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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.