Division of Health Care Financing and Policy

Medicaid and Nevada Check Up Fact Book

January 2013

DIVISION OF HEALTH CARE FINANCING AND POLICY
FACT BOOK
MEDICAID PROGRAM

MISSION

The mission of the Nevada Division of Health Care Financing and Policy (DHCFP) 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.

HEALTH CARE FINANCING AND POLICY

Nevada adopted the Medicaid program in 1967 with the passage of state legislation placing the Medicaid program in the Division of Welfare and Supportive Services (DWSS). During the 1997 legislative session, the DHCFP was created. The division has 290 authorized positions with offices in Carson City, Las Vegas, Reno, and Elko. The DHCFP administers two major federal health coverage programs (Medicaid and Children's Health Insurance Program (CHIP)) which provide medically necessary health care to eligible Nevadans. The largest program is Medicaid, which provides health care to low-income families, as well as aged, blind and disabled individuals. The CHIP program in Nevada is known as Nevada Check Up (NCU), and provides health care coverage to low-income, uninsured children who are not eligible for Medicaid.

FEDERAL HISTORY

In 1965, Congress established the Medicare and Medicaid programs as Title XVIII and Title XIX, respectively, of the Social Security Act (Act). Medicare was established in response to the specific medical care needs of the elderly (with coverage added in 1973 for certain persons with disabilities and certain persons with kidney disease). Medicaid was established in response to the widely perceived inadequacy of welfare medical care under public assistance; it provides medical assistance for certain individuals and families with low incomes and resources. It is a jointly funded cooperative venture between the federal and state governments. Medicaid is the largest program providing medical and health-related services to America's poorest people.

Responsibility for administering the Medicare and Medicaid programs, after several federal administrative changes, now rests with the Centers for Medicare and Medicaid Services (CMS).

NEVADA MEDICAID

The Medicaid program pays for medical and medically-related services for persons eligible for Medicaid.

Within broad federal guidelines, states determine eligibility and the amount, duration, and scope of services offered under their Medicaid programs. States may place appropriate limits on a Medicaid service based on such criteria as medical necessity or utilization control. For example, states may limit the number of covered physician visits or may require prior authorization be obtained prior to service delivery.

To meet eligibility for Federal Financial Participation (FFP) Nevada Medicaid must meet required

eligibility categories, minimum service requirements for eligible persons and some payment rate methods. The law also specifies additional categories of eligible persons and services which states may adopt and receive federal Medicaid funds.

With certain exceptions, a state's Medicaid plan must allow recipients freedom of choice among health care providers. States may provide and pay for Medicaid services through various prepayment arrangements, such as a Health Maintenance Organization (HMO), through a Fee-for-Service (FFS) model, or a combination of both (as in Nevada). In general, states are required to provide comparable services to all categorically needy eligible persons.

To assist Medicaid recipients who would otherwise be institutionalized, Nevada Medicaid administers “waiver” programs under Section 1915(c) of the Social Security Act. Waiver programs provide a range of home and community services that enable recipients to live independently as an alternative to unnecessary institutional care. Nevada, like all states, is not limited in the scope of services it can provide, as long as they are medically necessary and do not cost the State more than the cost of providing the care in an institution.

To ensure Medicaid-eligible children receive needed care while minimizing disruption to the education process, school districts and other governmental entities contract with Medicaid to provide medical services and administrative activities such as outreach. These entities receive Federal Financial Participation (FFP) allowable costs for their services.

In State Fiscal Year (SFY) 2012, Nevada Medicaid covered a monthly average of 285,485 individuals including pregnant women, children, the aged, blind, and/or disabled, and people who are eligible to receive Temporary Assistance for Needy Families (TANF).

ELIGIBILITY

The Medicaid program varies considerably from state to state. Within broad national guidelines provided by the federal government, each of the states:

1. Establishes its own eligibility standards;
2. Determines the type, amount, duration, and scope of services;
3. Sets the rate of payment for services; and
4. Administers its program.

States had broad discretion in determining which groups the Medicaid programs will cover and the financial criteria for Medicaid eligibility. States retain the option to expand Medicaid coverage; however, first in 2009 under the Recovery and Reinvestment Act (Federal Stimulus Act) and again in 2010 under the Patient Protection and Affordable Care Act (Health Care Reform) maintenance of effort regulations (MOE) have required state Medicaid programs to retain their current eligibility categories and levels to receive full FFP. The MOE regulations are in place until 2014 for adults and 2019 for children. For further details, please see the DWSS Fact Book for specifics on Medicaid eligibility and the coverage groups.

To be eligible for federal funds, states are required to provide Medicaid coverage for most individuals who receive federally assisted income maintenance payments, as well as for related groups not receiving cash payments. Some examples of the mandatory Medicaid eligibility groups are:

1. Low income families with children, as described in Section 1931 of the Social Security Act, who meet certain eligibility requirements in the state's Aid to Families with Dependent Children (AFDC) plan in effect on July 16, 1996.
2. Supplemental Security Income (SSI) recipients (or in states using more restrictive criteria -- aged, blind, and disabled individuals who meet criteria which are more restrictive than those of the SSI program and which were in place in the state's approved Medicaid plan as of January 1, 1972).
3. Infants born to Medicaid-eligible pregnant women. Medicaid eligibility must continue throughout the first year of life so long as the infant remains in the mother's household and she remains eligible, or would be eligible if she were still pregnant.
4. Children under age 6 and pregnant women whose family income is at or below 133 percent of the federal poverty level. States are required to extend Medicaid eligibility until age 19 to all children in families with incomes at or below the federal poverty level. Once eligibility is established, pregnant women remain eligible for Medicaid through the end of the calendar month in which the 60th day after the end of the pregnancy falls, regardless of any change in family income.
5. Recipients of adoption assistance and foster care under Title IV-E of the Social Security Act.
6. Certain Medicare beneficiaries.
7. Special protected groups who may keep Medicaid for a period of time. Examples are: persons who lose SSI payments due to earnings from work or increased Social Security benefits; and families who are provided 6 to 12 months of Medicaid coverage following loss of eligibility under Section 1931 due to earnings, or 4 months of Medicaid coverage following loss of eligibility under Section 1931 due to an increase in child or spousal support.

Examples of Eligibility Categories that were optional but now, under MOE regulations, are mandatory that Nevada covers:

1. Medical assistance to uninsured women, whose income exceeds the Medicaid limits, found to have breast or cervical cancer through a federally funded screening program; and
2. Disabled children who require medical facility care, but can appropriately be cared for at home, known as the Katie Beckett coverage group.
3. Health Insurance for Work Advancement (HIWA) is for individuals 16 to 64 who are disabled and have a Ticket to Work from SSA. It allows them to retain essential Medicaid benefits while working and earning income. This group is required to pay a prorated premium.
4. Children aging out of foster care (age 18) are now covered until age 21.

Medicaid does not provide medical assistance for all low-income persons. Even under the broadest provisions of the federal statute (except for emergency services for certain persons), the Medicaid program does not provide health care services, unless they are in one of the groups designated in the Medicaid State plan. Low income is only one test for Medicaid eligibility; for some eligibility groups, assets and resources are also tested against established

thresholds.

States may use more liberal income and resource methodologies to determine Medicaid eligibility for certain Temporary Assistance for Needy Families (TANF) related and aged, blind, and disabled individuals under Sections 1902(r)(2) and 1931 of the Social Security Act. For some groups, the more liberal income methodologies cannot result in the individual's income exceeding the limits prescribed for federal matching funds.

The Medicaid – Medicare Relationship

The Medicare program provides hospital insurance, known as Part A coverage, and supplemental medical insurance, known as Part B coverage. Coverage for Part A is automatic for persons aged 65 and older and for certain persons with disabilities that have insured status under Social Security or Railroad Retirement. Coverage for Part A or Part B may be purchased by individuals who do not have insured status through the payment of monthly premiums.

Medicare beneficiaries who have low income and limited resources may receive help paying for their out-of-pocket medical expenses from Nevada Medicaid. There are various benefits available to "dual eligibles" that are entitled to Medicare and are also eligible for some Medicaid benefit.

In January 2006, the Medicare Modernization and Improvement Act (MMA) conveyed prescription drug benefits to Medicare beneficiaries under the newly created Part D. Beginning at this time, State Medicaid agencies discontinued prescription drug coverage for full-benefit dual eligibles (beneficiaries receiving both Medicare and full Medicaid).

The transfer of prescription drug coverage for dual eligibles from Medicaid to Medicare does not reduce the amount of federal money that States receive for Medicaid. Instead, the MMA includes a provision called the phased-down state contribution (clawback) that requires States to make payments to Medicare in exchange for federal assumption of these prescription costs. The amount of each State’s contribution is based on a complex formula that considers previous per capita prescription drug costs, national growth factors, and enrollment of full-benefit dual eligibles.

MEDICAID SERVICES

Federally Mandated Medicaid Services

The Act requires that in order to receive federal matching funds, certain services must be offered to the categorically needy population in any state program.

Mandatory Services:

1. Inpatient hospital services;
2. Outpatient hospital services;
3. Physician services, medical and surgical dental services;
4. Nursing Facility (NF) services for individuals aged 21 or older who would otherwise be receiving SSI;
5. Home health care for persons eligible for NF services, including medical supplies and appliances for use in the home;

6. Family planning services and supplies;
7. Rural health clinic services and any other ambulatory services offered by a rural health clinic that are otherwise covered under the State plan;
8. Laboratory and x-ray services;
9. Pediatric and family nurse practitioner services;
10. Federally-qualified health center services and any other ambulatory services offered by a federally-qualified health center that are otherwise covered under the State plan;
11. Nurse-midwife services (to the extent authorized under State law);
12. Transportation; and
13. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services, for individuals under age 21. A preventive health care program providing to Medicaid-eligible children under the age of 21 preventive health care through the use of periodic examinations, standard immunizations, diagnostic services, and treatment services which are medically necessary and designed to correct or ameliorate defects in physical or mental illnesses or conditions. Nevada's program is named Healthy Kids.

Optional Services:

States may elect to include optional State plan services. These services are typically provided in a home and community based environment and reduce the overall cost of health care. Pharmacy benefits, for example, are optional services, however, without medication many Medicaid recipients would be in an acute care hospital at a much higher cost of care.

Nevada Medicaid has chosen to offer the following optional services and receives federal funding to do so:

1. pharmacy;
2. dental;
3. optometry;
4. psychologist;
5. physical, occupational, and speech therapies;
6. podiatry for those under 21 years of age and Qualified Medicare Beneficiaries (QMB) eligibles;
7. chiropractic for those under 21 years of age and QMB eligibles;
8. intermediate care facility services for those 65 years and older;
9. skilled nursing facility services for those under 21 years of age;
10. inpatient psychiatric services for those under 21 years of age;
11. personal care services;
12. private duty nursing;
13. adult day health care;
14. nurse anesthetists;
15. prosthetics and orthotics;
16. hospice; and
17. Intermediate Care Facility for the Mentally Retarded.

Nevada Medicaid also operates four waivers, authorized by the Secretary of the U.S. Department of Health and Human Services, whose regulations are found in Section 1915(c) of the Act.

Under a federally approved waiver, states may provide home and community-based care

services to certain individuals who are eligible for Medicaid. The services provided to these persons may include case management, personal care, respite care, adult day health, homemaker/home health aide, habilitation, and other services requested by the state and approved by CMS. Nevada's four Waiver Programs are:

1. Home and Community-Based Services (HCBS) offered to certain persons with mental retardation and related conditions throughout the state.
2. HCBS offered to certain frail elderly persons throughout the state.
3. HCBS offered to certain physically disabled persons throughout the state.
4. HCBS offered to certain elderly in assisted living facilities throughout the state.

DIVISION FUNDING

Funding for the Medicaid program comes from the following sources:

Federal Funding

Federal Financial Participation (FFP) as allowed under Title XIX of the Social Security Act: FFP is composed of two parts, the administrative FFP rate which is generally 50%. Enhanced administrative FFP is available for certain skilled medical professionals (75%), operation of a federally certified Medicaid Management Information System (MMIS) or certified equivalent system (75%) and design, development and implementation of MMIS (90%).

The second portion of FFP is for medical assistance payments referred to as Federal Medical Assistance Percentage (FMAP). FMAP is evaluated annually based on the per capita income of Nevada. Due to the temporary increase in FMAP as a result of the American Recovery and Reinvestment Act (ARRA), the blended FMAP for SFY 2011 was 62.05% and ARRA FMAP ended June 30, 2011; therefore SFY 2012 FMAP was 55.05%. Enhanced FMAP is available for family planning services (90%), payment to Indian Health Services (IHS) (100%) and coverage of individuals under the Breast and Cervical Cancer program (The same FMAP as the Children's Health Insurance Program which is currently between 68 and 70%).

Supporting Local Government

Disproportionate Share Hospital (DSH) Program

The DSH program is part of federal Medicaid regulations. The purpose of the program is to provide supplemental payments to those hospitals in the state which provide a disproportionate share of services to indigents and the uninsured. The federal government provides a specific annual allotment of federal funds for each state, which in turn must match those funds with state dollars. The Nevada formula for distributing these payments is authorized pursuant to Nevada Revised Statutes (NRS) 422.380 – 387 and the State Plan for Medicaid. The DSH allotments from the Federal Government are scheduled to decrease under the Patient Protection and Affordable Care Act as the number of insured individuals are expected to increase.

Upper Payment Limit (UPL) and Graduate Medical Education (GME) Programs

Federal Medicaid regulations allow for State Medicaid Agencies to pay hospitals under a Fee-For-Service (FFS) environment an amount that would equal what Medicare would have paid for the same services. This concept is referred to as the Upper Payment Limit (UPL). UPL payments have

many names: upper payment limit payments, supplemental payments, Graduate Medical Education (GME) payments, and enhanced payments. These payments must not be greater than the difference between the UPL and the amount of interim Medicaid payments made to hospitals within a specific category. Nevada currently has Inpatient (IP) and Outpatient (OP) public UPL programs and a GME Program. The formula for calculating and distributing these payments is authorized pursuant to the Medicaid State Plan.

County Match

Effective July 1, 2011, County Social Service Agencies pay the non-federal portion of costs associated with institutionalized and non-institutionalized waiver individuals with incomes at the Federal Benefit Rate (FBR) prescribed by the Director annually. The FBR for SFY 2012 was set at 142% to 300% of the SSI rate. Prior to SFY 2012, the counties were responsible for the non-federal share of costs for institutionalized recipients with incomes at 156% to 300% of the FBR.

Most other local government agencies providing medical services, and having a Medicaid contract, provide the non-federal share of the Medicaid costs which are incurred. The Medicaid program transfers the federal share of the Medicaid allowable costs to the local government agencies. The local government programs include school districts and county social service agencies.

General Fund Appropriation

Where the non-federal portion of the expenditure is not covered by some other source, a general fund appropriation is necessary. The general fund portion of most medical and administrative costs is included in the DHCFP budgets. The Division of Children and Family Services (DCFS) has the general fund match in their budget for rehabilitation services, Targeted Case Management and medical costs for children in their custody. The Division of Mental Health and Developmental Services (MHDS) has the general fund appropriation in their budget for mental health rehabilitation services, Targeted Case Management and the mental retardation and related conditions waiver services. The DWSS has the general fund in their budget for administrative (eligibility) services. The Aging and Disability Services Division (ADSD) has the general fund portion of the waiver administration for elders in their budget.

Nursing Facility Provider Tax Program

The Nursing Facility Provider Tax program (also known as the Fee to Increase the Quality of Nursing Care) is an optional part of federal Medicaid regulations. These regulations allow States to implement taxes on certain classes of providers and use those funds as state match for Medicaid reimbursements. These programs must adhere to strict regulatory criteria. The Nevada formula for this program is authorized pursuant to NRS 422.3755 – 379, the Nevada Medicaid State Plan and a federally approved waiver. The tax is assessed on all free-standing nursing facilities within the state on all non-Medicare bed days at a rate which cannot exceed 6% of revenues for all facilities.

The proceeds of the tax are placed in a special fund and then used to pay out the monthly provider tax supplemental payments to all qualified free standing nursing facilities.

DIVISION SECTIONS and PROGRAMS

Administration The Administrator is responsible for and oversees the Deputy Administrator, Administrative Services Officer (ASO) IV, the Compliance Chief, the Audit Chief and the Chief of Information Services in their functions. The Deputy Administrator handles all non-fiscal program aspects of Nevada Medicaid and Check Up programs; including medical care issues, service authorizations, regulatory compliance with federal and state rules; serves as liaison with state agencies, community and legislature, supervises professional and administrative support staff. The ASO IV is responsible for directing the Administrative Services staff including all financial accounting, budgeting personnel, rate development and cost containment functions of the division. The Chiefs of Compliance, Audits, and Information Services direct their respective sections. The rest of the support staff in the administrative office support the Administrator, Deputy and ASO IV in all aspects of secretarial and word processing duties.

Administrative Services

Finance and Accounting

The Accounting section is responsible for cash receipts, including deposits and federal draws for Medicaid Title XIX, CHIP Title XXI and all other grants. (These include Medicaid Incentives for Prevention of Chronic Disease Grant and the Money Follows the Person Grant.) The Accounting section also audits and processes division payroll, employee travel claims, cost allocations, contract payments, county match, cost containment and drug rebate invoices and payments, Medicare Buy-In payments, interagency billings, and purchase orders.

Budget

The Budget section is responsible for the development, analysis and completion of the biennial budget for Medicaid (BA 3243), Nevada Check Up (BA 3178), DHCFP Administration (BA 3158), Intergovernmental Transfer (BA 3157), and Fund to Increase the Quality of Nursing Care (BA 3160). The Budget Section monitors the fiscal year budget to ensure revenues and expenditures do not exceed work program (budget) authority, prepares revenue and expenditure projections, and prepares work programs as needed.

Contracts

The Contract section is responsible for assisting Division staff in creating contracts and ensuring that all legal requirements are met while protecting the interests of the State. Final approval of all contracts is provided by the Board of Examiners (BOE), and once the contract is in force, the contract section monitors expenditures to ensure sufficient contract and budget authority. Contract amendments and renewals are also maintained by the contract section.

MMIS Finance

The MMIS Finance Reporting section is responsible for maintaining the MMIS budget and finance functions, monitoring MMIS budget authority, and resolving issues with claims pended because of MMIS budget issues. The section responds to requests for information from both internal and external users and supports financial and budget operations by providing critical financial reports. The reporting staff is responsible for filing Medicaid related revenue and expenditure reports to CMS quarterly, including the CMS 64 (actual Medicaid Expenditures), the CMS 37 (forecasting Medicaid Expenditures) and the CMS 21 and 21B reports which forecast and report expenditures for the CHIP Program, Nevada Check Up. The CMS 37 and 21B forecast reports initiate the release of allowable funding amounts per quarter from CMS to the State. Initial awards and grants combined with the quarterly reporting allow the State to be reimbursed from the Federal government. This staff is responsible for requesting and monitoring the transfer of federal dollars between the State and Federal treasury departments. Reporting staff ensures the State is reimbursed for all claims in accordance with applicable federal requirements as set forth in the CMS State Medicaid Manual. The reporting staff is also responsible for Medicaid related financial reports to the State Controller's Office and other State agencies.

MMIS and reporting staff provides technical expertise to analyze provider claims data and serve as information management consultants to programs and committees throughout the division. This group consists of Decision Support System power users who perform Medicaid data analysis and are charged with producing information upon request (reports) for the division, department and other Medicaid stakeholders.

Personnel

The Personnel section is responsible for all personnel functions for the division. These functions include: employee relations; employee evaluations; recruitment; orientation; disciplinary actions; grievances; personnel paperwork for Central Records; Public Employee Benefit Program (PEBP); and Public Employee Retirement System (PERS); personnel database management; records and files management; workers' compensation; position classification; and support for supervisors and staff in interpreting personnel rules and regulations.

Rates and Cost Containment Section

The Rates and Cost Containment section provides technical expertise on medical finance. The primary functions are reimbursement rate setting, collection of data, and reporting on provider finances, claims data analysis, and management of supplemental payment programs. This includes rate setting for FFS providers. The section is divided into two teams.

The Rate Methodology and Policy Team is responsible for provider rate setting. They provide expertise on federally allowable reimbursement

methodologies and industry standards. They perform research into rate setting methodologies used in other states. They conduct reimbursement workshops with providers and draft State Plan amendments pertaining to rate methodologies.

The Cost Containment Team focuses on the collection of financial data from institutional providers. This includes collection of Medicare and Medicaid cost reports and the oversight of audit contractors. This team manages the DSH and UPL supplemental payment programs, collects provider taxes and oversees other cost based reimbursement. They also oversee the collection of provider data posted to Nevada Compare Care, a transparency website created by and administered under contract to the University of Nevada, Las Vegas.

Audit

The Audit section is responsible for performing activities to verify and maintain the fiscal integrity and policy compliance of the Medicaid and NCU programs. In addition, the Audit Section coordinates all audits and reviews by external agencies: CMS; Health and Human Services (HHS); Office of the Inspector General (OIG); Nevada Department of Administration; Division of Internal Audits; and the Legislative Counsel Bureau. The section is divided into four main sections: Fiscal Agent Audits; Contract Audits; Payment Error Rate Measurement (PERM), system and other Internal Audits; and audits associated with the Medicaid Electronic Health Record (EHR) Incentive Program.

Fiscal Agent Audits

The DHCFP has a contract with a fiscal agent that performs a myriad of essential core services: adjudication and payment of all provider claims; generation and posting of MMIS financial transactions; provider enrollment activities; prior authorizations and other care management services; third party payer identification and recovery; provider appeals; and distribution of medical cards and required notices to recipients. All fiscal agent invoices are validated for accuracy and contract compliance and regular performance audits are conducted on core services to ensure contract compliance and adherence to federal and state laws and regulations.

Contract Audits

The DHCFP has contracts with many large vendors responsible for performing crucial services for the agency. Vendors include: two Managed Care Organizations (MCOs); and a non-emergency transportation services broker; and others. The Audit section conducts periodic audits and reviews to validate contract performance and compliance. In addition, the Audit section oversees audits performed by commercial audit firms. These audit and oversight functions are necessary to ensure proper payment for services and compliance with federal and state laws and regulations.

Payment Error Rate Measurement (PERM) System and Internal Audits

The Audit section coordinates activities and reviews associated with the PERM program. PERM is a federally mandated program that measures the accuracy of payments made for services rendered to Medicaid and NCU recipients. PERM reviews are conducted once every three years (FFY 2008, FFY 2011, FFY 2014, etc.). The program is administered by CMS and includes comprehensive system processing, medical record and eligibility reviews. Due to the complexity of the Medicaid Management Information System (MMIS) the Audit Section conducts ongoing claims payment review utilizing federal PERM guidelines to ensure continued system accuracy and to prevent unnecessary overpayments.

The Medicaid and NCU programs are regulated by complex federal and state laws and regulations. The Audit section performs regular reviews of agency internal policies, procedures systems and control processes to validate agency compliance.

Medicaid Electronic Health Record (EHR) Incentive Program

The Health Information Technology for Economic and Clinical Health (HITECH) Act (part of the American Recovery and Reinvestment Act of 2009 (ARRA)) was enacted to promote the adoption and meaningful use of Health Information Technology (HIT). One aspect of the HITECH Act allows states to provide incentive payments to eligible hospitals and professionals to adopt implement and upgrade to certified EHR technology and become meaningful users of EHR technology. CMS requires a robust audit component for this program. The Audit Section performs pre-payment verifications and post payment audits for eligible providers, oversees pre-payment verifications of eligible hospitals conducted by a contracted vendor and performs post payment audits of hospitals and eligible professionals for the Medicaid EHR Incentive Program.

Business Lines

The Business Lines section's principal areas of responsibility are Managed Care, and medically necessary transportation for Medicaid and NCU recipients as well as developing a program for care coordination for a specific high risk Medicaid population that is identified by chronic conditions and high utilization patterns.

Managed Care

Managed care is a method of payment and a care delivery model. The DHCFP contracts for the delivery of healthcare through managed care organizations for certain Medicaid and NCU populations. The objectives for the program are to improve access to care and coordination of care, while managing the cost of services.

Managed care is only available in the urban areas of Washoe County and Clark County. It is administered by two Managed Care Organizations (MCO)s, currently Health Plan of Nevada (HPN) and AMERIGROUP Community Care.

The DHCFP and the Division's external quality review organization, Health Services Advisory Group (HSAG) closely monitors these two MCOs to assure that they continue to provide better health care outcomes, improved quality of life for recipients and monetary savings for taxpayers.

The MCOs are able to provide certain benefits to recipients that neither Medicaid nor NCU are able to cover under the FFS payment model. Among these added value benefits are additional dental benefits, infant circumcision, recipient education programs, childhood obesity programs and camps, asthma camps, free membership to the Boys & Girls Club, smoking cessation programs, disease management, and healthy pregnancy programs. These added value benefits are provided to recipients at no additional charge to the State.

Medically Necessary Transportation

In addition to emergency ambulance transportation, the DHCFP also provides recipients with transportation to covered non-emergency services that are medically necessary. This is accomplished through a brokered transportation system. The non–emergency transportation (NET) broker maintains a call center, arranges transportation and contracts with various transportation providers for services.

Federal rules require the broker to use the most cost effective method of transportation. The NET broker will assist Medicaid recipients in scheduling a needs assessment with local Regional Transportation Centers (RTC)s to determine the appropriate means of transportation. Depending on their needs and the availability of services, recipients may receive gas reimbursement for their own vehicles, passes on public conveyance such as the city bus or paratransit, stretcher van service or other methods of transportation.

Recipients must call the NET broker to request rides. Prior to authorizing the ride, the NET broker confirms the medical appointment and the assessed level of need.

Currently approximately 50,000 rides are provided every month, with a recipient complaint rate of less than one half of 1%.

Compliance

Recipient Civil Rights and Advance Directives

Pursuant to Title VI of the Civil Rights Laws of 1964 and the Patient Self-Determination Act of 1990, medical facilities and health care providers must comply with federal and state laws concerning Civil Rights and Advance Directives. The DHCFP monitors compliance through a CMS approved process that includes tri-annual provider self-evaluation certification and periodic on-site reviews conducted by State of Nevada Department of Health and Human Service employees.

Medicaid Estate Recovery (MER)

In October 1993, federal and state laws were passed requiring states to have a Medicaid Estate Recovery (MER) program. The program, required by Section 1917 of the Social Security Act and established in Nevada under Nevada Revised Statues 422.29302-422.29306, enforces federal laws requiring the recovery of payments from the estates of Medicaid recipients 55 years of age or older and Medicaid recipients of any age who were institutionalized. Recovery is accomplished only after the death of the Medicaid recipient. There is no recovery during the lifetime of the surviving spouse or if there is a disabled and/or blind child of any age or a child under age 21 living in the home.

Hearings

The Hearings section provides any Nevada Medicaid/Check Up recipient an opportunity to have a Fair Hearing for covered services that have been denied, reduced, suspended or terminated. This section also provides any Nevada Medicaid/Check Up provider of services a Fair Hearing for review of an action taken against them. A recipient or provider may choose to request a Fair Hearing when they believe an adverse action taken against them was made incorrectly.

Health Insurance Portability and Accountability Act (HIPAA)

The HIPAA of 1996 was enacted to improve the efficiency and effectiveness of the health care system by adopting standards for the electronic transmission of health care information as well as standards to ensure the privacy and security of personal health information. In general, these regulations require the DHCFP to:

1. develop and maintain policies and procedures regarding HIPAA compliance;
2. conduct employee training to ensure compliance with privacy and security regulations;
3. inform recipients how their information is used and disclosed;
4. provide recipients access to their information; and
5. implement and maintain privacy and security safeguards to protect personal information against unauthorized access or disclosure.

The protection of recipient personal health information is essential to the DHCFP's commitment to respect patient privacy and confidentiality.

Surveillance and Utilization Review (SUR)

SUR is a statewide program to safeguard against unnecessary or inappropriate use of services and prevent excess payments in the Nevada Medicaid and NCU programs. The SUR section develops statistical provider profiles; analyzes claims data; identifies potential fraud, waste, over-utilization, and abuse; conducts preliminary investigations of potential fraud and abuse

based on complaints and referrals; collects provider overpayments; and refers appropriate cases to the Medicaid Fraud Control Unit (MFCU) for criminal investigation and prosecution.

During the 2011 Legislative Session an additional five staff were approved for the SUR section. SUR is now comprised of 14 staff. From July 1, 2011 through June 30, 2012 SUR opened 513 cases and recovered $4,589,878.32 as a result of improper or abusive provider billing.*

Cases reviewed include provider claims for radiopharmaceuticals billed incorrectly, personal care agencies out of compliance with the DHCFP policies, claims with incorrectly reported units, behavioral health companies billing for undocumented services, and providers billing for excessive services not allowed under policy.

*Not all recoupments are identified and collected during the same fiscal year. In addition, some recoupments are done via direct reimbursement from the provider or a negative balance can be established and repayment will be in the form of reimbursement reductions when new claims are processed.

Provider Support

The Provider Support section is responsible for overall problem resolution for both providers and recipients. Staff acts as a liaison between the fiscal intermediary, Emdeon (Third Party Liability vendor) and the DWSS to identify system issues, answer complaints, and resolve Third Party Liability (TPL) inconsistencies. The section also develops policies with regard to Provider Enrollment, National Provider Identifier (NPI), TPL and dual eligibles (individuals eligible for both Medicare and Medicaid). In addition, the section is responsible for issuing notices of Medicaid contract suspension and/or termination when a provider is found to be out of compliance with the rules and regulations of the Medicaid program. Provider suspensions and terminations have steadily increased over the last couple years due to the increased program integrity efforts from the SUR and program sections.

Continuum of Care

The Continuum of Care section is responsible for the implementation and operation of specific State Plan services, home and community-based 1915(c) waiver programs, policy, procedures and support systems for community-based and long-term care services in accordance with Federal and State regulations and divisional goals and objectives. Services administered are designed to address recipient needs and desires to live as independently as possible. The services implemented by the Continuum of Care section are: Home and Community-Based Waivers (HCBW) Operations and Quality; Disability Determinations; Nursing Facilities; Pre-Admission Screening and Resident Review (PASRR); Case Mix; Out-of-State Placements; Intermediate Care Facilities for the Mentally Retarded (ICF/MR); Program Quality Assurance; Home Health; Hospice; Private Duty Nursing; Personal Care Services; Intermediary Service Organizations; Facility Outreach and Community Integration Services (FOCIS); Health Insurance for Work Advancement (HIWA) and the Katie Beckett Eligibility Option. The Continuum of Care section also includes the operations of the four DHCFP District Offices. The Continuum of Care section structure is outlined below.

Waiver Operations Section

The Home and Community-Based Waiver (HCBW) section exercises administrative authority over the Division’s four waiver programs – HCBW for Persons with Mental Retardation or Related Conditions, HCBW for the Frail Elderly, HCBW for Persons with Physical Disabilities and HCBW for Assisted Living. In addition, this section is responsible for Adult Day Health Care Services and Home Based Habilitation Services.

Note: The HCBW for the Elderly in Adult Residential Care merged with the HCBW for the Frail Elderly effective July 1, 2011.

Program and Waiver Quality Section

The Program and Waiver Quality section is responsible for federally required quality assurance for the Division's four waiver programs and for quality reviews of all other programs under the Continuum of Care section.

Facility Care Section

The Facility Care section is responsible for the following programs: Nursing Facilities, Intermediate Care Facilities for the Mentally Retarded, Out of State Placements, Pre-Admission Screening and Resident Review (PASRR) and Case Mix.

Home Care Services Section

The Home Care Services section is responsible for the following programs: Home Health Services, Private Duty Nursing, Personal Care Services, Intermediary Service Organization and Hospice Services.

District Offices

The District Offices implement Medicaid services and programs. District Office staff provide information and referral and care coordination to Medicaid recipients participating in the following programs: Facility Outreach and Community Integration Services (FOCIS), Comprehensive Outpatient Rehabilitation, Waiver for Persons with Physical Disabilities, and the Katie Beckett Eligibility Option. District Office staff also participate in Personal Care Agency reviews and the Case Mix Review Team. Customer Service staff and Health Care Coordinators assist the recipients in accessing medical care.

Health Insurance for Work Advancement (HIWA)

HIWA is designed for employed Nevadans with disabilities who usually do not qualify for Medicaid because of income and/or assets. Participants eligible for Medicaid through the HIWA program receive the same health care benefits as individuals who receive Medicaid under other Medicaid eligibility criteria.

HIWA serves individuals between 16 and 64 who meet Social Security

Disability criteria and are employed or self-employed, meet eligibility requirements established by the State of Nevada and pay a monthly Medicaid Buy-in premium.

Grants Management

The Grants Management section is responsible for researching federal grant opportunities; determining when an opportunity is a good fit for Nevada Medicaid; developing grant applications in collaboration with subject matter experts and submitting them timely to http://www.grants.gov; negotiating grant budgets; receiving and processing grant awards; managing grant activities and the hiring of staff; managing grant contracts and budgets; overseeing the preparation and submission of grant reports to federal funding agencies; and the close-out of grants at the end of the grant period and completion of activities.

The section currently manages two grants:

Nevada Money Follows the Person Rebalancing Demonstration Grant: Grant period from April 1, 2011 to March 31, 2016. The $9.9 million budget and the required Operational Protocol were approved by CMS in August 2011. An additional $400,000 was approved by CMS in December 2011 for an Aging and Disability Resource Center (ADRC) partnership with Money Follows the Person. The grant is under the direction of the Chief of the Grants Management Section. Three staff members conduct the grant activities and include a Project Director, Management Analyst II and an Administrative Assistant II. The staff is working on various projects to achieve five program benchmarks. The benchmarks include building upon the success of the Facility Oversight and Community Integration Services (FOCIS) program to successfully transition eligible individuals in three target groups from qualified institutions to qualified residences; rebalance State Medicaid expenditures for Home and Community Based Services (HCBS) to increase the percent of HCBS expenditures compared to institutional expenditures; rebalance the state's method of nursing home financing through a pilot program with selected counties; integrate multiple data streams into a single, statewide database; and consolidate across the Department of Health and Human Services (DHHS) divisions, the quality assurance efforts to ensure high quality services delivery in administratively efficient, effective, and consistent manner.

Medicaid Incentives for Prevention of Chronic Disease Grant: Grant period from August 1, 2011 to December 31, 2015. Nevada has been awarded nearly $3.5 million over a five-year grant period from the CMS for the Medicaid Incentives for Prevention of Chronic Diseases (MIPCD) Demonstration. The Nevada DHHS recognizes that the prevalence of chronic disease has risen to become a principle problem confronting the healthcare system. The goal for this grant is to encourage participants to use preventive services and adopt healthy behaviors that can potentially improve outcomes and reduce utilization of acute health care services and subsequent costs. Prevention goals for Nevada's MIPCD Demonstration include controlling or reducing weight, lowering cholesterol, lowering blood pressure, and avoiding the onset of diabetes or in the case of a diabetic, improving the management of the condition. The grant is under the direction of the Chief of the Grants

Management Section. A Health Resource Analyst has been hired and is working on various grant projects.

Nevada Check Up

Nevada Check Up is the State of Nevada's Children's Health Insurance Program under Title XXI (CHIP). The program provides health care benefits to uninsured children from low-income families who are not eligible for Medicaid and whose family income is at or below 200% of the Federal Poverty Level.

Information Systems

Information Technology (IT)

The IT section is responsible for technical oversight of the agency's IT resources, information system security, and application development for the Division.

Technical oversight includes the deployment, operation and maintenance of the personal computer and LAN/WAN systems; development of the Agency PC and Network System Plan; approval of all computer hardware/software purchases, hardware/software service contracts and inventories, systems and data security; and the identification and implementation of system solutions to ensure ongoing operations of the agency's information system infrastructure.

The agency has a designated Information Security Officer (ISO) responsible for ensuring appropriate application of the HIPAA Security Rule and protection of personally identifiable information. Satisfaction of these responsibilities is achieved through the development/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/implementation of the Division Information Security Plan and Business Continuity/Disaster Recovery plan.

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

Business Services

These resources provide process analysis and project management support to program staff in support of the MMIS as well as other agency information systems.

The Business Process Management section is comprised primarily of Business Analysts whose purpose is to assist the DHCFP program staff and administration by serving as the subject matter experts in their assigned areas of the system(s) and the Division's business areas. This section is responsible for the enforcement, oversight, coordination, and monitoring of the Change Management (CM) process for the entire systems toolset, commonly referred to as the MMIS, our internally developed business applications, and interfaces with other agencies' systems.

The Project Management Office is responsible for managing projects and contracts related to Medicaid information technology (including the MMIS and peripheral systems) as well as performing research and analysis relating to emerging technologies, systems, initiatives and regulatory changes.

Program Services

The Nevada Medicaid state-wide programs encompassed in this section are: inpatient services (hospitals, ambulatory surgical centers, critical access hospitals and specialty hospitals), outpatient services (therapies, physicians, physician assistants, advanced practice nurses, audiology, ocular, radiology, Federally Qualified Health Center (FQHC), Rural Health Centers (RHC) and laboratory), School Based Child Health Services (SBCHS), Pharmacy, Durable Medical Equipment (DME), Indian Health Services (IHS) and Behavioral Health Services. This section is responsible for the development and implementation of state plans, policies, procedures and support systems in accordance with Federal/State regulations and Division goals and objectives. The section participates in stakeholder education for medical coverage policies, and serves as a liaison with multiple professional associations, advisory groups and other regulatory officials on the interpretation of state policies and procedures for the related services.

For State Fiscal Years 2011 and 2012 Program Services (the Medical Policy) was primarily focused on implementing the immediate policies for the Patient Protection and Affordable Care Act (PPACA). The PPACA has an emphasis on preventive care. To accomplish this, policies were implemented for birthing centers, smoking cessation for pregnant women, aligned preventive policies with the US Preventive Services Task Force (USPSTF), added developmental screens for Early and Periodic Screening Diagnosis and Treatment (EPSDT), and added preventive screens for obesity, alcohol, and depression.

For newborn deliveries, two very important policies were implemented in FY12. To reduce unnecessary c-sections, Medicaid implemented a policy that requires non-medically necessary c-sections to be reimbursed at the vaginal rate. To partner with this policy, an early induction policy was implemented to reduce deliveries of babies born before 39 weeks. These policies will assist Nevada in reducing the frequency and amount of newborns who are born prematurely and use the neo-intensive care units.

Pharmacy costs are beginning to trend upward across the nation regardless of the payor source, primarily due to a price increase in drugs. The largest increase in expenditures is within the therapeutic classes of specialty drugs such as autoimmune, multiple sclerosis, hepatitis, HIV/AIDS, oncology and transplants drugs. Specialty drugs are increasing due to the actual cost of the drugs in the market. They accounted for approximately 15% and 20% of overall drug spend, respectively in FY11 and FY12. Overall initiatives such as the preferred drug list, OBRA and supplemental rebates, and clinical prior authorization continue to assist Medicaid in maintaining a moderate overall expenditure growth.

STATISTICS

Chart I	A list of Medicaid service provider types is provided. Federal law under Early Periodic Screening, Diagnosis and Treatment (EPSDT) (Healthy Kids) requires that children under the age of 21 be given the ability to access all mandatory and optional services with Medicaid coverage. Federally mandated services for the majority of adults are listed with an "M". Those services designated with an "O" are optional covered services which Nevada Medicaid has chosen to cover through its State Plan. This chart also indicates the number of clients served and the amount paid by provider type for SFY 12.
Chart II	Expenditures made through the claims system for services to each provider type in fiscal years 2008 through 2012 are provided. The payments made in each FY are for services that occurred in the current and previous two fiscal years. A summary chart indicating expenditures by major provider categories is provided, along with the percentage increase or decrease over expenditures in the previous year.
Chart III	A summary of Medicaid expenditures by major aid groupings for SFY 2008 – 2012 is provided.
Chart IV	Summary charts are provided, indicating the percent of the total Medicaid population for each eligibility category and the percent of Medicaid expenditures for each eligibility group.

MEDICAID SERVICES - SFY 2012

CHART I – Page 1

Provider #	Federally Mandatory (M), Optional Coverage Area (O), Supports Govt. Program (G), Tribal (T), Intergovernmental Transfer (IGT), Maintenance of Effort (MOE)	Number of Clients Served[1]	Total Medicaid Paid Amount	Name of Service Area
010	M	3,856	$2,966,770.91	Outpatient Surgery, Hosp Based
011	M	27,265	$320,812,673.02	Hospital, Inpatient
012	M	69,610	$28,563,596.69	Hospital, Outpatient
013	O + G*	1,590	$7,317,307.00	Psychiatric, Inpatient
014	O + G*	14,786	$77,175,896.41	Mental Health, Outpatient
015	M	0	$0.00	Rural Health Clinics
016	O	52	$10,225,884.75	IFC-MR/Public
017	M/O	17,764	$6,358,700.58	Special Clinics
019	M/O	5,548	$186,573,708.69	Nursing Facility
020	M	133,998	$100,804,967.36	Physician, M.D., Osteopath
021	O	1,017	$55,254.86	Podiatrist
022	O	54,070	$29,679,119.82	Dentist
023	O	1,096	$344,547.89	Hearing Aid Dispenser/Rel Ltd
024	M	16,076	$1,407,398.40	Certified RN Practitioner
025	O	21,330	$4,654,288.53	Optometrist
026	O	3,462	$3,414,802.42	Psychologist
027	M	9,448	$1,087,047.00	Radiology/Noninvasive Diagnostic Center
028	O	91,943	$124,688,430.17	Pharmacy
029	M	686	$10,319,890.80	Home Health Agency
030	O	6,512	$67,957,496.25	Personal Care Aid-Provider Agency
032	M	13,171	$ 5,563,030.62	Ambulance, Air/Ground
033	M	19,456	$21,709,109.87	DME, Disposable, Prosthetics
034	O	10,930	$9,500,076.03	Therapy
035	M	0	$11,703,625.14	Non-Emergency Transportation

036	O	75	$10,940.68	Chiropractor
037	O	9	$18,645.30	Intravenous Therapy
038	MOE	1,755	$80,330,377.09	Home/Comm Based Waiver-MR or RC (MRRC)
039	O	754	$4,966,764.10	Adult Day Health Center
041	O	3,533	$598,548.72	Optician, Optical Business
042	M	28	$0.00	Outpatient Private
043	M	47,099	$4,066,113.33	Laboratory, Pathology/Clinical
045	O	1,022	$3,452,362.11	ESRD Facility
046	M	6,838	$4,980,553.93	Ambulatory Surgical Center
047	T + G	3,594	$7,794,317.85	IHS and Tribal Clinics
048	MOE	1,551	$3,093,959.62	HCBW for Frail Elderly (CHIP)
052	T + G	0	$0.00	IHS Hospital/Outpatient/Tribal
054	O + G*	25,053	$38,523,557.79	Targeted Case Management
055	O*	11	$460,489.50	Trans Rehab Center, Outpatient
056	M	1,333	$9,597,966.36	Rehab/Specialty Hospitals
057	MOE	660	$5,958,798.20	HCBW for Elderly in Adult Residential Care (WEARC)
058	MOE	591	$3,028,676.39	Physically Disabled Waiver
059	MOE	39	$263,921.75	HCBW for Assisted Living (AL)
060	IGT	8,801	$9,201,853.42	School Based
061	O + G*	2	($600.08)	Mental Health Rehab Service
062	Alternative Delivery System	0	$348,790,440.70	Health Maint Org (HMO)
063	O	753	$37,936,870.93	Residential Treatment
064	O	1,439	$3,186,586.53	Hospice
065	O	596	$6,857,064.91	Hospice, Long Term Care
068	O	59	$7,884,471.58	ICF-MR/Private
072	M	2,365	$510,018.48	Nurse Anesthetist
074	M	62	$5,472.43	Nurse Midwife
075	M	859	$10,225,718.42	Critical Access Hosp/Inpatient

076	O	3,106	$692,375.59	Audiologist
077	M	18,582	$1,712,954.39	Physicians Assistant
082	O	3,898	$28,697,564.66	Mental Hlth Rehab Svc/Non-Res
083	O	453	$4,986,780.82	Pers Care Aid-Inter Serv Org
~		0	$569,751.62	Non-Claims/Non-Categorized
TOTAL		**658,586**	**$1,661,286,940.33**	

NOTES:

Federal law under early periodic screening, diagnosis, and testing (EPSDT) requires that children under the age of 21 be given the ability to access all mandatory and optional services with Medicaid coverage.

*Payments go to State Mental Health agencies; e.g., NMHI, Rural Mental Health Clinics.

FOOTNOTES:

[1]"Number of Clients Served" is not a unique count. A client receiving multiple services will be counted more than once.

Total Medicaid Paid Amount is composed of Medicaid Expenditures only.

PT 35 is a Capitation Payment to the transportation vendor. Vendor provided the count of recipients who utilized the service in SFY 2012.

Expenditures 2008 - 2012 by Expenditure Type

Expenditure Type

	FY08	FY09	FY10	FY11	FY12
Inpatient Hospital	$294,523,202.03	$301,710,445.39	$290,536,214.27	$313,220,767.92	$340,946,648.14
Outpatient Hospital	$46,320,754.42	$32,847,606.23	$38,271,328.06	$41,880,170.43	$40,354,955.99
Physician	$94,759,459.69	$92,352,275.82	$101,711,650.98	$102,458,079.59	$101,616,674.83
Pharmacy	$81,444,395.40	$93,689,080.46	$102,881,072.00	$109,852,458.54	$125,401,091.00
Long Term Care	$165,682,562.60	$176,968,154.20	$179,767,863.04	$186,190,054.68	$193,518,403.60
Mental Health/ Developmental	$66,028,604.79	$111,476,598.68	$107,753,300.25	$82,985,593.55	$104,398,998.42
HMOs	$208,947,730.26	$235,871,819.75	$295,722,879.50	$355,755,946.07	$374,996,657.69
Community Based Services	$80,218,744.15	$77,925,105.39	$78,041,327.49	$84,368,962.15	$91,460,329.79
Dental	$16,084,203.45	$20,129,018.88	$24,429,015.96	$27,907,710.15	$32,812,095.87
Waiver Services	$87,653,853.95	$80,249,821.06	$115,569,957.41	$110,232,523.11	$105,261,624.34
Other Professional Services	$14,010,014.45	$15,535,807.97	$17,405,231.54	$18,053,848.48	$20,599,125.84
All Other Services	$81,004,132.81	$78,120,899.61	$99,080,604.76	$113,608,541.33	$104,937,894.28
Rebates and Recoveries	($39,202,796.98)	($36,402,440.58)	($46,740,488.11)	($63,935,502.22)	($82,383,599.77)
State Totals*	**$1,197,474,861.02**	**$1,280,474,192.66**	**$1,404,429,957.15**	**$1,482,579,153.78**	**$1,553,911,900.02**

* There were fluctuations in MHDS expenditures related to changes in provider enrollment.

**Totals do not match totals in Chart I because Chart II totals include rebates and recoveries.

Percentage Increase Over Prior Year

	FY 2008 to 2009	FY 2009 to 2010	FY 2010 to 2011	FY 2011 to 2012
Inpatient Hospital	2.44%	-3.70%	7.81%	8.85%
Outpatient Hospital	-29.09%	16.51%	9.43%	-3.64
Physician	-2.54%	10.13%	0.73%	-0.82%
Pharmacy	15.03%	9.81%	6.78%	14.15%
Long Term Care	6.81%	1.58%	3.57%	3.94%
Mental Health/Developmental	68.83%	-3.34%	-22.99%	25.79%
HMO	12.89%	25.37%	20.30%	5.41%
Community Based Services	-2.86%	0.15%	8.11%	8.41%
Dental	25.15%	21.36%	14.24%	17.57%
Waiver Services	-8.45%	44.01%	-4.62%	-4.51%
Other Professional Services	10.89%	12.03%	3.73%	14.10%
All Other Services	-3.56%	26.83%	14.66%	-7.63%
Rebates and Recoveries**	-7.14%	28.40%	36.79%	28.85%
Overall	**6.93%**	**9.68%**	**5.56%**	**4.81%**

**The fluctuation in MHDS expenditures is related to the re-enrollment of mental health providers from 2010 through 2012.

FOOTNOTE:

[1] Providers in Mental Health/Developmental Services were required to submit to a re-enrollment process in SFY 2011. A decline in expenditures is due to many providers were found to not qualify to enlist under those provider types.

Medicaid Claim Expenditures

Summary of On-line Medical Expenditures for State Fiscal Years 2008 through 2012 by Aid Group

Expenditures by Aid Group	2008	2009	2010	2011	2012
TANF/CHAP	$336,686,145.00	$372,903,150.00	$456,402,395.00	$528,167,010.00	$543,102,392.00
Aged/Blind/Disabled	$471,517,134.00	$489,812,566.00	$521,963,621.00	$550,283,674.00	$550,176,171.00
Waiver	$49,366,789.00	$49,497,233.00	$43,528,458.00	$47,227,942.00	$32,148,992.00
Child Welfare	$74,417,120.00	$118,609,886.00	$108,318,737.00	$81,090,998.00	$77,728,952.00
QMB/SLMB	$74,422,929.00	$87,764,678.00	$82,837,902.00	$97,462,225.00	$100,025,770.00
Subtotal	**$1,006,410,117.00**	**$1,118,587,513.00**	**$1,213,051,113.00**	**$1,304,231,849.00**	**$1,303,182,277.00**
County Match	$63,274,405.00	$71,091,870.00	$68,003,328.00	$70,215,887.00	$82,369,562.00
TOTAL	**$1,069,684,522.00**	**$1,189,679,383.00**	**$1,281,054,441.00**	**$1,374,447,736.00**	**$1,385,551,839.00**

An online Medical expenditure is one that is paid through the Medicaid Management Information System (MMIS). An offline expenditure is one that is not paid through the MMIS but is paid only through the State's Integrated Financial System (IFS). These expenditures are not claims based, but are financial transactions, and are therefore not categorized by aid group.

Annual Average Monthly Eligibles (w/retro) by Aid Group	2008	2009	2010	2011	2012
TANF/CHAP*	117,821	133,432	171,222	204,551	224,325
Aged/Blind/Disabled	34,233	35,538	37,936	40,536	42,558
Waiver**	3,638	3,624	3,687	3,860	3,906
Child Welfare	7,492	7,534	7,556	7,453	7,190
QMB/SLMB	14,194	15,502	16,890	19,903	23,700
Subtotal	**177,378**	**195,629**	**237,292**	**276,304**	**301,679**
County Match	1,419	1,425	1,397	1,373	1,448
TOTAL	**178,799**	**197,054**	**238,689**	**277,677**	**303,127**

*2012 TANF Caseloads include eligible retro's.**Waiver caseloads are sourced from CLEO.

Average Cost Per Eligible (without reduction for state facilities)**	2008	2009	2010	2011	2012
Category 12	$238.13	$232.89	$222.13	$215.17	$201.75
Category 14	$939.41	$928.34	$925.33	$897.86	$830.09
Category 15**	$1,130.94	$1,138.16	$983.76	$1,019.62	$1038.30
Category 17**	$3,716.99	$4,156.20	$4,057.24	$4,260.93	$3,790.78
Category 19	$827.71	$1,311.98	$1,194.58	$906.65	$900.90

NOTES:

*Categories represent subdivisions of budget account 3243 and contain a group or groups of aid categories. Category 12 contains TANF/CHAP recipients. Category 14 contains Aged, Blind, Disabled, and QMB recipients. Category 15 contains Waiver-eligible recipients who are a subset of the Aged, Blind, and Disabled population. Category 17 contains County Match recipients. Category 19 contains Child Welfare recipients.

**As a result of SB485, SFY12 expenditures have been adjusted to reflect a true Cost Per Eligible (CPE).

Medicaid Claims Expenditures
Percent of Costs vs. Percent of Caseload

OVERALL % of COSTS	2008	2009	2010	2011	2012
TANF/CHAP	31.48%	31.34%	35.63%	38.43%	39.20%
Aged/Blind/Disabled	44.08%	41.17%	40.74%	40.04%	39.71%
QMB/SLMB	6.96%	7.38%	6.47%	7.09%	7.22%
Waiver	4.62%	4.16%	3.40%	3.44%	2.32%
County Match	5.92%	5.98%	5.31%	5.11%	5.94%
Child Welfare	6.96%	9.97%	8.46%	5.90%	5.61%
TOTAL	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**

OVERALL % of CASELOAD	2008	2009	2010	2011	2012
TANF/CHAP	65.90%	67.71%	71.73%	73.67%	74.00%
Aged/Blind/Disabled	19.15%	18.03%	15.89%	14.60%	14.04%
QMB/SLMB	7.94%	7.87%	7.08%	7.17%	7.82%
Waiver	2.03%	1.84%	1.54%	1.39%	1.29%
County Match	0.79%	0.72%	0.59%	0.49%	0.48%
Child Welfare	4.19%	3.82%	3.17%	2.68%	2.37%
TOTAL	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**

FAQs

Q1 What is Medicaid?

A1 Medicaid is a Federal-State health insurance plan for low-income and needy citizens. Nationally, Medicaid helps over 62 million individuals including children; older citizens, blind and/or disabled people, and people eligible to receive federal-assistance income maintenance payments. Medicaid funds nearly half of all nursing home care.*

**Medicaid recipient data from Fed Fiscal Year 2009 Kaiser www.statehealthfacts.org.*

Q2 Why does Medicaid vary from state to state?

A2 Medicaid is an optional medical coverage program that states elect to provide to their residents. Federal regulations define mandatory and optional groups and services to be covered. States determine which optional groups and services they want to cover and how they want to operate their program. Because of these state choices, Medicaid varies from state to state.

Q3 How can I receive Long Term Care (LTC)?

A3 There are several LTC Programs available to potential clients. They include Home and Community Based Services (services in the home) and placement in nursing and alternative care facilities. Eligibility is based on financial criteria and the recipient meeting the level-of-care (service eligibility) for these programs.

Q4 What are the income requirements used for Medicaid eligibility?

A4 Due to the differences from state to state, the maximum income level allowed differs depending on where you live. Income, assets, and other resources are the primary considerations that determine eligibility and coverage. Once coverage is determined, Medicaid generally pays expenses for (up to) three months prior to application. Some states impose nominal deductions, co-insurance, or co-payments on some Medicaid recipients.

Q5 Can Medicaid pay for Medicare charges?

A5 Medicaid pays the deductibles, co-insurance payments, and premiums for Part A, Part B, and Part D of the Medicare plan for low-income individuals. These people are called "Qualified Medicare Beneficiaries" or QMBs.

Q6 What are the income and resource levels for Medicaid?

A6 The Income cap states “limit income to three times the SSI benefit level”. In 2013 the benefit level is $710.00 per month, and the income cap is $2,130.00. No spend down is allowed and any excess will disqualify the individual in these states.

For resources, Nevada uses the Federal SSI levels. For 2013, these limits were $2,000 for an individual and $3,000 for a married couple.

Q7 Will Medicaid pay for my Medicare premiums and deductibles?

A7 *Medicaid pays the deductibles, coinsurance and premiums for Medicare Part A, Part B, and Part D for low income persons. These individuals are called "Qualified Medicare Beneficiaries" or QMB's.*

Q8 Can Medicaid place a lien on property or recover against an estate?

A8 *Aside from the resource rules described above, there are many exemptions, the largest being a home. However, Medicaid may impose a lien on a recipient's property under certain limited circumstances. States are also required to seek recovery from estates of Medicaid recipients. There are complex rules on estate recoveries.*

Q9 Are adult children responsible for the medical bills of their parents?

A9 *In determining Medicaid eligibility of an adult, Federal law does not permit states to use the income or resources of non-spouses. States cannot collect reimbursement from adult children of these relatives or the recipient.*

Q10 Are well spouses legally responsible for Medicaid expenses of an ill spouse?

A 10 *Federal Medicaid law permits states to "deem" the income and resources of the well spouse as available to the sick spouse. The extent of this "deeming" depends on whether the sick spouse is at home or institutionalized. States also vary in how they apply these deeming rules. In Nevada the deeming rules do not apply. When there is a community spouse and an institutionalized spouse, there are Federal guidelines as to both income and resources and how they are considered.*

Q11 What is Medicaid Managed Care?

A11 *Medicaid Managed Care is a system of providing health care benefits to Medicaid clients through one doctor, organization or clinic.*

A Health Maintenance Organization (HMO) is a health plan that provides comprehensive health care services to those enrolled Medicaid clients who have chosen their plan. A HMO emphasizes preventive health care along with providing acute medical treatment.

Q12 What does managed care mean and why do I need to select a Managed Care Plan?

A12 *Being in a managed care plan means when a person needs health care they will always go to their primary care provider (PCP) first. This person or place is responsible for coordinating all health care needs for their clients, including referrals to specialists. You will only be able to go to a certain pharmacy, use a certain home health provider, a certain hospital and a certain durable medical equipment vendor.*

Q13 What do I do if I am out-of-state and need Medicaid benefits?

A13 If you are temporarily out of state, but still a resident of Nevada, you may receive some Medicaid benefits under some conditions:

1. *It is a medical emergency.*
2. *Your health would be endangered if you were required to return to Nevada for the medical care/treatment.*

The doctor/hospital that treats you must enroll in the Nevada Medicaid Program in order to obtain reimbursement.

DIVISION OF HEALTH CARE FINANCING AND POLICY
FACT BOOK
NEVADA CHECK UP

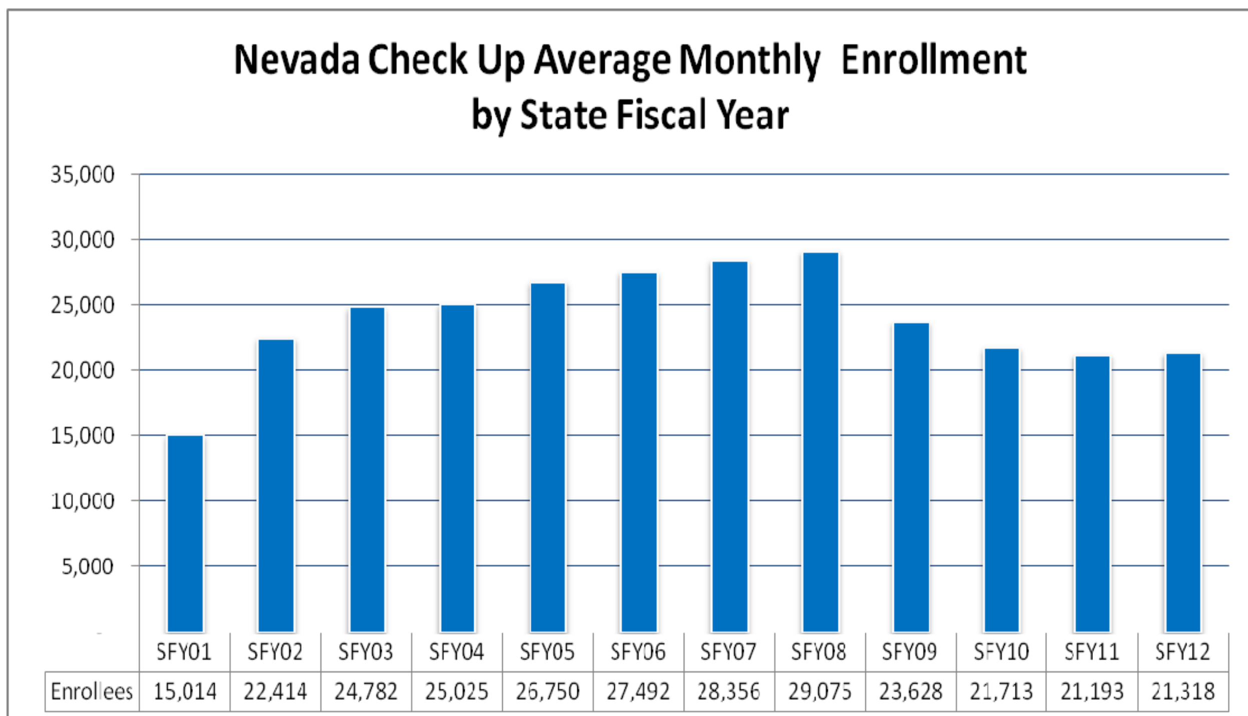
Background

The Children's Health Insurance Program (CHIP) was established by Congress to provide access to affordable health insurance to children in working, low-income families. The enabling legislation for CHIP, included in the Balanced Budget Act of 1997, made almost $40 billion available nationally over a 10-year period for this program. In 2009 through the Children's Health Insurance Program Reauthorization Act (CHIPRA) Congress provided for continuation of the Program. In 2010 the Patient Protection and Affordable Care Act (Health Care Reform) enacted maintenance of effort requirements for continuation of eligibility standards for children until October 1, 2019.

Nevada Check Up (NCU) is the name of the CHIP program in Nevada. Like Medicaid, CHIP is a joint federal-state program, with funding from both sources, and it is implemented by each state. States have options for administration of these programs, organization and definition of benefit plans. Currently, this program is defined as "Secretary approved," which means the Secretary of the Department of Health and Human Services determined that appropriate coverage is provided under the program.

The NCU program chose to adopt the basic Medicaid State Plan for service options with some minor exceptions. The Medicaid provider network and Medicaid-contracted HMOs (in the urban areas of Nevada) were also adopted for provision of services to eligible children. NCU recipients are mandated to receive treatment under an HMO in the urban areas of the state.

NCU began providing services to children on October 1, 1998. The chart below illustrates actual annual average monthly enrollment for the program, from its inception.



	SFY01	SFY02	SFY03	SFY04	SFY05	SFY06	SFY07	SFY08	SFY09	SFY10	SFY11	SFY12
Enrollees	15,014	22,414	24,782	25,025	26,750	27,492	28,356	29,075	23,628	21,713	21,193	21,318

The 1996 U.S. Census Bureau estimated 45,000 of Nevada's uninsured children fell under 200% of the federal poverty level. The Current Population Survey reported the 2011 number to be estimated at 79,000.

The federal government provides 69.34% (based on the Federal Fiscal Year 2012) of NCU expenditures and the state provides 30.66% of these costs. In SFY 2013, the blended FMAP is projected to increase to 71.20% for the Federal share and the state share decreases to 28.80%. (2014 is project to increase further to 72.66%/27.34%) Nevada's Medicaid match with federal funds is lower; so, with enrollment of qualified children, NCU provides a more advantageous match for the state, maximizing state funds.

Eligibility

Uninsured children in households where the family income is up to 200% of the Federal Poverty Level may qualify for NCU if they meet all the eligibility requirements. NCU eligibility requirements include: the child is not eligible for Medicaid; has not had private health insurance for the last six months or has recently lost insurance for reasons beyond the parents' control; does not have access to State Public Employee Benefits: the family's gross income meets federal guidelines, and the child is a U.S. citizen or "qualified alien." (Legal residents must have five years residency; applying for NCU will not affect a family's immigration status.)

Eligibility determinations are completed at the central office of NCU in Carson City and District Offices in Reno and Las Vegas.

1. Families complete a simple application and submit it with proof of income and other required documentation.
2. Eligibility workers review the application, calculate an estimated annual income for the family and determine eligibility.
3. Employees of public agencies who are eligible for the state employee benefit program are not eligible for enrollment in this program. This includes those who are employed 21 or more hours per week, and therefore eligible to access benefits, even if they cannot afford the cost. Those defined currently as *public agencies* include any agency/board that subscribes to the Public Employee Benefit Program (PEBP), e.g., University of Nevada, Las Vegas and Reno, some school district employees, some county/city/state retirees, Rural Housing Authority, Department of Transportation, etc.
4. When all requirements are met, the children are enrolled and the family is notified of the current premium due.
5. The children's coverage usually begins the first day of the next administrative month, following the date of the initial determination. Unlike Medicaid, NCU does not offer prior medical assistance.

Re-determinations

Federal regulations require that households be reviewed annually to ensure continuing eligibility for CHIP.

In order to comply with this requirement, documents are prepared from information in NCU's database and sent out to the participating families. They are asked to update their information including residency, family composition and employment, and to return the documents to NCU along with current income verification. When processed by eligibility staff, the re-determination

process will result in the family's continuation with NCU, a referral to Medicaid, or disenrollment if they no longer meet the eligibility criteria for NCU. Notification of the outcome is then sent to the participating family.

Medicaid Referrals

New applicants who appear eligible for Medicaid are denied for NCU and their application is forwarded to the DWSS for determination. Once a Medicaid determination is made, the children are either enrolled in Medicaid, or denied Medicaid and referred back to NCU. If the family fails to cooperate with DWSS, the children are not eligible for NCU. Current NCU enrollees are also screened for Medicaid eligibility during their annual re-determination. If the existing case appears eligible for Medicaid they are disenrolled from NCU, and their application information is forwarded to the DWSS for a determination. The family must cooperate with the Medicaid determination process.

Services Provided

NCU's benefit coverage mimics Medicaid except for non-emergency transportation and includes the following health care services:

Inpatient Hospital	Ambulance	X-ray	Well Baby/Well Child Care
Outpatient Hospital	Dental	Physician Services	Therapies
Mental Health	Vision	Prescription Drugs	Immunizations
Chiropractic	Home Health	Hearing Aids	Laboratory Services

Upon recommendation of the primary care physician, other services may be available.

Expenditures

For the fiscal year ending June 30, 2012, NCU medical expenditures totaled $34,560,437.67.

Premiums

The only cost to the NCU participant is a quarterly premium. Participants are not required to pay co-payments, deductibles, or other charges for covered services. Premiums are determined by family size and income. They are charged per family, not per child.

For American Indian Families who are members of federally recognized tribes, or an Eskimo, Aleut or other Alaska Native enrolled by the Secretary of the Interior, quarterly premiums are waived. To have the premium waived these families provide a copy of their tribal affiliation.

Family of two	Quarterly Premiums	Total Annual Premiums	Family of Three	Quarterly Premiums	Total Annual Premiums
Up to $21,000	$25	$100	Up to $26,400	$25	$100
$21,001-$24,500	$50	$200	$26,401-$30,800	$50	$200
$24,501-$28,000	$80	$320	$30,801-$35,200	$80	$320

Family of Four	Quarterly Premiums	Total Annual Premiums	Family of Five	Quarterly Premiums	Total Annual Premiums
*Up to $31,800	$25	$100	*Up to $37,200	$25	$100
$31,801- $37,100	$50	$200	$37,201- $43,400	$50	$200
$37,101- $42,400	$80	$320	$43,401- $49,600	$80	$320

Applications for NCU are available statewide at various locations, including Family Resource Centers, schools, Boys & Girls Clubs, DWSS offices and others. Applications can also be obtained by calling (877) 543-7669, or by visiting the website: www.nevadacheckup.nv.gov. Both English and Spanish applications are available.

RELATED WEBSITES

http://www.cms.hhs.gov/apps/glossary/default.asp?Letter=Q&Language=English

http://www.professorbeyer.com/Articles/Medicaid_FAQ.pdf

http://www.seniorlaw.com/medicaidfaq.htm

General Medicaid questions:

http://www.cms.hhs.gov

Medicaid Managed Care questions and other questions:

http://www.kff.org/medicaid/managedcare.cfm

http://www.medicaid.nv.gov

http://www.kff.org/content/2003/2236/