Table of Contents

State/Territory Name: Nevada

State Plan Amendment (SPA) #: NV-25-0030

This file contains the following documents in the order listed:

1) Approval Letter
2) Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Managed Care Group

March 18, 2026

Ann Jensen
Administrator
Nevada Medicaid
Nevada Health Authority
4070 Silver Sage Drive
Carson City, NV 89701

Re: Nevada State Plan Amendment (SPA) 25-0030

Dear Administrator Jensen:

The Centers for Medicare & Medicaid Services (CMS) completed review of Nevada's State Plan Amendment (SPA) Transmittal Number 25-0030 submitted on November 3, 2025. The purpose of this SPA is to expand the managed care program statewide.

We conducted our review of this amendment according to statutory requirements of Title XIX of the Social Security Act and implementing Federal regulations. This letter is to inform you that Nevada Medicaid SPA Transmittal Number 25-0030 is approved effective January 1, 2026.

If you have any questions regarding this amendment, please contact Nicole Gillette-Payne at 212-616-2465 or via email at nicole.gillette4@cms.hhs.gov.

S[redacted]
Bill Brooks
Director
Division of Managed Care Operations

cc: Jenifer Graham, NVHA
Matthew Rodriguez, DMCO

DEPARTMENT OF HEALTH ANDHUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 25-0030

2. STATE: NV

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2026

5. FEDERAL STATUTE/REGULATION CITATION
State Plan Authority (Section 1932(a)(1)(B)(i), Waiver Authority (Sections 1915(a) (1) (B)(ii), 42CFR 438.2, 45CFR 438.6, 42CFR 438.50(b)(1)-(2)

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2026 $ 0
b. FFY 2027 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
~~Section 3.1F - Pages 1 – 22~~
Section 3.1F - Pages 1 - 25

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attach 3.1-F Pages 1-23

~~9.~~ SUBJECT OF AMENDMENT

This SPA proposes to expand Managed Care statewide, including rural counties, effective 1/1/2026. Managed Care Organizations (MCOs) will assume responsibility for service delivery in all counties, including NEMT in rural counties.

10. GOVERNOR'S REVIEW *(Check One)*

(●) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
( ) OTHER, AS SPECIFIED:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
STACIE WEEKS

13. TITLE
DIRECTOR, NVHA

14. DATE SUBMITTED
11/03/2025

15. RETURN TO
Ann Jensen, Administrator
NVHA/Nevada Medicaid
4070 Silver Sage Drive
Carson City, NV 89701

FOR CMS USE ONLY

16. DATE RECEIVED
11/3/2025

17. DATE APPROVED
3/18/2026

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
1/1/2026

19. SIGNA[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Bill Brooks

21. TITLE OF APPROVING OFFICIAL
Director, Division of Managed Care Operations

22. REMARKS

Nevada concurred with pen and ink changes in Box 7 via email received on 12/17/2025.

INSTRUCTIONS FOR COMPLETING FORM CMS-179

Use Form CMS-179 to transmit State plan material to the Center for Medicaid & CHIP Services for approval. Submit a separate typed transmittal form with each plan/amendment.

Block 1 - Transmittal Number - Enter the State Plan Amendment transmittal number. Assign consecutive numbers on a **calendar year** basis with the first two digits being the two-digit year (e.g., 21-0001, 21-0002, etc.). Because states have different state fiscal years, a calendar year is required for consistency.

Block 2 - State - Enter the two-letter abbreviation code of the State/District/Territory submitting the plan material.

Block 3 - Program Identification - Enter the applicable Title of the Social Security Act (Title XIX Medicaid or Title XXI CHIP).

Block 4 - Proposed Effective Date - Enter the proposed effective date of material. The effective date of a new plan may not be earlier than the first day of the calendar quarter in which an approvable plan is submitted. With respect to expenditures for assistance under such plan, the effective date may not be earlier than the first day on which the plan is in operation on a statewide basis or earlier than the day following publication of notice of changes.

Block 5 - Federal Statute/Regulation Citation - Enter the appropriate statutory/regulatory citation.

Block 6 - Federal Budget Impact - 6(a) - IN WHOLE DOLLARS, NOT IN THOUSANDS, Enter 1st **Federal Fiscal Year** (FFY) impacted by the SPA & estimated Federal share of the cost of the SPA for 1st FFY. The first FFY should be the FFY inclusive of the earliest effective date of any amended payment language; **6 (b)** - Enter 2nd FFY impacted by the SPA & estimated Federal share of the cost for 2nd FFY. In general, the estimates should include any amount not currently approved in the state's plan for assistance.

Block 7 - Page No.(s) of Plan Section or Attachment - Enter the page number(s) of plan material amended and transmitted. If additional space is needed, use bond paper. **New pages** should be included in Block 7, but not in Block 8.

Block 8 - Page No.(s) of the Superseded Plan Section or Attachment (if Applicable) - Enter the page number(s) (including the transmittal number) that is being superseded. If additional space is needed, use bond paper. **Deleted pages** should be included in Block 8, but not in Block 7.

Block 9 - Subject of Amendment - Briefly describe plan material being transmitted.

Block 10 - Governor's Review - Check the appropriate box. See SMM section 13026 A.

Block 11 - Signature of State Agency Official - Authorized State official signs this block.

Block 12 - Typed Name - Type name of State official who signed block 11.

Block 13 - Title - Type title of State official who signed block 11.

Block 14 - Date Submitted - Enter the date that the state transmits plan material to CMCS. Unless the state officially withdraws this SPA and then resubmits it, this date should not be revised. Documentation of version revisions will be maintained in the CMCS administrative record.

Block 15 - Return To - Type the name and address of State official to whom this form should be returned.

Block 16–22 (FOR CMS USE ONLY).

Block 16 - Date Received - Enter the date plan material is received by CMCS. This is the date that the submission is received by CMCS via the subscribed submission process.

Block 17 - Date Approved - Enter the date CMCS approved the plan material.

Block 18 - Effective Date of Approved Material - Enter the date the plan material becomes effective. If more than one effective date, list each provision and its effective date in Block 22 or attach a sheet.

Block 19 - Signature of Approving Official - Approving official signs this block.

Block 20 - Typed Name of Approving Official - Type approving official's name.

Block 21 - Title of Approving Official - Type approving official's title.

Block 22 - Remarks - Use this block to reference and explain agreed to changes and strike-throughs to the original CMS-179 as submitted, a partial approval, more than one effective date, etc. If additional space is needed, use bond paper.

State: Nevada

Citation	Condition or Requirement

1932(a)(1)(A)

A. Section 1932(a)(1)(A) of the Social Security Act.

The State of Nevada enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization [MCOs], primary care case managers [PCCMs], and/or PCCM entities) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on state wideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230).

This authority may ***not*** be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries described in 42 CFR 438.50(d).

Where the state's assurance is requested in this document for compliance with a particular requirement of 42 CFR 438 et seq., the state shall place a check mark to affirm that it will be in compliance no later than the applicable compliance date. All applicable assurances should be checked, even when the compliance date is in the future. **Please see Appendix A of this document for compliance dates for various sections of 42 CFR 438.**

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.2
42 CFR 438.6
42 CFR 438.50(b)(1)-(2)

B. Managed Care Delivery System.

The State will contract with the entity(ies) below and reimburse them as noted under each entity type.

1. ☒MCO
   a. ☒Capitation
   b. ☒The state assures that all applicable requirements of 42 CFR 438.6, regarding special contract provisions related to payment, will be met.

The State of Nevada , Division of Nevada Medicaid oversees the administration of all Medicaid Managed Care Organizations (MCOs) in the state. Nevada Medicaid operates a fee-for-service and a managed care reimbursement and service delivery system with which to provide covered medically necessary services to its Medicaid eligible population. Contracted MCOs are currently the primary managed care entities providing Medicaid managed care in Nevada; at this time, Nevada contracts with zero PIHPs and one PAHP under a 1915(b) waiver.

2. ☐ PCCM (individual practitioners)
   a. ☐ Case management fee
   b. ☐ Other (please explain below)

3. ☐ PCCM entity
   a. ☐ Case management fee
   b. ☐ Shared savings, incentive payments, and/or financial rewards (see

State: Nevada

Citation	Condition or Requirement

42 CFR 438.310(c)(2))

c. ☐ Other (please explain below)

If PCCM entity is selected, please indicate which of the following function(s) the entity will provide (as in 42 CFR 438.2), in addition to PCCM services:

- ☐ Provision of intensive telephonic case management
- ☐ Provision of face-to-face case management
- ☐ Operation of a nurse triage advice line
- ☐ Development of enrollee care plans.
- ☐ Execution of contracts with fee-for-service (FFS) providers in the FFS program
- ☐ Oversight responsibilities for the activities of FFS providers in the FFS program
- ☐ Provision of payments to FFS providers on behalf of the State.
- ☐ Provision of enrollee outreach and education activities.
- ☐ Operation of a customer service call center.
- ☐ Review of provider claims, utilization and/or practice patterns to conduct provider profiling and/or practice improvement.
- ☐ Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers.
- ☐ Coordination with behavioral health systems/providers.
- ☐ Coordination with long-term services and supports systems/providers.
- ☐ Other (please describe): _____

42 CFR 438.50(b)(4) C.Public Process.

Describe the public process including tribal consultation, if applicable, utilized for both the design of the managed care program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan managed care program has been implemented. *(Example: public meeting, advisory groups.)*

Pursuant to 42 CFR 438.50(b)(4), the State shall provide public notice to promote public involvement in the design and initial implementation of the program as well as during contract procurement. The public notice shall be a notice of publication published via our public notice section on our website: http://dhcfp.nv.gov/Public/Home/. The Medical Care Advisory Committee (MCAC) advises the Nevada Medicaid regarding provisions of services for the health and medical care of Medicaid beneficiaries.

In addition, Nevada Medicaid will consult with Tribes and Indian Health Programs on Medicaid State Plan Amendments (SPAs), waiver requests, waiver renewals, demonstration project proposals and/or on matters that relate to Medicaid and Nevada Check Up programs, including Managed Care.

State: Nevada

Citation	Condition or Requirement
	If the program will include long term services and supports (LTSS), please indicate how the views of stakeholders have been, and will continue to be, solicited and addressed during the design, implementation, and oversight of the program, including plans for a member advisory committee (42 CFR 438.70 and 438.110) When changes are made to the LTSS services provided under the Managed Care contract, the same public process as outlined above will be followed, including tribal consultation and MCAC review. Pursuant to 42 CFR 438.110, contracted MCOs must also establish and maintain a member advisory committee that includes at least a reasonable representative sample of the LTSS populations, or other individuals representing those enrollees, covered under the contract.
	D. State Assurances and Compliance with the Statute and Regulations. If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.
1932(a)(1)(A)(i)(I) 1903(m) 42 CFR 438.50(c)(1)	1. ☒ The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.
1932(a)(1)(A)(i)(I) 1905(t) 42 CFR 438.50(c)(2) 1902(a)(23)(A)	2. ☐ The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts (including for PCCM entities) will be met.
1932(a)(1)(A) 42 CFR 438.50(c)(3)	3. ☒ The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring beneficiaries to receive their benefits through managed care entities will be met.
1932(a)(1)(A) 42 CFR 431.51 1905(a)(4)(C) 42 CFR 438.10(g)(2)(vii)	4. ☒ The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.
1932(a)(1)(A)	5. ☒ The state assures that it appropriately identifies individuals in the mandatory exempt groups identified in 1932(a)(1)(A)(i).
1932(a)(1)(A) 42 CFR 438 1903(m)	6. ☒ The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs, PCCMs, and PCCM entities will be met.
1932(a)(1)(A)	7. ☒ The state assures that all applicable requirements of 42 CFR 438.4, 438.5, 438.7, 438.8, and 438.74 for payments under any risk contracts will be met.

State: Nevada

Citation	Condition or Requirement

42 CFR 438.4
42 CFR 438.5
42 CFR 438.7
42 CFR 438.8
42 CFR 438.74
42 CFR 438.50(c)(6)

1932(a)(1)(A)
42 CFR 447.362
42 CFR 438.50(c)(6)

8. ☒ The state assures that all applicable requirements of 42 CFR 447.362 for payments under any non-risk contracts will be met.

45 CFR 75.326

9. ☒ The state assures that all applicable requirements of 45 CFR 75.326 for procurement of contracts will be met.

42 CFR 438.66

10. Assurances regarding state monitoring requirements:

☒ The state assures that all applicable requirements of 42 CFR 438.66(a), (b), and (c), regarding a monitoring system and using data to improve the performance of its managed care program, will be met.

☒ The state assures that all applicable requirements of 42 CFR 438.66(d), regarding readiness assessment, will be met.

☒ The state assures that all applicable requirements of 42 CFR 438.66(e), regarding reporting to CMS about the managed care program, will be met.

1932(a)(1)(A)
1932(a)(2)

E. Populations and Geographic Area.

1. **Included Populations.** Please check which eligibility groups are included, if they are enrolled on a **Mandatory (M)** or **Voluntary (V)** basis (as defined in 42 CFR 438.54(b)) or **Excluded (E),** and the geographic scope of enrollment. Under the **Geographic Area** column, please indicate whether the nature of the population's enrollment is on a statewide basis, or if on less than a statewide basis, please list the applicable counties/regions. Also, if type of enrollment varies by geographic area (for example, mandatory in some areas and voluntary in other areas), please note specifics in the **Geographic Area** column. Under the **Notes** column, please note any additional relevant details about the population or enrollment.

A. Mandatory Eligibility Groups (Eligibility Groups to which a state must provide Medicaid coverage)

1. Family/Adult

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
1. Parents and Other Caretaker Relatives	§435.110	X			Statewide	
2. Pregnant Women	§435.116	X			Statewide	
3. Children Under Age 19 (Inclusive of Deemed Newborns under §435.117)	§435.118	X			Statewide	

State: Nevada

Citation	Condition or Requirement

4. Former Foster Care Youth (up to age 26)	§435.150	X			Statewide	
5. Adult Group (Non-pregnant individuals age 19-64 not eligible for Medicare with income no more than 133% FPL)	§435.119	X			Statewide	
6. Transitional Medical Assistance (Includes adults and children, if not eligible under §435.116, §435.118, or §435.119)	1902(a)(52), 1902(e)(1), 1925, and 1931(c)(2) of SSA	X			Statewide	
7. Extended Medicaid Due to Spousal Support Collections	§435.115	X			Statewide	

2. Aged/Blind/Disabled Individuals

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
8. Individuals Receiving SSI age 19 and over only (See E.2. below regarding age <19)	§435.120			X	Statewide	
9. Aged and Disabled Individuals in 209(b) States	§435.121			X	Statewide	
10. Individuals Who Would be Eligible for SSI/SSP but for OASDI COLA Increase since April 1977	§435.135			X	Statewide	
11. Disabled Widows and Widowers Ineligible for SSI due to an increase of OASDI	§435.137			X	Statewide	
12. Disabled Widows and Widowers Ineligible for SSI due to Early Receipt of Social Security	§435.138			X	Statewide	
13. Working Disabled under 1619(b)	1619(b), 1902(a)(10)(A)(i)(II), and 1905(q) of SSA			X	Statewide	
14. Disabled Adult Children	1634(c) of SSA			X	Statewide	

B. Optional Eligibility Groups

1. Family/Adult

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
1. Optional Parents and Other Caretaker Relatives	§435.220			X	Statewide	
2. Optional Targeted Low-Income Children	§435.229			X	Statewide	
3. Independent Foster Care Adolescents Under Age 21	§435.226			X	Statewide	
4. Individuals Under Age 65 with Income Over 133%	§435.218			X	Statewide	

State: Nevada

Citation	Condition or Requirement

5. Optional Reasonable Classifications of Children Under Age 21	§435.222			X	Statewide	
6. Individuals Electing COBRA Continuation Coverage	1902(a)(10)(F) of SSA			X	Statewide	

2. Aged/Blind/Disabled Individuals

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if	Notes
7. Aged, Blind or Disabled Individuals Eligible for but Not Receiving Cash	§435.210 and §435.230			X	Statewide	
8. Individuals eligible for Cash except for Institutionalized Status	§435.211			X	Statewide	
9. Individuals Receiving Home and Community-Based Waiver Services Under Institutional Rules	§435.217			X	Statewide	
10. Optional State Supplement Recipients - 1634 and SSI Criteria States – with 1616 Agreements	§435.232			X	Statewide	
11. Optional State Supplemental Recipients- 209(b) States and SSI criteria States without 1616 Agreements	§435.234			X	Statewide	
12. Institutionalized Individuals Eligible under a Special Income Level	§435.236			X	Statewide	
13. Individuals Participating in a PACE Program under Institutional Rules	1934 of the SSA			X	Statewide	

State: Nevada

Citation	Condition or Requirement

14. Individuals Receiving Hospice Care	1902(a)(10)(A)(ii)(VII) and 1905(o) of the SSA	X Nevada Check Up		X Medicaid	Statewide	Medicaid beneficiaries who are receiving hospice services are not eligible for enrollment with the MCO. If a Medicaid beneficiary is made eligible for hospice services after MCO enrollment, the beneficiary will be disenrolled from the MCO and the hospice services will be reimbursed through FFS. Nevada Check Up beneficiaries who are receiving hospice services will not be disenrolled from managed care; however, payment for Nevada Check Up hospice services will be reimbursed through FFS.
15. Poverty Level Aged or Disabled	1902(a)(10)(A)(ii)(X) and 1902(m)(1) of the SSA			X	Statewide	
16. Work Incentive Group	1902(a)(10)(A)(ii)(XIII) of the SSA			X	Statewide	
17. Ticket to Work Basic Group	1902(a)(10)(A)(ii)(XV) of the SSA			X	Statewide	
18. Ticket to Work Medically Improved Group	1902(a)(10)(A)(ii)(XVI) of the SSA			X	Statewide	
19. Family Opportunity Act Children with Disabilities	1902(a)(10)(A)(ii)(XIX) of the SSA			X	Statewide	
20. Individuals Eligible for State Plan Home and Community-Based Services	§435.219			X	Statewide	

State: Nevada

Citation | Condition or Requirement

3. Partial Benefits

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
21. Family Planning Services	§435.214			X	Statewide	
22. Individuals with Tuberculosis	§435.215			X	Statewide	
23. Individuals Needing Treatment for Breast or Cervical Cancer (under age 65)	§435.213			X	Statewide	

C. Medically Needy

Per attachment 2.2-A, page 24, the Nevada State Plan does not include the medically needy. This table is not applicable.

Eligibility Group	Citation (Regulation [42 CFR] or SSA)	M	V	E	Geographic Area (include specifics if M/V/E varies by area)	Notes
1. Medically Needy Pregnant Women	§435.301(b)(1)(i) and (iv)					
2. Medically Needy Children under Age 18	§435.301(b)(1)(ii)					
3. Medically Needy Children Age 18 through 20	§435.308					
4. Medically Needy Parents and Other Caretaker Relatives	§435.310					
5. Medically Needy Aged	§435.320					
6. Medically Needy Blind	§435.322					
7. Medically Needy Disabled	§435.324					
8. Medically Needy Aged, Blind and Disabled in 209(b) States	§435.330					

2. **Voluntary Only or Excluded Populations.** Under this managed care authority, some populations cannot be subject to mandatory enrollment in an MCO, PCCM, or PCCM entity (per 42 CFR 438.50(d)). Some such populations are Eligibility Groups separate from those listed above in E.1., while others (such as American Indians/Alaskan Natives) can be part of multiple Eligibility Groups identified in E.1. above.

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

Population	Citation (Regulation [42 CFR] or SSA)	V	E	Geographic Area	Notes
Medicare Savings Program – Qualified Medicare Beneficiaries, Qualified Disabled Working Individuals, Specified Low Income Medicare Beneficiaries, and/or Qualifying Individuals	1902(a)(10)(E), 1905(p), 1905(s) of the SSA		X	Statewide	

State: Nevada

Citation Condition or Requirement

Population	Citation (Regulation [42 CFR] or SSA)	V	E	Geographic Area	Notes
"Dual Eligibles" not described under Medicare Savings Program - Medicaid beneficiaries enrolled in an eligibility group other than one of the Medicare Savings Program groups who are also eligible for Medicare			X	Statewide	
American Indian/Alaskan Native— Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes	§438.14	X		Statewide	
Children Receiving SSI who are Under Age 19 - Children under 19 years of age who are eligible for SSI under title XVI	§435.120		X	Statewide	
Qualified Disabled Children Under Age 19 - Certain children under 19 living at home, who are disabled and would be eligible if they were living in a medical institution.	§435.225 1902(e)(3) of the SSA		X	Statewide	
Title IV-E Children - Children receiving foster care, adoption assistance, or kinship guardianship assistance under title IV-E *	§435.145		X	Statewide	
Non-Title IV-E Adoption Assistance Under Age 21*	§435.227		X	Statewide	
Children with Special Health Care Needs - Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of Title V, and is defined by the State in terms of either program participation or special health care needs.		X		Statewide	

*** = Note – Individuals in these two Eligibility Groups who are age 19 and 20 can have mandatory enrollment in managed care, while those under age 19 cannot have mandatory enrollment. Use the Notes column to indicate if you plan to mandatorily enroll 19 and 20 year olds in these Eligibility Groups.**

3. **(Optional) Other Exceptions.** The following populations (which can be part of various Eligibility Groups) can be subject to mandatory enrollment in managed care, but states may elect to make exceptions for these or other individuals.

State: Nevada

Citation | Condition or Requirement

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

Population	V	E	Notes
Other Insurance--Medicaid beneficiaries who have other health insurance			**Not applicable:** Having other health insurance doesn't stop someone from being eligible for Medicaid. If a member has another plan, that coverage is used first. Medicaid only steps in after the other insurance has paid, acting as the backup or "last resort" coverage.
Reside in Nursing Facility or ICF/IID--Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).		X	**Nursing Facility:** The MCO is required to cover the first 180 days of nursing facility admission. The MCO shall notify Nevada Medicaid of any nursing facility stay admission expected to exceed 180 days. The beneficiary will be disenrolled from the MCO and the stay will be covered by FFS commencing on the 181st day of the facility stay. **ICF/ID:** Residents of ICF/ID facilities are not eligible for enrollment with the MCO. If a beneficiary is admitted to an ICF/ID after MCO enrollment, the beneficiary will be disenrolled from the MCO and the admission, bed day rate, and ancillary services will be reimbursed through FFS.
Enrolled in Another Managed Care Program--Medicaid beneficiaries who are enrolled in another Medicaid managed care program		X	
Eligibility Less Than 3 Months--Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program			**Not Applicable:** Eligible members are assigned to an MCO through the standard eligibility and enrollment processes. This occurs automatically and consistently, regardless of when eligibility is determined or enrollment takes place. Timing does not affect placement, as the process is designed to ensure that all qualified individuals are enrolled in the MCO without exception.
Participate in HCBS Waiver--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).		X	
Retroactive Eligibility–Medicaid beneficiaries for the period of retroactive eligibility.		X	
Other (Please define): Title XIX Medicaid children under 18 defined as the Severely Emotionally Disturbed (SED)	X		**Statewide** The MCO is required to notify Nevada Medicaid if a Title XIX Medicaid beneficiary elects to disenroll from the MCO following the determination of SED. However, in the event the Medicaid beneficiary, who has received such a determination, chooses to remain enrolled with the MCO, the MCO will be responsible for providing all patient care.

State: Nevada

Citation	Condition or Requirement

Other (Please define): Swing bed stays in acute hospitals over 45 days		X	The MCO is required to cover the first 45 days of a swing bed. The MCO shall notify Nevada Medicaid of any swing bed stay expected to exceed 45 days. The beneficiary will be disenrolled from the MCO and the stay will be covered by FFS commencing on the 46th day of the facility stay.
Other (Please define):			
Other (Please define):			

1932(a)(4)
42 CFR 438.54

F. Enrollment Process.

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

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

      State with voluntary enrollment must have an enrollment choice period or passive enrollment. Please indicate which will apply to the managed care program:

      Nevada uses a passive enrollment process for voluntary managed care populations.

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

State: Nevada

Citation | Condition or Requirement

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

i. If so, please describe the algorithm used for passive enrollment and how the algorithm and the state's provision of information meets all of the requirements of 42 CFR 438.54(c)(4),(5),(6),(7), and (8).

Voluntary populations are assigned an MCO using the same algorithm and notification process described in question 2 below for mandatory enrollment.

ii. Please indicate how long the enrollee will have to disenroll from the plan and return to the fee-for-service delivery system:

Nevada's voluntary managed care populations can request disenrollment from their plan to return to fee-for-service at any time during their managed care enrollment. Disenrollment approval is subject to voluntary population disenrollment requirements as outlined in policy.

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

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

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

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

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

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

For a beneficiary, new to Medicaid or returning, who is joining an open

State: Nevada

Citation	Condition or Requirement

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

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

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

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

If the beneficiary is returning to an open case where another family member is currently enrolled in an MCO, they will automatically be assigned to the same MCO as the rest of the family. They will not have a 90 day right to change period and will be considered locked in until the next open enrollment period.

If there are no other family members on the case currently enrolled in an MCO, and the beneficiary made a new MCO choice on their application, they will be enrolled into their MCO of choice and may disenroll without cause within the first 90 days of enrollment.

If the beneficiary did not make a new choice on their application, they will be assigned to their former MCO and may disenroll without cause within the first 90 days of enrollment.

Regardless of which enrollment or default assignment process is used, the head of household will be notified of all choices that need to be made, the timeframe for making these choices, and the consequence of not making a choice.

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

State: Nevada

Citation | Condition or Requirement

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

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

The beneficiary has a 90 day period in which they are entitled to change MCOs. Beneficiaries may also change their MCO once every 12 months during open enrollment. The Beneficiary has only one opportunity to change their MCO before they are enrolled with an MCO.

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

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

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

***Auto Assignment Algorithm**					
Number of Plans in Geographic Service Area	**Percentage of Beneficiaries Assigned to Largest Plan**	**Percentage of Beneficiaries Assigned to 2nd Largest Plan**	**Percentage of Beneficiaries Assigned to 3rd Largest Plan**	**Percentage of Beneficiaries Assigned to 4th Largest Plan**	**Percentage of Beneficiaries Assigned to 5th Largest Plan**
2 plans	**34%**	**66%**			
3 plans	**17%**	**33%**	**50%**		
4 plans	**10%**	**10%**	**30%**	**50%**	
5 plans	**8%**	**8%**	**14%**	**20%**	**50%**

State: Nevada

Citation | Condition or Requirement

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

Once the State has sufficient quality data from all MCO's in any geographic service area reflecting service delivery to members, the State will use an auto-assignment algorithm based on the MCO's performance on selected quality measures with preference given to high performing MCO's. The State will provide written communication to the MCO's on an annual basis. The quality-based algorithm is as follows:

Number of Contractors	% Assigned to Largest	% Assigned to Second Largest	% Assigned to Third Largest	% Assigned to Fourth Largest	% Assigned to Fifth Largest
Two	34%	66%	N/A	N/A	N/A
Three	17%	33%	50%	N/A	N/A
Four	10%	10%	30%	50%	N/A
Five	8%	8%	14%	20%	50%

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

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

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

3. State assurances on the enrollment process.

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

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

42 CFR 438.56(g)

i. Medicaid beneficiaries with mandatory enrollment in an MCO will have a choice of at least two MCOs unless the area is considered rural as defined in 42 CFR 438.52(b)(3);

ii. Medicaid beneficiaries with mandatory enrollment in a primary care case management system will have a choice of at least two primary care case managers employed by or contracted with the State;

iii. Medicaid beneficiaries with mandatory enrollment in a PCCM entity may be limited to a single PCCM entity and will have a choice of at least two PCCMs employed by or contracted with the PCCM entity.

State: Nevada

Citation	Condition or Requirement

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

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

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

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

42 CFR 438.71

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

1932(a)(4)
42 CFR 438.56

G. Disenrollment.

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

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

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

4. Describe the state's process for notifying the Medicaid beneficiaries of their right to disenroll without cause during the 90 days following the date of their initial enrollment into the MCO, PCCM, or PCCM entity. *(Examples: state generated correspondence, enrollment packets, etc.)*

   A beneficiary in their 90 day right to change period is notified by a Welcome to Managed Care letter mailed by the State's fiscal agent. The letter provides the beneficiary with the instructions and timeframe for requesting a switch in their MCO plan.

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

   A member may request a for "cause" disenrollment at any time. Disenrollments are determined by Nevada Medicaid on a case-by-case basis. Enrollment in a different MCO will be effective on the first of the second administrative month following the month in which the member requests the disenrollment. Disenrollments may not occur mid-month except where expressly required by federal or Nevada regulations.

H. Information Requirements for Beneficiaries.

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

☒The state assures that its state plan program is in compliance with 42 CFR 438.10 for information requirements specific to MCOs, PCCMs, and PCCM entity

State: Nevada

Citation	Condition or Requirement

42 CFR 438.10 programs operated under section 1932(a)(1)(A)(i) state plan amendments.

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

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

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

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

State Plan-Approved Service Delivered by the MCO	Medicaid State Plan Citation		
	Attachment #	Page #	Item #
Ex. Physical Therapy	*3.1-A*	*4*	*11.a*
Inpatient Hospital Services	3.1-A	1	1
Outpatient Hospital Services	3.1-A	1	2.a
Rural Health Clinic Services	3.1-A	1	2.b
FQHC Services	3.1-A	1	2.c
Laboratory and X-ray Services	3.1-A	1	3
Nursing Facility Services for individuals 21 years of age or older.	3.1-A	2	4.a
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	3.1-A	2	4.b
Family Planning Services and supplies for individuals of child-bearing age.	3.1-A	2	4.c
Physicians' Services	3.1-A	2	5.a
Medical and surgical services furnished by a dentist	3.1-A	2	5.b
Podiatrists' Services	3.1-A	2	6.a
Optometrists' Services	3.1-A	3	6.b
Chiropractors' Services	3.1-A	3	6.c
Other Practitioners' Services	3.1-A	3	6.d
Home Health Services	3.1-A	3	7
Private Duty Nursing Services	3.1-A	3	8
Clinic Services	3.1-A	4	9
Physical Therapy and Related Services	3.1-A	4	11.a
Occupational Therapy	3.1-A	4	11.b

State: Nevada

Citation	Condition or Requirement		
Services for individuals with speech, hearing, and language disorders	3.1-A	4	11.c
Prescribed Drugs	3.1-A	5	12
Prosthetic devices	3.1-A	5	12.c
Eyeglasses	3.1-A	5	12.d
Diagnostic Services	3.1-A	5	13.a
Screening Services	3.1-A	6	13.b
Preventive Services	3.1-A	6	13.c
Rehabilitative Services	3.1-A	6	13.d
Services for individuals aged 65 or older in institution for mental diseases	3.1-A	6	14
Inpatient hospital services	3.1-A	6	14.a
Nursing facility services	3.1-A	6	14.b
Medical Nutrition Therapy (MNT)	3.1-A	6a	N/A
Inpatient psychiatric facility services for individuals under 22 years of age.	3.1-A	7	16
Nurse-Midwife Services	3.1-A	7	17
Case Management Services	3.1-A	8	19.a
Extended services to pregnant women	3.1-A	8	20
Respiratory Care Services	3.1-A	8a	22
Certified Pediatric or Family Nurse Practitioners' Services	3.1-A	8a	23
Transportation	3.1-A	9	24
Nursing Facility services for patients under 21 years of age.	3.1-A	9	24.d
Emergency Hospital Services	3.1-A	9	24.e
Personal Care Services	3.1-A	10	26
Freestanding Birth Center Services	3.1-A	11	28
Certified Behavioral Health Center	3.1-A	6c	N/A
Doula Services	3.1-A	6a Cont'd	
Community Health Worker (CHW) Services	3.1-A	6a	

State: Nevada

Citation	Condition or Requirement

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

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

Non-Emergency Transportation (NEMT)
For the Urban Clark and Urban Washoe Service Areas Nevada Medicaid or its designee will authorize and arrange for all covered Medically necessary NEMT in accordance with policy and procedures outlined in the State MSM 1900. The Urban Clark and Urban Washoe MCO's will also coordinate with the NEMT broker and ensure that services are secured. For the Rural Service area, the MCO's are directly responsible for authorizing and arranging all covered Medically Necessary NEMT in accordance with policy and procedures outlined in MSM Chapter 1900.

Non- Emergency Secure Behavioral Health Transport
Non- Emergency Secure Behavioral Health Transport is available to members in accordance with MSM Chapter 1903 and reimbursed under FFS and outside the scope of NEMT. The MCO's are responsible for ensuring referral and coordination of care as well as educating Providers and Members, as appropriate, about the availability of this service.

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

School Health Services (SHS)
School Based Health Clinics are separate and distinct from School Health Services. The school districts can provide, through school district employees or contract personnel, medically necessary covered services. Medicaid reimburses the school districts for these services in accordance with the school districts' provider contract. The MCO will provide covered medically necessary services beyond those available through school districts, or document because the services are not medically necessary. Services may be obtained through the MCO rather than the school district if requested by the parent/legal guardian. The MCO case manager shall coordinate with the school district in obtaining any services which are not covered by the plan or the school district. The MCO

Citation	Condition or Requirement

must maintain regular check-ins between the SHS coordinator and LEAs to stay up to date on efforts to promote State Standards of SHS. The MCO will ensure their delivery system supports the integration of SHS with Medicaid and Nevada Check Up managed care services.

All Pre-Admissions Screening and Resident Review (PASRR) and Level of Care (LOC)
Pre-Admission Screening and Resident Review (PASRR) and Level of Care (LOC) Assessments. All PASRR and LOC are performed by the State's fiscal agent.

Adult Day Health Care (ADHC)
Adult Day Health Care (ADHC) services for eligible Managed Care beneficiaries are covered under fee-for-service in accordance with MSM Chapter 1800. The MCO is responsible for ensuring referral and coordination of care for ADHC services. The MCO must ensure that Members who are receiving ADHC services receive all Medically Necessary services covered in the managed care benefit package.

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

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

Health Homes
Health Home services for eligible managed care enrollees who have FASD are covered and reimbursed under FFS pursuant to MSM Chapter 4200.

Orthodontic Services
Orthodontic services for Members are covered under FFS pursuant to MSM Chapter 1000. The MCO is responsible for ensuring referral and the coordination of care for orthodontic services, pursuant to this Contract.

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

Pharmacy Drug Limitations
Zolgensma® is a high-cost gene therapy drug used to treat children less than 2 years old with spinal muscular atrophy (SMA) is carved out and covered by

Citation	Condition or Requirement

FFS. Members receiving this drug will not be disenrolled from managed care.

1915(C) HCBS Waiver Services.
Members who are receiving HCBS Waiver Services are not eligible for enrollment with the MCO. If a Member is made eligible for HCBS Waiver Services after MCO enrollment, the Member will be disenrolled and the HCBS Waiver Services will be reimbursed through FFS.

Day Habilitation and Residential Habilitation Services.
Day Habilitation and Residential Habilitation services for eligible managed care enrollees who have a traumatic brain injury (TBI) or acquired brain injury (ABI) are covered and reimbursed under FFS pursuant to MSM Chapter 1800.

All Nursing Facility Stays Over One Hundred Eighty (180) Calendar Days.
MCO's cover the first 180 days of a Nursing facility admission. The MCO's are to notify Nevada Medicaid if the Member's nursing facility stay is expected to exceed 180 calendar days. Member will be disenrolled and the stay will be covered under FFS on the 181st calendar day of the nursing facility stay.

Swing Bed Stays in Acute Hospitals.
Swing Bed Stays in Acute Hospitals Over Forty-Five (45) Calendar Days. The MCO is required to cover the first forty-five (45) calendar days of a swing bed admission. The MCO is also required to collect any Patient Liability (PL) for each month a capitation payment is received. The MCO shall notify the State by the fortieth (40th) day of any swing bed stay expected to exceed forty-five (45) calendar days, in accordance with the Reporting Requirements exhibit. The Member will be disenrolled from the MCO and the stay will be covered by FFS commencing on the forty-sixth (46th) calendar day of the facility stay.

1932(a)(5)(D)(b)(4) J. ☒ The state assures that each MCO has established an internal grievance and
42 CFR 438.228 appeal system for enrollees.

1932(a)(5)(D)(b)(5) K. Services, including capacity, network adequacy, coordination, and continuity. 42 CFR 438.62
42 CFR 438.68
42 CFR 438.206
42 CFR 438.207
42 CFR 438.208

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

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

☒ The state assures that all applicable

State: Nevada

Citation	Condition or Requirement

requirements of 42 CFR 438.206, regarding availability of services, will be met.

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

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

The State's contract requires Managed Care organizations to demonstrate that their Primary Care Provider (PCP) network has sufficient capacity, measured in Full-time Equivalent (FTE) requirements, to serve eligible beneficiaries in each service area. MCOs must use geo-mapping and data-driven analyses to comply with access standards and take appropriate corrective action', if necessary. The contract also mandates the division of Clark and Washoe counties into rural and urban areas for compliance purposes. It includes standards for appointment access and wait times, time and distance requirements, long-term services and support (LTSS) and active provider participation. If beneficiary's face issues accessing care, they can contact their MCO which must ensure timely access to the services covered. MCO's partner with Nevada Medicaid community providers, and stakeholders to identify and address issues and opportunities to improve health care access and availability for Medicaid and CHIP members. The following tables detail the access standards outlined in the contract: **Service Type**	**Maximum Appointment Wait Time from the Day of Request**		
	Urban	**Rural**	**Frontier**
Primary Care (adult)*	10 business days	15 business days	15 business days
Primary Care (pediatric)*	10 business days	15 business days	15 business days

State: Nevada

Citation | Condition or Requirement

Outpatient Mental Health and SUD Treatment (adult)	10 business days	10 business days	10 business days
Outpatient Mental Health and SUD Treatment (pediatric)	10 business days	10 business days	10 business days
Obstetrics/Gynecology, other than prenatal care	10 business days	15 business days	15 business days
Prenatal Care in 1st and 2nd trimester	7 calendar days	10 calendar days	10 calendar days
Prenatal Care in 3rd trimester or for high-risk pregnancies	3 calendar days	5 calendar days	5 calendar days
Physical, Occupational, or Speech Therapy	15 business days	20 business days	20 business days

	Maximum Time or Distance (Minutes/Miles)		
Service Type	**Urban**	**Rural**	**Frontier**
Primary Care (adult)	15/10	40/30	70/60
Primary Care (pediatric)	15/10	40/30	70/60
Obstetrics/Gynecology	15/10	40/30	70/60
Infectious Diseases (adult and pediatric)	60/40	110/90	145/130
Mental Health and SUD Treatment (adult)	45/30	75/60	110/100
Mental Health and SUD (pediatric)	45/30	75/60	110/100
Physical, Occupational, and Speech Therapy	45/30	75/60	110/100
Hospital	45/30	75/60	110/100
Pharmacy	15/10	40/30	70/60

1932(c)(1)(A)

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

42 CFR 438.330
42 CFR 438.340

1932(c)(2)(A)

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

42 CFR 438.350
42 CFR 438.354
42 CFR 438.364

1932 (a)(1)(A)(ii)

N. Selective Contracting Under a 1932 State Plan Option.

State: Nevada

Citation	Condition or Requirement

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

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

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

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

Nevada Medicaid contracts with five (5) managed care entities: Anthem Blue Cross Blue Shield, CareSource, Molina Healthcare of Nevada, Silver Summit Health Plan, and Health Plan of Nevada. These entities were contracted through the Nevada Medicaid Request for Proposal procurement process based off evaluation criteria and scoring of submissions.

During the procurement process, Nevada Medicaid received proposals. The State opted to increase the number of selected plans from prior procurement to increase competition in the market and offer more choice to Nevadan Medicaid Managed Care members.

Proposals were evaluated for demonstrated competence, experience in performance of comparable engagements, conformance with the terms of the RFP, expertise and availability of key personnel to serve Nevada Medicaid Managed Care members across Nevada's diverse geographic locations.

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

State: Nevada

Citation	Condition or Requirement

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

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

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

State: Nevada

Citation Condition or Requirement

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

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

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