NEVADA STATE DIVISION OF WELFARE & SUPPORTIVE SERVICES
PUBLIC HEARING TO ADOPT MEDICAID AND NEVADA CHECK UP STATE PLAN AND POLICY MANUAL AMENDMENTS

The Public Hearing to Adopt Medicaid and Nevada Check Up State Plan and Policy Manual Amendments was brought to order by Michael J. McMahon, Administrator of the Division of Welfare and Supportive Services, at 1:00 p.m. on Wednesday, September 11, 2013. This meeting was video-conferenced between the Division of Welfare and Supportive Services, Professional Development Center, 701 N. Rancho Drive, Training Room 5, Las Vegas, Nevada and Division of Welfare and Supportive Services, Central Office, 1470 College Parkway, Room 149, Carson City, Nevada.

STAFF PRESENT:

Michael J. McMahon, Administrator
Naomi Lewis, Chief, Eligibility & Payments
Dena Schmidt, Social Services Program Specialist
Jessica Crouch, Social Services Program Specialist
Trina Dahlin, Deputy Attorney General
Miki Allard, Staff Specialist
Kim Schlesener, Executive Assistant
Stephanie Lee, Administrative Assistant, Child Care

DWSS South
Howard Webb, Social Services Program Specialist
Yolanda Munoz, Social Services Program Specialist

GUESTS PRESENT:

North
Tom McCoy, American Cancer Society
Scott Mayne, Washoe and Clark County
Steve Boure, Nevada Rural Hospital Partners (NRHP)
Dwight Hansen, Nevada Hospital Association
Susan Lisagor, Senator Harry Reid's Office, Reno
Marta Stagliano, Department of Health Care Finance and Policy
Chris Bosse, Renown Health

South
Barry Gold, AARP, Las Vegas
Asha Jones, Senator Harry Reid's Office, Las Vegas

Mr. McMahon opened the public hearing at 1:00 p.m. and explained how the hearing will proceed. He explained this public hearing was noticed in accordance with the Open Meeting Law and posted on the Division's web-site. He asked everyone to please sign in and include e-mail addresses to be included on the Division's mailing list.

Mr. McMahon announced that one of the items on the agenda for discussion, S21-Presumptive Eligibility by Hospitals, has been removed from the agenda. The Division of Welfare and Supportive Services (DWSS) received final guidelines from the federal government after the public hearing notice was posted. This item will be heard at a later date.

Mr. McMahon stated that he will take public comment before and after items are heard. He asked if any public attending would like to make a general comment at this time.

Mr. Gold commented that AARP Nevada is very interested in this process and attending today to monitor the process for the implementation of the Affordable Care Act provisions. AARP is hoping to insure that any regulations that are adopted are consumer friendly and transparent to consumers. AARP has been giving a lot of presentations and consumers and Nevada families have a lot of questions about what is going to happen; how this is all going to work when they go to Nevada Health Link site and provide their information and what happens once that information goes into "computerland," or "cyberspace." Who will they be talking to? AARP is following this closely and hoping to get a lot of information that DWSS can share with Nevadans to make this work for them.

Mr. McMahon introduced Dena Schmidt, Social Services Program Specialist, Eligibility and Payments to provide a synopsis of the Medicaid portion of the agenda items. Mr. McMahon stated that he will open each item for comment.

I. Medicaid and Nevada Check Up:

Ms. Schmidt described the section updates as follows:

S10- MAGI Based Income Methodologies –

- In determining the family size for the eligibility determination of other individuals in a household that includes a pregnant woman the pregnant woman is counted just as herself.

- When determining eligibility for current beneficiaries, financial eligibility is based on current monthly household income and family size.

- In determining current monthly or projected annual household income, the state will use reasonable methods to include a prorated portion of a reasonably predictable increase in future income and/or family size and account for a reasonably predictable decrease in future income and/or family size.

- Household income does not include actually available cash support, exceeding nominal amounts, provided by the person claiming an individual described at §435.603(f)(2)(i) as a tax dependent

- The age used for children with respect to MAGI budgeting and eligibility is up to 19.

Mr. McMahon asked if there is any public comment in the north or south.

Hearing no public comment, Mr. McMahon asked Ms. Schmidt to proceed.

S14- AFDC Income Standards –

- The state is electing to adopt the minimum income standard allowable under ACA regulations. This standard reflect the states AFDC Payment standard converted to a MAGI equivalent dollar figure and is used to set the state's minimum income levels for the Parent/Caretaker population under 1931 of the Act.

- The state is not electing automatic increase option for this standard.

Mr. McMahon asked if there is any public comment in the north or south.

Hearing no public comment, Mr. McMahon reiterated that the next item on the agenda, S21-Presumptive Eligibility by Hospitals has been removed from the agenda and will be heard at a future public hearing.

Ms. Schmidt continued:

S25- Eligibility Groups – Mandatory coverage parents and other caretaker relatives

- The state elects to include in the definition of caretaker relative the domestic partner of the parent or other caretaker relative. Caretaker relative includes other relatives of the child based on blood, adoption or marriage and includes step-parents, siblings, step-siblings, grandparents, niece, nephew, uncle, aunt, first cousin and first cousin once removed.

- The state elects to eliminate the requirement that a child meet deprivation.

The state has submitted the minimum income standards for this group at:

Unit size	Standard
1	$ 229
2	$ 296
3	$ 363
4	$ 430
5	$ 496
6	$ 563
7	$ 630
8	$ 696
Each additional	$ 67

The state has submitted the maximum income standards for this group at:

Unit size	Standard
1	$ 319
2	$ 407
3	$ 495
4	$ 582
5	$ 670
6	$ 758
7	$ 846
8	$ 934
Each additional	$ 88

Mr. McMahon asked if there is any public comment in the south or the north.

Hearing no public comment, Mr. McMahon asked Ms. Schmidt to proceed.

S28- Eligibility Groups – Mandatory Coverage Pregnant Women

- The state did not have an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for pregnant women. Therefore the minimum income standard is set at 133% FPL.

- The state is electing to use the state's highest effective income level for coverage of pregnant women in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent of 159% FPL as the maximum income standard for this group.

- Pregnant women eligible under this group receive full Medicaid coverage under this state plan.

Mr. McMahon asked if there is any public comment in the south or the north.

Mr. Hansen asked how the income limits conversion to MAGI was calculated.

Ms. Schmidt responded that CMS suggested a methodology and the state had the option to provide its own methodology. The state presented a methodology using the old rules to determine the disregard people used to get and add that to the income limit. This was done in order to make sure that, while we don't give a disregard in the new world, our income level reflects our old disregards. That way people won't lose eligibility. The old income limit was 133% and once converted becomes 159%. This methodology was submitted to CMS and was approved.

Mr. Hansen asked if it was MAGI as it appears on income tax return.

Ms. Schmidt responded that it is MAGI according to Medicaid regulations, which is not the same as the income tax return. It is the income tax return with some adjustments.

Mr. McMahon asked if there were further comments. There were none.

Ms. Schmidt continued with the agenda items.

S30- Eligibility Groups – Mandatory Coverage Infants and Children under Age 19

- The state did not have an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for infants and children under age 6. Therefore the minimum income standard is set at 133% FPL.

- The maximum income standard for this group is the state's highest effective income level for coverage of infants and children under age 6 in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

- The state has elected the maximum income standard as the standard used for infants and children under age 6.

- For children age six through age eighteen the minimum income standard is 133%PFL and the maximum is the state's highest effective income level for coverage of children age six through eighteen in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of the FPL.

Mr. McMahon asked if there is any public comment in the south or the north.

Hearing no comments, Mr. McMahon asked Ms. Schmidt to proceed.

S32- Eligibility Groups – Mandatory Coverage Adult Group

- The state elects to cover the Adult Group defined as non-pregnant individuals age 19 through 64, not otherwise mandatorily eligible, with income at or below 133% FPL.

- Parents or other caretaker relatives living with a child under the age 19 are not covered unless the child is receiving benefits under Medicaid, CHIP or through the Exchange, or otherwise enrolled in minimum essential coverage.

Mr. McMahon asked if there was any public comment from the north or south.

Mr. Gold commented that AARP is very pleased that Governor and the legislature have chosen to expand Medicaid to include this group. There are an estimated 30,000+ adults aged 50-64 that will meet this threshold and will now be covered under Medicaid and get essential healthcare benefits. AARP will be reaching out to the 50+ community to let them know about this benefit, as well as benefits available through Nevada Health Link, including premium subsidies and insurance coverage, because there are a lot of people over the age of 50 who may have pre-existing conditions that previously could not get insurance. They are hoping that other entities will help AARP reach out to this target audience, including Nevada Health Link to let people know that this is available to them either through Medicaid or through other options.

Mr. McMahon responded that he appreciates AARP's efforts to reach out to the community and help educate our community about the changes that are coming down through the Affordable Care Act.

Ms. Lisagor asked for clarification about the section that states that parents or other caretaker relatives living with a child under the age 19 are not covered unless the child is receiving benefits under Medicaid, CHIP or through the Exchange, or otherwise enrolled in minimum essential coverage.

Ms. Schmidt responded that the parent can't be eligible under the new group unless their child is enrolled in minimum essential coverage. Minimum essential coverage includes Medicaid, CHIP or another health plan. In order for the adult to be eligible, their child has to be enrolled in a minimum essential plan.

Ms. Lisagor also asked if an individual will be eligible for Medicaid as an adult in the 50-64 age range and feels they have just enough resources, though their income may show they are Medicaid eligible, that they would like to buy an exchange policy and get a subsidy, are they able to do that or do they have to take Medicaid?

Ms. Lewis responded that they cannot be eligible for Medicaid and have another insurance policy.

Mr. McMahon also responded, stating that the determination is made in the system, based on

the individual's income, as to whether the individual qualifies for Medicaid or some other form of insurance.

Mr. McMahon asked if there was any public comment from the north or south.

There were no further questions or comments.

Ms. Schmidt continued.

S33- Eligibility Groups – Mandatory Coverage Former Foster Care Children

- The state attests that it covers this new mandatory eligibility group which covers individuals meeting the following criteria:
  - Are under age 26
  - Are not otherwise eligible for and enrolled for mandatory coverage under the state plan, except that eligibility under this group takes precedence over eligibility under the Adult Group.
  - Were in foster care under the responsibility of the state or Tribe and were enrolled in Medicaid under the state's state plan or 1115 demonstration when they turned 18 or at the time of aging out of that state's or Tribe's foster care program.

- The state elects to only cover children who were in foster care and on Medicaid in Nevada at the time they turned 18 or aged out of the foster care system. Children aging out of foster care in another state continue to be covered under the optional group covering independent foster care adolescents up to the age of 21.

Mr. McMahon asked if there were any comments from the north or south.

Mr. Mayne asked for clarification about the section referring to foster care under responsibility of the state. Both Clark and Washoe County child welfare programs are different, even though in the other language the state has the oversight for up to age 26. Mr. Mayne referred to the section regarding care under the responsibility of state or tribe asking if counties should be included because they are the ones responsible for those kids.

Ms. Lewis responded that Washoe County DCFS state duties were transferred to Washoe and Clark counties so those were incorporated; it does cover the counties.

S57- Eligibility Groups Options for Coverage Independent Foster Care Adolescents

- The state continues to cover this optional group of individuals under age 21 who were in state sponsored foster care on their 18th birthday. This group is different from the mandatory group of former foster care children in that it does not require the child to be enrolled in Medicaid at age 18 and it does not provide the option to elect to not cover children aging out in other states. There is no income or resource limit for this

group.

Mr. McMahon asked if public comment from south and north.

Ms. Lisagor asked if children stay in foster care after age 18. How are they different from kids who age out at 18 and have to have been on Medicaid from the beginning to be considered eligible?

Ms. Schmidt responded that the qualifying event is different for these two groups. One group aged out and was in Medicaid program at the time they aged out. The other group could have been in foster care and for some reason not on Medicaid. They are eligible. One goes to 21 and one goes to 26.

Mr. McMahon asked if there are any more questions or comments from the north or south.

Hearing no further comments, Ms. Schmidt continued.

S89- Non-Financial Eligibility Citizenship and Non-Citizen Eligibility

- The state provides Medicaid to citizens and nationals of the United States and certain non-citizens consistent with requirements of 42 CFR 435.406, including during a reasonable opportunity period pending verification of their citizenship, national status or satisfactory immigration status.

- The state does not provide an extension to the reasonable opportunity period of 90 days.

- The state provides benefits during the reasonable opportunity period as of the date of application.

- The state does not elect to provide Medicaid coverage to otherwise eligible individuals under 21 and pregnant women, lawfully residing in the United States.

- The state assures that it provides limited Medicaid services for treatment of an emergency medical condition, not related to an organ transplant procedure, as defined in 1903(v)(3) of the SSA and implemented at 42 CFR 440.255, to the following individuals who meet all Medicaid eligibility requirements, except documentation of citizenship or satisfactory immigration status and/or present a SSN.

Mr. McMahon asked if there were any comments in south or north.

Mr. Boure asked if the eligibility determination takes more than 90 days, do they still have benefits beyond that 90-day period.

Ms. Schmidt responded that this eligibility determination is one that is made when they meet all eligibility criteria except for citizenship.

Mr. McMahon asked if there were any additional comments in the north or south.

Hearing no further comments, Ms. Schmidt continued.

S94- General Eligibility Requirements Eligibility Process

- The state elects to use an alternative single, streamlined application developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary.

- The state elects to use a separate application for individuals applying for coverage who may be eligible on a basis other than the applicable modified adjusted gross income standard.

- The agency permits an individual or authorized person acting on behalf of the individual, to submit an application via the internet website, by telephone, via mail, and in person.

- The agency attests it has procedures to take applications, assist applicants and perform initial processing of applications for the eligibility groups listed below at locations other than those used for the receipt and processing of applications for the title IV-A program, including Federally-qualified health centers and disproportionate share hospitals.

- The agency attest that redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 435.916:
    - Once every 12 months
    - Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency
    - If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.

- Redeterminations of eligibility for individuals whose financial eligibility is not based on the applicable modified adjusted gross income standard are performed, consistent with 42 CFR 435.916:
    - Once every 12 months

- The state attests to meeting the requirements of 42 CFR 435, Subpart M relative to

coordination of eligibility and enrollment between Medicaid, CHIP, Exchanges and other insurance affordability programs. The single state agency has entered into agreements with the Exchange and with other agencies administering insurance affordability programs.

Mr. McMahon asked if there were any comments in the north or south.

Mr. Gold asked if the application process is going to be the same as the current application process for the Medical Assistance to the Aged, Blind and Disabled (MAABD) Program.

Ms. Schmidt responded that, yes, it will continue as it is today.

Mr. McMahon asked if there were any additional comments or questions in the north or south.

Mr. Hansen thanked DWSS for putting in the pre-populated form.

Ms. Bosse asked if an individual submits an application under MAABD, will they first be eligible under another program while waiting to be eligible under MAABD?

Ms. Schmidt responded yes, the process is that they will be evaluated for any eligible group; therefore, because we have that new adult population, if they meet that criteria at the time of the application, they will be enrolled in that program while the state waits, for instance, for an SSI decision.

Ms. Bosse also asked how the 12-month re-determination shows up when an individual goes to the doctor's office. Do they get a card that expires after 12 months or is it an online look up to see if the individual is eligible this month?

Ms. Schmidt responded that it will be online.

Mr. McMahon also responded, stating that in the existing system, the Medicaid eligibility provider would go into the system and look up the individual, confirming the individual's eligibility status.

Ms. Lisagor asked for clarification as to how a review is initiated. Will it be done automatically? Does the information come from the IRS?

Ms. Schmidt responded that the process will be completed based on the information available electronically. Resources will be used such as the work number that gives employer information; this is the current method, which would be used before contacting another source. IRS data is not used.

Mr. McMahon asked if there were any further comments in the north or south.

Hearing no more comments, Ms. Schmidt continued.

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- The state is electing to provide Medicaid eligibility under Transitional Medical Assistance (TMA) for a period of 12 months. The state currently provides 12 months of coverage which requires families to meet reporting requirements and income eligibility to continue coverage in the second six months. The 12 month option removes the reporting requirements.

  In order to be eligible for TMA a family must have been Medicaid eligible under section 1931 in at least 3 of the 6 months immediately preceding the month in which the family became ineligible under section 1931.

Mr. McMahon asked if there were any comments in the north or south.

Hearing no comments, Ms. Schmidt introduced Jessica Crouch, the Nevada Check UP Program Specialist to describe the updates to the Nevada Check Up program.

CS3- Eligibility for Medicaid Expansion Program

- Children 6-18 years of age will be eligible under the Medicaid expansion with income between 123-133% of FPL.

Mr. McMahon asked if there were any comments in the north or south.

Hearing no comments, Ms.Crouch continued.

CS14- Child Health Insurance Program Eligibility Children Ineligible for Medicaid as a Result of the Elimination of Income Disregards

- The state assures that separate CHIP coverage will be provided for children ineligible for Medicaid due to the elimination of income disregards in accordance with 42 CFR 457.310(d). Coverage for this population will cease when the last child protected from loss of Medicaid coverage as a result of the elimination of income disregards has been afforded 12 months of coverage in a separate CHIP (expected to be no later than April 1, 2016.)

- The state will enroll children in a separate CHIP whose family income falls above the converted MAGI Medicaid FPL but at or below the following percentage of FPL. The state has demonstrated and CMS has agreed that all or almost all the children who would have maintained Medicaid eligibility if former disregards were applied will be within this income range and therefore covered in the separate CHIP.

- This population will be provided the same benefits as are provided to children in the

state's separate CHIP. Premiums and cost sharing are the same as for targeted low-income children in the state's CHIP program.

Mr. McMahon asked if there were any comments in the north or south.

Ms. Allard commented that the second bullet in the second line states "at or below the following percentage of FPL", the percentage is not noted.

Ms. Crouch responded that it is 200%.

Ms. Allard stated for clarification, if we adopt this change, it should state that the percentage rate is "at or below 200% FPL."

Ms. Crouch responded that this is correct.

Mr. McMahon asked if there were any other comments in the north or south.

CS15- Separate Child Health Insurance Program MAGI-Based Income Methodologies

- The CHIP program will apply Modified Adjusted Gross Income methodologies for all separate CHIP covered groups. MAGI methodologies will not be applied to ongoing eligible CHIP recipients until March 31, 2014 or the next regularly scheduled renewal of eligibility.

- When determining eligibility for current beneficiaries, financial eligibility is based on current monthly household income and family size.

- In determining current monthly or projected annual household income, the state will use reasonable methods to include a prorated portion of the reasonably predictable increase in future income and/or family size and account for a reasonably predictable decrease in future income and/or family size.

- Household income does not include actually available cash support provided by the person claiming an individual as a tax dependent.

Mr. McMahon asked if there were any comments in the north or south.

Hearing no comments, Ms. Crouch continued.

CS20 -Separate Child Health Insurance Program Non-Financial Eligibility - Substitution of Coverage

- The CHIP agency is electing to remove the waiting period during which an individual is

ineligible due to having dropped group health coverage.

Mr. McMahon asked if there were any comments in the north or south.

Ms. Lisagor asked if someone could give an example of what this means; how it plays out.

Ms. Crouch responded that initially, under the under the CHIP program there was what is refer to as crowd out, which requires 6 month waiting period for a child to be eligible for the Nevada Check Up program. There were, of course, exceptions involved with that crowd out category but this reduces that.

Mr. McMahon also responded that in the old world we had to wait 6 months; in the new world we want to make sure people have continuity of care.

Mr. McMahon asked if there were any comments in the north or south.

Hearing no comments, Ms. Crouch continued.

CS21 - Non-Financial Eligibility-Non-Payment of Premiums Health Separate Child Insurance Program

- The state is implementing the following lock out period related to non-payment of premiums.
  - 90 day lock-out or until paid whichever is sooner. Client reinstated in future month when premium paid within lock-out period. If client does not pay within 90 day lock-out new application will be required.

- The state does not require the collection of past due premiums or enrollment fees as a condition of eligibility for enrollment once the lock-out period has expired.

- Enrollees have an opportunity for an impartial review to address disenrollment from the program in accordance with section 457.1130(a)(3).

- The child will be reenrolled in CHIP during the lock-out period upon payment of past due premiums or enrollment fees.

Mr. McMahon asked if there were any comments in the north or south.

Hearing no comments, Ms. Crouch continued.

CS24- Separate Child Health Insurance Program General Eligibility Processing

- The state elects to use an alternative single, streamlined application developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary.

- The CHIP agency has coordinated eligibility and enrollment screening procedures in place that are applied at time of initial application, periodic redeterminations, and follow-up eligibility determinations. The procedures ensure that only targeted low income children are provided CHIP coverage and that enrollment is facilitated for applicants found to be potentially eligible for other insurance affordability programs.

- Redeterminations of eligibility will be processed once every 12 months without requesting information from the individual if able to do so based on electronic data sources.

- The CHIP agency has adopted procedures to accept and process electronic accounts of individuals screened for potential eligibility by the Exchange.

Mr. McMahon asked if there were any comments in the north or south.

Mr. Hansen asked what criteria is used to determine eligibility.

Ms. Schmidt responded that it would be the same as previously stated, the work number, Social Security or unemployment information.

Mr. McMahon stated that this concludes the items on the agenda and asked if there were any other general comments or questions pertaining to the agenda or anything else that was not listed in the agenda.

Ms. Bosse asked if there was some idea when item S21 – Presumptive Eligibility would be discussed.

Mr. McMahon responded that the final regulations were received on July 15th and that those regulations would be discussed at a hearing which would occur prior to January 2014.

Ms. Lisagor stated that the language is challenging and contradictory in bullets 2 and 4 of CS21. Bullet 2 states that it doesn't require collection of past due premiums or enrollment fees as a condition of eligibility for enrollment once the lockout period is expired and on 4, the child will be reenrolled in CHIP during the lockout period upon payment of past due premiums. So do you have to pay past due to be re-enrolled?

Ms. Crouch responded that to obtain eligibility, this no longer requires that. If it's during the lockout, they have to pay to stay enrolled.

II. GENERAL PUBLIC COMMENT:

Mr. McMahon asked if there were any other comments on this hearing or any items not mentioned at this hearing.

Hearing no comments, Mr. McMahon adopted the amendments on behalf of Mike Willden, Director of the Department of Health and Human Services effective October 1, 2013, as they have been submitted, noting the clarification on item CS14, the verbiage “200% FPL” will be added.

Mr. McMahon thanked those in attendance for their participation in this public hearing. He closed the public hearing at 1:47 p.m.