NEVADA MEDICAID MATTERS

2022 Biennial Report on the Condition, Operation and Functioning of Nevada Medicaid | NRS 422.2358

Division of Health Care Financing and Policy

Nevada Department of Health and Human Services

The information provided in this report reflects data available to the Division as of May 2022.

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INTRODUCTION

Since 1967, Nevada Medicaid has steadily grown to become the largest health insurance provider in the state today. We are a partnership. Local, state, and federal leaders recognize the value of supporting a healthy workforce, providing a safety net for Nevadans, focusing on the health needs of children and families as they grow, and demonstrating compassion for our most vulnerable populations.

Nevada Medicaid is diverse, touching the lives of one in every four Nevadans across every race, gender, and age group in every corner of the state. This tremendous growth combined with the diverse needs, the complexity of health care and new technology requires transparency and robust discussion with our partners to achieve our common goals.

Thank you for joining us in the effort by taking the time to learn more about how, together, we can, and are, implementing new opportunities to benefit all Nevadans. We look forward to hearing from you about what we can incorporate in next year's report.

Sincerely,

Suzanne Bierman
Nevada Medicaid Administrator

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MISSION

The mission of the Nevada Division of Health Care Financing and Policy, also known as Nevada Medicaid, is to purchase and provide quality health care services to low-income Nevadans in the most efficient manner. We promote equal access to health care at an affordable cost to the taxpayers of Nevada, restrain the growth of health care costs, and review Medicaid and other state health care programs to maximize potential federal revenue.

VISION – THE FUTURE WE AIM TO CREATE

A Healthy Nevada

PURPOSE – WHAT WE DO AND WHO WE SERVE

Nevada Medicaid contributes to the health and well-being of Nevadans by promoting access to a quality health care system in a financially responsible manner.

OUR CORE VALUES – THE PRINCIPLES THAT GUIDE OUR WORK

- Member-Focused
- Accountable
- Collaborative
- Adaptable
- Results-Oriented

STRATEGIC GOALS

1. Promote health coverage for all Nevadans
2. Increase access to and use of primary care and preventive services
3. Improve the quality of and access to behavioral health services available to members
4. Ensure all people who are pregnant, children, and parents have the support they need for a strong start
5. Plan to support healthy aging for Nevadans
6. Develop a comprehensive strategy for health care coverage and a sustainable cost growth strategy

ABOUT US

The Division of Health Care Financing and Policy (DHCFP) oversees the Nevada Medicaid and Nevada Check Up programs and is instrumental in developing Nevada's Public Option health insurance program.

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WHAT IS MEDICAID?

Medicaid is the nation's public health insurance program for people with low incomes and disabilities and is the single largest source of health coverage in the United States. Medicaid is administered by states within broad federal requirements and operates under Title XIX of the Social Security Act and other federal regulations. The Centers for Medicare and Medicaid Services (CMS) are responsible for oversight of state Medicaid programs.

Nevada's Medicaid program is within the Department of Health and Human Services (DHHS). Nevada Medicaid covers approximately one in four Nevadans. The Division also administers Nevada Check Up which provides low-cost, comprehensive health care coverage to low-income, uninsured children who are not covered by private insurance or Medicaid. These programs provide access to health care for recipients and cover a broad range of services. Nevada Medicaid is a core source of financing for safety-net hospitals and health centers that serve low-income communities in both urban and rural areas. Medicaid is also the main source of coverage and financing for nursing homes and community-based long-term care.

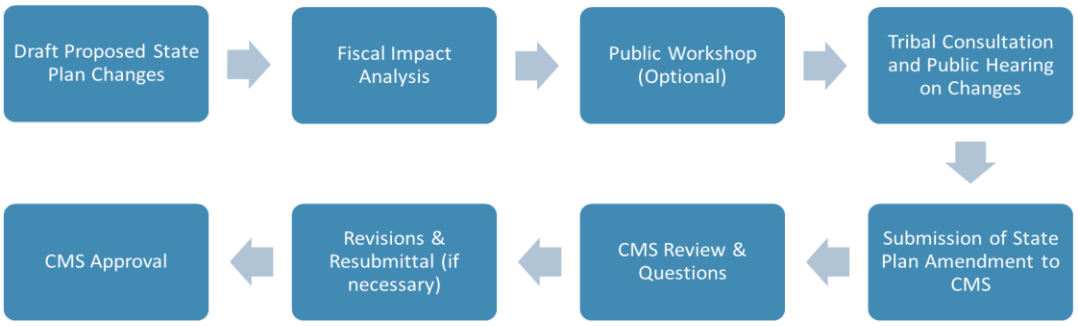
HOW IS NEVADA MEDICAID ADMINISTERED?

While Nevada Medicaid administers the programs, the Division of Welfare and Supportive Services (DWSS) handles eligibility determinations. Both divisions work closely with CMS to ensure that Nevada's programs comply with federal requirements.

Section 1902 of the Social Security Act requires each state to develop a Medicaid State Plan. The Medicaid State Plan is an agreement between the state and federal government describing the nature and scope of the state's Medicaid program. It gives an assurance that the state will abide by federal rules to claim federal matching funds for program activities. The Medicaid State Plan describes groups of individuals eligible for coverage, services to be provided, methodologies for providers to be reimbursed, and state administrative activities.

CMS requires the submittal of State Plan Amendments (SPAs) when the state proposes to make a change to program policies or rate methodologies. The state may also submit SPAs to request program changes, make corrections, or update the Medicaid State Plan with new information. Figure 1 shows Nevada's SPA process.

FIGURE 1: STATE PLAN AMENDMENT PROCESS



CMS reviews SPAs to ensure that they comply with the Social Security Act and other related regulations. CMS must approve, disapprove, or issue a formal request for additional information (RAI) within 90 calendar days. Once a state responds to an RAI, CMS must approve or disapprove the action within a second 90-day review period.

Nevada Medicaid maintains a compilation of regulations adopted under NRS 422.2368 and 422.2369 in the Medicaid Services Manual (MSM). The Manual sets guidelines and limitations regarding how the Division operates and what services are covered. Changes to the MSM are approved at public hearings. Nevada Medicaid posts public notices about public workshops and public hearings at dhcfp.nv.gov. The Division encourages tribes, stakeholders, recipients, and other interested parties to provide feedback through these forums.

WAIVERS APPROVED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES

States can apply for waivers to obtain additional flexibility under Medicaid's federal requirements. Currently, Nevada Medicaid has five waivers approved by CMS. Three are home and community-based services (HCBS) waivers and the remaining two limit the number of providers for specific services.

- 1915(c) Home and Community-Based Waivers. Once an individual is approved, they can qualify for Medicaid at a higher income level than would normally be required for Medicaid. Each waiver also offers specialized services.
  - Individuals with Intellectual and Developmental Disabilities (ID) – Available to financially eligible individuals of any age who received a diagnosis of intellectual disability prior to age 18 and/or developmental disabilities prior to age 22. Must meet level of care criteria for Intermediate Care Facilities for individuals with Intellectual disability (ICF/ID).
  - Persons with Physical Disabilities (PD) – Available to financially eligible individuals of any age who meet the criteria for nursing facility level of care. Must have a physical disability according to Social Security Disability standards.
  - Frail Elderly (FE) – Available to financially eligible individuals aged 65 and older who meet the criteria for nursing facility level of care.
- 1915(b1) and (b4) Dental Benefits Administrator (DBA) – Available to all recipients enrolled in managed care. Limited to a single dental benefits administrator.
- 1915(b4) Certified Community Behavioral Health Centers (CCBHC) – Limited to ten qualified providers statewide.

WHO QUALIFIES?

Eligibility for Medicaid and Check Up is generally based on household income, age, and disability status. Residency, immigration, and citizenship status also may impact coverage. All eligible individuals can enroll in Medicaid and most programs do not require cost-sharing. Exceptions related to enrollment and cost-sharing include:

- Nevada's **HCBS waiver programs** are capped at legislatively approved caseloads, so some eligible individuals may be added to waitlists until waiver slots become available. Individuals on waiver waitlists receive other Medicaid services while waiting for a waiver slot.
- The **Katie Beckett** program offers Medicaid eligibility to children under age 19 who have long-term disabilities or complex medical needs. This program enables these children to be cared for at home

instead of in an institution. The Katie Beckett program requires family contributions between $20 and $250 monthly.

- The **Health Insurance for Work Advancement** (HIWA) program provides Medicaid coverage to employed individuals with disabilities. The program is designed to help these individuals retain their Medicaid coverage when earning income from employment. This program requires premiums of 5%-7.5% of monthly net income.
- **Nevada Check Up** is the state's Children's Health Insurance Program (CHIP). Families enrolled in Check Up are responsible for paying premiums of up to $80 per quarter to maintain coverage in the program. No additional cost-sharing is required. Enrollment in the Check Up program can be capped to keep expenditures within the annual CHIP allotment. The program is not currently capped.

COVERED INDIVIDUALS

Covered individuals are categorized into Family Medical categories (FMC) including children, people who are pregnant, parents/caretakers of children, and childless adults under age 65. Eligibility is based on a household's Modified Adjusted Gross Income (MAGI) and how it aligns with the federal poverty level (FPL). MAGI represents a household's adjusted gross income (AGI) plus any untaxed foreign income, non-taxable Social Security benefits, and tax-exempt interest. It does not include the receipt of Supplemental Security Income (SSI).

Each year, the Federal Register publishes an Annual Update of the Health and Human Services Poverty Guidelines. These guidelines show the annual incomes for various household sizes associated with the poverty level (100% FPL). Table 1 provides information on the household income levels for different incomes and federal poverty levels.

TABLE 1: 2022 FEDERAL POVERTY GUIDELINES

Household Size	100%	138%	165%	205%
1	$13,590	$18,754	$22,424	$27,860
2	$18,310	$25,268	$30,212	$37,536
3	$23,030	$31,781	$38,000	$47,212
4	$27,750	$38,295	$45,788	$56,888
5	$32,470	$44,809	$53,576	$66,564
6	$37,190	$51,322	$61,364	$76,240
7	$41,910	$57,836	$69,152	$85,916
8	$46,630	$64,349	$76,940	$95,592

Nevada Medicaid is available for older children and adults with household incomes up to 138% of the Federal Poverty Level. Younger children and people who are pregnant are eligible with household incomes up to 165% FPL. The Check Up program covers children with household incomes up to 205% FPL. Table 2 below provides the income eligibility levels for each of the groups covered through the Family Medical categories.

TABLE 2: MEDICAID AND CHECK UP INCOME ELIGIBILITY LEVELS

Group	Medicaid	Check Up
Children Aged 0-5	0% - 165% FPL	166% - 205% FPL
Children Aged 6-18	0% - 138% FPL	139% - 205% FPL
Adults Aged 19-64	0% - 138% FPL	N/A
People who are pregnant	0% - 165% FPL	N/A

OTHER MEDICAID CATEGORIES OF COVERAGE

Eligibility for other Medicaid categories of coverage is based on demographics, income (not MAGI-based), health status, or other household characteristics. These categories are described broadly below.

- **Aged, Blind, and Disabled (ABD)** – Open to individuals aged 65 plus and individuals who are blind and/or disabled per Social Security Administration criteria. Income eligibility for this group varies by program and may include asset and resource limits. Nevada Medicaid strives to use People First Language (PFL); however the ABD category is a technical phrase required for reporting purposes.
- **Waiver** – Open to individuals with a nursing facility, or intermediate care facility for intellectual disabilities, level of care but who are still living at home. To be eligible, countable income must be at or below 300% of the Federal Benefits Rate (FBR). Resource limits of $2,000 for individuals and $3,000 for married couples also apply. Waiver slots are limited, and eligible individuals may be placed on a waitlist until a slot becomes available.
- **County Match** – Open to individuals with a hospital or nursing facility level of care and incomes between 142% and 300% of the FBR. These individuals may be in a nursing facility or living at home and receiving waiver services. This program is a joint federal/state/county program in which the counties pay the non-federal share of expenditures for eligible recipients.
- **Child Welfare** – Covers children involved with the child welfare system. Eligibility is not tied to household income.

EMERGENCY MEDICAID

Emergency Medicaid Only (EMO) provides limited services to certain non-citizens who meet other eligibility requirements and need treatment after a sudden onset of an emergency condition (including emergency labor and delivery). These individuals are eligible for coverage of emergency services only. This coverage group accounted for less than 0.5% of the total caseload in June 2021. Table 9 in Appendix C provides additional historical data on this group.

HOW TO APPLY?

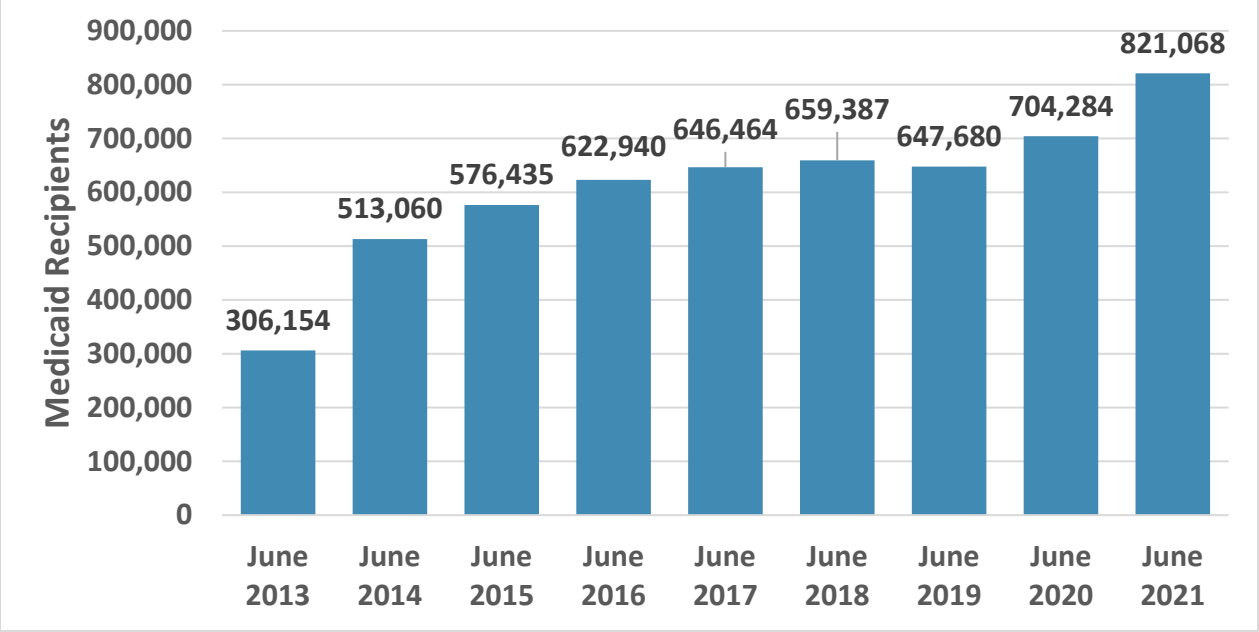
DWSS eligibility workers processed an average of 726 applications per business day during SFY 2021 and most applications were processed within 15 days.[i] Nevadans have multiple ways to apply for Medicaid:

- Online through www.AccessNevada.dwss.nv.gov
- Over the phone by dialing 1-800-992-0900
- Call 211 for over 100 on-site community partner locations.
- Be referred through www.NevadaHealthLink.com
- Providers may apply on behalf of individuals who are presumed eligible.
- If pregnant, be determined eligible for immediate, temporary coverage through the "presumptive eligibility" process at a qualified hospital or community partner; individuals determined eligible through this process must still submit a formal application and be determined eligible for Medicaid to receive long-term coverage.

WHO NEVADA MEDICAID SERVES

Medicaid is the largest source of health insurance in Nevada. Along with Check Up, Medicaid provides health care coverage to one in every four Nevadans. In addition, these programs cover the majority of births in Nevada, 56% in 2020.[ii] Nevada Medicaid and Check Up caseloads have increased by 159% between June 2013 and June 2021. See Figure 2 below, which shows the combined state fiscal year (SFY) end caseloads (June counts).

FIGURE 2: COMBINED MEDICAID AND CHECK UP CASELOAD, JUNE 2013 – JUNE 2021

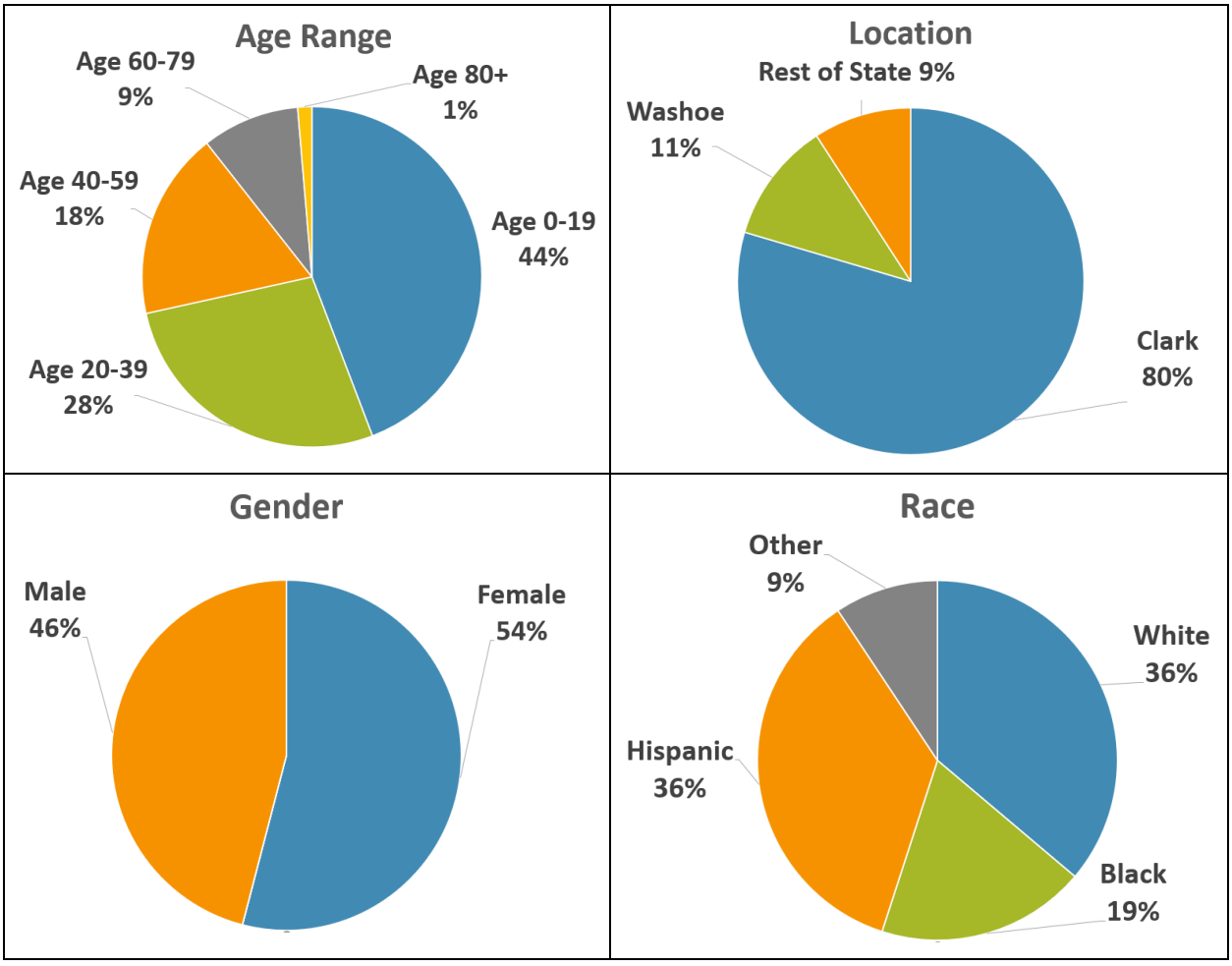


SOURCE: DWSS MASTER

About 53% the caseload growth occurred in the last two fiscal years during to the COVID-19 Public Health Emergency (PHE). Under the PHE, recipients retain their coverage regardless of changes in household income or composition. During this time, Nevada Medicaid saw an increase of 239,472 in enrolled recipients between February 2020 and March 2022. Caseloads are projected to decline slowly after the end of the PHE.

The charts in Figure 3 provide a demographic summary of Medicaid and Check Up recipients for SFY 2021. Tables with annual data for SFY 2013 through SFY 2021 are available in Appendix C. As illustrated below, a large portion of Nevada's Medicaid population is made up of children and youth, with 44% of enrollees being under the age of 20. A slightly higher percentage of enrollees also report as female as compared to those who report as male. With respect to race and ethnicity, most enrollees identify as white or Hispanic, with 36% reporting as white and 36% reporting as Hispanic. Additionally, 80% of enrollees live in Clark County and 11% live in Washoe County.

FIGURE 3: CHARACTERISTICS OF RECIPIENTS, SFY 2021



SOURCE: DWSS INDIVIDUAL LEVEL DATA

WHAT SERVICES ARE COVERED BY NEVADA MEDICAID?

Nevada Medicaid covers a wide range of services to meet the diverse health needs of recipients. The Check Up State Plan aligns most services and rates with the Medicaid State Plan.

Covered services include hospital care, primary and preventive care, behavioral health services, and dental care. Medicaid also covers long-term care including both nursing home care and many home and community-based long-term services and supports. Both Medicaid and Check Up provide comprehensive benefits for children, known as Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services.

MANDATORY BENEFITS

The federal government mandates that all state Medicaid programs provide the following mandatory services:

- Certified Pediatric and Family Nurse Practitioner
- Early and Periodic Screening, Diagnostic, and Treatment
- Family Planning
- Federally Qualified Health Center
- Freestanding Birth Center
- Home Health
- Inpatient Hospital
- Laboratory and X-ray
- Nursing Facility
- Nurse Midwife
- Outpatient Hospital
- Physician
- Rural Health Clinic
- Transportation to Medicaid services
- Tobacco Cessation Counseling for people who are pregnant

OPTIONAL BENEFITS

States may also cover other State Plan benefits as permitted under federal law, often referred to as "optional benefits." Nevada covers the following optional benefits:

- Adult Day Health Care
- Chiropractic (recipients aged 21 and under, Qualified Medicare Beneficiaries)
- Dental (full coverage for people who are pregnant and recipients under age 21; pain and palliative care for other adults)
- Habilitation - Day or Residential services (individuals with traumatic or acquired brain injury)
- Hospice
- Inpatient psychiatric services (recipients under age 21; recipients aged 65 and older)
- Intermediate Care Facility (individuals with intellectual disabilities)
- Optometry
- Nurse Anesthetists
- Personal Care Services
- Pharmacy
- Physical, Occupational, and Speech Therapies
- Podiatry
- Private Duty Nursing
- Prosthetics and Orthotics
- Psychologist

The list above is not exhaustive and can be amended with waivers. For instance, in addition to the services listed above, Nevada also has federal waiver authority to cover home and community-based services. For more information on these waivers, see https://dhcfp.nv.gov/Pgms/LTSS/LTSSHome/.

SERVICE DELIVERY MODELS

Nevada Medicaid and Check Up use two service delivery models to provide health care to recipients, managed care, and fee-for-service (FFS). Most recipients in Nevada are covered through managed care. Under managed care, the state pays a managed care organization (MCO) a capitation payment, which is a fixed amount per member month, to coordinate services for enrolled recipients, and to pay providers for that care. One of the goals of using managed care is to help minimize budgetary fluctuations because the cost per recipient to the state is fixed for the period of a calendar year. Under FFS, the state pays health care providers directly based on the services received by Medicaid and Check Up recipients. Utilization of services by enrollees can be difficult to predict and manage, which complicates projecting medical expenditures and budget building.

MANAGED CARE

In Nevada, MCOs serve approximately 76% of all recipients in the Medicaid and Check Up programs.[iii] Covered populations include children, parents, caretakers, and newly eligible adults in urban Clark and Washoe counties. Currently, the state contracts with four managed care plans to serve recipients. These plans include Anthem, Health Plan of Nevada, Molina, and Silver Summit Health Plan. In addition, Liberty Dental serves as the dental benefits administrator (DBA) for this population.

Prior to the start of each month, Nevada Medicaid releases a capitation payment to the MCOs and DBA for each recipient enrolled in that plan. The capitation rate is a predetermined rate at which Nevada Medicaid will reimburse the provider for rendered services. The plan coordinates the recipient's medical and dental care and pays the providers that deliver those services according to the capitation rate. Payments made by Nevada Medicaid to the MCOs and DBA reached nearly $2 billion in SFY 2021.[iv] The amount of the capitation payment is based on the recipient's age, gender, category of aid, and location of residence.

Federal regulations require that capitation rates paid to Medicaid MCOs be "actuarially sound", meaning that the projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs for the plans' coverage of recipients. Nevada Medicaid contracts with an actuarial consulting firm for the development and certification of actuarially sound capitation rates.

The capitation rate-setting cycle for Nevada Medicaid and Check Up aligns with the calendar year, with updated rates becoming effective in January of each year. The development of these capitation rates in preparation for the January start date is a lengthy and complex process. Figure 4 below provides an overview of the capitation rate-setting process.

FIGURE 4: CAPITATION RATE SETTING PROCESS

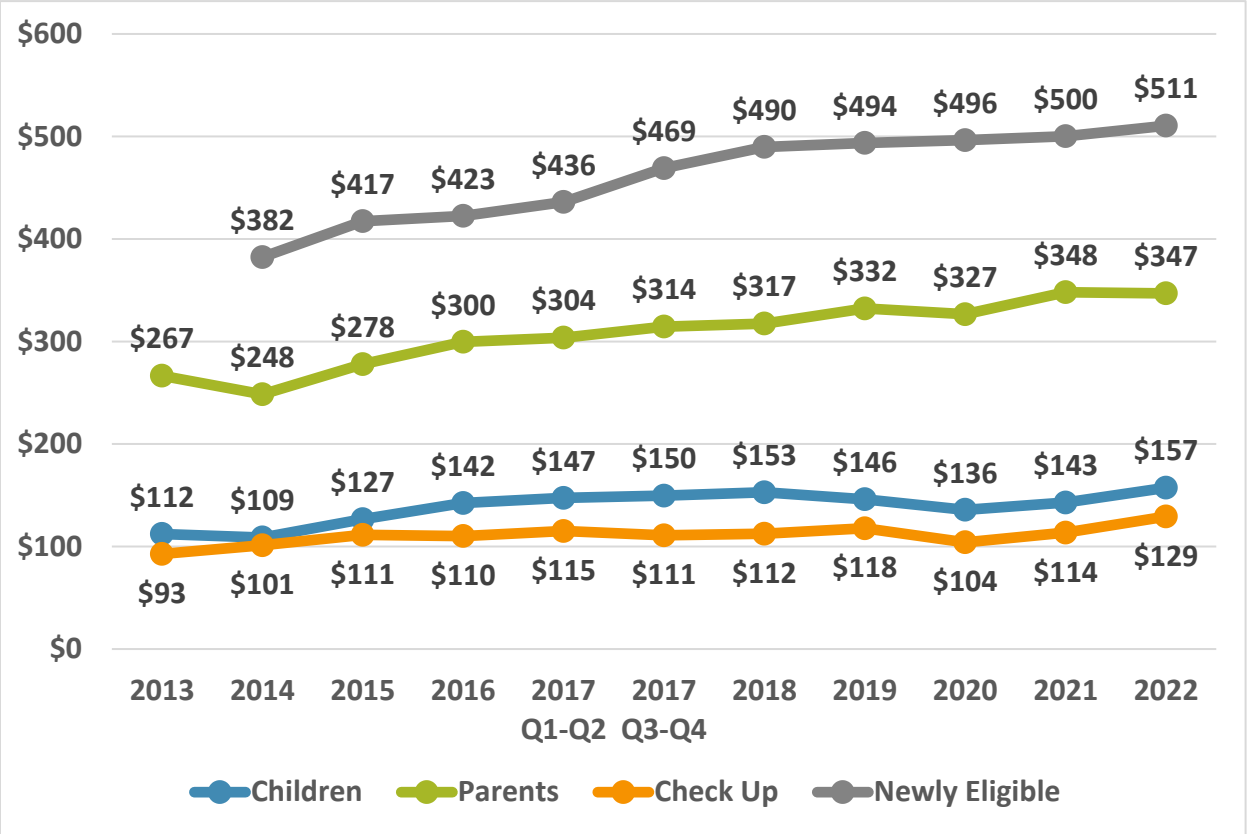
Detailed steps in rate-setting process:

- **Develop Base Data** – The actuary uses base data as a foundation for the capitation rate-building process. This data consists of the plan expenditures for services received by recipients from a prior year, known as the "base year." Typically, the base year is two calendar years prior to the current rate-setting cycle.
- **Identify and Forecast Trends** – This trend reflects any changes in service utilization and unit costs over time. The actuary uses the base data to analyze and forecast trends across multiple types of medical services including hospitals, home health services, durable medical equipment sales, physicians, and other professionals. Pharmacy trends are also analyzed and projected, considering anticipated changes in the utilization and cost of generic, brand, and specialty pharmacy drugs.
- **Adjust for Rate and Program Changes** – The actuary adjusts for changes in covered services and FFS rates, which are the floor for managed care reimbursement rates. If a rate or program change happens during the calendar year, managed care capitation rates must be recalculated and recertified if the resulting change to any rate cell exceeds 1.5 %.
- **Apply Risk Mitigation Tools** – Capitation rates also reflect several risk-sharing mechanisms that help minimize the financial impact on plans of exceptionally high-cost members. These mechanisms include:
    - Delivery case rate – Payment per birth
    - Very low birth weight payment – Payment per live birth of a newborn weighing less than or equal to 1,500 grams
    - Risk Adjustment – Payments/remittances to mitigate recipient health differences across plans
    - Stop-Loss Coverage – State payments to offset a portion of inpatient hospital costs of more than $500,000 per recipient per year
    - Minimum Medical Loss Ratio (MLR) – Remittance to the state if a plan does not meet the minimum MLR requirement of 85% of capitation revenues spent on medical services.
- **Calculate Cost of Administration and Taxes** – The final step is to calculate the administrative load or cost to the plans, which includes general administrative expenses, taxes, licensing and regulatory fees, and plan contribution to reserves, risk margin, and cost of capital. The Nevada insurance premium tax (3.5% of premiums) is reflected separately in the capitation rates.

After the actuary certifies the final capitation rates for the upcoming calendar year, they are submitted to the Office of the Actuary at CMS. The review and approval process may take longer than a year. The state pays the managed care organizations the certified capitation rates starting each January. If CMS requires revision of the rates, then a retroactive true-up process and contract amendments occur to ensure that the plans receive the final approved rates.

Figure 5 shows the composite managed care capitation rates for the last ten years. This table reflects medical capitation and does not include dental.

FIGURE 5: COMPOSITE MANAGED CARE CAPITATION RATE HISTORY, 2013-2022



SOURCE: ESTIMATED BASED ON ANNUAL CAPITATION RATE CERTIFICATIONS. THESE ESTIMATES RELY ON THE PROJECTED CASELOAD MIX AT THE TIME OF CERTIFICATION AND MAY DIFFER SLIGHTLY FROM PAID COMPOSITE AMOUNTS DUE TO DIFFERENCES BETWEEN PROJECTED AND ACTUAL CASELOAD MIX.

FEE-FOR-SERVICE

The FFS delivery model covers Family Medical recipients (children, parents, and newly eligible adults) in rural areas of the state, as well as aged, blind, and disabled, waiver, County Match, and child welfare recipients statewide. Under the FFS delivery model, Nevada Medicaid's fiscal agent pays providers directly for health care services rendered to Nevada Medicaid and Check Up recipients.

FFS payments are reimbursements for specific services provided to a recipient, for instance an office visit or lab test. An FFS rate and payment is specific to the provider type and service provided. Nevada Medicaid uses various methodologies to determine rates:

- **Fee-Schedule-Based Method** – Most FFS rates are set using the relevant Medicare fee schedules and formulas with data provided by CMS. These formulas incorporate factors like Relative Value Units, Geographic Practice Cost Index, location of service, and conversion factors which measure the effort and expense associated with providing a service, adjusted for cost variances due to provider location.
- **Cost-Based Method**– Some services are paid based on a provider's costs. These FFS rates are typically determined using certain cost factors related to the provision of specific services, such as provider salary or payroll, benefits, time studies, overhead, facility costs, and insurance.

- **Prospective Payment System (PPS)** – A method of reimbursement in which payment is a predetermined, fixed amount. The rate for a service or encounter is derived based on the classification system of that service.
    - **Per Diem Rates** – An all-inclusive flat rate is used to pay for services provided each day during a facility stay. Nevada Medicaid uses a per diem rate for hospital and skilled nursing reimbursement.
    - **Encounter Rates**
        - Federally Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs) receive an all-inclusive flat rate for all services provided during an encounter. Different encounter codes are used to reflect different types of services (medical, dental, or behavioral health). Rates are based on cost-report data and are updated annually using the Medicare Economic Index (MEI).
        - CCBHC rates are an all-inclusive flat rate covering behavioral health and primary care needs. Rates are based on cost-report data and are updated annually using the MEI.
- **Negotiated Rates (Provider-Specific)** – Rates are set through negotiations with specific providers to cover a percentage of billed charges or a specific flat rate that covers an acceptable portion of the provider's costs. This is typically done for out-of-state providers and certain types of specialized care.

Nevada Revised Statutes (NRS) 422.2704 requires Nevada Medicaid to review each FFS reimbursement rate at least once every four years to determine if the rates are sufficient to cover providers' costs for delivering the service to recipients. This Quadrennial Rate Review (QRR) process relies on cost information collected through provider surveys. Nevada Medicaid analyzes the survey data and makes recommendations to the DHHS Director regarding proposed rate changes for the upcoming budget cycle.

WHO PROVIDES SERVICES?

Nevada currently has over 39,000 enrolled providers. Providers that enroll with Nevada Medicaid's managed care organizations must also enroll as FFS providers. The ten most common provider types are shown in Table 3 below. A complete list for all provider types is included in Appendix D.

TABLE 3: ENROLLED PROVIDERS, JUNE 2021

Provider Type Number and Description	Enrolled Providers
20 Physicians	18,367
14 Behavioral Health Outpatient Treatment	5,202
24 Advanced Practice Registered Nurses	3,761
34 Therapy	1,856
77 Physician Assistant	1,819
85 Applied Behavior Analysis (ABA)	1,312
22 Dentist	1,138
28 Pharmacy	660
25 Optometrist	569
72 Nurse Anesthetist	450

Source: Provider Enrollment June 2021 Dashboard

HOW IS MEDICAID FUNDED?

The Medicaid program is funded with a mix of federal, state, and other funds. There is no cap on the amount of federal funds available to states for their Medicaid programs, but the share of expenditures covered by federal funds varies from state to state. This guaranteed federal funding helps ease budgetary pressures on the state when Medicaid caseloads grow due to deteriorating economic conditions or health crises like the COVID-19 Public Health Emergency that began in early 2020.

FUNDING SOURCES

Nevada Medicaid's total budget (i.e., state and federal expenditures) for SFY 2022 is just over $5.4 billion. According to the most recent expenditure data collected by the federal government for SFY 2019, when compared to other states, Nevada spends an average of $6,374 per enrollee which is below the national median of $8,436 per enrollee on a per capita basis. As illustrated below in figure 5, federal funds, including Title XIX Medicaid funds and Title XXI Children's Health Insurance Program funds, make up the largest share of Medicaid revenues. The non-federal share of funding for Medicaid expenditures comes from a variety of sources including state general funds, intergovernmental transfers (IGT) from county and local government entities, drug rebate revenue, provider tax revenue, as well as other sources of revenue.

FIGURE 6: BUDGETED FUNDING SOURCES, SFY 2022

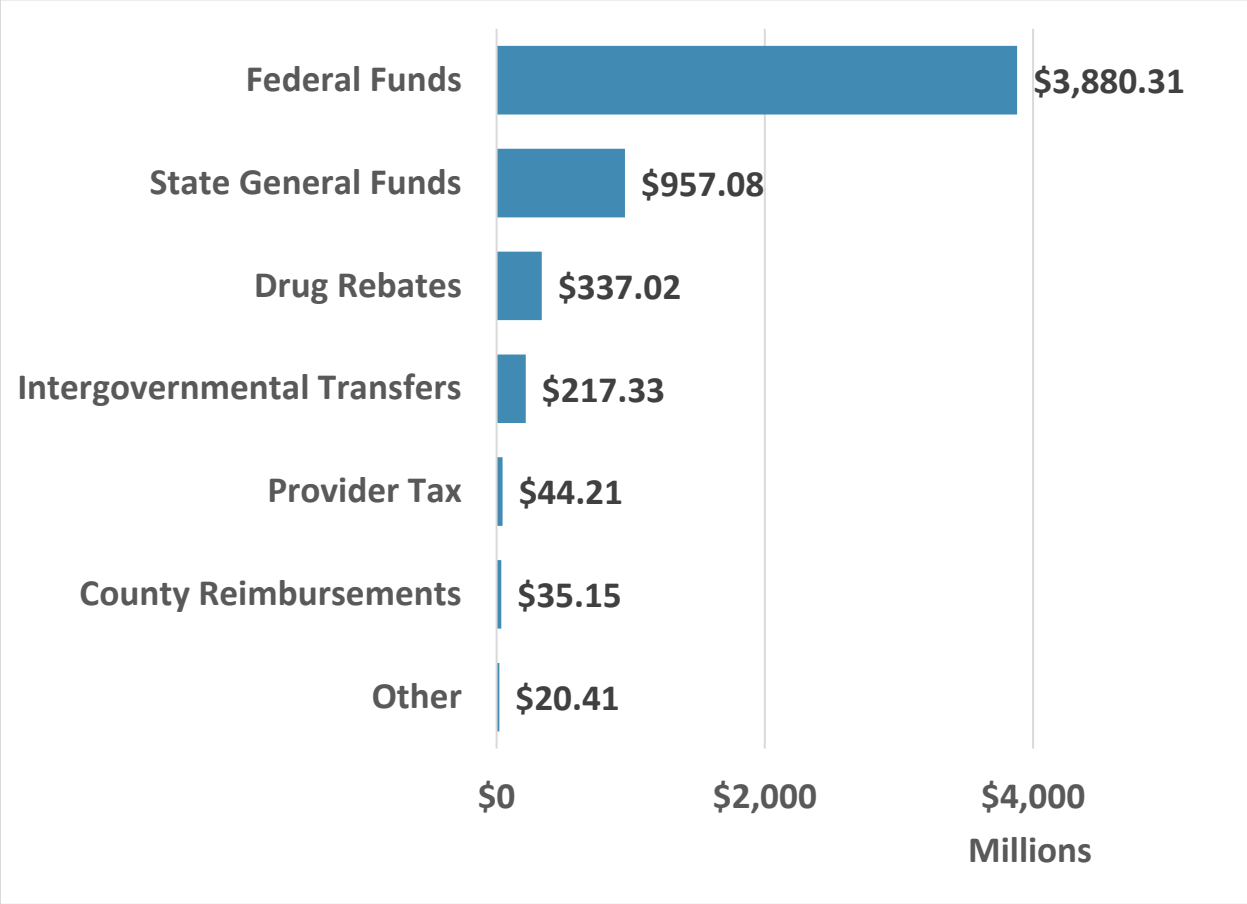


Figure 5 Source: Data Warehouse of Nevada (DAWN)

DHCFP currently has five grants that provide additional federal funding for specific expenditures:

- **Money Follows the Person (MFP) Demonstration Grant** – This funding is targeted to Medicaid recipients residing in a long-term care facility for a minimum of 60-days. These recipients receive assistance with housing coordination, transition navigation, community transition services as well as select waiver services to support their return to a community-based setting. The demonstration grant has a specific number of slots available which changes each calendar year. The grant is set to expire 9/30/2024.
- **MFP Capacity Building Grant** – This grant was available only to states operating an MFP Demonstration Grant. It is a one-time supplemental grant of up to $5 million over a five-year period ending 9/30/2025. This funding is targeted to activities that expand home and community-based services capacity with the goal of transforming the long-term services and supports system. At this time Nevada has received conditional approval for three proposals that expedite HCBS eligibility authorizations; expand the Electronic Visit Verification (EVV) system for Home Health Care services; and modernize Nevada's HCBS case management system.
- **Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) Act Planning Grant** – Nevada was one of 15 states awarded a SUPPORT Act planning grant to increase Medicaid substance use provider capacity. The grant amount was nearly $1.7 million. Through this

grant, Nevada Medicaid is focusing on increasing access to services for people who are pregnant, postpartum, and prenatal as well as infants, adolescents, and young adults ages 12-21. Nevada Medicaid has requested a no-cost extension through 9/29/2022 to finalize planning grant activities.

- **SUPPORT Act Post-Planning Grant** – This grant supports the implementation of the strategic plan and other activities developed during the planning grant phase. This is a three-year agreement for an enhanced federal match for these services. The grant period is 9/30/2021 through 9/29/2024.
- **Mobile Crisis Planning Grant** – Under this grant, Nevada Medicaid is eligible for an enhanced federal match (85%) for a maximum of three years for qualifying community-based mobile crisis intervention services and for services furnished by qualifying mobile crisis intervention service providers. Nevada will be focusing on developing sustainable funding for Medicaid Mobile Crisis Services through evaluation and technical assistance. The grant includes $615,937 for administrative costs. The grant period is 9/30/2021 through 9/29/2022.

FMAP

The Federal Medical Assistance Percentage (FMAP) is a formula set forth in federal statute that is used to determine the federal share of the cost of Medicaid in each state. The state's FMAP is calculated annually and is based on state per capita income in order to be responsive to changes in state economies. The lower the state's per capita income, the higher the state's FMAP, or federal Medicaid matching rate. However, it is important to note that there is a lag of three years in necessary data for FMAP changes which can cause fiscal stress for states facing economic challenges. Small changes in the FMAP rate can also impact the state's Medicaid budget. For example, based on current expenditure levels, a one percentage point decrease in FMAP increases the need for state general funds by approximately $16 million per year.

FMAP is set on a federal fiscal year (FFY) basis. Nevada's FMAP rate for FFY 2022 is 62.59%. This means that for every state dollar spent on Medicaid services, the state is eligible to receive 63 cents in federal matching funds. The federal government also provides an enhanced federal match for certain populations through two additional FMAP rates. These include:

- **Enhanced CHIP FMAP** - The Enhanced CHIP FMAP is calculated by reducing the state's share of expenditures by 30%. Nevada's Enhanced CHIP FMAP is 73.81% for FFY 2022. The Enhanced CHIP FMAP applies to the Check Up program and a subset of children in the Medicaid program.
- **Newly Eligible FMAP** – To encourage states to implement the Medicaid expansion, the Affordable Care Act (ACA) provides an enhanced FMAP for newly eligible adults. This FMAP is based on the calendar year rather than the federal fiscal year and was at 100% in 2014 and slowly declined until it reached 90% in the calendar year 2020. The Newly Eligible FMAP is currently 90% and will remain at 90% under current federal law.

During the COVID-19 Public Health Emergency, the Families First Coronavirus Response Act (FFCRA) increased Nevada's FMAP rate by an additional 6.2 percentage points to 68.79% for FFY 2022. The Enhanced CHIP FMAP increased by 4.34 percentage points as well (78.15%). For those who are newly eligible, the FMAP remains unchanged at 90% during the PHE. The FFCRA enhanced FMAPs are scheduled to end in September 2022 pending extensions of the PHE.

Figure 6 below shows the FMAP, Enhanced CHIP FMAP, and the Newly Eligible FMAP for the quarters between July 2019 and June 2023. The yellow bar identifies the quarters that include the FFCRA FMAP enhancement. As noted above, the enhancement does not apply to the Newly Eligible FMAP.

FIGURE 7: FMAP RATES BY QUARTER, JULY 2019 - JUNE 2023

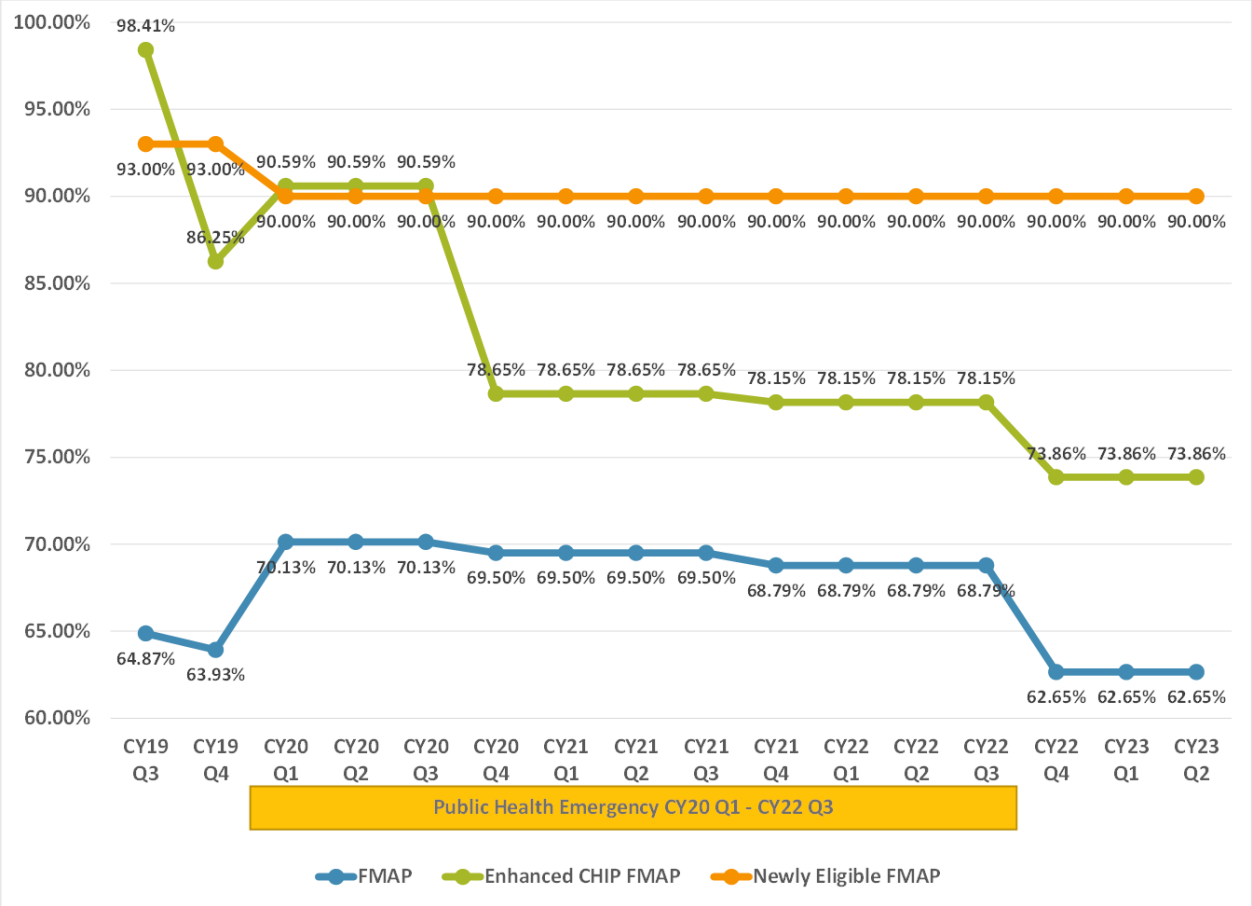


Figure 6 Source: FMAP Recalculation with PHE through September 2022

Enhanced federal funding is also available for specific services:

- Indian Health Services – 100% federal match under Title XIX of the Social Security Act
- Family Planning Services – 90% federal match under Title XIX of the Social Security Act
- Substance Use Disorder (SUD) Services – 80% federal match through the SUPPORT Act Post-Planning Grant
- Mobile Crisis Services - 85% federal match through the Mobile Crisis Planning Grant
- Home and Community Based Services – 10 percentage point increase in federal match from April 2021 through March 2022 through American Rescue Plan Act (ARPA)

Because Nevada's budget is based on a state fiscal year (July through June) rather than a federal fiscal year (October through September), Nevada Medicaid converts the federal fiscal year FMAP into a "blended" rate to use for budgeting purposes. The blended rate takes into account one quarter from the prior federal fiscal year and three quarters from the current federal fiscal year. The blended FMAP for state fiscal year 2022 is 68.97%, including the additional 6.2 percentage points from FFCRA. Please see Table 18 in Appendix E for historical data on Nevada's blended FMAP rate.

MEDICAID EXPENDITURES

Nevada Medicaid expenditures on health care services have grown significantly over time, increasing by 164% between SFY 2013 and SFY 2021. Multiple factors affect state Medicaid spending trends and projections, including state economic, demographic, and programmatic factors.

- **Economic factors** can include trends in health care costs, state wages, and unemployment.
- **Demographic factors** often include growth in the size of the population eligible for coverage in addition to changes in the health needs, acuity, or age of recipients.
- **Programmatic factors** include changes to the program that affect service utilization, provider reimbursement, managed care costs, coverage of benefits, and administrative expenses.

Figure 7 below shows total Medicaid revenues and expenditures for SFY 2013 through SFY 2021. Note that the expenditures reflected in the chart below reflect all expenditures in budget account (BA) 3243 Nevada Medicaid including FFS medical expenditures, managed care capitation payments, supplemental payments to providers, and other service-related expenditures.

FIGURE 8: MEDICAID REVENUES AND EXPENDITURES

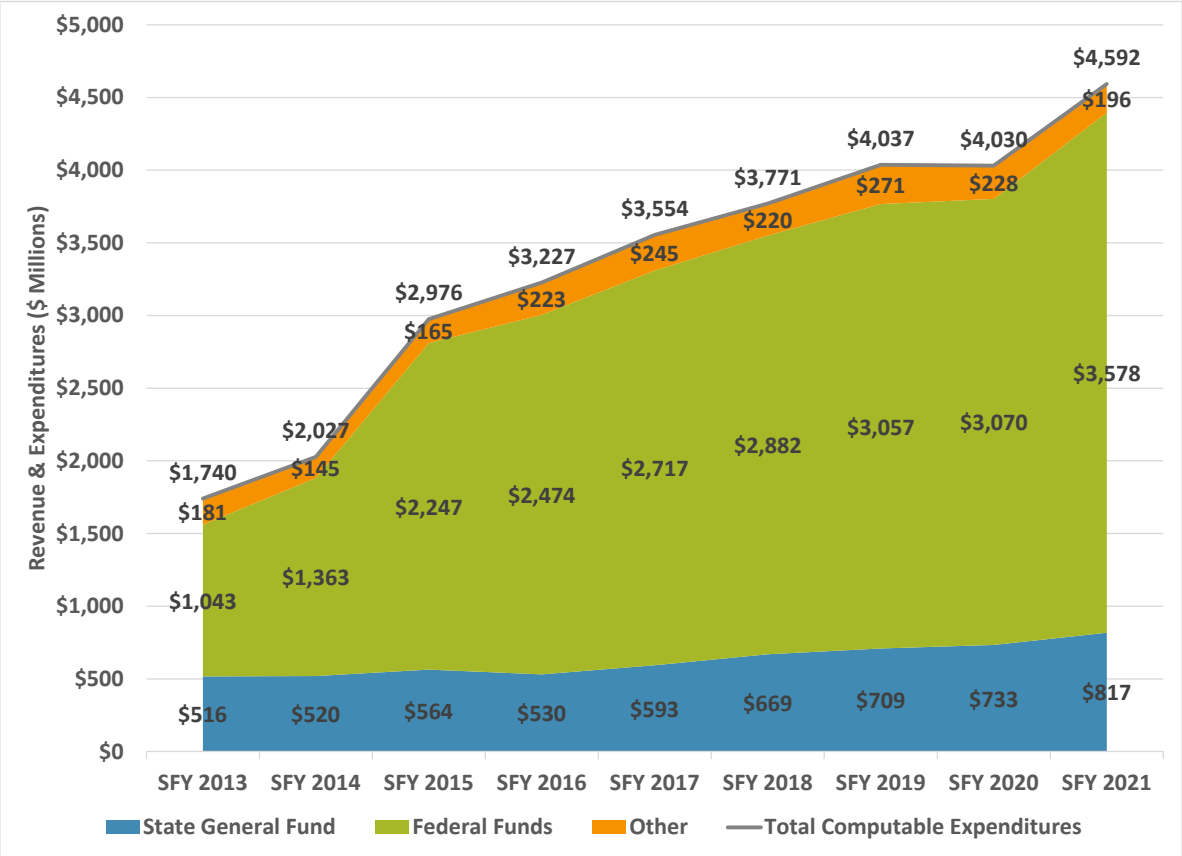


Figure 7 Source: Data Warehouse of Nevada (DAWN)

In SFY 2021, Nevada Medicaid made an average of $17.7 million dollars each business day in payments to providers and managed care organizations. Although total expenditures have grown significantly, the average annual cost per recipient has been relatively stable between SFY 2013 and SFY 2021, as shown

in Figure 8 below. Note that the calculation used for this chart reflects all expenditures in the Nevada Medicaid budget account divided by the state fiscal year average caseload.

FIGURE 9: AVERAGE ANNUAL COSTS PER RECIPIENT

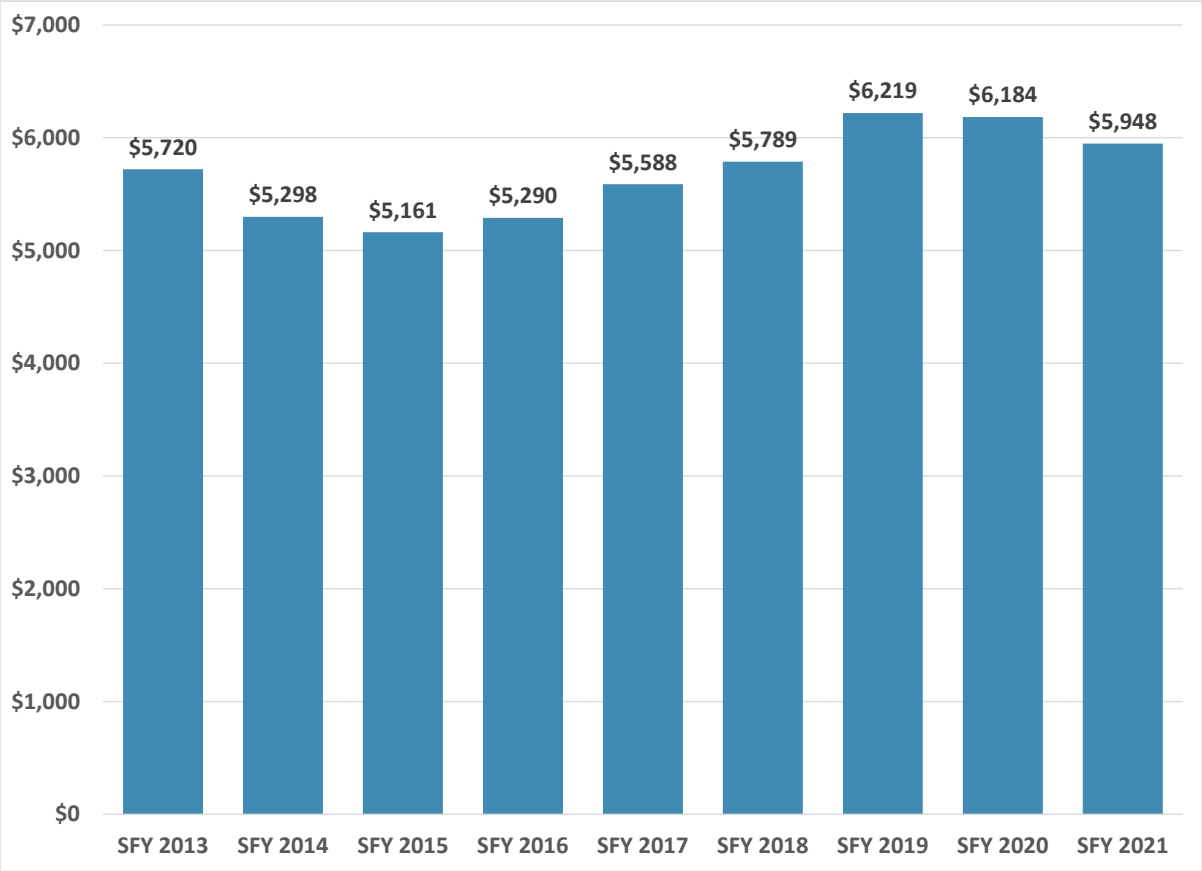


Figure 8 Sources: DAWN, Nevada Medicaid Caseload Master

Medicaid expenditures vary by eligibility group. Although the Aged, Blind and Disabled population makes up only 13% of the caseload (total recipients), medical expenditures for this group represent nearly a quarter of total Medicaid expenditures. Parents and Children make up 44% of the caseload, but only represent nearly a quarter of total Medicaid expenditures. Figure 9 below provides this comparison for each eligibility group.

FIGURE 10: SHARE OF CASELOAD VS. SHARE OF EXPENDITURES BY ELIGIBILITY GROUP, SFY 2021

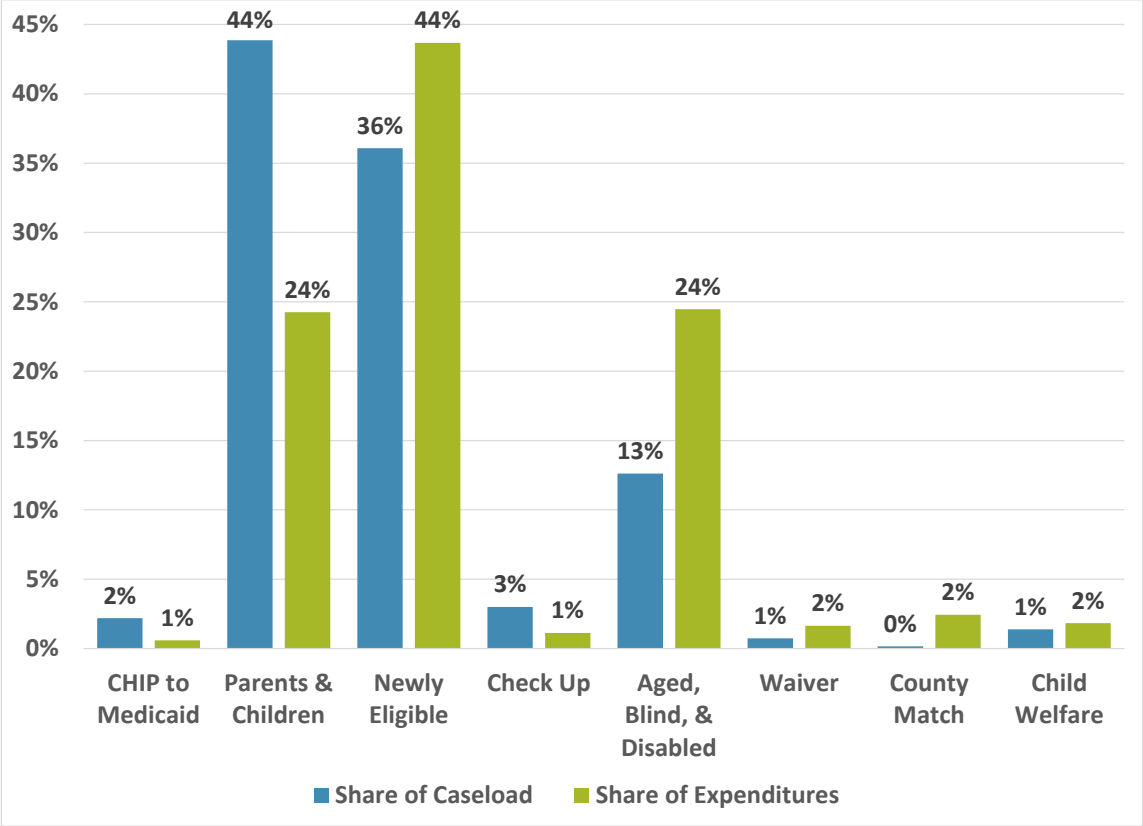


Figure 9 Sources: DWSS Master; DAWN

Medicaid expenditures also vary by provider type. The tables below list the providers with the highest expenditures in the FFS and managed care delivery models. FFS expenditures include financial transactions such as supplemental payments. Managed care expenditures represent payments from the MCOs and DBA to providers, not state expenditures. In SFY 2021, combined FFS and managed care pharmacy expenditures equaled $804,031,821. After applying drug rebates, the net pharmacy spend was $410,465,500.

TABLE 4: TOP FFS AND MANAGED CARE EXPENDITURES BY PROVIDER TYPE, SFY 2021

Provider Type Code - Description	Fee-for-Service
11 - Hospital Inpatient	$340,281,052
19 - Nursing Facility	$301,885,800
20 – Phys, M.D. Osteop. D.O.	$210,881,043
38 - Waiver for Intellectual Disabilities	$107,894,275
30 - Personal Care Services - Provider Agency	$104,888,141
14 - Behavioral Health Outpatient Treatment	$91,470,378
17 - Special Clinics	$44,251,336
54 - Targeted Case Management	$42,305,230
32 - Ambulance Air or Ground	$37,605,756
12 - Hospital Outpatient	$35,506,535
63 - Residential Treatment Centers (RTC)	$32,959,411
29 - Home Health Agency	$32,612,916
33 - DME Disposable Prosthetics	$30,519,620
22 -Dentist	$28,925,694
34 - Therapy	$26,039,437
75 - Critical Access Hospital (CAH) Inpatient	$23,435,811
24 - Advanced Practice Registered Nurses	$22,046,387
35 - Travel	$20,977,839
47 - Indian Health Services (IHS) and Tribal Clinics	$15,145,026

Source: Decision Support System (DDS)

Provider Type Code - Description	Managed Care
20 – Phys. M.D. Osteop. D.O.	$377,947,299
11 - Hospital Inpatient	$360,531,059
12 - Hospital Outpatient	$72,232,646
22 - Dentist	$54,636,348
14 - Behavioral Health Outpatient Treatment	$49,186,846
33 - DME Disposable Prosthetics	$42,101,328
13 - Psychiatric Hospital Inpatient	$36,935,690
19 - Nursing Facility	$22,526,981
34 - Therapy	$21,606,804
43 - Laboratory Pathology Clinical	$19,428,180
46 - Ambulatory Surgical Centers	$19,245,362
17 - Special Clinics	$18,162,162
56 - Inpatient Rehabilitation & LTAC Specialty Hospital	$7,246,433
45 - End Stage Renal Disease (ESRD) Facility	$7,238,517
25 - Optometrist	$7,053,236
27 - Radiology and Non-Invasive Diagnostic Centers	$6,933,614
35 - Travel	$5,582,931
24 - Advanced Practice Registered Nurses	$5,075,918
29 - Home Health Agency	$3,993,456

Source: Data Warehouse Dimensional Data Model (DDM)

SUPPLEMENTAL PAYMENT PROGRAMS

Nevada Medicaid supports access to care through multiple supplemental payment programs to providers. Federal regulations allow state Medicaid agencies to reimburse under an FFS environment up to an amount equal to what Medicare would have paid for the same services. This amount is referred to as the Upper Payment Limit (UPL). The total of standard reimbursements and supplemental payments cannot exceed the UPL. Nevada Medicaid's supplemental payment programs include:

- **Disproportionate Share Hospital (DSH)** – This federally mandated program provides supplemental payments to hospitals that provide a disproportionate share of services to indigents and the uninsured. The federal government provides an annual allotment of federal funds, which Nevada matches with an IGT of funds.
- **Graduate Medical Education (GME) –** This supplemental payment program supports hospitals that provide GME in an inpatient environment. All Medicaid participating public hospitals in Nevada that offer an accredited GME program are eligible to participate in this supplemental payment program. In addition, two private hospitals in Nevada are eligible to participate as there is no public hospital in their county offering GME services.
- **Hospital Indigent Fund (HIF)** – This supplemental payment program helps preserve access to inpatient hospital services for needy Nevadans. The HIF was created to provide funding for the nonfederal share of Medicaid supplemental payments. Acute care hospitals are eligible to participate in this supplemental payment program. Three percent of the total supplemental payment is designated for trauma center hospitals and the remaining 97% is distributed based on a hospital's case-mix and weighted Medicaid bed days. Note that this program is sometimes referred to by its previous name, Indigent Accident Fund (IAF).
- **Nursing Facility** – Supplemental payments are issued to Medicaid-participating nursing facilities based on Medicaid occupancy, patient acuity and complexity, and quality measures. Nursing facilities with higher Medicaid occupancy and higher quality scores receive larger supplemental payments. A provider fee equal to 6% of net patient revenues for all free-standing skilled nursing facilities (SNFs) funds the non-federal share of these payments. All SNFs in Nevada are assessed a provider fee for all non-Medicare bed days.
- **Upper Payment Limit for Inpatient Private Hospitals** –This program provides supplemental payments to private hospitals affiliated with a state or local government entity through a Low Income and Needy Care Collaboration Agreement. A Low Income and Needy Care Collaboration Agreement is an agreement between a hospital and a state or local government entity to collaborate in providing health care services to low income and needy patients. This collaboration frees up state funds that can be used as the non-federal share of these supplemental payments. Sixteen private hospitals participate in this program.
- **Upper Payment Limit for Inpatient Public Hospitals** – Eight public hospitals participate in this supplemental payment program, which helps preserve access to inpatient care at public hospitals. Seven of the eight participating hospitals are designated as critical access hospitals (CAHs) and are in rural areas across Nevada.
- **Upper Payment Limit for Outpatient Public Hospitals** – Similar to the Inpatient Public program, this program provides supplemental payments to these eight participating hospitals to help preserve access to outpatient care at public hospitals.
- **Upper Payment Limit for Medical Practitioners** – To incentivize and promote medical education services provided in an outpatient setting, Nevada Medicaid reimburses eligible medical practitioners an enhanced rate of payment for FFS Medicaid services when delivered in a teaching environment. This program allows Medicaid to issue an enhanced rate of reimbursement equal to

the difference between the Medicaid base rate and the Average Commercial Rate (ACR) that a teaching entity would have received for the service. Participating medical practitioners must be providing teaching services in conjunction with one of the designated teaching entities: University of Nevada-Las Vegas School of Medicine; University of Nevada-Reno School of Medicine; and University Medical Center of Southern Nevada.

TABLE 5: SUPPLEMENTAL PAYMENT PROGRAMS, SFY 2021

Supplemental Payment Program	SFY 2021 Payments	Source of Non-Federal Share
Disproportionate Share Hospital	$74,349,874	Intergovernmental Transfer
Graduate Medical Education	$32,125,987	Intergovernmental Transfer
Hospital Indigent Fund	$75,496,676	DHHS transfer from HIF
Nursing Facility	$132,288,770	Provider Fee Revenue
Upper Payment Limit Inpatient Private	$18,120,800	State Funds
Upper Payment Limit Inpatient Public	$48,914,822	Intergovernmental Transfer
Upper Payment Limit Outpatient Public	$17,086,971	Intergovernmental Transfer
Upper Payment Limit Practitioner	$5,011,220	Intergovernmental Transfer
TOTAL	**$403,395,120**	

STRUCTURE OF NEVADA MEDICAID

In SFY 2021, the division had 311.51 full time equivalent (FTE) positions. Most division staff are divided into four functional areas that may overlap but are overseen by four deputy administrators. In addition, 10 DHCFP positions are located within the DHHS Office of Analytics to provide data analysis and reporting to support the division's data-driven decision-making processes.

POSITION FUNDING

Most positions are funded at a 50% federal, 50% state administrative match. Certain information services and data analytic positions are funded at a 75%/25% federal/state match. In SFY 2021, total expenditures for personnel services were $22.6 million.[v]

Funding and expenses for DHCFP's programs and activities are tracked in six budget accounts (BA):

- **BA 3157 Intergovernmental Transfer** receives revenues from counties and local governments to support the division's supplemental payment programs.
- **BA 3158 DHCFP Administration** tracks the division's administrative expenses including personnel, fiscal agent costs, and contractual obligations.
- **BA 3160 Increased Quality of Nursing Care** receives provider tax revenues that are used to support the nursing facility supplemental payment program.
- **BA 3178 Nevada Check Up** reflects expenditures on medical services and capitation payments for Check Up recipients. Check Up premium revenue also flows into this budget account.
- **BA 3243 Nevada Medicaid** reflects expenditures on medical services and capitation payments for Medicaid recipients. The "offline" category also includes expenditure offsets such as third-party liability, Medicaid Estate Recovery, and other recoveries/payments.
- **BA 3245 Prescription Drug Rebates** is a new budget account established during the 81st Legislative Session to track drug rebate revenues. These revenues offset funds in the Nevada Medicaid budget account.

SFY 2021 actual expenditures and SFY 2022 budgeted expenditures (work program amount) are shown in the table below.

TABLE 6: TOTAL EXPENDITURES BY BUDGET ACCOUNT, SFY 2021 - SFY 2022

Budget Account	SFY 2021 Expenditures	SFY 2022 Budgeted
3157 Intergovernmental Transfer	$114,109,382	$265,718,778
3158 DHCFP Administration	$130,765,172	$185,269,461
3160 Increased Quality of Nursing Care	$40,579,925	$45,191,552
3178 Nevada Check Up	$48,079,592	$56,090,436
3243 Nevada Medicaid	$4,592,130,330	$5,491,510,963
3245 Prescription Drug Rebates	N/A	$337,020,899
TOTAL	**$4,925,664,401**	**$6,380,802,089**

Source: DAWN

FIGURE 11: NEVADA MEDICAID FUNCTIONAL AREAS

Policy & Programs	Health Plan Programs & Quality	Health Information Technology & Compliance	Fiscal Services
•Medical Programs •Pharmacy •Behavioral Health •Transportation •Long-Term Services & Supports •District Offices •Primary Care Office	•Dental Benefits Administrator •Managed Care Program •Quality Assurance •Public Option •Special Projects & Innovation	•MMIS •Business Process Management •Project Management •IT Operations •Information Security & HIPAA •Document Control •Audit •Program Integrity •Hearings •Provider Enrollment •Surveillance Utilization Review	•Medicaid Estate Recovery •Recoveries and Recoupments •Budget •Accounting •Federal Reporting •Rates Analysis & Development •Supplemental Payments •Procurement •Human Resources

POLICY AND PROGRAMS

MEDICAL PROGRAMS

The Medical Programs unit is responsible for researching, developing, implementing, managing, and evaluating medical coverage policies and procedures. This includes collaborating with community stakeholders, providers, CMS, divisions within DHHS, and other partners in improving existing services or creating new ones. The Medical Programs Unit also works with other units within the division on Medicaid Management Information Systems (MMIS) functionality, establishing rates, publication of policy, billing guides, manuals, web announcements, and resolving claims issues.

PHARMACY

Pharmacy Services oversees the administration of the pharmacy benefit for FFS recipients. The unit coordinates the functions of the Silver State Scripts Board, which is responsible for developing and maintaining a preferred drug list, and the Drug Use Review Board. The Board recommends prior authorization and quantity limits for drugs and drug classes under review. Pharmacy Services staff ensure prescription drug policies are updated and assist in resolving issues with prescription drug claims. The unit monitors prescription drug spending and trends and implements projects to address the increasing costs associated with maintaining the prescription drug benefit.

BEHAVIORAL HEALTH

Behavioral Health oversees the policy development and program management for all behavioral policy benefits for recipients receiving insurance coverage through Nevada Medicaid. These policies include outpatient mental health, rehabilitative mental health, substance use prevention and treatment, targeted case management, applied behavior analysis, services specific for youth in specialized foster care, inpatient psychiatric services, as well as psychiatric residential treatment centers/facilities. There are several behavioral health models delivering services, such as Certified Community Behavioral Health Centers (CCBHCs), Behavioral Health Community Networks (BHCN), and the Substance Use Agency Model. To develop and implement policy, the Behavioral Health unit works collaboratively with other systems, including divisions across the DHHS and contracted partners of those divisions. Examples include the Center for the Application of Substance Abuse Treatment (CASAT), service providers, and other community stakeholders.

LONG-TERM SERVICES & SUPPORTS

Long-Term Services and Supports (LTSS) is responsible for policy development and program management of multiple services many of which are targeted to individuals who need ongoing care due to age, physical or intellectual disability, or chronic illness. Services are delivered either in an HCBS setting or an institution. HCBS State Plan services include personal care services, home health, private duty nursing, hospice, adult day health care, and residential habilitation. The LTSS unit also oversees three 1915(c) HCBS Waivers targeted to the Frail Elderly, Persons with Physical Disabilities, and Individuals with Intellectual Disabilities. Institutional services include nursing facility care and intermediate care facility for individuals with intellectual disabilities. Transportation is also included as a service: non-Emergency Medical Transportation operated through a broker and emergency transportation either via ground or air ambulance.

DISTRICT OFFICES

The District Offices assist Medicaid recipients with accessing health care (in-state and out-of-state). This includes identifying providers, explaining coverage benefits, assisting with placement issues, transitioning to community placement, identifying support services to stay in the home, researching and resolving complex billing issues, reviewing, and following up on serious-occurrence reports, and identifying and troubleshooting computer interface issues affecting eligibility. Medicaid recipients are served through the customer service line or assigned to a health care coordinator. Additional services managed at the District Office level are Nevada Check Up policies and collection, tracking of premiums, assisting with Medicare Buy-in issues, management of the HIWA Program, conducting verification reviews of nursing facilities, and participating in community outreach events. Program units that operate these functions within the District Offices include Care Coordination, Customer Service, Katie Beckett Eligibility Option, Minimum Data Set, and Facility Outreach and Community Integration Services.

PRIMARY CARE OFFICE

The Primary Care Office (PCO) is funded by grants from the Health Resources Services Administration (HRSA) to support multiple programs, with its main goal being to improve access to care and expand the health care workforce.

The Primary Care Office works closely with health facilities and HRSA for the designation of Health Professional Shortage Areas, or Medically Underserved Areas or Populations, and for the approval of National Health Service Corps Clinical Sites. These designations and site approvals support access to federal health care resources, including grants to health centers, training and recruitment of health professionals, enhanced payment through Medicare and Medicaid, and immigration policies for health professionals.

Another focus for the PCO is the recruitment and retention of health care providers. The PCO utilizes programs such as NHSC loan repayment and scholarship programs, and the J-1 Physician Visa Waiver and National Interest Waiver policies, which bring in foreign medical graduates to underserved areas. The Primary Care Office supports up to 30 waiver applications for physicians holding J-1 Visas in order to improve access to primary or specialty care in Nevada.

The PCO also works closely with the Director's Office to review Certificate of Need applications. The construction of new health facilities at a cost of over $2 million in all rural communities in Nevada requires a letter of approval from the Nevada Director of the Department of Health and Human Services. The review process helps control increases in the cost of health care, to provide adequate supply and distribution of resources, and to provide equal access to quality health care at a reasonable cost.

HEALTH PLAN PROGRAMS AND QUALITY ASSURANCE

DENTAL BENEFITS

When a member is enrolled in an MCO, they are automatically enrolled with the Dental Benefits Administrator (DBA). Dental benefits in Nevada are provided by LIBERTY Dental Plan of Nevada, Inc. Nevada Medicaid works closely with the DBA, and the Division of Welfare and Supportive Services (DWSS) to ensure recipients in covered areas are informed and supported as they seek dental care.

MANAGED CARE AND QUALITY ASSURANCE

Managed Care and Quality Assurance is responsible for contract monitoring and oversight of four managed care entities that provide medically necessary services to members residing in Washoe and Clark counties, as well as one Dental Benefits Administrator, that provides medically necessary dental services to members. Program staff oversee contract components such as network adequacy, performance improvement, and quality initiatives and improvement activities. Staff maintain reports related to progress on MCO and DBA activities, which is located here: https://dhcfp.nv.gov/Resources/AdminSupport/Reports/CaseloadData/.

The unit also monitors quality and compliance for 1915(i) State Plan services and three 1915 (c) waivers for: Frail Elderly; Individuals with Intellectual Disabilities; Persons with Physical Disabilities. Nevada's federally approved 1915(i) State Plan services currently include adult day health care, habilitation services, as well as services for the Specialized Foster Care population. The unit administers MSM Chapter 1000—the policy for Medicaid-covered dental services. Program staff communicate policy coverage to providers, recipients, and the public; and represent the state during fair hearings related to denied coverage of dental services. Staff maintain reports related to progress on MCO and DBA activities, located here: https://dhcfp.nv.gov/Resources/AdminSupport/Reports/CaseloadData/.

PUBLIC OPTION

Nevada Medicaid is working closely with the Director of the Department of Health and Human Services, Commissioner of Insurance and Executive Director of the Silver State Health Exchange to design, establish and operate the Public Option health benefit plan. This innovative effort is guided by legislation passed during the 2021 Legislative Session and signed into law by Governor Steve Sisolak on June 9, 2021. For more information, meetings, reports, studies, progress and to sign up for notifications regarding this effort, please go to https://dhhs.nv.gov/PublicOption/

SPECIAL PROJECTS & INNOVATION

This new functional area is necessitated by Nevada's recent groundbreaking efforts that require the expertise of a Deputy for execution. One example is embarking on the implementation of the Public Option as well as more focused and vigorous efforts to zero in on particularly challenging populations.

HEALTH INFORMATION TECHNOLOGY AND COMPLIANCE

MEDICAID MANAGEMENT INFORMATION SYSTEM

MMIS is an integrated group of procedures and computer processing operations (subsystems) developed at the general design level to meet principal objectives. For Title XIX purposes, "systems mechanization" and "mechanized claims processing and information retrieval systems" are identified in section 1903(a)(3) of the Act and defined in regulation at 42 CFR 433.111. The objectives of this system and its enhancements include the Title XIX program control and administrative costs; service to recipients, providers, and inquiries; operations of claims control and computer capabilities; and management reporting for planning and control.

BUSINESS PROCESS MANAGEMENT

The Business Process Management is comprised of two teams: the Eligibility/Advanced Planning Document team and the Claims/Data Quality Management team. Both teams are made up of Business Process Analysts that define, train, and enforce the Change Management Process for implementing change into MMIS and its peripheral systems. Staff act as a liaison between Nevada Medicaid and the system vendor programmers to ensure the business needs of the division are met. Staff are tasked with research, analysis, and reporting of system issues through the drafting of Production Discrepancy Reports and track the issues to resolution. There are also two Management Analysts that develop system enhancements to obtain more Federal Financial Participation from CMS.

PROJECT MANAGEMENT

The Project Management Office includes managers who define and maintain standards for project management. The office follows the Project Management Body of Knowledge from the Project Management Institute for traditional projects. The office also provides rapid application development through guidance and standards in the execution of projects using methods, processes, and tools. The PMO creates tangible goals, aligned with the overall division vision, and ensure all business needs are met. The office follows an approved project plan while facilitating communication and collaboration between all project team members, to provide accurate and reliable information to stakeholders so they can make the best possible decisions when circumstances dramatically change. Staff works closely with our various external vendors to oversee the approved scopes of work and manage them to successful outcomes. The office also plays a significant role in the gathering of evidence and facilitation of certification efforts with CMS for systems requiring certification.

IT OPERATIONS

The IT Operations unit monitors and maintains technical aspects of the division including systems, networks, databases, hardware, software and all aspects of system and network administration. This includes the cloud applications team, which implements and maintains various commercial off-the-shelf products and manages the divisions software environments such as Teams and SharePoint. This unit also includes the DHCFP IT Help Desk which is available to configure and maintain computer equipment and troubleshoot/resolve IT-related issues for the division and its users.

INFORMATION SECURITY

Information Security is responsible for maintaining the confidentiality, integrity, and availability of information, both electronic and physical. This is achieved by preventing unauthorized access, use, disclosure, disruption, modification, or destruction of the information that Nevada Medicaid is responsible for by following the methodologies and controls recommended by Federal and State regulations and the National Institute of Standards and Technology Cyber Security Framework.

The unit creates and maintains DHCFP's security policies and procedures, Security Awareness Training, system access requests, contractor background checks, and system audits from federal and state entities.

HEALTH INSURANCE AND PORTABILITY AND ACCOUNTABILITY ACT

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Officer is responsible for ensuring that Nevada Medicaid adheres to the regulations established by the HIPAA Privacy Rule. The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other individually identifiable health information (collectively defined as "protected health information") and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The rule also gives individuals rights over their protected health information, including rights to examine and obtain a copy of their health records, to direct a covered entity to transmit to a third party an electronic copy of their protected health information in an electronic health record, and to request corrections.

DOCUMENT CONTROL

Document Control keeps current and archived versions of the SPA, the Medicaid Services Manuals the Medicaid Operations Manual, and the Division Administrative Manual. This unit maintains the current version of all forms, procedure memos, and Numbered Internal Memos; posts all agendas to the website for public hearings and workshops, the Medical Care Advisory Committee, the Silver State Scripts Board, the Drug Use Review Board, the Tribal Consultations, and the Advisory Committee on Medicaid Innovation. Document Control maintains ADA compliance of documents on the web and acts as a facilitator between Gainwell Technologies and Nevada Medicaid for the purpose of posting information on the Medicaid website for providers (https://www.medicaid.nv.gov/).

AUDIT

Audit is responsible for performing multiple internal audits related to DHCFP including systems audits of FFS claims for individual large dollar claims and provider types with the highest claim value, and audits of the agency's internal controls. The unit performs audits of external organizations related to DHCFP including the agency's Fiscal Agent, contractors that the agency does business with, and providers who apply for incentive payments related to CMS' Promoting Interoperability Audit. The unit performs oversight and/or liaison duties for outside entities auditing Nevada Medicaid including CMS, Legislative Counsel Bureau, Governor's Office, State, Inspector General, and the federal Payment Error Rate Measurement Audit. Staff also perform oversight and/or liaison duties for outside entities performing audits on behalf of the division, such as the company that audits Patient Trust Funds at skilled nursing facilities. Audits and audit-like studies are tracked for the division and the unit is available to perform special audits requested by management and others as time and resources permit.

HEARINGS

Hearings provides fair hearings to any Nevada Medicaid or Nevada Check Up recipient who disagrees with any action resulting in the reduction, suspension, termination, denial, or denial-in-part of a Medicaid service, or any recipient who makes a request for a service and believes the request was not acted upon with reasonable promptness. Hearings also provides an opportunity for fair hearings to any resident of a nursing facility where the facility has taken action to evict or transfer the resident. Providers of the State Plan for Medicaid may also dispute an adverse action that affects the provider's participation in the Medicaid program, which includes reimbursement for services rendered to eligible Medicaid recipients, recoupment of overpayments, or disenrollment. See the fair hearing web site (https://dhcfp.nv.gov/Resources/PI/Hearings/) and Medicaid Services Manual Chapter 3100 (https://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/C3100/Chapter3100/).

PROVIDER ENROLLMENT

Provider Enrollment works very closely with the state's fiscal agent, to ensure that qualified providers are enrolled and able to provide Nevadans with an array of health care services. The unit is responsible for oversight of enrollment and revalidations, contract suspensions and terminations, policy development and maintenance, and provider exclusion verification. Staff work closely with the state's fiscal agent and is the first step in preventing fraud, waste, and abuse. With the implementation of the ACA, Provider Enrollment has enhanced screening and disclosure requirements as part of the application process. These enhancements include ownership and disclosure, enrollment of Ordering, Prescribing or Referring providers, increased federal database checks and reporting, assign risk levels and/or elevated risk levels for existing providers, pre and post-enrollment on-site visits, required revalidation of all providers to five years, with the exception of Durable Medical Equipment providers, who have to revalidate every three years, and Fingerprint Criminal Background Check. In addition, Provider Enrollment is responsible for the oversight and review of termination referrals, contract suspensions and/or terminations, exclusion verifications, and policy development and maintenance.

SURVEILLANCE AND UTILIZATION REVIEW

Surveillance and Utilization Review is primarily responsible for the identification of overpayments made to Medicaid providers due to potential fraud, waste, abusive billing, or other improper payments. The unit conducts reviews based on referrals and analyses of billed claims, and findings from these reviews may result in provider education and recoupment of overpayments. The unit may also provide referrals to other agencies, recommend payment suspensions, contract terminations, and/or enrollment sanctions. The unit also performs other functions, such as recommending revisions to Medicaid regulations, policy, billing guides and/or the claims processing system, and administering the provisions of the False Claims Act. Referrals of any allegations of provider fraud, waste, or abusive billing related to payments from Nevada Medicaid may be submitted to the unit online at: https://dhcfp.nv.gov/Resources/PI/ContactSURSUnit/.

FISCAL SERVICES

MEDICAID ESTATE RECOVERY

Medicaid Estate Recovery is a federally mandated program that seeks monetary recovery from a deceased recipient's estate for Medicaid benefits paid on the deceased recipient's behalf. The unit must determine the amount of claims against each recipient, provide that information to certain persons, determine the assets in each recipient's estate, expenses of each estate and recover either the full amount of its paid claim or the amount of assets remaining in each estate, whichever amount is less in accordance with state and federal law. The program is required by the Social Security Act, NRS 422.29302 and the Medicaid Operations Manual, Chapter 800. Operations are managed by Health Management Systems through a legislatively approved contract in place since May 2021.

RECOVERIES & RECOUPMENTS

The Recoveries and Recoupments team works with agency units, the fiscal agent, and the agency vendors to develop and institute repayment and settlement agreements with providers who have been overpaid. The team enacts and enforces debt recovery and collections policies for Nevada Medicaid and manages the provider debt turnover process with the State Controller's Office (SCO). It investigates possible financial process issues with the fiscal agent and contractors, and actively engages these entities for explanations and resolutions. All activities are done in accordance with the 1996 Fair Debt Collection Practice Act, NRS 353C, Nevada Administrative Code 353C, and Debt Collection Policy.

ACCOUNTING

The Accounting Team is responsible for processing all accounts payables, accounts receivables, deposits, travel, purchasing, invoices, and bank reconciliations. The team works closely with the rest of the Fiscal Services team and other Nevada Medicaid units to ensure payments for services are made timely and accurately.

FEDERAL REPORTING

Federal Reporting is responsible for the completion of federal draws, quarterly CMS reporting of Medical and Administrative expenditures, submittal of quarterly budget requests to CMS for Medical and Administrative expected costs. The Federal Reporting Unit works with all stakeholders to gain the most accurate information for the quarterly budget development as well as gain information on any new programs and initiatives.

RATE ANALYSIS AND DEVELOPMENT

Rate Analysis and Development is responsible for FFS provider rate methodology development, rate studies and reviews, rate appeals, Medicaid Rate Policies, the QRR process, letters of agreement, and scheduled rate updates. RAD is also responsible for fiscal impact analyses associated with these processes as well as policy and legislative changes to the Medicaid and Check-Up programs. The RAD unit is also responsible for collaborating with the Managed Care Organizations (MCO) and contracted actuaries to develop capitation rates for members enrolled in an MCO.

SUPPLEMENTAL PAYMENTS

Supplemental Reimbursement is responsible for managing supplemental payments and reimbursement programs to Nevada Medicaid providers and MCOs, DSH reporting, Governor's Report on Activities and Operations of Nevada Hospitals, Upper Payment Limit reporting, coordinating the collection of provider

utilization and financial data for the Nevada Health Care Quarterly Reports posted to the Nevada Compare Care Website by the Center for Health Information Analysis. This unit manages the collection of financial data from institutional providers such as hospitals, nursing facilities and intermediate care facilities to include the collection of Medicare and Medicaid cost reports and the oversight of audit contractors. The unit monitors approximately 70 contracts and interlocal agreements related to supplemental payment programs.

PROCUREMENT AND CONTRACTS

The Procurement and Contracts adheres to State rules and regulations for contract management and facilitation and establishes and standardizes Nevada Medicaid's contracting procedures to ensure proper compliance with NRS and the State Administrative Manual (SAM). The unit works collaboratively with all involved stakeholders of the procurement and contracting process and represents the interests of the State.

HUMAN RESOURCES

Human Resources provides support to all DHCFP employees to attract and retain highly skilled staff and provide optimum working conditions to encourage maximum output, morale, and retention.

APPENDICES

These appendices include an acronym list, relevant links, and data tables related to caseloads, providers, expenditures, and revenues.

APPENDIX A: ACRONYMS

ABA	Applied Behavioral Analysis
ABD	Aged, Blind, and Disabled
ACA	Affordable Care Act
ACR	Average Commercial Rate
ARRA	American Recovery and Reinvestment Act
ARPA	American Rescue Plan Act
BA	Budget Account
BHCN	Behavioral Health Community Networks
CAH	Critical Access Hospital
CASAT	Center for the Application of Substance Abuse Treatment
CCBHC	Certified Community Behavioral Health Center
CHIP	Children's Health Insurance Program
CHW	Community Health Worker
CMS	Centers for Medicare and Medicaid Services
CPE	Cost Per Eligible
CY	Calendar Year
DAWN	Data Warehouse of Nevada
DBA	Dental Benefits Administrator
DHCFP	Division of Health Care Financing and Policy
DHHS	Department of Health and Human Services
DWSS	Division of Welfare and Supportive
EMO	Emergency Medicaid Only
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
ESRD	End State Renal Disease
EVV	Electronic Visit Verification
FBR	Federal Benefits Rate
FE	Frail Elderly (Waiver)
FFCRA	Families First Coronavirus Response Act
FFS	Fee-for-Service
FFY	Federal Fiscal Year
FMAP	Federal Medical Assistance Percentage
FMC	Family Medical Category
FPL	Federal Poverty Level
GME	Graduate Medical Education
HCBS	Home and Community Based Services
HIF	Hospital Indigent Fund
HIPAA	Health Insurance Portability and Accountability Act

HIWA	Health Insurance for Work Advancement
IAF	Indigent Accident Fund (see HIF)
ICF	Intermediate Care Facility
ID	(Individuals with) Intellectual Disabilities (Waiver)
IGT	Intergovernmental Transfer
IHS	Indian Health Services
IID	Individuals with Intellectual Disabilities
LTAC	Long-Term Acute Care
LTSS	Long Term Services and Supports
MAABD	Medical Assistance for the Aged, Blind and Disabled (see ABD)
MAGI	Modified Adjusted Gross Income
MCO	Managed Care Organization
MEI	Medicare Economic Index
MFP	Money Follows the Person
MLR	Medical Loss Ratio
MMIS	Medicaid Management Information System
MOE	Maintenance of Effort
NEMT	Non-Emergency Medical Transportation
NRS	Nevada Revised Statutes
PBM	Pharmacy Benefits Manager
PCS	Personal Care Services
PD	(Individuals with) Physical Disabilities (Waiver)
PFL	People First Language
PHE	Public Health Emergency
PMPM	Per Member Per Month
PPS	Prospective Payment System
PT	Provider Type
QRR	Quadrennial Rate Review
RAI	Request for Additional Information
RTC	Residential Treatment Center
SED	Severely Emotionally Disturbed
SFY	State Fiscal Year
SMI	Severely Mentally Ill
SNF	Skilled Nursing Facility
SPASNF	State Plan Amendment Skilled Nursing Facility
SSI	Supplemental Security Income
SUD	Substance Use Disorder
SUPPORT	Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment
UPL	Upper Payment Limit

APPENDIX B: LINKS

Description	Link
Access Nevada	https://accessnevada.dwss.nv.gov/public/landing-page
Centers for Medicare and Medicaid Services	https://www.cms.gov/
Department of Health and Human Services	https://dhhs.nv.gov/
Division of Health Care Financing and Policy	https://dhcfp.nv.gov/
Division of Health Care Financing and Policy Public Notices	https://dhcfp.nv.gov/Public/AdminSupport/PublicNotices/
Drug Use Review Board	https://dhcfp.nv.gov/Boards/CPT/DURMain/
Medical Assistance Manual	https://dwss.nv.gov/Medical-Manual/
Medicaid Chart Pack	https://tinyurl.com/yckjezym
Medicaid Operations Manual	https://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MOM/MOMHome/
Medicaid Services Manual	https://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSP/MSPHome/
Nevada Check Up State Plan	https://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/MSMHome/
Nevada Health Link	https://www.nevadahealthlink.com/
Nevada Legislature	https://www.leg.state.nv.us/
Nevada Medicaid Access to Care Monitoring Review Plan	https://dhcfp.nv.gov/Resources/AccesstoCare/NevadaAccesstoCareMonitoringReviewPlan/
Nevada Medicaid Provider Portal	https://www.medicaid.nv.gov/
Nevada Medicaid Quadrennial Rate Reviews	https://dhcfp.nv.gov/Resources/Rates/QRR/
Nevada Medicaid State Plan	https://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSP/MSPHome/
Nevada Public Notice Website	https://notice.nv.gov/
Nevada Revised Statutes	https://www.leg.state.nv.us/NRS/
Office of Analytics	https://dhhs.nv.gov/Programs/Office_of_Analytics/DHHS_Office_of_Analytics/
Open Government	https://open.nv.gov/
Patient Protection Commission	https://ppc.nv.gov/
Report Medicaid Provider Fraud	https://dhcfp.nv.gov/Resources/PI/ContactSURSUnit/
State of Nevada	https://nv.gov/
Supplemental Security Income (SSI) Payment Amounts	https://www.ssa.gov/OACT/COLA/SSI.html

APPENDIX C: RECIPIENT DATA

This appendix provides caseload counts and demographic information on Medicaid and Check Up recipients.

TABLE 7: MEDICAID AND CHECK UP CASELOADS WITH PERCENT CHANGE FROM PREVIOUS STATE FISCAL YEAR

Month	Medicaid	% Change	Check Up	% Change	Total	% Change
Jun-13	306,154	4%	21,266	-1%	327,420	4%
Jun-14	513,060	68%	23,655	11%	536,715	64%
Jun-15	576,435	12%	21,089	-11%	597,524	11%
Jun-16	622,940	8%	23,728	13%	646,668	8%
Jun-17	646,464	4%	26,165	10%	672,629	4%
Jun-18	659,387	2%	27,406	5%	686,793	2%
Jun-19	647,680	-2%	26,425	-4%	674,105	-2%
Jun-20	704,284	9%	27,075	2%	731,359	8%
Jun-21	821,068	17%	25,363	-6%	846,431	16%

Source: DWSS Master

TABLE 8: CASELOADS BY ELIGIBILITY GROUP

Table shows recipient counts and share of total recipients. Data includes both Medicaid and Check Up recipient counts.

Eligibility Group	Jun-13	Jun-14	Jun-15	Jun-16	Jun-17	Jun-18	Jun-19	Jun-20	Jun-21
Family Medical Categories									
CHIP to Medicaid	0	5,647	9,698	11,689	12,901	13,028	13,127	11,637	18,527
	0%	1%	2%	2%	2%	2%	2%	2%	2%
Parents & Children	223,082	291,102	287,017	304,307	311,588	316,653	307,092	336,665	371,299
	68%	54%	48%	47%	46%	46%	46%	46%	44%
Newly Eligible	0	125,989	180,817	201,613	210,960	214,489	209,695	235,160	305,329
	0%	23%	30%	31%	31%	31%	31%	32%	36%
Check Up	21,266	23,655	21,089	23,728	26,165	27,406	26,425	27,075	25,363
	6%	4%	4%	4%	4%	4%	4%	4%	3%
Other Medicaid Categories									
Aged, Blind, & Disabled	69,318	75,531	82,992	88,660	93,746	97,376	99,027	102,206	106,745
	21%	14%	14%	14%	14%	14%	15%	14%	13%
Waiver	3,970	4,225	4,508	4,611	4,935	5,185	5,442	5,931	6,236
	1%	1%	1%	1%	1%	1%	1%	1%	1%
County Match	1,295	1,317	1,318	1,307	1,340	1,350	1,353	1,452	1,291
	0%	0%	0%	0%	0%	0%	0%	0%	0%
Child Welfare	8,489	9,249	10,085	10,753	10,994	11,306	11,944	11,233	11,641
	3%	2%	2%	2%	2%	2%	2%	2%	1%

Source: DWSS Master

TABLE 9: EMERGENCY MEDICAID RECIPIENTS

Emergency Medicaid	June 2013	June 2014	June 2015	June 2016	June 2017	June 2018	June 2019	June 2020	June 2021
Emergency Medicaid Recipients	1,630	1,868	2,895	3,315	3,985	3,753	3,504	3,565	3,868
Percent of Total Recipients	0.5%	0.3%	0.5%	0.5%	0.6%	0.5%	0.5%	0.5%	0.5%

Source: DWSS Individual Level Data

TABLE 10: RECIPIENTS BY GENDER

Table shows recipient counts and share of total recipients. Data includes both Medicaid and Check Up recipient counts.

Gender	Jun-13	Jun-14	Jun-15	Jun-16	Jun-17	Jun-18	Jun-19	Jun-20	Jun-21
Female	172,045	297,337	328,142	354,363	369,693	377,911	372,210	402,585	462,498

	55%	54%	54%	54%	54%	54%	54%	54%	54%
Male	138,452	248,955	277,493	300,832	312,759	318,978	312,025	337,920	393,165
	45%	46%	46%	46%	46%	46%	46%	46%	46%

Source: DWSS Individual Level Data

TABLE 11: RECIPIENTS BY RACE

Table shows recipient counts and share of total recipients. Data includes both Medicaid and Check Up recipient counts.

Race	Jun-13	Jun-14	Jun-15	Jun-16	Jun-17	Jun-18	Jun-19	Jun-20	Jun-21
White	112,308	204,769	226,545	239,587	244,484	246,613	238,807	254,273	290,154
	36%	37%	37%	37%	36%	35%	35%	34%	34%
Black	58,409	95,574	112,182	124,541	135,508	143,060	143,486	154,047	175,366
	19%	17%	19%	19%	20%	21%	21%	21%	20%
Hispanic	110,833	191,432	205,883	224,067	231,925	233,124	226,627	246,948	287,624
	36%	35%	34%	34%	34%	33%	33%	33%	34%
Other	28,947	54,517	61,025	67,000	70,535	74,092	75,315	85,237	102,519
	9%	10%	10%	10%	10%	11%	11%	12%	12%

Source: DWSS Individual Level Data

TABLE 12: RECIPIENTS BY AGE RANGE

Table shows recipient counts and share of total recipients. Data includes both Medicaid and Check Up recipient counts.

Age Range	June 2013	June 2014	June 2015	June 2016	June 2017	June 2018	June 2019	June 2020	June 2021
0-5	85,794	112,281	110,177	116,252	119,212	119,645	114,802	117,789	125,676
	28%	21%	18%	18%	17%	17%	17%	16%	15%
6-10	52,689	80,187	82,108	87,347	88,731	88,041	84,240	87,129	96,907
	17%	15%	14%	13%	13%	13%	12%	12%	11%
11-15	40,218	62,766	65,757	71,923	75,682	79,339	79,155	84,503	95,410
	13%	11%	11%	11%	11%	11%	12%	11%	11%
16-18	18,933	29,899	31,546	34,346	36,379	37,843	37,633	40,745	47,468
	6%	5%	5%	5%	5%	5%	6%	6%	6%
19-20	4,835	14,057	16,126	16,977	17,211	17,225	16,495	18,612	24,191
	2%	3%	3%	3%	3%	2%	2%	3%	3%
21-30	25,963	65,129	78,727	87,319	91,679	92,271	88,582	98,616	118,995
	8%	12%	13%	13%	13%	13%	13%	13%	14%
31-40	19,429	50,860	63,071	70,879	75,568	79,135	79,013	91,203	113,156
	6%	9%	10%	11%	11%	11%	12%	12%	13%
41-50	14,863	43,677	52,719	56,154	57,219	57,757	56,221	63,611	76,669
	5%	8%	9%	9%	8%	8%	8%	9%	9%
51-60	14,667	43,551	54,006	57,585	59,882	60,443	59,215	64,147	73,664
	5%	8%	9%	9%	9%	9%	9%	9%	9%
61-70	14,803	24,161	29,847	33,295	36,154	38,605	40,338	44,328	51,679
	5%	4%	5%	5%	5%	6%	6%	6%	6%
71-80	11,653	12,743	14,083	15,260	16,421	17,841	18,842	20,155	21,807
	4%	2%	2%	2%	2%	3%	3%	3%	3%
81-90	5,595	5,888	6,253	6,595	6,961	7,356	7,625	8,098	8,436
	2%	1%	1%	1%	1%	1%	1%	1%	1%
91+	1,017	1,068	1,205	1,258	1,348	1,386	1,488	1,569	1,604
	0%	0%	0%	0%	0%	0%	0%	0%	0%

Source: DWSS Individual Level Data

TABLE 13: RECIPIENTS BY COUNTY

Table shows recipient counts and share of total recipients including Medicaid and Check Up recipients.

County	June 2013	June 2014	June 2015	June 2016	June 2017	June 2018	June 2019	June 2020	June 2021
Carson City	6,535	11,368	11,482	12,294	12,458	12,422	11,883	12,362	13,564
	2%	2%	2%	2%	2%	2%	2%	2%	2%
Churchill	2,756	5,031	5,359	5,561	5,583	5,509	5,309	5,507	6,201
	1%	1%	1%	1%	1%	1%	1%	1%	1%
Clark	226,070	396,792	450,927	489,953	520,788	536,903	528,583	577,645	670,051
	75%	74%	76%	77%	78%	78%	79%	79%	80%
Douglas	2,867	5,690	5,763	6,159	6,099	5,897	5,700	5,919	6,780
	1%	1%	1%	1%	1%	1%	1%	1%	1%
Elko	3,482	6,287	6,545	7,588	7,986	8,124	8,331	8,990	10,342
	1%	1%	1%	1%	1%	1%	1%	1%	1%
Esmeralda	63	113	127	131	166	134	133	147	176
	0%	0%	0%	0%	0%	0%	0%	0%	0%
Eureka	61	119	134	145	169	219	215	245	290
	0%	0%	0%	0%	0%	0%	0%	0%	0%
Humboldt	1,198	2,453	2,799	3,164	3,234	3,286	3,272	3,492	4,031
	0%	0%	0%	0%	0%	0%	0%	0%	0%
Lander	416	851	795	976	986	984	963	996	1,126
	0%	0%	0%	0%	0%	0%	0%	0%	0%
Lincoln	345	622	733	795	801	812	827	890	976
	0%	0%	0%	0%	0%	0%	0%	0%	0%
Lyon	5,463	10,020	10,719	11,271	11,287	11,133	10,822	11,253	13,002
	2%	2%	2%	2%	2%	2%	2%	2%	2%
Mineral	602	942	1,119	1,184	1,204	1,210	1,239	1,298	1,457
	0%	0%	0%	0%	0%	0%	0%	0%	0%
Nye	6,362	10,463	11,249	12,098	12,706	13,074	12,988	13,988	15,842
	2%	2%	2%	2%	2%	2%	2%	2%	2%
Pershing	415	753	790	855	896	1,003	966	1,070	1,188
	0%	0%	0%	0%	0%	0%	0%	0%	0%
Storey	59	124	170	159	158	162	153	162	187
	0%	0%	0%	0%	0%	0%	0%	0%	0%
Washoe	43,717	81,246	83,289	84,477	83,578	81,542	78,445	83,553	95,017
	15%	15%	14%	13%	12%	12%	12%	11%	11%
White Pine	893	1,385	1,484	1,651	1,592	1,590	1,611	1,657	1,881
	0%	0%	0%	0%	0%	0%	0%	0%	0%

Source: DWSS Individual Level Data

APPENDIX D: PROVIDER DATA

This section provides information on the providers who serve Nevada Medicaid and Check Up recipients.

TABLE 14: ENROLLED PROVIDERS BY TYPE AS OF JUNE 2021

Provider Type Number & Description	Enrolled Providers	Provider Type Number & Description	Enrolled Providers
10 Outpatient Surgery, Hospital Based	44	43 Laboratory, Pathology Clinical	73
11 Hospital, Inpatient	161	44 Swing-bed, Acute Hospital	9
12 Hospital, Outpatient	202	45 End Stage Renal Disease Facility	55
13 Psychiatric Hospital, Inpatient	22	46 Ambulatory Surgical Centers	62
14 Behavioral Health Outpatient	5,202	47 Indian Health Services (IHS) and Tribal Clinics	23
15 Registered Dietitian	167	48 Waiver for the Frail Elderly	145
16 ICF - Intellectually Disabled/ Public	1	51 Indian Health Service Hospital, Inpatient (Tribal)	0
17 Special Clinics	201	54 Targeted Case Management	40
19 Nursing Facility	84	55 Home Based Habilitation Services	10
20 Physician, M.D., Osteopath, D.O.	18,367	56 Inpatient Rehab. & LTAC Spec Hosp.	15
21 Podiatrist	124	57 Waiver for Adult Group Care	178
22 Dentist	1,138	58 Waiver for Persons with Disabilities	176
23 Hearing Aid Disp. & Supplies	13	59 Facility Based Assisted Living	7
24 Advanced Practice Registered Nurses	3,761	60 School Based	8
25 Optometrist	569	63 Residential Treatment Centers	47
26 Psychologist	376	64 Hospice	47
27 Radiology Non-Invasive Diag. Center	41	65 Hospice, Long Term Care	37
28 Pharmacy	660	68 ICF-Intellectually Disabled/ Private	10
29 Home Health Agency	63	72 Nurse Anesthetist	450
30 Personal Care Service Provider Agency	208	74 Nurse Midwife	77
32 Ambulance, Air or Ground	102	75 Critical Access Hospital, Inpatient	17
33 DME, Disposable, Prosthetics	433	76 Audiologist	130
34 Therapy	1,856	77 Physician Assistant	1,819
35 Travel	1	81 Hospital Based ESRD Provider	21
36 Chiropractor	47	82 Behavioral Health Rehab. Treatment	171
38 Waiver for Intellectual Disabilities and Related	122	83 Personal Care Services - Intermediary Service Org.	22
39 Adult Day Health Center	32	85 Applied Behavior Analysis	1,312
40 PCCM Services	1	86 Specialized Foster Care Services	1
41 Optician, Optical Business	65	**TOTAL**	**39,025**

Source: Provider Enrollment June 2021 Dashboard

TABLE 15: ENROLLED PROVIDERS BY COUNTY AS OF JUNE 2021

Provider Location	Enrolled Providers
Carson City	741
Churchill	140
Clark	18,929
Douglas	226
Elko	383
Eureka	7
Humboldt	125
Lander	32
Lincoln	28
Lyon	167
Mineral	52
Nye	257
Pershing	24
Storey	4
Washoe	4,847
White Pine	98
Catchment	7,271
Out-of-State	5,694
TOTAL	**39,025**

Source: Provider Enrollment June 2021 Dashboard

APPENDIX E: FUNDING

TABLE 16: NEVADA MEDICAID FUNDING SOURCES, SFY 2013 – SFY 2021

The funding sources shown below reflect only Budget Account 3243 Nevada Medicaid.

State Fiscal Year	State General Fund	Federal Funds	Other	Total Computable
SFY 2013	$515,970,808	$1,043,464,713	$180,909,513	$1,740,345,035
SFY 2014	$519,758,769	$1,363,105,597	$144,617,493	$2,027,481,859
SFY 2015	$564,081,027	$2,246,689,244	$164,780,312	$2,975,550,583
SFY 2016	$530,318,224	$2,473,665,125	$222,902,673	$3,226,886,022
SFY 2017	$593,018,243	$2,716,801,170	$244,659,843	$3,554,479,256
SFY 2018	$668,749,838	$2,881,995,148	$220,004,136	$3,770,749,122
SFY 2019	$709,446,861	$3,056,761,824	$271,051,141	$4,037,259,826
SFY 2020	$733,094,757	$3,069,548,690	$227,852,626	$4,030,496,073
SFY 2021	$817,492,910	$3,578,235,596	$196,401,824	$4,592,130,330

Source: DAWN

TABLE 17: NEVADA CHECK UP FUNDING SOURCES, SFY 2013 – SFY 2021

State Fiscal Year	State General Fund	Federal Funds	Other	Total Computable
SFY 2013	$9,032,030	$24,932,624	$2,452,249	$36,416,903
SFY 2014	$9,208,719	$27,272,090	$1,593,550	$38,074,359
SFY 2015	$9,353,356	$33,120,045	$3,640,563	$46,113,964
SFY 2016	$2,268,863	$39,112,039	$3,074,862	$44,455,764
SFY 2017	$476,192	$43,649,444	$3,086,908	$47,212,545
SFY 2018	$530,222	$49,149,846	$2,690,571	$52,370,639
SFY 2019	$643,986	$51,984,626	$2,754,610	$55,383,222
SFY 2020	$4,266,749	$45,099,660	$2,701,881	$52,068,290
SFY 2021	$8,174,633	$37,656,022	$2,248,936	$48,079,592

Source: DAWN

TABLE 18: BLENDED FMAP, SFY 2005 - SFY 2023

Blended FMAP converts federal fiscal year and calendar year FMAP rates into state fiscal years and is used for budgeting purposes only.

State Fiscal Year	Regular FMAP	Enhanced CHIP FMAP	Newly Eligible FMAP
SFY 2005	55.66%	68.96%	
SFY 2006	55.05%	68.53%	
SFY 2007	54.14%	67.90%	
SFY 2008	52.96%	67.07%	
SFY 2009	61.11%	72.78%	
SFY 2010	63.93%	74.75%	
SFY 2011	62.05%	70.44%	
SFY 2012	55.05%	68.54%	
SFY 2013	58.86%	71.20%	
SFY 2014	62.26%	73.58%	100.00%
SFY 2015	64.04%	74.83%	100.00%
SFY 2016	64.79%	92.60%	100.00%
SFY 2017	64.74%	98.32%	97.50%
SFY 2018	65.48%	98.84%	94.50%
SFY 2019	65.09%	98.57%	93.50%
SFY 2020	67.27%	91.46%	91.50%
SFY 2021	69.66%	81.64%	90.00%
SFY 2022	68.97%	78.28%	90.00%
SFY 2023	64.19%	74.93%	90.00%
SFY 2024	62.06%	73.44%	90.00%
SFY 2025	62.63%	73.84%	90.00%

Notes:

- The American Recovery and Reinvestment Act (ARRA) stimulus-adjusted FMAPs were in place for October 2008-December 2010.
- The Affordable Care Act (ACA) increased the Enhanced CHIP FMAP by 23 percentage points between FFY16-FFY19 and by 11.5 percentage points for FFY20.
- The Families First Coronavirus Response Act (FFCRA) increased the regular FMAP by 6.2 percentage points from January 1, 2020, through the end of the calendar quarter during which the emergency ends. This increase flows through the regular FMAP into the calculation of the Enhanced CHIP FMAP, resulting in a 4.34 percentage point increase.
- This table assumes that the emergency declaration continues through September 2022. If the emergency declaration differs from this time period, these blended rates will need to be recalculated.

APPENDIX F: EXPENDITURES

TABLE 19: EXPENDITURES BY ELIGIBILITY GROUP, SFY 2013 – SFY 2021

The table below shows expenditures by eligibility group and the share of caseload expenditures for each group. The share is calculated using caseload-related expenditures only in the Nevada Medicaid and Nevada Check Up budget accounts. The data is split into two tables due to size.

Eligibility Group	SFY 2013	SFY 2014	SFY 2015	SFY 2016	SFY 2017
Family Medical Categories					
CHIP to Medicaid	$0	$2,958,759	$13,831,792	$19,118,683	$20,938,028
	0%	0%	1%	1%	1%
Parents & Children	$589,173,674	$682,867,658	$808,168,711	$854,569,337	$904,820,163
	42%	40%	30%	29%	28%
Newly Eligible	$0	$154,816,777	$917,872,725	$1,062,125,125	$1,203,221,770
	0%	9%	34%	36%	37%
Check Up	$33,828,828	$36,965,936	$44,940,963	$42,698,920	$45,242,767
	2%	2%	2%	1%	1%
Other Medicaid Categories					
Aged, Blind, & Disabled	$601,587,198	$656,921,525	$680,098,976	$749,733,609	$852,921,160
	43%	38%	25%	25%	26%
Waiver	$33,550,204	$45,573,737	$54,497,714	$57,714,244	$65,473,131
	2%	3%	2%	2%	2%
County Match	$69,436,551	$62,739,685	$64,964,147	$65,739,165	$68,426,429
	5%	4%	2%	2%	2%
Child Welfare	$82,420,833	$80,223,551	$85,312,224	$89,989,977	$91,022,953
	6%	5%	3%	3%	3%

TABLE 19 CONTINUED

Eligibility Group	SFY 2018	SFY 2019	SFY 2020	SFY 2021
Family Medical Categories				
CHIP to Medicaid	$22,809,849	$22,387,930	$20,774,729	$24,425,960
	1%	1%	1%	1%
Parents & Children	$941,643,300	$934,128,501	$895,412,524	$1,009,393,996
	27%	26%	25%	24%
Newly Eligible	$1,324,445,103	$1,431,912,629	$1,397,332,501	$1,817,737,029
	38%	40%	39%	44%
Check Up	$50,399,924	$52,686,554	$49,630,232	$46,448,048
	1%	1%	1%	1%
Other Medicaid Categories				
Aged, Blind, & Disabled	$923,534,341	$927,907,829	$992,764,036	$1,017,948,819
	27%	26%	28%	24%
Waiver	$65,730,075	$66,779,510	$60,456,429	$68,108,799
	2%	2%	2%	2%
County Match	$67,824,549	$80,357,472	$104,742,389	$101,262,064
	2%	2%	3%	2%
Child Welfare	$82,336,017	$72,285,590	$76,363,468	$76,169,521
	2%	2%	2%	2%

Source: DAWN

[i] DHHS Office of Analytics, Medicaid Chart Pack, Microsoft Power BI (powerbigov.us), accessed 12/23/2021.
[ii] DHHS Office of Analytics, Nevada Resident Births, Nevada Resident Births, State of Nevada and Nevada Medicaid including Nevada Check Up (nv.gov), accessed 12/27/2021.
[iii] DHHS Office of Analytics, Medicaid Chart Pack, Microsoft Power BI (powerbigov.us), accessed 12/23/2021.
[iv] Nevada Medicaid Decision Support System (DSS), accessed 12/27/2021.
[v] DAWN, accessed 12/27/2021.