

**DIVISION  
OF  
HEALTH CARE  
FINANCING AND POLICY**



**MEDICAID AND NEVADA CHECK UP  
FACT BOOK**

**JANUARY 2009**

**DIVISION OF HEALTH CARE FINANCING AND POLICY  
FACT BOOK  
MEDICAID PROGRAM**

**MISSION**

The mission of the Nevada Division of Health Care Financing and Policy 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 Welfare Division. During the 1997 legislative session, the Division of Health Care Financing and Policy (DHCFP) was created. The division has 246 staff with offices in Carson City, Las Vegas, Reno, and Elko. DHCFP administers two major federal health coverage programs (Medicaid and State Health Insurance for Children Program or S-CHIP) which provide 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 SCHIP program in Nevada is known as Nevada Check Up, and provides healthcare coverage to low-income, uninsured children who are not eligible for Medicaid.

**NEVADA MEDICAID**

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. Title XIX of The Act is a program that 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 to assist states in the provision of adequate medical care to eligible needy persons. Medicaid is the largest program providing medical and health-related services to America's poorest people.

Responsibility for administering the Medicare and Medicaid programs was entrusted to the Department of Health, Education, and Welfare - the forerunner of the current Department of Health and Human Services (DHHS). Until 1977, the Social Security Administration (SSA) managed the Medicare program, and the Social and Rehabilitation Service (SRS) managed the Medicaid program. Duties were then transferred from SSA and SRS to the newly formed Health Care Financing Administration (HCFA), which is now known as the Centers for Medicare and Medicaid Services (CMS).

Within broad Federal guidelines, states determine eligibility and the amount, duration, and scope of services offered under their Medicaid programs, sufficient to reasonably achieve its purpose. States may place appropriate limits on a Medicaid service based on such criteria as medical

necessity or utilization control. For example, states may place a reasonable limit on the number of covered physician visits or may require prior authorization be obtained prior to service delivery.

With certain exceptions, a state's Medicaid plan must allow recipients freedom of choice among health care providers participating in Medicaid. States may provide and pay for Medicaid services through various prepayment arrangements, such as a health maintenance organization (HMO). In general, states are required to provide comparable services to all categorically needy eligible persons.

There is an important exception to the State plan related to home and community-based service "waivers" under which states offer a service package for persons who would otherwise be institutionalized under Medicaid. The Secretary of DHHS must "waive" selected sections of the Act for states to implement such programs. This is described under Section 1915 (c) of the Social Security Act. States are not limited in the scope of services they can provide under such waivers, as long as they are cost effective and medically necessary. Cost effectiveness is determined based on the cost of institutional care for an individual covered by the waiver services. An exception allows that, other than as a part of respite care, states may not provide room and board for such recipients.

The Medicaid program pays for medical and medically-related services for persons eligible for Medicaid. The federal legislation specifies required eligibility categories, minimum service requirements for eligible persons and some payment rate methods states must meet to be eligible for Federal Financial Participation (FFP). The law also specifies additional categories of eligible persons and services which states may adopt and receive federal Medicaid funds.

School districts and other governmental entities providing medical services and having a Medicaid contract provide the non-federal share of the Medicaid cost incurred by the school districts or other governmental entity. The Medicaid program transfers the federal share of the Medicaid allowable costs to the local school districts.

In State Fiscal Year 2008, Nevada Medicaid covered an average of 180,347 individuals including pregnant women, children, the aged, blind, and/or disabled, and people who are eligible to receive federally assisted income maintenance payments. Service reimbursement may be offered either through a fee-for-service model or under a managed care contract, or a combination of both. Nevada Medicaid administers both fee-for-service and managed care programs.

## **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 have broad discretion in determining which groups the Medicaid programs will cover and the financial criteria for Medicaid eligibility. For further detail, please see the Division of Welfare and Supportive Services 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 Optional Eligibility Categories in Nevada Medicaid:

1. Federal changes allow Nevada to provide 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 are known as participants in 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 poor 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, even for very poor persons, 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 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 (Title XVIII of the Act) 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 type of Medicaid benefit.

The Medicare Modernization and Improvement Act (MMA) conveyed prescription drug benefits to Medicare beneficiaries under the newly created Part D beginning January 1, 2006. At this time, State Medicaid agencies discontinued prescription drug coverage for full-benefit dual eligibles (beneficiaries receiving both Medicare and full Medicaid). States may offer wrap-around coverage for the small co-payments required of this population. However, that coverage will likely be administered by State Pharmaceutical Assistance Programs (such as Nevada's Senior Rx) rather than by Medicaid agencies since the MMA allows only State dollars to be used for this purpose.

The transfer of prescription drug coverage for dual eligibles from Medicaid to Medicare will not reduce the amount of federal money that States receive for Medicaid. Instead, the MMA

includes a provision called the phased-down state contribution (aka 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 will be based on a complex formula that considers 2003 per capita prescription drug costs, national growth factors, and enrollment of full-benefit dual eligibles.

More detailed information about the impact of Medicare Part D on States is available in DHCFP's MMA White Paper.

## **MEDICAID SERVICES**

### Federally Mandated Medicaid Services

Title XIX of the Social Security 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 nursing facility 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. EPSDT (early and periodic screening, diagnosis, and treatment) Services, for individuals under age 21. It is a preventive health care program. The goal is to provide to Medicaid-eligible children under the age of 21 the most effective, 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. 42 U.S.C. Section 1396d (a) (4) (B). (Recipients eligible under the pregnancy-related only category are not eligible for this service) 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 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. hospice.

Nevada Medicaid also operates five waivers, authorized by the Secretary of the Federal 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 services, respite care services, adult day health services, homemaker/home health aide, habilitation, and other services requested by the state and approved by CMS.

1. Home or community-based services (HCBS) offered to certain persons with mental retardation and related conditions throughout the state;
2. Home and community-based services offered to certain frail elderly persons throughout the state;
3. Home and community-based services offered to certain elderly in adult residential care throughout the state;
4. Home and community-based services offered to certain physically disabled persons throughout the state.
5. Home and community-based services offered to certain elderly in affordable assisted living facilities throughout the state.

## **DIVISION FUNDING**

### Federal Funding

Funding for the Medicaid program comes from the following sources:

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 Medicaid Management Information System (90%).

The second portion of FFP is for medical assistance payments referred to as FMAP. FMAP is evaluated annually based on the per capita income of Nevada. The blended FMAP for State Fiscal Year, 2007 (SFY 2007) was 53.93% and SFY 08 was 52.64%. Enhanced FMAP is available for family planning services (90%) payment to Indian Health Services (100%) and coverage of individuals under the Breast and Cervical Cancer program (65%).

Supporting Local Government

### **Disproportionate Share Hospital (DSH) Program**

The Disproportionate Share Hospital (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 NRS 422.380 – 387 and the State Plan for Medicaid. This methodology was developed based on a study completed by the Legislative Committee on Health Care and includes certain minimum payment guarantees to several Nevada hospitals, including rural hospitals.

### **Upper Payment Limit (UPL) Program**

The Upper Payment Limit (UPL) program is an optional part of federal Medicaid regulations. These regulations allow states to make supplemental payments to non-state, government owned hospitals (i.e. county or municipal hospitals). The Nevada formula for these payments is authorized pursuant to the Medicaid State Plan. This methodology includes calculating the difference between Medicaid reimbursements and an estimate of what Medicare would have paid for these same services. That amount is then distributed to qualifying hospitals based on Medicaid bed days.

### **County Match**

County Social Service Agencies pay the non-federal portion of costs associated with institutionalized individuals with income over 156% and at or less than 300% of the Supplemental Security Income (SSI) rate.

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**

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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 Division of Welfare and Supportive Services has the general fund in their budget for administrative (eligibility) services.

### **Nursing Facility Provider Tax Program**

The Nursing Facility Provider Tax program (also know 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. Due to a recent change in federal regulations, this amount declines to 5.5% of revenues in October 2007. The proceeds of the tax are placed in a special fund and then used to provide enhanced Medicaid rates to facilities. This has resulted in a statewide average rate increase of \$44 per bed day (from \$122 before the tax to \$166 after).

### **DIVISION UNITS and PROGRAMS**

**Administration** The Administrator is responsible for and oversees the Deputy Administrator, Administrative Services Officer IV, the Compliance 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, and liaison with state agencies, community and legislature, supervision of professional and administrative support staff. The Administrative Services Officer 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 and Information Services direct their respective units. 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 Finance and Accounting Services**

The Accounting Unit is responsible for cash receipts, including deposits and federal draws for Medicaid Title XIX, SCHIP Title XXI and all other grants (Medicaid Infrastructure Grant, Robert Wood Johnson, etc.). The Accounting Unit 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. The Accounting Unit also completes quarterly Federal reports (CMS 64, 21, 37 and 21B).

### **Budget**

The Budget Unit is responsible for the development, analysis and completion of the biennial budget for Medicaid (BA 3243), Check Up (BA 3178), DHCFP Administration (BA 3158), Intergovernmental Transfer (BA 3157) Institutional Care - Medical Indigents (BA 3246) and Fund to increase the Quality of Nursing Care (BA 3160). The Budget Unit 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.

### **MMIS Finance/Fiscal Analysis**

The MMIS Finance/Fiscal Analysis Unit 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 unit performs fiscal analysis for legislative fiscal notes, in response to external requests for information, and to support accounting and budget operations. The HIFA fiscal function and the contract function are also in this unit.

### **Personnel**

The Personnel Unit 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, PEBP, and PERS, personnel database management, records and files management, workers' compensation, position classification, and support for supervisors and staff in interpreting rules and regulations.

### **Medical Finance Unit**

The Medical Financial Analysis Unit provides technical expertise on medical finance. Their primary functions are reimbursement rate setting, collection and reporting of provider finances, claims data analysis, and medical costs forecasting. This includes both fee for service and managed care rate setting. The Unit is divided into three sections.

The Provider Reimbursement group focuses on 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 also conduct reimbursement workshop with providers and draft State Plan amendments pertaining to rate methodologies.

The Provider Cost Reporting group 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 unit calculates DSH and UPL supplemental payments, provider taxes and other cost based reimbursements.

The Data Analysis and Forecasting group provides technical expertise to analyze provider claims data. They provide forecasting expertise to project the medical costs of program initiatives. This group consists of DSS power users who perform many of the MMIS analysis and ad hoc reporting needs of the division. They produce the MPP and CPP aggregate Medicaid and Check Up expenditure forecasts quarterly. They also project Check Up caseload forecasts.

**Compliance**

The Compliance Unit oversees the development of division policy with respect to the provision and delivery of items and services; provides information about access, items, services and processes of Medicaid assistance to our customers; preserves and maintains the financial integrity of the Medicaid program; detects fraud, waste, over-utilization, and abuse in the Medicaid program, and ensures and opportunity for Fair Hearings.

**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 the Department of Health and Human Services employees.

**Medicaid Estate Recovery**

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 Statutes 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 and Policy**

The Hearings Unit provides any Nevada Medicaid/Check Up recipient an opportunity to request a Fair Hearing for covered services that have been denied, reduced, suspended or terminated. This unit 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 the action taken against them was made incorrectly. Changes made to the Medicaid Services Manual and the Medicaid State Plan are reviewed and monitored by the Hearings Unit.

### **HIPAA**

HIPAA stands for 'The Health Insurance Portability and Accountability Act of 1996' and was enacted to improve the efficiency and effectiveness of the health care system by adopting standards for the electronic submission 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 provide quality care and service to Medicaid and SCHIP recipients.

### **Surveillance and Utilization Review (SUR)**

Surveillance and Utilization Review (SUR) is a statewide program to safeguard against unnecessary or inappropriate use of services and prevent excess payments in the Nevada Medicaid and Nevada Check Up programs. The SUR Unit 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.

### **Provider/Recipient Support**

The Provider/Recipient Support unit is responsible for resolution of eligibility discrepancies due to system interfaces and overall problem resolution for both providers and recipients. Staff acts as a liaison between the fiscal intermediary, HMS, Welfare, and NOMADS to identify system issues and answer complaints. The unit also develops policies with regard to Provider Enrollment, National Provider Identifier (NPI), Third Party Liability, Dual Eligibles and Appeals.

The Rural Health Specialist serves as a liaison for the Native American Tribal Clinics, as well as Critical Access Hospitals, Federally Qualified Health Centers and Rural Health Clinics, assisting as provider support, resolving eligibility issues, and providing information on available programs.

Provider Support works to ensure quality health coverage is achieved through collaboration with Indian Health Services, the federal agency designated to aid Native Americans in obtaining the health services due to them.

### **Payment Error Rate Measurement (PERM) Program**

The Payment Error Rate Measurement (PERM) program measures the accuracy of payments made for services rendered to Medicaid and SCHIP (Nevada Check Up) recipients. This is a federal program mandated for all states by the Office of Management and Budget (OMB) and administered by the Center for Medicare and Medicaid Services (CMS). In order to measure payment accuracy, comprehensive system processing, medical record and eligibility reviews are conducted for each state once every three years. The medical record and system processing reviews are completed by federal contractors. States are responsible to complete the eligibility reviews. After compiling the results of all reviews for all states in the three year cycle, CMS develops a national error rate for each program and reports this information to Congress. To prevent future payment errors, states are required to develop and implement corrective actions for all problems discovered during PERM reviews.

### ***Continuum of Care***

The Continuum of Care Unit is responsible for the implementation of State Plans, Waiver programs, policy, procedures, and support systems for community-based and long-term care services. All the services administered are designed to provide an array of services addressing recipient needs and desires to live as independently as possible. The Unit ensures compliance with applicable State and Federal regulations and supports Division goals and objectives.

### **Waiver Unit**

The Home and Community Based (HCB) Waiver Unit exercises administrative authority over the Division's five waiver programs – Mental Retardation and Related Conditions, Home and Community Based Waiver for the Frail Elderly, Elderly in Adult Residential Care, Persons with Physical Disabilities, and Assisted Living. In addition, the HCB Waiver Unit operates the Waiver for Persons with Physical Disabilities.

### **Facilities Based Services**

This unit is responsible for the following programs: Nursing Facilities, Adult Day Health Care, Hospice, Intermediate Care Facilities for the Mentally Retarded and Facility Outreach and Community Integration Services (FOCIS).

### **Home Health Care Services**

The unit is responsible for the following programs: Home Health Services, Private Duty Nursing, Personal Care Services, and the Comprehensive Outpatient Rehabilitation Programs.

### **District Offices**

The District Offices operationalize Medicaid services and programs. District Office staff provide Information and Referral and Care Coordination to recipients participating in the following programs: Facility Oversight and Community Integration Services (FOCIS), Comprehensive Outpatient Rehabilitation, Waiver for Independent Nevadans (WIN), and the Katie Beckett Eligibility Option. District Office staff also participate in Personal Care Agency reviews and the Case Mix Review Team.

### **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 programs.

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.

### ***Nevada Check Up and HIFA Waiver*** **Nevada Check Up**

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

Nevada also has a Health Insurance Flexibility and Accountability (HIFA) waiver, a demonstration project authorized under section 1115 of the Social Security Act and funded under Title XXI (SCHIP). The Nevada HIFA waiver program includes two eligibility groups and is intended to increase coverage of uninsured individuals within the State of Nevada. One coverage group comprises uninsured pregnant women who do not qualify for Medicaid and whose net annual income is above 133% and up to and including 185% of the Federal Poverty Level (FPL). This group receives pregnancy-related services outlined in the Medicaid Services Manual and uses the Nevada Medicaid Provider Panel. The Division of Welfare and Supportive Services determines eligibility for this program.

The second coverage group comprises parents, caretaker relatives, and legal guardians whose income is at or below 200% of FPL, who work for a qualified small employer offering a creditable insurance plan where the contribution by the employer is not less than 50% of the total monthly insurance premium. Once eligible, members of this group receive a subsidy reimbursement of up to

\$100 toward their monthly premium for health care insurance. The Division of Health Care Financing and Policy determines eligibility for this program.

**Information  
Systems**

**Information Technology**

The IT Unit is responsible for the administrative oversight, deployment, operation and maintenance of the personal computer and LAN/WAN systems for the division. This includes the 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 Agencies information system infrastructure.

**Medicaid Management Information System (MMIS)**

MMIS is currently involved in supporting a Medicaid Management Information System. This unit provides oversight, monitoring, data change / updates and release control for each of our information systems (MMIS, NCU, and HIWA). The Decision Support and System Change Management (DSS/SCM) Section is charged with producing information for the division upon request (reports), and controlling any changes to the MMIS system.

**Managed Care  
/ Business  
Lines**

DHCFP contracts for delivery of health care through managed care organizations for certain Medicaid and Nevada Check Up populations. The objectives for the program are to improve access and coordination of care while managing the cost of services.

Enrollment in a managed care plan is mandatory in Clark and Washoe counties for the TANF/CHAP and Nevada Check Up populations. Services provided through the managed care plans include dental, as well as, medical care. Combined statewide Medicaid and Nevada Check Up enrollment is over 200,000 members.

Among the services covered in the Nevada Medicaid Managed Care contract are; all inpatient services (hospitals, ambulatory surgical centers and specialty hospitals), outpatient services (therapies, physicians, physician assistants, advanced practice nurses, audiology, ocular, radiology, laboratory), Dental, Pharmacy, Durable Medical Equipment and all Behavioral Health Services.

In the last year, the Managed Care unit successfully rebid its managed care contracts. Health Plan of Nevada was chosen to continue providing services to Nevada Medicaid and Nevada Check Up recipients. Anthem Blue Cross Blue Shield Partnership Plan was added as a new vendor. The contract incorporates key elements of Nevada Medicaid's Behavioral Health Redesign including out-patient or rehabilitative mental health services using an integrated wraparound model. The contract also expands the very successful dental HMO program in Washoe County. It also ensures that Nevada's Medicaid managed care plans work to increase immunization rates for children.

The new managed care contract also includes an innovative Pay-for-Performance Program which incentivizes managed care plans to increase dental and well-child visits, and also provide best-practice treatments for children with asthma.

On November 1, 2006 DHCFP has re-procured MCO contracts and specified the following HEDIS measures;

HEDIS measures:

- Annual Dental Visit,
- All three Well-Child Visit measures, and
- Childhood Immunization Status Combination 2.

The Managed Care Unit also oversees a very successful non-emergency transportation broker contract. The contract is with LogistiCare, which provides transportation to medically necessary covered services statewide 24 hours a day, seven (7) days per week, including weekends and holidays. Over the last year, LogistiCare has arranged almost 30,000 trips a month, and has maintained a very low complaint rate of less than one half of one percent.

**Program  
Services**

The Nevada Medicaid state-wide programs encompassed in this unit are: all inpatient services (hospitals, ambulatory surgical centers and specialty hospitals), outpatient services (therapies, physicians, physician assistants, advanced practice nurses, audiology, ocular, radiology, and laboratory), Pharmacy, Durable Medical Equipment and all Behavioral Health Services. This unit is responsible for the development and implementation of state plans, policies, procedures and support systems in accordance to Federal and State regulation and in accordance to divisional goals and objectives. The unit participates in provider education for policy and reimbursement procedures, 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.

After experiencing an increase in overall drug expenses of 21.6% in 2004, the Nevada Medicaid program was able to reduce the annual increase to 2.5% in 2005. According to the Kaiser Foundation, drug costs were expected to increase nationally at 10.7%. A recent Kaiser Foundation survey of Medicaid programs in other states revealed an estimated annual increase of 14.3% for 2005.

These significant cost savings are the result of three strategic initiatives: developing a Preferred Drug List, collaborating with the Nevada Medicaid Drug Use Review Board, and implementing the State Maximum Allowable Cost program.

Nevada Medicaid implemented the Behavioral Health Redesign that was funded during the 2005 Legislative session.

In addition, policies, procedures, and rate methodologies for mental health rehabilitative services were redefined for Nevada Medicaid and Check Up, to align with goals of the State, Legislature, providers, families, and recipients. Nevada Medicaid has not received approval at this time from CMS.

**STATISTICS**

- Chart I List of Medicaid service provider types. All services are mandatory for children if referred from an EPSDT (Healthy Kids) screening. 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 FY 08.
- Chart II Expenditures made through the claims system for services to each provider type in fiscal years 2003 through 2008 are provided. The payments made in each FY are for services paid for 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 the previous year.
- Chart III A summary of Medicaid expenditures by major aid groupings for FY 03 through FY 08 is provided.
- Chart IV The percent of the total Medicaid population for each eligibility category is given. The percent of the Medicaid expenditures for each eligibility group is given.

**MEDICAID SERVICES - SFY 2008**

CHART I – Page 1

Provider #	Federally Mandatory/Optional Coverage Area (M/O), or Supports Govt. Program (G)	Number of Clients Served	Total Medicaid Paid Amount	Name of Service Area
010	M	2,101	\$1,265,856.50	Outpatient Surgery, Hospital Based
011	M	33,112	\$276,267,064.43	Hospital, Inpatient
012	M	54,198	\$34,209,804.56	Hospital, Outpatient
013	M	1,111	\$6,564,126.16	Psychiatric, Inpatient
014	**O	8,616	\$24,718,844.04	Mental Health, Outpatient
016	O	75	\$6,410,753.36	ICF-MR / Public
017	M/O	17,779	\$5,187,993.69	Special Clinics
019	M/O	5,062	\$157,989,088.72	Nursing Facility
020	M	109,114	\$94,759,459.69	Physician, M.D., Osteopath
021	* O	3,358	\$130,054.14	Podiatrist
022	* O	31,241	\$16,084,203.45	Dentist
023	* O	189	\$94,907.12	Hearing Aid Dispenser/Rel Ltd
024	M	6,092	\$859,177.31	Certified R.N. Practitioner
025	* O	14,500	\$3,022,934.90	Optometrist
026	* O	2,342	\$1,752,720.02	Psychologist
027	M/O	6,788	\$1,093,528.57	Radiology/Noninvasive Diag Ctr
028	* O	73,958	\$81,444,395.40	Pharmacy
029	M	978	\$3,443,220.07	Home Health Agency
030	* O	5,826	\$68,194,409.27	Personal Care Aid - Prov Agency
031	M	3,904	\$372,773.79	Healthy Kids Screening
032	M	12,345	\$6,804,463.78	Ambulance, Air/Ground
033	* M	29,495	\$21,971,718.88	DME, Disposable, Prosthetics
034	* O	3,284	\$5,001,639.13	Therapy
035	M		\$8,477,866.51	Travel

**DHCFP FACT BOOK 2009**

				CHART I – Page 2
036	O	79	\$2,892.60	Chiropractor
037	* O	1,428	\$729,532.76	Intravenous Therapy
038	* O	1,633	\$35,496,764.65	Home/Comm Based Waiver-MR
039	O	383	\$2,437,308.03	Adult Day Health Center
041	* O	2,667	\$429,435.38	Optician,Optical Business
042	M	28	\$19,599.52	Outpatient Psych Hosp.,Private
043	M	39,300	\$2,924,185.60	Laboratory, Pathology/Clinical
045	M	684	\$7,397,096.93	ESRD Facility
046	M	5,151	\$3,359,602.75	Ambulatory Surgical Centers
047	M	2,234	\$3,146,849.10	IHS And Tribal Clinics
048	O	1,599	\$3,600,221.65	Senior Waiver(Frail Elderly)
049	M	4	\$1,182.34	IHS Travel
052	M	110	\$88,393.68	IHS Hospital/Outpat/Tribal
054	**	12,210	\$17,471,952.54	Case Management
055	* O	31	\$704,216.50	Trans Rehab Center, Outpatient
056	M	976	\$15,786,590.42	Mental Hosp(Rehab/Sp), Inpat
057	O	479	\$4,046,819.06	Adult Group Care Waiver
058	* O	585	\$2,842,930.16	Physically Disabled Waiver
059	O	65	\$1,228,493.53	Facility Based Assisted Living
060	* O	5,780		School Based
061	**O	1,555	\$19,814,278.29	Mental Hlth Rehab Svc/Res
062	O	100,000	\$208,947,730.26	Managed Care/Health Maint Org (HMO)
063	* O	675	\$27,561,569.11	Residential Treatment Ctr
064	* O	316	\$1,561,749.69	Hospice
065	* O	601	\$7,693,473.88	Hospice, Long Term Care
068	O	59	\$7,367,867.21	ICF-MR / Private



Delineation of provider payments by MPP provider category

**MPP Provider  
Category**

	<b>FY03</b>	<b>FY04</b>	<b>FY05</b>	<b>FY06</b>	<b>FY07</b>	<b>FY08</b>
Hospital In-Patient	\$166,518,130	\$254,016,776	\$271,702,359	\$285,037,645.30	\$304,564,587.89	\$294,523,202.03
Hospital Out-Patient	\$26,155,111	\$30,755,889	\$55,411,715	\$64,856,612.47	\$64,745,701.09	\$46,320,754.42
Physician	\$74,917,223	\$63,260,396	\$86,060,199	\$84,036,447.62	\$86,411,485.39	\$94,759,459.69
Pharmacy	\$99,893,539	\$125,261,101	\$132,585,351	\$113,262,727.79	\$82,666,204.02	\$81,444,395.40
Long-Term Care*	\$112,606,106	\$136,327,587	\$162,408,919	\$157,609,508.63	\$161,884,122.46	\$165,682,562.60
MH/MR*	\$82,305,208	\$62,430,098	\$87,765,546	\$74,070,363.29	\$78,529,452.98	\$107,193,985.48
HMOs	\$129,763,137	\$149,672,559	\$172,721,218	\$168,689,640.01	\$192,105,814.46	\$208,947,730.26
Community Based Services	\$ -	\$43,178,897	\$47,399,669	\$57,323,407.59	\$71,428,384.36	\$80,218,744.15
Dental	\$ -	\$11,030,109	\$14,641,980	\$14,871,312.80	\$16,479,618.76	\$16,084,203.45
Waiver Services*	\$ -	\$28,394,653	\$64,577,559	\$57,487,798.72	\$44,938,535.51	\$46,488,473.26
Other Professional Services	\$ -	\$8,200,846	\$9,435,821	\$11,507,017.42	\$15,335,681.93	\$14,010,014.45
All Others*	\$161,203,459	\$58,701,090	\$72,687,241	\$78,877,045.79	\$79,348,556.07	\$81,004,132.81
<b>State Totals</b>	<b>\$853,361,913.91</b>	<b>\$971,230,000.29</b>	<b>\$1,177,397,577.65</b>	<b>\$1,167,629,527.43</b>	<b>\$1,198,438,144.92</b>	<b>\$1,236,677,658.00</b>

\*These totals vary from the fact book to Medicaid Overview handout based on how the aid codes were categorized.

**Percentage Increase  
Over Prior**

	<b>FY 2003 to 2004</b>	<b>FY 2004 to 2005</b>	<b>FY 2005 to 2006</b>	<b>FY 2006 to 2007</b>	<b>FY 2007 to 2008</b>
Hospital In-Patient	52.55%	6.96%	4.91%	6.85%	-3.30%
Hospital Out-Patient	17.59%	80.17%	17.04%	-0.17%	-28.46%
Physician	-15.56%	36.04%	-2.35%	2.83%	9.66%
Pharmacy	25.39%	5.85%	-14.57%	-27.01%	-1.48%
Long-Term Care	21.07%	19.13%	-2.96%	2.71%	2.35%
MH/MR	-24.15%	40.58%	-15.60%	6.02%	36.50%
HMO	15.34%	15.40%	-2.33%	13.88%	8.77%
Community Based Services	100.00%	9.78%	20.94%	24.61%	12.31%
Dental	100.00%	32.75%	1.57%	10.81%	-2.40%
Waiver Services	100.00%	127.43%	-10.98%	-21.83%	3.45%
Other Professional Services	100.00%	15.06%	21.95%	33.27%	-8.64%
All Others	-63.59%	23.83%	8.52%	0.60%	2.09%
<b>Overall</b>	<b>13.81%</b>	<b>21.23%</b>	<b>-0.83%</b>	<b>2.64%</b>	<b>3.19%</b>

**Medicaid Claim Expenditures (Source: DSS-R16)**

**Summary of On line Medical Expenditures for State Fiscal Years 2003 through 2008 by aid group**

<u>Expenditures by Aid Group</u>	2003	2004	2005	2006	2007	2008
TANF	\$ 97,902,761	\$ 151,802,769	\$ 207,526,659	\$ 167,197,418	\$ 259,245,782	\$ 253,933,064
CHAP	\$ 70,956,324	\$ 59,924,432	\$ 70,074,085	\$ 46,991,152	\$ 72,678,391	\$ 81,587,578
TANF	\$207,526,659	\$167,197,418	\$259,245,782	\$253,933,064	\$206,279,486.11	\$221,019,246.08
CHAP	\$70,074,085	\$46,991,152	\$72,678,391	\$81,587,578	\$82,090,864.57	\$92,036,750.68
Aged	\$113,179,525	\$119,688,063	\$158,339,778	\$143,967,028	\$130,929,706.82	\$132,865,064.22
Blind/Disabled	\$357,206,250	\$494,968,346	\$479,267,919	\$458,075,695	\$446,433,645.73	\$426,032,964.04
QMB/SLMB <sup>1</sup>	\$4,496,960	\$2,908,703	\$9,427,833	\$5,491,849	\$4,472,653.72	\$3,999,683.27
Child Welfare	\$50,204,512	\$32,122,127	\$59,897,688	\$58,736,340	\$70,608,479.64	\$93,772,440.17
<b>Sub Total</b>	<b>\$802,687,991</b>	<b>\$863,875,809</b>	<b>\$1,038,857,391</b>	<b>\$1,001,791,552</b>	<b>\$940,814,836.59</b>	<b>\$969,726,148.46</b>

<u>Annual Average Monthly Eligibles (w/retro) by Aid Group</u>	2003	2004	2005	2006	2007	2008
TANF	89,831	92,885	92,435	87,555	80,721	85,573
CHAP	24,495	26,627	26,752	27,912	29,036	32,896
Aged	9,404	9,841	10,125	10,445	10,684	11,151
Blind/Disabled	22,865	24,522	25,111	25,453	25,687	27,021
QMB/SLMB	10,813	12,531	12,683	12,557	13,300	14,247
Child Welfare	4,966	5,139	5,887	7,301	7,629	8,238
<b>Sub Total</b>	<b>162,374</b>	<b>171,545</b>	<b>172,993</b>	<b>171,223</b>	<b>167,056</b>	<b>179,126</b>
County Match	1,410	1,346	1,409	1,462	1,490	1,464
<b>TOTAL</b>	<b>163,784</b>	<b>172,891</b>	<b>174,402</b>	<b>172,685</b>	<b>168,546</b>	<b>180,590</b>

<u>Average Cost Per Eligible (without reduction for state facilities)</u>	2003	2004	2005	2006	2007	2008
Total	\$405.80	\$393.55	\$422.74	\$475.70	\$493.26	\$464.20
Category 12*	\$197.69	\$186.10	\$210.30	\$235.39	\$244.57	\$224.96
Category 14	\$864.17	\$810.36	\$917.78	\$1,000.28	\$950.28	\$886.38
Category 15	\$1,110.63	\$1,787.15	\$741.68	\$1,278.67	\$1,214.86	\$1,154.12
Category 17	\$3,117.60	\$3,455.32	\$3,868.04	\$3,739.10	\$3,681.63	\$3,662.01
Category 19	\$791.99	\$426.67	\$397.21	\$410.90	\$720.97	\$885.88

**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/SLMB. Category 15 contains Waiver eligible recipients that are a subset of the Aged Blind and Disabled population. Category 17 contains County Match recipients. Category 19 contains Child Welfare recipients.

Medicaid Claims Expenditures  
Percent of caseload vs. percent of costs

<b>OVERALL % of COSTS</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>
TANF	24.32%	18.13%	23.32%	23.74%	20.45%	21.36%
CHAP	8.21%	5.10%	6.54%	7.63%	8.14%	8.90%
Aged	13.26%	12.98%	14.25%	13.46%	12.98%	12.84%
Blind/Disabled	41.86%	53.68%	43.12%	42.82%	44.26%	41.18%
QMB/SLMB	0.53%	0.32%	0.85%	0.51%	0.44%	0.39%
Child Welfare	5.88%	3.48%	5.39%	5.49%	7.00%	9.06%
<b>Sub Total</b>	<b>94.06%</b>	<b>93.69%</b>	<b>93.46%</b>	<b>93.65%</b>	<b>93.27%</b>	<b>93.73%</b>
County Match	5.94%	6.31%	6.54%	6.35%	6.73%	6.27%
<b>TOTAL</b>	<b>100.00%</b>	<b>100.00%</b>	<b>100.00%</b>	<b>100.00%</b>	<b>100.00%</b>	<b>100.00%</b>

<b>OVERALL % of CASELOAD</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>
TANF	54.85%	53.69%	59.45%	58.06%	47.89%	47.39%
CHAP	14.96%	15.41%	17.05%	18.08%	17.23%	18.22%
Aged	5.74%	5.70%	4.13%	4.24%	6.34%	6.17%
Blind/Disabled	13.96%	14.19%	10.37%	10.20%	15.24%	14.96%
QMB/SLMB	6.60%	7.25%	5.65%	5.48%	7.89%	7.89%
Child Welfare	3.03%	2.97%	2.66%	3.23%	4.53%	4.56%
<b>Sub Total</b>	<b>99.14%</b>	<b>99.22%</b>	<b>99.30%</b>	<b>99.29%</b>	<b>99.12%</b>	<b>99.19%</b>
County Match	0.86%	0.78%	0.70%	0.71%	0.88%	0.81%
<b>TOTAL</b>	<b>100.00%</b>	<b>100.00%</b>	<b>100.00%</b>	<b>100.00%</b>	<b>100.00%</b>	<b>100.00%</b>

## FAQs

### **Q1 What is Medicaid?**

A1 *Medicaid is a U.S. Federal-State health insurance plan for low-income and needy citizens. Nationally, Medicaid helps over 45 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.*

### **Q2 Why does Medicaid vary from state to state?**

A2 *The federal government funds approximately 50% of Medicaid. Individual states pay the rest but are given leeway regarding who to cover and what benefits to provide. There is a single state agency in charge of the program, but many states have the program administered by each county or city.*

### **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 from (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 *Income cap states limit income to three times the SSI benefit level. In 2006 the benefit level was \$637 per month, and the income cap is \$1,911. No spend down is allowed and any excess will disqualify the individual in these states.*

*For resources, many states use the Federal SSI levels. For 2006, these limits were \$2000 for an individual and \$3000 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 biggest 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? And what are my choices?**

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

*An Health Maintenance Organization (HMO) is a health plan that provides comprehensive health care services to those enrolled Medicaid clients who have chosen their plan. An 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 home health provider, a certain hospital and 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.*

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

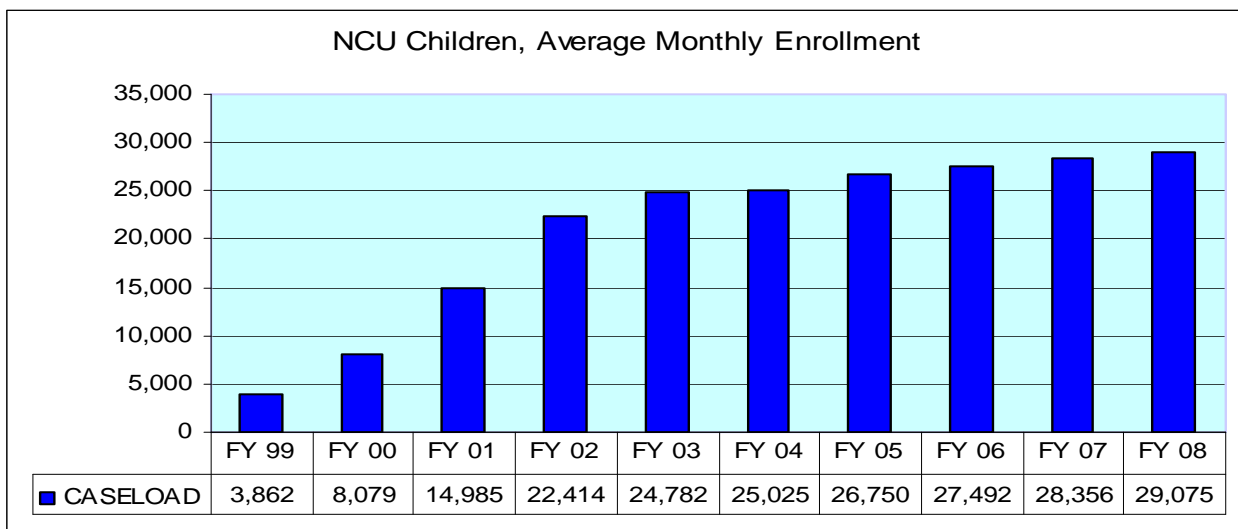
**BACKGROUND**

The State Children’s Health Insurance Program (SCHIP) was established by Congress to provide health insurance to uninsured children whose family income was too high for Medicaid coverage but too low to allow the family access to private health insurance coverage. The enabling legislation for SCHIP, included in the Balanced Budget Act of 1997, made available nationally almost \$40 billion over a 10-year period for this program. This block grant expired at the end of September 2007, and Congress provided continuing funding through March 2009.

Like Medicaid, SCHIP is a joint federal-state program, with funding from both sources, but it is implemented by each state. States each had the option of organizing their program in the form of a new State Children’s Health Insurance program, expanding Medicaid coverage, or establishing a combination of these two approaches. There are options for administration of these programs and definition of benefit plans.

Nevada Check Up (NCU) is the State Children’s Health Insurance Program (SCHIP) for Nevada. Developed as a stand alone program and different from Medicaid expansion programs, this type of program can charge fees related to services. Currently, this program is defined as “Secretary approved,” which means the Secretary determined that appropriate coverage for the population of targeted low-income children is provided under the program.

Nevada Check Up began providing services to children on October 1, 1998. In SFY 2008, the average monthly enrollment was 29,075 children served. The chart below illustrates actual annual average monthly enrollment for the program, from its inception.



Initial estimates of uninsured children who fall under 200% of the federal poverty level in Nevada were 45,000 based on the 1996 U.S. Census Bureau. Statistics in 2005 define that number to be estimated more accurately at 63,000 (three year average for 2003, 2004, and 2005). This is

a drop from the 2004 data that report the three year average at 72,000.

Uninsured children, ages birth through 18, whose family incomes are too high for Medicaid and too low to purchase private insurance coverage, can be covered by Nevada Check Up. Family income levels up to 200% of the Federal Poverty Level may qualify. The federal government provides 67.75% (based on the Federal Fiscal Year 2007) of Nevada Check Up expenditures and the state provides 32.25% of these costs. Nevada's Medicaid match with federal funds is approximately 50-50; so, with enrollment of qualified children, Nevada Check Up provides a more advantageous match for the state, maximizing state funds.

The Nevada Check Up program chose to adopt the basic Medicaid fee-for-service plan 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. Nevada Check Up recipients are mandated to receive treatment under an HMO in the urban areas of the state.

## **ELIGIBILITY**

Eligibility determinations are completed at the central office of Nevada Check Up in Carson City and district offices in Reno and Las Vegas.

- Families complete a simple application and submit it along with proof of income.
- Eligibility workers review the application, calculate an estimated annual income for the family, and determine eligibility.
- 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.
- When all requirements including legal residency, non-Medicaid eligible children, etc., are met, the children are enrolled and the families are notified of the current premium due.
- The children's coverage usually begins the first day of the next administrative month, following the date of the initial determination.

### Re-determinations

Federal regulations require that family income and composition be reviewed annually to ensure continuing eligibility for the State Children's Health Insurance Programs.

In order to comply with this requirement, documents are prepared from information in Nevada Check Up's database and sent out to the participant families. They are asked to update their information including residency, family composition and employment, and to return the documents to Nevada Check Up along with current income verification. When processed by eligibility staff, the re-determination forms either result in the family's continuation with Nevada Check Up, referral to Medicaid, or disenrollment if they no longer meet the eligibility criteria for Check Up. Notification of the outcome of this process is then sent to the participant family.

### Medicaid Referrals

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Children whose families apply for the Nevada Check Up program and, at eligibility determination, appear eligible for Medicaid, will be denied NCU and their application will be forwarded to Medicaid for determination. Once a Medicaid determination is made, the children are either enrolled in Medicaid, or denied Medicaid and referred back to Nevada Check Up. If the family fails to cooperate with Medicaid, the children are not eligible for Nevada Check Up as well. Current NCU enrollees will be screened for Medicaid eligibility on their annual re-determination date and, if they appear eligible for Medicaid, they will be disenrolled from NCU, and their application information will be forwarded to Medicaid for a determination. The family must cooperate with the Medicaid determination process.

**SERVICES PROVIDED**

Nevada Check Up’s benefit coverage is similar to Medicaid’s and includes the following health care services:

Inpatient Hospital	Ambulance	X-ray	Well Baby/Well Child Care
Outpatient Hospital	Dental – up to \$600.00 cap	Physician Services	Therapies
Mental Health	Medical 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, 2008, Nevada Check Up expenditures totaled \$41,946,162.00.

**Premiums**

Federal regulation allows for the participant’s share of cost to be up to 5% of their annual income. For example, a single mother with one child, making \$16,000 annually, could then be charged up to \$800 per year for her child’s coverage. As each state is allowed to set the rate and frequency of these collections, Nevada has chosen to charge only \$25.00 per quarter for families earning less than \$31,800 for a family of four. (Income guidelines vary according to family size and %FPL; in the example given, the family of 4 earns 150% FPL) The rationale for this is that this program is designed to encourage enrollment and is geared towards those living between 100% - 200% of the Federal Poverty Level.

**Growth**

Although there may be an expectation of market saturation, Nevada is one of the fastest growing states in the U.S. As new families relocate to Nevada, more children enter the population of the uninsured. Due to administrative changes in the program, current enrollment is significantly under budgeted levels. Disenrollment’s continue to impact overall enrollment growth.

**FAQs**

**1Q What is Nevada Check Up?**

1A *Nevada Check Up is Nevada’s State Children’s Health Insurance Program (SCHIP). The program was authorized by Congress and has been implemented in every state.*

**2Q How do I qualify?**

2A *Children may qualify for Nevada Check Up if they are not eligible for Medicaid; have not had private health insurance for the last 6 months or have recently lost insurance for reasons beyond the parents’ control; are under the age of 19 at the date coverage will begin; do 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 5 years residency; applying for Nevada Check Up will not affect a family’s immigration status.)*

**3Q How do I apply?**

3A *Applications for Nevada Check Up are available statewide at various locations, including Family Resource Centers, Schools, Boys & Girls Clubs, Welfare offices and others. Applications can also be obtained by calling (877) 543-7669, or by visiting the web site <http://\nevadacheckup.nv.gov>. Both English and Spanish versions are available.*

**4Q How much does it cost?**

4A *The only cost to the Nevada Check Up 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 instance, if your family is at the \$25 premium level, you will pay only \$25 for all your children to be covered.*

*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 need to mark “American Indian” and to write down their child’s tribal affiliation in the optional race section on the application.*

**5Q How do I access health care services?**

5A *Children who reside in Reno/Sparks and Clark County access care through managed care health plans. Children in the rural areas access care through Medicaid fee-for-service providers.*

**6Q Can parents be covered by the Nevada Check Up program?**

6A *At this time, the program provides health insurance only to children from birth through age 18.*

*For eligible parents, caretaker relatives, and legal guardians who work for qualified small employers, Nevada Check Up Plus will, through the HIFA waiver, provide assistance with*

*insurance-premium payments on employer-sponsored insurance programs for employee and spouse coverage. It also provides for pregnancy-related medical coverage for eligible women whose income is above 133% but at or below 185% of the Federal Poverty Level.*

**7Q If my children have medical bills, may I submit them to Nevada Check Up with my application?**

*7A No. Nevada Check Up does not enroll children for prior months. Your family's enrollment will begin the first day of the month of premium payment. Recipients should contact the provider of service regarding claims received during an eligible month. All claims must be submitted by the provider of service; recipients are not reimbursed for claim expenses.*

**FACT BOOK  
HIFA WAIVER and  
NEVADA CHECK UP PLUS**

The Nevada Health Insurance Flexibility and Accountability (HIFA) Waiver program was adopted in 2007 by the State of Nevada within the Section 1115 of the Social Security Act. This section provides the Secretary of Health and Human Services broad authority to authorize experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid statute. It is intended to demonstrate and evaluate a policy or approach that has not been demonstrated on a widespread basis. This project is funded under Title XXI of the Social Security Act. Nevada has expanded eligibility to individuals not otherwise eligible under the Nevada Medicaid program. The Nevada HIFA waiver program includes two eligibility groups and is intended to increase coverage of uninsured individuals within the State of Nevada.

The HIFA-P program is designed for uninsured pregnant women who do not qualify for Medicaid and whose net annual income is above 133% and up to and including 185% of the Federal Poverty Level (FPL). HIFA-P coverage is a comprehensive pregnancy-related health package. HIFA-P includes all pregnancy-related services outlined in the Medicaid Services Manual and uses the Nevada Medicaid Provider Panel. Eligibility for this coverage group is completed by the Division of Welfare and Supportive Services.

The HIFA-S program is a subsidy payment for qualifying individuals and is paid directly to eligible participants upon receipt of evidence of enrollment in the employer sponsored insurance program. The program is designed for parents, caretaker relatives or legal guardians of Medicaid or Nevada Check Up children or other low-income parents, caretaker relatives or legal guardians. The eligible participant cannot qualify for Medicaid; must have a gross annual income less than or equal to 200% of the FPL, and must be employed by a qualified small employer offering a creditable insurance plan where the contribution by the employer is not less than 50% of the total monthly insurance premium. Eligibility for this coverage group is conducted by the Division of Health Care Financing and Policy, and the program is called the Nevada Check Up Plus program. The program was implemented in January 2007.

## **RELATED WEBSITES**

<http://www.quia.com/jg/138610list.html>

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

[http://www.professorbeyer.com/Articles/Medicaid\\_FAQ.pdf](http://www.professorbeyer.com/Articles/Medicaid_FAQ.pdf)

<http://seniorlaw.com/medicaidfaq.htm>

### **General Medicaid questions:**

<http://www.cms.hhs.gov/>

<http://www.dhhs.nv.gov/DHHS/MEDICAIDPROGRAM/FAQs/default.htm>

[http://answers.hhs.gov/cgi-bin/hhs.cfg/php/enduser/std\\_alp.php?p\\_sid=fYAgGDzg&p\\_lva=&p\\_li=&p\\_page=1&p\\_cat\\_lv1=14&p\\_search\\_text=&p\\_new\\_search=1](http://answers.hhs.gov/cgi-bin/hhs.cfg/php/enduser/std_alp.php?p_sid=fYAgGDzg&p_lva=&p_li=&p_page=1&p_cat_lv1=14&p_search_text=&p_new_search=1)

[http://www.hhsc.state.tx.us/programs/childrens\\_medicaid/faq.html](http://www.hhsc.state.tx.us/programs/childrens_medicaid/faq.html)

<http://www.dhcfp.nv.gov/HCFP/elig/faq.asp>

<http://www.dhhs.nv.gov/DHHS/MEDICAIDPROGRAM/FAQs/default.htm>

[http://answers.hhs.gov/cgi-bin/hhs.cfg/php/enduser/std\\_alp.php?p\\_sid=fYAgGDzg&p\\_lva=&p\\_li=&p\\_page=1&p\\_cat\\_lv1=14&p\\_search\\_text=&p\\_new\\_search=1](http://answers.hhs.gov/cgi-bin/hhs.cfg/php/enduser/std_alp.php?p_sid=fYAgGDzg&p_lva=&p_li=&p_page=1&p_cat_lv1=14&p_search_text=&p_new_search=1)

[http://www.dhs.state.tx.us/Programs/childrens\\_medicaid/FAQ.html](http://www.dhs.state.tx.us/Programs/childrens_medicaid/FAQ.html)

<http://www.dhcfp.nv.gov/elig/FAQ.html#general>

### **Medicaid Managed Care questions and other questions:**

[http://www.dhcfp.nv.gov/HCPF/mcc/NewV2/mmc\\_home\\_v2.html](http://www.dhcfp.nv.gov/HCPF/mcc/NewV2/mmc_home_v2.html)

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

<http://firsthealth.com/>

<http://www.dhcfp.nv.gov/elig/FAQ.html#MngdCare>

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