Amendment No. 745

Assembly Amendment to Assembly Bill No. 374 (BDR 38-881)
Proposed by: Assembly Committee on Health and Human Services
Amends: Summary: Yes Title: Yes Preamble: No Joint Sponsorship: No Digest: Yes

ASSEMBLY ACTION		Initial and Date	SENATE ACTION		Initial and Date
Adopted ☐	Lost ☐	_____	Adopted ☐	Lost ☐	_____
Concurred In ☐	Not ☐	_____	Concurred In ☐	Not ☐	_____
Receded ☐	Not ☐	_____	Receded ☐	Not ☐	_____

EXPLANATION: Matter in (1) ***blue bold italics*** is new language in the original bill; (2) variations of **green bold underlining** is language proposed to be added in this amendment; (3) ~~red strikethrough~~ is deleted language in the original bill; (4) ~~purple double strikethrough~~ is language proposed to be deleted in this amendment; (5) orange double underlining is deleted language in the original bill proposed to be retained in this amendment.

MKM/RBL Date: 5/17/2017

A.B. No. 374—Requires the Department of Health and Human Services to make coverage through the Medicaid managed care program available for purchase. (BDR 38-881)

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 **, if authorized by federal law,** to ~~[make coverage through the Medicaid managed care program available]~~ **establish a health care plan within Medicaid** for purchase ~~[.]~~ **by persons who are not otherwise eligible for Medicaid.** (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 **, if authorized by federal law,** to ~~[make coverage through the]~~ **establish a health care plan within** Medicaid ~~[managed care program]~~ **which is** available for purchase ~~[.]~~ **by certain persons;** requiring the Director of the Department to seek any necessary waivers from the Federal Government to ~~[provide]~~ **establish** such ~~[coverage]~~ **a plan** and to provide certain incentives to persons who purchase ~~[such]~~ coverage ~~[, authorizing the Department to make such coverage]~~ **through such a plan; including the Nevada Care Plan within the qualified health plans that are** available ~~[on]~~ **through** the Silver State Health Insurance Exchange ~~[in certain circumstances,]~~ **; making an appropriation;** and providing other matters properly relating thereto.

Legislative Counsel's Digest:

The Patient Protection and Affordable Care Act (Public Law 111-148, as amended) provides a refundable federal income tax credit and cost-sharing reductions to certain eligible persons who earn not more than 400 percent of the federally designated poverty level in order to offset the cost of certain health care plan premiums. (26 U.S.C. § 36B, 42 U.S.C. § 18071; 45 C.F.R. § 155.305) The Act further requires that such credits and cost-sharing reductions only be made available to purchase health insurance which is offered on a state health insurance exchange, which includes, without limitation, the Silver State Health Insurance Exchange established by this State in 2011. (26 U.S.C. § 36B, 42 U.S.C. § 18071; NRS 695I.200) Existing federal law authorizes the Secretary of the United States Department of

Health and Human Services to waive certain Medicaid requirements or provisions of the Act to promote state health care innovation. (42 U.S.C. §§ 1315, 18052)

Existing federal law states that the purpose of the Medicaid program is to promote access to health insurance for certain low-income persons. (42 U.S.C. § 1396) Existing law authorizes this State to enroll Medicaid recipients in a managed care program provided by a health maintenance organization pursuant to a contract with the Nevada Department of Health and Human Services. (42 U.S.C. § 1396u-2; NRS 422.273) Existing federal law also authorizes a state to receive its Federal Medical Assistance Percentage (FMAP) allotment of money from the Federal Government to reimburse providers of health care for medical services which are provided as part of a managed care program. (42 U.S.C. §§ 1396d, 1396u-2) Existing law requires this State to develop a State Plan for Medicaid which includes, without limitation, a list of the medical services provided to Medicaid recipients. (42 U.S.C. § 1396a; NRS 422.063) Existing law also prohibits a state from using FMAP or other federal Medicaid money to reimburse a provider of health care for medical services which are provided to a person who earns more than 138 percent of the federally designated poverty level or for other expenses which are unrelated to the administration of Medicaid. (42 U.S.C. §§ 1396a, 1396b(a)(7); 42 C.F.R. 433.15(b))

Section 2 of this bill requires the Director of the Nevada Department of Health and Human Services to seek any necessary waiver of certain provisions of federal law to allow ~~[a Medicaid managed care program]~~ **the Nevada Care Plan, if established pursuant to section 3 of this bill,** to be offered **by certain insurers or** for purchase through the Silver State Health Insurance Exchange to persons who are otherwise ineligible for Medicaid. Additionally, **section 2** ~~[of this bill]~~ requires the Director to seek any necessary federal waiver to allow persons to use the federal income tax credits and cost-sharing reductions authorized by the Act to purchase coverage through ~~[a Medicaid managed care program which is made available for purchase from the Department or on the Silver State Health Insurance Exchange.]~~ **the Nevada Care Plan.** **Section 5** of this bill revises the definition of "qualified health plan" to include the ~~[Medicaid managed care program]~~ **Nevada Care Plan** so that it may be offered for purchase in the same manner as other health plans through the Silver State Health Insurance Exchange ~~[.]~~ **, if established.**

Section 3 of this bill requires the Department, to the extent allowed by federal law, to **establish the Nevada Care Plan within Medicaid and** make coverage through the ~~[Medicaid managed care program]~~ **Plan** available for purchase to any person who is not otherwise eligible for Medicaid. ~~[To purchase such coverage, the person must apply to the Division or may purchase coverage through the Silver State Health Insurance Exchange if the waiver has been obtained from the Secretary of the United States Department of Health and Human Services. Section 3 requires the annual premium charged for such coverage to be set at an amount which represents 150 percent of the median expenditure paid on behalf of a Medicaid recipient during the immediately preceding fiscal year.]~~ **Section 3** further requires the benefits offered ~~[in such a managed care program]~~ **by the Nevada Care Plan** to be the same as those provided to ~~[other]~~ Medicaid recipients. ~~[. Finally, section 3 prohibits the Nevada Department of Health and Human Services from using any federal money to carry out the provisions of that section.]~~ **who do not participate in the Medicaid managed care program, except that transportation services that are provided when there is not an emergency are not required to be covered.**

Section 5.5 of this bill makes an appropriation to the Division of Health Care Financing and Policy of the Department for costs associated with establishing and administering the Nevada Care Plan.

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

Section 1. Chapter 422 of NRS is hereby amended by adding thereto the provisions set forth as sections 2 and 3 of this act.

Sec. 2. *The Director shall apply to the Secretary of the United States Department of Health and Human Services for any necessary waiver pursuant to 42 U.S.C. § 1315 or § 18052, as applicable, to:*

1. Allow the ~~[Medicaid managed care program authorized by NRS 422.273 to be]~~ Director to enter into a contract with one or more insurers to provide coverage to persons who enroll in the Nevada Care Plan established pursuant to section 3 of this act and which may be made available for purchase through the Silver State Health Insurance Exchange established by NRS 695I.200 ; ~~[to a person who is otherwise ineligible for Medicaid;]~~ and

2. Allow a person who is determined eligible for advance payments of the premium tax credit and cost-sharing reductions pursuant to 45 C.F.R. § 155.305 to use such credits and reductions to purchase coverage through the ~~[Medicaid managed care program.]~~ Nevada Care Plan.

Sec. 3. *1. To the extent allowed by federal law, the Director shall establish the Nevada Care Plan within Medicaid and make coverage ~~[through the Medicaid managed care program]~~ available for purchase through the Plan to any person who is not otherwise eligible for Medicaid . ~~[:~~*

~~(a) Through an application made to the Division in the manner established by the Department by regulation; or~~

~~(b) If the Secretary of the United States Department of Health and Human Services grants any necessary waiver described in section 2 of this act, through the Silver State Health Insurance Exchange.]~~

2. The ~~[amount to be charged for the annual premium to a person who purchases coverage through the Medicaid managed care program must be set at an amount which represents 150 percent of the median expenditure that was paid on behalf of a recipient of Medicaid during the immediately preceding fiscal year.~~

~~3. A]~~ coverage provided to a person who enrolls in ~~[a Medicaid managed care program pursuant to this section]~~ the Nevada Care Plan must ~~[receive]~~ be the same ~~[benefits]~~ as ~~[those received by other]~~ the coverage provided to recipients of Medicaid ~~[.~~

~~4. The Department must not use any federal money to carry out the requirements of this section.~~

~~5.]~~ who do not participate in a Medicaid managed care program, except that transportation services that are provided when there is not an emergency, including, without limitation, pursuant to NRS 422.27495, are not required to be included in such coverage.

3. If the Secretary of the United States Department of Health and Human Services grants any necessary waiver described in section 2 of this act:

(a) The Director may enter into a contract with one or more providers of insurance to provide the coverage described in this section to persons who enroll in the Nevada Care Plan; and

(b) May make the Nevada Care Plan available for purchase through the Silver State Health Insurance Exchange established by NRS 695I.200.

4. The Director shall , in consultation with the Commissioner of Insurance and the Executive Director of the Silver State Health Insurance Exchange, adopt such regulations as necessary to carry out the provisions of this section.

5. As used in this section, "provider of insurance" has the meaning ascribed to it in NRS 679A.118.

Sec. 4. ~~[NRS 422.273 is hereby amended to read as follows:~~

~~422.273 1. For any Medicaid managed care program established in the State of Nevada, the Department shall contract 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.~~

~~(c) "Managed care organization" has the meaning ascribed to it in NRS 695G.050.]~~ **(Deleted by amendment.)**

Sec. 5. NRS 695I.080 is hereby amended to read as follows:

695I.080 Except as otherwise provided in NRS 695I.370, "qualified health plan" ~~[has the meaning ascribed to it in]~~ ***means:***

1. A health plan which meets the requirements of § 1301 of the Federal Act ~~[]~~ ***; or***

2. The ~~[Medicaid managed care program to the extent that it is made available as described in section 2 of this act.]~~ Nevada Care Plan if established pursuant to section 3 of this act.

Sec. 5.5. **1. There is hereby appropriated from the State General Fund to the Division of Health Care Financing and Policy of the Department of Health and Human Services for the administrative expenses to establish and administer the Nevada Care Plan pursuant to sections 2 and 3 of this act the following sums:**

For the Fiscal Year 2017-2018 ..... $89,540

For the Fiscal Year 2018-2019 ..... $89,540

2. Any balance of the sums appropriated by subsection 1 remaining at the end of the respective fiscal years must not be committed for expenditure after June 30 of the respective fiscal years by the entity to which the appropriation is made or any entity to which money from the appropriation is granted or otherwise transferred in any manner, and any portion of appropriated money remaining must not be spent for any purpose after September 21, 2018, and September 20, 2019, respectively, by either the entity to which the money was appropriated or the entity to which the money was subsequently granted or transferred, and must be reverted to the State General Fund on or before September 21, 2018, and September 20, 2019, respectively.

Sec. 6. 1. This section and sections 1 and 2 of this act become effective upon passage and approval.

2. **Section 5.5 of this act becomes effective on July 1, 2017.**

3. Sections 3, 4 and 5 of this act become effective upon passage and approval for the purpose of adopting regulations and performing any other preparatory administrative tasks that are necessary to carry out the provisions of this act and on January 1, ~~[~~2018,~~]~~ **2019,** for all other purposes.