is unable to pay the charge and the means by which such an individual is identified to providers.

(F) Procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b); and

(G) Cumulative maximum that applies to all deductible, coinsurance or copayment charges imposed on a specified time period.

☐ Not applicable. There is no maximum.

State/Territory: Nevada

Citation			
1916 (c) of	4.18 (b) (4)	☐	A monthly premium is imposed on pregnant woman and infants who are covered under Section 1902 (a) (10) (A) (ii) (IX) of the Act and whose income equals or exceeds 150 percent of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916 (c) of the Act are met. ATTACHMENT 4.18-D specifies the method the State uses for determining the premium and the criteria for determining what constitutes undue hardship for waiving payment of premiums by recipients.
1902 (a) (52) and 1925(b) of the Act	4.18 (b) (5)	☐	For families receiving extended benefits during a second 6-month period under section 1925 of the Act, a monthly premium is imposed in accordance with sections 1925(b) (4) and (5) of the Act.
1916 (d) of the Act	4.18 (b) (6)	☐	A monthly premium, set on a sliding scale, imposed on qualified disabled and working individuals who are covered under section 1902 (a) (10) (E) (ii) of the Act and whose income exceeds 150 percent (but does not exceed 200 percent) of the Federal poverty level applicable to a family of the size involved. The requirements of section 1916 (d) of the Act are met. ATTACHMENT 4.18-E specifies the method and standards the State uses for determining the premium.

State/Territory: Nevada

Citation

42 CFR447.513 through 447.58

4.18 (c)

☐ Individuals are covered as medically needy under the plan.

(1) ☐ An enrollment fee, premium or similar charge is imposed. ATTACHMENT 4.18-B specifies the amount of and liability period for such charges subject to the maximum allowable charges in 42 CFR 447.52 (b) and defines the State's policy regarding the effect on recipients of non-payment of the enrollment fee, premium, or similar charge.

447.51 through 447.58

(2) ☐ No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:

(i) Services to individuals under age 18, or under—

☐ Age 19

☐ Age 20

☐ Age 21

Reasonable categories of individuals who are age 18, but under age 21, to whom charges apply are listed below, if applicable.

State/Territory: Nevada

Citation

4.18 (c) (2) (Continued)

42 CFR 447.51 through

(ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

(iii) All services furnished to pregnant women.

☐ Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.

(iv) Services furnished to any individual who is in an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution, to spend for medical care costs all but a minimal amount of his income required for personal needs.

(v) Emergency services if the services meet the requirements in 42 CFR 447.53 (b) (4).

(vi) Family planning services and supplies furnished to individuals of childbearing age.

1916 of the Act, P.L. 99-272 (Section 9505)

(vii) Services furnished to an individual receiving hospice care, as defined in section 1905 (o) of the Act.

447.51 through 447.58

(viii) Services provided by a health maintenance organization (HMO) to enroll individuals.

☐ Not applicable. No such charges are imposed.

State/Territory: Nevada

Citation 4.18 (c) (3) Unless a waiver under 42 CFR 431.55 (g) applies, nominal deductible, coinsurance, copayment or similar in charges are imposed on services that are not excluded from such charges under item (b) (2) above.

☐ Not applicable. No such charges are imposed.

(i) For any service, no more than one type of charge is imposed.

(ii) Charges apply to services furnished to the following age group:

☐ 18 or older

☐ 19 or older

☐ 20 or older

☐ 21 or older

Reasonable categories of individuals who are 18 years of age, but under 21, to whom charges apply are listed below, if applicable.

Revision: HCFA-PM-91-4 (BPD)
August 1991

OMB No. 1 0938-

State/Territory: Nevada

Citation

4.18(c)(3) (continued)

447.51 through
447.58

(iii) For the medically needy, and other optional groups, ATTACHMENT 4.18-C specifies the:

(A) Service(s) for which charge(s) is applied;

(B) Nature of the charge imposed on each service

(C) Amount(s) of and basis for determining the charge(s);

(D) Method used to collect the charge(s);

(E) Basis for determining whether an individual is unable to pay the charge(s) and the means by which such an individual is identified to providers;

(F) Procedures for implementing and enforcing the exclusions from cost sharing contained n 42 CFR 447.53(b); and

(G) Cumulative maximum that applies to all deductible, coinsurance, or copayment charges imposed on a family during a specified time period.

____ Not applicable. There is no maximum.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nevada

A. The following charges are imposed on the categorically needy for services other than those provided under section 1905(a)(1) through (5) and (7) of the Act:

Effective 1 October 1981 (no change as of 10/1/85)

Type Charge

Service	Deduct	Coins	Copay	Amount and Basis for Determination
6a. Podiatrists			X	$1 per office visit (POV)
6c. Chiropractors			X	$1 POV
9. Mental Health Clinics			X	$1 per clinic visit
10. Dental			X	$2 POV
11a. Physical Therapy			X	$1 POV
11b. Occupational Therapy			X	$1 POV
11c. Services for Individuals with Speech, Hearing and Language Disorders			X	$1 POV
12a. Prescribed Drugs			X	$1 per prescription
12b. Dentures			X	$3 denture
12c. Prosthetic Devices			X	$3 per item
12d. Eyeglasses			X	$3 per pair
14b. Services for Individuals Age 65 or Older in Institutions for Mental Diseases			X	One-half first days per diem rate (PDR)
15. Intermediate Care Facility (ICF)			X	One-half first day's PDR
15a. ICF Services in Institutions for the Mentally Retarded			X	One-half first day's PDR
17a. Transportation – Ambulance (ground)			X	$3 one way
Ambulance (air)			X	$3 one way
Medi-van			X	$2 each way
Taxi			X	$1 each way

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEVADA

A. The following charges are imposed on the categorically needy for services other than those provided under section 905(a)(1) through (5) and (7) of the Act:

	Type Charge			
Service	Deduct	Coins	Co-pay	Amount and Basis for Determination

Exceptions:

1. Services furnished to children under the age of 19.

2. Services furnished to pregnant women if such services relate to the pregnancy.

3. Services furnished to any individual who is an inpatient in a hospital, long-term care facility or other medical institution and who is required, as a condition of receiving services in the institution, to spend down for medical costs all but a minimal amount required for personal needs.

4. Services provided in a facility equipped to furnish the required care to meet a medical emergency.

5. Services and supplies furnished to individuals of child-bearing age as part of the family planning program.

6. Services furnished by a health maintenance organization (HMO); (at such time as HMO services become a part of the Nevada Medicaid program).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEVADA

B. The method used to collect cost sharing charges for the categorically needy individuals:

☒ Providers are responsible for collecting the cost sharing charges from individuals.

☐ The agency reimburses providers the full Medicaid rate for a service and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

The provider determines whether the recipient can pay by asking. However, certain groups of recipients are exempt from copayment by Medicaid policy. These individuals are identified by notation on their Medicaid certificate. The recipients include: those under the age of 19; pregnant women for those services related to pregnancy; institutionalized individuals; those receiving emergency services; those receiving family planning services; and those receiving services as part of an HMO program. Co-payment amounts are deducted automatically from the computer-calculated Medicaid payments to the provider.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: NEVADA

D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below:

Providers were informed by bulletin December 8, 1983; the recipient's Medicaid Certificate would show under the notes column the recipient was exempt from copayment. Through Medicaid's post-payment review system, three percent of the recipients whose services are paid each month are sent VOS forms which include a question about recipient payment for service. In addition, recipients are informed of their exempt status.

E. Cumulative maximums on charges:

☒ State policy does not provide for cumulative maximums.

☐ Cumulative maximums have been established as described below:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nevada

A. The following charges are imposed on the medically needy for services: N/A

Service	Type of Charge			Amount and Basis for Determination
	Deduct	Coins	Co-pay	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nevada

B. The method used to collect cost sharing charges for medically needy individuals: N/A

☐ Providers are responsible for collecting the cost sharing charges from individuals.

☐ The agency reimburses providers the full Medicaid rate for services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.52(b) are described below:

N/A

E. Cumulative maximums on charges:

☐ State policy does not provide for cumulative maximums.

☐ Cumulative maximums have been established as described below:

Citation
42 CFR
447.252
1902 (a) (13)
and 1923 of
the Act
1902 (e) (7) of
the Act

4.19 Payment for Services

(a) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, and sections 1902(a)(13) and 1923 of the Act with respect to payment for inpatient hospital services.

ATTACHMENT 4.19-A describes the methods and standards used to determine rates for payment for inpatient hospital services.

___ Inappropriate level of care days is covered and are paid under the State plan at lower rates than other inpatient hospital services, reflecting the level of care actually received, in a manner consistent with section 1861(v)(1)(G) of the Act.

X Inappropriate level of care days are not covered.

Citation
42 CFR 447.201
42 CFR 447.302
52 FR 28648
1902 (a) (13) (E)
1903 (a) (1) and (n), 1920, and 1926 of the Act

4.19(b) In addition to the services specified in paragraphs 4.19(a), (d), (k), (l), and (m), the Medicaid agency meets the follow requirements.

1. Section 1902 (a) (13) (E) of the Act regarding payment for services furnished by Federally qualified health centers (FQHCs) under Section 1905 (a) (2) (C) of the Act. The agency meets the requirements of Section 6303 of the State Medicaid Manual (HCFA-Pub. 45-6) regarding payment for FQHC services.

   ATTACHMENT 4.19-B describes the method of payment and how the agency determines the reasonable costs of the services (for example, cost or budget reviews, or sample surveys).

2. Sections 1902 (a) (13) (E) and 1926 of the Act, and 42 CFR Part 447, Subpart D, with respect to payment for all other types of ambulatory services provided by rural health clinics under the plan.

   ATTACHMENT 4.19-b describes the methods and standards used for the payment of each of these services except for inpatient hospital, nursing facility services and services in intermediate care facilities for the mentally retarded that are described in other attachments.

1902 (a) (10) and

SUPPLEMENT 1 to ATTACHMENT 4.19-B describes general methods and standards used for establishing payment for Medicare Part A and B deductible/ coinsurance.

1902 (a) (30) of the Act

SUPPLEMENT 2 to ATTACHMENT 4.19-B describes general methods and standards used for establishing payment for organ transplant services and out-of-state emergency services and the limitations placed on reimbursement of these services.

State/Territory: Nevada

Citation
42 CFR 447.40
AT-78-90

4.19(c) Payment is made to reserve a bed during a recipient's temporary absence from an inpatient facility.

X Yes. The State's policy is described in ATTACHMENT 4.19-C.

___ No.

Citation

42 CFR 447.252
47 FR 47964
48 FR 56046
42 CFR 447.280
47 FR 31518
52 FR 28141

4.19(d)

X (1) The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart C, with respect to payments for skilled nursing and intermediate care facility services

ATTACHMENT 4.19-D describes the methods and standards used to determine rates for payment for skilled nursing and intermediate care facility services as well as the services covered by those rates.

(2) The Medicaid agency provides payment for routine skilled nursing facility services furnished by a swing-bed hospital.

X At the average rate per patient day paid to SNFs for routine services furnished during the previous calendar year.

___ At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.

___ Not applicable. The agency does not provide payment for SNF services to a swing-bed hospital.

(3) The Medicaid agency provides payment for routine intermediate care facility services furnished by a swing-bed hospital.

X At the average rate per patient day paid to ICFs, other than ICFs for the mentally retarded, for routine services furnished during the previous calendar year.

___ At a rate established by the State, which meets the requirements of 42 CFR Part 447, Subpart C, as applicable.

___ Not applicable. The agency does not provide payment for ICF services to a swing-bed hospital.

(4) Section 4.19(d)(1) of this plan is not applicable with respect to intermediate care facility services; such services are not provided under this State plan.

State/Territory: Nevada

Citation	
42 CFR 447.45(c) AT-79-50	4.19(e) The Medicaid agency meets all requirements of 42 CFR 447.45 for timely payment of claims. ATTACHMENT 4.19-E specifies, for each type of service, the definition of a claim for purposes of meeting these requirements.

Citation	
42 CFR 447.15 AT-78-90 AT-80-34 48 FR 5730	4.19(f) The Medicaid agency limits participation to providers who meet the requirements of 42 CFR 447.15. No provider participating under this plan may deny services to any individual eligible under the plan on account of the individual's inability to pay a cost sharing amount imposed by the plan in accordance with 42 CFR 431.55(g) and 447.53. This service guarantee does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the cost sharing change.

Citation	
42 CFR 447.201 42 CFR 447.202 AT-78-90	4.19(g) The Medicaid agency assures appropriate audit of records when payment is based on costs of services or on a fee plus cost of materials.

Citation	
42 CFR 447.201 42 CFR 447.203 AT-78-90	4.19(h) The Medicaid agency meets the requirements of 42 CFR 447.203 for documentation and availability of payment rates.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

OMB No.: 0938-0193

State/Territory: Nevada

Citation	
42 CFR 447.201 42 CFR 447.204 AT-78-90	4.19(i) The Medicaid agency's payments are sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population.

Citation		
42 CFR 447.201 and 447.205	4.19(j)	The Medicaid agency meets the requirements of 42 CFR 447.205 for public notice of any changes in Statewide method or standards for setting payment rates.
1903 (v) of the Act	(k)	The Medicaid agency meets the requirements of Section 1903(v) of the Act with respect to payment for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law. Payment is made only for care and services that are necessary for the treatment of an emergency medical condition, as defined in Section 1903(v) of the Act.

Revision: HCFA-PM□92□7 (MB)
October 1992

OMB No.: 0938-0193

State/Territory: Nevada

Citation

1903(i)(14)
of the Act

4.19(1) The Medicaid agency meets the requirements of Section 1903(i)(14) of the Act with respect to payment for physician services furnished to children under 21 and pregnant women. Payment for physician services furnished by a physician to a child or a pregnant woman is made only to physicians who meet one of the requirements listed under this section of the Act.

Citation

4.19(m) Medicaid Reimbursement for Administration of Vaccines under the Pediatric Immunization Program

1928(c)(2)(C)(ii) of Act (i) A provider may impose a charge for the administration of a qualified pediatric vaccine as stated in 1928(c)(2)(C)(ii) of the Act. Within this overall provision, Medicaid reimbursement to providers will be administrated as follows:

(ii) The State:

___ sets a payment rate at the level of the regional maximum established by the DHHS Secretary.

___ is a Universal Purchase State and sets a payment rate at the level of the regional maximum established in accordance with State law.

X sets a payment rate below the level of the regional maximum established by the DHHS Secretary.

___ is a Universal Purchase State and sets a payment rate below the level of the regional maximum established by the Universal Purchase State.

1926 of the Act (iii) Medicaid beneficiary access to immunization is assured through the following methodology:

The Nevada State Health Division is designated as the lead Agency for the Pediatric Immunization Program. As such, the Health Division is responsible for the ordering, storage and shipping of vaccine from the Centers for Disease Control and Prevention as well as for the recruitment, education, and review of immunization practices of providers. The Nevada Medicaid Program (through the Division of Health Care Financing and Policy) reimburses health care professionals who are contracted with the Nevada Medicaid Program for the administration of immunizations provided to Medicaid eligible individuals.

The Division of Health Care Financing and Policy (Nevada Medicaid Program) and the Nevada State Health Division are sister agencies. Nevada Medicaid staff collaborate with the Health Division and staff of the District Offices to provide outreach regarding immunizations.

Nevada Medicaid Program Managed Care Organizations (MCO) require network providers to enroll in the Vaccines for Children (VFC) Program and to work with the Health Division regarding immunizations.

ASSURANCES

All general rates described in Attachment 4.19 may be accessed at:

http://dhcfp.nv.gov/RatesUnit.htm

PAYMENT FOR INPATIENT HOSPITAL SERVICES
ASSURANCES AND RELATED INFORMATION

A. State Assurances and Findings. The State assures that it has made the following findings:

1. 447.253(b)(1)(i) - The State pays for inpatient hospital services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

2. With respect to inpatient hospital services

   a. 447.253(b)(1)(ii)(B) - The methods and standards used to determine payment rates take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs.

   b. 447.253(b)(1)(ii)(B) - The State elects in its State Plan to cover inappropriate level of care services (that is, services furnished to hospital inpatients who require a lower covered level of care such as skilled nursing services or intermediate care services) under conditions similar to those described in Section 1861 (v)(1)(G) of the Act. The methods and standards used to determine payment rates specify that the payments for this type of care must be made at rates lower than those for inpatient hospital level of care services, reflecting the level of care actually received, in a manner consistent with Section 1861(v)(1)(G) of the Act.

   c. 447.253(b)(1)(ii)(C) - The payment rates are adequate to assure that recipients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality.

3. 447.253(b)(2) - The proposed rate will not exceed the upper payment limits as specified in 42 CFR 447.272:

   a. 447.272(a) - Aggregate payments made to hospitals for inpatient services when considered separately, will not exceed the amount that can reasonably be estimated would have been paid for under Medicare Payment principles.

   b. 447.272(b) - Aggregate payments to State-operated hospitals for inpatient services when considered separately will not exceed the amount that can reasonably be estimated would have been paid for under Medicare payment principles.

c. 447.272(c) B Aggregate disproportionate share hospital (DSH) payments do not exceed the DSH payment limits at 42 CFR 447.296 through 447.299.

d. OBRA 93 B DSH payments to each hospital, including those owned or operated by the state or an instrumentality or unit of government within the state, beginning in SFY 1996, are limited to 100% of uncompensated costs.

B. State Assurances. The State makes the following additional assurances:

1. For hospitals --

a. 447.253(c) - In determining payment when there has been a sale or transfer of the assets of a hospital, the State's methods and standards provide that payment rates can reasonably be expected not to increase in the aggregate solely as a result of changes of ownership, more than payments would increase under Medicare under 42 CFR 413,130, 414.134, 413.153 and 413.157 insofar as these sections affect payment for depreciation, interest on capital indebtedness, return on equity (if applicable), acquisition costs for which payments were previously made to prior owners, and the recapture of depreciation.

2. 447.253(e) - The State provides for an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the State determines appropriate, of payment rates.

3. 447.253(f) - The State requires the filing of uniform cost reports by each participating provider.

4. 447.253(g) - The State provides for periodic audits of the financial and statistical records of participating providers.

5. 447.253(h) The State has complied with the public notice requirements of 42 CFR 447.205. Notice published on N/A (Amendment not significant).

6. 447.253(i) - The State pays for inpatient hospital services using rates determined in accordance with the methods and standards specified in the approved state plan.

C. Related Information

1. a. 447.255(a) - Inpatient hospital:

Estimated average proposed payment rate as a result of this amendment: $1,067

Estimated payment rate in effect for the immediately preceding rate period: $1,067

Amount of change: 0 Percent of change: 0%

b. 447.255(a) - DSH:

Estimated proposed payment per Medicaid day as a result of this amendment: $576.02

Estimated payment per Medicaid day for the immediately preceding rate period: $576.02

Amount of change: 0 Percent of change: 0%

Nevada=s aggregate DSH payment for this year and the immediately preceding year is $73,560,000. The DSH program this year is based on uncompensated costs for the majority of the hospitals, and not on Medicaid utilization. The amendment to the DSH methodology will have no effect on the payment per day.

2. 447.255(b) - The estimated short term and long-term effect of the change in the estimated average rate on:

a. The availability of services on a statewide and geographic area basis: NONE

b. The type of care furnished: NONE

c. The extent of provider participation: NONE

d. The degree to which costs are covered in hospitals that serve a disproportionate number of low income patients with special needs.

The change in the disproportionate share program will restrict payment to those hospitals that specialize in providing mental health services to low income patients. Since payments to such specialized hospitals was minimal there is no indication that this change will limit provider participation, type of care provided or availability of services. In aggregate, none of the remaining hospitals will receive less and some will receive more as a result of the proposed change.

PAYMENT FOR INPATIENT HOSPITAL SERVICES
METHODS AND STANDARDS

I. HOSPITALS UNDER PROSPECTIVE RATES

Types of rates: Inpatient hospital services, which have been authorized for payment at the acute level by a quality improvement organization (QIO-like vendor), as specified in the contract between the QIO-like vendor and Nevada Medicaid, are reimbursed by all-inclusive, prospective per diem rates by type of admission. The all-inclusive prospective rates cover routine and ancillary services furnished by the hospital, including direct patient care for professional services furnished to inpatients by hospital-staffed physicians and practitioners. All-inclusive per diem rates are developed for Maternity, Newborn, Neonatal, Rehabilitative/Specialty Hospital, Level I Trauma, Medical/Surgical, and Psychiatric/Substance Abuse Treatment admissions, as described in Sections II, III, and IV. All-inclusive rates for selected Organ Transplants are described in Section III. Administrative day rate development is covered in Section V. Critical Access Hospitals under Medicare retrospective cost reimbursements are described in Section VII.

II. PROSPECTIVE RATE DEVELOPMENT (Prior to September 1, 2003)

The primary goals of the inpatient hospital rate methodology are: Rates should be based on actual, reasonable and allowable hospital costs and the rate development method should comply with federal requirements. The prospective rates are inclusive of all ancillary services required by patients.

A. Basic data sources for tier rate development.

1. The most recently filed Hospital Health Care Complex Cost Report (HCFA 2552) was the basis for identifying allowable cost. Routine cost limits were not applied.

2. Paid claims and billing information were taken from the Nevada database for Medicaid claim payment history report for services provided during the period covered by the HCFA 2552.

B. Adjustments made to determine allowable cost.

The following adjustments were made to each individual hospital's cost report:

1. An audit adjustment was applied to the total Medicaid cost for each hospital. The adjustment was determined by using an average for each hospital of the audit adjustment percentages for the three most recent years available. Adjustments for two years were used if three were not available.

2. Since the hospitals' cost report periods vary, all cost data was indexed to the same period, using the Medicare inflation factor for non-prospective payment system (non-PPS) hospitals.

III. Conversion of Existing Tier Rates to Per Diem Rates as of September 1, 2003

The current hospital inpatient tier rates for Medical/Surgical, Maternity, and Newborn inpatient categories are in effect for Medicaid payments made through August 31, 2003.

In order to convert to a MMIS system on September 1, 2003, hospital reimbursement tier rates will be converted to per diem rates. The Maternity and Newborn service categories will be retained. The service category Medical/Surgical will be converted to Level I Trauma and Medical/Surgical categories.

These per diem rates will be effective for claims paid on or after September 1, 2003, with admission dates before September 8, 2008. The Level I Trauma will be retained at the September 1, 2003 amount.

A. Maternity Rate Conversion

An all-inclusive per diem rate is paid for obstetrical hospital admissions. The rate also covers related admissions such as false labor, undelivered OB, and miscarriages.

Historical Medicaid data for the Calendar Year (CY) ended December 31, 2002, has been extracted showing Medicaid Maternity admissions and Maternity patient days by tier. Projected Maternity payments for each tier are calculated as CY2002 Maternity admissions per tier times the current tier rate. Total projected Maternity payments are the sum of all projected tier payments.

The conversion per diem rate for Maternity has been determined by the following formula:

$$\frac{\text{Total Projected Maternity Payments}}{\text{CY2002 Historical Maternity Patient Days}} = \text{Maternity Per Diem Rate}$$

For services performed on or after January 1, 2006, the maternity per diem rate will be determined by multiplying a factor of 1.1001 times the conversion per diem rate.

For services performed on or after July 1, 2007, the maternity per diem rate will be determined by multiplying a factor of 1.0757 times the conversion per diem rate.

For services performed for claims with an admission date on or after September 8, 2008, the maternity per diem rate will be calculated as follows:

1. Charges submitted for claims paid in SFY 2007 were used from the Nevada Medicaid claims data.

2. The number of days admitted (the length of stay) for claims paid in SFY 2007 was used to calculate each claim's billed charges per day.

3. The per diem rate will be 34% of the median of billed charges per day for Nevada in-patient hospitals for obstetric services.

This rate will be used as a prospective rate until rebased as directed by the Department of Health and Human Services. There will be no cost settlement.

For services performed for claims with an admission date on or after July 9, 2015, the maternity per diem rate will be determined by multiplying a factor of 1.05 times the September 8, 2008 per diem rate.

B. Newborn Rate Calculation

An all-inclusive per diem rate will be developed for newborns admitted through routine delivery at a hospital.

Historical Medicaid data for the Calendar Year (CY) ended December 31, 2002, has been extracted showing Medicaid Newborn admissions and Newborn patient days by tier. Projected Newborn payments for each tier are calculated as CY2002 Newborn admissions per tier times the current tier rate. Total projected Newborn payments are the sum of all projected tier payments.

The conversion per diem rate for Newborn has been determined by the following formula:

$$\frac{\text{Total Projected Newborn Payments}}{\text{CY2002 Historical Newborn Patient Days}} = \text{Newborn Per Diem Rate}$$

For services performed on or after January 1, 2006, the newborn per diem rate will be determined by multiplying a factor of 1.1001 times the conversion per diem rate.

For services performed on or after July 1, 2007, the newborn per diem rate will be determined by multiplying a factor of 1.0757 times the conversion per diem rate.

For services performed for claims with an admission date on or after September 8, 2008, the newborn per diem rate will be calculated as follows:

1. Charges submitted for claims paid in SFY 2007 were used from the Nevada Medicaid claims data.

2. The number of days admitted (the length of stay) for claims paid in SFY 2007 was used to calculate each claim's billed charges per day.

3. The per diem rate will be 34% of the median of billed charges per day for Nevada in-patient hospital routine services related to the care of a newborn.

This rate will be used as a prospective rate until rebased as directed by the Department of Health and Human Services. There will be no cost settlement.

For services performed for claims with an admission date on or after July 9, 2015, the newborn per diem rate will be determined by multiplying a factor of 1.05 times the September 8, 2008 per diem rate.

For services performed for claims with an admission date on or after January 1, 2020, the reimbursement methodology described above will apply only to Revenue Codes 0170 and 0171.

For services performed for claims with an admission date on or after January 1, 2020, the newborn per diem rate will be determined by multiplying a factor of 1.25 times the July 9, 2015 per diem rate.

1. This increase applies only to Revenue Code 0172.

C. Neonatal Intensive Care Rate Calculation

For admissions prior to September 8, 2008:

A separate rate is used for patients admitted to Level III Neonatal Intensive Care Units. The current rate was developed from historical costs pursuant to Section II, Prospective Rate Development. The calculated cost per day of each neonatal unit was arrayed from highest to lowest. The prospective per diem rate was then calculated at the 55th percentile and indexed.

For admissions on or after September 8, 2008:

1. Charges submitted for claims paid in SFY 2007 were used from the Nevada Medicaid claims data.

2. The number of days admitted (the length of stay) for claims paid in SFY 2007 was used to calculate each claim's billed charges per day.

3. The per diem rate will be 34% of the median of billed charges per day for Nevada in-patient hospital services for Neonatal Intensive Care.

This rate will be used as a prospective rate until rebased as directed by the Department of Health and Human Services. There will be no cost settlement.

For services performed for claims with an admission date on or after January 1, 2020, the per diem rate for Neonatal Intensive Care services will be determined by multiplying a factor of 1.25 times the September 8, 2008 per diem rates.

1. This increase applies only to Revenue Codes 0173 and 0174.

D. Rehabilitative and Specialty Hospital Rate Calculation

A few Nevada hospitals are licensed to provide acute care in single diagnostic category. Rehabilitative and specialty hospital patients generally have hospital stays of ninety or more days. The length of stay does not significantly influence the cost per day.

To the extent these hospitals participate in Medicaid, they are reimbursed as follows:

1. Inpatient hospital services which have been certified for payment at the acute level by a QIO-like vendor are reimbursed an all-inclusive per diem rate at the lowest rate acceptable to both parties. In establishing the lowest rate acceptable to both parties, Nevada Medicaid reviews cost information filed by the provider, amounts paid by other insurers and national literature on comparable costs for similar services. The rate cannot exceed the reasonable and customary charges of the facility for similar services.

E. Medical/Surgical Rate Development

The current tier rate will be paid for Medical/Surgical payments made on or prior to August 31, 2003. Beginning September 1, 2003, an all-inclusive per diem rate will be paid for general hospital admission, not meeting the criteria of patients described in Parts B. - D. and F. of this Section or Section IV.

Historical Medicaid data for the Calendar Year (CY) ended December 31, 2002, has been extracted showing Medicaid Medical/Surgical admissions and Medical/Surgical patient days by tier. Projected Medical/Surgical payments for each tier are calculated as CY2002 Medical/Surgical admissions per tier times the current tier rate. Total projected Medical/Surgical payments are the sum of all projected tier payments.

The conversion per diem rate for the Medical/Surgical category has been determined by the following formula:

Total Projected Medical/Surgical Payments
---------- = Medical/Surgical Per
CY2002 Historical Medical/Surgical Patient Days Diem Rate

For services performed on or after January 1, 2006, the medical/surgical per diem rate will be determined by multiplying a factor of 1.1001 times the conversion per diem rate.

For services performed on or after July 1, 2007, the medical/surgical per diem rate will be determined by multiplying a factor of 1.0757 times the conversion per diem rate.

For services performed for claims with an admission date on or after September 8, 2008, the medical/surgery per diem rate will be calculated as follows:

1. Charges submitted for claims paid in SFY 2007 were used from the Nevada Medicaid claims data.

2. The number of days admitted (the length of stay) for claims paid in SFY 2007 was used to calculate each claim's billed charges per day.

3. The per diem rate will be 22% of the median of billed charges per day for Nevada in-patient hospital services for medical/surgery procedures.

This rate will be used as a prospective rate until rebased as directed by the Department of Health and Human Services. There will be no cost settlement.

For services performed for claims with an admission date on or after July 9, 2015, the medical/surgical per diem rate will be determined by multiplying a factor of 1.05 times the September 8, 2008 per diem rate.

For services performed for claims with an admission date on or after January 1, 2020, the medical/surgical/ICU per diem rate will be determined by multiplying a factor of 1.025 times the July 9, 2015 per diem rate.

F. Pediatric Intensive Care Rate Calculation

For services performed on or after January 1, 2020:

A separate rate is used for patients admitted to a Pediatric Intensive Care Unit (PICU). The rate was developed by applying a multiplying factor of 1.15 percent to the July 9, 2015 Medical Surgical per diem rate.

1. This increase only applies to Revenue Code 0203.

F. Level I Trauma Centers

Nevada Medicaid will pay an enhanced rate for full trauma team cases at Level I Trauma Centers. For payments made on or before August 31, 2003, the enhanced trauma rate is 1.63 times the Medical/Surgical tier rate. For services paid September 1, 2003, and after the enhanced trauma rate is 1.63 times the Medical/Surgical rate in effect on September 1, 2003.

G. Transplants

A. Basic Date Sources for Rate Development
   1. 2014 Milliman Research Report – U.S. Organ and Tissue Transplant and Cost Estimate.
   2. 2013 The Lewin Group Study – Cost Benefit Analysis of Corneal Transplant

B. Rate Conversion
   1. Hospital Services will be reimbursed at 35% of the Hospital Billed Charges for each transplant procedure as listed in the 2014 Milliman Study.
   2. Procurement will be reimbursed at 100% of the Procurement charges for each transplant procedure as listed in the 2014 Milliman Study with the exception of Cornea Procurement. Cornea procurement will be reimbursed at 100% of the Procurement charges as listed in the 2013 The Lewin Group Study.

For hospitals with accredited transplant programs, Nevada Medicaid will pay the lower of 1) billed charges; or 2) an all-inclusive fixed fee set forth below for the entire admission period (from admission date to discharge date). Organ procurement is a separate reimbursable charge, over and above the facility inpatient component of the transplant service. Organ procurement is reimbursed the lower 1) billed charges; or 2) the maximum reimbursement set forth below.

The maximum reimbursement rate for organ transplant procedures and procurement are:

Organ	Hospital Services	Procurement
Liver	$139,685	$95,000
Kidney	$41,860	$84,400
Tissue		
Bone Marrow - Autologous	$74,305	$10,700
Bone Marrow - Allogeneic Related	$167,860	$55,700
Bone Marrow - Allogeneic Unrelated	$167,860	$55,700
Cornea	$7,000	$2,500

Commencing July 1, 2016 and annually thereafter, the amounts listed above shall be adjusted for inflation using the Consumer Price Index for Inpatient Services; BLS Series CUUR0000SS5702.

IV. PSYCHIATRIC/SUBSTANCE ABUSE TREATMENT RATE DEVELOPMENT

Psychiatric/substance abuse treatment admissions can vary from short stays to several weeks. The length of stay does not significantly impact the cost per day. Therefore, a per diem rate is a more appropriate method to pay acute care hospitals providing this type of service.

1. Psychiatric/substance abuse treatment costs for each hospital are divided by the number of psychiatric/substance abuse treatment days to determine a cost per day. The Medicaid related costs of freestanding psychiatric hospitals are determined using the steps in Section II, Parts A and B, then dividing their Medicaid costs by their total Medicaid days to determine the cost per day. The calculated cost per day of each general acute care hospital and freestanding psychiatric hospital is arrayed from highest to lowest. The prospective per diem rate is then calculated at the 55th percentile and indexed in accordance with Section II, Part E of this plan.

   a. These rates do not apply to facilities accredited as Residential Treatment Centers by the Joint Commission on Accreditation of Health Organizations (JCAHO).

   For services performed on or after July 1, 2014, the psychiatric/substance abuse per diem rate will be determined as follows:

2. General acute hospitals providing inpatient psychiatric services will be reimbursed with a per diem.

   a. Billed charges for inpatient psychiatric claims paid in SFY ending June 30, 2013 were used from the Nevada Medicaid claims data.

   b. The aggregate average billed charges per day was calculated for all Nevada Medicaid enrolled general acute hospitals using this data.

   c. The per diem rate will be 37% of the aggregate average billed charges per day for Nevada Medicaid enrolled inpatient general acute hospital psychiatric services.

3. Freestanding psychiatric hospitals are reimbursed at the lowest rate acceptable to Nevada Medicaid and the provider. In establishing the lowest rate acceptable to both parties, Nevada Medicaid will review cost information filed by the provider, rates received from other state Medicaid programs and other information it deems pertinent to calculate an average cost per day. Considering this information, Nevada Medicaid will then assign an individual rate to each provider. This rate will remain in effect until the DHCFP authorizes a change. The rate cannot exceed the reasonable and customary charges of the facility.

4. State-operated Inpatient Psychiatric Hospitals are reimbursed under Medicare principles of retrospective reimbursement described in 42 CFR 413 and further specified in CMS Publication 15.

   a. In no case may payment exceed audited allowable costs.

   b. Interim rates will be based upon the most recent audited cost reports for the current state fiscal year. The interim rate for the initial year of operation will be based upon cost and utilization projections.

   c. Each facility is paid an interim rate subject to a cost settlement.

V. ADMINISTRATIVE DAY RATE DEVELOPMENT

For those patients who remain in an acute care hospital awaiting admittance to a long-term care facility, an administrative day rate is used. Services so reimbursed are call "administrative days."

The administrative rate is based on statewide weighted average payment rate established in 2003 for skilled and intermediate levels of care. The administrative rate is lower than the hospital rate as described in Part II of the State Plan.

For services performed for claims with an admission date on or after July 9, 2015, the intermediate level administrative day per diem rate will be determined by multiplying a factor of 1.05 times the rate.

VI. RESIDENTIAL TREATMENT CENTERS

Nevada Medicaid will only pay for stays in facilities accredited by the Joint Commission on Accreditation Health Organizations (JCAHO) as Residential Treatment Centers (RTCs). All stays must be pre-approved by the QIO-like vendor. These services will be reimbursed at the lowest rate acceptable to both parties. In establishing the lowest rate acceptable to both parties, Nevada Medicaid reviews cost information filed by the RTC, amounts paid by other insurers, and national literature on costs for RTCs. Each facility will have a negotiated rate established for each general level of service. If a placement is being proposed which is different from the general level of care offered by the facility, a rate will be negotiated after considering the average cost per day of the facility and the additional will be reviewed based upon cost information received on or prior July 1 of the year of review. The rate cannot exceed the reasonable and customary charges of the facility for similar services.

VII. HOSPITALS UNDER MEDICAID RETROSPECTIVE COST REIMBURSEMENT (CRITICAL ACCESS HOSPITALS)

A few Nevada hospitals have been designated by Medicare as Critical Access Hospitals.

To the extent these hospitals participate in Medicaid, they are reimbursed under Medicare's retrospective cost reimbursement, as follows:

A. Inpatient hospital services which have been certified for payment at the acute level by the QIO-like vendor, as specified in the contract between the QIO-like vendor and Nevada Medicaid, upon final settlement are reimbursed allowable costs under hospital-specific retrospective Medicare principles of reimbursement in accordance with 42 CFR 413 and further described in CMS Publications 15-I and 15-II.

1. Critical Access Hospitals (CAH) will use the CMS-2552-10 cost report form and apply Medicare cost principles and cost apportionment methodology.

2. Critical Access Hospitals will file this cost report with the state annually within five months of their respective fiscal year end.

3. In general, underpayments will be paid to the provider in a lump sum upon discovery and overpayments will either be recouped promptly or a negative balance set up for the provider. However, other solutions acceptable to both parties may be substituted.

4. The federal share of any overpayment is refunded to the federal government in accordance with 42 CFR 433 Subpart F.

B. On an interim basis, each hospital is paid for certified acute care at the Provider specific interim Medicaid inpatient per diem rate as follows:

1. Effective July 1, 2009, the base interim rate for Critical Access Hospitals (CAH) will be the FY2007 Total Medicare inpatient per diem rate. This interim rate is defined as total Medicare in-patient cost divided by total Medicare in-patient days, and applies to the revenue codes billed by general acute hospitals that fall under the Medical/Surgery level of service category for inpatient services.

2. The CAH Medical/Surgery interim rate will be updated annually for each provider on either January 1st or July 1st, depending upon the facilities' fiscal year as reported on the Medicare/Medicaid cost report. The annual rate is not to exceed 150% or decrease more than 25% from the facilities' prior year interim rate.

3. The updated CAH Medical/Surgery interim rate will be calculated by dividing the total Title XIX program inpatient costs by the total program inpatient days as reported in the latest available as-filed or latest available audited Medicare/Medicaid cost report.

4. If Title XIX data reported in the latest available as-filed or latest available audited Medicare/Medicaid cost report is not sufficient to calculate the adjusted CAH Medical/Surgery interim rate, the CAH Medical/Surgery interim rate will default to the Medical/Surgery rate paid to general acute care hospitals for the same service. This applies only to Critical Access Hospitals that have an existing CAH Medical/Surgery interim rate for the prior year.

5. Maternity, newborn, Psychiatric/Substance Abuse and administrative days will be reimbursed at the rate paid to general acute care hospitals for the same in-patient services.

6. Critical Access Hospitals that do not have a CAH Medical/Surgery interim rate for the prior year based on the methodology in Paragraph VII.B.3, will be assigned either the prior years' Total Medicare inpatient per diem rate if available or the rate paid to general acute care hospitals for the same Medical/Surgery level of services until such time as the CAH Medical/Surgery interim rate can be updated according to the methodology detailed in Paragraphs VII.B.2 and VII.B.3.

Facilities accredited as Residential Treatment Centers by the Joint Commission on Accreditation of Health Organization (JCAHO) are not considered specialty or general acute hospitals. Residential Treatment Centers are paid in accordance with Paragraph VI above.

III. HOSPITALS SERVING LOW-INCOME PATIENTS
DISPROPORTIONATE SHARE HOSPITALS (DSH)

A. Eligibility – A Nevada hospital will qualify for DSH payment if it meets the conditions of either Paragraph 1 or 2.

1. Subject to the provisions of Subparagraph c, a Nevada hospital will be deemed to qualify for DSH payment if it meets either of the conditions under subparagraphs a or b. The data used to determine eligibility is from the prior State Fiscal Year ending June 30th. For example, eligibility for SFY 14 DSH is done in the third quarter of SFY 13, using data from SFY 12.

a. A hospital's Medicaid inpatient utilization rate (MIUR) is at least one standard deviation above the mean MIUR for hospitals receiving Medicaid payment in the State.

i. MIUR is the total number of inpatient days of Medicaid eligible patients, including patients who receive their Medicaid benefits through a health maintenance organization, divided by the total number of inpatient days of all patients during a fiscal year.

b. The hospital’s low-income utilization rate (LIUR) is at least 25%. LIUR is the sum (expressed as a percentage) of the fractions, calculated as follows:

i. Total Medicaid patient revenues paid to the hospital, plus the amount of the cash subsidies for patient service received directly from State and local governments in the cost reporting period, divided by the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the same cost reporting period; and,

ii. The total amount of the hospital's charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third-party or personal resources) in a cost reporting period, less the portion of any cash subsidies received directly from the state or local government for inpatient hospital services, divided by the total amount of hospital charges for inpatient services in the hospital in the same period. The total inpatient hospital charges attributed to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for Medicaid assistance under an approved Medicaid State plan), that is, reductions in charges given to other third-party payors, such as HMOs, Medicare or Blue Cross Blue Shield.

c. A hospital must:

i. have a MIUR of not less than 1%;

ii. have at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under State Medicaid plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget) the term "obstetrician" includes any physician with staff privileges at the hospital to perform non-emergency obstetric procedures. This does not apply to a hospital in which:

(a) the inpatients are predominantly individuals under 18 years of age; or

(b) non-emergency obstetric services were not offered as of December 22, 1987.

iii. not be an institution for mental disease or other mental health facility subject to the limitation on DSH expenditures under Section 4721 of the Balanced Budget Act of 1997.

2. Subject to the provisions of subparagraph 1c above, a hospital will qualify for DSH payments if it is:

a. a public hospital (i.e., hospital owned or operated by a Nevada hospital district, county or other unit of local government); or

b. in Nevada counties, which do not have a public hospital, the private hospital which provided the greatest number of Medicaid inpatient days in the previous year; or

c. a private hospital – located in a Nevada county which has a public hospital, if the public hospital has a MIUR greater than the average for all the hospitals receiving Medicaid payment in the State.

B. Distribution Pools: Hospitals qualified under Paragraph "A" above will be grouped into distribution pools on the following basis:

1. Distribution pools are established as follows:

a) All public hospitals qualifying under Paragraph A above and in counties whose population is 700,000 or more, the total annual disproportionate share payments will be 87.97% of the total computable DSH allotment for the State Fiscal Year.

b) All private hospitals qualifying under paragraph A above and in counties whose population is 700,000 or more, the total annual disproportionate share payments will be 1.69% of the total computable DSH allotment for the State Fiscal Year.

c) All private hospitals qualifying under Paragraph A above and in counties whose population is 100,000 or more but less than 700,000, the total annual disproportionate share payments will be 5.86% of the total computable DSH allotment for the State Fiscal Year.

d) All public hospitals qualifying under Paragraph A above and in counties whose population is less than 100,000, the total annual disproportionate share payments will be 1.34% of the total computable DSH allotment for the State Fiscal Year.

e) All private hospitals qualifying under Paragraph A above and in counties whose population is less than 100,000, the total annual disproportionate share payments will be 3.14% of the total computable DSH allotment for the State Fiscal Year.

f) Note: There is no public hospital in counties whose population is 100,000 or more but less than 700,000.

2. The total amount distributed to an individual hospital may not, under any circumstance, exceed the total uncompensated care costs (DSH limit) for that facility.

3. Total annual uncompensated care costs equal the cost of providing services to Medicaid inpatients, Medicaid outpatients and uninsured patients, less the sum of:

Regular Medicaid FFS rate payments (excluding DSH payments);
Medicaid managed care organization payments;
Supplemental/enhanced Medicaid payments;
Uninsured revenues; and
Federal Section 1011 payments for uncompensated services to eligible aliens with no source of coverage.

4. An "uninsured patient" is defined as an individual without health insurance or other source of third-party coverage (except coverage from State or local programs

based on indigency). A system must be maintained by the hospitals to report revenues on Medicaid and uninsured patient accounts to determine uncompensated care cost consistent with Section 1923 (g) of the Social Security Act and implementing regulations at 42 CFR 447 Subpart E. Costs for Medicaid and uninsured patients will be based upon the methodology used in the HCFA 2552 report. Revenue will be deducted from cost. The total costs on the report will be subject to an independent audit. The HCFA 2552 report must be submitted within six months of the hospital's fiscal year end.

C. Calculation of Hospital DSH Payments

1. Using supplemental payment data for the DSH program year and the same period outlined on Subparagraph A.1 for all other data, the Division will calculate the DSH payments for each hospital as follows:

a. Fifty percent of the pool amount will be distributed based on the percent to total of the uncompensated care percentage of the hospitals within the pool.

i. Uncompensated Care Percentage is the uncompensated care cost of the hospital divided by the net patient revenues of the hospital, as reported on the Medicare Cost Report, which is required to be filed with the State.

(a) Net patient revenues are total patient revenues less contracted allowances and discounts. This comes from Medicare cost report, Worksheet G-3 Line 3, less any net patient revenue from non-hospital inpatient and non-hospital outpatient services.

b. The remaining 50% of the pool amount will be distributed based on the percent to total of the uncompensated care cost of the hospitals within the pool.

2. The DSH payments will be made monthly to the eligible hospitals. Payments will be based on the State Fiscal Year. DSH payment will in no instance exceed a hospital’s DSH limit. If any hospital’s calculated DSH payment exceeds its DSH limit, the excess will be redistributed to the remaining hospitals within the pool using the same formula above.

D. Adjusting DSH payments based on DSH Independent Certified Audit results

1. The Division will audit each hospital for each year in which the hospital received a disproportionate share payment pursuant to NRS, NAC and in accordance with the provisions of Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 et seq.

2. After conducting an audit, if a hospital’s eligibility changes or its initial DSH payment exceeded its audited DSH limit, the Division will recalculate the

following for all hospitals in the affected pool:

a. Audited uncompensated care costs

b. Audited uncompensated care percentages

c. Final DSH payment amounts using the same methodology as defined in Paragraph C. Final DSH payment amounts are calculated using the audited amounts in Subparagraphs D 2a and b.

d. The amount of monies available for redistribution within each pool based on a comparison of each hospital's final DSH payment amount and the initial DSH payment received by each hospital in the pool.

3. For all hospitals in the affected pool(s), the Division will reconcile each hospital's initial DSH payment to its final DSH payment as calculated in Paragraph D 2. Any hospital whose initial DSH payment is greater than the final DSH payment will return the difference to the Division, and any hospital whose initial DSH payment is less than the final DSH payment will be paid the difference. The final DSH payment amount for an individual hospital, as calculated in Paragraph D 2 and in accordance with the methodology in Paragraph C, will in no instance exceed that hospital's audited DSH limit.

4. If each hospital within a pool of hospitals has received the maximum amount of disproportionate share payments allowable by federal and state statutes and regulations, the Division will use the money returned to pay additional disproportionate share payments as follows in the method described in Paragraph C above:

a. If the money was returned by a hospital that is a member of Pool A, to hospitals in Pool B;

b. If the money was returned by a hospital that is a member of Pool B, to hospitals in Pool C;

c. If the money was returned by a hospital that is a member of Pool C, to hospitals in Pool D;

d. If the money was returned by a hospital that is a member of Pool D, to hospitals in Pool E; or

e. If the money was returned by a hospital that is a member of Pool E, to hospitals in Pool A.

IX. MEDICARE CROSS OVER CLAIMS

Payment of crossover claims will be as follows:

A. The lower of the Medicare deductible amount or the difference between the Medicare payment and Medicaid prospective payment for that service.

X. HOSPITALS OUT OF STATE

Elective out-of-state admissions require prior authorization by Nevada Medicaid's Peer Review Organization, which must verify medical services required by Medicaid-eligible or pending-eligible clients are not available in Nevada. The out-of-state payment rate for inpatient care is based on one of the following criteria, whether emergency or elective in nature.

A. For California hospitals, the following rates will be paid:

1. If the hospital has no signed contract with the State of California to provide Medi-Cal services, the California interim reimbursement Medi-Cal rate.

2. If the hospital has a signed contract with the State of California to provide Medi-Cal services, the Medi-Cal contract rate is paid. If the contract rate is not made available to Nevada Medicaid, the California interim Medi-Cal rate is paid.

B. For Utah hospitals the payment rate is 45% of billed charges.

C. For all other states' hospitals, the payment rate will be either the Nevada Medicaid prospective rate or the Medicaid rate for the state in which the hospital is located, but not more than billed charges. To receive the Medicaid rate for the state in which the hospital is located, the hospital must attach documentation to the UB-92 Billing Claim, produced and generated by that state's Medicaid program, verifying the state's payment rate to that hospital.

D. All other states' freestanding psychiatric/substance abuse hospitals are reimbursed 70% of billed charges.

E. For Medicare crossover claims, the payment will be the lower of the Medicare deductible amount or the difference between the Medicare payment and the Nevada Medicaid prospective payment for that service.

F. For services that cannot be provided by a provider that accepts payments under (A) through (E), the State will maintain a list of other qualified out-of-state providers and will negotiate competitive rates that will not exceed the provider's customary charge.

XI. RATE ADJUSTMENTS

Payment is made for services provided in inpatient hospital facilities in accordance with Section 1902(a)(13) of the Social Security Act as amended by Section 4711 of the Balanced Act of 1997. Prospective payment rates are based using the most current hospital costs reports (HCFA 2552) and cost reimbursement series (CRS) reports following the steps described in Section II - V above. Rates in effect on June 30, 1999 will be continued without adjustment except as may be directed by the Department of Human Resources.

XII. MONITORING FUTURE RATES

Nevada Medicaid monitors cost and utilization experience of all hospitals by evaluation of the cost reports filed each year. Payments are examined closely. Should modification of any elements or procedures such as creation or deletion of a rate or group appear necessary, this State Plan Attachment will be amended.

XIII. ADVANCES

Upon request, each hospital may receive each month an advance payment that represents expected monthly Medicaid reimbursement to that facility. Each advance is offset by claims processed during the month. Month-end +/- discrepancies automatically adjust the advance issued the following month.

(Reserved for Future Use)

(Reserved for Future Use)

XIV. DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS

This section of the state plan contains the provisions for making additional Medicaid payments to recognize the additional direct costs incurred by hospitals with approved graduate medical education programs.

Fee-for-Service (FFS) Direct Graduate Medical Education (GME) Payments

A. Qualifying Hospitals:

Non-state government owned hospitals that participate in the Medicaid program are eligible for additional reimbursement related to the provision of Direct GME activities. To qualify for these additional Medicaid payments, the hospital must report costs associated with residents, interns or fellows who participate in an approved medical residency program on their CMS Form 2552, Hospital Cost Report.

If there is not a non-state government owned hospital located in a county, certain private hospitals may qualify for additional reimbursement related to the provision of Direct GME activities. To qualify for these additional Medicaid payments, the hospital must report costs associated with residents, interns or fellows who participate in an approved medical residency program on their CMS Form 2552, Hospital Cost Report. The private hospitals that qualify under this section are Northeastern Nevada Regional Hospital located in Elko County and Renown Regional Medical Center in Washoe County.

No payment under this section is dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.

B. FFS Direct GME Definitions:

(i) Base Year Per Resident Amount - for hospitals receiving Medicaid GME supplemental payments prior to July 1, 2017, the base-year per resident amount is the Medicaid allowable inpatient direct GME cost as reported on CMS Form 2552-96, Hospital Cost Report; Worksheet B, Part I, Line 22, Column 22 and Line 23, Column 23, divided by the un-weighted FTE residents from Worksheet S-3; Part I; Line 12 and Line 14, Column 7 of the Hospital Cost Report ending in June 30, 2008.

For hospitals that begin receiving Medicaid GME supplemental payments on or after July 1, 2017, the base-year per resident amount is the Medicaid allowable inpatient direct GME cost as reported on CMS Form 2552-10, Hospital Cost Report; Worksheet B, Part I, Line 21, Column 21, and Line 22, Column 22, divided by the un-weighted FTE residents from Worksheet S-3; Part I; Line 27 of Column 9 of the Hospital Cost Report ending in June 30, 2015.

For hospitals that did not have approved GME program costs in its Hospital Cost Report for the period ending on June 30, 2015, the base year per resident amount will be calculated in the same manner as above for hospitals that begin participating in the GME supplemental payment on or after July 1, 2017 based on the first CMS Form 2552-10, Hospital Cost Report that includes the approved GME program costs.

(ii) Current Number of FTE Residents - means the number of FTE interns, residents or fellows who participate in an approved medical residency program, including programs in osteopathy, dentistry and podiatry, as required in order to become certified by the appropriate specialty board reported on CMS Form 2552-10, Hospital Cost Report; Worksheet S-3: Part I; Line 27, Column 9.

(iii) FFS Medicaid Patient Load – is the ratio of FFS Medicaid inpatient days to total hospital inpatient days. The FFS Medicaid patient load ratio is determined by the following: Medicaid inpatient days as reported on CMS Form 2552-10, Hospital Cost Report; Worksheet S-3, Part I; Lines 14, 16,17 and 18; Column 7; divided by the hospital's total inpatient days, as reported on worksheet S-3; Part I; Lines 14, 16, 17 and 18; Column 8.

(iv) The cost report data used to determine a hospital's GME payment amount is subject to state review to ensure compliance with federal principles, including those at 42 CFR 412, 42 CFR 413, and Provider Reimbursement Manual Part I and Part II.

C. Methodology for Determining FFS Direct GME Payments:

The hospitals that qualify for FFS Medicaid GME payments will have their hospital specific payment amount determined as follows:

(i) The base-year per resident amount is multiplied by the latest available market basket adjustment factor for each federal fiscal year used for Medicare Inpatient Prospective Payment Systems (IPPS) as published in the Federal Register. The market basket change reflects the Medicare payment increases before application of any Medicare adjustments.

(ii) The results in (i) are multiplied by the current number of FTE residents; the current number of FTE residents and the FFS Medicaid patient load will be updated annually using data from the most recent Medicare Hospital Cost Report (CMS Form 2552-10) submitted to Medicare by each qualifying hospital;

(iii) The results in (ii) are multiplied by the FFS Medicaid patient load which results in the total direct FFS GME payment for the hospitals;

(iv) The annual FFS direct GME supplemental payment for each hospital will be included in the FFS UPL calculation for the annual time period.

D. Payments of FFS Direct GME:

(i) The state will determine the annual direct FFS GME amount payable to qualifying hospitals prospectively for period that will begin each July 1. On a quarterly basis, each qualifying hospital will receive a FFS GME payment equal to 25% of the annually determined FFS GME amount. Quarterly payments will be made in each calendar quarter during the state's fiscal year.

Managed Care Organization (MCO) Direct GME Payments

A. Qualifying Hospitals:

Non-state government owned hospitals that participate in the Medicaid program are eligible for additional reimbursement related to the provision of Direct GME activities. To qualify for these additional Medicaid payments, the hospital must report costs associated with residents, interns or fellows who participate in an approved medical residency program on their CMS Form 2552, Hospital Cost Report.

If there is not a non-state government owned hospital located in a county, certain private hospitals may qualify for additional reimbursement related to the provision of Direct GME activities. To qualify for these additional Medicaid payments, the hospital must report costs associated with residents, interns or fellows who participate in an approved medical residency program on their CMS Form 2552, Hospital Cost Report. The private hospitals that qualify under this section are Northeastern Nevada Regional Hospital located in Elko County and Renown Regional Medical Center in Washoe County.

No payment under this section is dependent on any agreement or arrangement for providers or related entities to donate money or services to a government entity.

B. MCO Direct GME Definitions:

(i) Base Year Per Resident Amount - for hospitals receiving Medicaid GME supplemental payments prior to July 1, 2017, the base-year per resident amount is the Medicaid allowable inpatient direct GME cost as reported on CMS Form 2552-96, Hospital Cost Report; Worksheet B, Part I, Line 22, Column 22 and Line 23, Column 23, divided by the un-weighted FTE residents from Worksheet S-3; Part I; Line 12 and Line 14, Column 7 of the Hospital Cost Report ending in June 30, 2008.

For hospitals that begin receiving Medicaid GME supplemental payments on or after July 1, 2017, the base-year per resident amount is the Medicaid allowable inpatient direct GME cost as reported on CMS Form 2552-10, Hospital Cost Report; Worksheet B, Part I, Line 21, Column 21, and Line 22, Column 22, divided by the un-weighted FTE residents from Worksheet S-3; Part I; Line 27 of Column 9 of the Hospital Cost Report ending in June 30, 2015.

For hospitals that did not have approved GME program costs in its hospital cost report period ending in June 30, 2015, the base year per resident amount will be calculated in the same manner as above for hospitals that begin participating in the GME supplemental payment on or after July 1, 2017 based on the first CMS Form 2552-10, Hospital Cost Report that includes the approved GME program costs.

(ii) Current Number of FTE Residents - means the number of full-time-equivalent interns, residents or fellows who participate in an approved medical residency program, including programs in osteopathy, dentistry and podiatry, as required in order to become certified by the appropriate specialty board reported on CMS Form 2552-10, Hospital Cost Report; Worksheet S-3: Part I; Line 27, Column 9.

(iii) MCO Medicaid Patient Load – is the ratio of MCO Medicaid inpatient days to total hospital inpatient days. The MCO Medicaid patient load ratio is determined by the following: Medicaid inpatient days as reported on CMS Form 2552-10, Hospital Cost Report; Worksheet S-3; Part I; Lines 2, 3 and 4, Column 7 are divided by the hospital's total inpatient days, as reported on Worksheet S-3; Part I; Lines 14, 16, 17 and 18; Column 8.

(iv) The cost report data used to determine a hospital's GME payment amount is subject to state review to ensure compliance with federal principles, including those at 42 CFR 412, 42 CFR 413, and Provider Reimbursement Manual Part I and Part II.

C. Methodology for Determining MCO Direct GME Payments:

The hospitals that qualify for GME payments will have their hospital specific MCO payment amount determined as follows:

(i) The base-year per resident amount is multiplied by the latest available market basket adjustment factor for each federal fiscal year used for Medicare IPPS as published in the Federal Register. The market basket change reflects Medicare payment increases before application of any Medicare adjustments;

(ii) The results in (i) are multiplied by the current number of FTE residents; the current number of FTE residents and the MCO Medicaid patient load will be updated annually using data from the most recent Medicare Hospital Cost Report (CMS Form 2552-10) submitted to Medicare by each qualifying hospital;

(iii) The results in (ii) are multiplied by the MCO Medicaid patient load which results in the total direct MCO GME payment for the hospitals;

D. Payments of MCO Direct GME:

(i) The state will determine the annual direct MCO GME amount payable to qualifying hospitals prospectively for period that will begin each July 1. On a quarterly basis, each qualifying hospital will receive an MCO GME payment equal to 25% of the annually determined MCO GME amount. Quarterly payments will be made in each calendar quarter during the state's fiscal year.

XV. FEDERAL UPPER PAYMENT LIMIT

In order to preserve access to inpatient hospital services for needy individuals in the state of Nevada, the state's Medicaid hospital reimbursement system shall provide for supplemental payments to non-state, governmentally owned or operated hospitals and private hospitals. Supplemental payments shall be made to non-state, governmentally owned or operated hospitals effective for services provided on after January 1, 2002. Supplemental payments shall be made to private hospitals effective for services provided on or after January 2, 2010. These supplemental payments shall be determined on an annual basis and paid to qualifying hospitals on a quarterly basis. The supplemental payments to non-state, governmentally owned or operated hospitals shall not exceed, when aggregated with other payments made to non-state, governmentally owned or operated hospitals, 100% of a reasonable estimate of the amount that would be paid for such services under Medicare payment principles for non-state, governmentally owned or operated hospitals, except that payments for the period prior to May 14, 2002, such payments shall not exceed 150% of a reasonable estimate of the amount that would be paid for such services under Medicare payment principles for non-state, governmentally owned or operated hospitals. The supplemental payments to private hospitals shall not exceed, when aggregated with other payments made to private hospitals, 100% of a reasonable estimate of the amount that would be paid for such services under Medicare payment principles for private hospitals.

The upper payment limit will be determined on an annual basis. In general, this approach identifies the upper limit through the application of Medicare's prospective payment system, which is a diagnosis related group (DRG) payment system. The upper limit computes, for each hospital, the Medicare DRG payment amount for each Medicaid discharge by determining a Medicare equivalent case mix index based on Medicaid discharges. This upper limit also uses a payment per discharge calculation of the amount of Medicare pass-through and add-on reimbursement including but not limited to outlier, direct graduate medical education, organ acquisition, routine and ancillary pass-through, IME, DSH, and capital payments. The Medicare pass-through and add-on reimbursement are identified from the Medicare cost report and adjusted for Medicaid where applicable. The hospital's Medicare payment per discharge, which includes the DRG and the pass-through/add on amounts, are applied to the number of Medicaid discharges. The latest available information is used for Medicare DRG, Medicare pass-through and add-on payments, Medicare discharges, and Medicaid discharges. Inflation factors are accordingly applied to determine an individual hospital's Medicare payment for the UPL period. The sum of each hospital's estimated Medicare payment for Medicaid discharges is the aggregate upper payment limit for the hospital class.

SUPPLEMENTAL PAYMENT FOR NON-STATE GOVERNMENTALLY OWNED OR OPERATED HOSPITALS

The state will determine annually the payments to be made to non-state, governmentally owned or operated hospitals under this section of the plan using the following methodology:

1. Identify all non-state government owned (NSGO) or operated acute care hospitals.
2. For each facility identified in Step #1, compute total Medicaid Fee-for-Service inpatient hospital payments using latest available data projected to the current period.
3. For each facility, calculate the difference between payments identified in Step #2, and the hospital's Medicare UPL. This difference is the total maximum disbursement available under this section of the state plan.

   These calculations will be set on a prospective basis and will not be retroactively adjusted to previous fiscal years.

   A. Calculation of Supplemental Payment for NSGO Hospitals

      The state shall determine the maximum annual supplemental amount payable to hospitals prospectively for period that will begin each July 1. The state shall determine the amount of supplemental payments to each facility using the following criteria:

      a. Total supplemental payments under this section of the state plan will not exceed the difference between Medicaid payments and the Medicare UPL calculated in Step #3 above.
      b. Facilities participating in the supplemental payment program will be identified.
      c. Total supplemental payments will be apportioned to public hospitals participating in the supplemental payment program using each hospital's participation percentage. This percentage is calculated by dividing each supplemental payment hospital's Medicaid days by the total Medicaid days for all supplemental payment hospitals.
      d. Medicaid days for each supplemental payment hospital shall be identified using the most recent Medicare cost report data available at the time the calculation are prepared.
      e. Once these participation percentages are determined they will be final and not subject to recalculation, except when errors are found in the calculations. The state will not recalculate the percentages following receipt of more accurate data, such as a more current or audited Medicare cost report.

   B. Adjustment to Supplemental Payment for NSGO Hospitals to Preserve DSH

      1. The total annual supplemental payment for each hospital will be the lesser of:

         a) The total supplemental payment as calculated above in Paragraph A; or

b) If the uncompensated care limit of DSH Distribution Pool A or Distribution Pool D per the Medicaid State Plan Attachment 4.19-A, Page 23 for the same time period beginning July 1 as above is less than the maximum amount of DSH payment available to the Distribution Pool, the supplemental payment as calculated in this section above for the individual hospitals in the DSH Distribution Pool will be reduced by the amount necessary to allow the Distribution Pool to receive the maximum DSH payment allowable. In no event will the adjustment for each individual hospital reduce the supplemental payment as calculated in Section A to less than $0.

2. For the purpose of the reduction discussed in Paragraph B.1.b above, the Supplemental Payment for NSGO Hospitals for all hospitals in each DSH Pool will be reduced by the lesser of:

a) The amount of the smallest calculated annual Supplemental Payment for NSGO Hospitals in Paragraph A, if there are sufficient DSH funds in the pool to distribute this DSH payment amount equally to all hospitals in the pool, or

b) The remaining amount of DSH funds available in the pool which will be distributed by dividing a hospital's maximum allowed DSH payment by the total maximum allowed DSH payments for the hospitals in the distribution calculation.

No hospital will receive a DSH payment greater than the hospital's uncompensated care limit. If a hospital in the pool is projected to have negative uncompensated care costs, as determined in Section VIII of this Attachment 4.19-A, prior to the adjustment calculation described in Paragraph B.2, the hospital will be excluded from the adjustment calculation; the Supplemental Payment for NSGO Hospitals for such hospital will be that as calculated in Paragraph A. If a hospital in the pool has its annual Supplemental Payment for NSGO Hospitals reduced to $0, this hospital will be removed from further repetitions of Paragraph B.2.

The process in Paragraph B.2.a – b will be repeated until all DSH funds allocated to the DSH Distribution Pool have been distributed or the annual Supplemental Payment for NSGO Hospitals for all hospitals in the DSH Pool have been reduced to $0.

C. Payment of the Supplemental Payment for NSGO Hospitals

On a quarterly basis, hospitals will receive a supplemental payment equal to 25% of the annually determined supplemental amount. A quarterly payment will be made in each calendar quarter during the state's fiscal year.

SUPPLEMENTAL PAYMENT FOR INPATIENT HOSPITALS

In order to preserve access to inpatient hospital services for needy individuals in the state of Nevada, effective on or after January 1, 2014, the state's Medicaid reimbursement system shall provide for supplemental payments to inpatient hospitals. These supplemental payments shall be determined on an annual basis and paid to qualifying private and public inpatient hospitals on a quarterly basis. The payments will be based on inpatient hospital Medicaid Fee-for-Service utilization. No payment under this section is dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.

A. Amount for Distribution

1. For the period July 1, 2019 to June 30, 2020 the total computable payment will be $104,375,281.15.

2. The aggregated amount of supplemental payments to inpatient hospitals shall not exceed the Upper Payment Limit (UPL) for each one of the respective periods. The supplemental payment for the period of July 1, 2019 to June 30, 2020 will be accounted for in the UPL room available for July 1, 2019 to June 30, 2020.

B. Eligibility

1. Nevada Acute Care Inpatient Hospitals (PT 11), that are not designated as Critical Access Hospitals (CAH) (PT 75), Psychiatric Inpatient Hospitals (PT 13), Rehabilitation, Specialty or Long-Term Acute Care (LTAC) (PT 56), will be deemed to qualify.

2. Nevada Acute Care Inpatient Hospitals (PT 11) certified as Trauma I, Trauma II and Trauma III levels will additionally qualify for the distribution of the Trauma case portion of the allotment.

C. Methodology

1. Data Source

a. Days count, by date of service, obtained from the Nevada Medicaid Management Information System (MMIS) for the Med/Surg/ICU, Maternity, NICU and Psych/Detox revenue codes.

b. Data used is from the calendar year two years prior.

i. For example, the calculation for payment in State Fiscal Year 2014 would be computed in calendar year 2013 using data from calendar year 2011.

c. Case Mix Index (CMI) is calculated using the same claims data described above, in (a) and (b) by Contractor University of Nevada Las Vegas, Center for Health Information Analysis (CHIA).

d. Trauma cases are determined using the same claims data described above, in (a) and (b) by counting the number of patient discharges which have a trauma revenue code.

2. Calculation – The calculation will be computed annually, based on the total allocation amount specified above in A.1 with quarterly payments to be made during calendar year quarters as described in D.1 using the following methodology:

a. Identify all eligible hospitals as described above in (A).

b. Determine which hospitals are trauma certified (Levels 1, 2 and 3).

c. Determine the total allocation.

d. Determine the total count of trauma cases for any trauma certified hospital.

e. Calculate 3% of the total allocation to determine the trauma portion of the allocation.

f. Level I and Level II trauma cases will be given a weight of 100% of the amount to be paid for each trauma case; Level III trauma cases will be given a weight of 50%.

g. Divide the number of Level I plus Level II plus half the number of Level III trauma cases into the product of 2 (e) above to determine the amount to be paid for each 100% weighted trauma case.

a. To calculate the 50% weighted trauma case amount, divide the 100% weighted trauma case by 2.

b. Multiply the number of trauma cases of hospitals certified as trauma Level I and Level II by the 100% weighted amount determined in (g), to calculate the payment for each hospital in this category.

c. Multiply the number of trauma cases of hospitals certified as trauma Level III by the amount determined in (h), to calculate the payment for each hospital in this category.

d. Subtract the trauma portion of the allocation from the total allocation to determine the amount remaining for distribution to eligible hospitals as identified in Step 2 (a).

e. Multiply the number of each hospital's Medicaid Fee-for-Service days, by their Medicaid CMI to determine the number of adjusted days per hospital.

f. Divide the remaining allocation (the amount in Step (c) reduced by the amount in Step (e)) by the total adjusted days to determine the per day rate.

g. Multiply the per day rate times the individual hospital adjusted days to determine each hospital payment.

h. Add hospital day rate payment amount to the trauma payment, if any, to determine the total payment to each hospital.

B. Payment

1. Payment issued to hospitals participating in the supplemental payment will be deducted and tracked to ensure that total Medicaid payments do not exceed the aggregate amount of (UPL) calculated for the corresponding period. (see A.2 above).

2. One fourth of the total annual allocation (not to exceed the aggregate amount of UPL for the corresponding period) will be paid out quarterly to each eligible hospital, in supplemental payments, in the last month of the quarter for which the payment is calculated (Effective July 1, 2015: e.g. the supplemental payment for SFY 2016 Quarter 1 will be issued in September 2015).

3. Each hospital will be issued the supplemental payment by EFT as a financial transaction through the MMIS.

B. SUPPLEMENTAL PAYMENT FOR PRIVATE HOSPITALS

In order to preserve access to inpatient hospital services for needy individuals in the state of Nevada, effective for services provided on or after January 2, 2010, the state's Medicaid hospital reimbursement system shall provide for supplemental payments to private hospitals affiliated with a state or unit of local government in Nevada through a Low Income and Needy Care Collaboration Agreement (Affiliated Private Hospitals). A Low Income and Needy Care Collaboration Agreement is defined as an agreement between a hospital and a state or unit of local government to collaborate for purposes of providing healthcare services to low income and needy patients. These supplemental payments shall be determined on an annual basis and paid to qualifying hospitals on a quarterly basis.

The supplemental payments are payments for Medicaid Fee-for-Service inpatient hospital service. The supplemental payments shall not exceed, when aggregated with other payments made to private hospitals, 100% of a reasonable estimate of the amount that would be paid for such services under Medicare payment principles for private hospitals.

The state will determine the payments to be made under this section of the plan using the following methodology:

1. Identify all Nevada private hospitals. Non-state government owned or operated acute care hospitals and state owned hospitals do not qualify under this methodology.
2. For those facilities identified in Step #1, compute the Medicare UPL according to the methodology set out on Page 32 above.
3. The amount computed in Step #2, less the Medicaid Fee-for-Service inpatient hospital payments to those facilities identified in Step #1, is the total maximum disbursement available under this section of the state plan in each fiscal year. If the payments under this section of the plan exceed this total maximum disbursement, the state will calculate the percentage by which the Medicare UPL is exceeded and reduce payments to all hospitals under this section of the state plan by the same percentage.

The Medicaid director shall then determine the amount of supplemental payments to each facility using the following criteria.

1. Total supplemental payments under this section of the state plan will not exceed the difference between Medicaid payments and the Medicare UPL calculated in Step #3 above.
2. Facilities participating in the supplemental payment program will be identified. All Affiliated Private Hospitals are eligible to participate in the supplemental payment program.

3. Each Affiliated Private Hospital will receive quarterly supplemental payments. The annual supplemental payments in any fiscal year will be the lesser of:

   a) The difference between the hospital's Medicaid inpatient billed charges and Medicaid payments the hospital receives for services processed for Fee-for-Service Medicaid recipients during the fiscal year.
   b) For hospitals participating in the Nevada Medicaid DSH program, the difference between the hospital's total uncompensated costs (as defined in Section VIII) and the hospital's Medicaid DSH payments during the fiscal year.

XVI. INPATIENT HOSPITAL SERVICES REIMBURSEMENT TO INDIAN HEALTH SERVICE AND TRIBAL 638 HEALTH FACILITIES

Effective January 1, 2000, Nevada Medicaid will reimburse Indian Health Services facilities and Tribal 638 facilities for inpatient hospital services a daily rate in accordance with the most recent published Federal Register notice. This rate does not include physician services.

Physician services are reimbursed in accordance with Attachment 4.19-B, Item 5 of the Nevada State Plan.

Citation

42 CFR 447, 434, 438 and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A and Sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19 (A).

> **_X_** Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section(s) 4.19-A

> **__X__** Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.
>
> ____ Additional Other Provider-Preventable Conditions identified below *(please indicate the section(s) of the plan and specific service type and provider type to which the provisions will be applied. For example – 4.19(d) Nursing Facility Services, 4.19(b) Physician Services)* of the plan:

Methodology for Identifying Provider-Preventable Conditions

Beginning July 1, 2012, Nevada, which pays claims on a per-diem basis, will use two methods to identify PPCs: screening Prior Authorization requests and a retrospective review of claims.

PRIOR AUTHORIZATION (PA)

Prior Authorizations (PAs) will be screened for PPC codes and reviewed by the fiscal agent's medical review staff, which will make determinations for denials of payment for continued stay requests and/or level of care increases if the request appears to be related to a PPC. Payment denial does not consider medical necessity. Providers can appeal a PPC denial utilizing the existing appeals process.

RETROSPECTIVE REVIEW

Prior Authorization

A provider who caused a PPC may be discovered in the process of reviewing a PA request from a second provider from whom the patient seeks treatment. If it is determined in the PA screening that a provider other than the provider requesting the PA may be responsible for causing a PPC, a retrospective review of claims of the provider possibly causing the PPC will be done. Payments associated with treating the PPC will be recovered, from the original provider, if those increases in payments can be reasonably isolated to the PPC event.

Claims Review

Under NRS 449.485 and R151-8 the Nevada Division of Health Care Financing and Policy (DHCFP) and University of Nevada Las Vegas (UNLV) Center for Health Information and Analysis (CHIA) collects and maintains billing record fields for Nevada hospitals and ambulatory surgical centers. This data set captures the Present on Admission (POA) indicator for the UB-04 claims for principal and each secondary (other) diagnosis field. Claims data with dates of service on or after July 1, 2012 will be reviewed and those fitting the criteria for PPCs will be identified. Providers will be supplied information identifying claims with the potential PPCs and will be given 30 days to review and respond to any discrepancies. Provider-confirmed PPCs will be subject to payment adjustment.

Payment Adjustment

For per diem payments, the number of covered days shall be reduced by the number of days associated with any PPC not present on admission. Nevada will use nationally accepted standards to determine the number of days attributable to the diagnosis absent the PPC and the incremental number of days attributable to the PPC. Reimbursement may also be reduced for level of care changes attributable to a PPC.

PAYMENT FOR MEDICAL CARE AND SERVICES

1. This paragraph intentionally left blank.
2. Outpatient Hospital
   a. Payments for services billed by Outpatient Hospitals using Current Procedural Terminology (CPT) codes will be calculated using the January 1, 2014 unit values for the Nevada-specific resource based relative value scale (RBRVS) and the 2014 Medicare Physician Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amounts specified below:
      i. Surgical Codes 10000 – 58999 and 60000 – 69999 will be reimbursed at 90% of the Medicare facility rate.
      ii. Radiology Codes 70000 – 79999 will be reimbursed at 100% of the Medicare facility rate.
      iii. Effective February 15, 2012, Radiopharmaceutical and Contrast codes will be reimbursed at the 2012 Medicare Mean Unit Cost plus 5%.
      iv. Medicine Codes 90000 – 99199 will be reimbursed at 85% of the Medicare facility rate.
      v. Vaccine Products require a National Drug Code (NDC) and will be reimbursed according to the drug reimbursement algorithm set forth on page 3 of Attachment 4.19-B.
      vi. Evaluation and Management Codes 99201 – 99499 will be reimbursed at 90% of the Medicare facility rate.
      vii. Obstetrical Service Codes 59000 – 59999 will be reimbursed at 90% of the Medicare facility rate.
      viii. Anesthesia Codes 00100 – 01999 will be reimbursed based on the Centers for Medicare and Medicaid Services (CMS) 2009 base units for anesthesia. Payment is determined by adding the base units plus time units and multiplying the result by the CMS 2013 anesthesia conversion factor of $22.57. Anesthesia Codes 01967 – 01969 are occurrence-based codes that are paid a flat rate. Anesthesia Codes 99100 – 99140 are not covered.
      ix. Prescribed drugs (Page 3, Paragraph 12a).
      x. Outpatient laboratory and pathology services (Page 1a, Paragraph 3).
      xi. Dental services (CDT Codes, Page 2c, Paragraph 10).
      xii. Durable medical equipment; prosthetics and orthotics (Page 2, Paragraph 7c); and disposable supplies (Page 2, Paragraph 7d).

      Assurance: Except as otherwise noted in the plan, state developed fee schedule rates are the same for both public and private providers of the service. The agency's outpatient hospital fee schedule rates were set as of January 1, 2017 and are effective for services provided on or after that date. All rates are published on our website: http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/.

   b. (This paragraph intentionally left blank.)

c. Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)

Nevada Medicaid uses a Prospective Payment System (PPS) for FQHCs/RHCs as required by S.S.A. §1902 (a) (15) [42 U.S.C. § 1396a (a) (15)] and S.S.A. §1902 (bb) [42 U.S.C. §1396a (bb)]. The PPS for FQHCs/RHCs was implemented and took effect on January 1, 2001.

Prospective Payment System (PPS) Reimbursement for Existing Facilities

On January 1, 2001, the State began paying FQHCs/RHCs (including "FQHC look alike clinics") based on a PPS rate methodology, per CMS requirements. The baseline for a PPS was set at 100% of the average of an FQHC/RHC per visit rate based on the reported reasonable and allowable costs of providing Medicaid-covered services during the FQHC/RHC fiscal years 1999 and 2000, adjusted to take into account any reported increase (or decrease) in the scope of services furnished during FY 2001 by the FQHC/RHC (calculating the payment amount on a per visit basis). Medicaid-covered services that are considered to be FQHC/RHC services are those services that were identified and approved to be provided by the facility as it applies to HRSA in order to be deemed as an FQHC/RHC facility.

Beginning in Federal fiscal year 2002, and for each fiscal year thereafter, each FQHC/RHC is entitled to the payment amount (on a per visit basis) to which the center or clinic was entitled under the Act in the previous year, increased each October 1st (FFY) by the percentage increase (or decrease) in the Medicare Economic Index (MEI) for primary care services as defined in Section 1842 (i)(3) of the Social Security Act, which is intended to account for the basic cost increases associated with providing such services.

After February 6, 2016, the DHCFP will allow reimbursement for up to three encounters/visits per person per day provided that the FQHC has separate PPS rates for each reimbursable service type; medical, mental behavioral health and dental. FQHCs that only provide two of the specified service types will be allowed reimbursement for up to two encounters/visits per patient per day. For FQHCs that only have one PPS rate will be allowed reimbursement for only one encounter/visit per patient per day. For FQHCs that do not have separate Service Specific Prospective Payment Systems (SSPPS) rates already established, they may opt to change to an Alternative Payment Methodology (APM) wherein their costs/visits will be reviewed after a full year of providing and receiving reimbursement for up to three (or two) visits/encounters per patient per day, resulting in separate Service Specific Alternative Payment Methodology (SSAPM) rates being established.

FQHCs may choose to retain their current SSPPS rates and not bill up to three encounters/visits per patient per day, which will not result in a change to an SSAPM and a current review of their costs and visits.

PPS rates will not be subject to rebasing after their initial computation unless authorized by Congress. Only the actual costs related to any reported change in scope of services will be calculated (based on a full year of providing those services) and an adjustment or add-on to the baseline PPS rate will be made. Any other changes to the PPS rate(s) will be considered an APM and will be outlined below in this State plan.

Prospective Payment System (PPS)-Service Specific Reimbursement for New Facilities

Newly qualified FQHCs/RHCs after Federal fiscal year 2012 will have initial payments (interim Service Specific PPS (SSPPS) rates) established either by reference to payments to one or more other clinics in the same or adjacent areas with similar caseloads and/or similar scope of services or based on an average of rates for other FQHC/RHC clinics throughout the State.

Once their average per visit reasonable costs of providing Medicaid-covered services based on their first full year of operation can be determined, the initial interim SSPPS payments of the FQHC/RHC will be cost settled and any over or under payments will be reconciled and the SSPPS rate will then be established based on the actual cost to provide those services for their first full year. The per visit SSPPS rate(s) will then be adjusted annually every October 1st beginning at the next federal fiscal year by the percentage change in the Medicare Economic Index (MEI) for primary care services as defined in Section 1842 (i)(3) of the Social Security Act, for that calendar year as published in the Federal Register. The MEI adjustment is the mechanism used to account for the basic cost increases associated with providing such services. All required documentation of actual costs for the first full year of providing services must be furnished to the DHCFP no later than six months after completion of the first full year of services. If the required documentation is not received within six months after the completion of a full year of services, the annual MEI adjustments will be suspended until such time as the documentation is received and an actual SSPPS rate is determined.

PPS/SSPPS rates will not be subject to rebasing after their initial computation unless authorized by Congress. Only the actual costs related to any reported change in scope of services will be calculated (based on a full year of providing those services) and an adjustment or add-on to the baseline PPS/SSPPS rate will be made. Any other changes to the PPS/SSPPS rate(s) will be considered an Alternative Payment Methodology (APM) and will be outlined below in this State Plan.

Alternative Payment Methodology (APM) Reimbursement

For any fiscal year after FY 2002, a State may use an APM methodology other than the Medicaid PPS, but only if the following statutory requirements are met. First, the APM must be agreed to by the State and by each individual FQHC/RHC to which the State wishes to apply the methodology. Second, the methodology must result in a payment to the center or clinic that is a least equal to the amount to which the center or clinic is entitled under the Medicaid PPS. Third, the methodology must be described in the approved State plan.

Service Specific APM (SSAPM) rates are based on the specific service type being provided. SSAPM rates are set at 100% of the average of an FQHC/RHC per visit rate based on the reported reasonable and allowable costs of providing Medicaid-covered services during the time period under review (calculating the payment amount on a per visit basis per service type). For FQHCs that have separate service specific APM rates established, the DHCFP will allow reimbursement for up to three (or two) SSAPM encounters/visits per patient per day for the different service types: one medical, one behavioral health and one dental.

Effective October 1st (FFY) of each year after an SSAPM rate has been established, for services

furnished on or after that date, the DHCFP will adjust the SSAPM rate by the percentage increase in the MEI applicable to primary care services as published in the Federal Register for that calendar year, which will account for basic cost increases associated with providing such services.

APM to Reflect Other Payment Adjustments

FQHC/RHC's may request an APM to reflect other payment adjustments in the event of extraordinary circumstances, not otherwise reimbursed by other sources, including but not limited to acts of God; acts of nature; acts of terrorism and acts of war. However, if an FQHC/RHC's existing PPS/SSPPS/SSAPM rate is sufficient to cover its overall costs, including those associated with the extraordinary circumstances, other payment adjustment is not warranted. The FQHC/RHC must show that its PPS/SSPPS/SSAPM rate is not sufficient to cover the costs associated with the extraordinary circumstance. The adjusted rate will only apply to the extent, and only for the period of time, that the additional costs for the event are reimbursable under federal Medicaid law and regulations governing claims for federal financial participation (FMAP). The DHCFP will work with the provider to gather the appropriate data at the time the incident occurs and a written request for a rate adjustment is made by the Provider.

Change in Scope of Services

PPS/SSPPS/SSAPM rates may be adjusted to take into account any requested, documented and approved increase (or decrease) in the scope of services furnished by the FQHC/RHC in any given fiscal year. The FQHC/RHC must submit a written request detailing the change in scope of services to the Division within 60 days of the effective date of those changes in order for the rate adjustment to be retroactive to the date of the Change in Scope of Services. If a written request is not received within 60 days of those changes, the effective date for a rate adjustment will be the date the written request for a Change in Scope of Services was received by the DHCFP. Documentation and notification to support an increase or decrease in the scope of services is the responsibility of the provider and must specify all the changes up for review.

An FQHC/RHC requesting a rate adjustment for changes in scope of services must submit data/documentation/schedules that substantiate the changes in scope and the related adjustment of reasonable costs following Medicare principals of reimbursement.

An interim rate will be determined using the first three months of actual cost data available from the provider. After a full year of providing the services related to the change in scope, an analysis will be performed on the actual costs for a full year of service and an adjustment will be made to the PPS/SSPPS/SSAPM. Adjustments to the PPS/SSPPS/SSAPM rate for qualified/approved changes in scope will be based on Medicare Cost Reimbursement methodology, allocating costs related to patient care based upon a providers audited and approved costs for the change in scope services. The PPS/SSPPS/SSAPM rate adjustment will then be determined by dividing the approved allocated costs by the number of approved total visits for the given time period.

A Change in Scope of Services has been defined as a change in the type, intensity, duration and/or amount of any service that meets the definition of FQHC/RHC services as defined in Section 1905 (a)(2)(B) and (C) of the Social Security Act; and the service is included as a covered Medicaid service under the Medicaid state plan. General increases or decreases in costs associated with programs that were already a part of an established PPS/SSPPS/SSAPM rate do NOT constitute a Change in Scope. A Change in Scope must meet all of the following requirements:

- The change in the scope of services is a change in the type, intensity, duration, or amount of services, or any combination thereof as defined in Section 1905 (a)(2)(B) and (C) of the Social Security Act.

- The cost is allowable under Medicare reasonable cost principals set forth in 45 CFR Part 75 Uniform Administrative Requirements, Cost Principles and Audit Requirements for HHS Awards and /or 42CFR Part 413 Principles of Reasonable Cost Reimbursement.

- The net change in the FQHC/RHC's per visit PPS/SSPPS/APM rate must equal or exceed 4% for the affected FQHC/RHC site(s). For FQHC/RHC's that filed consolidated cost reports for multiple sites to establish the initial Prospective Payment reimbursement rate (PPS), the 4% threshold will be applied to the average per visit rate (medical, dental and mental health) of all sites that provide the specific service for the purposes of calculating the cost associated with a scope of service change. "Net change" means the per visit rate change attributable to the cumulative effect of all increases and decreases for a particular fiscal year for the specific service type.

A Change in Scope of Services includes any of the following:

- A change in the types of services offered, i.e., the addition of dental services, may qualify as a Change in Scope which may warrant an adjustment to the PPS/SSPPS/SSAPM rate or the establishment of a new PPS/SSPPS/SSAPM rate.

- A change in intensity/duration or character of services offered by an FQHC/RHC attributable to changes in the types of patients served may qualify, such as services to patients with HIV/AIDS or other chronic diseases and other special populations requiring more intensive and frequent care.

- A change in the magnitude, intensity or character of currently offered services, demonstrated and documented by an increase or decrease in the patient volume of certain high risk populations that require more intensive and frequent care, which may reasonably be expected to span at least one year may qualify.

- A change in the type, intensity, duration or amount of service caused by changes in technology and medical practice used may qualify.

If a Change in Scope rate increase request is denied, the provider may request a formal rate appeal from the DHCFP. Rate appeal procedures are defined in the Medicaid Service Manual (MSM) Chapter 700.

Definition of a "Visit"/"Encounter"

A "visit" or an "encounter" for the purposes of reimbursing FQHC/RHC services is defined as face-to-face contact with one or more qualified health professionals and multiple contacts with the same health professional that take place on the same day with the same patient for the same service type.

Qualified Health Professional

To be eligible for PPS/SSPPS/SSAPM reimbursement, services must be delivered exclusively by one or more of the following licensed Qualified Health Professionals or a provider working under his or her direct supervision: Physician, Osteopath, Podiatrist, Physician's Assistant, Advanced Practice Registered Nurse, Certified Nurse Midwife, Clinical Psychologist, Clinical Social Worker, Dentist or Dental Hygienist and other Medicaid Qualified Providers.

Documentation Required to Support a Request for Change in Scope of Services

- Year End Payroll Reports for identified time periods
- Trial Balances for all Revenues and Expenses for identified time periods
- Grouping Schedule/Mapping of Trial Balance Accounts to the Cost Reports
- Detailed General Ledger with Vendor Information for identified time periods
- Claims reports showing Unique Patient Visits, DOS, Procedure Codes, Service Facility ID#, Amount Paid and Payer
- Other Items as Deemed Necessary

Record keeping and Audit

All participating FQHC/RHC's shall maintain an accounting system which identifies costs in a manner that conforms to generally accepted accounting principles and must maintain documentation sufficient to support all cost/visit data.

The DHCFP, its fiscal agent or a designated and contracted financial entity may conduct periodic on-site or desk audits of all cost data, including financial and statistical records of the FQHCs/RHCs.

FQHCs/RHCs must submit information (statistics, costs and financial data or other data) as deemed necessary by the DHCFP or its fiscal agent. Failure to submit requested documentation may result in denial of a rate adjustment request.

The DHCFP will conduct one audit annually (at a minimum) to the claims submitted by the FQHC/RHC for supplemental payments.

Supplemental Payments for FQHCs/RHCs Enrolled with a Managed Care Entity (MCE)

FQHCs/RHCs that provide services under a contract with a Medicaid Managed Care Entity (MCE) will receive quarterly or monthly (as agreed upon between the provider and the state) supplemental payments for furnishing such services, that are a calculation of the difference between the payments the FQHC/RHC receives from the MCE(s) for all qualified Medicaid FQHC/RHC visits and the payments the FQHC/RHC would have received under the PPS/SSPPS or SSAPM methodology.

At the end of each payment period, the total amount of MCE payments received by the FQHC/RHC will be reviewed against the amount that the actual number of visits provided under the FQHC's/RHC's contract with MCE(s) would have yielded under the PPS/SSPPS/SSAPM methodology. If the amount exceeds the total amount of MCE payments, the FQHC/RHC will be paid the difference, if the amount is less, the FQHC/RHC will refund the difference to the DHCFP. The FQHC/RHCs must provide sufficient documentation (as requested) to the DHCFP to facilitate supplemental payment calculations. If the required documentation is not provided to support the supplemental payment, future supplemental payments may be suspended.

Documentation Required to Calculate/Support Supplemental Payments

The FQHC/RHC will submit an electronic request for supplemental payment which will contain at least the following information for each line item of every qualified encounter during the reporting time period (Quarterly or Monthly): Medicaid Billing Provider ID#, Recipient MCE ID Number, Recipient Medicaid ID Number, Date of Service, Procedure Code(s), MCE Name, Total Billed Amount, MCE Paid Amount, Other Paid Amount, Total Amount Paid and Recipient Date of Birth.

The FQHC/RHC will submit claim data for supplemental payment no later than 30 days after the end of the reporting period agreed upon with the DHCFP (Quarterly or Monthly).

Any discrepancy found in the audits will be adjusted based on the audit findings.

3. Laboratory and pathology services deemed to be Nevada Medicaid covered benefits will be paid at:

a. For Codes 80000 - 89999, the lower of billed charges not to exceed 50% of the rate allowed by the 2014 Medicare Clinical Diagnostic Laboratory Fee Schedule for Nevada;

b. Allowed laboratory and pathology codes/services outside of the ranges listed in 3.1 and 3.2 or not listed in the Medicare Clinical Diagnostic Laboratory Fee Schedule for Nevada will be paid in accordance with other sections of this State Plan based on rendering provider type;

b. For "BR" (by report) and "RNE" (relativity not established) codes that fall within the Code Range 80000 - 89999, the payment will be set at 62% of billed charges; or

c. Contracted or negotiated amount.

4. EPSDT and Family Planning

A. Early and periodic screening, diagnosis and treatment (EPSDT) services, including School Health Services (SHS), will be reimbursed the lower of a) billed charge, or b) fixed fee per unit as indicated for specific services listed elsewhere in this attachment.

B. SHS – Reimbursement Methodology

SHS described in Attachment 3.1-A, Page 2a of the Nevada State Plan will be reimbursed the lower of: a) billed charges; or b) a fixed fee schedule.

School Health Services (SHS) delivered by Local Education Agencies (LEAs) and provided to children. Services include:

1. Physician's services,
2. Physician's assistant services,
3. Nursing services including registered nurses, licensed practical nurses and advanced nurse practitioners,
4. Psychological services,
5. Physical therapy services,
6. Speech therapy, language disorders and audiology services,
7. Occupational therapy services,
8. Applied Behavior Analysis (ABA),
9. Personal Care Services (PCS),
10. Home health care services,
11. Case management,
12. EPSDT preventative screenings,
13. Dental services,
14. Optometry services,
15. Non-Residential mental health rehabilitative services,
16. Outpatient alcohol and substance abuse services,
17. Medical supplies, equipment and appliance services – Assistive Communication Devices, audiological supplies and other Durable Medical Equipment (DME), and
18. Services provided by telehealth.

All costs described within this methodology are for Medicaid services provided by qualified practitioners that have been approved under Attachment 3.1-A of the Medicaid state plan.

All providers and services are paid the same as providers and services outside of the school-based setting (with the same fee schedules as the rest of the state).

A fixed fee schedule: as indicated for specific services listed elsewhere in this attachment. All rates are published on the agency's website:

http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers of SHS listed above.

4. EPSDT and Family Planning (cont.)

A. Applied Behavior Analysis (ABA) services as stated in Nevada State Plan Attachment 3.1-A, ABA

ABA Reimbursement Methodology

ABA Services described in Attachment 3.1-A, Pages 2i-2k of the Nevada State Plan and provided by an enrolled qualified medical professional according to ABA requirements listed in Attachment 3.1-A, Pages 2j and 2k, are reimbursed the lower of: a) billed charges; or b) a fixed fee schedule.

A fixed fee schedule: as indicated for specific services listed elsewhere in this attachment e.g., ABA. All rates are published on the agency's website: http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/

The Agency's rates are set as of January 1, 2016 and are effective for services on or after January 1, 2016.

Payments for services billed by ABA Qualified Medical Professionals will be reimbursed based on provider qualifications and procedure codes.

i. Nevada Licensed Physician (MD/DO) or Board-Certified Behavior Analyst (BCBA) or Psychologist with a specialty in Behavior Intervention (PhD) will be reimbursed at 65% of Medicare rates as published in the Federal Register on July 14, 2014. 42 CFR 411, 412, 416, *et al.*

ii. Board Certified Assistant Behavior Analyst (BCaBA) will be reimbursed at 60% of the ABA Physician rate as shown above in (i).

iii. Registered Behavioral Technicians (RBT) rate methodology:

a. The rates are based on several factors used to determine the cost associated with performing the applicable services. This model was developed to reflect provider requirements, operational service delivery, recruitment, credentialing, ongoing training/certification and administrative considerations. The following elements were used to determine the rates:

1. Wage Information – The wage is based on similarly qualified occupations (required education and training) identified by Medicaid staff as comparable.

1. Employee Related Expenses (ERE) – ERE includes paid vacation, sick leave, holiday, health/life insurance, disability, worker's compensation, payroll taxes, Medicare and Federal Income taxes.

2. Productivity Adjustment Factor – Costs include non-billable services that are required for normal business operations such as staff meetings, personnel requirements, travel time and mileage. This also includes non-billable time spent by staff to include required case documentation and record keeping and time associated with missed/cancelled appointments.

3. Allowances for Supervisory Time – Costs for the time spent supervising the field staff, which is not reimbursable under separate billing codes, as required by regulations.

4. Certification/Training Expenses – Costs include initial and ongoing certification and training costs required to maintain provider qualifications.

5. Administrative Overhead (10% Cap) – This includes costs associated with non-direct care activities required for normal business operations, such as building rent/utility costs, program support staff and office supplies, etc.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for governmental and private providers of ABA services and the related fee schedule is published on the agency's website:
http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/.

II. Family planning services and supplies: as indicated for specific services listed elsewhere in this attachment, e.g., physician services, prescribed drugs.

5. Payments for services billed by Physicians using Current Procedural Terminology (CPT) codes will be calculated using the January 1, 2014 unit values for the Nevada-specific resource based relative value scale (RBRVS) and the 2014 Medicare Physician Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amounts specified below:

   a. Surgical Codes 10000 – 58999 and 60000 – 69999 will be reimbursed at 95% of the Medicare facility rate.

      1. Pediatric enhancement for recipients under the age of 21 will be the lesser of billed charges or 115% of the currently established Medicaid rates for Surgical Codes 10000 – 58999 and 60000 – 69999.

   b. Radiology Codes 70000 – 79999 will be reimbursed at 100% of the Medicare facility rate. Effective February 15, 2012, Radiopharmaceutical and Contrast codes will be reimbursed at the 2012 Medicare Mean Unit Cost plus 5%.

   c. Medicine Codes 90000 – 99199 will be reimbursed at 85% of the Medicare non-facility rate.

      1. Pediatric enhancement for recipients under the age of 21 will be the lesser of billed charges or 115% of the currently established Medicaid rates for Procedure Codes 93000 – 93350.

   d. Evaluation and Management Codes 99201 – 99499 will be reimbursed at 90% of the Medicare non-facility rate effective July 1, 2015 through June 30, 2016. Effective July 1, 2016 Evaluation and Management Codes 99201 – 99499 will be reimbursed at 95% of the Medicare non-facility rate.

   e. Obstetrical Service Codes 59000 – 59999 will be reimbursed at 95% of the Medicare non-facility rate.

   f. Anesthesia Codes 00100 – 01999 will be reimbursed based on the Centers for Medicare and Medicaid Services (CMS) 2009 base units for anesthesia. Payment is determined by adding the base units plus time units and multiplying the result by the CMS 2013 anesthesia conversion factor of $22.57. Anesthesia Codes 01967 – 01969 are occurrence-based codes that are paid a flat rate. Anesthesia Codes 99100 – 99140 are not covered.

   g. Medicine Codes 90281 – 90399, and all other pharmaceuticals that are not identified above, will be reimbursed according to the drug reimbursement algorithm set forth on Page 3 of Attachment 4.19-B.

   Assurance: Except as otherwise noted in the plan, state developed fee schedule rates are the same for both public and private providers of the service. The agency's physician fee schedule rates were set as of October 1, 2017 and are effective for services provided on or after that date. All rates are published on our website: http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/

6. Medical care and any other type of remedial care provided by licensed practitioners:

a. Payment for services billed by a Podiatrist will be calculated using the January 1, 2014 unit values for the Nevada-specific resource based relative value scale (RBRVS) and the 2014 Medicare Physician Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amount specified below:
   1. Surgical Codes 10000 – 58999 and 60000 – 69999 will be reimbursed at 75% of the Medicare facility rate.
   2. Radiology Codes 70000 – 79999 will be reimbursed at 100% of the Medicare facility rate.
   3. Medicine Codes 90000 – 99199 will be reimbursed at 85% of the Medicare non-facility rate.
   4. Vaccine Products require a National Drug Code (NDC) and will be reimbursed according to the drug reimbursement algorithm set forth on Page 3 of Attachment 4.19-B.
   5. Evaluation and Management Codes 99201 – 99499 will be reimbursed at 90% of the Medicare non-facility rate.

b. Payment for services billed by an Optometrist will be calculated using the January 1, 2014 unit values for the Nevada-specific RBRVS and the 2014 Medicare Physician Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amount specified below:
   1. Surgical Codes 10000 – 58999 and 60000 – 69999 will be reimbursed at 75% of the Medicare non-facility rate.
   2. Radiology Codes 70000 – 79999 will be reimbursed at 100% of the Medicare facility rate.
   3. Medicine Codes 90000 – 99199 and Evaluation and Management Codes 99201 – 99499 will be reimbursed at 90% of the Medicare non-facility rate. See also Page 3a, 12.d.

c. Payment for services billed by a Chiropractor will be calculated using the January 1, 2014 unit values for the Nevada-specific RBRVS and the 2014 Medicare Physician Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amount specified below:
   1. Radiology Codes 70000 – 79999 will be reimbursed at 100% of the Medicare facility rate.
   2. Medicine Codes 90000 – 99199 will be reimbursed at 85% of the Medicare non-facility rate.
   3. Evaluation and Management Codes 99201 – 99499 will be reimbursed at 90% of the Medicare non-facility rate.

d. Payment for services billed by an Advanced Practitioner of Nursing/Physician Assistant/Nurse-Midwife will be calculated using the January 1, 2014 unit values for the Nevada specific resource based relative value scale (RBRVS) and the 2014 Medicare Physicians Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amounts specified below:

1. Surgical Codes 10000 – 58999 and 60000 – 69999 will be reimbursed at 59% of the Medicare facility rate.
2. Radiology Codes 70000 – 79999 will be reimbursed at 75% of the Medicare facility rate.
3. Medicine Codes 90000 – 99199 and Evaluation and Management Codes 99201 – 99499 will be reimbursed at 63% of the Medicare non-facility rate.
4. Obstetrical Service Codes 59000 – 59999 will be reimbursed at 75% of the Medicare non-facility rate.

e. Payment for community paramedicine services will be calculated using the January 1, 2014 unit values for the Nevada-specific resource based relative value scale (RBRVS) and the 2014 Medicare Physician Fee Schedule conversion factor. Payment will be the lower of billed charges or the amounts specified below:

1. Anesthesia Codes 00100 – 01999 will be reimbursed based on the Centers for Medicare and Medicaid Services (CMS) 2009 base units for anesthesia. Payment is determined by adding the base units plus time units and multiplying the result by the CMS 2013 anesthesia conversion factor of $22.57. Anesthesia Codes 01967 – 01969 are occurrence-based codes that are paid a flat rate. Anesthesia Codes 99100 – 99140 are not covered.
2. Surgical Codes 10000 – 58999 and 60000 – 69999 will be reimbursed at 59% of the Medicare facility rate.
3. Medicine Codes 90000 – 99199 and Evaluation and Management Codes 99201 – 99499 will be reimbursed at 63% of the Medicare non-facility rate.
4. Vaccine Products require a National Drug Code (NDC) and will be reimbursed according to the drug reimbursement algorithm set forth on Page 3 of Attachment 4.19-B.

f. Payment for services billed by a Psychologist will be calculated using the January 1, 2014 unit values for the Nevada-specific RBRVS and the 2014 Medicare Physician Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amounts specified below:

1. Medicine Codes 90000 – 99199 will be reimbursed at 85% of the Medicare non-facility-based rate.
2. Vaccine Products require a NDC and will be reimbursed according to the drug reimbursement algorithm set forth on Page 3 of Attachment 4.19-B.
3. Evaluation and Management Codes 99201 – 99499 will be reimbursed at 90% of the Medicare non-facility-based rate.

Assurance: Except as otherwise noted in the plan, state developed fee schedule rates are the same for both public and private providers of the service. The agency's Advanced Practitioner of Nursing/Physician Assistant/Nurse-Midwife fee schedule rates were set as of July 1, 2015 and are effective for services provided on or after that date. Podiatrist, Optometrist, Chiropractor, Nurse Anesthetist and Psychologist fee schedule rates were set as of January 1, 2017 and are effective for services provided on or after that date. All rates are published on our website: http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/

7. Telehealth Services

Telehealth is the delivery of services from a provider of health care to a patient at a different location, through the use of information and audio-visual communication technology, not including standard telephone, facsimile or electronic mail.

a. The originating site provider will be paid a telehealth originating site facility fee per completed transmission. Payment for an originating site facility fee will be reimbursed at the rate established in the CY 2012 Medicare Physician Fee Schedule.

b. The distant site provider is paid the current applicable Nevada Medicaid fee for the telehealth service provided. Instructions for submitting billing claims may be found on the Nevada Medicaid website: https://www.medicaid.nv.gov/providers/BillingInfo.aspx.

c. A provider will not be eligible for payment as both the originating and distant site for the same patient, same date of service.

d. Fee schedule rates are the same for both governmental and private providers. The Nevada Medicaid fee schedules may be found on the following website: http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/

7. Home Health Care Services:

a. Home health care services include the following services and items:

1. physical therapy – 1 unit per 15 minutes,
2. occupational therapy – 1 unit per 15 minutes,
3. speech therapy – 1 unit per 15 minutes,
4. family planning education – 1 unit per visit,
5. skilled nursing services (RN/LPN visits) 1 unit per 60 minutes or 1 unit per 15 minutes for brief visits or 1 unit per 15 minutes for extended visits (after 1st hour),
6. home health aide services – 1 unit per 60 minutes or 1 unit per 30 minutes for extended visits (after 1st hour),
7. durable medical equipment, prosthetics, orthotics, and
8. disposable medical supplies.

b. Reimbursements for Home Health Care services listed above in a.1. through a.6, provided by Home Health Agencies are the lower of a) billed charges, or b) a fixed fee schedule which includes the rate for each of the home health services and a rate for "mileage" as an add-on. The Division's rates were set as of July 1, 2016 and are effective for services on or after that date. All rates can be found on the official Website of the Division of Health Care Financing and Policy at http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/

Effective July 1, 2016, pediatric enhancement rates do not apply for services listed above in a.5.

c. Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)

1. Reimbursement for purchase of DMEPOS is the lower of: a) usual and customary charge, or b) a fixed fee schedule rate.
2. Reimbursement for rental of DMEPOS is the lower of: a) usual and customary charge, or b) a fixed fee schedule rate.
3. If there is no fee schedule available, reimbursement will be the lower of: a) manufacturer's suggested retail price (MSRP) less 25%, verifiable with quote or manufacturer's invoice that clearly identifies MSRP; b) if there is no MSRP, reimbursement will be acquisition cost plus 20%, verifiable with manufacturer's invoice; or c) the actual charge submitted by the provider.
4. Reimbursement for the Healthcare Common Procedure Coding System (HCPCS) codes E2609 (Custom fabricated wheelchair seat cushion, any size) and E2617 (Custom fabricated wheelchair back cushion, any size) will be the lower of: a) MSRP less 20% verifiable with submission of a quote or manufacturer's invoice that clearly identifies MSRP for HCPCS codes E2609 and E2617; b) if there is no MSRP, reimbursement will be acquisition cost plus 20% verifiable with manufacturer's invoice, or c) the actual charge submitted by the provider.
   a. This reimbursement methodology for procedure codes E2609 and E2617 apply only to Complex Rehab Technologies (CRT) providers.
   b. CRT products may only be provided by individuals who are certified, registered or otherwise credentialed by recognized organizations in the field of CRT and who are employed by a business specifically accredited by a Centers for Medicare and Medicaid (CMS) deemed accreditation organization to provide CRT.

Payments for DMEPOS will be calculated using the 2016 Nevada-specific non-rural fee schedule issued by the Centers for Medicare and Medicaid Services (CMS). Reimbursement will be set at 100% of the Nevada-specific rates.

d. Disposable supplies:

1. If a supply item is billed through point of sale (POS), using a National Drug Code (NDC) number, reimbursement is the lower of: a) usual and customary charge, or b) gross amount due or c) Wholesale Acquisition Cost (WAC) + 8% as indicated on the current national drug data base utilized in Point-of-Sale plus a handling fee. For drugs without a WAC acquisition cost will be reimbursed plus a handling fee.

2. All other supplies billed outside POS, using Healthcare Common Procedure Coding System (HCPCS) codes and/or Current Procedural Terminology (CPT) codes are reimbursed the lower of: a) billed charge, or b) fixed fee schedule.

Assurance: Except as otherwise noted in the plan, state developed fee schedule rates are the same for both public and private providers of the service. The Division's Home Health Care Services fee schedule rates were set as of July 1, 2016 and are effective for services provided on or after that date.

The Division's Durable Medical Equipment, Prosthetics, Orthotics and Supplies fee schedule rates were set as of July 1, 2019 and are effective for services provided on or after that date. All rates are published on our website: http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/

8. Private duty nursing services: lower of a) billed charges, or b) fixed fee schedule. The Agency's rates were set as of July 1, 2000 and are effective for services on or after July 1, 2000.

Assurance: State developed fee schedule rates are the same for both public and private providers of the service and the fee schedule and any annual/periodic adjustments to the fee schedule(s) are published on our website: http://www.dhcfp.nv.gov

9. Special clinic services: as indicated for specific services listed elsewhere in this attachment, e.g., physicians' services, prescribed drugs, therapy. Payment will be the lower of billed charges, or the amounts specified below:
   a. Surgical Codes will be reimbursed at 69% of the Medicare facility rate.
   b. Radiology Codes will be reimbursed at 100% of the Medicare facility rate.
   c. Medicine Codes and Evaluation and Management codes will be reimbursed at 60% of the Medicare non-facility rate. Vaccine Products will be reimbursed at 85% of the Medicare non-facility rate.
   d. When Codes 90465 – 90468, 90471 – 90474, 99381 – 99385 and 99391 – 99395 are used for EPSDT services, the reimbursement will be 85% of the Medicare non-facility rate.
   e. Obstetrical Service Codes will be reimbursed at 88% of the Medicare non-facility rate.
   f. Medicine Codes 90281 – 90399, and all other pharmaceuticals that are not identified above, will be reimbursed according to the drug reimbursement algorithm set forth on Page 3 of Attachment 4.19-B with the exception of the pharmacy dispensing fee component of the algorithm.
   g. Freestanding Obstetrical/Birth Centers will be reimbursed an all-inclusive (one time) rate for Procedure Code 59409 that shall not exceed 80% of the Hospital In-patient Maternity daily rate. The rate will be reviewed and updated annually as necessary at the FFY (Oct. – Sept.).

Assurance: State developed fee schedule rates are the same for both public and private providers of the service and the fee schedule and any annual/periodic adjustments to the fee schedule(s) are published on our website: http://dhcfp.nv.gov/

Dental services:

I. STANDARD DENTAL SERVICES

Current Dental Terminology (CDT) codes will be reimbursed based on the base units in the "Relative Values for Dentists" publication by Relative Value Studies; Incorporated for the year the specific CDT code was set in the system. Effective July 1, 2013, payment is determined by multiplying the base units by the conversion factor of $20.50.

II. MEDICAL/SURGICAL PROCEDURES RELATED TO DENTAL SERVICES

Services billed using Current Procedure Terminology (CPT) codes will be calculated using the January 1, 2014 unit values for the Nevada-specific resource based relative value scale (RBRVS) and the 2014 Medicare Physician Fee Schedule conversion factor. Payment will be the lower of billed charges, or the amounts specified below:

a. Surgical Codes 10000 – 58999 and 60000 – 69999 will be reimbursed at 95 % of the Medicare facility rate, effective October 1, 2019.
b. Radiology Codes 70000 – 79999 will be reimbursed at 100% of the Medicare facility rate.
c. Evaluation and Management Codes 99201 – 99499 will be reimbursed at 95% of the Medicare non-facility rate, effective October 1, 2019.

Assurance: Except as otherwise noted in the plan, state developed fee schedule rates are the same for both public and private providers of the service. The agency's rates for medical/surgical procedures related to dental services were set as of October 1, 2019 and are effective for services provided on or after that date. All rates are published on our website: http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/.

11. Physical therapy, occupational therapy, respiratory therapy and audiology services for individuals with speech, hearing and language disorders will be reimbursed the lower of a) billed charges, or b) fee schedule rate which is 77% of the Medicare non-facility rate. The Medicare non-facility rate is calculated using the January 1, 2014 unit values for the Nevada-specific resource based relative value scale (RBRVS) and the 2014 Medicare Physician Fee Schedule conversion factor.

Assurance: State developed fee schedule rates are the same for both public and private providers of the service. The agency's therapy fee schedule rates were set as of January 1, 2017 and are effective for services provided on or after that date. All rates are published on our website: http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/

12. a. Nevada Medicaid will meet all reporting and provision of information requirements of Section 1927(b)(2) and the requirements of subsections (d) and (g) of Section 1927.

The State assures that the State will not provide reimbursement for an innovator multi-source drug, subject to the Federal Upper Limits (42 CFR 447.332(a)), if, under applicable State law, a less expensive non-innovator multi-source drug could have been dispensed.

1. Payment for multi-source drugs shall be the lowest of (a) Federal Upper Limit (FUL) as established by the Centers for Medicare and Medicaid Services (CMS) for listed multi-source drugs plus a professional dispensing fee of $10.17 per prescription; (b) State Maximum Allowable Cost (MAC) plus a professional dispensing fee of $10.17 per prescription; (c) Actual Acquisition Cost (AAC) plus a professional dispensing fee of $10.17 per prescription; or (d) the pharmacist's usual and customary charge.

2. Payment for covered outpatient drugs other than multi-source drugs shall not exceed the lower of (a) AAC plus a professional dispensing fee of $10.17 per prescription; or (b) the pharmacist's usual and customary charge to the general public.

3. Actual Acquisition Cost (AAC) is defined by Nevada Medicaid as the Agency's determination of the actual prices paid by pharmacy providers to acquire drug products marked or sold by specific manufacturers and is based on the National Average Drug Acquisition Cost (NADAC). Wholesale Acquisition Cost (WAC) + 0% will be offered for those drugs not available on NADAC, plus a professional dispensing fee of $10.17 per prescription.

4. A generic drug may be considered for MAC pricing if there are two or more therapeutically equivalent, multi-sources, non-innovator drugs with a significant cost difference. The MAC will be based on drug status (including non-rebatable, rebatable, obsolete, therapeutic equivalency ratings) marketplace availability and cost. The obsolete drug status will be taken into account to ensure that the MAC pricing is not influenced by the prices listed for obsolete drugs. The MAC will be based on drug prices obtained from a nationally recognized comprehensive data file maintained by a vendor under contract with the Department.

5. Ingredient cost reimbursement for 340B covered entities shall be the lowest of (a) AAC, or (b) the 340B ceiling price. A professional dispensing fee of $10.17 will also be paid.

6. Drugs acquired through the federal 340B drug pricing program and dispensed by 340B contract pharmacies are not covered.

7. For drugs that are purchased outside the 340B program, the ingredient cost reimbursement will be based on AAC plus a professional dispensing fee of $10.17 per prescription.

8. For drugs purchased through the Federal Supply Schedule (FSS), the ingredient cost reimbursement is based on AAC plus a professional dispensing fee of $10.17 per prescription.

9. For drugs acquired at a nominal price (outside of 340B or FSS), the ingredient cost reimbursement is based on AAC plus a professional dispensing fee of $10.17 per prescription.

10. Providers that are approved to be reimbursed through an encounter rate(s) meet AAC requirements.

11. For drugs (such as specialty drugs) not distributed by a retail community pharmacy, and distributed primarily through the mail, the ingredient cost reimbursement is based on AAC plus a professional dispensing fee of $10.17 per prescription.

12. For drugs (such as a long-term care facility drugs) not distributed by a retail community pharmacy, the ingredient cost reimbursement will be based on AAC plus a professional dispensing fee of $10.17 per prescription.

13. For physician-administered drugs, the ingredient cost reimbursement shall be the lowest of (a) MAC; (b) AAC; or (c) the physician's usual and customary charge.

    a. For 340B physician-administered drugs, the ingredient cost reimbursement will be the lowest of (a) AAC or (b) 340B ceiling price.

14. For clotting factor drugs, ingredient cost reimbursement will be the lowest of AAC plus a professional dispensing fee of $10.17 per prescription, or the pharmacist's usual and customary charge.

    a. For clotting factor drugs provided by 340B entities, the ingredient cost reimbursement will be the lowest of (a) AAC, or (b) 340B ceiling price, plus a professional dispensing fee of $10.17 per prescription.

15. Out-of-state providers will be reimbursed a professional dispensing fee of $10.17 per prescription.

16. The state of Nevada does not cover investigational drugs.

12. b. Dentures: lower of a) billed charge, or b) fixed fee per unit value. See also 10.

c. Prosthetic devices: (1) hearing aids: wholesale cost plus fixed fee; (2) all others: retail charge less negotiated discount.

d. Eyeglasses: (1) frames: wholesale cost to a fixed maximum; (2) lenses: laboratory invoice cost; (3) material services: lower of a) billed charge, or b) fixed fee per Medicaid assigned unit value.

Assurance: State developed fee schedule rates are the same for both public and private providers for dentures, prosthetic devices and eyeglasses. The Agency's fee schedule rates were set as of January 1, 2017 and are effective for services provided on or after that date. All rates are published on the Agency's website at:
http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/

13. a. Other diagnostic services: lower of a) billed charges, or b) fixed fee per unit value.

b. Other screening services: lower of a) billed charges, or b) fixed fee per unit value.

c. Other preventive services: lower of a) billed charges, or b) fixed fee per unit value.

1. Payment for medical nutrition therapy services billed by a Licensed and Registered Dietician will be calculated using the January 1, 2014 unit values for the Nevada specific resource based relative value scale (RBRVS) and the 2014 Medicare Physicians Fee Schedule conversion factor. Payment for Medicine Codes 90000 – 99199 will be reimbursed the lower of billed charges or 63% of the Medicare non-facility rate.

d. Other rehabilitative services: PROVIDED WITH LIMITATIONS

Assurance: State developed fee schedule rates are the same for both public and private providers for other diagnostic, screening, preventive and rehabilitative services. The Agency's fee schedule rates were set as of January 1, 2018 and are effective for services provided on or after that date. All rates are published on the Agency's website at:
http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/

Other rehabilitative services: PROVIDED WITH LIMITATIONS:

1. Non-Residential Mental Health Rehabilitative Services

A. Reimbursement Methodology for Non-Residential Mental Health Rehabilitation Services provided by a state or local government entity:

Non-residential mental health rehabilitation services:
Examination, Psychiatric Diagnostic Interview – 1 unit per 75 to 80 minutes
Examination, Interactive Psychiatric Diagnostic Interview – 1 unit per 75 to 80 minutes
Individual Psychotherapy – 1 unit per 20 to 30 minutes; or 1 unit per 45 to 50 minutes; or 1 unit per 75 to 80 minutes
Psychoanalysis – 1 unit per 60 minutes
Family Psychotherapy – 1 unit per 60 minutes
Group Psychotherapy – 1 unit per 90 minutes; or 1 unit per 120 minutes
Individual Psychophysiological Therapy – 1 unit per 20 to 30 minutes; or 1 unit per 45 to 50 minutes
Biofeedback – 1 unit per 20 to 30 minutes; or one unit per 40 to 50 minutes
Psychological Testing – 1 unit per 60 minutes
Developmental Testing – 1 unit per 60 minutes
Examination, Neurobehavioral Status – 1 unit per 60 minutes
Neuropsychological Testing – 1 unit per 60 minutes
Assessment, Health and Behavior – 1 unit per 15 minutes
Intervention, Health and Behavior – 1 unit per 15 minutes
Evaluation and Management – 1 unit per 10 minutes; or 1 unit per 15 minutes; or 1 unit per 25 minutes; or 1 unit per 40 minutes
Screening, Behavioral Health – 1 unit per 15 minutes
Out of Office Therapy – 1 unit per 15 minutes
Out of Office Assessment – 1 unit per 90 minutes
Medication training and support, out of office – 1 unit per 15 minutes
Medication training and support, in office – 1 unit per 15 minutes
Peer to Peer support, individual – 1 unit per 15 minutes
Crisis Intervention, telephonic, face to face, team – 1 unit per 15 minutes
Day treatment – 1 unit per 15 minutes
Basic Skills Training, individual or group – 1 unit per 15 minutes
Psychosocial rehabilitation, individual or group – 1 unit per 15 minutes
Partial Hospitalization – 1 unit per 60 minutes
Intensive Outpatient Program – per diem
Not all of the above unit values are billing units, for those codes that have a unit of measure defined as an “encounter” in the current Procedural Coding Expert, the values listed are time comparables for rate development.

FIN REF: Attachment 3.1-A, Page 6b.1 – 6b.3

Non-Residential Mental Health services provided by a state or local government entity are reimbursed according to a methodology used to certify costs as representing expenditures eligible for FFP and may be used only by providers who undergo all Medicaid cost identification, reporting, reconciliation and settlement procedures.

The lower of: a) billed charges; or b) an interim rate. The Interim rate is the rate for a specific service for a period that is provisional in nature, pending the completion of cost reconciliation and a cost settlement for that period.

To determine the Medicaid-allowable direct and indirect costs of providing Non-Residential Mental Health services the following steps are performed:

1. Interim Rates

   Governmental providers are reimbursed on an interim basis for direct medical services per unit of service at the lesser of the provider's billed charges or a provider-specific interim rate. A provider-specific interim rate is an annual rate for the specific services for a period that is provisional in nature, pending the completion of cost reconciliation and a cost settlement for that period. Interim rates are based on program experience and cost data reported during the prior fiscal year.

2. Annual Cost Report Process

   Each governmental provider will complete an annual cost report in the format proscribed by Nevada Medicaid in the Medicaid Operations Manual for all medical services delivered during the previous state fiscal year covering July 1 through June 30. The cost report is due on or before December 1 of the year following the close of the reporting period.

   The primary purposes of the cost report are to:

   a. document the provider's total Medicaid-allowable cost for delivering the medical services, including direct costs and indirect costs, based on the methodologies/steps described below.

   b. reconcile its interim payments to its total Medicaid-allowable costs.

   The annual Medicaid Cost Report includes a certification of funds statement to be completed, certifying the provider's actual, incurred allocable and allowable costs/expenditures. All filed annual Cost Reports are subject to audit by DCHFP or its designee.

To determine the Medicaid-allowable direct and indirect costs of providing covered services to Medicaid-eligible clients, the following steps are performed:

A. Facilities that are primarily providing medical Services:

(a) Direct costs for covered services include unallocated payroll costs and other unallocated costs that can be directly charged to covered medical services. Direct payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct care staff. Other direct costs include costs directly related to the delivery of covered services, such as supervision, materials and supplies, professional and contracted services, capital outlay, and travel. These costs must be in compliance with Medicaid non-institutional reimbursement policy and are accumulated on the annual cost report, resulting in total direct costs.

(b) Total direct costs from Item (a) are reduced by any amount that is not in compliance with Medicaid non-institutional reimbursement policy and are further reduced by any federal payments for those costs, resulting in adjusted direct costs for covered services.

(c) Indirect costs are determined by applying the agency specific approved indirect cost rate to its net direct costs. If the provider has no approved indirect cost rate, the allocated indirect costs can be derived from the allocation process through the provider's approved cost allocation plan. These allocated indirect costs are reduced by any unallowable amount based on Medicaid non-institutional reimbursement policy. The indirect costs details are accumulated on the annual cost report.

(d) Net direct costs (Item b) and indirect costs (Item c) are combined.

(e) A CMS approved time study is required when providers of service do not spend 100% of their time providing the Medical services described in the applicable Section 3.1-A State Plan pages and is used to determine the percentage of time that medical service personnel spend on direct medical services, general and administrative time, and all other activities to account for 100% of the time to assure that there is no duplicate claiming. This CMS approved time study methodology will be used to separate administrative activities and direct services. The direct medical services time study percentage is applied against the net direct and indirect costs.

(f) Medicaid's portion of total allowable costs is calculated by multiplying the result from Item (e) above to the ratio of the total units of service provided to Medicaid eligible clients to the total units of service provided.

(g) Total Medicaid allowable costs (Item f) is reduced by any revenue, e.g. Medicaid co-payments, TPL, received for the same services to arrive at the total Medicaid net allocable and allowable costs.

B. Facilities that are used for multiple purposes and the provision of medical services are not the primary purpose:

(a) Direct costs include unallocated payroll costs and medical equipment and supplies. Unallocated payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct care staff. These costs are accumulated on the annual cost report.

(b) The Direct costs from Item (a) are reduced by any amount that is not in compliance with Medicaid non-institutional reimbursement policy and are further reduced by any federal payments for those costs, resulting in adjusted direct costs.

(c) Indirect costs are determined by applying the agency specific approved indirect cost rate to its net direct costs (Item b.). If the entity has no approved indirect cost rate, the allocated indirect costs can be derived from the allocation process through the provider's approved cost allocation plan. These indirect costs are reduced by any unallowable amount. For these facilities, allowable costs are only those cost that are "directly attributable" to the professional component of providing the medical services and are in compliance with Medicaid non-institutional reimbursement policy. For those costs incurred that "benefit" multiple purposes but would be incurred at the same level if the medical services did not occur are not allowed, e.g. room and board, allocated cost from other related organizations. The indirect cost details are accumulated on the annual cost report.

(d) Net direct costs (Item (b)) and indirect costs (Item (c)) are combined.

(e) A CMS approved time study is required when providers of service do not spend 100% of their time providing the Medical services described in the applicable Section 3.1-A State Plan pages and is used to determine the percentage of time that medical service personnel spend on direct medical services, general and administrative time, and all other activities to account for 100% of the time to assure that there is no duplicate claiming. This CMS approved time study methodology will be used to separate administrative activities and direct services. The direct medical services time study percentage is applied against the net direct and indirect costs.

(f) Medicaid's portion of the total net allocable and allowable costs is calculated by multiplying the result from Item (e) above to the ratio of total units of service provided to Medicaid eligible clients to the total units of service provided.

(g) Total Medicaid allowable costs (Item f) is reduced by any revenue received for the same services, e.g. Medicaid co-payments and TPL, to arrive at the total Medicaid net

(h) allocable and allowable costs.

3. Cost Reconciliation Process

Governmental providers will be responsible for reconciling total allowable computable costs reported on the cost report to the provider's Medicaid interim payments for Medicaid services delivered during the reporting period as document in the MMIS, resulting in cost reconciliation. The cost reconciliation process must be completed within 24-months of the end of the reporting period covered by the annual Cost Report.

4. Cost Settlement Process

If a governmental provider's interim payments exceed the actual, certified costs of the provider for services to Medicaid clients, the DHCFP will recoup the federal share of the overpayment using one of the following two methods:

1. Off-set all future claims payments from the provider until the amount of the federal share of the overpayment is recovered;
2. The provider will return an amount equal to the overpayment.

If the actual, certified costs exceed the interim Medicaid payments, the DHCFP will pay the federal share of the difference to the provider in accordance with the final actual certification agreement.

The DHCFP will issue a notice of settlement that denotes the amount due to or from the provider.

B. Reimbursement Methodology for Non-residential Mental Health Rehabilitation Services provided by non-governmental entities and governmental entities who do not undergo the Medicaid cost identification and reporting procedures:

Non-residential mental health rehabilitation services:

Examination, Psychiatric Diagnostic Interview – 1 unit per 75 to 80 minutes
Examination, Interactive Psychiatric Diagnostic Interview – 1 unit per 75 to 80 minutes
Individual Psychotherapy – 1 unit per 20 to 30 minutes; or 1 unit per 45 to 50 minutes; or 1 unit per 75 to 80 minutes
Psychoanalysis – 1 unit per 60 minutes
Family Psychotherapy – 1 unit per 60 minutes
Group Psychotherapy – 1 unit per 90 minutes; or 1 unit per 120 minutes
Individual Psychophysiological Therapy – 1 unit per 20 to 30 minutes; or 1 unit per 45 to 50 minutes
Biofeedback – 1 unit per 20 to 30 minutes; or one unit per 40 to 50 minutes
Psychological Testing – 1 unit per 60 minutes
Psychological Testing – 1 unit per 60 minutes
Developmental Testing – 1 unit per 60 minutes
Examination, Neurobehavioral Status – 1 unit per 60 minutes
Neuropsychological Testing – 1 unit per 60 minutes
Neuropsychological Testing – 1 unit per 60 minutes
Assessment, Health and Behavior – 1 unit per 15 minutes
Intervention, Health and Behavior – 1 unit per 15 minutes
Evaluation and Management – 1 unit per 10 minutes; or 1 unit per 15 minutes; or 1 unit per 25 minutes; or 1 unit per 40 minutes
Screening, Behavioral Health – 1 unit per 15 minutes
Out of Office Therapy – 1 unit per 15 minutes
Out of Office Assessment – 1 unit per 90 minutes
Medication training and support, out of office – 1 unit per 15 minutes
Medication training and support in office – 1 unit per 15 minutes
Peer to Peer support, individual – 1 unit per 15 minutes
Crisis Intervention, telephonic, face to face, team – 1 unit per 15 minutes
Day treatment – 1 unit per 15 minutes
Basic Skills Training, individual or group – 1 unit per 15 minutes
Psychosocial rehabilitation, individual or group – 1 unit per 15 minutes

Not all above unit values are billing units, for those codes that have a unit of measure defined as an "encounter" in the current Procedural Coding Expert, the values listed are time comparables for rate development.

1. Non-residential mental health rehabilitation services provided by private entities or governmental entities that do not undergo the Medicaid cost identification and reporting procedures will be reimbursed based on a statewide fee schedule.

Rate Methodology:

The rates are market based. This model is developed to reflect service definitions, provider requirements, operational service delivery and administrative considerations. The following elements are used to determine the rates:

- Wage information is taken from the Bureau of Labor Statistics (BLS). The wage is based on similar occupations reported by BLS and identified by Medicaid staff as comparable to services provided under the mental health rehabilitation program.
- Employee related expenses (ERE) percentage of 27% was based on input from the Task Force members and Medicaid Staff. It includes paid vacation, paid sick leave, holiday pay, health insurance, life insurance, disability, workers compensation and legally required payroll taxes.
- Productivity adjustment factor which accounts for the amount of non-billable time spent by staff. This includes the time staff needs to complete required documentation and record keeping, time associated with missed appointments and average travel time by the provider.
- Program Support costs – costs based on average of four hours per day. This is to assist with paperwork and follow-up related to treatment.
- Allowance for supervisory time – costs for the time directly spent in supervising the medical professional providing these services.
- Allowances for capital costs – the costs are not included in the Administrative overhead. It includes the average hourly expense for building rental and maintenance, equipment leasing and utility expenses.
- Administrative overhead, 10%, is the percentage of service costs that should result from non-direct care activities. It includes insurance, administrative staff, operations and management activities and office supplies. Capital and related expenses is not included. It also does not include staff training.

The following steps are used to determine the rates:

1. The State will use Nevada-specific hourly wages from the Bureau of Labor Statistics.
2. The hourly amount is increased by the 27% ERE.
3. A productivity factor is applied to the hourly compensation calculated in Item 2 to equal to the hourly rate.
4. The adjusted hourly rate per individual is the hourly rate per individual (Item 3) increased by the program support costs per hour per individual, allowance for supervisory time and capital costs per hours.
5. Administrative overhead (10%) is applied to the adjusted hourly rate per individual (Item 4).
6. Total hourly rate is the sum of the adjusted hourly rate per individual before administrative overhead (Item 4) and the administrative overhead (Item 5).
7. Total hourly rate is scaled to the proper unit based on the unit of service.
8. Group rate is the individual rate divided by the group size assumption.

Basic Skills Training rate effective January 1, 2019 was determined using wage information obtained from the provider network through a wage survey.

When a Nevada specific hourly wage cannot be determined using the Bureau of Labor Statistics, the State may use wage information obtained from the provider network.

These rates have been compared to other private sector Fee-for-Service rates. Documentation of the assumptions used, rate development methodology and fee schedule payment rates will be maintained by The Division of Health Care Financing and Policy.

The Agency's rates were set as of January 1, 2006 and are effective for services on or after that date. The Basic Skills Training rate that is established under SPA 18-010 will be effective January 1, 2019. All rates, including the Basic Skills Training rate, are published on the Agency's website at http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/

Services provided by an out-of-state provider require prior authorization by Nevada Medicaid, which must verify that the services required by Medicaid-eligible or pending-eligible clients are not available in Nevada. The out-of-state payment rate for services provided by an out-of-state provider is based on one of the following criteria:

1. The out-of-state provider will be paid the lesser of the provider's billed charges or the Fee-for-Service rate that is paid to an in-state provider for the service.

2. If the out-of-state provider refuses to accept this rate, then the out-of-state provider may be paid the lesser of the provider's billed charges or the same Fee-for-Service rate as it would be paid by its home state Medicaid program.

c. For services that cannot be provided by a provider that accepts payment under (A) or (B), the State will maintain a list of other qualified out-of-state providers and will negotiate competitive rates that will not exceed the provider's customary charge."

For Individuals with Chronic Mental Illness, the following services provided by non-governmental entities and governmental entities who do not undergo the Medicaid cost identification and reporting procedures.

The billable units of service for HCBS Day Treatment or Other Partial Hospitalization Services for Individuals with Chronic Mental Illness are:

Partial Hospitalization – 1 unit per 60 mins
Intensive Outpatient Program – per diem

Rate Methodology:

The rate is market based. This model is developed to reflect service definitions, provider requirements, operational service delivery and administrative considerations. The following elements are used to determine the rate:

- Wage information is taken from the Bureau of Labor Statistics (BLS). The wage is based on similar occupations reported by BLS and identified by Medicaid staff as comparable to services provided under the intensive outpatient program and partial hospitalization program.
- Employee related expenses (ERE) percentage of 27% was based on input from the Task Force members and Medicaid Staff. It includes paid vacation, paid sick leave, holiday pay, health insurance, life insurance, disability, workers compensation, and legally required payroll taxes.
- Productivity adjustment factor which accounts for the amount of non-billable time spent by staff. This includes the time staff needs to complete required documentation and record keeping, time associated with missed appointments and average travel time by the provider.
- Program Support costs – costs based on average of four hours per day. This is to assist with paperwork and follow-up related treatment.
- Allowance for supervisory time – costs for the time directly spent in supervising the medical professional providing these services.
- Allowance for capital costs – the costs is not included in the Administrative overhead. It includes the average hourly expense for building rental and maintenance, equipment leasing and utility expenses.
- Administrative overhead, 10%, is the percentage of service cost that should result from non-direct care activities. It includes insurance, administrative staff, operations and management activities and office supplies. Capital and related expenses is not included. It also does not
- include staff training.

The following steps are used to determine the rates:

1. The State will use Nevada-specific hourly wages from the Bureau of Labor Statistics as of May 2004 inflated to June 2006.
2. The hourly amount is increased by the 27% ERE.
3. A productivity factor is applied to the hourly compensation calculated in Item 2 to equal the hourly rate.
4. The hourly rate per individual is the hourly rate (Item 3) divided by the number of individuals based on staffing ratio assumption.
5. The adjusted hourly rate per individual is the hourly rate per individual (Item 4) increased by the program support costs per hour per individual, allowance for supervisory time and capital costs per hours.
6. Administrative overhead 10% is applied to the adjusted hourly rate per individual (Item 5).
7. Total hourly rate is the sum of the adjusted hourly rate per individual before administrative overhead (Item 5) and the administrative overhead (Item 6).
8. Total hourly rate is scaled to the proper unit based on the billable unit of service.

These rates have been compared to other private sector Fee-for-Service rates. Documentation of the assumptions used, rate development methodology and fee schedule payment rates will be maintained by the DHCFP.

The agency's rates were set as of January 1, 2006 and are effective for services on or after January 1, 2006. All rates are published on the agency's website at: http://dhcfp.nv.gov

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers. The agency's fee schedule rates were set as of July 1, 2013 and are effective for services provided on or after that date. All rates are published on the agency's website: http://dhcfp.nv.gov/Resources/Rates/RatesMain/

14. RESERVED

15. RESERVED

16. RESERVED

17. RESERVED

18. Prior to the beginning of each rate year, governmental providers of emergency medical transportation, ground ambulance services, must select one of the reimbursement methodologies described below. Governmental providers must select their reimbursement methodology by April 30 for the rate year beginning July 1 and will not be able to change the selected reimbursement methodology until the following rate year.

I. Reimbursement methodology for emergency medical transportation, ground or air ambulance services, provided by non-governmental entities and governmental entities that do not undergo the Medicaid cost identification, reporting, reconciliation and settlement procedures.

Emergency Medical Transportation: Ground Ambulance or Air Ambulance (fixed wing or rotary aircraft): lower of: a) billed charge, or b) fixed basic rate plus fixed fee per mile. Effective July 1, 2013, the reimbursement rates will be increased 15%.

II. Reimbursement methodology for emergency medical transportation, ground ambulance services, provided by a government entity which selects cost identification, reporting, reconciliation and settlement.

Governmental entities may select a reimbursement methodology for emergency medical transportation that is based on cost identification, reporting, reconciliation and settlement. This methodology reimburses governmental entities for uncompensated care costs for providing emergency medical transportation services to Nevada Medicaid beneficiaries. Uncompensated care costs are allowable costs in excess of payments made by Nevada Medicaid. This reimbursement will include a base payment per emergency medical transportation claim plus a final supplemental payment adjustment so that total reimbursement does not exceed or fall short of the total cost of providing services to Medicaid beneficiaries.

A. Definitions:

1. "Emergency Medical Transportation" is synonymous with "Emergency Medical Response." It includes both the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient, as well as the advanced, limited-advanced and basic life support services provided to an individual by emergency medical transportation providers before or during the act of transportation.

2. "Emergency Medical Response" is a cost objective that includes expenditures for medical services performed at the point of injury or illness, typically outside of a medical facility, to evaluate or treat a health condition. An emergency medical response is classified as "medical" by dispatch if the primary reason for the response is to provide medicalservices.

3. "Direct costs" means all costs that can be identified specifically with particular final cost objectives in order to meet all medical transportation mandates.

4. "Shared Direct Costs" are direct costs that can be allocated to two or more departmental functions or cost objectives on the basis of shared benefits.

5. "Indirect costs" means costs for a common or joint purpose benefitting more than one cost objective that are allocated to each benefitting objectives using an agency approved indirect rate or an allocation methodology. Indirect costs rate or allocation methodology must comply with 2 CFR, Part 200 and CMS non-institutional reimbursement policies.

6. "Service Period" means the period from July 1st through June 30th of each Nevada state fiscal year.

B. Provider Eligibility for Medicaid Reimbursement Based on Cost Identification.

To be eligible to receive reimbursement based on cost identification for emergency medical transportation, a provider must meet all of the requirements described below:

1. The provider is owned or operated by an eligible government entity to include the state, a city, a county, a consolidated city and county, a fire protection district organized pursuant to Nevada Revised Statutes Chapter 474 or a federally recognized Indian tribe.

2. The provider is enrolled as a Nevada Medicaid provider for the period being claimed.

3. The provider delivers emergency medical transportation services to Nevada Medicaid beneficiaries.

4. The provider has a Cost Allocation Plan (CAP) approved by the State Medicaid Agency on file with the State.

C. Interim Medicaid Payment

1. "Base Payment" is the interim reimbursement paid for each transport as a result of Medicaid claiming by the provider throughout the year. The base payment in the period October 1, 2015 through September 30, 2017 is determined by the Nevada Medicaid Fee-for-Service ambulance fee schedule. For periods beginning October 1, 2017, the base payment is the average cost per transport as determined in the most recent available cost report. The average cost per transport is determined by dividing the total allowable costs of providing emergency medical transportation services by the total number of emergency medical transports.

D. Methodology for Reimbursement of Emergency Medical Transportation Services Based on Cost Identification.

1. A provider's specific allowable cost per-medical transport rate will be calculated based on the provider's audited financial data reported on the CMS-approved cost report. The per-medical transport cost rate will be the sum of actual allowable direct and indirect costs of providing medical transport services divided by the actual number of medical transportation services provided for the applicable service period.

a. Direct costs for providing medical transport services include only the unallocated payroll costs for those emergency response staff who dedicate 100% of their time to providing medical transport services; medical equipment and supplies, and other costs directly related to the delivery of covered services, such as first-line supervision, materials and supplies, professional and contracted services, capital outlay, travel and training. These costs must be in compliance with Medicaid non-institutional reimbursement policies and are directly attributable to the provision of the medical transport services.

b. Shared direct costs for emergency medical transportation services as defined by Section A.1, must be allocated for personnel, capital outlay and other costs; such as, medical supplies, professional and contracted services, training and travel. The personnel costs will be allocated based on the percentage of total hours logged performing emergency medical transportation activities versus other activities. The capital and other direct costs will be allocated based on the percentage of total call volume.

c. Indirect costs are determined based on the provider's approved cost allocation plan.

d. The provider specific per-medical transport cost rate is calculated by dividing the total net medical transport allowable costs (Item 1.a, Item 1.b and Item 1.c) of the specific provider by the total number of medical transports provided by the provider for the applicable service period.

2. Medicaid's portion of the total allowable cost for providing emergency medical transportation services by each eligible provider is calculated by multiplying the total number of Medicaid FFS transports provided by the provider's specific per-medical transport cost rate (Paragraph D.1.d) for the applicable service period.

E. Eligible Provider Reporting Requirements:

Eligible provider shall:

1. Report and certify total computable allowable costs annually on a CMS-approved Nevada Medicaid Emergency Transportation Services Cost Report, which is to be submitted annually by December 1 to the State Medicaid Agency. The Cost Report includes a certification of expenditures statement that states the total costs reported are accurately reported and allowable.

2. Provide documentation to serve as evidence supporting the information on the cost report and the cost determination as specified by the State Medicaid Agency.

3. Keep, maintain and have readily retrievable, such records as specified by the State Medicaid Agency.

4. The provider will comply with the allowable cost requirements provided in 42 CFR, Part 413, 2 CFR, Part 200 and Medicaid non-institutional reimbursement policies.

F. State Medicaid Agency's Responsibilities:

1. The State will submit to CMS claims based on total computable certified expenditures for emergency transportation services provided that are allowable and in compliance with federal laws and regulations and Medicaid non-institutional reimbursement policies.

2. As part of its financial oversight responsibilities, the State will review each provider's Cost Report for reasonableness and accuracy and reconcile the Cost Report to the provider claims data obtained from the Medicaid Management Information System (MMIS). The state will complete the cost report review and settlement process of the interim payments for the service

period within three years of the postmark date of the cost report.

3. If the interim Medicaid payments exceed the actual certified costs of a provider, the State will recoup any overpayments and return the Federal share to the Federal government in accordance with 42 CFR 433.316. If the actual certified costs exceed the interim Medicaid payments, the DHCFP will pay the federal share of the difference to the provider in accordance with the final actual certification agreement.

III. Non-emergency transportation:

A. Non-emergency transportation is authorized through a contracted NET Broker, as specified in Attachment 3.1-D.

B. Reimbursement Methodology for Non-Emergency Paratransit services provided by the Regional Transportation Commission (RTC) operated by local government entities:

1. The lower of: A) billed charges; or b) a cost based rate.

The cost based rate is calculated annually using each public provider's annual operating budget and service utilization forecast and an applicable 10% indirect cost rate. Each public provider will submit an annual operating budget and service utilization forecast at least 60 days before the start of the next fiscal year. The budget forecast must reflect a projection for allowable, necessary and proper direct cost in providing services. The cost based rate is calculated as follows:

a. Direct costs include the costs for fuel, tires and subcontracted costs that are directly related in providing the non-emergency transportation services. These costs must be in compliance with the Medicare reimbursement principle and OMB A-87.

b. The total direct costs (from Item A) are reduced by any federal grant funds received for the same services to arrive at the net allowable direct costs.

c. Indirect costs are determined by applying a ten percent indirect cost rate to the net allowable direct costs (from Item B).

Continued on Page 4 (Addendum)

1. Net allowable costs are the sum of the net allowable direct costs (Item 2) and indirect costs (Item 3).

2. The cost-based rate is the net allowable costs (from Item 4) divided by the total forecasted transportation service utilization.

15. a. Services of Religious non-medical Healthcare Institution nurses: NOT PROVIDED.

b. Services in Religious non-medical Healthcare Institutions sanitoria: NOT PROVIDED.

c. Hospice Services: Reimbursed at the established annual Medicaid rate regardless of billed charges. The agency's rates were set as of October 1, 2008 and are effective for services on or after that date. Rates are adjusted annually each year thereafter in accordance with 42CFR 418.

d. Hospice provided in a long-term care facility: Reimbursed 95% of the nursing facility daily rate for room and board provided by the nursing facility or long-term care facility.

16. Emergency hospital services out-of-state: lower of: a) billed charges, or b) local Medicaid maximums. The agency's rates were set as of July 1, 2005 and are effective for services on or after that date.

17. Personal care services in recipients' home and setting outside the home: fixed hourly rate established by the State of Nevada legislative body.

For personal care services performed on or after January 1, 2020, fixed hourly rate will be determined by multiplying a factor of 1.033 (equal to 3.3%) times the July 1, 2009 rate.

The Agency's rates for personal care services will be updated on January 1, 2020 to reflect the rate increase, as specified above. All rates are published on the Agency's website at http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/.

18. RESERVED

All Targeted Case Management groups will be reimbursed using the following methodologies effective as of July 1, 2009.

23. Targeted Case Management (TCM) services will be reimbursed as follows:

Prior to the beginning of each rate year, each of the governmental providers providing TCM services must select one the reimbursement methodologies described below for reimbursement. For example, by April 30, 2009, governmental providers must select a methodology for the rate year beginning July 1, 2009. Once a selected methodology is determined for a rate year, governmental providers will not be able to change the selected methodology until the following rate year.

A. Reimbursement Methodology for Targeted Case Management Services provided by a non-governmental entity and governmental entities who do not undergo the Medicaid cost identification and reporting procedures:

I. TCM: One unit per 15 minutes.

II. TCM services provided by a private/non-governmental entity and governmental entities that do not undergo the Medicaid cost identification and reporting procedures will be reimbursed the lower of a) billed charges, or b) a fixed quarter hour rate.

III. The quarterly hour rate is a market based model. This model reflects service definitions, provider requirements, operational service delivery and administrative considerations. The following elements are used to determine the rate:

1. Wage Information is taken from the Bureau of Labor Statistics (BLS). The wage is based on similar occupations reported by BLS and identified by Medicaid staff as comparable to CM and TCM services.
2. Employee rated expenses (ERE) percentage of 27% was based on input from the Provider Rates Task Force members and Medicaid Staff. It includes paid vacation, paid sick leave, holiday pay, health insurance, life insurance, disability, workers compensation and legally required payroll taxes.
3. Productivity adjustment factor which accounts for the amount of non-billable time spent by staff. This includes the time staff needs to complete required documentation and record keeping, time associated with missed appointments and average travel time by the provider.
4. Allowance for supervisory time – costs for the time directly spent in supervising the professional providing this CM and/or TCM service.
5. Allowance for capital costs – the costs are not included in the administrative overhead. It includes the average hourly expense, for building rental and maintenance, equipment leasing and utility expenses.
6. Allowance for mileage – the average costs related to the miles to travel to clients.

7. Administrative overhead, 10%, is the percentage of service cost that should result from non-direct care activities. It includes insurance, administrative staff, operations and management activities and office supplies. Capital and related expenses is not included. It also does not include staff training.

IV. The following steps are used to determine the fixed quarter hour rate:

1. The State will use Nevada-specific hourly wages from the Bureau of Labor Statistics.
2. This hourly compensation is increased by the 27% ERE.
3. A productivity factor is applied to the hourly compensation calculated in Item 2 to equal the adjusted hourly rate.
4. Allowance for supervisory time is determined.
5. Administrative overhead (10%) is applied to the sum of adjusted hourly rate (Item 3) and the allowance for supervisory (Item 4).
6. Allowance for mileage cost is determined.
7. Allowance for capital costs is determined.
8. Fixed hourly rate is the sum of adjusted hourly rate (Item 3), allowance for supervisory time (Item 4), administrative overhead (Item 5), allowance for mileage (Item 6), and allowance for capital costs (Item 7).
9. Quarter hour rate is the fixed hourly rate (Item 8) divided by 4.

This rate has been compared to other private sector fee-for-service rates.

Documentation of the assumptions used, rate development methodology, and fee schedule payment rates will be maintained by the DHCFP.

The Agency's rates were set as of January 1, 2006 and are effective for services on or after January 1, 2006. All rates are published on the Agency's website at www.dhcfp.nv.gov

B. Reimbursement Methodology for Targeted Case Management Services provided by a state or local government entity:

Targeted Case Management services provided by a state or local government entity are reimbursed according to one of the following two payment methodologies. The second methodology must be used by providers who undergo all Medicaid cost identification, reporting, reconciliation and settlement procedures.

I. The lower of: a) billed charges; or b) a cost based rate. The cost-based rate is an annual rate developed based on historic costs. Cost based rates will be calculated annually and are determined by dividing estimated reimbursable costs of providing Medicaid-covered services by the projected total direct medical service utilization for the upcoming fiscal period.

Each public provider will submit an annual operating budget and service utilization forecast at least 60 days before the start of the next fiscal year. The budget forecast must reflect a projection for allowable, necessary and proper expenses in providing Medicaid-covered services. Allowable costs are those direct and indirect costs deemed allowable by CMS which are incurred and are proper and necessary to efficiently deliver needed services. Direct costs include unallocated payroll costs and other unallocated costs that can be directly charged to covered medical services. Direct payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct care staff. Other direct costs include costs directly related to the delivery of covered services, such as supervision, materials and supplies, professional and contracted services, capital outlay, and travel. These direct costs are accumulated on the annual cost report, resulting in total direct costs.

The Agency's rates were set as of July 1, 2007 and are effective for services on or after July 1, 2009. All rates are published on the Agency's website at www.dhcfp.nv.gov

II. The lower of: a) billed charges; or b) an interim rate. The Interim rate is the rate for a specific service for a period that is provisional in nature, pending the completion of cost reconciliation and a cost settlement for that period.

To determine the Medicaid-allowable direct and indirect costs of providing Targeted Case Management services the following steps are performed:

1. Interim Rates

Governmental providers are reimbursed on an interim basis for direct medical services per unit of service at the lesser of the provider's billed charges or a provider-specific interim rate. A provider-specific interim rate is an annual rate for the specific services for a period that is provisional in nature, pending the completion of cost reconciliation and a cost settlement for that period. Interim rates are based on program experience and cost data reported during the prior fiscal year.

2. Annual Cost Report Process

Each governmental provider will complete an annual cost report in the format prescribed by Nevada Medicaid in the Medicaid Operations Manual for all medical services delivered during the previous state fiscal year covering July 1 through June 30. The cost report is due on or before December 1 of the year following the close of the reporting period. The primary purposes of the cost report are to:

a. document the provider's total Medicaid-allowable cost for delivering the medical services, including direct costs and indirect costs.
b. reconcile its interim payments to its total Medicaid-allowable costs.

The annual Medicaid Cost Report includes a certification of expenditures statement to be completed, certifying the provider's actual, incurred allocable and allowable costs/expenditures. All filed annual Cost Reports are subject to audit by the DCHFP or its designee.

To determine the Medicaid-allowable direct and indirect costs of providing covered services to Medicaid-eligible clients, the following steps are performed:

A. Settings that are primarily providing medical services:

(a.) Direct costs for covered services include unallocated payroll costs and other unallocated costs that can be directly charged to covered medical services. Direct payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct care staff. Other direct costs include costs directly related to the delivery of covered services, such as supervision, materials and supplies, professional and contracted services, capital outlay and travel. These costs must be in compliance with Medicaid non-institutional reimbursement policy and are accumulated on the annual cost report, resulting in total direct costs.

(b.) Total direct costs from Item (a) are reduced by any amount that is not in compliance with Medicaid non-institutional reimbursement policy and are further reduced by any federal payments for those costs, resulting in adjusted direct costs for covered services.

(c.) Indirect costs are determined by applying the agency specific approved indirect cost rate to its net direct costs. If the provider has no approved indirect cost rate, the allocated indirect costs can be derived from the allocation process through the provider's approved cost allocation plan. These allocated indirect costs are reduced by any unallowable amount based on Medicaid non-intuitional reimbursement policy. The indirect costs details are accumulated on the annual cost report.

(d.) Net direct costs (b) and indirect costs (c) are combined.

(e.) A CMS approved time study is required when providers of service do not spend 100% of their time providing the Targeted Case Management services described in the applicable Section 3.1-A State plan pages and is used to determine the percentage of time that case management service personnel spend on direct Targeted

Case Management services, general and administrative time, and all other activities to account for 100% of the time to assure that there is no duplicate claiming. This CMS approved time study methodology will be used to separate administrative activities and direct services. The direct Targeted Case Management services time study percentage is applied against the net direct and indirect costs.

(f.) Medicaid's portion of total allowable costs is calculated by multiplying the result from item (e) above to the ratio of the total units of service provided to Medicaid eligible clients to the total units of service provided.

(g.) Total Medicaid allowable costs (f) is reduced by any revenue, e.g. Medicaid co-payments, TPL, received for the same services to arrive at the total Medicaid net allocable and allowable costs.

B. Facilities that are used for multiple purposes and the provision of medical services is not the primary purpose:

(a) Direct costs include unallocated payroll costs and medical equipment and supplies. Unallocated payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct care staff.

(b) The Direct costs from Item (a) are reduced by any amount that is not in compliance with Medicaid non-institutional reimbursement policy and are further reduced by any federal payments for those costs, resulting in adjusted direct costs.

(c) Indirect costs are determined by applying the agency specified approved indirect cost rate to its net direct costs (Item b.). If the entity has no approved indirect cost rate, the allocated indirect costs can be derived from the allocation process through the provider's approved cost allocation plan. These indirect costs are reduced by any allowable amount. For these facilities, allowable costs are only those costs that are "directly attributable" to the professional component of providing the medical services and are in compliance with Medicaid non-institutional reimbursement policy. For those costs incurred that "benefit" multiple purposes but would be incurred at the same level if the medical services did not occur are not allowed, e.g., room and board, allocated cost from other related organizations. The indirect cost details are accumulated on the annual cost report.

(d) Net direct costs (Item (b)) and indirect costs (Item (c)) are combined.

(e) A CMS approved time study is required when providers of service do not spend 100% of their time providing the Targeted Case Management services described in the applicable Section 3.1-A State Plan pages and is used to determine the percentage of time that case management service personnel spend on direct Targeted Case Management services, general and administrative time and all other activities to account for 100% of the time to assure that there is no duplicate claiming. This CMS approved time study methodology will be used to separate administrative activities and direct services. The direct Targeted Case Management services time study percentage is applied against the net direct and indirect costs.

(f) Medicaid's portion of the total net allocable and allowable costs is calculated by multiplying the result from Item (e) above to the ratio of total units of service provided to Medicaid eligible clients to the total units of service provided.

(g) Total Medicaid allowable costs (Item f) is reduced by any revenue received for the same services, e.g. Medicaid co-payments and TPL, to arrive at the total Medicaid net allocable and allowable costs.

3. Cost Reconciliation Process

Governmental providers will be responsible for reconciling total computable costs reported on the cost report to the provider's Medicaid interim payments for Medicaid services delivered during the reporting period as document in the MMIS, resulting in cost reconciliation. The cost reconciliation process must be completed within twenty-four months of the end of the reporting period covered by the annual Cost Report.

4. Cost Settlement Process

If a governmental provider's interim payments exceed the actual, certified costs of the provider for services to Medicaid clients, the DHCFP will recoup the federal share of the overpayment using one of the following two methods:

1. Off-set all future claims payments from the provider until the amount of the federal share of the overpayment is recovered;

2. The provider will return an amount equal to the overpayment.

If the actual, certified costs exceed the interim Medicaid payments, the DHCFP will pay the federal share of the difference to the provider in accordance with the final actual certification agreement.

The DHCFP will issue a notice of settlement that denotes the amount due to or from the provider.

24. RESERVED

25. Newly developed Current Procedural Terminology (CPT) codes determined to be for Nevada Medicaid covered services: Codes for those services with a rate methodology which uses resource based relative value scale (RBRVS), as specified elsewhere in this Attachment, will be entered into the system using the Nevada specific unit value developed by Medicare. The 2014 Medicare Physician Fee Schedule conversion factor will be used to calculate payment for these newly developed codes where the RBRVS is used. The maximum allowable will be established by multiplying the unit value and the 2014 conversion factor and then paying the appropriate percentage, as specified elsewhere in this Attachment, based on the provider type, service type and CPT code range.

    If a code is billed that has no Nevada specific Medicare rate, the Division will determine if there is national Medicare pricing. If so, the service will be paid at the appropriate percentage of the rate, as specified elsewhere in this Attachment. If there is no national Medicare pricing, the Division will establish pricing based on similar services.

(Reserved for Future Use)

(Reserved for Future Use)

26. Surgical services provided in both hospital-based and freestanding Ambulatory Surgical Centers (ASC)

a. Payments for services billed by hospital-based and freestanding Ambulatory Surgical Centers (ASC) will be calculated using the Centers for Medicare & Medicaid Services (CMS) Ambulatory Payment Classification (APC) grouping as published in 42 CFR Parts 405, 410, 412 ,413, 416 and 419. A Nevada ASC Base Rate will be established for each service by multiplying the associated 2016 ASC payment weight from the APC group (found in CMS-1633-FC-Addenda file) by the 2016 ASC conversion factor of 44.177 (found in CMS–1633–FC; CMS–1607–F2), then multiplying the result by the 2016 NV Wage Index of 0.9299 (Found in CMS-1633-FC Wage Index file).

1. Surgical Codes 10000 – 58999 and 60000 – 69999 will be reimbursed at 85% of the NV ASC Base Rate.

b. Services that CMS identifies as excluded from payment in an ASC setting, but are deemed appropriate to be performed in that setting by NV Medicaid Policy, will be paid using the CMS Outpatient Prospective Payment System (OPPS) relative weight from the associated APC group for that service in place of the ASC payment weight to establish the NV ASC Base Rate.

c. In the case of multiple procedures, the following adjustments to the fee schedule are made:

1) First procedure 100% of fee schedule
2) Second procedure 50% of fee schedule
3) Third procedure 25% of fee schedule
4) Fourth procedure 10% of fee schedule
5) Fifth and thereafter procedures 5% of fee schedule

d. Professional services are reimbursed as indicated in Page 1c of Section 4.19-B.

e. Cornea Procurement will be reimbursed at 100% of the procurement charges as listed in the 2013 The Lewin Group Study.

Assurance: Except as otherwise noted in the plan, state developed fee schedule rates are the same for both public and private providers of the service. The agency's outpatient surgery (ASC) fee schedule rates were set as of January 1, 2017 and are effective for services provided on or after that date. All rates are published on our website: http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/

Methods and Standards Used to Determine Payment
For Emergency Medical Services for Illegal Aliens

Hospital, emergency clinics and county social service/welfare departments have been informed about the availability of emergency medical services and application procedures for aliens who have not been lawfully admitted for permanent residence or otherwise are not permanently residing in the United States under color of law.

When a hospital, clinic or county social service department determines a person receiving emergency services is indigent and an illegal alien, the alien will be referred to the State Welfare Division District Office for application. If the applicant is unable or reluctant to go to the Welfare District Office, the hospital/clinic/social service department will assist the applicant in completing the application and gathering verification and will send the application and verification to the Welfare District Office with the billing(s).

The District Office eligibility worker will request from the provider a bill or other evidence services were rendered and will obtain an application (if not already completed) and necessary verifications/information. The eligibility worker will approve eligibility for the months in which services were rendered and the applicant meets income/resource and other criteria (e.g., disability or incapacity). (A Medicaid card will not be issued to the client.) Providers will be notified of client eligibility so applicable bills may be submitted to the Medicaid fiscal agent for payment determination and processing based on whether the alleged qualifying services actually met the emergency criteria. The fiscal agent will notify providers of the reason for any payment denial.

Medicaid will make payment only for the alien's care and services which are necessary for the treatment after sudden onset of an emergency medical condition. As defined in Section 1903(v), an "emergency medical condition means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

(A) placing the patient's health in serious jeopardy,

(B) serious impairment to bodily functions, or

(C) serious dysfunction of any bodily organ or part.

Payment for Qualified Medicare Beneficiaries (QMBs)

For Qualified Medicare Beneficiaries, Nevada Medicare will pay the Medicare deductibles and coinsurance subject to the following limitation: The Medicare payment (allowable charge) plus the deductible and coinsurance may not exceed the Medicaid maximum allowable payment. For Medicare services, which are not covered by Nevada Medicaid, or for which Nevada Medicaid does not have an established payment rate, Nevada Medicaid will pay the Medicare deductible and coinsurance amounts.

QMB claims for services which are covered by Medicare are not subject to Medicaid limitations. Medicaid will reimburse the deductible and coinsurance up to the Medicaid maximum allowable payment. Also, prior authorization is not required for Medicare allowable services for dually entitled QMBs. If Medicare benefits are exhausted or Medicare does not cover the service and the service is covered by Medicaid, prior authorization is required if the service or benefit normally requires it.

REIMBURSEMENT FOR INDIAN HEALTH SERVICE TRIBAL 638 HEALTH FACILITIES

Nevada Medicaid reimburses Indian Health Services facilities and Tribal 638 facilities in accordance with the most recently published Federal Register.

The published, all inclusive, rate is paid for up to five face-to-face encounters/visits per eligible Medicaid recipient per day. Encounters/visits are limited to healthcare professionals as approved under the Nevada Medicaid State Plan.

Alternative Payment Methodology for Tribal Facilities Recognized as FQHCs

Outpatient health programs or facilities operated by a Tribe or Tribal organization that choose to be recognized as FQHCs in accordance with Section 1905 (I)(2)(B) of the Social Security Act and the Indian Self-Determination Act (Public Law 93-638) will be paid using an alternative payment methodology (APM) for services as described on Attachment 3.1-A, Page 1a, Paragraph 2c, that is the published, all-inclusive rate (AIR). The APM/AIR rate is paid for up to five face-to-face encounters/visits per recipient per day.

Nevada Medicaid will establish a Prospective Payment System (PPS) methodology for the Tribal facility so that the agency can determine on an annual basis that the published, all-inclusive rate is higher than the PPS rate. The PPS rate will be established by reference to payments to one or more other FQHCs in the same or adjacent areas with similar caseloads. If such an FQHC is not available, the PPS rate will be established by reference to payments to one or more other FQHCs in the same or adjacent areas with a similar scope of services. If there is no FQHC in the same or adjacent area with similar caseloads or similar scope of services, the PPS rate will be based on an average rate of other FQHCs throughout the state. The Tribal facility would not be required to report its costs for the purposes of establishing a PPS rate. The APM is effective for services provided on and after April 1, 2019.

Enhanced Rates for Practitioner Services
Delivered in a Teaching Environment

In order to ensure access to practitioner services by needy individuals in the state of Nevada and to recognize the higher cost of providing practitioner services in a teaching environment, enhanced payments will be made for services provided by Designated Practitioners through one of the following four eligible public teaching entities:

- University of Nevada, Las Vegas School of Dental Medicine
- University of Nevada, Las Vegas School of Medicine
- University of Nevada, Reno School of Medicine
- University Medical Center of Southern Nevada

Enhanced payments apply to claims paid on or after July 1, 2017 to Medicaid-enrolled Designated Practitioners providing approved Medicaid services through one of the eligible public teaching entities under the Nevada Medicaid State Plan. Medicaid Services must be billed under the Medicaid Billing Provider ID of a Designated Billing Provider.

The State of Nevada DHCFP must concur with the public teaching entity's designation of eligible practitioners in order for the payment adjustment to be applied.

The following Designated Practitioners are eligible for enhanced payments:

- Advanced Practitioner of Registered Nursing (APRN)
- Audiologist
- Clinical Psychologist
- Dentist
- Licensed Clinical Professional Counselor, Intern or Psychological Assistant
- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Nurse Practitioner
- Licensed Registered Nurse
- Oral Surgeon
- Physician (MD or DO)
- Physician Assistant (PA-C)
- Speech Pathologist
- Optometrist
- Ophthalmologist
- Registered Dietician
- Registered Behavioral Technician

Rehabilitative Services: Certified Community Behavioral Health Center (CCBHC)

The Medicaid program will provide coverage for a bundle of medically necessary rehabilitative services under "Service Array" in Attachment 3.1A provided by practitioners employed by, or associated with, provider entities to be known as Certified Community Behavioral Health Center (CCBHCs). CCBHCs are provider entities certified by the Nevada Department of Public and Behavioral Health (DPBH) as meeting the State's qualifications for a CCBHC.

The State agency will reimburse CCBHC practitioners a facility-specific bundled daily rate applicable to providers affiliated with CCBHCs.

These cost-based rates reflect the center's unique costs and they ensure that CCBHCs receive at least their costs for providing services to Medicaid members. Payments will be limited to one payment per day, per recipient, regardless of the number of services received within a single day by center users accessing services from CCBHC practitioners. Encounters with more than one health practitioner and multiple encounters with the same health practitioner that take place on the same day and that share the same or like diagnoses constitute a single billable encounter. This also applies to encounters with multiple CCBHC providers in the same day. Only providers affiliated with the CCBHC who are designated as the principle behavioral health provider and holds the plan of care, will be issued a facility-specific bundled daily rate.

The CCBHC bundled daily reimbursement methodology is effective for services provided on and after August 1, 2019.

Interim bundled daily rate for year one (new facilities without an established rate)

The State will allow the use of anticipated allowable costs to determine first year bundled daily rates. To determine the interim bundled daily rate for the first year of CCBHC operations, the State will:

- Utilize the CCBHC Cost Report as reviewed by the Centers for Medicare and Medicaid Services (CMS) to calculate the bundled per visit rate by dividing total allowable anticipated CCBHC services by total anticipated CCBHC visits.
- Allowable CCBHC cost include total direct cost of CCBHC services plus indirect cost applicable to CCBHC services.
    - Direct CCBHC cost include the actual salaries and benefits of Medicaid qualified providers, costs of services provided under agreement, and other direct CCBHC costs such as medical supplies or professional lability insurance specific to the CCBHC program. The CCBHC will also be required to identify the costs of providing "non-CCBHC services," so that related indirect costs can be excluded from the rate. Examples of "non-CCBHC" services that a community behavioral health provider might provide include psychiatric residential treatment programs and habilitative services for developmentally disabled individuals.

- Indirect costs include site and administrative costs associated with providing all clinic services, including both CCBHC and non-CCBHC services. Indirect costs are allocated based on a pro-rated share of CCBHC costs to non-CCBHC costs.

- Total CCBHC visits include all visits for CCBHC services, including both Medicaid and non-Medicaid visits. A CCBHC "visit" or an "encounter" for the purposes of reimbursing CCBHC services is defined as face-to-face contact with one or more qualified health professionals that take place on the same day with the same patient.

Reconciliation of bundled daily rate following year one

After the first year of operation, the CCBHC will be required to submit a cost report inclusive of all actual costs to provide services for the first year of operations to calculate the bundled per visit rate by dividing total allowable CCBHC services by total CCBHC visits. Cost and visit data vary based on CCBHC size, location, economy, and scope of services offered and must adhere to 45 Code of Federal Regulations (CFR) 75 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for the US Department of Health and Human Services (HHS) Awards and 42 CFR 413 Principles of Reasonable Cost Reimbursement. The CCBHC must submit all required documentation of actual costs for the first full year of providing services to Division of Health Care Financing and Policy (DHCFP) no later than 150 calendar days or 5 months after the first year of operations as a CCBHC. DHCFP will deem cost reports complete within 15 days of receipt. CCBHCs with missing documentation will be issued a cost report request letter, identifying missing documentation necessary to complete the cost report. The CCBHC will have 30 days from the date of the cost report request letter to submit additional documentation. If a CCBHC does not submit the required documentation to complete their cost report within 30 days, DHCFP reserves the right to suspend their Medicaid payments or require the CCBHC to pay back state Medicaid program payments received during the fiscal year period for which they were to provide a complete cost report. This process will remain in effect until the CCBHC has provided a complete cost report.

The DHCFP will conduct an annual settlement based on the difference in the anticipated costs used to inform the interim year one rate and the actual year one costs as determined by the cost report. The settlement will apply to all claims from the first day of services until the day the new rate is determined, which could result in a payout or a recoupment. CCBHCs will continue to be reimbursed at the year one rate until the determination of payment or recoupment is determined and the final bundled daily rate is calculated. Reconciliation will be completed within 18 months of deeming the cost report complete.

Bundled daily rate for year two

Once the daily bundled rate has been calculated using actual costs on the CCBHC cost report submitted after the end of year one, the rate effective date will be aligned with the start date of year two.

Bundled daily rate for year three onward

Thereafter, for each consecutive year on July 1st (SFY) the bundled daily rate will be trended by the current Medicare Economic Index (MEI) for primary care services as defined in Section 1842(i)(3) of the Social Security Act, which is intended to account for the basic cost increases associated with providing such services.

Bundled daily rates will not be subject to rebasing after the year 2 rate is set.

Quality Incentive Payments

All CCBHC practitioners are eligible for a Quality Incentive Payment (QIP) based on achieving specific numerical thresholds with regard to state mandated performance measures. The performance period shall be a state fiscal year (7/1-6/30). The eligibility of each CCBHC practitioner to receive a QIP is judged independently; and in order for a provider to receive a QIP, the CCBHC must achieve the thresholds on all of state mandated performance measures. A CCBHC will have met the particular performance measure by meeting or exceeding the posted improvement target goal for the measure. If the State chooses a measure for which there is no improvement target goal, the CCBHC can achieve the threshold for that measure by meeting or exceeding statewide mean for the measure. Performance measures shall be calculated exclusively on the basis of data for Medicaid beneficiaries, excluding beneficiaries dually eligible for the Medicaid and Medicare programs.

Each CCBHC will be required to submit electronic health record data to the State on a quarterly basis for calculation of the measures on an ongoing basis. CCBHCs that fail to submit all required data within six months following the end of the performance year will not be eligible for a QIP. Final results of the performance of each CCBHC on the required measures will be posted by June 30 of each year on DPBH website CCBHC pages and shared directly with each CCBHC.

DPBH shall establish the minimum patient volume in each performance measure denominator necessary for the performance measure to be valid. The amount of QIP to a CCBHC will be based on multiplying the total facility-specific bundled rate payments made to the CCBHC in the performance period by a statewide percentage not to exceed 10% based on pay for reporting requirements in the first year and 15% in each consecutive year based on pay for performance and pay for reporting requirements.

In the first year a 10% QIP is issued for submitting the required datasets, if a full year is reported. For a CCBHC practitioner who comes online partially through a fiscal year and a full year of data is not submitted, then a prorated amount will be paid for each month reported. For example, a CCBHC practitioner who came online effective January 1 would be eligible for 50% of the payment they would otherwise be eligible for the entire year.

In the second and subsequent years a 5% QIP will be issued if the required datasets are submitted. An additional 10% can be added to this payment and is broken down into 8.5% payment for attaining performance on all 6 required measures with another possible 1.5% payment for attaining performance for 1 optional measure (Plan All-Cause Readmission Rate).

When applicable, QIPs will be made in a lump sum payment, within 1 year following the end of the relevant measurement year (July 1 to June 30), and after all final data needed to calculate the QIP is received.

The state mandated QIP performance measures, technical specifications, patient volume minimums and target numerical thresholds for each measure are effective August 1, 2019 and are located at http://dpbh.nv.gov/Reg/CCBHC/CCBHC-Main/.

For the purposes of these enhanced payments for services provided by Designated Practitioners delivered in a teaching environment, the following definitions shall apply:

- Designated Practitioner means an individual practitioner or a practitioner group designated by one of the eligible public teaching entities as participating in medical education programs. To qualify for designation as a Designated Practitioner, the practitioner or practitioner group must be either an employee of the designating eligible public teaching entity or under contract with the designating eligible public teaching entity. Designations may apply to both public and private practitioners and practitioner groups.

- Designated Billing Provider means one of the eligible public teaching entities or a billing provider/provider group that facilitates meaningful medical education and is contracted by the designating eligible public teaching entity for billing Medicaid services provided by the Designated Practitioners.

  Medicaid Services means Fee-for-Service (FFS) practitioner services enumerated by Healthcare Common Procedure Coding System (HCPCS)/Common Procedural Terminology (CPT)/Code on Dental Procedures (CDT)/Code, delivered to Medicaid eligible recipients, and paid during the Claims Payment Period. The source of the service and payment data shall be the Nevada MMIS.

- The following services are excluded from the enhanced payment:

  - Services delivered to Medicaid eligible recipients enrolled in Medicaid Managed Care Organizations or Pre-Paid Ambulatory Health Plans (PAHP).
  - Clinical diagnostic lab procedures
  - Services provided to Medicaid recipients also eligible for Medicare
  - The technical component of radiological services
  - Services provided by practitioners/practitioner groups not designated by one of the eligible public teaching entities as Designated Practitioners for the entire Claims Payment Period
  - Services not billed by a Designated Billing Provider

- Medicaid Base Rate(s) means the applicable Medicaid FFS reimbursement rate(s) published by the DHCFP, applicable on the date of service.

- Claims Payment Period means the three-month period directly prior to the first day of each payment quarter.

- Base Period means the state fiscal year (July 1 – June 30) prior to the Claims Payment Period.

- Average Commercial Rate (ACR) means, for each procedure (HCPCS/CPT/CDT) code, the average reimbursement amount of the top five commercial payers to the public teaching entity. "Commercial payers" exclude Medicare, Workers Compensation and any other payer(s) not subject to market forces. The ACR for each procedure code is established separately for each public teaching entity every Base Period.

If an eligible public teaching entity's contracts with commercial payers do not include a rate for a Medicaid Service delivered by a Designated Practitioner, and the Designated Billing Provider's contracts with commercial payers do include a rate for the Medicaid Service, the designating public teaching entity's average ACR percentage increase over the Medicaid Base Rates will be applied to the Medicaid Base Rate for the Medicaid Service.

If an eligible public teaching entity does not have contracts in place with commercial payers during a Base Period, the ACRs will be calculated based on the public teaching entity's contracts with commercial payers in effect during the Claims Payment Period.

The enhanced payment for each eligible service will be the lesser of:

- The difference between Billed Charges and the Medicaid Base Rate.
- The difference between 100% of the ACR and the Medicaid Base Rate.

Each eligible public teaching entity will provide the following listings to the DHCFP no later than the fifth business day of the first month of a quarter:

- A list of Designated Practitioners to include the Practitioner Name, Practitioner National Provider Identification number (NPI), Designation Start Date, Designation End Date (if applicable) for the prior quarter.
- A list of Designated Billing Providers to include the Billing Provider Name, Billing Provider ID, Designation Start Date, Designation End Date (if applicable) for the prior quarter.

No later than the last business day of the first month of the quarter, the DHCFP will provide a separate report to each eligible public teaching entity which includes the utilization data for the services paid during the Claims Payment Period that were billed by their Designated Billing Providers and delivered by their Designated Practitioners. The public teaching entity must review the report and acknowledge the completeness and accuracy of the report no later than the last business day of the second month of the quarter. After receipt of this acknowledgement, the DHCFP will approve and process the quarterly enhanced payments for each Designated Billing Provider no later than the last business day of the last month of the quarter. The process includes a reconciliation that takes into account all valid claim replacements affecting claims previously processed, as well as a process for recoupment of erroneous enhanced payments.

The enhanced payments will be sent to the Designated Billing Providers through the identification number used to bill Medicaid under the FFS program.

End Stage Renal Disease (ESRD) Dialysis Procedure Payment and ESRD Facilities

Hemodialysis (HD) and peritoneal dialysis (PD) services, CPT Codes 90999 and 90945 respectively, will be paid the lower of 1.) billed charges, or 2.) a fixed fee. Dialysis services are all services provided in conjunction with the dialysis treatment as defined in the Medicare ESRD Facility Prospective Payment System.

The bundled prospective payment rate will be set according to the most current Centers for Medicare & Medicaid Services (CMS) ESRD Prospective Payment System base rate. The bundled rate will include all resources used in providing outpatient dialysis treatment, including biological, drugs and laboratory services.

The fixed fee for 90999 (HD) will be 100% of the Medicare ESRD Prospective Payment System (PPS) base rate multiplied by the current ESRD Wage Index Locality Factor for Nevada for independent and hospital-based facilities. The fixed fee for 90945 (PD) is set as an HD-equivalent session. This is accomplished by dividing HD rate by seven, and multiplying the result by three.

Vaccine Products require a National Drug Code (NDC) and will be reimbursed according to the drug reimbursement algorithm set forth on Page 3 of Attachment 4.19-B.

Assurance: Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of ESRD services. The agency's fee schedule rates were set as of January 1, 2017, and are effective for services on or after that date. All rates are published on the agency's website at: http://dhcfp.nv.gov/Resources/Rates/RatesMain/.

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Methods and Standards for Establishing Payment Rates

1. **Services Provided Under Section 1915(i) of the Social Security Act.** For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates*):

☐	HCBS Case Management
☐	HCBS Homemaker
☐	HCBS Home Health Aide
☐	HCBS Personal Care
☒	HCBS Adult Day Health
	Reimbursement Methodology for Adult Day Health Care (ADHC) Services provided by a non-governmental entity and governmental entities who do not undergo the Medicaid cost identification and reporting procedures: Prior to the beginning of each rate year, each of the governmental providers providing ADHC services must select one of the reimbursement methodologies described below for reimbursement. For example, by April 30, 2013, governmental providers must select a methodology for the rate year beginning July 1, 2013. Once a selected methodology is determined for a rate year, governmental providers will not be able to change the selected methodology until the following rate year. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of ADHC services. The Agency's rates were set as of October 1, 2017 and are effective for services on or after that date. All rates are published on the Agency's website at http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/. The billable unit of service for ADHC is one unit per 15 minutes or the daily rate. • If services are authorized and provided for less than six hours per day, provider should bill one unit for each 15 minutes; • If services are authorized and provided for six hours or more per day, provider should bill the per diem rate.

Rate Methodology:

The rate is market based. This model is developed to reflect service definitions, provider requirements, operational service delivery and administrative considerations. The following elements are used to determine the rate:

- Wage information is taken from the Bureau of Labor Statistics (BLS). The wage is based on similar occupations reported by BLS and identified by Medicaid staff as comparable to ADHC services.
- Employee related expenses (ERE) percentage of 27% was based on input from the Task Force members and Medicaid Staff. It includes paid vacation, paid sick leave, holiday pay, health insurance, life insurance, disability, workers compensation, and legally required payroll taxes.
- Productivity adjustment factor which accounts for the amount of non-billable time spent by staff. This includes the time staff needs to complete required documentation and record keeping, time associated with missed appointments and average travel time by the provider.
- Administrative overhead, 10%, is the percentage of service cost that should result from non-direct care activities. It includes insurance, administrative staff, operations and management activities and office supplies. Capital and related expenses is not included. It also does not include staff training.
- Allowances for capital costs – the costs are not included in the Administrative overhead. It includes the average hourly expense for building rental and maintenance, equipment leasing and utility expenses.

The following steps are used to determine the rate:

1. The State will use Nevada-specific hourly wages from the Bureau of Labor Statistics as of May 2004 inflated to June 2006.
2. This hourly compensation is increased by the 27% ERE.
3. A productivity factor is applied to the hourly compensation calculated in Item 2 to equal to the adjusted hourly rate.
4. Administrative overhead (10%) is applied to the adjusted hourly rate (Item 3).
5. Determine allowance for capital costs per hour.
6. Fixed hourly rate is the sum of adjusted hourly rate (Item 3), administrative overhead (Item 4) and capital costs (Item 5).
7. Fixed hourly rate is scaled to the proper unit based on the procedure code.

This rate has been compared to government entities who do not follow all cost reporting rules and other private sector fee-for-service rates. Documentation of the assumptions used, rate development methodology, and fee schedule payment rates will be maintained by the Division of Health Care Financing and Policy (DHCFP).

A. Reimbursement Methodology for Adult Day Health Care (ADHC) services provided by a state or local government entity:

ADHC services provided by a state or local government entity are reimbursed according to the following payment methodology. This methodology is used by providers who undergo all Medicaid cost identification, reporting, reconciliation and settlement procedures.

I. The lower of: a) billed charges; or b) an interim rate. The Interim rate is the rate for a specific service for a period that is provisional in nature, pending the completion of cost reconciliation and a cost settlement for that period.

To determine the Medicaid-allowable direct and indirect costs of providing Adult Day Health Care Services the following steps are performed:

1. Interim Rates

Governmental providers are reimbursed on an interim basis for direct medical services per unit of service at the lesser of the provider's billed charges or a provider-specific interim rate. A provider-specific interim rate is an annual rate for the specific services for a period that is provisional in nature, pending the completion of cost reconciliation and a cost settlement for that period. Interim rates are based on program experience and cost data reported during the prior fiscal year.

2. Annual Cost Report Process

Each governmental provider will complete an annual cost report in the format prescribed by Nevada Medicaid for all medical services delivered during the previous state fiscal year covering July 1 through June 30. The cost report is due on or before December 1 of the year following the close of the reporting period.

The primary purposes of the cost report are to:

a) document the provider's total Medicaid-allowable cost for delivering the medical services, including direct costs and indirect costs.

b) reconcile its interim payments to its total Medicaid-allowable costs.

The annual Medicaid Cost Report includes a certification of expenditures statement to be completed, certifying the provider's actual, incurred allocable and allowable costs/expenditures. All filed annual Cost Reports are subject to audit by the DHCFP or its designee.

B. Settings that are primarily providing medical services:

a) Direct costs for covered services include unallocated payroll costs and other unallocated costs that can be directly charged to covered medical services. Direct

payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct care staff. Other direct costs include costs directly related to the delivery of covered services, such as supervision, materials and supplies, professional and contracted services, capital outlay and travel. These costs must be in compliance with Medicaid non-institutional reimbursement policy and are accumulated on the annual cost report, resulting in total direct costs.

b) Total direct costs from Item (a) are reduced by any amount that is not in compliance with Medicaid non-institutional reimbursement policy and are further reduced by any federal payments for those costs, resulting in adjusted direct costs for covered services.

c) Indirect costs are determined by applying the cognizant agency approved indirect cost rate to its net direct costs. If the provider has no approved indirect cost rate, the allocated indirect costs can be derived from the allocation process through the provider's approved cost allocation plan. These allocated indirect costs are reduced by any unallowable amount based on Medicaid non-institutional reimbursement policy. The indirect cost details are accumulated on the annual cost report.

d) Net direct costs (b) and indirect costs (c) are combined.

e) A CMS approved time study is required when providers of service do not spend 100% of their time providing the ADHC services described in the applicable section 3.1-A State Plan pages and is used to determine the percentage of time that service personnel spend on direct ADHC.

f) Services, general and administrative time, and all other activities to account for 100 Services, general and administrative time and all other activities to account for 100 per percent of the time to assure that there is no duplicate claiming. This CMS approved time study methodology will be used to separate administrative activities and direct services. The direct Adult Day Health Care Services time study percentage is applied against the net direct and indirect costs

g) Medicaid's portion of total allowable costs is calculated by multiplying the result from item (e) above to the ratio of the total units of service provided to Medicaid eligible clients to the total units of service provided.

h) Total Medicaid allowable costs (f) is reduced by any revenue, e.g. Medicaid co-payments, TPL, received for the same services to arrive at the total Medicaid net allocable and allowable costs.

C. Facilities that are used for multiple purposes and the provision of medical services is not the primary purpose:

a) Direct costs include unallocated payroll costs and medical equipment and supplies. Unallocated payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct care staff.

b) The Direct costs from Item (a) are reduced by any amount that is not in compliance with Medicaid non-institutional reimbursement policy and are further reduced by any federal payments for those costs, resulting in adjusted direct costs.

c) Indirect costs are determined by applying the cognizant agency approved indirect cost rate to its net direct costs (Item b.). If the entity has no approved indirect cost rate, the allocated indirect costs can be derived from the allocation process through the provider's approved cost allocation plan. These indirect costs are reduced by any allowable amount. For these facilities, allowable costs are only those costs that are "directly attributable" to the professional component of providing the medical services and are in compliance with Medicaid non-institutional reimbursement policy. For those costs incurred that "benefit" multiple purposes but would be incurred at the same level if the medical services did not occur are not allowed, e.g., room and board, allocated cost from other related organizations. The indirect cost details are accumulated on the annual cost report.

d) Net direct costs (Item (b)) and indirect costs (Item (c)) are combined.

e) A CMS approved time study is required when providers of service do not spend 100% of their time providing the Adult Day Health Care Services described in the applicable section 3.1-A State Plan pages and is used to determine the percentage of time that service personnel spend on direct Adult Day Health Care Services, general and administrative time, and all other activities to account for 100 percent of the time to assure that there is no duplicate claiming. This CMS approved time study methodology will be used to separate administrative activities and direct services. The direct Adult Day Health Care Services time study percentage is applied against the net direct and indirect costs.

f) Medicaid's portion of the total net allocable and allowable costs is calculated by multiplying the result from Item (e) above to the ratio of total units of service provided to Medicaid eligible clients to the total units of service provided.

g) Total Medicaid allowable costs (Item f) is reduced by any revenue received for the same services, e.g. Medicaid co-payments and TPL, to arrive at the total Medicaid net allocable and allowable costs.

1. Cost Reconciliation Process

Governmental providers will be responsible for reconciling total computable costs reported on the cost report to the provider's Medicaid interim payments for Medicaid services delivered during the reporting period as documented in the MMIS, resulting in cost reconciliation. The cost reconciliation process must be completed within twenty-four months of the end of the reporting period covered by the annual Cost Report.

2. Cost Settlement Process

If a governmental provider's interim payments exceed the actual, certified costs of the provider for services to Medicaid clients, the DHCFP will recoup the federal share of the overpayment using one of the following two methods:

1. Off-set all future claims payments from the provider until the amount of the federal share of the overpayment is recovered;
2. The provider will return an amount equal to the overpayment.

If the actual, certified costs exceed the interim Medicaid payments, the DHCFP will pay the federal share of the difference to the provider in accordance with the final actual certification agreement.

The DHCFP will issue a notice of settlement that denotes the amount due to or from the provider.

Services provided by an out-of-state provider require prior authorization by Nevada Medicaid, which must verify that the services required by Medicaid-eligible or pending-eligible clients are not available in Nevada. The out-of-state payment rate for services provided by an out-of-state provider is based on one of the following criteria:

a. The out-of-state provider will be paid the lesser of the provider's billed charges or the fee-for-service rate that is paid to an in-state provider for the service.

b. If the out-of-state provider refuses to accept this rate, then the out-of-state provider may be paid the lesser of the provider's billed charges or the same fee-for-service rate as it would be paid by its home state Medicaid program.

c. For services that cannot be provided by a provider that accepts payment under (A) or (B), the State will maintain a list of other qualified out-of-state providers and will negotiate competitive rates that will not exceed the provider's customary charge.

	Fixed hourly rate is scaled to the proper unit based on the procedure code. This rate has been compared to other private sector Fee-for-Service rates. Documentation of the assumptions used, rate development methodology, and fee schedule payment rates will be maintained by The Division of Health Care Financing and Policy. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of ADHC services. The agency's rates were set as of October 1, 2017 and are effective for services on or after that date. All rates are published on the agency's website at: http://dhcfp.nv.gov/Resources/Rates/FeeSchedules/
☒	HCBS Habilitation
	Rates paid to the private providers for: Day Habilitation, and Residential Support Services were set in 2002 by the Nevada Provider Rates Task Force. EP&P consultant was contracted by the DHCFP to conduct an analysis of provider rates and make recommendations on rate-setting. The base rate for these services were developed and adopted by the DHCFP using a provider cost survey and market analysis. The rates are comprised of 1. The level of staffing (FTEs) per billing unit; 2. The wage level for supervisor and direct care staff using wage information from the Bureau of Labor Statistics; 3. Employee related expenses at 27% which includes benefits such as paid vacation, paid sick leave, holiday pay, health insurance, etc.; amount of non-billable time spent by staff (productivity adjustment at 30 minutes per day) as well as staff training time; 4. 15% was added to the hourly direct care and ERE cost for non-direct care activities. This is the base rate for these services. Public testimony is allowed during the Legislative process when rate increases are proposed through the budget process. The base rate is the same for all private providers.

☐	HCBS Respite Care	
For Individuals with Chronic Mental Illness, the following services:		
	☐	HCBS Day Treatment or Other Partial Hospitalization Services
	☐	HCBS Psychosocial Rehabilitation
	☐	HCBS Clinic Services (whether or not furnished in a facility for CMI)

☐	Other Services (specify below)

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2. Presumptive Eligibility for Assessment and Initial HCBS. Period of presumptive payment for HCBS assessment and initial services, as defined by 1915(i)(1)(J):

☒ The State does not elect to provide for a period of presumptive payment for individuals that the State has reason to believe may be eligible for HCBS.

☐ The State elects to provide for a period of presumptive payment for independent evaluation, assessment, and initial HCBS. Presumptive payment is available only for individuals covered by Medicaid that the State has reason to believe may be eligible for HCBS, and only during the period while eligibility for HCBS is being determined. The presumptive period will be 60 days (not to exceed 60 days).

1. OUTPATIENT HOSPITAL SUPPLEMENTAL PAYMENTS

This section of the state plan contains the provisions for making additional Medicaid payments, in order to preserve access to outpatient hospital services for needy individuals in the state of Nevada. Effective for services provided on or after March 1, 2010, the state's Medicaid hospital reimbursement system shall provide for supplemental outpatient payments to non-state, governmentally owned or operated hospitals. These supplemental payments shall be determined on an annual basis and paid to qualifying hospitals on a quarterly basis. The supplemental payments shall not exceed, when aggregated with other fee-for-services outpatient hospital payments made to non-state, governmentally owned or operated hospitals, 100% of a reasonable estimate of the amount that would be paid for such services under Medicare payment principles in accordance with the federal upper limit regulations at 42 CFR §447.321.

a. Methodology for Determining Outpatient Supplemental Payments:

The hospitals that qualify for outpatient supplemental payments will have their payment amount determined using a payment-to-charge ratio UPL methodology.

Outpatient supplemental payments for each hospital will be calculated using following method:

(i) Calculate Total Medicare Outpatient Payments from: CMS 2552-96 Wkst E Part B, Col 1, Line 17 + CMS 2552-96 Wkst E Part B, Col 1, Line 17.01 + CMS 2552-96 Wkst E Part B, Col 1, Line 21+22 [Add comparable fields for sub providers 1 and 2]

(ii) Calculate Total Medicare Outpatient Charges from: CMS 2552-96 Wkst D Part V, Line 104, Col 5 + CMS 2552-96 Wkst D Part V, Line 104, Col 5.01 + CMS 2552-96 Wkst D Part V, Line 104, Col 5.02 + CMS 2552-96 Wkst D Part V, Line 104, Col 5.03 [Add comparable fields for sub providers 1 and 2]

(iii) Calculate Medicare Outpatient Payment to Charge Ratio. The ratio is calculated by dividing the result of (i) by (ii)

[Total Medicare Outpatient Payments] ÷ [Total Medicare Outpatient Charges]

(iv) The result of (iii) is multiplied by Medicaid Outpatient charges in order to determine the Estimated Medicare Outpatient Services Upper Payment Limit. Total Medicaid Outpatient charges shall be derived from Nevada Medicaid Management Information System (MMIS) adjudicated claims data.

(v) Total Medicaid Outpatient Payments for the period are subtracted from the result (iv) to determine the annual amount of Outpatient Supplemental Payment. Total Medicaid Outpatient payment shall be derived from Nevada Medicaid Management Information System (MMIS) adjudicated claims data.

b. Outpatient Supplemental Payments:

(i) Each qualifying hospital will provide documentation of CMS Form 2552 cost report for Medicare charge and payment information for the previous fiscal year to Medicaid by April 1st of each year.

(ii) Beginning April 2010, Medicaid will calculate the total outpatient supplement payment for qualifying hospitals using the methodology in Section A. above. At the end of each calendar quarter, hospitals will receive a payment amount equal to 25% of the hospital's total outpatient supplemental payment.

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and Sections 1902(a)(4),1902(a)(6) and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions (OPPCs) for non-payment under Section(s) 4.19-B.

X Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

____ Additional Other Provider-Preventable Conditions identified below *(please indicate the section(s) of the plan and specific service type and provider type to which the provisions will be applied. For example – 4.19(d) Nursing Facility Services, 4.19(b) Physician Services)* of the plan:

Methodology for Identifying Other Provider-Preventable Conditions

The State Agency's fiscal agent will review claims with dates of service on or after July 1, 2012 for OPPCs and report to the State. The state's Surveillance and Utilization Review (SUR) unit will review each claim identified in that report and recover payments associated with the OPPC.

Payment Adjustment

For OPPCs not present on admission, payment will be reduced to those costs not associated with an OPPC, using standard rates assigned to CPT and HCPCS codes for reimbursement by the DHCFP.

The existing appeals process will be available to providers who dispute the determination.

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Assurances

These reimbursement methodologies are sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that these services are available to the general population, as required by 42 CFR 447.204.

These rates comply with the requirements of Section 1902(a)(30) of the Social Security Act and 42 CFR 447.200, regarding payments and are consistent with economy, efficiency and quality of care.

Rate methodology and provider retention will be reviewed periodically to ensure that access to care and adequacy of payments are maintained.

Assurances

The reimbursement methodology described in Attachment 4.19B, Page 5 will not exceed the federal upper payment limit for such services as described in 42 CFR 442.321. To the extend reimbursements exceed upper payment limits, the State will return to CMS any federal funds used to reimburse these providers in excess of this limit. To establish the federal upper payment limit for these services the following methodology is used:

1. Segregation: Providers are divided into two primary categories – hospital based providers and free-standing clinics. These two categories are further segregated three additional categories:
   a. Privately-owned or operated facilities.
   b. State government-owned or operated facilities
   c. Non-state government-owned or operated facilities

2. Free-Standing Privately-owned or operated facility UPL estimation
   a. A sample of at least one calendar quarter of Medicaid claims for these providers will be used as base data.
   b. Medicaid reimbursement is estimated for these claims using the methodology described in 4.19B, Page 5.
   c. Medicare reimbursement is estimated using the guidelines established in the Medicare Claims Processing Manual and Transmittal AB-03-116.
   d. The amounts calculated in b. and c. are compared. If b. is less than c. Medicaid reimbursement is in conformance with the provisions of 42 CFR 422.321.

3. Free-Standing state and non-state government-owned or operated facilities – there are no facilities providing services under attachment 4.19B, Page 5 in Nevada.

4. Hospital-based privately-owned or operated facilities.
   a. The methodology utilizes Medicare cost principles to estimate UPL
   b. The methodology includes all hospital outpatient services, including those provided under 4.19B, Page 1 and Page 5.
   c. The most recently filed Medicare cost report outpatient cost to charge ratio is used for each facility.
   d. A sample of at least one calendar quarter of Medicaid claims for the services described in 4.b. above will be used as base data.
   e. Medicaid reimbursement is estimated for these claims using the methodology described in attachment 4.19B.
   f. Medicare reimbursement is estimated by multiplying the total billed charges for each facility from d. above by the cost to charge ratio from b. above. The result is the Medicare UPL for these services.
   g. The amounts calculated in e. and f. are compared. If e. is less than f. Medicaid reimbursement is in conformance with the provisions of 42 CFR 422.321

5. Hospital-based state government-owned or operated facilities – there are no facilities providing services under attachment 4.19B, Page 5 in Nevada.

6. Hospital-based non-state government owned or operated facilities estimations are based on the same methodology described in 4. above.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nevada

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State plan), if applicable, the Medicaid agency uses the following general method for payment:

1. Payments are limited to State plan rates and payment methodologies for the groups and payments listed below and designated with the letters "SP".

   For specific Medicare services which are not otherwise covered by this State plan, the Medicaid agency uses Medicare payment rates unless a special rate or method is set out on Page 3 in item __ of this attachment (see 3. below).

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters "MR."

3. Payments are up to the amount of a special rate, or according to a special method, described on Page 3 in item __ of this attachment, for those groups and payments listed below and designated with the letters "NR".

4. Any exceptions to the general methods used for a particular group or payment are specified on Page 3 in Item 1 of this attachment (see 3. above).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nevada

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

QMBs:	Part A SP Deductibles	SP Coinsurance
	Part B SP Deductibles	SP Coinsurance
Other Medicaid Recipients	Part A ____ Deductibles	____ Coinsurance
	Part B SP Deductibles	SP Coinsurance
Dual Eligible (QMB Plus)	Part A SP Deductibles	SP Coinsurance
	Part B SP Deductibles	SP Coinsurance

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT METHODS AND STANDARDS FOR ESTABLISHING PAYMENT FOR ORGAN TRANSPLANT SERVICES AND OUT-OF-STATE EMERGENCY SERVICES

In order to ensure adequate access to organ transplant services and to emergency services for a recipient while outside of the State of Nevada, Nevada Medicaid uses the following general method for payment for professional services related to organ transplant services and out-of-state emergency services:

1. Scope: This section is applicable to all professional services rendered by a physician outside of those services provided by the acute care hospital. This includes charges for attendant physicians and post discharge care. Additionally, this applies to all organ search and match services and emergency transportation services.

2. Reimbursement: Provider reimbursements under this supplement must conform to the following:

   a) All providers are reimbursed by default according to Nevada Medicaid in-state provider rates as described in Attachment 4.19B of the State Plan.

   b) If the provider refuses to accept these rates, Nevada Medicaid will negotiate reimbursement at the applicable rate of the provider's home state Medicaid program.

   c) If the provider refuses to accept the rates in either a) or b) above, Nevada Medicaid will negotiate provider specific reimbursement agreements according to the following criteria:

      1) The service must only be available from a limited number of out-of-state providers. In Nevada Medicaid's judgment, the service provider which is most cost effective will be authorized to provide the service.

      2) Reimbursement agreements will be established only for a limited specific set of services applicable under this section and not for all general services the provider may render.

      3) Reimbursement agreements will be for a limited duration of time not to exceed two years to ensure the requirements in 1) above are met.

      4) Reimbursement agreements may be in the form of a total amount for the entire service (such as for a particular type of transplant), a percentage of billed charges, or a specific fee schedule.

      5) Under no circumstances will reimbursement agreements exceed the usual and customary charges of the provider.

Payments for Selected Critical Access Hospitals for Providing Telehealth Services

For dates of service beginning November 24, 2016 and ending July 31, 2019, Battle Mountain General Hospital, Grover C Dils Medical Center, Mount Grant General Hospital and Pershing General Hospital will be reimbursed for telehealth services using a cost-based methodology as described below:

1. Interim Payments

   a) Each facility identified above is reimbursed on an interim basis for telehealth services provided at the Nevada Medicaid outpatient hospital services fee-for-services rates.

2. Quarterly Cost Reconciliation/Payment Process

   a) Within 60 days after the end of each quarter each facility identified above will submit to the DHCFP a summary of all telehealth encounters paid during the previous quarter, identified by the telehealth Originating Site Facility Fee code, Q3014, and the related Medicaid charges.

   b) The DHCFP will determine the total Medicaid charges for each facility by totaling the Medicaid charges for all telehealth encounters submitted under #a above.

   c) The DHCFP will apply the facility's most current available Medicare approved telemedicine cost to charge ratio to the total Medicaid charges (see #b above) to determine the total cost of Medicaid telehealth services provided in the quarter.

   d) If the total quarterly actual costs for providing Medicaid telehealth services as determined under #c exceeds the total interim Medicaid payments for the quarter, the DHCFP will pay the facility the difference.

      If the facility's total interim quarterly Medicaid payments for the telehealth services exceeds the actual cost determined under #c above, the DHCFP will recoup the overpayment using one of the following two methods:

      i. Off-set all future claims payment from the facility until the amount of the overpayment is recovered;
      ii. The facility will return an amount equal to the overpayment.

PAYMENT FOR RESERVED BEDS FOR THERAPEUTIC LEAVE OF ABSENCE

1. Payment for reserved beds will not be made in an acute care facility.

2. Payment for therapeutic leave of absence, or reserved beds, may be made in an institution for mental diseases (IMD), a skilled nursing facility (SNF), a nursing facility (NF), an intermediate care facility (ICF) or an ICF for the mentally retarded (ICF/MR), subject to the following conditions:

   a. The purpose of the therapeutic leave of absence is for rehabilitative home and community visits including preparation for discharge to community living;

   b. The patient's attending physician authorizes the therapeutic leave of absence and the plan of care provides for such absences;

   c. An IMD, SNF, NF, ICF, or ICF/MR will be reimbursed their per diem rate for reserving beds for Medicaid recipients who are absent from the facility on therapeutic leave up to a maximum of 24 days annually. For this purpose, annually is defined as a calendar year beginning on January 1 and ending on December 31 of the same year.

PAYMENT FOR NURSING FACILITIES
ASSURANCES AND RELATED INFORMATION

A. State Assurances and Findings. The State assures that it has made the following findings:

1. 447.253(b)(1)(i) - The State pays for long-term care facility services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations and quality and safety standards.

2. With respect to nursing facility services -

   a. 447.253(b)(1)(iii)(A) – Except for preadmission screening for individuals with mental illness and mental retardation under 42 CFR 483.20 (f), the methods and standards used to determine payment rates take into account the costs of complying with the requirements of 42 CFR Part 483 Subpart B.

   b. 447.253(b)(1)(iii)(B) - The methods and standards used to determine payment rates provide for an appropriate reduction to take into account the lower costs (if any) of the facility for nursing care under a waiver of the requirements in 42 CFR 483.30 (c) to provide licensed nurses on a 24-hour basis.

   c. 447.253(b)(1)(iii)(C) - The State has established procedures under which the data and methodology used to establish payment rates are made available to the public.

3. 447.253(b)(2) - The proposed rate will not exceed the upper payment limits as specified in 42 CFR 447.272:

   a. 447.272(a) – Aggregate payments made to nursing facilities when considered separately, will not exceed the amount that can reasonably be estimated would have been paid for under Medicare Payment principles. (There are no state-operated nursing facilities to which this assurance is applicable.)

   b. 447.272(b) – Aggregate payments to ICFs/MR will not exceed the amount that can reasonably be estimated would have been paid for under Medicare payment principles. And, aggregate payments to state-operated facilities (that is ICFs/MR) - when considered separately will not exceed the amount that can reasonably be estimated would have been paid for under Medicare payment principles.

B. State Assurances. The State makes the following additional assurances:

1. For nursing facilities and ICFs/MR

a. 447.253(d)(1) – When there has been a sale or transfer of the assets of a NF or ICF/MR on or after July 18, 1984, but before October 1, 1985, the State's methods and standards provide that payment rates can reasonably be expected not to increase in the aggregate, solely as a result of a change in ownership, more than payments would increase under Medicare under 42 CFR 413.130, 413.134, 413.153 and 413.157 insofar as these sections affect payment for depreciation, interest on capital indebtedness, return on equity (if applicable), acquisition costs for which payments were previously made to prior owners and the recapture of depreciation.

b. 447.253(d)(2) – When there has been a sale or transfer of the assets of a NF or ICF/MR on or after October 1, 1985, the State's methods and standards provide that the valuation of capital assets for purposes of determining payment rates will not increase (as measured from the date of acquisition by the seller to the date of the change of ownership) solely as a result of a change of ownership, by more than the lesser of:

(i) 1/2 of the percentage increase (as measured from the date of acquisition by the seller to the date of the change of ownership) in the Dodge construction index applied in the aggregate with respect to those facilities that have undergone a change of ownership during the fiscal year; or

(ii) 1/2 of the percentage increase (as measured from the date of acquisition by the seller to the date of the change of ownership) in the Consumer Price Index for All Urban Consumers (CPI-U) United State city average) applied in the aggregate with respect to those facilities that have undergone a change of ownership during the fiscal year.

2. 447.253(e) – The State provides for an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the State determines appropriate, of payment rates.

3. 447.253(f) – The State requires the filing of uniform cost reports by each participating provider.

4. 447.253(g) – The State provides for periodic audits of the financial and statistical records of participating providers.

5. 447.253(h) The State has complied with the public notice requirements of 42 CFR 447.205

   Notice published on: May 22, 1995

6. 447.253(i) – The State pays for long term care services using rates determined in accordance with the methods and standards specified in the approved state plan.

C. Related Information

1. 447.255(a)

   Estimated average proposed payment rate **for ICFs/MR** as a result of this amendment: $190

   Average payment rate **for ICFs/MR** for the immediately preceding rate period: $186

   Amount of change: $4 Percent of change: 2.15%

   Estimated average proposed payment rate **for nursing facilities** as a result of July 1, 1995 rebasing of rates: $82.94 (There is no change in the rate attributed to the amendment.)

   Average payment rate in effect **for nursing facilities** for immediately preceding rate period: $79.33

   Amount of change: $3.61 Percent of change: 4.55%

2. 447.255(b) – The estimated short term and long-term effect in the estimated average rate on:

   (a) The availability of services on a statewide and geographic area basis: NONE

   (b) The type of care furnished: NONE

   (c) The extent of provider participation: NONE

PAYMENT FOR LONG TERM NURSING FACILITY SERVICES
METHODS AND STANDARDS

Payment is made for services provided in nursing facilities, including nursing facilities for the mentally retarded, in accordance with Section 1902(a) (13) of the Social Security Act as amended.

A. Hospital-Based Facilities: (Hospital-based facility is defined as: a) a facility sharing a common building or common tract of land with a hospital owned or operated by the state, or an instrumentality or unit of government within the state, located within a county of a population of 100,000 or less; or b) a facility (public or private) which prior to July 1, 1992, was paid for both inpatient hospital services under Attachment 4.19-A of the Medicaid State Plan and long-term nursing facility services under this section.

1. Hospital-based nursing facility services are paid for under Medicare reasonable cost-based reimbursement principles, including the routine cost limitation (RCL), and the lesser of cost or charges (LCC).

   Effective October 1, 2001, hospital-based nursing facilities shall continue to be reimbursed under Medicare's cost-based reimbursement principles, along with the other provisions of Paragraphs A.2 and A.3.

   Under this methodology, payment will follow any and all applicable Medicare upper payment limitation (UPL) requirements such that payments will not exceed the UPL. The rates the State of Nevada would pay per day of nursing facility care comply with the Medicare upper payment limit at 42 CFR 447.272, as amended.

   The routine cost limit (RCL) used in cost settlements will be $160.14 per day, effective October 1, 2001. This RCL will apply to cost reports ending on or after October 1, 2001, and will only apply to the portion of the cost report period on or after October 1, 2001. For those cost reports beginning prior to October 1, 2001 and ending on or after October 1, 2001, a weighted average RCL will be used. The RCL applicable to the portion of the cost report period prior to October 1, 2001 will be the per diem routine service cost paid to the facility during the most current cost report period ending prior to October 1, 2001. The RCL applicable to the portion of the cost report period on or after October 1, 2001, will be the RCL of $160.14, as adjusted for inflation. For example: If a hospital-based facility with a June 30 year end was paid $140 per day for routine service cost during its year ending June 30, 2001, the $140 per day would be the RCL for this facility during the portion of the cost reporting year from July 1, 2001 through September 30, 2001. The RCL for the remainder of the year ending June 30, 2002 (October 1, 2001 through June 30, 2002) would be the $160.14 RCL, as adjusted for inflation.

   The $160.14 RCL will be indexed (adjusted for inflation) from October 1, 2001 to the midpoint of the cost-reporting period to which it is applied. The Skilled and Intermediate Care Facilities without capital (non-seasonally adjusted) Table 9: Percent Change in Medical Prices as published by MEI will be used in indexing the RCL. If this index becomes unavailable, a comparable index will be used.

The Medicaid program will re-base the RCL every other year, beginning July 1, 2003, using audited hospital-based nursing facility cost report data, input from the hospital-based nursing facility providers, and other information deemed appropriate.

1. In no case may payment for hospital-based nursing facility services exceed the provider's customary charges to the general public for these services.

2. Effective October 1, 2013, each facility will receive an interim payment of 100% of billed charges.

B. Free-standing Nursing Facilities (Free-standing nursing facility is defined as any other facility providing nursing facility services, except hospital-based nursing facilities.):

1. Reimbursement Methodology – January 1, 2002 through June 30, 2002:

a. In preparing the free-standing nursing facilities for a resource utilization group (RUG) based Medicaid reimbursement system; a transitional rate setting process will be adopted effective January 1, 2002. The significant elements of this system include the following:

b. Base operating rates will be calculated for each facility effective January 1, 2002. The base operating rates will be calculated for each free-standing nursing facility using the weighted average operating rate for each facility effective October 1, 2001, (excluding SNL-3 days and rates). The days used to prepare the weighted average operating rates will be paid nursing facility days from January 1, 2001 through June 30, 2001 (excluding SNL-3 days) as shown on a paid claims listing prepared in November 2001. Each facility's capital rate effective October 1, 2001, will be added to their weighted average operating rate. If the statewide Medicaid day weighted average operating and capital rates, calculated as described above, exceed the budget target rate of $121.02, a budget adjustment factor will be employed to adjust the calculated rates to meet the budget target.

c. For those facilities with unstable occupancy (i.e. facilities receiving their initial Medicaid certification on or after January 1, 2000), their base rate will be adjusted for changes in Medicaid acuity as follows:

1. A snapshot Medicaid average case mix index (CMI) will be calculated for each facility effective October 1, 2001.

2. Medicaid average CMIs will be prepared for these facilities as of January 1, 2002 and April 1, 2002, using the same weights as were used to prepare the October 1, 2001 snapshot.

3. The change in average Medicaid CMI, for each unstable occupancy nursing facility as measured from October 1, 2001 to January 1, 2002, and from October 1, 2001 to April 1, 2002, will be used to proportionally increase or decrease 40% of that facility's operating rate effective January 1, 2002 and April 1, 2002.

2. Reimbursement Methodology July 1, 2002 through June 30, 2003:

a. Effective July 1, 2002, each nursing facility's base rate (the rate in effect for each facility on June 30, 2002) will be adjusted for the change in their average Medicaid CMI. The ratio to use in this calculation will be developed using as its numerator each facility's simple average of their Medicaid CMI as of January 1, 2002 and April 1, 2002. The denominator will be the simple average of each facility's Medicaid CMI calculated as of October 1, 2001 and January 1, 2002.

b. The rates in 2.a. will be further acuity-adjusted quarterly. In preparing these rate adjustments, the denominator of the fraction described in Item 2.a. above will remain unchanged for each facility. The numerator of the fraction for October 1, 2002 adjustment will reflect the simple average of each facility's Medicaid CMI as of April 1, 2002 and July 1, 2002. The July 2002 and October 2002 average Medicaid CMI will be used in the January 1, 2003 rate setting, while the October 2002 and January 2003 average Medicaid CMI will be used in the April 1, 2003 rate adjustments.

c. The acuity-adjusted rates, as described above in Items 2.a. and b., will be further adjusted by an adjustment factor to not exceed the industry Medicaid weighted average per patient day rate effective January 1, 2002 as described in B. 1. b. above.

d. Forty percent of each facility's weighted average operating rate will be subject to the acuity adjustments described in this section.

e. Facilities that were initially certified between July 1, 1999 and December 31, 1999, will have their rates adjusted to reflect the adjustments to rates that were made to unstable occupancy facilities during the period of January 1, 2002 through June 30, 2002. These rate adjustments will be effective July 1, 2002. The intent of this provision is to treat facilities initially certified during this period as if they had been identified as unstable occupancy facilities during the period from January 1, 2002 through June 30, 2002.

(Reserved for Future Use)

3. Reimbursement Methodology – Effective July 1, 2003:

Effective July 1, 2003, a nursing facility price-based reimbursement system will be implemented. Individual facility rates will be developed from prices established for three separate cost centers: operating, direct health care and capital. The allowable cost used in these rate setting activities will be nursing facility health care cost determined to be allowable in accordance with the Medicare/Medicaid provider reimbursement manual, commonly referred to as HIM 15.

a. **Operating Cost Center** – The operating cost center will be comprised of all allowable cost excluding direct care cost, capital cost and direct ancillary service cost. The statewide price for this cost center will be set at 105% of the Medicaid day weighted median.

b. **Direct Health Care Cost Center** – The direct health care cost center will be comprised of allowable RN, LPN, and Nursing Aide salaries and wages; a proportionate allocation of allowable employee benefits; and the direct allowable cost of acquiring RN, LPN and Nurse Aide staff from outside staffing companies. The statewide price will be established for this cost center at 110% of the Medicaid day weighted median case mix neutralized cost. In preparing the case mix neutralization, a minimum of two calendar quarters from each facility's available quarterly facility wide case mix index information that most closely matches their base year cost report will be used to calculate the Medicaid day weighted average. On a quarterly basis, each facility's specific direct health care price is determined by adjusting the statewide price using as the numerator, the facility's most current quarterly Medicaid case mix index and as the denominator, the Medicaid day weighted average of the facility wide case mix indexes used in setting the statewide price.

c. **Capital Cost Center** – This cost center will be comprised of allowable depreciation, capital related interest, rent / lease, and amortization expenses. A fair rental value (FRV) reimbursement system will be used to determine each facility's capital rate. The following items will be used in determining each facility's FRV rate:

i.	Value of New Beds (7/01/03)	$73,000.00
ii.	Bed Value Indexed Annually (using Marshall Swift, Class C nursing facility index)	
iii.	Rate of Depreciation	1.5% Year
iv.	Maximum Age	40 Years
v.	Rental Rate	9.0% Annually
vi.	Minimum Occupancy Percent	92%

These values will be used to determine a facility's FRV payment as demonstrated below:
(Example facility has 100 beds and is 10 years old)

Licensed Beds	100
Times Value/Bed	$73,000
Gross Value	$7,300,000
Depreciation Rate (1.5% x 10 Years)	15%
Depreciated Value (85%)	$6,205,000
Rental Rate	9%
FRV Payment (Gross)	$558,450
Divided by Greater of Actual or Minimum Days	33,580
Fair Rental Value Payment	$16.63

1) **Capital Renovations / Remodeling Projects** – The fair rental value of each facility will be adjusted (increased) to reflect the cost of major renovation/replacement projects completed by each facility not to exceed a 24-month period. The renovation/replacement adjustment would be made at the start of the first-rate year following completion of the renovation/ replacement project.

The cost of renovation/replacement projects must be documented within each facility's depreciation schedule, must be reported to the Medicaid program by May 1st prior to the July 1st rate year when they would first be eligible for incorporation into the FRV rate setting process, and must exceed $1,000.00 per licensed bed in order to be considered a major renovation/replacement. The cost of these renovation/replacement projects will be depreciated at a rate of 4% per year, but will also be indexed (inflated) annually using the bed value indexing methodology incorporated into this fair rental value system.

2) **Initial Age of Nevada Nursing Facilities for July 1, 2003 FRV Calculations** – The initial age for each facility shall be determined as of July 1, 2003, using each facility's year of construction. This age will be reduced for renovations and/or additions of beds that have occurred since the facility was built. If a facility added beds, these new beds will be averaged in with the original beds and a weighted average age for all beds will be used as the initial age. If a facility performed a major renovation project between the time the facility was built and the time when the initial age is determined, the cost of the renovation project will be used to determine the equivalent number of new beds that project represents. The equivalent number of new beds would then be used to determine the weighted average age of all beds for this facility. The equivalent number of new beds from a renovation project will be determined by dividing the cost of the renovation project by the cost of a new bed (using the new bed valuation methodology incorporated into the FRV system) at the time the renovation project was completed. Facility ages will be rounded to the nearest whole number.

d. **Inflation Factor Used in Rate Setting** – When establishing the medians for the operating and direct health care cost centers, cost will be adjusted from the midpoint of each provider's base year cost report to the midpoint of each state fiscal year using the Nursing Home Services without capital (non-seasonally adjusted Table 9: Percent Change in Medical Prices) as published by MEI. If this index becomes unavailable, a comparable index will be used. In non-rebasing years, the Medians from the most recent rebasing period will be indexed forward to the midpoint of the current rate year using this indexing methodology.

e. **Base Year Cost Report (July 1, 2003 Rate Year) and Rebasing Frequency** – Cost reports used to establish the July 1, 2003 operating and direct care medians, and ultimate prices, will be the most current cost report for each facility whose audit or desk review was completed at least three months prior to the July 1st rate effective date. Only audited or desk reviewed cost reports will be used in the rate setting process. New cost report information will be brought into the rate setting process on a periodic basis. The cost report information used to establish the operating and direct health care medians, and ultimate prices, will be rebased no less frequently than once every two years.

f. **Minimum Direct Care Staffing Requirement** – In the event that a nursing facility does not incur direct care cost, at least equal to 94% of the direct care median, the Department will have the option to recoup from future Medicaid payments to that provider an amount equal to 100% of the difference between the provider's direct care rate and the actual cost the provider incurred. This provision is intended to encourage adequate direct care staffing.

g. **Rate Add-On to Reflect Changes in State / Federal Laws –** The Medicaid director can make adjustments to the operating price to reflect changes in state or federal laws, rules or regulations that have yet to be reflected in the base period cost report data.

a. **Budget Adjustment Factor –** In the event that the reimbursement system described in this section would result in anticipated payments to nursing facility providers being greater or less than the funding appropriated by the Nevada legislature, proportional increases or decreases will be made to the rates so that anticipated payments will equal legislative appropriations. This adjustment to rates will be made as a percentage increase or decrease in each provider's rate. The percentage will be determined in accordance with the following fraction: (Legislative appropriations / (The Sum of Each Facility's Calculated Rate Multiplied by Each Facility's Proportional Share of the Anticipated (Budgeted) Case Load for All Freestanding Nursing Facilities)). Medicaid days from the cost reports used in rate setting will be the basis for the proportional allocation of anticipated case load across all freestanding facilities.

b. Effective October 1, 2017, The Weighted Average Budget Neutral Per Diem is $128.33.

C. Cost Reporting Requirements:

1. Hospital-based and free-standing nursing facilities must complete and file an annual cost report with the Medicaid program. Cost and other statistical information within the cost report must be reported in compliance with allowable and non-allowable cost definitions contained in the Medicare/Medicaid provider reimbursement manual (commonly referred to as HIM 15).

2. Free-standing nursing facility cost reports are to be received by the Medicaid program by the last day of the third month following a facility's fiscal year end. If the facility is unable to complete their cost report within this time frame, a request for a 30-day extension can be requested from the Medicaid program (DHCFP) prior to the original cost report due date. Reasonable extension requests will be granted.

3. Hospital-based nursing facility cost reports are to be filed with the Medicaid program following the cost report filing deadlines adopted by the Medicare program. If a facility requests an extension from the Medicare program, they must also request an extension from the Medicaid program (DHCFP). Extension requests approved by Medicare will automatically be approved by the Medicaid program, once the DHCFP receives evidence of Medicare approval from the facility.

4. Facilities failing to file a Medicaid cost report in accordance with these provisions may have their payments suspended or be required to pay back to the Medicaid program all payments received during the fiscal year period upon which they were to provide a cost report. Facilities may also be subject to late filing fees assessed in accordance with guidelines issued pursuant to the Medicaid Services Manual.

D. New Facilities and Change of Ownership:

1. New facilities are those entities whose beds have not previously been certified to participate in the Medicaid program. New free-standing facilities will be reimbursed an interim rate computed from the following Nursing Facility rate components in effect on the date of the facility's Medicaid certification:

   a. The Fair Rental Value per diem will be determined based upon an initial capital survey the new provider completes and submits to the DHCFP, and upon the methodology described in Section B.3.c. of this attachment.

   b. The operating component for the rate will be the "Operating Statewide Price" as described in Section B.3.a. of this attachment.

   c. The direct health care component will be the "Statewide Direct Health Care Price" as described in Section B.3.b. of this attachment.

   d. The "Budget Adjustment Factor," as described in Section B.3.h. of this attachment, will be applied to determine the Facility Medicaid Rate.

   This interim rate will be paid until such time that the rate is rebased under the provisions of Section B.3.e of this attachment.

2. New hospital-based facilities will receive an interim rate equal to the average rate (expressed as a percent of charges) paid to all other hospital-based nursing facilities effective at the start of the state fiscal year in which the facility began providing services to Medicaid recipients.

3. A change of ownership exists if the beds of the new owner have previously been certified to participate in the Medicaid program under the previous owner's provider agreement. Rates paid to free-standing nursing facilities that have undergone a change of ownership will be based upon the base rate and acuity data of the previous owner. The new owner's acuity data will be used to adjust the facility's rate following the rate adjustment schedule discussed in this rule. Facilities (hospital-based and free-standing) that undergo a change in ownership are required to file a closing cost report for the seller within 45 days of the date of sale. A new cost reporting period for the buyer will start on the effective date of the transaction. The interim rate paid to a new hospital-based owner will be the same interim rate the prior owner was receiving.

Case Mix Index Calculation (Free-standing Nursing Facilities Only):

1. In calculating the case mix for each facility, CMS-mandated RUG and MDS systems will be utilized.

2. Each nursing facility resident in a facility, with a completed and submitted MDS shall be assigned to a RUG classification group on the first day of each calendar quarter. These RUG assignments will be based upon each resident's most current MDS assessment available on the first day of each calendar quarter. Using the facility's simple average of the individual residents' case mix indexes, two case mix indexes (CMIs) will be calculated for the facility. One being a facility wide CMI, which will be based upon all of the facility's residents, and the other being the Medicaid CMI, which will be calculated using only the Medicaid residents for each facility. Both of these average case mix indexes will be rounded to four decimal places.

E. Special Care Rates:

1. The Division of Health Care Financing and Policy shall establish special care rates for recipients ages 21 and over that are ventilator dependent, or behaviorally complex, and pediatric recipients less than 21 years of age with special high cost care needs and/or who are ventilator dependent. These special care rates will be all-inclusive per diem rates based on the costs of providing services to recipients.

   a. Effective August 1, 2011 the per diem rate for recipients ages 21 and over that are ventilator dependent is the facility-specific fair rental value per diem, as computed under Section B.3.c. of this attachment, plus an add-on of $495.00.

   b. The per diem rate for behaviorally complex individuals is the facility-specific per diem rate plus an add-on rate for each of the following three tier categories. Tier definitions can be found in the Division of Health Care Financing and Policy Medicaid Services Manual Section 503.10, Page 15, as that section reads as of January 28, 2016.

Tier I.	$111.23
Tier II.	$222.45
Tier III.	$326.26

   c. The per diem rate for recipients less than 21 years of age with special high cost care needs that meet the Level of Care requirements for Pediatric Level I as defined, effective March 25, 2013, in the Medicaid Services Manual is $635.00.

   d. The per diem rate for recipients less than 21 years of age that meet the Level of Care requirements for Pediatric Level II as defined, effective March 25, 2013, in the Medicaid Services Manual is $695.00.

2. The Division of Health Care Financing and Policy shall establish negotiated facility specific all-inclusive per diem rates for Medicaid recipients with unique high cost care needs. Nursing facilities may not bill the Medicaid program for special care recipients other than on a per diem basis using the established negotiated rate. Rates will address the following client care issues:

   a. Patient's acuity

   b. Availability of beds

   c. Patient's freedom of choice

3. When special care rates are required or when multiple facilities are equally acceptable under E.2. above, the nursing facility with the lowest per diem rate will be selected. The per diem rate will not exceed the facility's usual and customary rate for similar services.

G. Nurse Aide Training Cost:

Nursing facilities are required to reimburse certified nurse's aides (CNAs) if the CNA paid for the training within one year of being employed by the facility and has not previously been reimbursed. The amount nursing facilities are required to reimburse the CNA is limited to the cost of the class and books at Nevada community colleges. The aide is to be reimbursed after three months of employment in the facility. Nursing facilities must follow the procedures specified by Nevada Medicaid to receive reimbursement from Medicaid for their share of the amount paid to the CNA. Facilities which conduct a training program will continue to bill Medicaid for the cost of the training and competency evaluation.

Supplemental Payment to Free-Standing Nursing Facilities

Effective October 1, 2011, free-standing nursing facilities will receive a supplemental Medicaid payment in addition to its standard or special care per diem payment. Supplemental payments are not available for nursing facilities owned by the State of Nevada or any of its political subdivisions. Fifty percent of the supplemental payment is based on Medicaid occupancy, MDS accuracy, and quality measures. Fifty percent of the payment is based on acuity. The amount available for supplemental payments is computed quarterly and reimbursed in the quarter in three equal monthly payments.

A. The amount available for Supplemental Payments to Nursing Facilities (NF) will be calculated each quarter based on actual net revenues from patient services and actual patient days for each facility during the Base Quarter.

1. The Base Quarter is defined as the quarter beginning six months prior to the quarter in which the supplemental payments are being distributed. (For the quarter beginning October 1, 2011, the supplemental payment computation would be based on actual net revenues and bed days for the quarter April 1 through June 30, 2011.)

2. The total amount available for Supplemental Payments is calculated by multiplying the net revenues from patient services in the Base Quarter by 6%.

3. One percent of this amount each quarter is retained by Nevada Medicaid to pay administrative costs associated with the Supplemental Payment Program. The remaining funds are the amount available to pay the state share of Supplemental Payments to free-standing nursing facilities.

4. The amount available to pay the state share of Supplemental Payments to free-standing nursing facilities is matched by federal Medicaid funds calculated according to the formula in 42 CFR 433.10 (b).

B. Calculation of Fifty Percent of Supplemental Payments Based on Medicaid Occupancy, MDS Accuracy, and Quality

1. Fifty percent of the amount available to pay the state share of Supplemental Payments to Nursing Facilities is paid out based on the facility's Medicaid occupancy, MDS accuracy, and quality scores.

2. Calculations for the Medicaid occupancy and MDS accuracy components of Supplemental Payments require bed day counts, which are the actual bed days reported by the free-standing nursing facilities for the Base Quarter.

3. The Medicaid occupancy, MDS accuracy and quality components are calculated by assigning points to each facility for each component according to the methodologies described below. The unit reimbursement value for each of the component points is determined by calculating the amount available to pay the state share of Supplemental Payments to Nursing Facilities

for that component plus the federal Medicaid matching funds and dividing by the total points in the component for all facilities receiving Supplemental Payments for that quarter.

Calculation of the Unit Reimbursement Value for a Component

	Total Dollars Available for Component
Divided by	Total Points for Component
Equals	Unit Reimbursement Value for Component

4. Supplemental Payment for Medicaid Occupancy, MDS Accuracy, and Quality Components

i. Medicaid Occupancy Component: Distribution of 82% of the state funds available for the portion of the Supplemental Payments based on Medicaid occupancy, MDS accuracy, and quality plus the federal Medicaid matching dollars is based on Medicaid occupancy. The facility receives a Medicaid occupancy rate modifier, which is the Medicaid nursing facility and LTC hospice bed days divided by total occupied bed days times 100. The facility's Medicaid occupancy rate modifier is multiplied by the number of Medicaid nursing facility and LTC hospice bed days to yield the Medicaid occupancy points. The Medicaid occupancy points will be multiplied times the unit reimbursement value to determine the Medicaid occupancy component of the facilities' reimbursement.

Calculation of the Facility Specific Medicaid Occupancy Component of the Supplemental Payment:

	Facility Occupied Medicaid NF and LTC Hospice Bed Days
Divided by	Facility Total Occupied Bed Days
Equals	Facility Medicaid Occupancy Rate
Times	100
Equals	Facility Medicaid Occupancy Rate Modifier
Times	Facility Occupied Medicaid NF and LTC Hospice Bed Days
Equals	Facility Medicaid Occupancy Points
Times	Medicaid Occupancy Component Unit Reimbursement Value
Equals	Facility Total Medicaid Occupancy Component Payment

ii. MDS Accuracy Component: Distribution of 9% of the state funds available for the portion of the supplemental payments based on Medicaid occupancy, MDS accuracy, and quality plus the federal Medicaid matching dollars are based on MDS accuracy rate from the most current review performed by Medicaid staff. To qualify for MDS accuracy payments, the facility must have an accuracy rate of 70% or higher. Accuracy rates will be rounded to the nearest whole percentage. If the partial

percentage point is less than 0.5%, it will be rounded down to the next whole percentage point. If the partial percentage point is 0.5% or greater, it will be rounded up to the next whole percentage point. Facilities who qualify for MDS accuracy payments will be assigned an MDS accuracy modifier as follows:

Accuracy Rate	Modifier
0 – 69%	0
70 – 79%	1
80 – 89%	3
90 – 100%	5

The MDS accuracy modifier is multiplied times the number of Medicaid nursing facility and LTC hospice bed days to determine MDS accuracy points. Each facility's MDS accuracy points will be multiplied by the unit reimbursement value to determine the facility's total reimbursement for MDS accuracy component.

Calculation of the MDS Accuracy Component

	Facility MDS Accuracy Modifier
Times	Facility Occupied Medicaid NF and LTC Hospice Bed Days
Equals	Facility MDS Accuracy Points
Times	MDS Accuracy Unit Reimbursement Value
Equals	Facility Total MDS Accuracy Component Payment

iii. Quality Component: Distribution of 9% of the state funds available for the portion of supplemental payments based on Medicaid occupancy, MDS accuracy, and quality plus the federal Medicaid matching dollars is based on quality measures. The quality component of the supplemental payment provides reimbursement for a facility's efforts to improve resident care and safety. Quality measures are selected from MDS data compiled by the Nevada State Health Division Bureau of Health Care Quality and Compliance (HCQC). Four quality measures are chosen based on MDS data and input from HCQC and stakeholders. The four quality measures currently selected include: 1) Percent of long-stay residents who have moderate to severe pain; 2) Percent of high risk long-stay residents who have pressure sores; 3) Percent of long-stay residents who had a urinary tract infection; 4) Percent of long-stay residents who lose too much weight. Facilities receive one quality point for each percentage point they are better than the Nevada MDS average for each measure. Quality measure percentages are rounded to the nearest whole percentage. If the partial percentage point is less than 0.5%, it is rounded down to the next whole percentage point. If the partial percentage point is 0.5% or greater, it is rounded up to the next whole percentage point. The facility's total quality points are multiplied by the unit reimbursement value for the quality component to determine the facility specific amount of the quality component of the supplemental payment. Nursing facilities that are identified by the Centers for Medicare and Medicaid Services as

Special Focus Facilities are not eligible for the quality component of the supplemental payments. Special Focus Facilities are nursing homes that have a history of persistent poor quality of care. These nursing homes have been selected for more frequent inspections and monitoring. A current list of Special Focus Facilities is available at the CMS Certification and Compliance website.

5. Facilities that do not have MDS or MDS Accuracy data available have MDS accuracy and quality component payments calculated using the average component points of all facilities receiving Supplemental Payments for which data is available. Facilities that are not enrolled as Medicaid providers are not eligible for payments of the MDS accuracy or quality components or any other components of this supplemental payment for the quarter.

C. Calculation of the Component of the Supplemental Payments Based on Acuity

1. Nursing facility standard per diem reimbursement is calculated for each Medicaid provider quarterly based on methodology described in the Medicaid State Plan, Attachment 4.19-D, Pages 5a through 5i. The per diem rate is adjusted for acuity and fair rental value. Fifty percent of the funds available for Supplemental Payments plus the Federal matching funds is paid under this acuity component as described below.

Calculation of the Supplemental Payment Portion Based on Acuity

The weighted average total amount of reimbursement based on acuity per Medicaid nursing and LTC hospice bed day is calculated by dividing the total for amount available for the acuity component of Supplemental Payments by the total nursing and LTC hospice bed days in the Base Quarter. This is added to the weighted average budget neutral per diem for all facilities to determine the total amount of reimbursement that will be based on acuity. Effective October 1, 2017, the weighted average budget neutral per diem is increased by 10%.

	Total Available for Supplement Payments
Times	50%
Equals	Total Available for Supplemental Payments Based on Acuity
	Total Available Supplemental Payments Based on Acuity
Divided by	Total Medicaid Nursing and LTC Hospice Days
Equals	Weighted Average Acuity Supplemental Payment Per Medicaid Day
	Weighted Average Budget Neutral Per Diem
Plus	Weighted Average Acuity Supplemental Payment Per Medicaid Day
Equals	Weighted Average Portion of Reimbursement Based on Acuity

The full rate per diem is calculated by dividing the number of Medicaid nursing and LTC

hospice bed days in the Base Quarter for facilities receiving Supplemental Payments into the total amount of reimbursement these facilities would have received if they were paid at the full per diem amount. The full rate per diem is the amount the facilities would receive if the budget adjustment factor in Nevada Medicaid State Plan, Attachment 4.19-D, Page 5i, were not applied to the per diem rates. The weighted average portion of reimbursement based on acuity is divided by weighted average full rate per diem to yield a budget adjustment factor for the acuity component of the Supplemental Payment.

Total Full Rate Reimbursement for Facilities Receiving Supplemental Payments

Divided by	Total Nursing and LTC Hospice Days
Equals	Weighted Average Full Rate Per Diem

	Weighted Average Portion of Reimbursement Based on Acuity
Divided by	Weighted Average Full Rate Per Diem
Equals	Budget Adjustment Factor for Supplemental Payment

The budget adjustment factor for supplemental payments is applied to the facility specific full rate per diem to arrive at a facility specific unit reimbursement value based on acuity.

The facility specific NF per diem rate for each facility is calculated by multiplying the budget adjustment factor described in Attachment 4.19-D, Page 5i, times the facility specific per diem rate. This budget adjustment factor also equals the weighted average budget neutral per diem for all facilities divided by the weighted average full rate per diem.

The facility specific NF per diem rate is subtracted from the facility specific unit reimbursement value based on acuity to yield the facility specific unit reimbursement value for the Supplemental Payment based on acuity. The facility specific reimbursement unit value for the Supplemental Payment portion based on acuity is multiplied by the number of Medicaid nursing facility and hospice days in the Base Quarter to determine the quarterly Supplemental Payment based on acuity.

Calculation of the Facility Specific Supplemental Payment Based on Acuity

	Facility Specific Full Rate Per Diem
Times	Budget Adjustment Factor for Supplemental Payment
Equals	Facility Specific Unit Reimbursement Value Based on Acuity

	Facility Specific Full Rate Per Diem
Times	Budget Adjustment Factor for Base NF Rates
Equals	Facility Specific NF Per Diem Rate

	Facility Specific Unit Reimbursement Value Based on Acuity
Minus	Facility Specific NF Per Diem Rate
Equals	Facility Specific Unit Value of Supplemental Payment Based on Acuity
Times	Number of Medicaid NF and LTC Hospice Days in Base Quarter
Equals	Facility Specific Quarterly Supplemental Payment Based on Acuity

D. The facility Supplemental Payment based on Medicaid occupancy, MDS accuracy, and quality is added to the facility specific Supplemental Payment based on acuity to yield the total facility specific Supplemental Payment amount for the quarter. The quarterly facility specific amount is divided by three to calculate the monthly Supplemental Payment.

E. Nursing facilities with negotiated facility-specific rates that exceed the standard or special care rates in the Nevada Medicaid State Plan are ineligible for supplemental payments.

The state will make a one-time supplemental payment to each freestanding nursing facility that is not a state-owned or operated (SGO) or non-state government owned or operated (NSGO) for the quarter ending December 31, 2017. This payment will be equal to the difference between the individual facility's budget neutral per diem in effect for the quarter ending September 30, 2017 and what the individual facility's budget neutral per diem would have been with a 10% increase to the state's weighted average budget neutral per diem, multiplied by the facility's number of Medicaid Fee-for-Service days in the same quarter ending September 30, 2017.

H. Intermediate Care Facilities for the Mentally Retarded (ICFs/MR):

1. ICFs/MR (state-operated):

a. ICFs/MR, excluding non-state-operated ICFs/MR, are reimbursed under Medicare principles of retrospective reimbursement described in 42 CFR 413 and further specified in HCFA Publication 15.

b. In no case may payment exceed audited allowable costs.

c. Interim rates will be based upon the most recent audited cost reports for the current state fiscal year. The interim rate for the initial year of operation will be based upon cost and utilization projections.

d. Each facility is paid an interim rate subject to settlement in accordance with a. through c. above.

2. ICFs/MR (non-state-operated):

a. Prospective Payment Rate: Non-state-operated ICFs/MR-Small ("small" is defined as facilities having six beds or less) will be paid a prospective payment rate for basic service costs, other than day training costs and property costs, on a per patient day basis. Day training costs and property costs, excluded from the basic prospective rate, will be reimbursed under Medicare principles of retrospective reimbursement as described in paragraph 1 above.

1. The initial basic prospective payment rate per patient day will be the average of costs (excluding residential staff wages and benefits) of the four private ICFs/MR-Small operating a full year, from 1993 audited cost reports. Costs will be indexed to the common time period of December 31, 1993. Residential staff wages and benefits cost is calculated, and added to the average, at the rate of $11 per hour for 6.4 full-time equivalents. The initial rate period is one year from July 1, 1995 through June 30, 1996. Therefore, the rate will be adjusted for inflation for the period June 30, 1993 - December 31, 1995 (the midpoint of the cost report period to the midpoint of the rate period) by the percentage change in the Consumer Price Index - All Urban and Clerical Workers (CPI), for calendar year 1993 times 2.5. The initial rate will be effective for private ICFs/MR-Small on July 1, 1995.

2. Rates in effect March 31, 2002, will be continued without adjustment. When rebasing, costs will be indexed to a common point in time, arrayed from highest to lowest, and the cost of the 60th percentile facility selected. The rate will further be adjusted for inflation by the CPI. Only audited cost reports of private facilities completed by March 31st of the same year will be used.

3. In addition, the rate will be adjusted for increased costs of services over basic inflation resulting from new federal or state guidelines.

4. Day training costs must be approved by the Division of Mental Health Developmental Services (MHDS). These approvals must be obtained annually on all patients and anytime there is an increase in service cost.

5. Property costs consist of a property lease (or in the case of an owned facility, interest and depreciation) as well as depreciation of equipment, property insurance and property taxes.

b. Prospective Payment Rate: Non-state-operated ICFs/MR-Large ("large" is defined as facilities having more than six beds) will be paid an all-inclusive prospective per diem rate equal to the interim rate in effect at December 31, 2003.

1. These all-inclusive rates will be effective for services rendered after December 31, 2003, until the rates are rebased as directed by the Department of Health and Human Services.

(Reserved for Future Use)

I. Swing-bed hospitals:

1. Inpatient hospital services furnished by a certified swing-bed hospital which have been certified by the Peer Review Organization for payment at the nursing facility level are reimbursed in accordance with 42 CFR 447.280.

2. Average statewide weighted per diem payments for all nursing facility routine services (excluding ICF/MR) are calculated for a calendar year; each rate is rounded to the nearest even dollar and becomes the swing-bed rate for routine nursing facility services provided in the subsequent calendar year. Swing-bed rates are not subject to later adjustment.

3. Ancillary services required by swing-bed patients are separately payable as "outpatient hospital services;" see Attachment 4.19-B, Item 2.a.

J. Out-of-state nursing facilities and ICF/MRs:

Out-of-state nursing facilities and ICF/MRs are reimbursed according to the following:

1. The same rate that the facility is reimbursed by its own state Medicaid program (rounded up to the nearest dollar); or

2. A per diem rate may be negotiated when the following client care issues are such that the rate in J.1. is insufficient to provide placement:

   a. Patient's acuity

   b. Availability of beds

   c. Patient's freedom of choice

3. When negotiation is required or when multiple facilities are equally acceptable under J.1. & 2. above, the out-of-state nursing facility or ICF/MR with the lowest per deim rate will be selected. The per diem rate will not exceed the facility's usual and customary rate for similar services.

K. Nevada State Veterans Nursing Home:

1. The Nevada State Veterans Nursing Home is reimbursed under Medicare principles of retrospective reimbursement described in 42 CFR 413 and further specified in CMS (HCFA) Publication 15.

2. In no case may payment exceed audited allowable costs.

3. For cost reporting periods prior to November 30, 2004, Medicaid reimbursement will be less any per diem payments received by the Home from the Veteran's Administration, payments from the recipient, or other third-party payments. For cost reporting periods on or after November 30, 2004 Medicaid reimbursement will not be reduced by any per diem payments received by the Home from the Veteran's Administration, but will be less payments from the recipient, or other third-party payments.

4. Interim rates will be based upon the most recent audited cost reports for the current state fiscal year. The interim rate for the initial year of operation will be based upon cost and utilization projections.

5. The Home is paid at the lower of 1) billed charge; or 2) an interim rate subject to settlement in accordance with 1. through 3. above.

Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and Sections 1902(a)(4), 1902(a)(6) and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions (OPPCs) for non-payment under Section(s) 4.19-D.

> **X** Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.
>
> ____ Additional Other Provider-Preventable Conditions identified below *(please indicate the section(s) of the plan and specific service type and provider type to which the provisions will be applied. For example – 4.19(d) Nursing Facility Services, 4.19(b) Physician Services)* of the plan:

Methodology for Identifying Other Provider-Preventable Conditions

The State Agency's fiscal agent will review claims with dates of service on or after July 1, 2012 for OPPCs and report to the State. The state's Surveillance and Utilization Review (SUR) unit will review each claim identified in that report and recover payments associated with the OPPC.

Payment Adjustment

For per diem payments, the number of covered days shall be reduced by the number of days associated with any PPC not present on admission. Nevada will use nationally accepted standards to determine the number of days attributable to the diagnosis absent the PPC and the incremental number of days attributable to the PPC. Reimbursement may also be reduced for level of care changes attributable to a PPC.

DEFINITION OF A CLAIM

For all services covered by the Nevada Medicaid program, the following definition applies:

Claim: A bill for services rendered by a provider. A bill may contain more than line item.

Citation

4.20 Direct Payments to Certain Recipients for Physicians' or Dentists' Services

42 CFR 447.25(b)
AT-78-90

Direct payments are made to certain recipients as specified by, and in accordance with, the requirements of 42 CFR 447.25.

__ Yes, for __ physicians' services

__ dentists' services

ATTACHMENT 4.20-A specifies the conditions under which such payments are made.

X Not applicable. No direct payments are made to recipients.

Revision: HCFA-AT-81-34 (BPP)
October 1981

OMB No.: 0938-0193

State/Territory: Nevada

Citation

42 CFR 447.10(c)
AT-78-90
46 FR 42699

4.21 Prohibition Against Reassignment of Provider Claims

Payment for Medicaid services furnished by any provider under this plan is made only in accordance with the requirements of 42 CFR 447.10.

Attachment 4.21-A specifies conditions under which a provider may compensate another person or entity to do his billing.

Attachment 4.21-A

Payment may be made to a provider of services who compensates any other person or entity to do his Medicaid billing only if such compensation is:

(1) Related to the actual cost of processing the billing;

(2) Not related on a percentage or other basis to the amount that is billed or collected; and

(3) Not dependent on the collection of the payment.

Payment may be made to the facility in which a provider rendered services, if the provider has a contract under which the facility submits the claim; and his compensation is:

(1) Not made to or through a factor; defined as an individual or an organization such as a collection service that advances money to a provider for accounts receivable that the provider has assigned, sold or transferred to the individual organization for an added fee or a deduction of a portion of the accounts receivable.

(2) Not related on a percentage or other basis to the amount that is billed or collected; and

(3) Not dependent on the collection of the payment.

Revision: HCFA-PM-94-1 (MB)
FEBRUARY 1994

State/Territory: NEVADA

REQUIREMENTS FOR THIRD PARTY LIABILITY

Citation:		
	4.22	Third Party Liability
42 CFR 433.137 1902(a)(25)(H) and (I) of the Act	(a)	The Medicaid agency meets all requirements of: (1) 42 CFR 433.138 and 433.139. (2) 42 CFR 433.145 through 433.148. (3) 42 CFR 433.151 through 433.154. (4) Sections 1902(a)(25)(H) and (I) of the Act.
42 CFR 433.138(f)	(b)	ATTACHMENT 4.22-A: IDENTIFING LIABLE RESOURCES
	(1)	Specifies the frequency with which the data exchanges required in 433.138(d)(1), (d)(3) and (d)(4) and the diagnosis and trauma code edits required in 433.138(e) are conducted;
42 CFR 433.138 (g)(1)(ii) and (2) (ii)	(2)	Describes the methods the agency uses for meeting the follow-up requirements contained in 433.138(g)(1)(i) and (g)(2)(i);
42 CFR 433.138 (g)(3)(i) and (iii)	(3)	Describes the methods the agency uses for following up on information obtained through the State motor vehicle accident report file data exchange required under 433.138(d)(4)(ii) and specifies the time frames for incorporation into the eligibility case file and into its third-party data base and third-party recovery unit of all information obtained through the follow-up that identifies legally liable third-party resources; and
42 CFR 433.138 (g)(4)(i) through (iii)	(4)	Describes the methods the agency uses for following up on paid claims identified under 433.138(e) (methods include a procedure for periodically identifying those trauma codes that yield the highest third party collections and giving priority to following up on those codes) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the follow-up that identifies legally liable third party resources.

42 CFR 433.139(b)(3)(ii)(A)	X	(c)	Providers are required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency.
		(d)	ATTACHMENT 4.22B – PAYMENT OF CLAIMS
CFR 433.139(b)(3)(ii)(C)		(1)	The method used in determining a provider's compliance with the third-party billing requirements at '433.139(b)(3)(ii)(C).
42 CFR 433.139(f)(2)		(2)	The threshold amount or other guideline used in determining whether to seek recovery of reimbursement from a liable third party, or the process by which the agency determines that seeking recovery of reimbursement would not be cost effective.
42 CFR 433.139(f)(3)		(3)	The dollar amount or time period the State uses to accumulate billings from a particular liable third party in making the decision to seek recovery of reimbursement.
42 CFR 447.20		(e)	The Medicaid agency ensures that the provider furnishing a service for which a third party is liable follows the restrictions specified in 42 CFR 447.20.

Citation

4.22 (continued)

42 CFR 433.151(a)

(f) The Medicaid agency has written cooperative agreements for the enforcement of rights to and collection of third-party benefits assigned to the State as a condition of eligibility for medical assistance with at least one of the following: (Check as appropriate.)

X State title IV-D agency. The requirements of 42 CFR 433.152(b) are met.

___ Other appropriate State agency(s).

___ Other appropriate agency(s) of another State.

___ Courts and law enforcement officials.

1902(a)(60) of the Act

(g) The Medicaid agency assures that the State has in effect the laws relating to medical child support under Section 1908 of the Act.

1906 of the Act

(h) The Medicaid agency specifies the guidelines used in determining the cost effectiveness of an employer-based group health plan by selecting one of the following.

___ The Secretary's method as provided in the State Medicaid Manual, Section 3910.

X The State provides methods for determining cost effectiveness on Attachment 4.22-C.

THIRD PARTY LIABILITY – IDENTIFYING LIABLE RESOURCES

Expansion of Third-Party Liability – Payment of Claims associated to Cost Saving Programs in Attachment 4.22-B of the State Plan.

433.138(d)(1) &(d)(3) (IV-A); (Exchange of Data)

(1) Nevada obtains information for the purpose of determining the legal liability of third parties from data exchanges with the Department of Employment, Training and Rehabilitation, Employment Security Division (ESD), Title IV-A Agency, Title IV-D Agency, Commercial Insurance Carriers, Referrals, Health Insurance Premium Program (HIPP), Third Party Liability (TPL) Reviews and from the diagnosis and trauma code edits for a data match. At the time of application for assistance, a match is done automatically.

The Division of Welfare and Supportive Services (DWSS) is the State IV-A agency for employment information. Employment information is utilized to determine Medicaid eligibility and employment TPL. The State's TPL management team updates and populates the data into the Medicaid Management Information System (MMIS).

The State of Nevada Department of Personnel conducts an exchange of data with the states TPL management team. A match of all Medicaid eligibles with responsible absent parent (IV-D) or parent (IV-A) by Social Security Number to determine if they are employed by the state of Nevada.

Support Enforcement (IV-D) has an automated quarterly match with ESD's quarterly wage report and can obtain information upon request. IV-D will follow up on court ordered health insurance or will seek a court order on employed non-custodial parents. TPL information is obtained through data match of majority insurers for court ordered health insurance to be populated into MMIS.

433.138(d)(4) and 433.138 (g)(3)(i) and (iii) (Workers Compensation and Motor Vehicle)

DWSS oversees initial application through single point entry system for Medicaid applications, applicants self-report through a form process; documentation requirement.

THIRD PARTY LIABILITY – IDENTIFYING LIABLE RESOURCES

Worker's Compensation and the Department of Motor Vehicles and Public Safety (DMV&PS) information is not available through Nevada's Department Motor Vehicle and Public Safety.

The DHCFP TPL management is responsible for review and submission of injury accident questionnaires for worker compensation and vehicle accidents. Claims which edit for trauma codes are referred to the Fiscal Agent (FA) Subrogation Unit for follow-up if the billed amount of the claim is greater than the tolerance level. The claim is reviewed to determine the possibility of other liable parties for claim payment. Managed Care Organizations and the Dental Benefit Administrator are required to data mine Medicaid enrollees through identifying potential casualty claims.

The claim is reviewed to determine if the nature of the trauma is one which warrants follow-up (e.g., a broken leg as a result of a fall in individual's own home versus a traffic accident). If an investigation is not in process or probable liability has not been established at the time the claim was filed, the investigator will begin research to determine if a probable third party is liable. If TPL is not established within 60 days, the claim is processed for payment.

The DMV&PS has a computerized system containing information of individuals involved in accidents, associated injuries for Nevada Highway Patrol reported accidents only. No medical insurance coverage information is reported. (A copy of the letter from DMV&PS is attached.)

433.138(e) (Diagnosis and Trauma Edits)

The Medicaid claims processing system on a per claim basis edits were updated to reflect new International Classification of Diseases (ICD) codes:

The TPL management team reviews to determine if the nature of the trauma is one which warrants follow-up (e.g., a broken leg as a result of a fall in individual's own home versus a traffic accident). If an investigation is not in process or probable liability has not been established at the time the claim was filed, the investigator will begin research to determine if a probable third party is liable. If TPL is not established within 60 days, the claim is processed for payment.

As of 2016, the Centers for Medicare & Medicaid Services (CMS) no longer specifies codes for follow up or reviews. CMS approved State Medicaid Agency (SMA) exemptions of specific codes from none productive trauma code recovery.

433.138(g) (1) (i) and (g) (2) (i)

Follow-up procedures for identifying legally liable third-party resources:

Within 45 days from application, redetermination, or anytime TPL is discovered, the DWSS collects TPL coverage and incorporates the information into the eligibility case file. The eligibility case file is shared with the DHCFP and used to update MMIS to be used for medical claims adjudication. TPL data is identified, verified and recorded into the MMIS monthly and used to cost avoid claims, as well as for pay and chase recoveries of claim overpayments.

433.138(g)(2)(i) & (ii)

Upon discovery of a liable third party, post payment recovery is sought within 60 days or in the case of legal actions, a lien is filed to protect the State's rights and recoupment of medical payments are sought.

Information regarding probable liability and subrogation is forwarded to the DWSS monthly through a secured HIPAA compliant system. Information is maintained in a secured file by the Fiscal Agent third party recovery unit and/or third-party vendor for subrogation case audits and incorporated into the Medicaid and CHIP third-party data base for claims processing.

The tolerance levels for suspension or termination of recovery efforts are identified in Third Party Liability, Attachment 4.22-B.

THIRD PARTY LIABILITY – PAYMENT OF CLAIMS

The Nevada Medicaid program is designed to function primarily as a cost avoidance system, with cost savings. This method was chosen as the most efficient and least costly due to the multitude of insurance companies utilized by Nevada residents. Also, insurance data is fed through a secured transmittal bill paying system on an individual basis. Direct contact is made by the fiscal agent TPL unit directly with insurance carriers and all available information is collected.

The Nevada bill paying system has a direct connection to the Center for Medicare and Medicaid Services' system. Cost savings occur when post-payment recovery is also incorporated. Criteria have therefore been established for both systems with emphasis on cost effectiveness and FFP compliance.

42 CFR 433.139(b)(3)(ii)(C)

I. Cost Avoidance Method

a. Claims with Medicaid paid amounts greater than zero are rejected on the remittance advice with insurance billing instructions and carrier information.

b. Services identified by individual policies as non-covered are not subject to cost avoidance or recovery.

42 CFR 433.139(f)(2&3), 42 CFR 447.20 and 7 CFR 273.18(e)(8)(ii)

II. Post-Payment Recovery

a. Recovery - Provider

1. States only pursue recoveries from providers whenever Medicare is the primary source.

2. Claims which were unidentified or missed in cost avoidance are subject to claims with Medicaid outlined in 1.a above. Recovery is made by computer history adjustments.

3. Due to Medicare timely filing, recovery efforts are not attempted when more than 12 months have elapsed from date of service to the projected adjustment date.

b. Recovery – Insurance Carrier

1. When necessary, direct recovery is attempted through individual insurance carriers. This can occur when providers are unsuccessful with billing attempts, but the fiscal agent (FA) has sufficient information to pursue collection. Claims with Medicaid paid amounts of less than $25 are not pursued.

A. Claims with Medicaid paid amounts of less than $25 are not pursued.

2. Claims with Medicaid paid amounts of $25 or greater are pursued by the FA through the individual insurance company.

III. Casualty – Subrogation

42 CFR 433.139(f)(e)

A. Claims which edit for trauma codes are processed through the regular processing cycle. If the billed amount is $125 or greater and no insurance has paid on the claim, the claim is referred to the fiscal agent for subrogation follow-up.

B. If the billed amount is less than $125, no investigation is initiated unless large quantities of claims exist for this diagnosis or service date.

C. Claims with billed amounts of $125 or more are investigated and followed through the legal process until settlements are reached or a determination made to drop the case.

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 benefit 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.

STATE LAW REQUIRES THIRD PARTIES TO PROVIDE COVERAGE ELIGIBILITY AND CLAIMS DATA

1902(a)(25)(I) The State has in effect laws that require third parties to comply with the provisions, including those which require third parties to provide the State with coverage, eligibility and claims data, of 1902(a)(25)(I) of the Social Security Act.

The 2007 Session of the Nevada Legislative enacted Senate Bill 529 which incorporates the requirements of Section 6035 of the Deficit Reduction Act of 2005 effective July 1, 2007.

42 CFR 434.4
48 FR 54013

State: NEVADA

4.23 Use of Contracts

The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 434. All contracts meet the requirements of 42 CFR Part 434.

[ ] Not applicable. The State has no such contracts.

42 CFR Part 438

The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 438. All contracts meet the requirements of 42 CFR Part 438. Risk contracts are procured through an open, competitive procurement process that is consistent with 42 CFR Part 74. The risk contract is with (check all that apply):

[**X**] a Managed Care Organization that meets the definition of 1903(m) of the Act and 42 CFR 438.2

[ ] a Prepaid Inpatient Health Plan that meets the definition of 42 CFR 438.2

[ ] a Prepaid Ambulatory Health Plan that meets the definition of 42 CFR 438.2

[ ] Not applicable.

Revision: HCFA-AT-81-20 (BPP) OMB No.: 0938-0193
APRIL 1981

State/Territory: Nevada

Citation

42 CFR 442.10
and 442.100
AT-78-90
AT-79-18
AT-80-25
AT-80-34
52 FR 32544
P.L. 100-203
(Sec, 2411)
54 FR 5316
56 FR48826

4.24 Standards for Payments for Skilled Nursing and Intermediate Care Facility Services

With respect to skilled nursing and intermediate care facilities for the mentally retarded, all applicable requirements of 42 CFR Part 442, Subparts B and C are met.

___ Not applicable to intermediate care facilities for the mentally retarded; such services are not provided under this plan.

Citation

4.25 Program for Licensing Administrators of Nursing Homes

42 CFR 431.702
AT-78-90

The State has a program that, except with respect to Christian Science sanatoria, meets the requirements of 42 CFR Part 431, Subpart N, for the licensing of nursing home administrators.

Revision: HCFA-PM-93-3 (MB)
March 1993

State/Territory: Nevada

Citation

1927(g)
42 CFR 456.700

4.2 Drug Utilization Review Program

A.1. The Medicaid agency meets the requirements of Section 1927(g) of the Act for a drug use review (DUR) program for outpatient drug claims.

2. The DUR program assures that the prescriptions for outpatient drugs are:

- Appropriate
- Medically necessary
- Are not likely to result in adverse medical results

B. The DUR program is designed to educate physicians and pharmacists to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and patients or associated with specific drugs as well as:

- Potential and actual adverse drug reactions
- Therapeutic appropriateness
- Overutilization and under utilization
- Appropriate use of generic products
- Therapeutic duplication
- Drug disease contraindications
- Drug-drug interactions
- Incorrect drug dosage or duration of drug treatment
- Drug-allergy interactions
- Clinical abuse/misuse

Revision: HCFA-PM-93-3 (MB)
March 1993

State/Territory: Nevada

Citation		
1927(g)(1)(B) 42 CFR 456.703 (d) and (f)	C.	The DUR program shall assess data use against predetermined standards whose source materials for their development are consistent with peer-reviewed medical literature which has been critically reviewed by unbiased independent experts and the following compendia: - American Hospital Formulary Service Drug Information - United States Pharmacopia-Drug Information - American Medical Association Drug Evaluations
1927(g)(1)(D) 42 CFR 456.703(b)	D.	DUR is not required for drugs dispensed to residents of nursing facilities that are in compliance with drug regiment review procedures set forth in 42 CFR 483.60. The State has never-the-less chosen to include nursing home drugs in: ___ Prospective DUR _X_ Retrospective DUR
1927(g)(2)(A) 42 CFR 456.705(b)	E.1.	The DUR program includes prospective review of drug therapy at the point of sale or point of distribution before each prescription is filled or delivered to the Medicaid recipient.
1927(g)(2)(A)(i) 42 CFR 456.705(b), (1)-(7))	2.	Prospective DUR includes screening each prescription filled or delivered to an individual receiving benefits for potential drug therapy problems due to: - Therapeutic duplication - Drug-disease contraindications - Drug-drug interactions - Drug-interactions with non-prescription or over-the-counter drugs - Incorrect drug dosage or duration of drug treatment - Drug allergy interactions - Clinical abuse/misuse

1927(g)(2)(A)(ii) 42 CFR 456.705(c) and (d)	3.	Prospective DUR includes counseling for Medicaid recipients based on standards established by state law and maintenance of patient profiles.
1927(g)(2)(B) 42 CFR 456.709(a)	F.1	The DUR program includes retrospective DUR through its mechanized drug claims processing and information retrieval system or otherwise which undertakes ongoing periodic examination of claims data and other records to identify: ▪ Patterns of fraud and abuse ▪ Gross overuse ▪ Inappropriate or medically unnecessary care among physicians, pharmacists, Medicaid recipients, or associated with specific drugs or groups of drugs.
1927(g)(2)(C) 42 CFR 456.709(b)	F.2	The DUR program assesses data on drug use against explicit predetermined standards including but not limited to monitoring for: ▪ Therapeutic appropriateness ▪ Overutilization and underutilization ▪ Appropriate use of generic products ▪ Therapeutic duplication ▪ Drug-disease contraindications ▪ Drug-drug interactions ▪ Incorrect drug dosage/duration of drug treatment ▪ Clinical abuse/misuse
1927(g)(2)(D) 42 CFR 456.711	3.	The DUR program through its State DUR Board, using data provided by the Board, provides for active and ongoing educational outreach programs to educate practitioners on common drug therapy problems to improve prescribing and dispensing practices.
1927(g)(3)(A) 42 CFR 456.716(a)	G.1	The DUR program has established a State DUR Board either: _X_ Directly, or ___ Under contract with a private organization

1927(g)(3)(B) 42 CFR 456.716 (A) and (B)	2.	The DUR Board membership includes health professionals (one-third licensed actively practicing pharmacists and one-third but no more than 51 percent licensed and actively practicing physicians) with knowledge and experience in one or more of the following: ▪ Clinically appropriate prescribing of covered outpatient drugs ▪ Clinically appropriate dispensing and monitoring of covered outpatient drugs ▪ Drug use review, evaluation and intervention ▪ Medical quality assurance
1927(g)(3)(C) 42 CFR 456.716(d)	3.	The activities of the DUR Board include: ▪ Retrospective DUR; ▪ Application of Standards as defined in section 1927(g)(2)(C); and ▪ Ongoing interventions for physicians and pharmacists targeted toward therapy problems or individuals identified in the source of retrospective DUR.
1927(g)(3)(C) 42 CFR 456.711 (a)-(d)	G.4	The interventions include in appropriate instances: ▪ Information dissemination ▪ Written, oral, and electronic reminders ▪ Face-to-face discussions ▪ Intensified monitoring/review of prescribers/dispensers

1927(g)(D) 42 CFR 456.712 (A) and (B)		H.	The State assures that it will prepare and submit an annual report to the secretary, which incorporates a report from the State DUR Board and that the State will adhere to the plans, steps, procedures as described in the report.
1927(h)(1) 42 CFR 456.722	____	I.1	The State establishes, as its principal means of processing claims for covered outpatient drugs under this title, a point-of-sale electronic claims management system to perform on-line: ▪ Real time eligibility verification ▪ Claims data capture ▪ Adjudication of claims ▪ Assistance to pharmacists, etc., applying for and receiving payment
1927(g)(2)(A)(i) 42 CFR 456.705(b)		2.	Prospective DUR is performed using an electronic point of sale drug claims processing system.
1927(j)(2) 42 CFR 456.703(c)		J.	Hospitals which dispense covered outpatient drugs are exempted from the drug utilization review requirements of this section when facilities use drug formulary systems and bill the Medicaid program no more than the hospital's purchasing cost for such covered outpatient drugs. The hospitals will provide documentation to the State to allow the State to make such exemptions.

Revision: HCFA-PM-93-3 (MB)
March 1993

State/Territory: NEVADA

Citation

1927(g)
42 CFR 456.700

4.26 Drug Utilization Review Program

A.1. The Medicaid agency meets the requirements of Section 1927(g) of the Act for a drug use review (DUR) program for outpatient drug claims.

1927(g)(1)(A)

2. The DUR program assures that prescriptions for outpatient drugs are:

-Appropriate
-Medically necessary
-Are not likely to result in adverse medical results

1927(g)(1)(a)
42 CFR 456.705(b)
and 456.709(b)

B. The DUR program is designed to educate physicians and pharmacists to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and patients or associated with specific drugs as well as:

- Potential and actual adverse drug reactions
- Therapeutic appropriateness
- Overutilization and under utilization
- Appropriate use of generic products
- Therapeutic duplication
- Drug disease contraindications
- Drug-drug interactions
- Incorrect drug dosage or duration of drug treatment
- Drug-allergy interactions
- Clinical abuse/misuse

Revision: HCFA-PM-93-3 (MB)
March 1993

State/Territory: NEVADA

Citation		
1927(g)(1)(B) 42 CFR 456.703 (d) and (f)	C.	The DUR program shall assess data use against predetermined standards whose source materials for their development are consistent with peer-reviewed medical literature which has been critically reviewed by unbiased independent experts and the following compendia: - American Hospital Formulary Service Drug Information - United States Pharmacopia-Drug Information - American Medical Association Drug Evaluations
1927(g)(1)(D) 42 CFR 456.703(b)	D.	DUR is not required for drugs dispensed to residents of nursing facilities that are in compliance with drug regimen review procedures set forth in 42 CFR 483.60. The State has never-the-less chosen to include nursing home drugs in: __ Prospective DUR X Retrospective DUR
1927(g)(2)(A) 42 CFR 456.705(b)	E.1.	The DUR program includes prospective review of drug therapy at the point of sale or point of distribution before each prescription is filled or delivered to the Medicaid recipient.
1927(g)(2)(A)(i) 42 CFR 456.705(b), (1)-(7))	2.	Prospective DUR includes screening each prescription filled or delivered to an individual receiving benefits for potential drug therapy problems due to: - Therapeutic duplication - Drug-disease contraindications - Drug-drug interactions - Drug-interactions with non-prescription or over-the-counter drugs - Incorrect drug dosage or duration of drug treatment - Drug allergy interactions - Clinical abuse/misuse

1927(g)(2)(A)(ii)
42 CFR 456.705(c)
and (d)

3. Prospective DUR includes counseling for Medicaid recipients based on standards established by state law and maintenance of patient profiles.

1927 (g)(2)(B)
42 CFR 456.709(a)

F.1 The DUR program includes retrospective DUR through its mechanized drug claims processing and information retrieval system or otherwise which undertakes ongoing periodic examination of claims data and other records to identify:

- Patterns of fraud and abuse
- Gross overuse
- Inappropriate or medically unnecessary care among physicians, pharmacists, Medicaid recipients, or associated with specific drugs or groups of drugs.

1927 (g)(2)(C)
42 CFR 456.709(b)

F.2. The DUR program assesses data on drug use against explicit predetermined standards including but not limited to monitoring for:

- Therapeutic appropriateness
- Overutilization and underutilization
- Appropriate use of generic products
- Therapeutic duplication
- Drug-disease contraindications
- Drug-drug interactions
- Incorrect drug dosage/duration of drug treatment
- Clinical abuse/misuse

1927 (g)(2)(D)
42 CFR 456.711

3. The DUR program through its State DUR Board, using data provided by the Board, provides for active and ongoing educational outreach programs to educate practitioners on common drug therapy problems to improve prescribing and dispensing practices.

1927 (g)(3)(A)
42 CFR 456.716(a)

G.1. The DUR program has established a State DUR Board either:

X Directly, or
__ Under contract with a private organization

1927(g)(3)(B)
42 CFR 456.716
(A) and (B)

2. The DUR Board membership includes health professionals (one-third licensed actively practicing pharmacists and one-third but no more than 51 percent licensed and actively practicing physicians) with knowledge and experience in one or more of the following:

- Clinically appropriate prescribing of covered outpatient drugs
- Clinically appropriate dispensing and monitoring of covered outpatient drugs.
- Drug use review, evaluation and intervention
- Medical quality assurance

1927(g)(3)(C)
42 CFR 456.716(d)

3. The activities of the DUR Board include:

- Retrospective DUR
- Application of Standards as defined in section 1927(g)(2)(C), and
- Ongoing interventions for physicians and pharmacists targeted toward therapy problems or individuals identified in the source of retrospective DUR

1927(g)(3)(C)
42 CFR 456.711
(a)-(d)

G.4. The interventions include in appropriate instances:

- Information dissemination
- Written, oral, and electronic reminders
- Face-to-face discussions
- Intensified monitoring/review of prescribers/dispensers

1927(g) (D)
42 CFR 456.712
(A) and (B)

H. The state assures that it will prepare and submit an annual report to the secretary, which incorporates a report from the State DUR Board and that the State will adhere to the plans, steps, procedures as described in the report.

1927(h) (1)
42 CFR 456.722

I.1. The State establishes, as its principal means of processing claims for covered outpatient drugs under this title, a point-of-sale electronic claims management system to perform on-line:

- Real time eligibility verification
- Claims data capture
- Adjudication of claims
- Assistance to pharmacists, etc., applying for and receiving payment

1927(g)(2)(A)(i)
42 CFR 456.705(b)

2. Prospective DUR is performed using an electronic point of sale drug claims processing system.

1927(j)(2)
42 CFR 456.703(c)

J. Hospitals which dispense covered outpatient drugs are exempted from the drug utilization review requirements of this section when facilities use drug formulary systems and bill the Medicaid program no more than the hospital's purchasing cost for such covered outpatient drugs. The hospitals will provide documentation to the State to allow the State to make such exemptions.

1902(a)(85) and Section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act)

K.1 Claims Review Limitations:

a. Prospective safety edits on opioid prescriptions to address days' supply, early refills, duplicate fills and quantity limitations for clinical appropriateness.

b. Prospective safety edits on maximum daily morphine milligram equivalents (MME) on opioids prescriptions to limit the daily morphine milligram equivalent (as recommended by clinical guidelines).

c. Retrospective reviews on opioid prescriptions exceeding these above limitations on an ongoing basis.

d. Retrospective reviews on concurrent utilization of opioids and benzodiazepines as well as opioids and antipsychotics on an ongoing periodic basis.

2. Programs to monitor antipsychotic medications to children:

a. Antipsychotic agents are reviewed for appropriateness for all children including foster children based on approved indications and clinical guidelines.

3. Fraud and abuse identification:

a. The State's DUR program has established a process that identifies potential fraud or abuse of controlled substances by enrolled individuals, health care providers and pharmacies.

Citation

42 CFR 431.115(c)
AT-78-90
AT-79-74

4.27 Disclosure of Survey Information and Provider or Contractor Evaluation

The Medicaid agency has established procedures for disclosing pertinent findings obtained from surveys and provider and contractor evaluations that meet all the requirements in 42 CFR 431.115.

State/Territory: NEVADA

Citation	
42 CFR 431.152l AT-79-18 52 FR 22444; Secs. 1902(a)(28)(D)(i) And 1919(e)(7) of the Act; P.L. 100-203 (Sec. 4211(c)).	4.28 Appeals Process (a) The Medicaid agency has established appeals procedures for NFs as specified in 42 CFR 431.153 and 431.154. (b) The State provides an appeals system that meets the requirements of 42 CFR 431 Subpart E, 42 CFR 483.12, and 42 CFR 483 Subpart E for residents who wish to appeal a notice of intent to transfer or discharge from a NF and for individuals adversely affected by the readmission and annual resident review requirements of 42 CFR 483 Subpart C.

State: NEVADA

Citation		
1902(a)(4)(C) of the Social Security Act P.L. 105-33	4.29	Conflict of Interest Provisions The Medicaid agency meets the requirements of Section 1902(a)(4)(C) of the Act concerning the Prohibition against acts, with respect to any activity Under the plan, that is prohibited by section 207 or 208 of title 18, United States Code.
1902(a)(4)(D) of the Social Security Act P.L. 105-33 1932 (d)(3) 42 CFR 438.58		The Medicaid agency meets the requirements of 1902(a)(4)(D) of the Act concerning the safeguards against conflicts of interest that are at least as stringent as the safeguards that apply under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423).

Citation

42 CFR 1002.203
AT-79-54
48 FR 3742
Subpart 51 FR 34772

4.30 Exclusion of Providers and Suspension of Practitioners and Other Individuals

(a) All requirements of 42 CFR Part 1002, B are met.

N/A The agency, under the authority of State law, imposes broader sanctions.

State: Nevada

Citation

(b) The Medicaid agency meets the requirements of –

1902(p) of the Act

1. Section 1902(p) of the Act by excluding from participation—

42 CFR 438.808

a. At the State's discretion, any individual or entity for any reason for which the Secretary could exclude the individual or entity from participation in a program under title XVIII in accordance with sections 1128, 1128A or 1866(b)(2).

b. An MCO (as defined in section 1903(m) of the Act), or an entity furnishing services under a waiver approved under section 1915(b)(1) of the Act, that:

(i) Could be excluded under section 1128(b)(8) relating to owners and managing employees who have been convicted of certain crimes or received other sanctions, or

1932(d)(1)
42 CFR 438.610

(ii) Has, directly or indirectly, a substantial contractual relationship (as defined by the Secretary) with an individual or entity that is described in section 1128(b)(8)(B) of the Act.

2. An MCO, PIHP, PAHP or PCCM may not have prohibited affiliations with individuals (as defined in 42 CFR 438.610(b)) suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. If the State finds that an MCO, PCCM, PIPH or PAHP is not in compliance, the State will comply with the requirements of 42 CFR 438.610(c).

Revision: HCFA-AT-87-14 (BERC) OMB No.: 0938-0193
OCTOBER 1987

State: Nevada

Citation

4.30 continued

1902(a)(39) of the Act
P.L. 100-93
(sec. 8(f))

(2) Section 1902(a)(39) of the Act by--

(A) Excluding an individual or entity from participation for the period specified by the Secretary, when required by the Secretary to do so in accordance with sections 1128 or 1128A of the Act; and

(B) Providing that no payment will be made with respect to any item or service furnished by an individual or entity during this period.

(C) The Medicaid agency meets the requirements of--

1902(a)(41)

P.L. 96-272
(sec 308(c))

(1) Section 1902(a)(41) of the Act of the Act with respect to prompt notification to HCFA whenever a provider is terminated, suspended, sanctioned, or otherwise excluded from participating under this State plan; and

1902(a)(49) of the Act
P.L. 100-93
(sec. 5(a)(4))

(2) Section 1902(a)(49) of the Act with respect to providing information and access to information regarding sanctions taken against health care practitioners and providers by State licensing authorities in accordance with section 1921 of the Act.

State/Territory: Nevada

Citation		Sanctions for Psychiatric Hospitals
1902(y)(1), (a) 1902(y)(2)(A), and Section 1902(y)(3) of the Act (P.L. 101-508, Section 4755(a)(2))	(a)	The State assures that the requirements of section 1902(y)(1), section 1902(y)(2)(A), and section 1902(y)(3) of the Act are met concerning sanctions for psychiatric hospitals that do not meet the requirements of participation when the hospital's deficiencies immediately jeopardize the health and safety of its patients or do not immediately jeopardize the health and safety of its patients.
1902(y)(1)(A) of the Act	(b)	The State terminates the hospital's participation under the State plan when the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies immediately jeopardize the health and safety of its patients.
1902(y)(1)(B) of the Act	(c)	When the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies do not immediately jeopardize the health and safety of its patients, the State may: 1. Terminate the hospital's participation under the State plan; or 2. Provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding; or 3. Terminate the hospital's participation under the State plan and provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding.
1902(y)(2)(A) of the Act	(d)	When the psychiatric hospital described in (c) above has not complied with the requirements for a psychiatric hospital within 3 months after the date the hospital is found to be out of compliance with such requirements, the State shall provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the end of such 3-month period.

State/Territory: Nevada

Citation
1932(e)
42 CFR 428.726

Sanctions for MCOs and PCCMs

a) The State will monitor for violations that involve the actions and failure to act specified in 42 CFR Part 438 Subpart I and to implement the provisions in 42 CFR 438 Subpart I, in manner specified below:

(1) civil penalties in the amounts specified in 42 CFR 438.704;
(2) appointment of temporary management for the contractor as provided in 42 CFR 438.706;
(3) granting enrollees the right to terminate enrollment without cause and notifying the affected enrollees of their right to disenroll;
(4) suspensions of all new enrollments, including default enrollment, after the effective date of the sanction;
(5) suspension of payment for recipients enrolled after the effective date of the sanction until CMS or the State is satisfied that the reason for the sanction no longer exists and is not likely to recur; or,
(6) any additional sanctions allowed under State statute or State regulations that address areas of non-compliance specified in 42 CFR 438.700 as well as additional areas of non-compliance. Additional sanctions may include liquidated damages and imposition of plans of correction in addition to its remedies at law.

Before imposing any intermediate sanction, liquidated damages, plans of correction, or other remedy against a managed care entity, DHCFP shall provide the Contractor with notice and such other due process protections as the State may provide, except that DHCFP will not provide the Contractor with a pre-termination hearing before imposing the sanction described in SSA, Section 1932(e)(2)(B) (Temporary Management).

b) The State uses the definition below of the threshold that would be met before an MCO is considered to have repeatedly committed violations of section 1903(m) and thus subject to imposition of temporary management:

The State of Nevada may impose the optional sanction of temporary management if it finds through on–site survey, enrollee complaints, financial audits, or any other means that there is continued egregious behavior by the Contractor, including but not limited to behavior described in 42 CFR 438.700 or that is

State: NEVADA

Citation	Sanctions for MCOs and PCCMs
1932(e) 42 CFR 428.726	contrary to any sections of 1903(M) and 1932 of the Act; or if there is substantial risk to the enrollees' health; or the sanction is necessary to ensure the enrollees' health while improvements are made to remedy violations of 42 CFR 438.700 or until there is an orderly termination of the contract.

c) The State's contracts with MCOs provide that payments provided for under the contract will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS under 42 CFR 438.730(e).

____ Not applicable; the State does not contract with MCOs, or the State does not choose to impose intermediate sanctions on PCCMs.

Citation

455.103
44 FR 41644
1902 (a)(38)
of the Act
P.L. 100-93
(sec. 8(f))

4.31 Disclosure of Information by Providers and Fiscal Agents

The Medicaid agency has established procedures for the disclosure of information by providers and fiscal agents as specified in 42 CFR 455.104 through 455.106 and Sections 1128(b)(9) and 1902(a)(38) of the Act.

435.940
through 435.960
52 FR 5967
52 FR 8738

4.32 Income and Eligibility Verification System

(a) The Medicaid agency has established a system for income and eligibility verification in accordance with the requirements of 42 CFR 435.940 through 435.960.

(b) ATTACHMENT 4.32-A describes, in accordance with 42 CFR 435.948(a)(6), the information that will be requested in order to verify eligibility or the correct payment amount and the agencies and the State(s) from which that information will be requested.

(c) The State has an eligibility determination system that provides for data matching through the Public Assistance Reporting Information System (PARIS), or any successor system, including matching with medical assistance programs operated by other States. The information that is requested will be exchanged with States and other entities legally entitled to verify Title XIX applicants and individuals eligible for covered Title XIX services consistent with applicable PARIS agreements. The State will transmit and receive data quarterly (February, May, August and November).

Citation

455.103
44 FR 41644
1902 (a)(38)
of the Act
P.L. 100-93
(sec. 8(f))

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435.940
through 435.960
52 FR 5967
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Nevada

INCOME AND ELIGIBILITY VERIFICATION SYSTEM PROCEDURES
REQUESTS TO OTHER STATE AGENCIES

The Nevada State Welfare Division requests information to verify Medicaid eligibility and recipient income for each applicant as specified under provisions of 42 CFR 435.948 (a) (1) through (a) (6).

Provision 42 CFR 435.948 (a) (6) is met by Nevada State Welfare as follows:

a) All applications ask whether an applicant has lived in another state and whether benefits were applied/received in that state. If an applicant indicates he/she has applied/received benefits in another state, the worker will verify. Any resources indicated by the other state which were not claimed by the applicant in Nevada will be evaluated.

b) The State has an eligibility determination system that provides for data matching through the Public Assistance Reporting Information System (PARIS), or any successor system, including matching with medical assistance programs operated by other States. The information that is requested will be exchanged with States and other entities legally entitled to verify title XIX applicants and individual eligible for covered title XIX services consistent with applicable PARIS agreements.

Citation

1902(a)(48) of the Act
P.L. 99-570 (Section 11005)
P.L. 100-93 (sec. 5(a) (3))

4.33 Medicaid Eligibility Cards for Homeless Individuals

(a) The Medicaid agency has a method for making cards evidencing eligibility for medical assistance available to an individual (sec. 5(a)(3)) eligible under the State's approved plan who does not reside in a permanent dwelling or does not have a fixed home or mailing address.

(b) ATTACHMENT 4.33-A specifies the method for issuance of Medicaid eligibility cards to homeless individuals.

State/Territory: Nevada

METHOD FOR ISSUANCE OF MEDICAID ELIGIBILITY CARDS TO HOMELESS INDIVIDUALS

Nevada does not require a person to have a home address to be eligible for Medicaid. The person may have his Medicaid card mailed wherever it is convenient (e.g., a friend or relative's address or general delivery or other legal address). This is the same method used for anyone applying for Medicaid. There is not a different method specifically for homeless individuals.

Citation

1137 of the Act

P.L. 99-603 (sec.121)

4.34 Systematic Alien Verification for Entitlements

The State Medicaid agency has established procedures for the verification of alien status through the Immigration & Naturalization Service (INS) designated system, Systematic Alien Verification for Entitlements (SAVE), effective October 1, 1988.

N/A The State Medicaid agency has elected to participate in the option period of October 1, 1987 to September 30, 1988 to verify alien status through the INS designated system (SAVE).

N/A The State Medicaid agency has received the following type(s) of waiver from participation in SAVE.

_ Total waiver

_ Alternative system

_ Partial implementation

REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS FOR MEDICAL ASSISTANCE

The following is a description of Nevada law concerning advance directives (NRS 449.540 to 449.690, inclusive, and sections 2 to 12, inclusive of Chapter 258, Statutes of Nevada 1991):

WHAT IS AN ADVANCE DIRECTIVE?

An advance directive is generally a written statement, which individuals complete in advance of serious illness, about how they want medical decisions made. The two most common forms of advance directive are:

- a "Living Will," or "Declaration";
- a "Durable Power of Attorney for Health Care."

An advance directive allows individuals to state their choices for health care or to name someone to make those choices for them, if they become unable to make decisions about their medical treatment. In short, an advance directive can enable individuals to make decisions about their future medical treatment. They can say "yes" to treatment they want, or say "no" to treatment they do not want.

WHAT IS A LIVING WILL OR DECLARATION?

A Living Will or Declaration generally states the kind of medical care individuals want (or do not want) if they become unable to make their own decisions. It is called a "Living Will" because it takes effect while they are still living.

WHAT IS A DURABLE POWER OF ATTORNEY FOR HEALTH CARE?

A "Durable Power of Attorney for Health Care" is a signed, dated, and witnessed paper naming another person, such as a husband, wife, daughter, son, or close friend as an "agent" or "proxy" to make medical decisions for an individual who should become unable to make such decisions. The power of attorney includes instructions about any treatment the individual may want or wish to avoid, such as surgery or artificial feeding.

IS IT REQUIRED TO WRITE AN ADVANCE DIRECTIVE UNDER THE LAW?

No. It is entirely up to the individual.

CAN AN INDIVIDUAL CHANGE HIS/HER MIND AFTER A LIVING WILL OR HEALTH CARE POWER OF ATTORNEY IS WRITTEN?

Yes. Individuals may change or cancel these documents at any time in accordance with state law. Any change or cancellation should be written, signed, and dated in accordance with state law, and copies should be given to the family doctor, or to others to whom the individual may have given copies of the original.

If an individual wishes to cancel an advance directive while in the hospital, the individual should notify his/her doctor, family, and others who may need to know.

Even without a change in writing, wishes stated in person directly to an individual's doctor generally carry more weight than a living will or durable power of attorney, as long as the individual can decide and can communicate his/her wishes. The individuals must be sure to state their wishes clearly and be sure that they are understood.

This is a form of a "Declaration," provided for under Nevada Statutes:

DECLARATION

If I should have an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician, cause my death within a relatively short time, and I am no longer able to make decisions regarding my medical treatment, I direct may attending physician, pursuant to NRS 449.540 to 449.690, inclusive, and section 2 to 12, inclusive, of this act, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain.

If you wish to include this statement, you must INITIAL the statement in the box provided. (If the statement reflects your desires, initial the box next to the statement.)

I direct my attending physician not to withhold or withdraw artificial nutrition and hydration by way of the gastrointestinal tract if such a withholding or withdrawal would result in my death by starvation or dehydration. [_____]

Signed this _____ day of _____, 19____.

Signature: _____
Address: _____

The declarant voluntarily signed this writing in my presence.

Witness: _____
Address: _____

Witness: _____
Address: _____

This is the form of a "Durable Power of Attorney" for health care decisions provided for under Nevada Statutes:

DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

WARNING TO PERSONS EXECUTING THIS DOCUMENT

This is an important legal document. It creates a Durable Power of Attorney for Health Care. Before executing this document, you should know these important facts:

1. This document gives the person you designate as your attorney-in-fact the power to make health care decisions for you. This power is subject to any limitations or statement of your desires that you include in this document. The power to make health care decisions for you may include consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. You may state in this document any types of treatment or placements that you do not desire.

2. The person you designate in this document has a duty to act consistent with your desires as stated in this document or otherwise made known or, if your desires are unknown, to act in your best interests.

3. Except as you otherwise specify in this document, the power of the person you designate to make health care decisions for you may include the power to consent to your doctor not giving treatment or stopping treatment which would keep you alive.

4. Unless you specify a shorter period in this document, this power will exist indefinitely from the date you execute this document and if you are unable to make health care decisions for yourself, this power will continue to exist until the time when you become able to make health care decisions for yourself.

5. Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to the particular decision. In addition, no treatment may be given to you over your objection, and health care necessary to keep you alive may not be stopped if you object.

6. You have the right to revoke the appointment of the person designated in this document to make health care decisions for you by notifying that person of the revocation orally or in writing.

7. You have the right to revoke the authority granted to the person designated in this document to make health care decisions for you by notifying the treating physician, hospital, or other provider of health care orally or in writing.

8. The person designated in this document to make health care decisions for you has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document.

9. This document revokes any prior Durable Power of Attorney for Health Care.

10. If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

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1. DESIGNATION OF HEALTH CARE AGENT

I, _____ (insert your name) do hereby designate and appoint:

Name: _____

Address: _____

Telephone: _____

as my attorney-in-fact to make health care decisions for me as authorized in this document.

(Insert the name and address of the persons you wish to designate as your attorney-in-fact to make health care decisions for you. Unless the person is also your spouse, legal guardian, or the person most closely related to you by blood, none of the follow-ing may be designated as your attorney-in-fact: 1) your treating provider of health care; 2) an employee of your treating provider of health care; 3) an operator of a health care facility; or 4) an employee of an operator of a health care facility.)

2. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE

By this document, I intend to create a durable power of attorney by appointing the person designated above to make health care decisions for me. This power of attorney shall not be affected by my subsequent incapacity.

3. GENERAL STATEMENT OF AUTHORITY GRANTED

In the event that I am incapable of giving informed consent with respect to health care decisions, I hereby grant to the attorney-in-fact named above full power and authority to make health care decisions for me before, or after my death, including: consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat physical or mental condition, subject only to the limitations and special providers, if any, set forth in paragraph 4 or 6.

4. SPECIAL PROVISIONS AND LIMITATIONS

(Your attorney-in-fact is not permitted to consent to any of the following: commitment to or placement in a mental health treatment facility, convulsive treatment, psychosurgery, sterilization, or abortion. If there are any other types of treatment or placement that you do not want your attorney-in-fact's authority to give consent for or other restrictions you wish to place on his or her attorney-in-fact's authority, you should list them in the space below. If you do not write any limitations, your attorney-in-fact will have the broad powers to make health care decisions on your behalf which are set forth in paragraph 3, except to the extent that there are limits provided by law.)

In exercising the authority under this Durable Power of Attorney for Health Care, the authority of my attorney-in-fact is subject to the following special provisions and limitations:

_____
_____
_____
_____

5. DURATION

I understand that this power of attorney will exist indefinitely from the date I execute this document unless I establish a shorter time. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted by attorney-in-fact will continue to exist until the time when I become able to make health care decisions for myself.

(IF APPLICABLE)

I wish to have this power of attorney end on the following date:

_____

6. STATEMENT OF DESIRES

(With respect to decisions to withhold or withdraw life-sustaining treatment, your attorney-in-fact must make health care decisions that are consistent with your known desires. You can, but are not required to, indicate your desires below. If your desires are unknown, your attorney-in-fact has the duty to act in your best interests; and, under some circumstances, a judicial proceeding may be necessary so that a court can determine the health care decision that is in your best interests. If you wish to indicate your desires, you may INITIAL the statement or statements that reflect your desires and/or write your own statements in the space below.) (If the statement reflects your desires, initial the box next to the statement.)

1. I desire that my life be prolonged to the greatest extent possible, without regard to my condition, the chances I have for recovery or long-term survival, or the cost of the procedures. [_____]

2. If I am in a coma which my doctors have reasonably concluded is irreversible, I desire that life-sustaining or prolonging treatments not be used. (Also should utilize provisions of NRS 449.540 to 449.690, inclusive, and sections 2 to 12, inclusive, of chapter 258, Statutes of Nevada 1991, if this subparagraph is initialed.) [_____]

3. If I have an incurable or terminal condition or illness and no reasonable hope of of long-term recovery or survival, I desire that life-sustaining or prolonging treatments not be used. (Also should utilize provisions of NRS 449.540 to 449.690, inclusive, and sections 2 to 12, inclusive, of chapter 258, Statutes of Nevada 1991, if this subparagraph is initialed.) [_____]

4. I do not desire treatment to be provided and/or continued if the burdens of the treatment outweigh the expected benefits. My attorney-in-fact is to consider the relief of suffering, the preservation or restoration of functioning, and the quality as well as the extent of the possible extension of my life. [_____]

(If you wish to change your answer, you may do so by drawing an "X" through the answer you do not want, and circling the answer you prefer.)

Other or Additional Statements of Desires: _____
_____
_____
_____

7. DESIGNATION OF ALTERNATE ATTORNEY-IN-FACT

(You are not required to designate any alternative attorney-in-fact, but you may do so. Any alternative attorney-in-fact you designate will be able to make the same health care decisions as the attorney-in-fact designated in paragraph to act as your attorney-in-fact. Also, if the attorney-in-fact designated in paragraph 1 is your spouse, his or her designation as your attorney-in-fact is automatically revoked by law if your marriage is dissolved.)

If the person designated in paragraph 1 as my attorney-in-fact is unable to make health care decisions for me, then I designate the following persons to serve as my attorney-in-fact to make health care decisions for me as authorized in this document, such person to serve in the order listed below:

A. First Alternative Attorney-in-Fact
Name: _____
Address: _____
Telephone: _____

B. Second Alternative Attorney-in-Fact
Name: _____
Address: _____
Telephone: _____

8. PRIOR DESIGNATIONS REVOKED

I revoke any prior Durable Power of Attorney for Health Care.

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY.)

I sign my name to this Durable Power of Attorney for Health Care on _____(date) at _____(city), _____(state).

_____
Signature

(This power of attorney will not be valid for making health care decisions unless it is either: 1) signed by at least two qualified witnesses who are personally known to you and who are present when you sign or acknowledge your signature; or 2) acknowledged before a notary public.)

CERTIFICATE OF ACKNOWLEDGEMENT OF NOTARY PUBLIC

(You may use acknowledgement before a notary public instead of statement of witnesses.)

State of Nevada)
) ss:
County of_____)

On this _____ day of _____, in the year _____, before me, _____ (here insert name of notary public) personally appeared _____ (here insert name of principal) personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it. I declare under penalty of perjury that the person whose name is ascribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

NOTARY SEAL

_____
Signature of Notary Public

STATEMENT OF WITNESSES

(You should carefully read and follow this witnessing procedure. This document will not be valid unless you comply with the witnessing procedure. If you elect to use witnesses instead of having this document notarized, you must use two qualified adult witnesses. None of the following may be used as a witness: 1) a person you designate as the attorney-in-fact; 2) a provider of health care; 3) an employee of a provider of health care; 4) the operator of a health care facility; 5) an employee of an operator of a health care facility. At least one of the witnesses must make the additional declaration set out following the place where the witnesses sign.)

I declare under penalty of perjury that the principal is personally known to me, that the principal signed or acknowledged this durable power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as attorney-in-fact by this document, and that I am not a provider of health care, an employee of a provider of health care, the operator of a community care facility, nor an employee of an operator of a health care facility.

Signature: _____
Print Name: _____
Residence Address: _____
Date: _____

Signature: _____
Print Name: _____
Residence Address: _____
Date: _____

(At least one of the above witnesses must also sign the following declaration.)

I declare under penalty of perjury that I am not related to the principal by blood, marriage, or adoption, and to the best of my knowledge I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Signature: _____
Signature: _____

Names: _____
Print Names: _____
Address: _____
Date: _____

COPIES: You should retain an executed copy of this document and give one to your attorney-in-fact. The power of attorney should be avail-able so a copy may be given to your providers of health care.

Under section 11 of Chapter 258, Nevada Statutes 1991, a health care provider is allowed to transfer care of a patient to another provider if the first provider objects on the basis of conscience to implementation of an advance directive.

Revision: HCFA-PM-90-2 (BPD)
JANUARY 1990

OMB No.: 0938-0193

State/Territory: NEVADA

Citation

4.35 Remedies for Skilled Nursing and Intermediate Care Facilities that Do Not Meet Requirements of Participation

1919(h)(1) and (2) of the Act, P.L. 100-203 Sec.4213(a))

(a) The Medicaid agency meets the requirements of section 1919(h)(2)(A) through (D) of the Act concerning remedies for skilled nursing and intermediate care facilities that do not meet one or more requirements of participation.

ATTACHMENT 4.35-A describes the criteria for applying the remedies specified in section 1919(h)(2)(A)(i) through (iv) of the Act.

___ Not applicable to intermediate care facilities; these services are not furnished under this plan.

X (b) The agency uses the following remedy(ies):

(1) Denial of payment for new admissions.

(2) Civil money penalty.

(3) Appointment of temporary management.

(4) In emergency cases, closure of the facility and/or transfer of residents.

1919(h)(2)(B)(ii) of the Act

X (c) The agency establishes alternative State remedies to the specified Federal remedies (except for termination of participation).

ATTACHMENT 4.35-B describes these alternative remedies and specifies the basis for their use.

1919(h)(2)(F) of the Act

_ (d) The agency uses one of the following incentive programs to reward skilled nursing or intermediate care facilities that furnish the highest quality care to Medicaid residents:

_ (1) Public recognition.

_ (2) Incentive payments.

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

State/Territory: NEVADA

Citation 4.35 Enforcement of compliance for Nursing Facilities

42 CFR 488.402(f)

(a) Notification of Enforcement Remedies

When taking an enforcement action against a non-State operated NF, the State provides notification in accordance with 42 CFR 488.402(f).

(i) The notice (except for civil money penalties and State monitoring) specifies the:

(1) nature of compliance,
(2) which remedy is imposed,
(3) effective date of the remedy, and right to appeal the determination leading to the remedy.
(4) Right to appeal the determination leading to the remedy.

42 CFR 488.434

(ii) The notice for civil money penalties is in writing and contains the information specified in 42 CFR 488.434.

42 CFR 488.402(f)(2

(iii) Except for civil money penalties and State monitoring, notice is given at least 2 calendar days before the effective date of the enforcement remedy for immediate jeopardy situations and at least 15 calendar days before the effective date of the enforcement remedy when immediate jeopardy does not exist.

42 CFR

(iv) Notification of termination is given to the facility and to the public at least 2 calendar days before the remedy's effective date if the noncompliance constitutes immediate jeopardy and at least 15 calendar days before the remedy's effective date if the noncompliance does not constitute immediate jeopardy. The State must terminate the provider agreement of an NF in accordance with procedures in parts 431 and 422.

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

State/Territory: NEVADA

Citation 4.35 Enforcement of Compliance for Nursing Facilities (continued)

(b) Factors to be Considered in Selecting Remedies

42 CFR 448.404 (b)(1) and (2)

(i) In determining the seriousness of deficiencies, the State considers the factors specified in 42 CFR 488.404(b)(1) and (2).

X The State considers additional factors. Attachment 4.35-A describes the States other factors.

(c) Application of Remedies

42 CFR 448.410

(i) If there is immediate jeopardy to resident health or safety, the State terminates the NF's provider agreement within 23 calendar days from the date of the last survey or immediately imposes temporary management to remove the threat within 23 days.

42 CFR 448.417(b) 1919(h)(2)(c) of the Act.

(ii) The State imposes the denial of payment (or its approved alternative) with respect to any individual admitted to an NF that has not come into compliance within 3 months after the last day of the survey.

42 CFR 448.414 1919(h)(2)(d) of the Act.

(iii) The State imposes the denial of payment for new admissions remedy as specified in 488.417 (or its approved alternative) and a state monitor as specified at 488.422, when a facility has been found to have provided substandard quality of care on the last three consecutive standard survey.

42 CFR 448.408 1919(h)(2)(A) of the Act.

(iv) The State follows the criteria specified at 42 CFR 488.408(c)(2), 488.408(d)(2), and 488.408(e)(2), when it imposes remedies in place or in addition to termination.

42 CFR 448.412(a)

(v) When immediate jeopardy does not exist, the State terminates an NF's provider agreement no late than 6 months from the finding of noncompliance, if the conditions of 42 CFR 488.412(a) are not met.

Revision: HCFA-PM-95-4 (HSQB)
JUNE 1995

State/Territory: NEVADA

Citation 4.35 Enforcement of Compliance for Nursing Facilities (Continued)

42 CFR 448.406(b) 1919(h)(2)(A) of the Act.

(d) Available Remedies

(i) The State has established the remedies defined in 42 CFR 488.406(b).

__x__ (1) Termination
__x__ (2) Temporary Management
__x__ (3) Denial of Payment for New Admissions
__x__ (4) Civil Money Penalties
__x__ (5) Transfer of Residents; Transfer of Residents with Closure of Facility
__x__ (6) State Monitoring

Attachments 4.35-B through 4.35-G describe the criteria for applying the above remedies. Nevada Revised Statues NRS 449.163 through 449.170 are the authority for remedies cited above.

42 CFR 448.406(b)

(ii) ____ The State uses alternative remedies. The State has established alternative remedies that the State will impose in place of a remedy specified in 42 CFR 488.406(b).

_____ (1) Temporary Management
_____ (2) Denial of Payment for New Admissions
_____ (3) Civil Money Penalties
_____ (4) Transfer of Residents; Transfer of residents with Closure of Facility
_____ (5) State Monitoring

Attachments 4.35-B through 4.35-G describe the criteria for applying the above remedies.

42 CFR 488.303(b) 1919(h)(2)(F)

(e) State Incentive Programs

_____ (1) Public Recognition
_____ (2) Incentive Payments

Not Applicable

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: NEVADA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

The State uses other factors described below to determine the seriousness of deficiencies in addition to those described at '488.404(b)(1):

(1) The relationship of the one deficiency with other deficiencies:

(2) The facility's prior survey history; and

(3) The facility's ownership (or party/entity responsible for operating the facility), specifically, the prior and current status of the owner's (operator's) other facilities in relationship to the deficiency(ies) cited.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: NEVADA

CRITERIA FOR APPLICATION OF SPECIFIED REMEDIES
SPECIFIED REMEDIES AS ON PAGE 79C

DENIAL OF PAYMENT FOR NEW ADMISSIONS

Sec. 133 1. The Bureau of Regulatory Health Services (bureau) may request the welfare division to deny Medicaid payment to a facility for new admissions if:

(a) The facility does not substantially correct the deficiencies within 90 days or within the time required by federal Medicaid law after the facility is notified by the bureau of the deficiencies; or

(b) The bureau has cited a facility with substandard quality of care (severity score of level three or more and scope of level three or more as defined under federal survey guide-lines) on two of the last three consecutive standard surveys.

2. If the facility achieves and maintains compliance with the requirements, the bureau shall request the welfare division to resume payments to the facility prospectively; effective on the date compliance was achieved.

Sec. 134 1. The bureau may request the welfare division to deny payment to a facility for new admissions who have certain specified diagnoses or special care needs if:

(a) The facility is not currently able to provide appropriate care, services, or treatment for these persons; or

(b) Caring for these persons will adversely affect care provided to other recipients.

2. If the facility achieves and maintains compliance with the requirements, the bureau must request the welfare division to resume payment to the facility prospectively, effective on the date compliance was achieved.

Sec. 135 1. The bureau may request the welfare division to suspend all or part of the Medicaid payments to a facility for services furnished to a Medicaid recipient on or after the date of the deficiency, regardless of whether the recipient was admitted before, on, or after the date of the deficiency.

2. If the facility achieves compliance with the requirements, the bureau shall request the department of human resources to resume payments retroactively.

CIVIL MONEY PENALTIES

Sec. 106 The bureau may impose a monetary penalty alone or in addition to other penalties. The purpose of a monetary penalty is to provide a fund for protecting the health, safety, rights, welfare, and well-being of recipients and the property of residents in facilities and to deter future deficiencies. If a penalty is imposed, the criteria in section 107 below must be applied.

Sec. 107 1. Except as otherwise provided in subsection 4, the bureau may impose a monetary penalty on any facility that is not in compliance with any federal participation requirement, regardless of whether the deficiency constitutes an immediate and serious threat.

2. If a monetary penalty is imposed, the initial penalty based on the severity and scope score of the deficiency must be imposed as provided in section 111 below.

3. In addition to the initial penalty, the bureau may impose a monetary penalty for each day of noncompliance from the date the noncompliance occurs or is identified until compliance is veri-fied.

4. A facility is not subject to a monetary penalty for a de minimis deficiency. As used in this subsection, "de minimis deficiency" means a finding rated as having a severity level of one or two under federal survey guidelines.

Sec. 108

1. The bureau shall impose an initial penalty pending a hearing or appeal. The payment of the penalty must not be stayed during the pendency of any administrative appeal.

2. The payment of any daily penalties that accrue while the facility has a hearing pending on the initial determination of deficiencies leading to the imposition of sanctions must be stayed pending the appeal.

Sec. 109

If the bureau imposes a monetary penalty, the penalty must be imposed as provided in sections 109, 110, and 111 of this attachment. In imposing the penalty, the total penalty assessed against any facility bears interest at the rate of 10 percent per annum.

Sec. 110

1. In no event may the principal amount of the total daily monetary penalty assessed against any facility exceed $1,000 per deficiency per day.

2. Where more than one deficiency is subject to a monetary penalty, the total daily penalty assessed against a facility may not exceed the maximum daily penalty per facility permitted by 42 U.S.C. ' 1396r for monetary penalties assessed against Medicaid facilities.

3. If the maximum daily administrative penalty per facility permitted by federal law for a facility of the type being sanctioned is less than that permitted by 42 U.S.C ' 1396r, the lower maximum penalty amount must be imposed.

Sec. 111

1. In determining the amount of an initial penalty, the bureau shall consider the severity alone if the severity level is four. In determining the amount of the monetary penalty where the severity level is less than four, both severity and scope must be considered. In determining whether to impose a daily monetary penalty, the bureau shall consider the severity and scope and the factors indicated for increased and decreased penalties provided in sections 112 and 114 of this attachment.

2. For initial deficiencies with a severity level of four, an initial monetary penalty of $500 per deficiency must be imposed. In addition, a penalty of $10 per recipient per day may be imposed for each day the deficiency continues.

3. For initial deficiencies rated with a severity level of three and a scope level of three or more, a monetary penalty of $400 per deficiency must be imposed. In addition, a penalty of $8 per recipient per day may be imposed for each day the deficiency continues.

4. For initial deficiencies with a severity level of three and a scope of level of two, an initial monetary penalty of $200 per deficiency must be imposed. In addition, a penalty of $4 per recipient per day may be imposed for each day the deficiency continues.

5. For initial deficiencies with a severity level of two and a scope level of three, an initial monetary penalty of $100 per deficiency-cy must be imposed. The payment of this penalty must be suspended if the facility has corrected the deficiencies within the time specified in the plan of correction. In addition, a penalty of $2 per recipient per day may be imposed for each day the deficiency continues.

Sec. 112

1. Penalties must be increased if deficiencies are uncorrected or repeated or compliance is falsely alleged.

2. For each uncorrected deficiency present after the time specified by the bureau for correction of the deficiency, the monetary penalty must be computed at the rate of one and one-half times the rate that was or could have been assessed initially for a deficiency of that severity and scope

3. For each repeat deficiency present within 18 months after an initial finding of the deficiency, the monetary penalty must be computed at the rate of one and one-half times the rate that was or could have been assessed initially for a deficiency of that severity and scope.

4. The bureau may double the daily penalty that was or could have been assessed if the facility alleges compliance and the bureau finds on a survey that at the time compliance was alleged, the deficiencies continued to exist.

Sec. 113 There is a rebuttable presumption that deficiencies identified on a subsequent survey were present on each day between the date of the initial finding and the date of the subsequent finding.

Sec. 114 1. If a facility against which a monetary penalty is imposed:

(a) waives the right to a hearing;

(b) corrects the deficiencies that were the basis for the penalty; and

(c) pays the penalty within 15 days after notice of the penalty,

the penalty must be reduced by 25 percent and no interest may be charged.

2. If, before a survey by the bureau, the facility identifies and corrects the deficiencies that are the basis for the penalty, the penalty must be reduced by 50 percent and no interest may be charged if the assessment is paid within the time required by sections 52 to 147, inclusive, of this attachment.

Sec. 115 If a monetary penalty is assessed on a daily basis according to the number of recipients and the number of recipients fluctuates, the penalty must be computed on the basis of the average daily number of recipients during the three (3) months preceding the imposition of the penalty.

Sec. 116 The effective beginning date of a daily monetary penalty is:

1. In the case of an immediate and serious threat, the date the deficiency occurred; and

2. In any other case, the day the deficiency is identified.

Sec. 117 1. Daily penalties and interest must be computed after compliance has been verified or the provider has been sent notice of termination of a license or provisional license. A daily penalty must end on the effective date of compliance or termination of the license of the facility.

2. If a provider achieves compliance, the bureau shall send a separate notice to the facility containing:

(a) The amount of penalty per day;

(b) The number of days involved;

(c) The due date of the penalty; and

(d) The total amount due.

3. If a license of a facility is to be terminated, the bureau shall send the information required by subsection 2 in the notice of termination.

4. If the bureau's decision of noncompliance is upheld on appeal or the facility waives its right to a hearing, the monetary penalty must be imposed for the number of days between the effective date of the penalty and the date of correction of the deficiencies or, if applicable, the date the license of the facility is terminated.

Sec. 118

1. The daily accrual of a monetary penalty must end if the facility demonstrates that substantial improvements have been made to correct the deficiencies and that the health, safety, and well-being of recipients are adequately protected and safeguarded.

2. A monetary penalty may be imposed on a daily basis for no longer than six (6) months, after which the bureau shall deny, suspend, or revoke the license of the facility and, if the facility is a Medicaid facility and major deficiencies remain, request the welfare division to terminate the Medicaid provider agreement of the facility.

3. If a deficiency in a Medicaid facility presents an immediate and serious threat and continues to exist on the 23rd day following the appointment of temporary management, the bureau shall request the welfare division to terminate the Medicaid provider agreement of the facility.

4. If the provider can supply credible evidence that substantial compliance with participation requirements was attained on a date preceding that of the survey, monetary penalties accrue only until that date of correction for which there is credible evidence. As used in this subsection, "credible evidence" means actual documentation that compliance has been achieved.

Sec. 119

1. Initial penalty assessment payments are due within 15 days after notice of the penalty and must be paid irrespective of any administrative appeal.

2. The daily monetary penalty is due and must be paid within 15 days after compliance is verified or termination of a license is effective and the facility is notified of the amount of the total daily penalty due.

3. If the facility has appealed a decision imposing a monetary penalty, the daily penalty is due and must be paid after the final administrative decision is rendered and 15 days after the facility has been notified of the amount of the total daily penalty due.

Sec. 120

1. If the facility fails to pay a monetary penalty, the health division may suspend the license of the facility.

2. The health division shall provide proper notice of its intent to suspend the license of the facility.

3. If the facility fails to pay the penalty, including any additional costs incurred in collection of the penalty, within 10 days after receipt of the notice, the health division shall suspend the license of the facility. The suspension must not be stayed during the pendency of any administrative appeal.

Sec. 121

Any costs, including attorney's fees, incurred by the bureau or the health division in the collection of any monetary penalty may be recovered from the facility.

Sec. 122

1. The amount of any penalty owed by a Medicaid facility, if it has been determined, may be deducted from any money otherwise owed to the facility by the welfare division.

2. If the facility does not pay a monetary penalty by the date it is due and no extension of time to pay is granted, the administrator of the health division shall notify the administrator of the welfare division of the amount of the penalty due and owing and shall request withholding of the amount owed.

3. The administrator of the welfare division will take the appropriate steps to withhold the amount of the penalty owed, including any interest and costs of collection, from the Medicaid payment otherwise due the facility. Money so withheld must be remitted to the health division for deposit in the special fund established pursuant to section 124 below. Money withheld for costs of collection must be applied by the administrator of the health division to the account incurring the costs.

Sec. 123 Unless it is waived as provided in section 114, interest at the rate prescribed in NRS 449.163 will be assessed on the unpaid balance of the penalty, beginning on the due date.

Sec. 124 1. Unless otherwise required by federal law, money collected by the health division as administrative penalties must be deposited into a separate fund and applied to the protection of the health, safety, well-being, and property of recipients, including residents of facilities that the health division finds deficient.

2. Any of the following applications of money collected, without limitation, are permissible:

(a) Reimbursement of costs related to the operation of a facility pending correction of deficiencies or closure;

(b) Reimbursement of residents for personal money lost; and

(c) Payment of the cost of relocating residents to other facilities.

Sec. 125 The bureau may settle a case at any time before a final administrative hearing decision.

APPOINTMENT OF TEMPORARY MANAGEMENT

Sec. 126 1. If a temporary manager is to be appointed, the bureau shall orally notify the facility of the appointment. Written notice that complies with the following requirements must be mailed within 24 hours after the oral notice:

"Except in an emergency or in a case in which the sanction is the issuance of a provisional license, the notice must be delivered at least 5 days before the imposition of the sanction and must include:

1. A citation of the statutory and regulatory authority for the sanction;

2. The factual findings providing the basis for the deficiency;

3. A description of any circumstances, such as self-correction or subsequent, uncorrected or repeated deficiencies, considered in determining the sanction;

4. Instructions for responding to the notice, including a statement of the right of the facility to a hearing, the time within which a hearing must be requested, and the consequences of waiving a hearing; and

5. If a monetary penalty is to be imposed, the amount of any initial and any daily monetary penalty per day of noncompliance."

2. If the facility does not accept the temporary manager or a temporary manager is not available within 10 days after the date of the deficiency, and the immediate and serious threat is not removed, the bureau shall deny, suspend, or revoke the license of the facility, and, if applicable, shall also recommend to the welfare division termination or suspension of the Medicaid provider agreement of the facility.

3. If the facility accepts the temporary manager, the bureau shall:

(a) Notify the facility that, unless it removes the immediate and serious threat, it's license will be denied, suspended, or revoked pursuant to NRS 449.160; and

(b) Where applicable, recommend to the welfare division that the Medicaid provider agreement of the facility be terminated, effective on the 23rd day after the date of appointment of the temporary manager.

4. If the immediate and serious threat is not removed on or before the 23rd day after the appointment of the temporary manager, the bureau shall deny, suspend, or revoke the license of the facility, and, if applicable, recommend to the welfare division that the Medicaid provider agreement be terminated.

Sec. 127 Appointment of a temporary manager where there is not an immediate and serious threat must be made in conformity with the provisions for notice contained in section 126.

Sec. 128 1. The temporary manager must:

(a) Be a person qualified to operate the facility pursuant to the provisions of chapter 449 of NRS relating to the licensing of the facility;

(b) Demonstrate prior competency as an administrator of a medical facility or a facility for the dependent, or have other relevant experience pertinent to the deficiencies identified; and

(c) Have had no disciplinary action taken against him by any licensing board or professional society in any state.

2. The temporary manager may be an employee of the health division or a private person or agency that contracts with the health division to serve in that capacity.

Sec. 129 The costs and expenses of temporary management, including the compensation of the manager, must be paid by the facility through the bureau while the temporary manager is assigned to the facility.

Sec. 130 The temporary manager may take such action as is required to mitigate the immediate danger at the facility, including without limitation providing for the safe transfer of residents or prohibiting the transfer of residents.

Sec. 131 If a facility fails to agree to the appointment of a temporary manager or fails to relinquish authority to the temporary manager, the health division shall:

1. Request the attorney general to bring an action pursuant to NRS 439.565;

2. Deny, suspend, or revoke the license of the facility; and

3. If applicable, request the welfare division to terminate the provider agreement of the facility in accordance with the requirements of the Medicaid program.

Sec. 132 1. Temporary management of a facility must be terminated if the bureau determines that:

(a) The facility has substantially corrected the deficiency and has secured management capable of ensuring continued compliance with applicable state and federal statutes, regulations, conditions, and standards;

(b) The facility has substantially corrected the deficiencies; or

(c) The license of the facility has been denied, revoked, or suspended.

2. If temporary management will be needed for more than 24 days, the bureau shall request the attorney general to initiate judicial proceedings as authorized by NRS 439.565.

IN EMERGENCY CASES, CLOSURE OF THE FACILITY AND/OR TRANSFER OF RESIDENTS

Sec. 144 1. Except as otherwise provided in subsection 2, if the bureau proposes to close a facility, the health division shall, at least five (5) days before the transfer, notify or cause to be notified personally or by written or telephonic means:

(a) each recipient; and

(b) any person indicated on the record of the recipient as a person to be notified in case of an emergency,

of the nature of the emergency and the proposed transfer.

2. In an acute emergency, residents may be transferred without prior notice. As used in this subsection, "acute emergency" means that action must be taken without prior notice as a result of an immediate and serious threat.

Sec. 145 If the residents of a residential facility are to be transferred, the following criteria must be applied in the following order to determine the most appropriate placement of each resident:

1. The medical and psychological health of the resident and the suitability of the proposed facility to meet the resident's medical and psychosocial needs;

2. The facility, if any, where the spouse or immediate family member of the resident is a resident; and

3. The geographical proximity of the proposed facility to the immediate family or regular visitors of the resident.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: NEVADA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Termination of Provider Agreement: Describe the criteria (as required at '1919(h)(2)(A)) for applying the remedy.

_X_ Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: NEVADA

ALTERNATE REMEDIES TO SPECIFIED REMEDIES FOR
SKILLED AND INTERMEDIATE CARE FACILITIES

Sec. 87 The sanctions available for all facilities include:

1. The requirement that the facility submit a plan of correction for approval by the bureau;

2. The issuance of a provisional license as provided by NRS 449.091;

3. The imposition of a limitation on the occupancy of a residential facility;

4. The imposition of a ban on admissions;

5. Monitoring of the facility by the bureau.

Sec. 88 For a facility that participates in Medicaid, in addition to imposing any sanction authorized by section 87 in this attachment, the bureau may recommend to the welfare division:

1. That the provider agreement of the facility be terminated.

2. That Medicaid payment for certain diagnostic categories or certain types of specialized care be denied.

3. That all or part of the payments to the facility be suspended.

4. That the facility be allowed to continue to participate as a Medicaid facility for 6 months after the date of the survey if:

   (a) The bureau finds that it is more appropriate to impose alternative sanctions than to recommend termination of the facility from the Medicaid program;

   (b) The facility has submitted an acceptable plan of correction;

(c) The bureau approves the plan of correction; and

(d) The facility agrees to repay the Federal Government for any payments received under the Medicare or Medicaid program if timely corrective action is not taken in accordance with the approved plan of correction.

If the facility does not substantially correct the cited deficiencies within six (6) months after the last day of the survey, the bureau shall recommend that the welfare division terminate the Medicaid agreement of any facility whose participation was continued under these conditions.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: NEVADA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Temporary Management: Describe the criteria (as required at '1919(h)(2)(A)) for applying the remedy.

_X_ Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and notice requirements and demonstrate that the alternative remedy is as effective in deterring noncompliance. Notice requirements are as specified in the regulations.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: NEVADA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Denial of Payment for New Admissions: Describe the criteria (as required at '1919(h)(2)(A)) for applying the remedy.

_X_ Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and notice requirements and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: NEVADA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Civil Money Penalty: Describe the criteria (as required at '1919(h)(2)(A)) for applying the remedy.

X Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and notice requirements and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: NEVADA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

State Monitoring: Describe the criteria (as required at '1919(h)(2)(A)) for applying the remedy.

_X_ Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and notice requirements and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: NEVADA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Transfer of Residents; Transfer of Residents with Closure of Facility: Describe the criteria (as required at '1919(h)(2)(A)) for applying the remedy.

_X_ Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy

(Describe the criteria and notice requirements and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: NEVADA

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Additional Remedies: Describe the criteria (as required at '1919(h)(2)(A)) for applying the remedy. Include the enforcement category in which the remedy will be imposed (i.e., category 1, category 2, or category 3 as described at 42 CFR 488.408).

NONE

Citation

4.36 Required Coordination Between the Medicaid and WIC Programs

1902(a)(11)(C) and 1902(a)(53) of the Act

The Medicaid agency provides for the coordination between the Medicaid program and the Special Supplemental Food Program for Women, Infants, and Children (WIC) and provides timely notice and referral to WIC in accordance with section 1902(a)(53) of the Act.

Revision: HCFA-PM-91-10 (BPD)
December 1991

State/Territory: NEVADA

Citation

42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec.4801(a)).

4.38 Nurse Aide Training and Competency Evaluation for Nursing Facilities

(a) The State assures that the requirements of 42CFR 483.150(a), which relate to individuals deemed to meet the nurse aide training and competency evaluation requirements, are met.

X (b) The State waives the competency evaluation requirements for individuals who meet the requirements of 42 CFR 483.150(b)(1).

X (c) The State deems individuals who meet the requirements of 42 CFR 483.150(b)(2) to have met the nurse aide training and competency evaluation requirements.

(d) The State specifies any nurse aide training and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.152 and competency evaluation programs it approves as meeting the requirements of 42 CFR 483.154.

_ (e) The State offers a nurse aide training and competency evaluation program that meets the requirements of 42 CFR 483.152.

X (f) The State offers a nurse aide competency evaluation program that meets the requirements of 42 CFR 483.154.

Citation

42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2) and 1919(f)(2), P.L. 100-203 (Sec. 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec.4801(a)).

(g) If the State does not choose to offer a nurse aide training and competency evaluation program or nurse aide competency evaluation program, the State reviews all nurse aide training and competency evaluation programs and competency evaluation programs upon request.

(h) The State survey agency determines, during the course of all surveys, whether the requirements of 483.75(e) are met.

(i) Before approving a nurse aide training and competency evaluation program, the State determines whether the requirements of 42 CFR 483.152 are met.

(j) Before approving a nurse aide competency evaluation program, the State determines whether the requirements of 42 CFR 483.154 are met.

(k) For program reviews other than the initial review, the State visits the entity providing the program.

(l) The State does not approve a nurse aide training and competency evaluation program or competency evaluation program offered by or in certain facilities as described in 42 CFR 483.151(b)(2) and (3).

Revision: HCFA-PM-91-10 (BPD)
December 1991

State/Territory: NEVADA

Citation

42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2) and 1919(f)(2) P.L. 100-203 (Sec 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec.4801(a)).

(m) The State, within 90 days of receiving a request for approval of a nurse aide training and competency evaluation program or competency evaluation program, either advises the requestor whether or not the program has been approved or requests additional information from the requestor.

(n) The State does not grant approval of a nurse aide training and competency evaluation program for a period longer than 2 years.

(o) The State reviews programs when notified of substantive changes (e.g., extensive curriculum modification).

(p) The State withdraws approval from nurse aide training and competency evaluation programs and competency evaluation programs when the program is described in 42 CFR 483.151(b)(2) or (3).

X (q) The State withdraws approval of nurse aide training and competency evaluation programs that cease to meet the requirements of 42 CFR 483.152 and competency evaluation programs that cease to meet the requirements of 42 CFR 483.154.

(r) The State withdraws approval of nurse aide training and competency evaluation programs and competency evaluation programs that do not permit unannounced visits by the State.

Revision: HCFA-PM-91-10 (BPD)
December 1991

State/Territory: NEVADA

Citation

42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2) and 1919(f)(2) P.L. 100-203 (Sec 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec.4801(a)).

(s) When the State withdraws approval from a nurse aide training and competency evaluation program or competency evaluation program, the State notifies the program in writing, indicating the reasons for withdrawal of approval.

(t) The State permits students who have started a training and competency evaluation program from which approval is withdrawn to finish the program.

(u) The State provides for the reimbursement of costs incurred in completing a nurse aide training and competency evaluation program or competency evaluation program for nurse aides who become employed by or who obtain an offer of employment from a facility within 12 months of completing such program.

(v) The State provides advance notice that a record of successful completion of competency evaluation will be included in the State's nurse aide registry.

(w) Competency evaluation programs are administered by the State or by a State-approved entity which is neither a skilled nursing facility participating in Medicare nor a nursing facility participating in Medicaid.

X (x) The State permits proctoring of the competency evaluation in accordance with 42 CFR 483.154(d).

(y) The State has a standard for successful completion of competency evaluation programs.

Revision: HCFA-PM-91-10 (BPD)
December 1991

State/Territory: NEVADA

Citation

42 CFR 483.75; 42 CFR 483 Subpart D; Secs. 1902(a)(28), 1919(e)(1) and (2) and 1919(f)(2), P.L. 100-203 (Sec 4211(a)(3)); P.L. 101-239 (Secs. 6901(b)(3) and (4)); P.L. 101-508 (Sec.4801(a))

(z) The State includes a record of successful completion of a competency evaluation within 30 days of the date an individual is found competent.

X (aa) The State imposes a maximum upon the number of times an individual may take a competency evaluation program (any maximum imposed is not less than 3).

(bb) The State maintains a nurse aide registry that meets the requirements in 42 CFR 483.156.

X (cc) The State includes home health aides on the registry.

_ (dd) The State contracts the operation of the registry to a non State entity.

X (ee) ATTACHMENT 4.38 contains the State's description of registry information to be disclosed in addition to that required in 42 CFR 483.156(c)(1)(iii) and (iv).

X (ff) ATTACHMENT 4.38-A contains the State's description of information included on the registry in addition to the information required by 42 CFR 483.156(c).

NEVADA STATE BOARD OF NURSING
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March 30, 1992

Additional information for HCFA-PM-91-10

Page 79n, Item e—The Bureau of Licensure and Certification via inter-local agreement with Nevada State Board of Nursing has programs approved; doesn't offer ([483.151(a)(2) says "state may review and approve...").

Page 79q, Item x—Nevada State Board of Nursing, via inter-local agreement with Community Colleges, allows them to choose and train their own raters; proctoring by Nursing Facility employees could happen, if community colleges hires and trained raters from Nursing Facility; raters may not administering exam to someone from own facility, or facility with which they have any fiduciary agreement.

Page 79r, Item dd—Nevada State Board of Nursing is a state agency.

Attachment 4.38A—Enclosed is an actual print-out from our LMS record-keeping system and a copy of a Nursing Assistant Application. Findings, including documentation of investigation, nature of allegation, evidence, hearing date, and the individual's statement are in hard copy in Registry files.

State/Territory: NEVADA

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
DISCLOSURE OF ADDITIONAL REGISTRY INFORMATION

The Nevada State Board of Nursing, upon written request, discloses within 10 working days, all information required, including verification of certification, date of CEP, name and entity performing CEP; all information in Registry on a nurse's aide will be provided to the nurse's aide within 30 days. [483.156]

In addition, Nevada State Board of Nursing will disclose all information designed by state law in the Nurse Practice Act (CNA-related sections and proposed revisions attached), including Advisory Committee minutes, approved training lists, statistics, approved test sites and dates, approved raters, approved curriculum.

The Nevada State Board of Nursing does not disclose those items protected by Public Law: complaints are confidential until taken to the Board and findings or facts, conclusions of law are made by the Nevada State Board of Nursing and placed on the Registry; "yes" answers to personal questions on the application are confidential until taken to the Board of Nursing.

State/Territory: NEVADA

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
COLLECTION OF ADDITIONAL REGISTRY INFORMATION

See attached print-out from LMS record-keeping system and copy of Nursing Assistant Application.

Revision: HCFA-PM-93-1 (BPD)
January 1993

State/Territory: Nevada

Citation

Secs 1902(a)(28)(D)(i) and 1919 (e)(7) of the Act; P.L. 100-203 (Sec. 4211(c)); P.L. 101-508 (Sec. 4801(b)).

4.39 Preadmission Screening and Annual Resident Review in Nursing Facilities

(a) The Medicaid agency has in effect a written agreement with the State mental health and mental retardation authorities that meet the requirements of 42 (CFR) 431.621(c).

(b) The State operates a preadmission and annual resident review program that meets the requirements of 42 CFR 483.100-138.

(c) The State does not claim as "medical assistance under the State Plan" the cost of services to individuals who should receive preadmission screening or annual resident review until such individuals are screened or reviewed.

(d) With the exception of NF services furnished to certain NF residents defined in 42 CFR 483.118(c)(1), the State does not claim as "medical assistance under the State plan" the cost of NF services to individuals who are found not to require NF services.

X (e) ATTACHMENT 4.39 specifies the State's definition of specialized services.

Revision: HCFA-PM-93-1 (BPD)
January 1993

State/Territory: NEVADA

4.39 (Continued)

X (f) Except for residents identified in 42 CFR 483.118(c)(1), the State mental health or mental retardation authority makes categorical determinations that individuals with certain mental conditions or levels of severity of mental illness would normally require specialized services of such an intensity that a specialized services program could not be delivered by the State in most, if not all, NFs and that a more appropriate placement should be utilized.

(g) The State describes any categorical determinations it applies in ATTACHMENT 4.39-A.

State/Territory: Nevada

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

DEFINITION OF SPECIALIZED SERVICES

MENTAL HEALTH SPECIALIZED SERVICES consists of an individual plan of care that prescribes specific therapies and activities to treat acute episodes of severe mental illness, developed, supervised, and provided by a physician and other qualified mental health professionals.

SPECIALIZED SERVICES FOR MENTAL RETARDATION, meaning a continuous program which includes aggressive, consistent implementation of specialized generic training, treatment, health services and related services that are directed toward the acquisition of the behaviors necessary to function with as much self-determination and independence as possible, and maintain current functional status.

State/Territory: Nevada

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

CATEGORICAL DETERMINATIONS

PASARR II Categorical Determination:

1) Criterion IIE= CONVALESCENT CARE from an acute physical illness which does not meet all the criteria for an exempted hospital discharge that is not subject to preadmission screening. These admissions shall be limited on a case by case basis to no more than 120 days, with a PASARR Level II Individual determination to be requested by the nursing facility if the resident's stay is anticipated to extend beyond the prescribed limit.

   In addition, PROVISIONAL ADMISSIONS will be allowed pending further assessment, in cases of DELIRIUM until the delirium clears but not to exceed 30 days; or in emergency situations requiring PROTECTIVE SERVICES, not to exceed seven days; or for RESPITE CARE to be determined on a case by case basis not to exceed a 30 day stay per year.

2) Criterion IIF= TERMINAL ILLNESS, a medical prognosis documented by the attending physician, indicating a life expectancy of six months or less.

3) Criterion IIG= SEVERITY OF ILLNESS, limited to:

   Comotose;
   Ventilator dependent;
   Brain stem level functioning;
   Chronic Obstructive Pulmonary Disease (COPD);
   Severe Parkinson's Disease;
   Huntington's Disease
   Amyotrophic Lateral Sclerosis (ALS);
   Congestive Heart Failure (CHF).

Revision: HCFA-PM-92-3 (HSQB) OMB No.:
April 1992

State/Territory: NEVADA

Citation

Sections 1919(g)(1) thru (2) and 1919(g)(4) thru (5) of the Act, P.L. 100-203 (sec. 4212(a))

4.40 Survey & Certification Process

(a) The State assures that the requirements of 1919(g)(1)(A) through (C) and section 1919(g)(2)(A) through (E)(iii) of the Act which relate to the survey and certification of non-State owned facilities based on the requirements of section 1919(b), (c) and (d) of the Act, are met.

1919(g)(1)(B) of the Act

(b) The State conducts periodic education programs for staff and residents (and their representatives). **Attachment 4.40-A** describes the survey and certification educational program.

1919(g)(1)(C) of the Act

(c) The State provides for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide of a resident in a nursing facility or by another individual used by the facility. **Attachment 4.40-B** describes the State's process.

1919(g)(1)(C) of the Act

(d) The State agency responsible for surveys and certification of nursing facilities or an agency delegated by the State survey agency conducts the process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property. If not the State survey agency, what agency?

1919(g)(1)(C) of the Act

(e) The State assures that a nurse aide, found to have neglected or abused a resident or misappropriated resident property in a facility, is notified of the finding. The name and finding is placed on the nurse aide registry.

1919(g)(1)(C) of the Act

(f) The State notifies the appropriate licensure authority of any licensed individual found to have neglected or abused a resident or misappropriated resident property in a facility.

Citation

1919(g)(2) (A)(i) of the Act	(g)	The State has procedures, as provided for at section 1919(g)(2)(A)(i), for the scheduling and conduct of standard surveys to assure that the State has taken all reasonable steps to avoid giving notice through the scheduling procedures and the conduct of the surveys themselves. **Attachment 4.40-C** describes the State's procedures.
1919(g)(2) (A)(ii) of the Act	(h)	The State assures that each facility shall have a standard survey which includes (for a case-mix stratified sample of residents) a survey of the quality of care furnished, as measured by indicators of medical, nursing and rehabilitative care, dietary and nutritional services, activities and social participation, and sanitation, infection control, and the physical environment, written plans of care and audit of resident's assessments, and a review of compliance with resident's rights not later than 15 months after the date of the previous standard survey.
1919(g)(2) (A)(iii)(I) of the Act	(i)	The State assures that the Statewide average interval between standard surveys of nursing facilities does not exceed 12 months.
1919(g)(2) (A)(iii)(II) of the Act	(j)	The State may conduct a special standard or special abbreviated standard survey within 2 months of any change of ownership, administration, management, or director of nursing of the nursing facility to determine whether the change has resulted in any decline in the quality of care furnished in the facility.
1919(g)(2) (B) of the Act	(k)	The State conducts extended surveys immediately or, if not practicable, not later that 2 weeks following a completed standard survey in a nursing facility which is found to have provided substandard care or in any other facility at the Secretary's or State's discretion.
1919(g)(2) (C) of the Act	(l)	The State conducts standard and extended surveys based upon a protocol, i.e., survey forms, methods, procedures and guidelines developed by HCFA, using individuals in the survey team who meet minimum qualifications established by the Secretary.

1919(g)(2) (D) of the Act	(m)	The State provides for programs to measure and reduce inconsistency in the application of survey results among surveyors. **Attachment 4.40-D** describes the State's programs.
1919(g)(2) (E)(i) of the Act	(n)	The State uses a multidisciplinary team of professionals including a registered professional nurse.
1919(g)(2) (E)(ii) of the Act	(o)	The State assures that members of a survey team do not serve (or have not served within the previous two years) as a member of the staff or consultant to the nursing facility or has no personal or familial financial interest in the facility being surveyed.
1919(g)(2) (E)(iii) of the Act	(p)	The State assures that no individual shall serve as a member of any survey team unless the individual has successfully completed a training and test program in survey and certification techniques approved by the Secretary.
1919(g)(4) of the Act	(q)	The State maintains procedures and adequate staff to investigate complaints of violations of requirements by nursing facilities and onsite monitoring. **Attachment 4.40-E** describes the State's complaint procedures.
1919(g)(5)(A) of the Act	(r)	The State makes available to the public information respecting surveys and certification of nursing facilities including statements of deficiencies, plans of correction, copies of cost reports, statements of ownership and the information disclosed under section 1126 of the Act.
1919(g)(5)(B) of the Act	(s)	The State notifies the State long-term care ombudsman of the State's finding of non-compliance with any of the requirements of subsection (b), (c), and (d) or of any adverse actions taken against a nursing facility.
1919(g)(5)(C) of the Act	(t)	If the State finds substandard quality of care in a facility, the State notifies the attending physician of each resident with respect to which such finding is made and the nursing facility administrator licensing board.
1919(g)(5)(D) of the Act	(u)	The State provides the State Medicaid fraud and abuse agency access to all information concerning survey and certification actions.

State/Territory: Nevada

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Survey and Certification Education Program

The State has in effect the following survey and certification periodic educational program for the staff and residents (and their representatives) of nursing facilities in order to present current regulations, procedures, and policies.

The survey and certification agency will:

1. Continue to actively participate in various private and public committees that deal with participation in Medicare of nursing facilities;

2. Participate in educational training programs, such as advance directives and the Americans With Disabilities Act;

3. Provide additional technical assistance, as needed, via telephone or by conference;

4. Participate in training for the Ombudsman. Survey staff shall continue to include the Ombudsman in the certification process as outlined in the Omnibus Budget Reconciliation Act of 1987;

5. Provide on an ongoing basis additional regulation information to residents/ provider staff during survey process;

6. Disseminate on an ongoing basis regulatory changes or clarifications to the provider/client community via informational newsletters/brochures and, as needed, through conferences or seminars;

7. Promote resident/client review of nursing facility records which are maintained within the certification agency. These records contain the last three years of compliance with licensing/certification requirements by the nursing facility and reflect a nursing facility's ability to meet the needs of the residents;

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

8. Disseminate and coordinate certification information through the Department of Human Resources, Bureau of Licensure and Certification;

9. Disseminate certification information through provider trade associations; and

10. Advise providers at the time of onsite surveys, regarding the availability of the survey and certification agency to answer resident/family/public questions regarding Medicare certification.

The State survey agency provides training to nursing facility staff, at least annually. This training covers regulatory changes, new technology, and care techniques as well as information on survey findings and expectations. Sessions may cover quality of care and quality of life issues as well as infection control, fire safety, assessments, care planning, and quality assurance.

In addition, the State survey agency issues on an as needed basis technical bulletins. These bulletins are used to advise medical facilities, including nursing facilities, of regulatory changes and to remind facilities of regulatory requirements that have surfaced during surveys and complaint investigations as areas of non-compliance.

During the facility surveys, staff meet with residents individually and in groups to discuss areas of regulation that reflect on resident rights and issues in a facility. This may include subjects such as how to file a complaint, right to formulate advance directives, confidentiality, and the treatment rights.

State/Territory: NEVADA

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

ELIGIBILITY CONDITIONS AND REQUIREMENTS

____ Process for the Investigation of Allegations of Resident Neglect and Abuse and Misappropriation of Resident Property

The State has in effect the following process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a resident in a nursing facility or by another individual used by the facility in providing services to such a resident.

INTERAGENCY COMPLAINT PROCEDURE

State agency receives complaint from complaining party.

Complaint is logged and prioritized per agency protocol. If the complaint is Priority One, the Health Division is notified immediately and the Health Division will investigate or a joint investigation will be arranged.

Complaint is investigated using the agency's legal authority to investigate.

Facility is notified of deficiencies (if any) and request/demand is made for corrective action.

If corrective action is appropriate, coded complaint form along with documentation is forwarded to the Health Division for follow up.

Health Division logs completed complaint into the "Complaint Registry."

Complaints requiring Health Division follow up will be investigated based on the Health Division assigned priority. A copy of the "Statement of Deficiencies and Plan of Correction" will be forwarded to the originating agency upon completion of the investigation and response by the provider.

SEE ATTACHED PRIORITY SYSTEM, CODING AND COMPLAINT FORM.

08/15/91 INTER-AGENCY COMPLAINT PROCEDURE

1. Agency receives complaint from complaining party.

2. Complaint is logged and prioritized per agency protocol. If the complaint is Priority One the Health Division is notified immediately and the Health Division will investigate or a joint investigation will be arranged.

3. Complaint is investigated using the agency's legal authority to investigate.

4. Facility is notified of deficiencies (if any) and request/demand is made for corrective action.

5. If corrective action is appropriate, coded complaint form along with documentation is forwarded to the Health Division.

6. If corrective action is appropriate, coded complaint form along with documentation is forwarded to the Health Division for follow-up.

7. Health Division logs completed complaint into the `Complaint Registry.

8. Complaints requiring Health Division follow-up will be investigated based on the Health Division assigned priority. A copy of the "Statement of Deficiencies and Plan of Correction" will be forwarded to the originating agency upon completion of the investigation and response by the provider.

COMPLAINT PRIORITY SYSTEM

PRIORITY DEFINITION

1. A Priority One complaint is one in which it appears that a life threatening situation exists or there is an "immediate and Serious Threat" to the health and safety of the patients or residents. Priority One complaints may be referred by telephone and followed in writing by the originating agency. Priority One complaint shall be referred to the Health Division immediately and investigated within 72 hours.

2. A Priority Two complaint is one in which no "Immediate and Serious Threat" exists, but there is situation where expeditious investigation could prevent harm or improve care delivery to patients or residents. Priority Two complaints are investigated by the Health Division within 14 days.

3. A Priority Three complaint is a complaint of a routine nature. Priority Three complaints are investigated at the time of the next visit to the facility.

COMPLAINT FORM CODING

FIELD DESCRIPTION

1. Complaint number is constructed with the agency identifier as the first digit. "A" for Aging Services Division, "W" for Welfare Division and "H" for Health Division.

   The next three digits are sequential numbers for counting complaints. Start a new numerical sequence at the beginning of the state fiscal year. Specific series may be assigned to field offices for tracking purposes. For example, 001 - 499 assigned to LV office, 500 - 999 assigned to CC office.

   The last three digits are the type of facility. "SNF" for Skilled Nursing Facility, "ICF" for Intermediate Care Facility, "AGC" for Adult Group Care, "ADC for Adult Day Care, "HHA" for Home Health Agency, "HOS" for Hospice, "JCA" for JCAHO accredited hospital, "UNL" for unlicensed facilities.

2. Four-digit number supplied by the Health Division. Leave blank for unlicensed facilities.

3. Priority 1-3 based on Priority System.

4. Date complaint received. (MM/DD/YY format)

5. Date complaint investigated. (MM/DD/YY format)

6. Date complaint closed. (MM/DD/YY format). This is the date that the complaint is forwarded to the Health Division.

7. Complaint category from Aging Services listing. Code this field after complaint is investigated. Code only the four most important complaint categories in the boxes marked 7a., 7b., 7c., and 7d.

8. Substantiated. "Y/N/R" answer only. Enter "R" if the complaint was referred to another agency or board with no investigation conducted by the originating agency. Complaints with an "R" in this block should have field "9" blank and an "N" in field "10."

9. Resolution OK. "Y/N" answer only.

10. Health Division Follow-up. Does this complaint require Health Division Follow-up? "Y/N" answer only.

11. This field is used for Health Division cross referencing.

CONFIDENTIAL COMPLAINT FORM

Complaint No.

Date_____ T XVIII__T XIX__T XVIII/XIX__OTHER
Complainant_____ Facility
Address_____ Address
_____
_____
Phone _____ Phone
Patient Affected

Nature of Compliant: Priority 1 ____ Priority 2 ____ Priority 3

_____Complaint Taken By

_____Investigated By _____ Date _____Substantiated? Yes

No

Findings

(Attach additional documentation if applicable)

_____Action

_____Recommendations

_____Follow-up Scheduled_____ Complainant Notified_____Complaint:_____ A. Scheduled For Follow-up Date _____ _____ B. Forwarded to Medicare Date_____ _____ C. Closed Date _____ _____ D. Other Date

Code

1. COMPLAINT NUMBER	2. PROVIDER	3. PRIORITY

4. DATE OPENED	5. DATE INVESTIGATED	6. DATE CLOSED

7a. COMPLAINT CATEGORY	7b. COMPLAINT CATEGORY	7c. COMPLAINT CATEGORY	7d. COMPLAINT CATEGORY

8. SUBSTANTIATED	9. RESOLUTION OK	10. H/D FOLLOW-UP	11. CROSS REFERENCE

compll.wcs revised 08/15/91

State/Territory: Nevada

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Procedures for Scheduling and Conduct of Standard Surveys

The State has in effect the following procedures for the scheduling and conduct of standard surveys to assure that it has taken all reasonable steps to avoid giving notice.

All scheduling of surveys is performed by one individual (Surveyor Supervisor in Carson City). Copies of the schedules are controlled with only the survey staff and Health Division Administrator. This will ensure that all surveys are unannounced in accordance with Federal and Bureau policies.

State/Territory: Nevada

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Programs to Measure and Reduce Inconsistency

The State has in effect the following programs to measure and reduce inconsistency in the application of survey results among surveyors.

The Bureau conducts quarterly meetings of all survey staff, at which time new Federal instructions and requirements and State policy and procedures, as well as problems that have been submitted by survey staff, are discussed and a Bureau position is agreed upon for standardization purposes.

State/Territory: Nevada

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for Investigations of Complaints and Monitoring

The State has in effect the following process for investigating complaints of violations of requirements by nursing facilities and monitors onsite on a regular, as needed basis, a nursing facility's compliance with the requirements of subsection (b), (c) and (d) for the following reasons:

(i) the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;

(ii) the facility was previously found not to be in compliance with such requirements and has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or

(iii) the State has reason to question the compliance of the facility with such requirements.

In addition to the routine complaint investigation process, the Bureau conducts annual inspections for Federal and State requirements.

A written plan of correction is required for all deficiencies identified and a follow-up survey is carried out to ensure the necessary corrections.

State: Nevada

4.42 Employee Education About False Claims Recoveries

a. The Medicaid agency meets the requirements regarding establishment of policies and procedures for the education of employees of entities covered by section 1902(a)(68) of the Social Security Act (the Act) regarding false claims recoveries and methodologies for oversight of entities' compliance with these requirements.

1. Definitions.

a. An "entity" includes a governmental agency, organization, unit, corporation, partnership or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists), whether for-profit or not-for-profit, which receives or makes payments, under a State Plan approved under title XIX or under any waiver of such plan, totaling at least $5,000,000 annually.

If an entity furnishes items or services at more than a single location or under more than one contractual or other payment arrangement, the provisions of section 1902(a)(68) apply if the aggregate payments to that entity meet the $5,000,000 annual threshold. This applies whether the entity submits claims for payments using one or more provider identification or tax identification numbers.

A governmental component providing Medicaid health care items or services for which Medicaid payments are made would qualify as an "entity" (e.g., a state mental health facility or school district providing school-based health services). A government agency which merely administers the Medicaid program, in whole or part (e.g., managing the claims processing system or determining beneficiary eligibility), is not, for these purposes, considered to be an entity.

An entity will have met the $5,000,000 annual threshold as of January 1, 2007, if it received or made payments in that amount in Federal fiscal year 2006. Future determinations regarding an entity's responsibility stemming from the requirements of section 1902(a)(68) will be made by January 1 of each subsequent year, based upon the amount of payments an entity either received or made under the State Plan during the preceding Federal fiscal year.

State: Nevada

b. An "employee" includes any officer or employee of the entity.

c. A "contractor" or "agent" includes any contractor, subcontractor, agent, or other person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of, Medicaid health care items or services, performs billing or coding functions, or is involved in the monitoring of health care provided by the entity.

2. The entity must establish and disseminate written policies which must also be adopted by its contractors or agents. Written policies may be on paper or in electronic form, but must be readily available to all employees, contractors, or agents. The entity need not create an employee handbook if none already exists.

3. An entity shall establish written policies for all employees (including management), and of any contractor or agent of the entity, that include detailed information about the False Claims Act and the other provisions named in section 1902(a)(68)(A). The entity shall include in those written policies detailed information about the entity's policies and procedures for detecting and preventing waste, fraud, and abuse. The entity shall also include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers and a specific discussion of the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

4. The requirements of this law should be incorporated into each State's provider enrollment agreements.

5. The State will implement this State Plan amendment on January 1, 2007.

b. ATTACHMENT 4.42-A describes, in accordance with section 1902(a)(68) of the Act, the methodology of compliance oversight and the frequency with which the State will re-assess compliance on an ongoing basis.

METHODOLOGIES FOR COMPLIANCE OVERSIGHT

Methods for administration of the State Plan in accordance with 1902(a)(68) of the Social Security Act, and 1396a(a)(68) of Title 42, United States Code are:

1. The Nevada Division of Health Care Financing and Policy (DHCFP) will ensure entities, providers and contractors who reach the $5,000,000 threshold as defined in 4.42(a)(1)(A), comply and maintain compliance with the above-mentioned Acts and Regulations by:

   a. Making current state policy and procedures, covering 1902(a)(68), available to all providers and contractors.

   b. Providing written notice to each entity, informing them of their obligation to comply with the above-mentioned Acts and Regulations as a condition of their continued participation in the Medicaid program.

   c. Requiring each entity submit, within 90 days of receipt of the notice, a certification declaring the entity, and any contractor or agent of the entity, is in compliance. The certification is to be accompanied by a new Provider Agreement or Managed Care contract, a copy of their written policies, current employee handbook, if one exists, and documentation of staff having received detailed information on the regulations.

   d. Reviewing, on an annual basis, the written policies and documents submitted by each entity to ensure they comply with 42 USC section 1396(a)(68). The documents will be used to create and maintain a record file on each entity.

   e. Requiring each entity submit a new certification, annually, to attest to their continued compliance, and include any revisions made to their policies.

   f. Identifying, at the beginning of each federal fiscal year, providers and contractors who have reached the $5,000,000 threshold in the previous fiscal year, and providing them written notice of their obligation to comply with the regulations.

      Initial notifications were mailed on March 27, 2007. Future notifications will be mailed, annually, within the first quarter of each calendar year.

2. The DHCFP may take administrative action for non-compliance through non-renewal of provider enrollment or contract, or suspension or termination of provider status.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nevada

Citation	4.43 Cooperation with Medicaid Integrity Program Efforts.
1902(a)(69) of The Act, P.L. 109-171 (Section 6034)	The Medicaid agency assures it complies with such requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program established under section 1936 of the Act.

Medicaid State Plan Preprint

State/Territory: _____

PROPOSED SECTION 4 – GENERAL PROGRAM ADMINISTRATION

4.44 Medicaid Prohibition on Payments to Institutions or Entities Located Outside of the United States.

Citation
Section 1902(a)(80) of the Social Security Act, P.L. 111-148 (Section 6505)

__X__ The State shall not provide any payments for items or services provided under the State plan or under a waiver to any financial institution or entity located outside of the United States.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____

4.46 Provider Screening and Enrollment

Citation	The State Medicaid agency gives the following assurances:
1902(a)(77) 1902(a)(39) 1902(kk); P.L. 111-148 and P.L. 111-152	
42 CFR 455 Subpart E	PROVIDER SCREENING __X__ Assures that the State Medicaid agency complies with the process for screening providers under section 1902(a)(39), 1902(a)(77) and 1902(kk) of the Act.
42 CFR 455.410	ENROLLMENT AND SCREENING OF PROVIDERS __X__ Assures enrolled providers will be screened in accordance with 42 CFR 455.400 et seq. __X__ Assures that the State Medicaid agency requires all ordering or referring physicians or other professionals to be enrolled under the State plan or under a waiver of the Plan as a participating provider.
42 CFR 455.412	VERIFICATION OF PROVIDER LICENSES __X__ Assures that the State Medicaid agency has a method for verifying providers licensed by a State and that such providers licenses have not expired or have no current limitations.
42 CFR 455.414	REVALIDATION OF ENROLLMENT __X__ Assures that providers will be revalidated regardless of provider type at least every 5 years.
42 CFR 455.416	TERMINATION OR DENIAL OF ENROLLMENT __X__ Assures that the State Medicaid agency will comply with section 1902(a)(39) of the Act and with the requirements outlined in 42 CFR 455.416 for all terminations or denials of provider enrollment.
42 CFR 455.420	REACTIVATION OF PROVIDER ENROLLMENT __X__ Assures that any reactivation of a provider will include re-screening and payment of application fees as required by 42 CFR 455.460.

42 CFR 455.422

APPEAL RIGHTS

__X__ Assures that all terminated providers and providers denied enrollment as a result of the requirements of 42 CFR 455.416 will have appeal rights available under procedures established by State law or regulation.

42 CFR 455.432

SITE VISITS

__X__ Assures that pre-enrollment and post-enrollment site visits of providers who are in "moderate" or "high" risk categories will occur.

42 CFR 455.434

CRIMINAL BACKGROUND CHECKS

__X__ Assures that providers, as a condition of enrollment, will be required to consent to criminal background checks including fingerprints, if required to do so under State law, or by the level of screening based on risk of fraud, waste or abuse for that category of provider.

42 CFR 455.436

FEDERAL DATABASE CHECKS

__X__ Assures that the State Medicaid agency will perform Federal database checks on all providers or any person with an ownership or controlling interest or who is an agent or managing employee of the provider.

42 CFR 455.440

NATIONAL PROVIDER IDENTIFIER

__X__ Assures that the State Medicaid agency requires the National Provider Identifier of any ordering or referring physician or other professional to be specified on any claim for payment that is based on an order or referral of the physician or other professional.

42 CFR 455.450

SCREENING LEVELS FOR MEDICAID PROVIDERS

__X__ Assures that the State Medicaid agency complies with 1902(a)(77) and 1902(kk) of the Act and with the requirements outlined in 42 CFR 455.450 for screening levels based upon the categorical risk level determined for a provider.

42 CFR 455.460

APPLICATION FEE

__X__ Assures that the State Medicaid agency complies with the requirements for collection of the application fee set forth in section 1866(j)(2)(C) of the Act and 42 CFR 455.460.

42 CFR 455.470

TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS OR SUPPLIERS

__X__ Assures that the State Medicaid agency complies with any temporary moratorium on the enrollment of new providers or provider types imposed by the Secretary under section 1866(j)(7) and 1902(kk)(4) of the Act, subject to any determination by the State and written notice to the Secretary that such a temporary moratorium would not adversely impact beneficiaries' access to medical assistance.

SECTION 5 - PERSONNEL ADMINISTRATION

Citation

42 CFR 432.10(a)
AT-78-90
AT-79-23
AT-80-34

5.1 Standards of Personnel Administration

(a) The Medicaid agency has established and will maintain methods of personnel administration in conformity with standards prescribed by the U.S. Civil Service Commission in accordance with section 208 of the Intergovernmental Personnel Act of 1970 and the regulations on Administration of the Standards for a Merit System of Personnel Administration, 5 CFR Part 900, Subpart F. All requirements of 42 CFR 432.10 are met.

_ The plan is locally administered and State-supervised. The requirements of 42 CFR 432.10 with respect to local agency administration are met.

(b) Affirmative Action Plan

The Medicaid agency has in effect an affirmative action plan for equal employment opportunity that includes specific action steps and timetables and meets all other requirements of 5 CFR Part 900, Subpart F.

5.2 [RESERVED]

State/Territory:

Citation

42 CFR Part 432,
Subpart B
AT-78-90

5.3 Training Programs; Sub professional and Volunteer Programs

The Medicaid agency meets the requirements of 42 CFR Part 432, Subpart B, with respect to a training program for agency personnel and the training and use of sub professional staff and volunteers.

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

OMB No.: 0938-0193

State/Territory:

SECTION 6 - FINANCIAL ADMINISTRATION

Citation

42 CFR 433.32
AT-79-29

6.1 Fiscal Policies and Accountability

The Medicaid agency and, where applicable, local agencies administering the plan, maintains an accounting system and supporting fiscal records adequate to assure that claims for Federal funds are in accord with applicable Federal requirements. The requirements of 42 CFR 433.32 are met.

State/Territory:

Citation

6.2 Cost Allocation

42 CFR 433.34
47 FR 17490

There is an approved cost allocation plan on file with the Department in accordance with the requirements contained in 45 CFR Part 95, Subpart E.

State/Territory:

Citation

42 CFR 433.33
AT-79-29(a)
AT-80-34

6.3 State Financial Participation

State funds are used in both assistance and administration.

_ State funds are used to pay all of the non-Federal share of total expenditures under the plan.

_ There is local participation. State funds are used to pay not less than 40 percent of the non-Federal share of the total expenditures under the plan. There is a method of apportioning Federal and State funds among the political subdivisions of the State on an equalization or other basis which assures that lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of care and services or level of administration under the plan in any part of the State.

(b) State and Federal funds are apportioned among the political subdivisions of the State on a basis consistent with equitable treatment of individuals in similar circumstances throughout the State.

SECTION 7 - GENERAL PROVISIONS

Citation

7.1 Plan Amendments

42 CFR 430.12(c)

The plan will be amended whenever necessary to reflect new or revised Federal statutes or regulations or material change in State law, organization, policy or State agency operation.

Page 87, Section 7.2

Citation	7.2	Civil Rights
45 CFR Parts 80, 84, 90, 1321 28 CFR Parts 35, 36		In accordance with: ▪ Title VI of the Civil Rights Act of 1964 (42 USC 2000d et. seq.), ▪ The regulations at 45 CFR Part 80, ▪ Section 504 of the Rehabilitation Act of 1973 (29 USC 70b), ▪ The regulations at 45 CFR Part 84, ▪ The Age Discrimination Act of 1975 (42 USC 6101-6107) ▪ The regulations at 45 CFR Part 90, ▪ Title II of the Americans with Disabilities Act of 1990 (Public Law 101-336), ▪ The regulations at 28 CFR Part 35, ▪ The Patient Self-Determination Act of 1990 (42 USC 1395), ▪ The Older Americans Act of 1965 and the Older Americans Act as Amended 2000 (Public Law 89-73, Public Law 106-501, 42 USC 3001), and ▪ The regulations at 45 CFR Part 1321 The Nevada Division of Health Care Financing and Policy assures that no individual shall be subjected to discrimination under this plan on the grounds of race, color, national origin, sex, religion, age or disability (including AIDS and related conditions), and that all individuals admitted to acute or long-term care facilities or programs will be informed of their right to self-determination with regard to health care decisions. The Nevada Division of Health Care Financing and Policy has methods of administration to assure that each program or activity for which it receives Federal financial assistance will be operated in accordance with the above listed regulations. These methods are described in ATTACHMENT 7.2A.

Methods for administration of the State Plan in accordance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, Title II of the Americans with Disabilities Act of 1990, the Patient Self-Determination Act of 1990, the Older Americans Act of 1965 and the Older Americans Act as Amended 2000, 45 CFR Parts 80, 84, 90 and 1321, and 28 CFR Part 35 are:

1. The Nevada Division of Health Care Financing and Policy (DHCFP) will inform and instruct its staff members concerning their obligations under the above Acts and Regulations by:

    a. Making current policies and procedures regarding Civil Rights requirements for employees and Medicaid providers, available to all DHCFP employees.

    b. Posting DHCFP's "Civil Rights Non-Discrimination Notice" in each district office and central office.

    c. Providing training for new staff members on the Civil Rights requirements and staff obligations for carrying out the policies. Providing training for existing staff members when requirements or policies and procedures change.

    d. Providing training for supervisory staff on non-discrimination hiring and employment practices.

    e. Conducting through supervisory channels, constant review of policies and practices to assure that no individual is being discriminated against on the basis of race, color, national origin, sex, age, religion, or disability (including AIDS and related conditions); and taking corrective action as may be required to assure DHCFP's practices are consistent with the above stated Acts and Regulations.

2. DHCFP will inform and instruct providers of service or benefits under the Medicaid program of their obligations to comply with the above-mentioned Acts and Regulations as a condition to their initial or continued financial participation in the Medicaid program. This will be accomplished by:

a. Providing written materials and personal explanations to providers regarding the requirements of the above-mentioned Acts and Regulations, and DHCFP policies and procedures to implement these requirements.

b. Assuring when a provider conducts any activity or furnishes services under contract or other arrangement, that such activity will be conducted or such services will be furnished in accordance with DHCFP's obligations under the above stated Acts and Regulations. In appropriate cases, DHCFP will determine that the provider has executed assurances in the form prescribed by the Department of Health and Human Services which are in effect and applicable to the program under which the activity is conducted or the services are furnished. In other cases, DHCFP will take appropriate steps to satisfy itself that the provider has agreed to and is conducting the activity or furnishing the services in accordance with the provisions of the above stated Acts and Regulations. This includes stating in provider agreements the specific obligations of the providers regarding their activities and provision of services.

3. DHCFP will inform its recipients, potential recipients and other interested persons that:

a. Services and other benefits under the Medicaid program are provided on a non-discriminatory basis as required by the above-mentioned Acts;

b. They have the right to file a complaint with DHCFP or the United States Department of Health and Human Services, Office for Civil Rights if they believe that discrimination on the basis of race, color, national origin, sex, age, religion, or disability (including AIDS and related conditions) is being practiced.

DHCFP will provide written notice of the above information to all applicants and recipients. Appropriate explanatory statements will be included in public information materials which are available to interested persons and particularly to those individuals and groups who may be sources of referrals and applications.

4. All complaints concerning alleged discriminatory conditions or practices in the operation of the Medicaid program on the basis of basis of race, color, national origin, sex, age, religion, or disability (including AIDS and related conditions) are to be filed with DHCFP or the Office for Civil Rights. Complaints filed with DHCFP will be investigated by DHCFP staff members to determine if discriminatory practice has occurred. If supported, appropriate action will be taken to correct past practices and to prevent the recurrence of such discrimination.

DHCFP will advise the complainant in writing of its finding. The identity of the complainant shall be kept confidential except to the extent necessary to carry out the complaint procedure.

Complaints regarding economic discrimination by Medicaid facility providers will be referred to the Division for Aging Services for investigation in accordance with the Older Americans Act.

DHCFP will maintain adequate records to show the action taken as a result of each complaint filed and will make such information available for Federal review.

5. DHCFP will require certain Medicaid and Medicare providers designated by the Office for Civil Rights and/or the Centers for Medicare and Medicaid Services to conduct and report the results of tri-annual self-evaluations of their compliance with the above-mentioned Civil Rights laws and regulations using the DHCFP provided self-evaluation tool. If the self-evaluations results are not satisfactory or timely, the providers will be required to cooperate with a DHCFP on-site compliance review in accordance with current DHCFP policies and procedures. Provider compliance with Civil Rights laws and regulations will also be reviewed during on-site visits by Division and Department personnel in conjunction with other business visits.

SECTION 7 - GENERAL PROVISIONS

Citation

7.1 Plan Amendments

42 CFR 430.12(c)

The plan will be amended whenever necessary to reflect new or revised Federal statutes or regulations or material change in State law, organization, policy or State agency operation.

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Methods for administration of the State Plan in accordance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, Title II of the Americans with Disabilities Act of 1990, the Patient Self-Determination Act of 1990, the Older Americans Act of 1965 and the Older Americans Act as Amended 2000, 45 CFR Parts 80, 84, 90 and 1321, and 28 CFR Part 35 are:

1. The Nevada Division of Health Care Financing and Policy (DHCFP) will inform and instruct its staff members concerning their obligations under the above Acts and Regulations by:

    a. Making current policies and procedures regarding Civil Rights requirements for employees and Medicaid providers, available to all DHCFP employees.

    b. Posting DHCFP's "Civil Rights Non-Discrimination Notice" in each district office and central office.

    c. Providing training for new staff members on the Civil Rights requirements and staff obligations for carrying out the policies. Providing training for existing staff members when requirements or policies and procedures change.

    d. Providing training for supervisory staff on non-discrimination hiring and employment practices.

    e. Conducting through supervisory channels, constant review of policies and practices to assure that no individual is being discriminated against on the basis of race, color, national origin, sex, age, religion, or disability (including AIDS and related conditions); and taking corrective action as may be required to assure DHCFP's practices are consistent with the above stated Acts and Regulations.

2. DHCFP will inform and instruct providers of service or benefits under the Medicaid program of their obligations to comply with the above-mentioned Acts and Regulations as a condition to their initial or continued financial participation in the Medicaid program. This will be accomplished by:

a. Providing written materials and personal explanations to providers regarding the requirements of the above-mentioned Acts and Regulations, and DHCFP policies and procedures to implement these requirements.

b. Assuring when a provider conducts any activity or furnishes services under contract or other arrangement, that such activity will be conducted or such services will be furnished in accordance with DHCFP's obligations under the above stated Acts and Regulations. In appropriate cases, DHCFP will determine that the provider has executed assurances in the form prescribed by the Department of Health and Human Services which are in effect and applicable to the program under which the activity is conducted or the services are furnished. In other cases, DHCFP will take appropriate steps to satisfy itself that the provider has agreed to and is conducting the activity or furnishing the services in accordance with the provisions of the above stated Acts and Regulations. This includes stating in provider agreements the specific obligations of the providers regarding their activities and provision of services.

3. DHCFP will inform its recipients, potential recipients and other interested persons that:

a. Services and other benefits under the Medicaid program are provided on a non-discriminatory basis as required by the above-mentioned Acts;

b. They have the right to file a complaint with DHCFP or the United States Department of Health and Human Services, Office for Civil Rights if they believe that discrimination on the basis of race, color, national origin, sex, age, religion, or disability (including AIDS and related conditions) is being practiced.

DHCFP will provide written notice of the above information to all applicants and recipients. Appropriate explanatory statements will be included in public information materials which are available to interested persons and particularly to those individuals and groups who may be sources of referrals and applications.

4. All complaints concerning alleged discriminatory conditions or practices in the operation of the Medicaid program on the basis of basis of race, color, national origin, sex, age, religion, or disability (including AIDS and related conditions) are to be filed with DHCFP or the Office for Civil Rights. Complaints filed with DHCFP will be investigated by DHCFP staff members to determine if discriminatory practice has occurred. If supported, appropriate action will be taken to correct past practices and to prevent the recurrence of such discrimination.

DHCFP will advise the complainant in writing of its finding. The identity of the complainant shall be kept confidential except to the extent necessary to carry out the complaint procedure.

Complaints regarding economic discrimination by Medicaid facility providers will be referred to the Division for Aging Services for investigation in accordance with the Older Americans Act.

DHCFP will maintain adequate records to show the action taken as a result of each complaint filed and will make such information available for Federal review.

5. DHCFP will require certain Medicaid and Medicare providers designated by the Office for Civil Rights and/or the Centers for Medicare and Medicaid Services to conduct and report the results of tri-annual self-evaluations of their compliance with the above-mentioned Civil Rights laws and regulations using the DHCFP provided self-evaluation tool. If the self-evaluations results are not satisfactory or timely, the providers will be required to cooperate with a DHCFP on-site compliance review in accordance with current DHCFP policies and procedures. Provider compliance with Civil Rights laws and regulations will also be reviewed during on-site visits by Division and Department personnel in conjunction with other business visits.

Citation 7.4 State Governor's Review

42 CFR 430.12(b)

The Medicaid agency will provide opportunity for the Office of the Governor to review State plan amendments, long-range program planning projections, and other periodic reports thereon, excluding periodic statistical, budget and fiscal reports. Any comments made will be transmitted to the Health Care Financing Administration with such documents.

X Not applicable. The Governor--

X Does not wish to review any plan material.

___ Wishes to review only the plan materials specified in the enclosed document.

I hereby certify that I am authorized to submit this plan on behalf of

Department of Human Resources
(Designated Single State Agency)

Date: March 19, 1993

(Signature)

Director, Department of Human Resources
(Title)

Section 7 – General Provisions
7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

Describe shorter period here.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

___X_ The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

a. __X__ SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. ___X_ Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

c. __X__ Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in Nevada Medicaid state plan, as described below:

Allow for alternative setting, Teleconference, video teleconferencing, Digital platforms

Section A – Eligibility

1. ___X__ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

*The state is selecting coverage for the o*ptional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals, for COVID testing. Effective March 18, 2020

2. ___ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

   a. ___ All individuals who are described in section 1905(a)(10)(A)(ii)(XX) Income standard: _____

   -or-

   b. _____ Individuals described in the following categorical populations in section 1905(a) of the Act:

   Income standard: _____

3. _____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

   Less restrictive income methodologies:

   Less restrictive resource methodologies:

4. ___X_ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. ___ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. _____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistences or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. _____ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

2. _____ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

3. ____ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

4. __ The agency adopts a total of __ months (not to exceed 12 months) continuous eligibility for children under age enter age ____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.

5. _____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every _____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).

6. _____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).

    a. _____ The agency uses a simplified paper application.

    b. _____ The agency uses a simplified online application.

    c. _____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. _____ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

Please describe whether the state suspends all cost sharing or suspends only specified deductibles, copayments, coinsurance, or other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g).

2. _____ The agency suspends enrollment fees, premiums and similar charges for:

    a. _____ All beneficiaries

    b. _____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

3. _____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

Section D – Benefits

Benefits:

1. _____ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. ___X__ The agency makes the following adjustments to benefits currently covered in the state plan:

   The State is electing the flexibility specified in 42 CFR 440.30(d) to choose to exempt 42 CFR 440.30(a) and 42 CFR 440.30(b).

3. ____X_ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. __x___ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

   a. __x__ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

   b. ____ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

   Please describe.

Telehealth:

5. _____ The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

   Please describe.

Drug Benefit:

6. _____ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.

7. _____ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. _____ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. _____ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. _____ Newly added benefits described in Section D are paid using the following methodology:

   a. ____ Published fee schedules –

   Effective date (enter date of change): _____

   Location (list published location): _____

   b. ____ Other:

   Describe methodology here.

Increases to state plan payment methodologies:

2. __x__ The agency increases payment rates for the following services:

Allow for 100 percent Medicaid reimbursement in accordance with Medicare reimbursement for COVID-19 laboratory testing procedure codes such as: U0001, U0002, 87635, 86328, 86769, and other COVID-19 laboratory testing procedure codes that are released by CMS

   a. _____ Payment increases are targeted based on the following criteria:

   Please describe criteria.

b. Payments are increased through:

i. ____ A supplemental payment or add-on within applicable upper payment limits:

Please describe.

ii. ____ An increase to rates as described below.

Rates are increased:

_____ Uniformly by the following percentage: _____

_____ Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

_____ Up to the Medicare payments for equivalent services.

_____ By the following factors:

Please describe.

Payment for services delivered via telehealth:

3. _____ For the duration of the emergency, the state authorizes payments for telehealth services that:

a. ____ Are not otherwise paid under the Medicaid state plan;

b. ____ Differ from payments for the same services when provided face to face;

c. ____ Differ from current state plan provisions governing reimbursement for telehealth;

Describe telehealth payment variation.

d. ____ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:

i. ____ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.

ii. ____ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

4. _____ Other payment changes:

Please describe.

Section F – Post-Eligibility Treatment of Income

1. ____ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:
   a. ____ The individual's total income
   b. ____ 300 percent of the SSI federal benefit rate
   c. ____ Other reasonable amount: _____
2. ____ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

   The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

   Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

PRA Disclosure Statement

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