Citation | Condition or Requirement

basis where one MCO is better able to provide for unusual needs of a specific family member, while at the same time the other MCO is better able to provide for unusual needs of a different family member.

H. Information Requirements for Beneficiaries.

1932(a)(5)(c)
42 CFR 438.50
42 CFR 438.10

☒The state assures that its state plan program is in compliance with 42 CFR 438.10 for information requirements specific to MCOs, PCCMs, and PCCM entity programs operated under section 1932(a)(1)(A)(i) state plan amendments.

1932(a)(5)(D)(b)
1903(m)
1905(t)(3)

I. List all benefits for which the MCO is responsible.

Complete the chart below to indicate every State Plan-Approved service that will be delivered by the MCO, and where each of those services is described in the state's Medicaid State Plan. For "other practitioner services", list each provider type separately. For rehabilitative services, habilitative services, EPSDT services and 1915(i), (j) and (k) services list each program separately by its own list of services. Add additional rows as necessary.

In the first column of the chart below, enter the name of each State Plan-Approved service delivered by the MCO. In the second – fourth column of the chart, enter a State Plan citation providing the Attachment number, Page number, and Item number, respectively.

State Plan-Approved Service Delivered by the MCO	Medicaid State Plan Citation		
	Attachment #	Page #	Item #
Ex. Physical Therapy	*3.1-A*	*4*	*11.a*
Inpatient Hospital Services	3.1-A	1	1
Outpatient Hospital Services	3.1-A	1	2.a
Rural Health Clinic Services	3.1-A	1	2.b
FQHC Services	3.1-A	1	2.c
Laboratory and X-ray Services	3.1-A	1	3
Nursing Facility Services	3.1-A	2	4.a
EPSDT	3.1-A	2	4.b
Family Planning Services	3.1-A	2	4.c
Physician Services	3.1-A	2	5.a
Podiatrists' Services	3.1-A	2	6.a
Optometrists' Services	3.1-A	3	6.b
Chiropractors' Services	3.1-A	3	6.c
Home Health Services	3.1-A	3	7
Private Duty Nursing	3.1-A	3	8
Clinic Services	3.1-A	4	9
Physical Therapy and Related Services	3.1-A	4	11
Prescribed Drugs	3.1-A	5	12

Citation	Condition or Requirement		
Diagnostic Services	3.1-A	5	13.a
Screen Services	3.1-A	6	13.b
Preventive Services	3.1-A	6	13.c
Rehabilitative Services	3.1-A	6	13.d
Inpatient Psychiatric Services	3.1-A	7	16
Nurse-Midwife Services	3.1-A	7	17
Case Management	3.1-A	8	19.a
Respiratory Care Services	3.1-A	8a	22
Certified Pediatric or Family Nurse Practioners' Services	3.1-A	8a	23
Emergency Hospital Services	3.1-A	9	24.d
Personal Care Services	3.1-A	10	26
Freestanding Birth Center Services	3.1-A	11	28

The MCOs are responsible for providing their members all Medicaid State Plan benefits, except the following services:

All services provided at Indian Health Service Facilities and Tribal Clinics:
Native Americans may access and receive covered medically necessary services at Indian Health Service (IHS) facilities and Tribal Clinics. If a Native American voluntarily enrolls with an MCO and seeks covered services from IHS, the MCO should request and receive medical records regarding those covered services/treatments provided by IHS. The MCO is required to coordinate all services with IHS.

Non-emergency transportation
The DHCFP or its designee will authorize and arrange for all medically necessary non-emergency transportation. The MCO must verify medical appointments upon request by the DHCFP or its designee.

School Health Services (SHS)
The DHCFP has provider contracts with several school districts to provide EPSDT medically necessary covered services to eligible Title XIX Medicaid and Title XXI Nevada Check Up (NCU) recipients. School Based Health Clinics are separate and distinct from School Health Services. The school districts can provide, through school district employees or contract personnel, medically necessary covered services. Medicaid reimburses the school districts for these services in accordance with the school districts' provider contract. The MCO will provide covered medically necessary services beyond those available through school districts, or document why the services are not medically necessary. Services may be obtained through the MCO rather than the school district if requested by the parent/legal guardian. The MCO case manager shall coordinate with the school district in obtaining any services which are not covered by the plan or the school district.

All Pre-Admissions Screening and Resident Review (PASRR) and Level of Care (LOC)
Assessments are performed by the State's Fiscal Agent. Conducting a PASRR and LOC will not prompt MCO disenrollment, however, if the beneficiary is admitted to a nursing facility as the result of a PASRR and LOC, the MCO is responsible for the first 45 days of admission.

Adult Day Health Care
Adult Day Health Care (ADHC) services for eligible managed care beneficiaries are covered under fee-for-service. The Vendor is responsible for ensuring referral and coordination of care for ADHC services.

Citation	Condition or Requirement

Habilitation Services
Habilitation services for eligible managed care enrollees who have a traumatic brain injury (TBI) or acquired brain injury (ABI) are covered under fee-for-service pursuant to the MSM Chapter 1800.

Targeted Case Management
Targeted Case Management (TCM) has a specific meaning for Nevada Medicaid and Nevada Check Up. TCM, as defined by Chapter 2500 in the Medicaid Services Manual is carved out of the managed care contracts. Case management, with differs from TCM, is required from the contracted Vendors.

Residential Treatment Centers (Medicaid Members)
The MCO vendor is responsible for reimbursement of all RTC charges including admission, bed day rate, and ancillary charges until properly disenrolled from managed care. MCO vendors must notify DHCFP within five days of member's RTC admission. Once disenrolled from the managed care vendor, then the RTC bed day rate and ancillary services will be reimbursed through FFS.

Residential Treatment Centers (Nevada Check Up Members)
The MCO vendor is responsible for reimbursement of all ancillary services for Nevada Check Up members throughout their RTC admission. The vendor must notify DHCFP of the member's admission within 5 calendar days. The RTC admission and bed day rate will be covered by Fee-for-Service (FFS) from the first date of admission.

Hospice
Once admitted into hospice care, Medicaid Managed Care recipients will be disenrolled immediately. Nevada Check Up recipients will not be disenrolled, however payment for Nevada Check Up hospice services will be carved out and FFS should be billed.

Orthodontic Services
The contracted PAHP is required to provide all covered medically necessary dental services with the exception of orthodontic services, which are covered under FFS.

Dental Services
The contracted PAHP provides all covered medically necessary dental services under a 1915(b) waiver for managed care members residing in Washoe and Clark counites.

Ground Emergency Medical Transportation (GEMT)
GEMT Services are available to eligible managed care members; however, the services are reimbursed under FFS pursuant to MSM Chapter 1900. The vendor is not responsible for payment of any GEMT service received by an enrolled recipient. The GEMT provider will submit their claims directly to the DHCFP's Fiscal Agent and will be paid by the DHCFP through the Medicaid FFS fee schedule. The MCO is responsible for ensuring referral and coordination of care for GEMT services.

Community Centered Behavioral Health Clinics (CCBHC)
Services furnished in a CCBHC are available to eligible managed care members; however, the services are reimbursed under FFS pursuant to MSM Chapter 2700. The vendor is not responsible for payment of any services received by an enrolled recipient at a CCBHC. The CCBHC will submit their claims directly to DHCFP's Fiscal Agent and will be paid by DHCFP through the Medicaid FFS fee schedule. The MCO is responsible for ensuring referral and coordination of care for CCBHC services.

Pharmacy Drug Limitations
Zolgensma® is a high-cost gene therapy drug used to treat children less than 2 years old with spinal muscular atrophy (SMA). Recipients receiving this drug will not be disenrolled from managed care; however, payment for the drug will be

Citation	Condition or Requirement

reimbursed under FFS.

1932(a)(5)(D)(b)(4)
42 CFR 438.228

J. ☒ The state assures that each MCO has established an internal grievance and appeal system for enrollees.

1932(a)(5)(D)(b)(5)
42 CFR 438.62
42 CFR 438.68
42 CFR 438.206
42 CFR 438.207
42 CFR 438.208

K. Services, including capacity, network adequacy, coordination, and continuity.

☒ The state assures that all applicable requirements of 42 CFR 438.62, regarding continued service to enrollees, will be met.

☒ The state assures that all applicable requirements of 42 CFR 438.68, regarding network adequacy standards, will be met.

☒ The state assures that all applicable requirements of 42 CFR 438.206, regarding availability of services, will be met.

☒The state assures that all applicable requirements of 42 CFR 438.207, regarding assurances of adequate capacity and services, will be met.

☒ The state assures that all applicable requirements of 42 CFR 438.208, regarding coordination and continuity of care, will be met.

The state has contract language that requires the MCOs to demonstrate that the capacity of their PCP network meets the FTE requirements for accepting eligible beneficiaries per service area. The MCOs are required to use geo-mapping and data-driven analyses to ensure compliance with access standards and take appropriate corrective action, if necessary, to comply with such access standards. The contract includes appointment access standards. If a recipient is having access to care issues, they can contact their MCO for assistance, which must ensure timely access to covered services. The MCOs partner actively with the DHCFP, community providers and stakeholders to identify and address issues and opportunities to improve health care access and availability for Medicaid and CHIP members.

1932(c)(1)(A)

42 CFR 438.330
42 CFR 438.340

L. ☒ The state assures that all applicable requirements of 42 CFR 438.330 and 438.340, regarding a quality assessment and performance improvement program and State quality strategy, will be met.

1932(c)(2)(A)

42 CFR 438.350

M. ☒ The state assures that all applicable requirements of 42 CFR 438.350, 438.354, and 438.364 regarding an annual external independent review conducted by a qualified independent entity, will be met.

Citation		Condition or Requirement
42 CFR 438.354 42 CFR 438.364		
1932 (a)(1)(A)(ii)	N.	Selective Contracting Under a 1932 State Plan Option.

To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

1. The state will ☒/will not ☐ intentionally limit the number of entities it contracts under a 1932 state plan option.

2. ☒ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)*

   The DHCFP contracts with 3 managed care entities: Health Plan of Nevada, Silver Summit Health Plan, and Anthem Blue Cross Blue Shield. These entities were contracted through the state's Request for Proposal procurement process based off evaluation criteria and scoring of submissions. During the procurement process, the DHCFP received 7 proposals. The DHCFP opted to increase the number of selected plans from the prior procurement to ensure that if any plan left the market, members would not be rolled back into fee-for-service. Proposals were evaluated for demonstrated competence, experience in performance of comparable engagements, conformance with the terms of the RFP, expertise and availability of key personnel and cost. Four plans were selected; however, in August 2017, one of the plans voluntarily terminated their contract.

4. ☐ The selective contracting provision in not applicable to this state plan.