NEVADA HEALTH AUTHORITY

Medicaid 101 – Beneficiary Advisory Council (BAC)

Nevada Medicaid

August 13, 2025

NVHA.nv.gov

What is Medicaid?

- State and federal **partnership** under Title XIX, Social Security Act (1965)
- States **share** in the cost with federal government
- Minimum federal requirements - **“mandatory”** populations and benefits
- May cover **“optional”** benefits and populations
- May seek to **“waive”** certain federal laws to tailor programs
- Each program reflects each state’s **unique** choices
- A person eligible in one State may not be eligible in another state
- Services differ from state to state

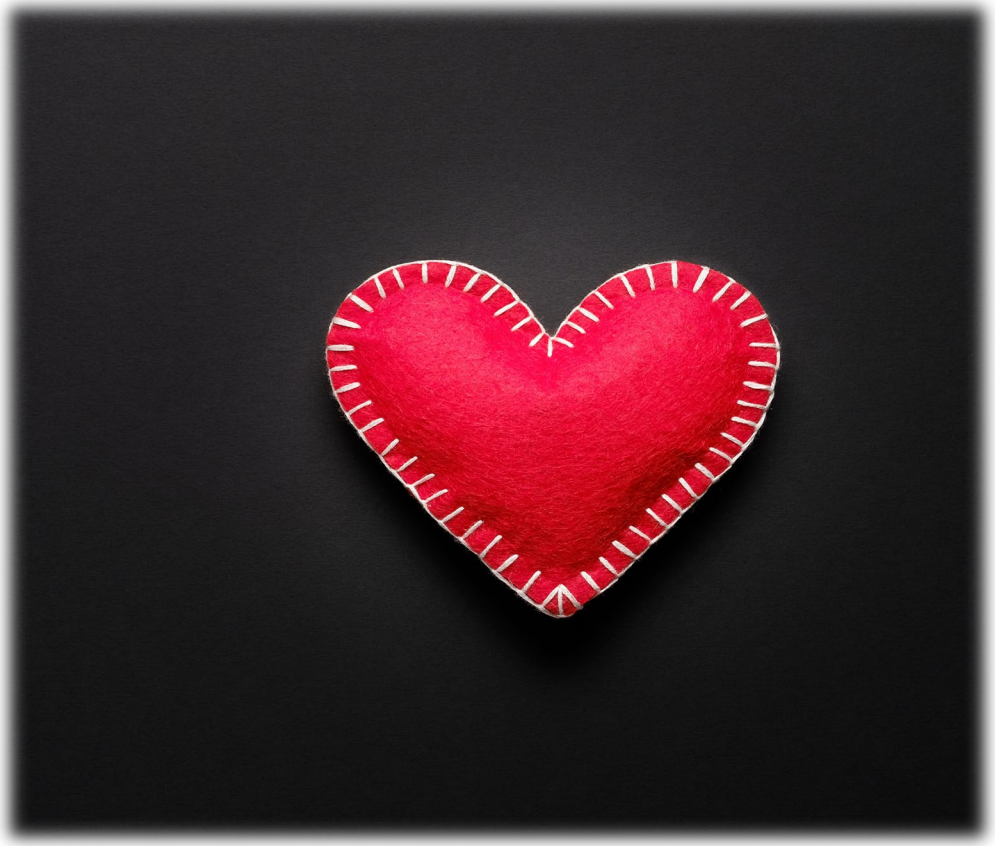
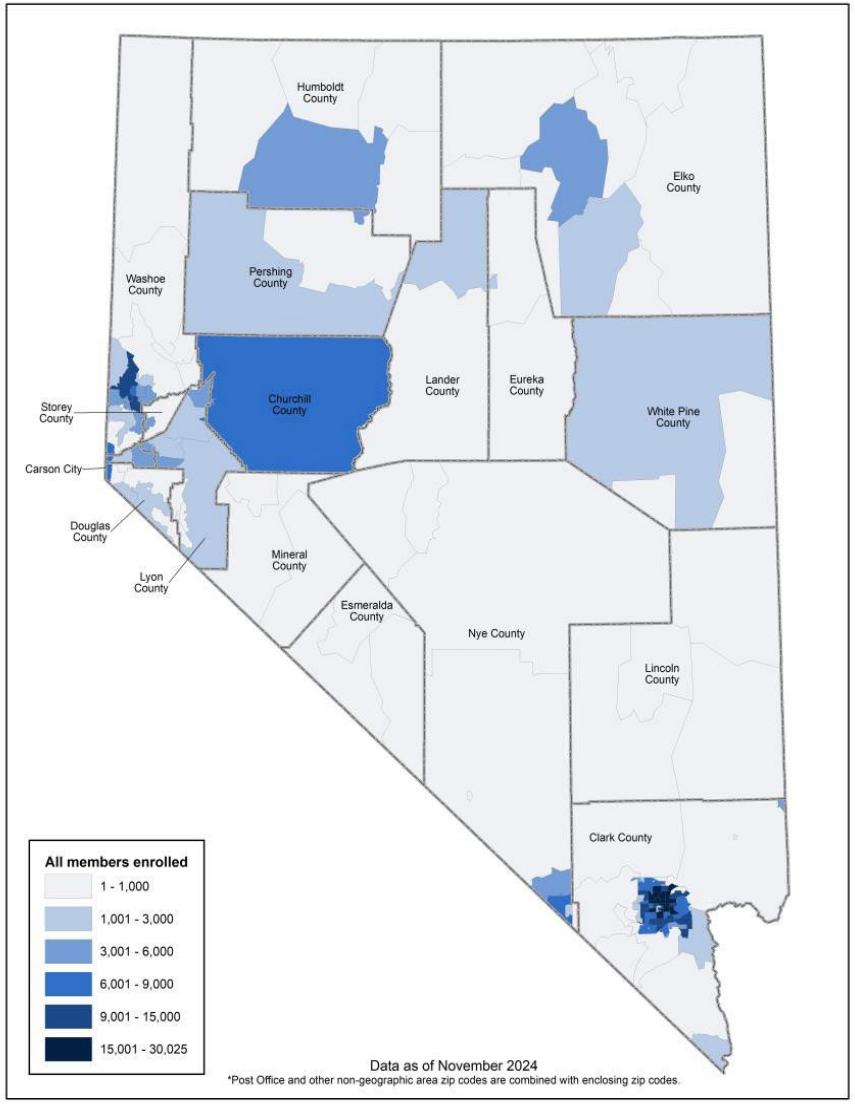


Image from Stock Photos, Microsoft PowerPoints

A few details on Nevada Medicaid

800,000	Average number of people covered; 1 in 3 Nevadans; 22% growth pre-COVID
$5 billion	Biennial Spending (state and federal share)
54%	Percentage of births covered by Nevada Medicaid; 1 in 2 births
75%	Recipients served by Medicaid Managed Care Plans
40%	Recipients who are children or youth (0-18)
11%	Dually eligible for Medicare & Medicaid (85,897 individuals)
78%	Recipients who live in Clark County
66%	Percentage of adults enrolled in Medicaid who are employed
71%	Nevadans enrolled in Medicaid who are people of color
57%	Number of nursing facility residents covered by Medicaid

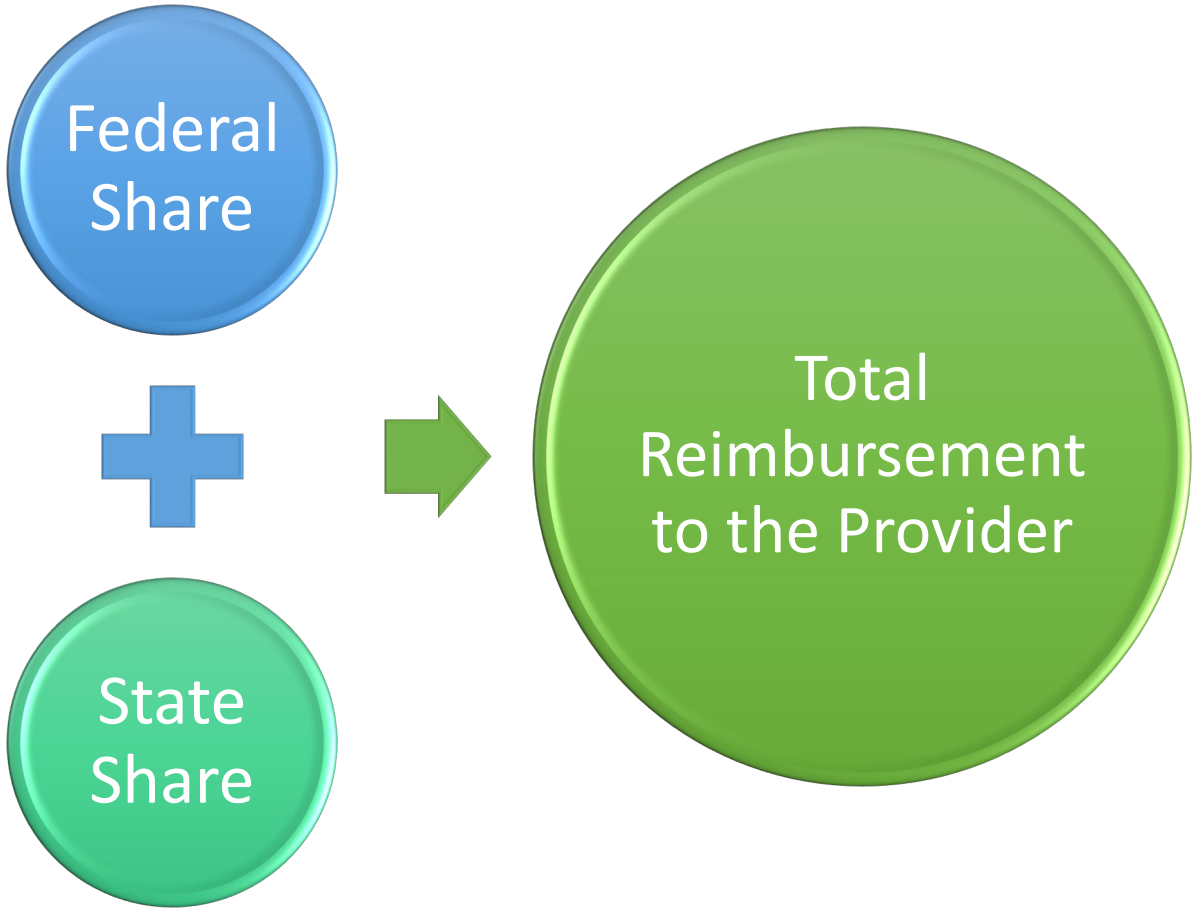
Nevada Enrolled Medicaid Participants by Zip Code*



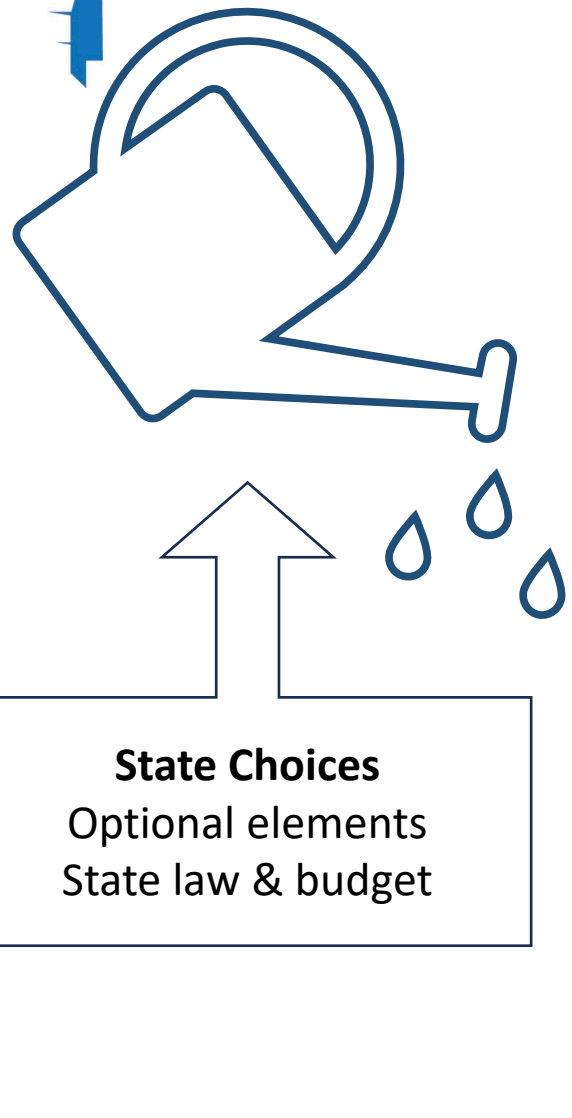
Sources: Office of Analytics, map based on Nevada Medicaid MMIS data warehouse, 2024; Nevada: State Facts, 2024, Kaiser Family Foundation, available here: https://www.kff.org/interactive/medicaid-state-fact-sheets/

Who pays for Medicaid services?

- Federal government pays a guaranteed share (or %) of the costs for services **when "matchable."**
- Amount of federal share varies by state and is based on a formula known as **FMAP** (Federal Medical Assistance Percentage) resulting in **FFP** (federal financial participation)
- Nevada's overall FMAP is typically in the 60% range, but it does **vary based on population or other factors**. For example, the newly eligible population (Medicaid expansion) receive a 90% FMAP



State Medicaid Program is a Special Flower



The Flower
Medicaid Policy Manual
Federal Waivers
Managed Care Contracts

The Stem
Medicaid State Plan
Approved by Center for Medicare and Medicaid Services (CMS)

The Foundation
Title XIX of Social Security Act
Regulations/Guidance
"Mandates"

State Choices
Optional elements
State law & budget

How is care "delivered" to Nevada Medicaid patients?

Nevada has two Medicaid delivery systems: fee-for-service and managed care. Medicaid services in the state are primarily delivered through managed care and will move to statewide managed care beginning January 1, 2026.

Fee For Service (FFS) System

- The state runs Medicaid directly
- They pay providers for each service without managing how much is used, which can be a risk for the state budget
- State pays providers directly per service
- State decides payment rates
- This system is used for rural areas and small populations with special needs

Medicaid Managed Care (MMC) System

- State hires managed care organizations (MCOs) to manage costs, usage, and quality of care
- MCOs create networks of providers and pay them
- MCOs negotiate payment rates with providers
- This system is used in Washoe and Clark counties, but not for small populations with special needs

In your opinion, how might the 2026 move to statewide managed care impact Medicaid members, especially in rural or special needs communities?

What is the State Plan?

- A formal, written agreement between the state and federal government about how the state will run its Medicaid program according to Title XIX.
  - It ensures that the state will follow federal rules to get federal matching funds.
  - It shows which optional groups, services, or programs the state has chosen to cover or implement.
  - It describes who is eligible, how providers are paid, and how the program is run, including details about benefits.
- Changes to program policies or operations may need a State Plan Amendment (SPA).

Core Sections of the State Plan

- Section 1 – Single State Agency Organization
- Section 2 – Coverage and Eligibility
- Section 3 – Services: General Provisions
- Section 4 – General Program Administration
- Section 5 – Personnel Administration
- Section 6 – Financial Administration
- Section 7 – General Provisions

Mandatory State Plan Benefits

Federal law requires that states cover the following as State Plan benefits:

Hospital Services	EPSDT (children); dental for children	Nursing Facility Services	Home Health Services	Physician Services
Rural Health Clinic Services	Federally Qualified Health Center Services	Lab & X-Ray Services	Family Planning Services and Supplies	Certified Pediatric & Family Nurse Practitioner Services & Nurse Midwives
	Freestanding Birth Center (when licensed/recognized by state)	Non-Emergency Medical Transportation	Tobacco Cessation for Pregnant Women	

Note: State Plan benefits must be available statewide (no geographic restrictions); enrollees must have freedom to choose any qualified/enrolled provider for the services covered by the benefit and such benefits must be provided in a comparable manner to all enrollees.

Optional State Plan Benefits

Federal law also allows states to choose to add other “optional” benefits:

Prescription Drugs	Podiatry	Physical, Occupational, Speech, and Respiratory Therapy	Home & Community Based Services (1915i)	Dental Services	Chiropractic Services for Children
Diagnostic, screening, preventive, and rehabilitative services	Prosthetics	Clinic Services	Optometry services, eyeglasses	Other Practitioner Services	Private Duty Nursing Services
Personal Care Services	Hospice	Case Management	Senior Care in Institution for Mental Disease	Services in Intermediate Care Facility for persons with IDD	Tuberculosis Services
	Inpatient Psychiatric Services for Children (under 21 years)	Self-Directed Personal Assistance Services* (1915j)	Community First Choice Option* (1915k)	Health Homes for Enrollees with Chronic Conditions* (Section 1945)	

Note: Those shaded in gray are the only benefits Nevada has not added to its Medicaid State Plan. Health Homes will be added for FASD in future.

What does Nevada Medicaid cover?

What is covered?

- **Doctor Visits**: Primary care and specialist visits.
- **Hospital Services**: Inpatient and outpatient care.
- **Prescription Drugs**: Medications prescribed by a doctor.
- **Preventive Care**: Immunizations, screenings, and wellness visits.
- **Mental Health Services**: Counseling, therapy, and psychiatric care.
- **Dental Services**: Basic dental care for children and limited services for adults.
- **Vision Services**: Eye exams and glasses for children.
- **Emergency Services**: Emergency room visits and ambulance services.
- **Maternity and Newborn Care**: Prenatal, delivery, and postnatal care.
- **Long-Term Care**: Nursing home care and home health services.
- **Rehabilitation Services**: Physical, occupational, and speech therapy.

What is not covered?

- **Cosmetic Surgery**: Procedures not medically necessary.
- **Experimental Treatments**: Non-FDA approved treatments.
- **Over-the-Counter Medications**: Unless prescribed by a doctor.
- **Alternative Therapies**: Acupuncture, chiropractic care, and naturopathy.
- **Certain Dental Procedures**: Cosmetic dental work for adults.
- **Personal Comfort Items**: Items like TVs or phones in hospital rooms.
- **Transportation**: Transportation not related to medical care.

What is the Medicaid Advisory Committee (MAC)?

- **Purpose:**
  - Advises the Medicaid agency on making rules and running programs
  - Making sure Medicaid services help the people who need them
- **Key Functions:**
  - Reviews and gives **feedback** on Medicaid rules
  - Suggest ways to **improve** Medicaid
  - Helps with **communication** between the Medicaid agency and other groups
- **Membership:**
  - Includes healthcare providers, people who use Medicaid, and other important members of our Nevada community
  - Members apply and are selected by the state Medicaid agency

What is the Beneficiary Advisory Council (BAC)?

How can the BAC help make sure that feedback from Medicaid members leads to real changes in services or policies?

- **Purpose:**
  - Help people who use Medicaid.
  - Let people share their stories and ideas.
- **Key Functions:**
  - Collect and share people's feedback with Medicaid.
  - Speak up for people’s needs and rights.
  - Work with Medicaid to make services better.
- **Membership:**
  - Includes people who use Medicaid, their families, and supporters.
  - Members are chosen for their experience and dedication to improving Medicaid.

How they work together…

- **Collaboration:**
  - Both committees work together to ensure Medicaid rules are effective and help those who need it.
  - Regular meetings and discussions to address problems and find solutions.
- **Impact:**
  - Better Medicaid services and rules.
  - Better communication between the Medicaid agency and those who use it.
  - Happier and more involved people who use Medicaid.

How do you think collaboration between the MAC & BAC will serve beneficiaries?

Questions?