ASSEMBLY BILL NO. 374–ASSEMBLYMEN SPRINKLE, FRIERSON, ARAUJO, CARLTON, COHEN; ELLIOT ANDERSON, BENITEZ-THOMPSON, BILBRAY-AXELROD, BROOKS, BUSTAMANTE ADAMS, CARRILLO, DALY, DIAZ, FLORES, FUMO, JAUREGUI, JOINER, MCCURDY II, MILLER, NEAL, OHRENSCHALL, SPIEGEL, SWANK, THOMPSON, WATKINS AND YEAGER

MARCH 20, 2017

Referred to Committee on Health and Human Services

SUMMARY—Requires the Department of Health and Human Services to make coverage through the Medicaid managed care program available for purchase. (BDR 38-881)

FISCAL NOTE: Effect on Local Government: No.
Effect on the State: Yes.

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EXPLANATION – Matter in ***bolded italics*** is new; matter between brackets [~~omitted material~~] is material to be omitted.

AN ACT relating to health care; requiring the Department of Health and Human Services to make coverage through the Medicaid managed care program available for purchase; requiring the Director of the Department to seek any necessary waivers from the Federal Government to provide such coverage and to provide certain incentives to persons who purchase such coverage; authorizing the Department to make such coverage available on the Silver State Health Insurance Exchange in certain circumstances; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

1 The Patient Protection and Affordable Care Act (Public Law 111-148, as
2 amended) provides a refundable federal income tax credit and cost-sharing
3 reductions to certain eligible persons who earn not more than 400 percent of the
4 federally designated poverty level in order to offset the cost of certain health care
5 plan premiums. (26 U.S.C. § 36B, 42 U.S.C. § 18071; 45 C.F.R. § 155.305) The
6 Act further requires that such credits and cost-sharing reductions only be made
7 available to purchase health insurance which is offered on a state health insurance

8 exchange, which includes, without limitation, the Silver State Health Insurance
9 Exchange established by this State in 2011. (26 U.S.C. § 36B, 42 U.S.C. § 18071;
10 NRS 695I.200) Existing federal law authorizes the Secretary of the United States
11 Department of Health and Human Services to waive certain Medicaid requirements
12 or provisions of the Act to promote state health care innovation. (42 U.S.C. §§
13 1315, 18052)
14 Existing federal law states that the purpose of the Medicaid program is to
15 promote access to health insurance for certain low-income persons. (42 U.S.C. §
16 1396) Existing law authorizes this State to enroll Medicaid recipients in a managed
17 care program provided by a health maintenance organization pursuant to a contract
18 with the Nevada Department of Health and Human Services. (42 U.S.C. § 1396u-2;
19 NRS 422.273) Existing federal law also authorizes a state to receive its Federal
20 Medical Assistance Percentage (FMAP) allotment of money from the Federal
21 Government to reimburse providers of health care for medical services which are
22 provided as part of a managed care program. (42 U.S.C. §§ 1396d, 1396u-2)
23 Existing law requires this State to develop a State Plan for Medicaid which
24 includes, without limitation, a list of the medical services provided to Medicaid
25 recipients. (42 U.S.C. § 1396a; NRS 422.063) Existing law also prohibits a state
26 from using FMAP or other federal Medicaid money to reimburse a provider of
27 health care for medical services which are provided to a person who earns more
28 than 138 percent of the federally designated poverty level or for other expenses
29 which are unrelated to the administration of Medicaid. (42 U.S.C. §§ 1396a,
30 1396b(a)(7); 42 C.F.R. 433.15(b))
31 **Section 2** of this bill requires the Director of the Nevada Department of Health
32 and Human Services to seek any necessary waiver of certain provisions of federal
33 law to allow a Medicaid managed care program to be offered for purchase through
34 the Silver State Health Insurance Exchange to persons who are otherwise ineligible
35 for Medicaid. Additionally, **section 2** of this bill requires the Director to seek any
36 necessary federal waiver to allow persons to use the federal income tax credits and
37 cost-sharing reductions authorized by the Act to purchase coverage through a
38 Medicaid managed care program which is made available for purchase from the
39 Department or on the Silver State Health Insurance Exchange. **Section 5** of this bill
40 revises the definition of "qualified health plan" to include the Medicaid managed
41 care program so that it may be offered for purchase in the same manner as other
42 health plans through the Silver State Health Insurance Exchange.
43 **Section 3** of this bill requires the Department, to the extent allowed by federal
44 law, to make coverage through the Medicaid managed care program available for
45 purchase to any person who is not otherwise eligible for Medicaid. To purchase
46 such coverage, the person must apply to the Division or may purchase coverage
47 through the Silver State Health Insurance Exchange if the waiver has been obtained
48 from the Secretary of the United States Department of Health and Human Services.
49 **Section 3** requires the annual premium charged for such coverage to be set at an
50 amount which represents 150 percent of the median expenditure paid on behalf of a
51 Medicaid recipient during the immediately preceding fiscal year. **Section 3** further
52 requires the benefits offered in such a managed care program to be the same as
53 those provided to other Medicaid recipients. Finally, **section 3** prohibits the Nevada
54 Department of Health and Human Services from using any federal money to carry
55 out the provisions of that section.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

1 **Section 1.** Chapter 422 of NRS is hereby amended by adding
2 thereto the provisions set forth as sections 2 and 3 of this act.
3 **Sec. 2.** ***The Director shall apply to the Secretary of the***
4 ***United States Department of Health and Human Services for any***
5 ***necessary waiver pursuant to 42 U.S.C. § 1315 or § 18052, as***
6 ***applicable, to:***
7 ***1. Allow the Medicaid managed care program authorized by***
8 ***NRS 422.273 to be made available for purchase through the Silver***
9 ***State Health Insurance Exchange established by NRS 695I.200 to***
10 ***a person who is otherwise ineligible for Medicaid; and***
11 ***2. Allow a person who is determined eligible for advance***
12 ***payments of the premium tax credit and cost-sharing reductions***
13 ***pursuant to 45 C.F.R. § 155.305 to use such credits and reductions***
14 ***to purchase coverage through the Medicaid managed care***
15 ***program.***
16 **Sec. 3.** ***1. To the extent allowed by federal law, the Director***
17 ***shall make coverage through the Medicaid managed care program***
18 ***available for purchase to any person who is not otherwise eligible***
19 ***for Medicaid:***
20 ***(a) Through an application made to the Division in the***
21 ***manner established by the Department by regulation; or***
22 ***(b) If the Secretary of the United States Department of Health***
23 ***and Human Services grants any necessary waiver described in***
24 ***section 2 of this act, through the Silver State Health Insurance***
25 ***Exchange.***
26 ***2. The amount to be charged for the annual premium to a***
27 ***person who purchases coverage through the Medicaid managed***
28 ***care program must be set at an amount which represents 150***
29 ***percent of the median expenditure that was paid on behalf of a***
30 ***recipient of Medicaid during the immediately preceding fiscal***
31 ***year.***
32 ***3. A person who enrolls in a Medicaid managed care***
33 ***program pursuant to this section must receive the same benefits as***
34 ***those received by other recipients of Medicaid.***
35 ***4. The Department must not use any federal money to carry***
36 ***out the requirements of this section.***
37 ***5. The Director shall adopt such regulations as necessary to***
38 ***carry out the provisions of this section.***
39 **Sec. 4.** NRS 422.273 is hereby amended to read as follows:
40 422.273 1. For any Medicaid managed care program
41 established in the State of Nevada, the Department shall contract
42 only with a health maintenance organization that has:

(a) Negotiated in good faith with a federally-qualified health center to provide health care services for the health maintenance organization;

(b) Negotiated in good faith with the University Medical Center of Southern Nevada to provide inpatient and ambulatory services to recipients of Medicaid; and

(c) Negotiated in good faith with the University of Nevada School of Medicine to provide health care services to recipients of Medicaid.

➥ Nothing in this section shall be construed as exempting a federally-qualified health center, the University Medical Center of Southern Nevada or the University of Nevada School of Medicine from the requirements for contracting with the health maintenance organization.

2. During the development and implementation of any Medicaid managed care program, the Department shall cooperate with the University of Nevada School of Medicine by assisting in the provision of an adequate and diverse group of patients upon which the school may base its educational programs.

3. The University of Nevada School of Medicine may establish a nonprofit organization to assist in any research necessary for the development of a Medicaid managed care program, receive and accept gifts, grants and donations to support such a program and assist in establishing educational services about the program for recipients of Medicaid.

4. For the purpose of contracting with a Medicaid managed care program pursuant to this section, a health maintenance organization is exempt from the provisions of NRS 695C.123.

5. The provisions of this section apply to any managed care organization, including a health maintenance organization, that provides health care services to recipients of Medicaid under the State Plan for Medicaid or the Children's Health Insurance Program pursuant to a contract with the Division [.] ***or pursuant to section 2 of this act.*** Such a managed care organization or health maintenance organization is not required to establish a system for conducting external reviews of adverse determinations in accordance with chapter 695B, 695C or 695G of NRS. This subsection does not exempt such a managed care organization or health maintenance organization for services provided pursuant to any other contract.

6. As used in this section, unless the context otherwise requires:

(a) "Federally-qualified health center" has the meaning ascribed to it in 42 U.S.C. § 1396d(l)(2)(B).

(b) "Health maintenance organization" has the meaning ascribed to it in NRS 695C.030.

1 (c) "Managed care organization" has the meaning ascribed to it
2 in NRS 695G.050.
3 **Sec. 5.** NRS 695I.080 is hereby amended to read as follows:
4 695I.080 Except as otherwise provided in NRS 695I.370,
5 "qualified health plan" [has the meaning ascribed to it in] ***means:***
6 ***1. A health plan which meets the requirements of*** § 1301 of
7 the Federal Act [.] ***; or***
8 ***2. The Medicaid managed care program to the extent that it is***
9 ***made available as described in section 2 of this act.***
10 **Sec. 6.** 1. This section and sections 1 and 2 of this act
11 become effective upon passage and approval.
12 2. Sections 3, 4 and 5 of this act become effective upon
13 passage and approval for the purpose of adopting regulations and
14 performing any other preparatory administrative tasks that are
15 necessary to carry out the provisions of this act and on January 1,
16 2018, for all other purposes.

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