

Nevada Medicaid Fact Book

This is a time of expansion and transformation of the Medicaid program.

The Patient Protection and Affordable Care Act and an array of program reforms represent the most sweeping changes to Medicaid since its enactment.

We at the Division of Health Care Financing & Policy (Nevada Medicaid) are controlling costs and delivering care in innovative and practical ways – including through the managed care model and the Health Care Guidance Program, integrating physical and behavioral health care. We are expanding efforts to detect fraud, waste, and abuse so funds can be allocated for medically necessary services.

We are honored to be a part of Medicaid in these changing times as we work to improve the health of Nevada Medicaid beneficiaries.

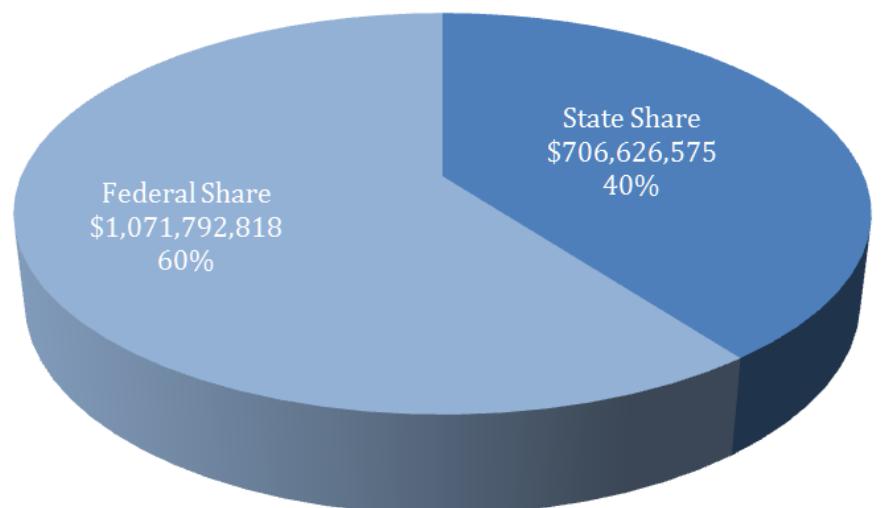
*Laurie Squartsoff
Administrator
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The mission of the Nevada Division of Health Care Financing and Policy (Nevada Medicaid and Nevada Check Up) is to: purchase and provide quality health care services to low-income Nevadans in the most efficient manner; 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.

What is Medicaid?

Total Medicaid
and Nevada Check
Up Spending in
SFY 2014:
\$1,778,419,393

Medicaid is the nation's main public health insurance program for people with low incomes and the single largest source of health coverage in the U.S. In Nevada, Medicaid covers over 600,000 individuals. Medicaid is administered by the states within broad federal requirements, and states and the federal government finance the program jointly.



The program facilitates access to care for beneficiaries, connecting most with managed care plans and their networks of providers, covering a broad range of benefits. As a major payer, Medicaid is a core source of financing for safety-net hospitals and health centers that serve low-income communities. It is also the main source of coverage and financing for nursing home and community-based long-term care.

Who does Medicaid cover?

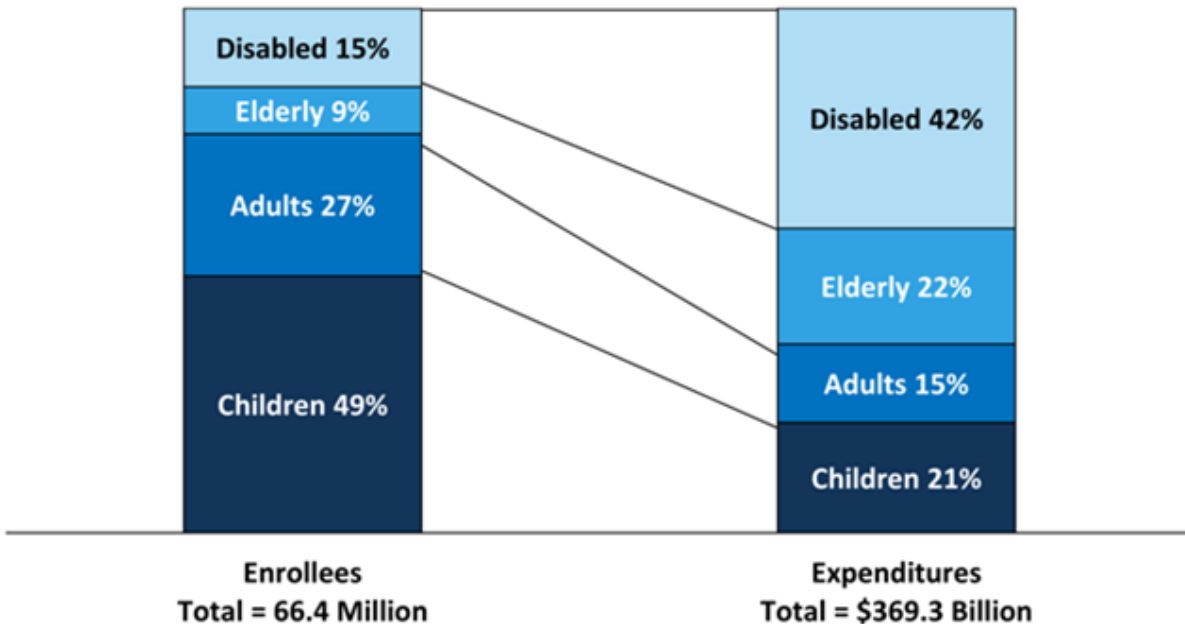
Before the enactment of the Patient Protection and Affordable Care Act (PPACA), federal law provided Medicaid federal funding for specific categories of low-income individuals: children, pregnant women, parents of dependent children, individuals with disabilities, and certain Medicare beneficiaries. Medicaid programs cover people in these groups with income levels up to federal mandatory minimum thresholds.

Key Patient Protection and Affordable Care Act Reforms

The PPACA extended coverage to many of the non-elderly uninsured people nationwide. The June 2012 Supreme Court Ruling made Medicaid expansion optional for states, and Nevada elected to join the expansion and maximize federal dollars. Effective January 1, 2014, this move broadened Medicaid eligibility to nearly all adults under age 65 with income at or below 138% of the Federal Poverty Level (FPL). At the end of SFY 2014 that meant that there were an additional 125,989 new enrollees in Nevada Medicaid, and increased expenditures of \$154,816,777.00. These new expenditures are 100% federally funded.

For details on requirements for Medicaid eligibility, see the Division of Welfare and Supportive Services Fact Book.

Medicaid Enrollees and Expenditures – National Estimate



SOURCE: KCMU/Urban Institute estimates based on data from FY 2010 MSIS and CMS-64. MSIS FY 2009 data were used for CO, ID, MO, NC, and WV, but adjusted to 2009 CMS-64.



How is Medicaid structured?

Federal/state partnership

The cost of Medicaid and Nevada Check Up is shared by the federal government and the State. The federal government matches state Medicaid spending based on a formula specified in the Social Security Act. In SFY 2014, the blended Federal Medical Assistance Percentage (FMAP) was 62.26% for most eligible beneficiaries. The FMAP for family planning services is 90%, Title XIX payments to Indian Health Services for tribal members is 100%, coverage for individuals with Breast and Cervical Cancer is funded with the blended Enhanced FMAP at 73.58%. In addition, the Children's Health Insurance Program (CHIP, known as Nevada Check Up) was funded at the SFY 2014 blended Enhanced FMAP rate of 73.58%. The expansion population (newly eligibles) are funded at 100%.

States administer Medicaid within broad federal guidelines

Each state creates a single agency that administers Medicaid. For Nevada, that agency is the Division of Health Care Financing & Policy (DHCFP). Federal law specifies core requirements, and beyond that states have broad flexibility regarding eligibility, benefits, provider payments, delivery systems, and other aspects of their programs. Every state has a Medicaid State Plan that describes its program in detail. To make a change in its program, a state must receive federal approval from the Centers for Medicare and Medicaid Services (CMS).

States may seek federal waivers of regular rules to administer programs

The Health and Human Services (HHS) Secretary may waive statutory and regulatory requirements for Medicaid, for budget-neutral research and demonstration purposes that are "likely to assist in promoting the objectives of the program." States also have the option of Section 1915 "program waivers" that permit them to provide care for certain beneficiaries and to obtain federal match to provide community-based long term support services to beneficiaries who would otherwise need nursing facility care.

What does Medicaid cover?

Services depend upon program and beneficiary

Because of the diverse and complex needs of the Medicaid population, Medicaid covers a broad array of health and long-term care services, including many services not covered by traditional insurance like transportation, long term care (nursing facilities) and home and community-based services. Benefits to children are comprehensive, while states have more latitude in defining benefits for adults.

Medicaid is the largest source of federal revenue in state budgets.*

Medicaid is a significant source of coverage for children

Medicaid, together with CHIP, covers more than one in every three children nationally. These are vital services for all children – especially those with disabilities and special needs.

Medicaid covers many with complex health care needs

Medicaid provides health and long-term care coverage for people with severe physical and behavioral health conditions and disabilities (e.g., cerebral palsy, Down Syndrome). Addressing the spectrum of needs and limited ability to pay out-of-pocket, Medicaid covers medical services and, in addition may provide services like transportation and community-based long-term care.

*Dual eligible beneficiaries account for 15% of Medicaid enrollees, but 38% of Medicaid spending.**

Medicaid provides assistance to low-income Medicare beneficiaries

Nationally, one in every five Medicare beneficiaries is also covered by Medicaid, based on income levels. For these individuals, known as “dual eligibles,” Medicaid covers Medicare premiums and cost sharing, and important services that Medicare limits or doesn’t cover at all, especially long term support services including personal care services.

Beneficiaries have a federal entitlement to coverage

Medicaid is an entitlement program, meaning that states who participate in the Medicaid program are federally mandated to provide services to any person who meets the state’s eligibility criteria. The state cannot limit enrollment or establish a waiting list. This guarantee of coverage should be distinguished from Medicaid waiver programs, CHIP and other block grant programs, in which funding levels are pre-set and enrollment can be capped.

Mandatory services

Federal law requires this set of “mandatory services.”

- Physician’s services
- Hospital Services
- Laboratory and x-ray services
- Early and periodic screening, diagnostic and treatment services for those under 21
- Federally-qualified health center and rural health clinic services
- Family planning services and supplies
- Pediatric and family nurse practitioner services
- Nurse midwife services
- Nursing facility services for individuals 21 and older
- Home health services
- Durable medical equipment
- Transportation services

Medicaid funds 44% of births in Nevada

Optional services offered in Nevada

Many of these optional services are vital for people with chronic conditions, disabilities, or the elderly. These services, typically provided in a home or community-based environment, aid to reduce the overall cost of health care while contributing to the individual's quality of life.

- Pharmacy
- Dental (under 21 except emergency care)
- Optometry
- Psychologist
- Physical, occupational, and speech therapies
- Podiatry (under 21)
- Chiropractic (under 21)
- Intermediate care facility for 65+
- Skilled nursing facility (under 21)
- Inpatient psychiatric services (21 and under; 65 and older)
- Personal care services
- Private duty nursing
- Adult day health care
- Nurse anesthetists
- Prosthetics and orthotics
- Hospice
- Intermediate care facility for individuals with intellectual disabilities

How do Medicaid beneficiaries receive care?

Beneficiaries obtain care primarily from private providers and health plans

Medicaid is publicly financed, but is not a government-run health care delivery system. The state pays medical providers for services furnished to beneficiaries on a fee-for-service basis or through risk-based contracts with managed care plans. Managed Care Organizations (MCOs) are paid on a capitation basis – a monthly premium based on the financial risk for providing comprehensive Medicaid benefits.

How is DHCFP structured?

DHCFP is divided into the following units

- Administration
- Human Resources
- Accounting/Budget
- Rates/Cost Containment
- Information Services
- Program Integrity
- Fiscal Integrity
- Business Lines
- Grants & Quality Assurance
- District Offices
- Long-term Support Services
- Clinical Policy

ADMINISTRATION

The DHCFP administration provides the leadership for the agency, working with federal, state, industry and customer stakeholders to ensure the Medicaid and CHIP programs operate within the agency Mission. The leadership works to promote innovation and change to ensure Nevada's Medicaid and CHIP programs evolve and provide quality up-to-date programs. The DHCFP administration also manages the agency fiscal oversight and policy, including document control processes.

HUMAN RESOURCES

The Human Resources Unit serves as liaison between the DHCFP and the Division of Human Resources Management, the Public Employees Retirement System (PERS), the Public Employees Benefit Program (PEBP), and the Division of Risk Management.

ACCOUNTING AND BUDGET

The Accounting and Budget Unit's functions are divided into four sections:

Finance and Accounting

This section is responsible for cash receipts, including deposits and federal draws for Medicaid Title XIX, CHIP Title XXI, and all other grants. The Accounting section is also responsible for the accounts payable for contract payments, cost containment and drug rebate invoices and payments, Medicare Buy-In payments, interagency billings, and purchase orders, along with regular accounting functions.

Budget

The Budget Section completes the biennial budget for Medicaid, Nevada Check Up, DHCFP Administration, Intergovernmental Transfer, and Fund to Increase the Quality of Nursing Care. This section continuously monitors the budget versus actual expenditures and adjusts as necessary.

Contracts

The Contract Section is responsible for monitoring contracts as well as assisting other Division staff in creating contracts.

Medicaid Management Information System (MMIS) Finance/Reporting

This section maintains the MMIS budget and finance functions, monitors MMIS budget authority, and resolves issues with claims pended because of MMIS budget issues. The section responds to requests for information/data and supports financial and budget operations by providing critical financial reports.

The reporting staff files Medicaid related revenue, expenditure, and forecasting reports to CMS quarterly. This staff requests and monitors the transfer of federal dollars between the state and federal treasury departments and ensures the state is reimbursed for all claims in accordance with applicable federal requirements. The reporting staff also makes Medicaid-related financial reports to the State Controller's Office and other state agencies.

This section also oversees the County Match Program, School Based Services Program, and para-transit non-emergency transportation services through the Regional Transportation Commissions. This includes invoicing and collecting the Intergovernmental Transfer funds

related to the programs identified above as well as setting cost-based reimbursement rates. This section is also responsible for all Certified Public Expenditure funding for Targeted Case Management, Behavioral Health services and Adult Day Health Care services, and for the Division's Cost Allocation Plan.

RATES/COST CONTAINMENT

The Rates and Cost Containment Unit's functions are reimbursement rate setting, management of supplemental payment programs, collection of data, reporting on provider finances, claims data analysis, and county contracts related to Intergovernmental Transfer. The Unit is divided into two sections:

Rates

This section sets rates for fee-for-service providers, establishes payment rates for hospital, nursing facility, and other provider type services, applying existing Nevada State Plan methodologies, federally allowable reimbursement methodologies, other state methodologies, and industry standards. They research and prepare responses to audits and rate appeals.

Cost Containment

This section manages the supplemental payment programs, some of which are described below:

- Disproportionate Share Hospital, providing supplemental payments to hospitals providing a disproportionate share of services to the indigent and uninsured.
- Upper Payment Limit, allowing Medicaid to pay hospitals under a fee-for-service environment an amount that would equal what Medicare would have paid for the same services.
- Graduate Medical Education payments, currently only provided to non-state governmentally owned hospitals (University Medical Center of Southern Nevada).
- Federally Qualified Health Center (FQHC) "wraparound" payments to cover the difference between what is paid by the Managed Care Organizations and the FQHC's prospective payment system cost-based rate.

The Unit collects Medicare and Medicaid cost reports from hospitals and other health care facilities and oversees contracted auditors who review cost reports for cost settlement purposes. The unit prepares annual financial and utilization reports that are provided to governmental entities and the general public. They have oversight of Nevada Compare Care, a transparency website created by and administered under contract to the Center for Health Information Analysis (CHIA) at the University of Nevada, Las Vegas.

INFORMATION SERVICES (IS)

The IS unit provides technical oversight of the agency's IS resources, and is divided into three sections: Information Technology, Application Development and Business Services.

Information Technology (IT)

The IT section provides technical oversight of the agency's IT resources and information system security.

The agency has a designated Information Security Officer (ISO) who ensures appropriate application of the Health Insurance Portability and Accountability Act's (HIPAA) Security Rule and protection of personally identifiable information through the development and implementation of Division security policies, standards, and procedures; education on the same; information security training; assessment of applied security controls; risk assessments; system

audits; system monitoring; development and implementation of the Division Information Security Plan and Business Continuity/Disaster Recovery plan.

Application Development

Application development includes the development and support of agency created applications to support business users. Applications include: time keeping, document review, MMIS issue tracking, HIPAA compliance, security manager and a JASPER business intelligence reporting tool used for state, federal and other reporting.

Business Services

The Business Services section of Information Services is comprised of Business Process and Project Management. These sections provide process analysis and project management support to program staff in support of the MMIS as well as other agency information systems.

PROGRAM INTEGRITY

The Program Integrity Unit guards against fraud, waste and abuse of Medicaid program benefits and resources, oversees enrollment of and provision of resources to providers, responds to requests for public records and confidential information, and coordinates in-house training to staff.

Sections within the Unit are:

Electronic Health Records (EHR)

The EHR section provides financial incentives to providers who adopt, implement and/or upgrade or demonstrate “meaningful use” of certified EHR technology as part of the American Recovery and Reinvestment Act and the Health Information Technology for Economic and Clinical Health Act. The EHR unit develops and implements changes to the program and provides project oversight of contractors performing work in support of program development. Eligible professionals and eligible hospitals must complete attestation and certify minimum Medicaid patient volume requirements.

Hearings

The Hearings Section administers a Fair Hearing process, available to any Nevada Medicaid or Nevada Check Up recipient who disagrees with any action resulting in the reduction, suspension, termination, denial, transfer, or discharge in part of any Medicaid service, and to a recipient who believes a request for a service was not acted upon within reasonable promptness. It is also available if there is a belief that Medicaid or a designated health plan has taken an erroneous action, if a nursing facility resident believes that facility has erroneously transferred or discharged them, or if a recipient believes an erroneous determination was made on their Preadmission Screening and Annual Resident Review.

Nevada Medicaid providers are also entitled to a Fair Hearing process when an adverse determination (such as a denied claim that has been through all appeal processes, provider lockout, recoupment or suspension of payments, or disenrollment) has been taken against them by the Division, the Fiscal Agent, Health Plan or third party Health Plan Administrator. Providers must exhaust internal grievance and/or appeal processes available through the Fiscal Agent, Health Plan or third party Health Plan Administrator prior to a Division Fair Hearing.

*In SFY 2014 DHCFP processed:
1172 Recipient Hearing Requests
331 Provider Hearing Requests*



The Electronic Health Records program has paid over \$30 million in federal dollars in incentive payments to Nevada providers

An attempt to resolve issues is offered through a Hearing Preparation Meeting, wherein an explanation of the adverse action is provided and attempts are made to resolve the matter without a Fair Hearing.

All Fair Hearings are conducted through the Department of Administration and are controlled by a Hearing Officer. The Division is represented by a Deputy Attorney General. Fair Hearings are conducted within 90 days of the request.

Provider Support

The Provider Support Section includes four work units:

Provider Support oversees the enrollment, termination and/or suspension process for Nevada Medicaid providers. They are a liaison between the fiscal agent and provider community to help resolve any enrollment issues and oversee provider outreach communication.

PPACA & Policy develops policy and oversees principal components of health care reform mandates as they relate to provider enrollment and screening. They research and evaluate federal and state statutes, regulations and policies to ensure the Division is in compliance.

Provider Services resolves provider and recipient issues. They also manage the Health Insurance Premium Payment program, which maximizes Medicaid resources by paying for private insurance premiums of eligible individuals, when cost effective.

Medicaid Estate Recovery is a federally-mandated program that locates and recovers assets of deceased Medicaid recipients over the age of 55 (with some exceptions). Assets can be liquid or real property, in which case the Division places a lien on the property. This unit also files Creditor's Claims on Probate cases and works with the Deputy Attorney General's Office to collect on them.

The SUR Unit recouped \$5,738,812.60 from providers in SFY 2014 for improper payments, fraud, waste and abuse

Surveillance and Utilization Review Unit (SUR)

The Surveillance and Utilization Review (SUR) unit identifies and investigates improper payments, waste, abuse, and fraud in the Nevada Medicaid and Check-Up programs and recoups identified overpayments, educates providers, recommends sanctions against a provider's contract, and refers credible allegation of fraud to the Medicaid Fraud Control Unit in the Attorney General's office.

SUR staff consults with Program staff to determine whether the intent of existing program policies is properly reflected in the manner in which claims are being paid. Discrepancies are addressed by recommendations for claim-processing edits and/or policy revisions or clarifications.

HIPAA/Civil Rights

This section implements and monitors processes to maintain compliance with state and federal privacy and confidentiality laws, which includes: developing policies and procedures; evaluating relationships with outside entities and securing appropriate legal agreements; employee training; investigation, mitigation and reporting of privacy incidents.

Release of various data is done under the auspices of this section, including hospital inpatient and ambulatory surgery center data (done in concert with UNLV's Center for Health Information Analysis), release of protected health information (for individuals, criminal, civil or administrative investigations or actions, subrogation, audits, research, and public health

activities), Medicaid data released under Limited Data Set Use Agreements and requests for public information.

Monitoring compliance to Civil Rights and Advance Directive regulations is also the responsibility of this section, as well as research and investigation of Civil Rights complaints.

FISCAL INTEGRITY

The main purpose of the Fiscal Integrity Unit is to ensure the division's fiscal and internal control processes are sufficient to prevent the loss of federal and state dollars. It is comprised of three units.

Audit Unit

The Audit Unit is responsible for fiscal agent contract performance and compliance audits and reviews, the federal Payment Error Rate Measurement audits, internal control audits, system and policy compliance audits, mandated audits associated with the EHR payment program, and a host of other audits and reviews that identify system, process or program inefficiencies or improper payments. The unit also oversees Patient Trust Fund audits and Managed Care Organization performance and compliance audits and reviews performed by agency audit contractors.

IN SFY 2014 the Fiscal Integrity Unit identified and recovered \$977,348.30 in improper payments to providers and agency contractors.

Recovery and Debt Collection Unit

The Recovery and Debt Collection Unit establishes and monitors debt resulting from overpayments or improper payments made to Medicaid providers. Staff make collection attempts to recover amounts due from providers, validates claim recoveries and adjustments to ensure they are properly processed in the Medicaid Management Information System, reports and turns over uncollected debt to the State Controller's Office.

Third Party Liability Unit

Third Party Liability (TPL) is the legal obligation of third parties (health insurance carriers, auto insurance companies, malpractice insurers, etc.) to pay all or part of the costs for medical services. This unit oversees the TPL activities performed by the fiscal agent and their sub-contracted TPL vendor and ensures the agency maximizes recovery from responsible third party payers. In most instances, Medicaid is the payer of last resort. TPL activities include discovery of recipient's other health insurance through data matching, recovery of payments that should have been paid by a third party, and recovery from entities liable for health care costs due to negligent acts or omissions generally related to an accident or injury.

BUSINESS LINES

The Business Lines Unit evaluates and implements alternative health care delivery systems, including managed care through contracted Managed Care Organizations (MCO) and a fee for service based Care Management Organization (CMO) known as the Health Care Guidance Program (HCGP).

The HCGP began mandatory enrollment of fee-for-service beneficiaries with chronic health and behavioral conditions and/or high cost/high utilization on June 1, 2014. These beneficiaries

are provided with direct case management to improve quality of care and provide care in a more efficient manner.

The Unit also oversees contracts for medical non-emergency transportation.

GRANTS & QUALITY ASSURANCE

The Grants Management Unit researches federal grant opportunities and determines when an opportunity is a good fit for Nevada Medicaid, develops grant applications, receives, implements and maintains grant awards.

The Quality Assurance Unit collaborates with state agencies to develop, operate and sustain quality improvement within the 1915(c) Home and Community Based Services Waiver Programs. The unit audits the operational agencies to ensure that all federal and state quality requirements are met and that the health, safety and welfare of Medicaid recipients are maintained.

MEDICAID DISTRICT OFFICES

The District Offices are the operational side of the DHCFP programs. District office staff provides information/referral and care coordination to Medicaid (fee-for-service) recipients. Programs operated by the District Office include: Facility Outreach and Community Integration Services, The Money Follows the Person Grant, Home Based Habilitation Services, The Home and Community Based Waiver for Persons with Physical Disabilities, Health Insurance for Work Advancement buy-in component and the Katie Beckett eligibility option. District office staff conducts Minimum Data Set reviews of Medicaid nursing facilities and reviews of new and existing Personal Care Agencies.

District Offices are located in Carson City, Elko, Reno, and Las Vegas.

LONG TERM SUPPORTIVE SERVICES

The Long Term Support Services (LTSS) Unit provides recipients with long-term care either inside or outside institutions. Staff within each of the following sections develop policy, serve as a liaison with stakeholders, providers, vendors, recipients and advocates, and initiate system changes.

Home and Community Based Services

This section manages three Home and Community Based Services waivers, three State Plan options, and oversees disability determinations for Medicaid. The waivers are: the Waiver for Persons with Physical Disabilities; the Waiver for Persons with Intellectual Disabilities and Related Conditions; and the Waiver for the Frail Elderly. The State Plan options are Adult Day Health Care ; Home Based Habilitation Services; and the Katie Beckett Eligibility option.

Home Based Care Services

This section maintains oversight of non-waiver programs that support Medicaid recipients in their homes: Personal Care Services, Personal Care Services Intermediary Service Organization, Home Health and Private Duty Nursing.

Facility Services

This section oversees the Medicaid recipients who receive care in long-term facilities. Generally these services are in institutions within the State of Nevada, though a small population

of recipients for whom no placement in Nevada can be found are placed in out-of-state institutions. In addition, Hospice Services falls under the auspices of this group.

CLINICAL POLICY

The Clinical Policy Unit develops and implements clinical policies in collaboration with stakeholder input and based upon federal/state requirements. The unit has five main areas of responsibility: medical coverage policy development, technical documentation in relation to policies, serving as policy liaisons for the Division, development of utilization management standards and oversight, and policy quality assurance.

The Clinical Policy Team is responsible for the following services:

- Inpatient, outpatient and ancillary services
- Behavioral health and substance abuse services
- Indian Health Programs
- Quality assurance within the unit

Policy development and technical documentation includes researching federal/state policies and regulations, best practice standards and evidence-based medicine, scope of services, provider qualifications and service limitations. Policy specialists serve as policy liaisons to stakeholders to interpret and apply current and future medical coverage policies. This includes involvement in internal and external boards, committees, workshops and hearings.

The Fiscal Agent is responsible for certain Utilization Management activities, with this unit providing an oversight role.

References

*All figures presented which are not specific to Nevada are attributed to Medicaid: A Primer – Key Information on the Nation’s Health Coverage Program for Low-Income People, March 01, 2013, The Kaiser Family Foundation

**2010, Kaiser Family Foundation

Regulations and Statutes governing Medicaid

- Title XIX of the Social Security Act
- Title XXI of the Social Security Act
- NRS Chapter 422

Nevada Medicaid Plan Documents

- Nevada Medicaid State Plan
<https://dhcfp.nv.gov/MSPTableofContents.htm>
- Medicaid Operations Manual
<https://dhcfp.nv.gov/MOM%20Table%20of%20Contents.htm>
- Medicaid Services Manual
<https://dhcfp.nv.gov/MSM%20Table%20of%20Contents.htm>

Nevada Data and Statistics Managed by DHCFP

University of Nevada Las Vegas, Center for Health Information Analysis
<http://www.chiaunlv.com/index.php>

Nevada Compare Care
<http://nevadacomparecare.net/>