State: Nevada

Citation | Condition or Requirement

1. Please indicate if any of the following populations are excluded from the program, or have only voluntary enrollment (even if they are part of an eligibility group listed above in E.1. as having mandatory enrollment):

Population	V	E	Notes
Other Insurance--Medicaid beneficiaries who have other health insurance			
Reside in Nursing Facility or ICF/IID--Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).		X	**Nursing Facility:** The MCO is required to cover the first ~~45~~ 180 days of a nursing facility admission. The MCO shall notify the DHCFP of any nursing facility stay admission expected to exceed ~~45~~ 180 days. The beneficiary will be disenrolled from the MCO and the stay will be covered by FFS commencing on the ~~46th~~-181st day of the facility stay. **ICF/ID:** Residents of ICF/ID facilities are not eligible for enrollment with the MCO. If a beneficiary is admitted to an ICF/ID after MCO enrollment, the beneficiary will be disenrolled from the MCO and the admission, bed day rate, and ancillary services will be reimbursed through FFS.
Enrolled in Another Managed Care Program--Medicaid beneficiaries who are enrolled in another Medicaid managed care program			
Eligibility Less Than 3 Months--Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program			
Participate in HCBS Waiver--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).		X	
Retroactive Eligibility–Medicaid beneficiaries for the period of retroactive eligibility.		X	
Other (Please define): Title XIX Medicaid children under 18 defined as the Severely Emotionally Disturbed (SED)	X		**Urban Washoe and Urban Clark Counties** The MCO is required to notify the DHCFP if a Title XIX Medicaid beneficiary elects to disenroll from the MCO following the determination of SED/SMI. However, in the event the Medicaid beneficiary, who has received such a determination, chooses to remain enrolled with the MCO, the MCO will be responsible for providing all patient care.

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Other (Please define): ~~Adults age 18 and over defined as Seriously Mentally Ill (SMI)**~~	~~X~~		~~**Urban Washoe and Urban Clark Counties** Nevada Medicaid Newly Eligibles, defined as childless adults ages 19-64, and the expanded parent and caretakers ages 19-64, who are made eligible as part of the PPACA expansion population and who are receiving the Alternative Benefit Plan, cannot opt out of managed care, where available, based on a determination of Serious Mental Illness (SMI).~~
Other (Please define): Swing bed stays in acute hospitals over 45 days		X	The MCO is required to cover the first 45 days of a swing bed. The MCO shall notify the DHCFP of any swing bed stay expected to exceed 45 days. The beneficiary will be disenrolled from the MCO and the stay will be covered by FFS commencing on the 46th day of the facility stay.
Other (Please define): ~~Residential Treatment Center (RTC)~~		~~X~~	~~Medicaid beneficiaries will be disenrolled from the MCO in the month following the RTC admission. The RTC admission, bed day rate, and ancillary services will be reimbursed through FFS thereafter for Title XIX Medicaid Beneficiaries.~~

~~**Nevada Medicaid Newly Eligibles, defined as childless adults ages 19-64, and the expanded parent and caretakers ages 19-64, who are made eligible as part of the Patient Protection and Affordable Care Act (PPACA) expansion population and who are receiving the Alternative Benefit Plan, cannot opt out of managed care, where available, based on a determination of Serious Mental Illness (SMI).~~

1932(a)(4)
42 CFR 438.54

F. Enrollment Process.

Based on whether mandatory and/or voluntary enrollment are applicable to your program (see E. Populations and Geographic Area and definitions in 42 CFR 438.54(b)), please complete the below:

1. For **voluntary** enrollment: (see 42 CFR 438.54(c))
   a. Please describe how the state fulfills its obligations to provide information as specified in 42 CFR 438.10(c)(4), 42 CFR 438.10(e) and 42 CFR 438.54(c)(3).

      State with voluntary enrollment must have an enrollment choice period or passive enrollment. Please indicate which will apply to the managed care program: Nevada uses a passive enrollment process for voluntary managed care populations.

   b. ☐ If applicable, please check here to indicate that the state provides an **enrollment choice period**, as described in 42 CFR 438.54(c)(1)(i) and 42 CFR 438.54(c)(2)(i), during which individuals who are subject to voluntary enrollment may make an active choice to enroll in the managed care program, or will otherwise continue to receive covered services through the

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fee-for-service delivery system.

i. Please indicate the length of the enrollment choice period:

c. ☒ If applicable, please check here to indicate that the state uses a **passive enrollment** process, as described in 42 CFR 438.54(c)(1)(ii) and 438.54(c)(2)(ii), for individuals who are subject to voluntary enrollment.

i. If so, please describe the algorithm used for passive enrollment and how the algorithm and the state's provision of information meets all of the requirements of 42 CFR 438.54(c)(4),(5),(6),(7), and (8). Voluntary populations are assigned an MCO using the same algorithm and notification process described in question 2 below for mandatory enrollment.

ii. Please indicate how long the enrollee will have to disenroll from the plan and return to the fee-for-service delivery system: Nevada's voluntary managed care populations can request disenrollment from their plan to return to fee-for-service at any time during their managed care enrollment. Disenrollment approval is subject to voluntary population disenrollment requirements as outlined in policy.

2. For **mandatory** enrollment: (see 42 CFR 438.54(d))

a. Please describe how the state fulfills its obligations to provide information as specified in 42 CFR 438.10(c)(4), 42 CFR 438.10(e) and 42 CFR 438.54(d)(3).

At the time of application, the applicant is provided with each MCO plan's telephone number and website. The MCOs have complete lists of active providers on their websites. The applicants also have access to a comparison chart of the MCOs which highlights each plan's added benefits.

A first-time beneficiary, that is one who has never been enrolled in an MCO and who is not joining an established case, will be asked to complete their selection of an MCO at the time of Medicaid application. Their enrollment will go into effect immediately upon approval of their Medicaid eligibility.

Absent a choice by the applicant, the State will complete a default enrollment process, and they will be assigned to an MCO based upon an algorithm developed by the State to distribute enrollees among the MCOs.

The beneficiary has a 90-day period in which they are entitled to change MCOs. Beneficiaries may also change their MCO once every 12 months during open enrollment.

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For a beneficiary, new to Medicaid or returning, who is joining an open case where another family member is currently enrolled in an MCO; they will automatically be assigned to the same MCO as the rest of the family and will not have a 90 day right to change period. Their enrollment will go into effect immediately upon approval of their Medicaid eligibility.

These new case members, as well as the rest of the family, remain locked-in until the next open enrollment period.

A returning Medicaid beneficiary who had a lapse in managed care enrollment for two months or less due to a loss in Medicaid eligibility will automatically be assigned to their former MCO. For those returning in the first month, their enrollment will go into effect the beginning of that month with no lapse in enrollment. For those returning in the second month, their enrollment will go into effect immediately upon approval of their Medicaid eligibility. They will not have a 90 day right to change period and will be considered locked-in until the next open enrollment period.

A returning Medicaid beneficiary, who had a lapse in managed care enrollment for two months or less for reasons other than a loss in Medicaid eligibility OR for more than two months no matter the reason, will have enrollment rules applied as follows. Their enrollment will go into effect immediately upon approval of their Medicaid eligibility.

If the beneficiary is returning to an open case where another family member is currently enrolled in an MCO, they will automatically be assigned to the same MCO as the rest of the family and they will not have a 90 day right to change period and will be considered locked-in until the next open enrollment period.
If there are no other family members on the case currently enrolled in an MCO, and the beneficiary made a new MCO choice on their application, they will be enrolled into their MCO of choice and may disenroll without cause within the first 90 days of enrollment.

If the beneficiary did not make a new choice on their application, they will be assigned to their former MCO and may disenroll without cause within the first 90 days of enrollment.
Regardless of which enrollment or default assignment process is used, the head of household will be notified of all choices that need to be made, the timeframe for making these choices, and the consequence of not making a choice.

For the MCOs, the total maximum lock-in period is 12 months inclusive of the initial 90 days up front to disenroll without cause. The beneficiaries will be notified of their option to change MCOs at least 60 days prior to the end

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of the lock-in period. Beneficiaries will be allowed to change MCOs during the annual open enrollment period.

b. ☒ If applicable, please check here to indicate that the state provides an **enrollment choice period**, as described in 42 CFR 438.54(d)(2)(i), during which individuals who are subject to mandatory enrollment may make an active choice to select a managed care plan, or will otherwise be enrolled in a plan selected by the State's default enrollment process.

i. Please indicate the length of the enrollment choice period:

The beneficiary has a 90-day period in which they are entitled to change MCOs. Beneficiaries may also change their MCO once every 12 months during open enrollment

c. ☒ If applicable, please check here to indicate that the state uses a **default** enrollment process, as described in 42 CFR 438.54(d)(5), for individuals who are subject to mandatory enrollment.

i. If so, please describe the algorithm used for default enrollment and how it meets all of the requirements of 42 CFR 438.54(d)(4), (5), (7), and (8).

To reduce large disparities and adverse risk between MCOs, the State uses a default assignment algorithm for auto-assignment of first-time beneficiaries. The algorithm will give weighted preference to any new MCO, as well as MCOs with significantly lower enrollments. This is based on a formula developed by the State. The State may also adjust the auto-assignment algorithm in consideration of the MCO's clinical performance measure results or other measurements. The algorithm is as follows:

***Auto Assignment Algorithm**				
Number of Plans in Geographic Service Area	**Percentage of Beneficiaries Assigned to Largest Plan**	**Percentage of Beneficiaries Assigned to 2nd Largest Plan**	**Percentage of Beneficiaries Assigned to 3rd Largest Plan**	**Percentage of Beneficiaries Assigned to 4th Largest Plan**
2 plans	**34%**	**66%**		

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3 plans	**17%**	**33%**	**50%**	
4 plans	**10%**	**10%**	**30%**	**50%**
*** The function of the algorithm is to ultimately achieve no more than a 10% differential in enrollment between all MCO contractors. Once the differential is achieved, use of this algorithm will be discontinued and head of households will be auto assigned on rotating basis.**				

d. ☐ If applicable, please check here to indicate that the state uses a **passive enrollment** process, as described in 42 CFR 438.54(d)(2), for individuals who are subject to mandatory enrollment.

i. If so, please describe the algorithm used for passive enrollment and how it meets all of the requirements of 42 CFR 438.54(d)(4), (6), (7), and (8).

1932(a)(4)
42 CFR 438.54
42 CFR 438.52

3. State assurances on the enrollment process.

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

a.☒ The state assures that, per the choice requirements in 42 CFR 438.52:

42 CFR 438.56(g)

i. Medicaid beneficiaries with mandatory enrollment in an MCO will have a choice of at least two MCOs unless the area is considered rural as defined in 42 CFR 438.52(b)(3);
ii. Medicaid beneficiaries with mandatory enrollment in a primary care case management system will have a choice of at least two primary care case managers employed by or contracted with the State;
iii. Medicaid beneficiaries with mandatory enrollment in a PCCM entity may be limited to a single PCCM entity and will have a choice of at least two PCCMs employed by or contracted with the PCCM entity.

b. ☐ The state plan program applies the rural exception to choose requirements of 42 CFR 438.52(a) for MCOs in accordance with 42 CFR 438.52(b). Please list the impacted rural counties:

☒This provision is not applicable to this 1932 State Plan Amendment.

c. ☒ The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

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Citation	Condition or Requirement

☐ This provision is not applicable to this 1932 State Plan Amendment.

42 CFR 438.71

d. ☒ The state assures that all applicable requirements of 42 CFR 438.71 regarding developing and implementing a beneficiary support system that provides support to beneficiaries both prior to and after MCO, PCCM, or PCCM entity enrollment will be met.

1932(a)(4)
42 CFR 438.56

G. Disenrollment.

1. The state will☒/ will not☐ limit disenrollment for managed care.

2. The disenrollment limitation will apply for 12 months (up to 12 months).

3. ☒The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56.

4. Describe the state's process for notifying the Medicaid beneficiaries of their right to disenroll without cause during the 90 days following the date of their initial enrollment into the MCO, PCCM, or PCCM entity. *(Examples: state generated correspondence, enrollment packets, etc.)*
A beneficiary in their 90 day right to change period is notified by a Welcome to managed Care letter mailed by the State's fiscal agent. The letter provides the beneficiary with the instructions and timeframe for requesting a switch in their MCO plan.

5. Describe any additional circumstances of "cause" for disenrollment (if any).

For cause disenrollments can be determined by the DHCFP on a case by case basis where one MCO is better able to provide for unusual needs of a specific family member, while at the same time the other MCO is better able to provide for unusual needs of a different family member.

H. Information Requirements for Beneficiaries.

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

☒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

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Citation | Condition or Requirement

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
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

State: Nevada

Citation	Condition or Requirement		
Personal Care Services	3.1-A	10	26
Freestanding Birth Center Services	3.1-A	11	28
Certified Behavioral Health Center	3.1-A	6c	N/A
Doula Services	3.1-A	3a Cont'd	6.d
Community Health Worker	3.1-A	3a Cont'd	6.d
Registered Pharmacist	3.1-A	3a Cont'd	6.d
Residential Treatment Center	3.1-A	7	16

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.

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

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Citation | Condition or Requirement

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 reimbursed under FFS.

State: Nevada

Citation	Condition or Requirement
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)	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

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Citation	Condition or Requirement

independent entity, will be met.

42 CFR 438.350
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~~ 4 managed care entities: Health Plan of Nevada, Silver Summit Health Plan, ~~and~~ Anthem Blue Cross Blue Shield, and Molina Healthcare of Nevada. 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~~ 8 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~~increase competition in the market and offer more choice to Nevadan Medicaid Managed Care members. 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.

State: Nevada

Citation | Condition or Requirement

Appendix A: Compliance Dates (from Supplementary Information in 81 FR 27497, published 5/6/2016)

States must comply with all provisions in effect as of the issuance of this preprint. Additionally, the following compliance dates apply:

Compliance Dates	Sections
For rating periods for Medicaid managed care contracts beginning before July 1, 2017, States will not be held out of compliance with the changes adopted in the following sections so long as they comply with the corresponding standard(s) codified in 42 CFR part 438 contained in 42 CFR parts 430 to 481, edition revised as of October 1, 2015. **States must comply with these requirements no later than the rating period for Medicaid managed care contracts starting on or after July 1, 2017.**	§§ 438.3(h), 438.3(m), 438.3(q) through (u), 438.4(b)(7), 438.4(b)(8), 438.5(b) through (f), 438.6(b)(3), 438.6(c) and (d), 438.7(b), 438.7(c)(1) and (2), 438.8, 438.9, 438.10, 438.14, 438.56(d)(2)(iv), 438.66(a) through (d), 438.70, 438.74, 438.110, 438.208, 438.210, 438.230, 438.242, 438.330, 438.332, 438.400, 438.402, 438.404, 438.406, 438.408, 438.410, 438.414, 438.416, 438.420, 438.424, 438.602(a), 438.602(c) through (h), 438.604, 438.606, 438.608(a), and 438.608(c) and (d)
For rating periods for Medicaid managed care contracts beginning before July 1, 2018, states will not be held out of compliance with the changes adopted in the following sections so long as they comply with the corresponding standard(s) codified in 42 CFR part 438 contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015. **States must comply with these requirements no later than the rating period for Medicaid managed care contracts starting on or after July 1, 2018.**	§§ 438.4(b)(3), 438.4(b)(4), 438.7(c)(3), 438.62, 438.68, 438.71, 438.206, 438.207, 438.602(b), 438.608(b), and 438.818
States must be in compliance with the requirements at § 438.4(b)(9) no later than the rating period for Medicaid managed care contracts starting on or after July 1, 2019.	§ 438.4(b)(9)
States must be in compliance with the requirements at § 438.66(e) no later than the rating period for Medicaid managed care contracts starting on or after the date of the publication of CMS guidance.	§ 438.66(e)
States must be in compliance with § 438.334 no later than 3 years from the date of a final notice published in the Federal Register.	§ 438.334
Until July 1, 2018, states will not be held out of compliance with the changes adopted in the following sections so long as they comply with the corresponding standard(s) codified in 42	§§ 438.340, 438.350, 438.354, 438.356, 438.358, 438.360, 438.362, and 438.364

State: Nevada

Citation Condition or Requirement

Compliance Dates	Sections
CFR part 438 contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015.	
States must begin conducting the EQR-related activity described in § 438.358(b)(1)(iv) (relating to the mandatory EQR-related activity of validation of network adequacy) **no later than one year from the issuance of the associated EQR protocol.**	§ 438.358(b)(1)(iv)
States may begin conducting the EQR-related activity described in § 438.358(c)(6) (relating to the optional EQR-related activity of plan rating) **no earlier than the issuance of the associated EQR protocol.**	§ 438.358(c)(6)

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0933. The time required to complete this information collection is estimated to average 10 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

CMS-10120 (exp. TBD – currently 4/30/17)