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State/Territory Name: Nevada

State Plan Amendment (SPA) #: 26-0011

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

Medicaid and CHIP Operations Group

August 13, 2026

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

Re: Nevada State Plan Amendment (SPA) – 26-0011

Dear Administrator Jensen:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN)-26-0011. This amendment proposes to make updates to reflect revisions to Section 202 of the Federal Consolidated Appropriations Act of 2022, which amended two requirements: to include the pursuit of recoveries associated with commercial insurance (CI) if the CI is the primary payer, and includes the requirement for any insurance carrier or third-party payer to respond to a state inquiry.

We conducted our review of your submittal according to statutory requirements in Section 1906A of the Social Security Act and implementing regulations. This letter informs you that Nevada's Medicaid SPA TN 26-0011 was approved on August 13, 2026, with an effective date of June 1, 2026.

Enclosed are copies of Form CMS-179 and approved SPA pages to be incorporated into the State Plan.

If you have any questions, please contact Cecilia Williams at (410) 786-2539 or via email at Cecilia.Williams@cms.hhs.gov.

Sincerely,

Mandy L. Strom
Acting Deputy Director, Division of Program Operations

Enclosures

cc: Jenifer Graham
Cathy Vairo
Cynthia Leech
Casey Angres
Kim Smalley
Cindy Kirste

DEPARTMENT OF HEALTH ANDHUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
0MB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 26-0011

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
June 1, 2026

5. FEDERAL STATUTE/REGULATION CITATION
~~TPL SPA 422 Attachment A, B and C 42 CFR 433.137~~
~~1902(a)(25)(H) and 42 CFR 433.138(f)~~ Section 1906 A of the SSA

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
~~Attachment 4.22-A Page 1 and 2, Attachment 4.22-B Page 1, 2, and 3, and Attachment 4.22-C Page 1, 2, and 3.~~
Attachment 4.22-A Page 1, Page 1 Continued and Page 2
Attachment 4.22 B Pages 1-2
Attachment 4.22 C Pages 1-3

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
~~Attachment 4.22-A Page 1 and 2, Attachment 4.22-B Page 1, 2, and 3, and Attachment 4.22-C Page 1, 2, and 3.~~
Attachment 4.22-A Page 1, Page 1 Continued and Page 2
Attachment 4.22 B Pages 1-2
Attachment 4.22 C Pages 1-3

9. SUBJECT OF AMENDMENT
Updates are being proposed to reflect revisions to Section 202 of the federal Consolidated Appropriations Act of 2022, which amended two requirements: to include the pursuit of recoveries associated with commercial insurance (CI) if the CI is the primary payer, and includes the requirement for any insurance carrier or third party payer to respond to a state inquiry.

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

12. TYPED NAME
ANN JENSEN

13. TITLE
ADMINISTRATOR, NEVADA MEDICAID

14. DATE SUBMITTED
June 2, 2026

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

FOR CMS USE ONLY

16. DATE RECEIVED
June 2, 2026

17. DATE APPROVED
August 13, 2026

PLAN APPROVED- ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL
Mandy L. Strom

21. TITLE OF APPROVING OFFICIAL
Acting Deputy Director, Division of Program Operations

22. REMARKS

07/28/2026: NV concurred to a P&I change to Box 5 via email.
08/11/2026: NV concurred to a P&I change to Boxes 7 &8

Instructions on Back

THIRD PARTY LIABILITY – IDENTIFYING LIABLE RESOURCES

Expansion of Third-Party Liability – Payment of Claims associated to Cost Saving Programs in Attachment 4.22-B of the State Plan.

433.138(d)(1) &(d)(3) (IV-A); (Exchange of Data)

(1) Nevada obtains information for the purpose of determining the legal liability of third parties from data exchanges with the Department of Employment, Training and Rehabilitation, Employment Security Division (ESD), Title IV-A Agency, Title IV-D Agency, Commercial Insurance Carriers, Referrals, Health Insurance Premium Program (HIPP), Third Party Liability (TPL), Nevada Health Authority (NVHA) or its TPL contractor compares Nevada Medicaid's eligibility file against the national commercial platform to determine legal liability of third parties.

The Division of Social Services (DSS) is the State IV-A agency for employment information. Employment information is utilized to determine Medicaid eligibility and employment TPL. Nevada Health Authority (NVHA) or its TPL contractor updates and populates the data into the Medicaid Management Information System (MMIS).

The Nevada Health Authority conducts an exchange of data with the state's TPL contractor. A match of all Medicaid eligibles with responsible absent parent (IV-D) or parent (IV-A) by Social Security Number to determine if they are employed by the state of Nevada.

Support Enforcement (IV-D) has an automated quarterly match with ESD's quarterly wage report and can obtain information upon request. IV-D will follow up on court ordered health insurance or will seek a court order on employed non-custodial parents.

433.138(d)(4) and 433.138 (g)(3)(i) and (iii) (Workers Compensation and Motor Vehicle)

DSS oversees initial application through single point entry system for Medicaid applications. Applicants self-report medical/insurance subrogation information via an online form process.

THIRD PARTY LIABILITY – IDENTIFYING LIABLE RESOURCES

Worker's Compensation and the Department of Motor Vehicles and Public Safety (DMV&PS) information is not available through Nevada's Department Motor Vehicle and Public Safety.

Nevada Health Authority (NVHA) or its TPL contractor are responsible for reviewing and monitoring diagnosis and trauma codes through internal claims review. Claim reports are reviewed by the TPL contractor to determine the possibility of other liable parties for claim payment. Managed Care Organizations and the Dental Benefit Administrator are required to data mine other insurance eligibility for Medicaid enrollees through identification of casualty claims.

The TPL contractor reviews billed claims to determine whether the nature of the trauma warrants follow-up (e.g., a broken leg as a result of a fall in individual's own home versus a traffic accident).

433.138(e) (Diagnosis and Trauma Edits)

The Medicaid claims processing system edits on a per-claim basis to reflect International Classification of Diseases (ICD) codes.

The TPL contractor reviews to determine if the nature of the trauma is one which warrants follow-up (e.g., a broken leg as a result of a fall in individual's own home versus a traffic accident). As of 2016, the Centers for Medicare & Medicaid Services (CMS) no longer specifies codes for follow up or reviews. CMS approved State Medicaid Agency (SMA) exemptions of specific codes from nonproductive trauma code recovery.

433.138(g) (1) (i) and (g) (2) (i)

Nevada Health Authority meets all requirements of 42 CFR 433.138(g) for follow-up procedures for identification of liable third parties.

Follow-up procedures for identifying legally liable third-party resources are as follows:

The eligibility case file is shared with the Nevada Health Authority and used to update MMIS. TPL data is identified, verified and recorded into the MMIS monthly and used to cost-avoid claims, as well as for pay and chase recoveries of claim overpayments.

433.138(g)(2)(i) & (ii)

Upon discovery of a liable third party, post payment recovery is sought within 60 days or in the case of legal actions or a casualty tort case, a lien is filed to protect the State's rights and recoupment of medical payments are sought.

The information is securely maintained by Nevada Health Authority's TPL contractor

for the purpose of subrogation case audits and is integrated into the Medicaid and Children's Health Insurance Program (CHIP) third-party liability database to support claims processing.

The tolerance levels for suspension or termination of recovery efforts are identified in Third Party Liability, Attachment 4.22-B.

THIRD PARTY LIABILITY – PAYMENT OF CLAIMS

Nevada Health Authority includes cost-avoidance strategies, but its primary function is to provide healthcare coverage and improve health outcomes for eligible populations. This approach is used to improve efficiency and reduce costs by coordinating with other insurers, ensuring Medicaid pays only when no other coverage is available. Insurance and claims data are transmitted through secure electronic systems, where each claim is processed individually to determine payment responsibility and ensure proper coordination of benefits. Nevada Health Authority's Third Party Liability (TPL) contractor, contacts insurance carriers directly to verify coverage and collect all relevant information for coordination of benefits.

The Nevada Medicaid billing system is directly connected to the Centers for Medicare & Medicaid Services systems for Medicare crossover claims, Medicare Buy-In, and submission of Transformed Medicaid Statistical Information System (T-MSIS) data. This integration allows coordination of benefits, ensures proper payment responsibilities, and enhances cost savings through post-payment recovery. To support these functions, Nevada has established criteria for both systems that emphasize cost-effectiveness and compliance with Federal Financial Participation (FFP) requirements.
42 CFR 433.139(b)(3)(ii)(C)

I. Cost Avoidance Method

A. Claims for which Nevada Medicaid has paid any amount greater than zero are rejected on the provider's remittance advice. This ensures that providers pursue payment from the appropriate third-party payer and helps Medicaid avoid duplicate payments.

B. Services that an individual insurance policy specifically lists as non-covered are excluded from Nevada Medicaid cost-avoidance or recovery efforts. Nevada Medicaid may pay for these services directly since the primary insurer will not provide coverage.

42 CFR 433.139(f)(2&3), 42 CFR 447.20 and 7 CFR 273.18(e)(8)(ii)

II. Post-Payment Recovery

A. Recovery - Provider

1. The Nevada Health Authority pursues post-payment recoveries from providers only when Medicare or Commercial Insurance is the primary payer. If Medicaid is the primary or sole payer, recovery efforts are not initiated.

2. Claims that were not identified or missed during the initial cost avoidance process are handled according to the procedures outlined in Section 1.a above. Recovery for these claims is performed through computerized history adjustments, ensuring that Medicaid recoups payments when appropriate.

3. Nevada Health Authority does not attempt recovery for claims when more than 36 months have passed between the date of service and the projected adjustment date. This time limit ensures compliance with regulatory and administrative guidelines.

B. Recovery – Insurance Carrier

1. When necessary, Nevada Health Authority may pursue direct recovery from individual insurance carriers. This typically occurs when providers are unsuccessful in billing the primary insurer, but the state, through the Medicaid TPL contractor, has sufficient information to initiate collection.

2. An insurance carrier or third-party payer must respond and not deny a claim submitted by the Nevada Health Authority or its TPL contractor for the following:
   a. Lack of prior authorization if the Nevada Health Authority authorized the medical item or service.
   b. Must respond no later than 60 days after receiving any inquiry by the Nevada Health Authority or its TPL contractor regarding a claim for payment for any medical item or service.
   c. The claim is submitted by the Nevada Health Authority or its TPL contractor, no later than 3 years after the date of the provision of the medical item or service.

III. Casualty – Subrogation

42 CFR 433.139(f)(e)

A. Claims which edit for trauma codes are processed through the regular processing cycle. If the billed amount is $30.00 or greater and no insurance has paid on the claim, the claim is referred to the Nevada Health Authority's TPL contractor for subrogation follow-up.

B. If the billed amount is less than $30.00, no investigation is initiated unless large quantities of claims exist for this diagnosis or service date.

C. Claims with billed amounts of $30.00 or more are investigated and followed through the legal process until settlements are reached or a determination made to drop the case.

IV. Compliance

The Nevada Health Authority is in compliance complies with the following requirements:

A. Apply cost avoidance procedures to claims for prenatal services, including labor, delivery, and postpartum care services.

B. Make payments without regard to potential TPL for pediatric preventive services unless the state has made a determination related to cost-effectiveness and access to care that warrants cost avoidance for up to 90 days.

C. Make payments without regard to potential TPL for up to 100 days for claims related to child support enforcement beneficiaries.

42 CFR 433.139(b)(3), SAA Section 1902 (a)(25)(E)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nevada

Citation	Condition or Requirements

1906 of the Act State Method on Cost Effectiveness of Group Health Plans

1. The methodology used by Nevada for determining cost effectiveness of paying individual or group health insurance premiums for existing coverage shall be as follows:

   a. Applicant must be eligible for Nevada Medicaid for a minimum of six months.

   b. The Nevada Health Authority or its TPL contractor will take the following steps:

      1. Total 6 months of premiums billed by group health plan divided by 6 = Average Premium Cost.

      2. Total 6 months Medicaid Medical Expenditures divided by 6 = Recognized Average Medicaid Expenditures.

      3. Recognized Average Medicaid Expenditures greater than Average Group Health Plan Premium plus Administrative Expenditures = Cost Effectiveness.

   c. The average Medicaid cost includes the benefits covered under the Medicaid eligibility group for which the individual would be determined eligible.

   d. Administrative costs include any additional costs to Medicaid for administering the premium assistance program as well as the following:

      1. Benefits wrap. If Medicaid services covered under the State Plan are not part of the services covered by a recipient's employer health care coverage, the recipient may obtain those services from participating Medicaid providers.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nevada

Citation	Condition or Requirements

2. Cost-sharing wrap. The State will provide a cost-sharing wrap to any cost-sharing amounts that exceed the cost-sharing limits described in the State Plan.

3. Premiums for non-eligible family members. Non-eligible family members are covered only if it is necessary in order to enroll a Medicaid eligible family member in the group health plan.

4. The state may also cover a recipient who has an existing medical confirmed condition or illness that is determined to be cost-effective under the Health Insurance Premium Program (HIPP) expenditure methodology.

2. Individuals enrolled in the premium assistance program are afforded the same beneficiary protections provided to all other Medicaid enrollees. As discussed in the cost-effectiveness test above, the Nevada Medicaid program will provide a benefit wrap and cost-sharing wrap. To effectuate the cost sharing wrap:

a. The State has a provider enrollment process for non-participating providers to ensure that providers that service Medicaid beneficiaries can be enrolled and paid through the state Medicaid program for any and all cost sharing amounts that exceed the Medicaid permissible limits.

b. The State will encourage non-participating providers to enroll by conducting outreach to the provider community to educate non-participating Medicaid providers on how to enroll in Medicaid for the purpose of receiving payment from the State.

c. The State will inform beneficiaries regarding how to contact the state's fiscal agent if the beneficiary intends to obtain care from a non-participating provider.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nevada

Citation	Condition or Requirements

d. In cases where the State becomes aware of a non-participating Medicaid provider, the State may implement a "single case" agreement with that provider to allow cost-sharing wrap for a specific individual.

The cost sharing wrap is required by section 1906(a)(3) of the Social Security Act.

3. Redetermination Review

a. The Nevada Health Authority's contracted Health Insurance Premium Payment (HIPP) vendor shall complete a redetermination review at least yearly for all HIPP enrollees. The yearly review shall consist of:

1. Verifying Medicaid eligibility; and

2. Completing a cost-effective analysis.

Failure to meet HIPP enrollment eligibility cost-effective criteria during annual redetermination review will result in disenrollment from the Nevada Medicaid HIPP Program.