[Nev. Rev. Stat. §§ 422.270 through 422.27495.]

§§ 422.270 through 422.27495: Health Care Financing and Policy -- State Plan for Medicaid and Children's Health Insurance Program

§ 422.270. Duties of Department regarding Medicaid and Children's Health Insurance Program.

The Department shall:

1. Administer Medicaid and the Children's Health Insurance Program.

2. Act as the single state agency of the State of Nevada and its political subdivisions in the administration of any federal money granted to the State of Nevada to aid in the furtherance of Medicaid and the Children's Health Insurance Program.

3. Cooperate with the Federal Government in adopting state plans, in all matters of mutual concern, including adoption of methods of administration found by the Federal Government to be necessary for the efficient operation of Medicaid and the Children's Health Insurance Program and in increasing the efficiency of Medicaid and the Children's Health Insurance Program by prompt and judicious use of new federal grants which will assist the Department in carrying out the provisions of this chapter.

4. Observe and study the changing nature and extent of needs for Medicaid and the Children's Health Insurance Program and develop through tests and demonstrations effective ways of meeting those needs and employ or contract for personnel and services supported by legislative appropriations from the State General Fund or money from federal or other sources.

5. Enter into reciprocal agreements with other states relative to Medicaid and institutional care, when deemed necessary or convenient by the Director.

§ 422.2703. Department required to establish and maintain system for electronic submission of applications for Medicaid or Children's Health Insurance Program.

1. The Department shall establish and maintain a system which allows an applicant for Medicaid or the Children's Health Insurance Program to submit the application electronically. The system must allow an applicant to submit an application through the Internet or another on-line service designated by the Department.

2. An agency designated by the Director to receive applications or determine eligibility for Medicaid or the Children's Health Insurance Program shall use the system established pursuant to subsection 1 to forward to the Department all applications received by the agency.

3. An applicant for Medicaid or the Children's Health Insurance Program must not be required to submit an application electronically. If an applicant submits a written application to an agency designated by the Director, the agency shall create an electronic application on behalf of the applicant and use the system established pursuant to subsection 1 to forward the application to the Department.

§ 422.2704. Review of rates of reimbursement.

On or before January 1, 2018, and every 4 years thereafter, the Division shall:

1. Review the rate of reimbursement for each service or item provided under the State Plan for Medicaid to determine whether the rate of reimbursement accurately reflects the actual cost of providing the service or item; and

2. If the Division determines that the rate of reimbursement for a service or item does not accurately reflect the actual cost of providing the service or item, calculate the rate of reimbursement that accurately reflects the actual cost of providing the service or item and recommend that rate to the Director for possible inclusion in the State Plan for Medicaid.

§ 422.2712. Reporting of certain rates of reimbursement for physicians.

1. The Department, with respect to the State Plan for Medicaid and the Children's Health Insurance Program, shall report every rate of reimbursement for physicians which is provided on a fee-for-service basis and which is lower than the rate provided on the current Medicare fee schedule for care and services provided by physicians.

2. The Director shall post on an Internet website maintained by the Department a schedule of such rates of reimbursement.

3. The Director shall, on or before February 1 of each year, submit a report concerning the schedule of such rates of reimbursement to the Director of the Legislative Counsel Bureau for transmittal to the Legislature in odd-numbered years or to the Legislative Committee on Health Care in even-numbered years.

§ 422.2717. State Plan for Medicaid: Inclusion of requirement that independent foster care adolescents are eligible for Medicaid.

1. The Director shall include in the State Plan for Medicaid a requirement that an independent foster care adolescent is eligible for Medicaid.

2. As used in this section, "independent foster care adolescent" means:

(a) A person described in 42 U.S.C. § 1396d(w)(1), as that section existed on July 1, 2005; or

(b) If the Director specifies a different category of adolescents in the manner set forth in 42 U.S.C. § 1396a(a)(10)(A)(ii)(XVII), as that section existed on July 1, 2005, a person who is within such a category.

§ 422.27172. State Plan for Medicaid: Inclusion of requirement for payment of certain costs related to family planning.

1. The Director shall include in the State Plan for Medicaid a requirement that the State pay the nonfederal share of expenditures incurred for:

(a) Up to a 12-month supply, per prescription, of any type of drug for contraception or its therapeutic equivalent which is:

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration; and

(3) Dispensed in accordance with NRS 639.28075;

(b) Any type of device for contraception which is lawfully prescribed or ordered and which has been approved by the Food and Drug Administration;

(c) Insertion or removal of a device for contraception;

(d) Education and counseling relating to the initiation of the use of contraceptives and any necessary follow-up after initiating such use;

(e) Management of side effects relating to contraception; and

(f) Voluntary sterilization for women.

2. Except as otherwise provided in subsections 4 and 5, to obtain any benefit provided in the Plan pursuant to subsection 1, a person enrolled in Medicaid must not be required to:

(a) Pay a higher deductible, any copayment or coinsurance; or

(b) Be subject to a longer waiting period or any other condition.

3. The Director shall ensure that the provisions of this section are carried out in a manner which complies with the requirements established by the Drug Use Review Board and set forth in the list of preferred prescription drugs established by the Department pursuant to NRS 422.4025.

4. The Plan may require a person enrolled in Medicaid to pay a higher deductible, copayment or coinsurance for a drug for contraception if the person refuses to accept a therapeutic equivalent of the contraceptive drug.

5. For each method of contraception which is approved by the Food and Drug Administration, the Plan must include at least one contraceptive drug or device for which no deductible, copayment or coinsurance may be charged to the person enrolled in Medicaid, but the Plan may charge a deductible, copayment or coinsurance for any other contraceptive drug or device that provides the same method of contraception.

6. As used in this section:

(a) "Drug Use Review Board" has the meaning ascribed to it in NRS 422.402.

(b) "Therapeutic equivalent" means a drug which:

(1) Contains an identical amount of the same active ingredients in the same dosage and method of administration as another drug;

(2) Is expected to have the same clinical effect when administered to a patient pursuant to a prescription or order as another drug; and

(3) Meets any other criteria required by the Food and Drug Administration for classification as a therapeutic equivalent.

§ 422.27174. State Plan for Medicaid: Inclusion of requirement for payment of certain costs for preventative care.

1. The Director shall include in the State Plan for Medicaid a requirement that the State pay the nonfederal share of expenditures incurred for:

(a) Counseling and support for breastfeeding;

(b) Screening and counseling for interpersonal and domestic violence;

(c) Counseling for sexually transmitted diseases;

(d) Screening for blood pressure abnormalities and diabetes, including gestational diabetes;

(e) An annual screening for cervical cancer;

(f) Screening for depression;

(g) Screening and counseling for the human immunodeficiency virus;

(h) Smoking cessation programs;

(i) All vaccinations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention of the United States Department of Health and Human Services or its successor organization; and

(j) Such well-woman preventative visits as recommended by the Health Resources and Services Administration.

2. To obtain any benefit provided in the Plan pursuant to subsection 1, a recipient of Medicaid must not be required to:

(a) Pay a higher deductible, any copayment or coinsurance; or

(b) Be subject to a longer waiting period or any other condition.

§ 422.27176. State Plan for Medicaid: Inclusion of requirement for payment of certain costs for mammogram.

The Director shall include in the State Plan for Medicaid a requirement that the State pay the nonfederal share of expenditures incurred for a mammogram.

§ 422.27178. State Plan for Medicaid: Inclusion of requirement for payment of certain costs for breastfeeding supplies and prenatal screenings and tests.

The Director may include in the State Plan for Medicaid a requirement that, to the extent money is available, the State pay the nonfederal share of expenditures incurred for:

1. Supplies for breastfeeding; and

2. Such prenatal screenings and tests as recommended by the American College of Obstetricians and Gynecologists or its successor organization.

§ 422.2718. State Plan for Medicaid: Inclusion of requirement for payment of certain expenses related to testing for human papillomavirus and administration of human papillomavirus vaccine.

1. The Director shall include in the State Plan for Medicaid a requirement that the State shall pay the nonfederal share of expenses incurred for:

(a) Testing for human papillomavirus; and

(b) Administering the human papillomavirus vaccine at such ages as recommended for vaccination by a competent authority, including, without limitation, the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the Food and Drug Administration or the manufacturer of the vaccine.

2. For the purposes of this section, "human papillomavirus vaccine" means the Quadrivalent Human Papillomavirus Recombinant Vaccine or its successor which is approved by the Food and Drug Administration to be used for the prevention of human papillomavirus infection and cervical cancer.

§ 422.2719. State Plan for Medicaid: Inclusion of requirement for payment of certain costs related to fetal alcohol spectrum disorders.

1. The Director shall include in the State Plan for Medicaid a requirement that the State pay the nonfederal share of expenditures incurred for screening for and diagnosis of fetal alcohol spectrum disorders and for treatment of fetal alcohol spectrum disorders to persons under the age of 19 years or, if enrolled in high school, until the person reaches the age of 21 years.

2. A 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, which provides coverage for outpatient care shall not require a longer waiting period for coverage for outpatient care related to fetal alcohol spectrum disorders than is required for other outpatient care covered by the plan.

3. A managed care organization shall cover medically necessary treatment of a fetal alcohol spectrum disorder.

4. Treatment of a fetal alcohol spectrum disorder must be identified in a treatment plan and must include medically necessary habilitative or rehabilitative care, prescription care, psychiatric care, psychological care, behavioral therapy or therapeutic care that is:

(a) Prescribed for a person diagnosed with a fetal alcohol spectrum disorder by a licensed physician or licensed psychologist; and

(b) Provided for a person diagnosed with a fetal alcohol spectrum disorder by a licensed physician, licensed psychologist, licensed behavior analyst or other provider that is supervised by the licensed physician, psychologist or behavior analyst.

A managed care organization may request a copy of and review a treatment plan created pursuant to this subsection.

5. Nothing in this section shall be construed as requiring a managed care organization to provide reimbursement to a school for services delivered through school services.

6. As used in this section:

(a) "Applied behavior analysis" means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including, without limitation, the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

(b) "Behavioral therapy" means any interactive therapy derived from evidence-based research, including, without limitation, discrete trial training, early intensive behavioral intervention, intensive intervention programs, pivotal response training and verbal behavior provided by a licensed psychologist, licensed behavior analyst, licensed assistant behavior analyst or registered behavior technician.

(c) "Evidence-based research" means research that applies rigorous, systematic and objective procedures to obtain valid knowledge relevant to fetal alcohol spectrum disorders.

(d) "Fetal alcohol spectrum disorder" has the meaning ascribed to it in NRS 432B.0655.

(e) "Habilitative or rehabilitative care" means counseling, guidance and professional services and treatment programs, including, without limitation, applied behavior analysis, that are necessary to develop, maintain and restore, to the maximum extent practicable, the functioning of a person.

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

(g) "Licensed assistant behavior analyst" means a person who holds current certification as a Board Certified Assistant Behavior Analyst issued by the Behavior Analyst Certification Board, Inc., or any successor in interest to that organization, who is licensed as an assistant behavior analyst by the Aging and Disability Services Division of the Department of Health and Human Services and who provides behavioral therapy under the supervision of a licensed behavior analyst or psychologist.

(h) "Licensed behavior analyst" means a person who holds current certification as a Board Certified Behavior Analyst issued by the Behavior Analyst Certification Board, Inc., or any successor in interest to that organization, and is licensed as a behavior analyst by the Aging and Disability Services Division of the Department.

(i) "Managed care organization" has the meaning ascribed to it in NRS 695G.050.

(j) "Medically necessary" means health care services or products that a prudent physician or psychologist would provide to a patient to prevent, diagnose or treat an illness, injury or disease, or any symptoms thereof, that are necessary and which are:

(1) Provided in accordance with generally accepted standards of medical practice;

(2) Clinically appropriate for the type, frequency, extent, location and duration;

(3) Not primarily provided for the convenience of the patient, physician, psychologist or other provider of health care;

(4) Required to improve a specific health condition of the patient or to preserve the existing state of health of the patient; and

(5) The most clinically appropriate level of health care that may be safely provided to the patient.

(k) "Prescription care" means medications prescribed by a licensed physician and any health-related services deemed medically necessary to determine the need or effectiveness of the medications.

(l) "Psychiatric care" means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

(m) "Psychological care" means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

(n) "Registered behavior technician" has the meaning ascribed to it in NRS 437.050.

(o) "Screening for and diagnosis of fetal alcohol spectrum disorders" means medically appropriate assessments, evaluations or tests to screen and diagnose whether a person has a fetal alcohol spectrum disorder.

(p) "Therapeutic care" means services provided by licensed or certified speech-language pathologists, occupational therapists and physical therapists.

(q) "Treatment plan" means a plan to treat a fetal alcohol spectrum disorder that is prescribed by a licensed physician or licensed psychologist and may be developed pursuant to a comprehensive evaluation in coordination with a licensed behavior analyst.

§ 422.272. State Plan for Medicaid: Inclusion of requirement for payment of certain costs.

1. The Director shall include in the State Plan for Medicaid a requirement that the State shall pay the nonfederal share of expenditures for the medical, administrative and transactional costs, to the extent not covered by private insurance, of a person:

(a) Who is admitted to a hospital, facility for intermediate care or facility for skilled nursing for not less than 30 consecutive days;

(b) Who is covered by the State Plan for Medicaid; and

(c) Whose net countable income per month is not more than a percentage prescribed annually by the Director of the supplemental security income benefit rate established pursuant to 42 U.S.C. § 1382(b)(1). The Director shall ensure that the percentage prescribed pursuant to this paragraph complies with federal law.

2. As used in this section:

(a) "Facility for intermediate care" has the meaning ascribed to it in NRS 449.0038.

(b) "Facility for skilled nursing" has the meaning ascribed to it in NRS 449.0039.

(c) "Hospital" has the meaning ascribed to it in NRS 449.012.

§ 422.2721. State Plan for Medicaid: Payment for services provided through telehealth.

1. The Director shall include in the State Plan for Medicaid:

(a) A requirement that the State, and, to the extent applicable, any of its political subdivisions, shall pay for the nonfederal share of expenses for services provided to a person through telehealth to the same extent as though provided in person or by other means; and

(b) A provision prohibiting the State from:

(1) Requiring a person to obtain prior authorization that would not be required if a service were provided in person or through other means, establish a relationship with a provider of health care or provide any additional consent to or reason for obtaining services through telehealth as a condition to paying for services as described in paragraph (a). The State Plan for Medicaid may require prior authorization for a service provided through telehealth if such prior authorization would be required if the service were provided in person or through other means.

(2) Requiring a provider of health care to demonstrate that it is necessary to provide services to a person through telehealth or receive any additional type of certification or license to provide services through telehealth as a condition to paying for services as described in paragraph (a).

(3) Refusing to pay for services as described in paragraph (a) because of the distant site from which a provider of health care provides services through telehealth or the originating site at which a person who is covered by the State Plan for Medicaid receives services through telehealth.

(4) Requiring services to be provided through telehealth as a condition to paying for such services.

2. The provisions of this section do not:

(a) Require the Director to include in the State Plan for Medicaid coverage of any service that the Director is not otherwise required by law to include; or

(b) Require the State or any political subdivision thereof to:

(1) Ensure that covered services are available to a recipient of Medicaid through telehealth at a particular originating site; or

(2) Provide coverage for a service that is not included in the State Plan for Medicaid or provided by a provider of health care that does not participate in Medicaid.

3. As used in this section:

(a) "Distant site" has the meaning ascribed to it in NRS 629.515.

(b) "Originating site" has the meaning ascribed to it in NRS 629.515.

(c) "Provider of health care" has the meaning ascribed to it in NRS 439.820.

(d) "Telehealth" has the meaning ascribed to it in NRS 629.515.

§ 422.2723. State Plan for Medicaid: Inclusion of requirement for payment of certain costs relating to dialysis and emergency care to treat kidney failure.

1. The Director shall include in the State Plan for Medicaid a requirement that the State shall pay the nonfederal share of expenses incurred in the administration of dialysis that is provided to stabilize a patient with kidney failure and further emergency care necessary for the treatment of such kidney failure.

2. For the purposes of this section, "dialysis" means the method by which a dissolved substance is removed from the body of a patient by diffusion, osmosis and convection from one fluid compartment to another fluid compartment across a semipermeable membrane.

§ 422.27234. State Plan for Medicaid: Inclusion of requirement for payment of certain costs related to sickle cell disease and its variants.

1. The Director shall include in the State Plan for Medicaid a requirement that the State pay the nonfederal share of expenditures incurred for:

(a) Necessary case management services for a participant in Medicaid who has been diagnosed with sickle cell disease and its variants.

(b) Medically necessary care for a participant in Medicaid who has been diagnosed with sickle cell disease and its variants including, without limitation, visits to specialists for evaluation, counseling, treatment for mental illness and education as needed.

(c) Services necessary to transition a recipient of Medicaid who is less than 18 years of age and has been diagnosed with sickle cell disease and its variants from pediatric care to adult care when the recipient reaches 18 years of age.

(d) Unlimited refills of each prescription drug for the treatment of sickle cell disease and its variants included on the list of preferred prescription drugs developed for the Medicaid program pursuant to NRS 422.4025.

(e) Each supplement included in the list of supplements prescribed pursuant to NRS 422.4026, including, without limitation, unlimited amounts of each such supplement.

2. As used in this section:

(a) "Case management services" means medical or other health care management services to assist patients and providers of health care, including, without limitation, identifying and facilitating additional resources and treatments, providing information about treatment options and facilitating communication between providers of services to a patient.

(b) "Sickle cell disease and its variants" has the meaning ascribed to it in NRS 439.4927.

§ 422.27238 State Plan for Medicaid: Reimbursement for crisis stabilization services.

The Department shall take any action necessary to ensure that crisis stabilization services provided at a psychiatric hospital established pursuant to NRS 449.0915 are reimbursable under Medicaid to the same extent as if the services were provided in another covered facility.

§ 422.27239. State Plan for Medicaid: Reimbursement for services of psychological assistant, psychological intern or psychological trainee.

1. The Department, through the Division, may reimburse, under the State Plan for Medicaid and to the extent authorized by the Federal Government, any psychologist licensed pursuant to chapter 641 of NRS who supervises a psychological assistant, psychological intern or psychological trainee for such services rendered under the authorized scope of practice of the psychological assistant, psychological intern or psychological trainee to persons eligible to receive that assistance if another provider of health care would be reimbursed for providing those same services.

2. As used in this section:

(a) "Psychological assistant" has the meaning ascribed to it in NRS 641.0263.

(b) "Psychological intern" has the meaning ascribed to it in NRS 641.0265.

(c) "Psychological trainee" has the meaning ascribed to it in NRS 641.0267.

§ 422.2724 State Plan for Medicaid: Reimbursement of registered nurse for certain services provided to persons eligible for Medicaid.

The Department, through the Division, may reimburse directly, under the State Plan for Medicaid, any registered nurse who is authorized pursuant to chapter 632 of NRS to perform additional acts in an emergency or under other special conditions as prescribed by the State Board of Nursing, for such services rendered under the authorized scope of the registered nurse's practice to persons eligible to receive that assistance if another provider of health care would be reimbursed for providing those same services.

§ 422.27241. State Plan for Medicaid: Reimbursement for services for hospice care provided to persons eligible for Medicaid.

1. Except as otherwise provided in subsection 2, the Department, through the Division, shall pay, under the State Plan for Medicaid:

(a) A facility for hospice care licensed pursuant to chapter 449 of NRS for the services for hospice care, including room and board, provided by that facility to a person who is eligible to receive Medicaid.

(b) A program for hospice care licensed pursuant to chapter 449 of NRS for the services for hospice care provided by that program to a person who is eligible to receive Medicaid.

2. The Department, through the Division, is required to pay, under the State Plan for Medicaid, for the services for hospice care provided by a facility or program described in subsection 1 only to the extent that the Federal Government provides matching federal money under Medicaid for the services for hospice care.

3. As used in this section:

(a) "Facility for hospice care" has the meaning ascribed to it in NRS 449.0033.

(b) "Hospice care" has the meaning ascribed to it in NRS 449.0115.

§ 422.27242. State Plan for Medicaid and Children's Health Insurance Program: Inclusion of authorization for enrollment of certain children.

1. Except as otherwise provided in subsection 2, the Director shall:

(a) To the extent authorized by federal law, include in the State Plan for Medicaid and in the Children's Health Insurance Program authorization for a child less than 19 years of age who is described in 42 U.S.C. § 1396b(v)(4)(A)(ii) to enroll in Medicaid and the Children's Health Insurance Program; and

(b) Take any action necessary to comply with the requirements of the Centers for Medicare and Medicaid Services and any other applicable federal law to carry out the requirements of paragraph (a).

2. The Director may reduce or eliminate any benefits available pursuant to subsection 1 if:

(a) The provision of such benefits is no longer authorized by federal law; or

(b) The federal medical assistance percentage calculated pursuant to 42 U.S.C. § 1396d(b) is significantly reduced below the percentage existing on July 1, 2017.

§ 422.27243 Program to provide medical assistance to certain persons who are employed and have disabilities.

1. Upon approval of the Interim Finance Committee, the Director, through the Division, shall establish a program for the provision of medical assistance to certain persons who are employed and have disabilities. The Director shall establish the program by:

(a) Amending the State Plan for Medicaid in the manner set forth in 42 U.S.C. § 1396a(a)(10)(A)(ii)(XIII);

(b) Amending the State Plan for Medicaid in the manner set forth in 42 U.S.C. § 1396a(a)(10)(A)(ii)(XV); or

(c) Obtaining a Medicaid waiver from the Federal Government to carry out the program.

2. The Director may require a person participating in a program established pursuant to subsection 1 to pay a premium or other cost-sharing charges in a manner that is consistent with federal law.

§ 422.27247. Application for federal waiver to provide certain dental care for certain persons.

1. The Department shall apply to the Secretary of Health and Human Services for a waiver granted pursuant to 42 U.S.C. § 1315 to authorize the Department to provide the dental care described in this section for persons with diabetes who are at least 21 years of age. To the extent authorized by the waiver and in accordance with any requirements of the waiver, including, without limitation, requirements concerning fiscal neutrality, such dental care must consist of an initial oral evaluation and, if that evaluation determines, in accordance with the criteria for periodontal disease prescribed by the American Academy of Periodontology or its successor organization, that:

(a) The person does not have periodontal disease:

(1) Dental prophylaxis for adults, an oral evaluation, the tracking and monitoring of glycosylated hemoglobin and notification of the person and his or her primary care provider, if any, concerning abnormal results once every 180 days;

(2) A comprehensive periodontal evaluation annually; and

(3) Filling of cavities, as necessary.

(b) The person has periodontal disease:

(1) Up to four quadrants of periodontal scaling and root planing every 36 months or, if periodontal scaling and root planing are determined to be unnecessary in accordance with the guidelines prescribed by the American Dental Association or its successor organization, dental prophylaxis for adults every 180 days;

(2) One periodontal maintenance procedure every 91 days;

(3) Tracking and monitoring of glycosylated hemoglobin and notification of the person and his or her primary care provider, if any, concerning abnormal results every 90 days; and

(4) Filling of cavities, as necessary.

2. The Director shall collaborate with the Division of Public and Behavioral Health of the Department when carrying out the provisions of this section.

3. As used in this section, "dental prophylaxis" means the use of dental tools and polishing procedures to remove plaque, tartar and stains from the portion of the tooth that extends above the gum line

§ 422.273. Establishment, development and implementation of Medicaid managed care program.

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. 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.

§ 422.2735. Program to provide increased capitation payments to Medicaid managed care plans for ground emergency medical transportation services provided by governmental provider. [Effective on the date that a program to provide increased capitation payments to governmental providers for ground emergency medical transportation services established pursuant to this section is approved by the Centers for Medicare and Medicaid Services.]

1. The Director may, in consultation with governmental providers and Medicaid managed care plans, develop a program to include in the managed care organization rate certification for the Medicaid managed care plans increased capitation payments to the Medicaid managed care plans for ground emergency medical transportation services which are provided by a governmental provider pursuant to a contract or other arrangement between the governmental provider and a Medicaid managed care plan. Participation in such a program by a governmental provider is voluntary and, if a governmental provider elects to participate in such a program, the governmental provider must pay the nonfederal share of the expenditures on the program.

2. If a program is established pursuant to this section, a governmental provider or Medicaid managed care plan that wishes to participate in the program must enter into an agreement with the Department to comply with any request by the Department for information or data necessary to claim federal money or obtain federal approval in connection with the program.

3. In addition to complying with subsection 2, a governmental provider that wishes to participate in a program established pursuant to this section must:

(a) Hold a permit to operate an ambulance or a permit to operate a vehicle of a fire-fighting agency at the scene of an emergency issued pursuant to NRS 450B.200; and

(b) Provide ground emergency medical services to recipients of Medicaid pursuant to a contract or other arrangement with a Medicaid managed care plan.

4. If a program is established pursuant to this section, a governmental provider that meets the requirements of subsections 2 and 3 and wishes to receive increased capitation payments must make an intergovernmental transfer of money to the Department in an amount corresponding with the amount that

the governmental provider has spent on ground emergency medical transportation services or pay the nonfederal share of expenditures on the program. To the extent that such money is accepted from a governmental provider, the Department shall make increased capitation payments to the applicable Medicaid managed care plan. To the extent permissible under federal law, the increased capitation payments must be in amounts actuarially equivalent to or greater than the supplemental cost based payments available under a program of supplemental reimbursements for governmental providers who provide services on a fee-for-service basis.

5. Except as otherwise provided in subsection 6, all money associated with intergovernmental transfers or the nonfederal share of expenditures made and accepted pursuant to subsection 4 must be used to make additional payments to governmental providers under a program established pursuant to this section. A Medicaid managed care plan shall pay all of any increased capitation payments made pursuant to subsection 4 to a governmental provider for ground emergency medical transportation services pursuant to a contract or other arrangement with the Medicaid managed care plan.

6. The Department may implement the program described in this section only to the extent that the program is approved by the Centers for Medicare and Medicaid Services and federal financial participation is available. To the extent authorized by federal law, the Department may implement the program for ground emergency medical transportation services provided before the effective date of this section.

7. If the Director determines that payments made under the provisions of this section do not comply with federal requirements relating to Medicaid, the Director may:

(a) Return or refuse to accept an intergovernmental transfer; or

(b) Adjust any payment made under the provisions of this section to comply with federal requirements relating to Medicaid.

8. As used in this section:

(a) "Advanced emergency medical technician" has the meaning ascribed to it in NRS 450B.025.

(b) "Ambulance" has the meaning ascribed to it in NRS 450B.040.

(c) "Emergency medical technician" has the meaning ascribed to it in NRS 450B.065.

(d) "Fire-fighting agency" has the meaning ascribed to it in NRS 450B.072.

(e) "Governmental provider" means a provider of ground emergency medical transportation services that is owned or operated by a state or local governmental entity or federally recognized Indian tribe.

(f) "Ground emergency medical transportation services" means emergency medical transportation services provided by an ambulance or a vehicle of a fire-fighting agency, including, without limitation, services

provided by emergency medical technicians, advanced emergency medical technicians and paramedics in prestabilizing patients and preparing patients for transport.

(g) "Medicaid managed care plan" means a health maintenance organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid.

(h) "Paramedic" has the meaning ascribed to it in NRS 450B.095.

§ 422.2748. Cooperation with Medicaid Fraud Control Unit.

1. The Director or a representative designated by the Director shall:

(a) Promptly comply with a request from the Unit for access to and free copies of any records or other information in the possession of the Department regarding a provider; and

(b) Refer to the Unit all cases in which the Director or designated representative suspects that a provider has committed an offense pursuant to NRS 422.540 to 422.570, inclusive.

2. As used in this section:

(a) "Provider" means a person who has applied to participate or who participates in the State Plan for Medicaid as the provider of goods or services.

(b) "Unit" means the Medicaid Fraud Control Unit established in the Office of the Attorney General pursuant to NRS 228.410.

§ 422.27482. Report concerning provision of health benefits by large employers.

1. On or before January 1 of each year, the Director shall prepare, in consultation with the Director of the Department of Business and Industry, a report which includes, without limitation:

(a) The name, street address of the office of the registered agent and the principal place of business of an employer in this State that employs 50 or more employees and whether the employer offers health benefits to its employees;

(b) The total number of persons enrolled in Medicaid who are employed on a full-time basis by such an employer;

(c) The number of persons enrolled in Medicaid who are married to or the dependent of an employee of such an employer; and

(d) The cost of providing coverage through Medicaid to the persons described in paragraphs (b) and (c).

2. The report prepared pursuant to subsection 1 must not contain any individually identifiable health information and must comply with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as amended.

3. The Director shall submit the report required pursuant to subsection 1 to:

(a) The Governor; and

(b) The Director of the Legislative Counsel Bureau for transmittal to the Legislature.

4. The report required pursuant to this section must not include any personally identifiable information of a person whose information is included in the report.

5. As used in this section, "individually identifiable health information" has the meaning ascribed to it in 45 C.F.R. § 160.103.

§ 422.27485. Enrollment of eligible Indian children in Children's Health Insurance Program: Duty of Department to seek assistance of and cooperate with Indian tribes; immediate action required; certain contracts for provision of services required.

The Department shall:

1. Seek the assistance of and cooperate with Indian tribes, tribal organizations and organizations that collaborate with Indian tribes to identify Indian children who may be eligible to enroll in the Children's Health Insurance Program and facilitate the enrollment of such children in the Children's Health Insurance Program;

2. Upon determining that an Indian child is eligible for the Children's Health Insurance Program, immediately take any necessary action to enroll the child in the Children's Health Insurance Program; and

3. Contract with the Indian Health Service and tribal clinics that provide health care services to Indians to provide health care services to Indian children who are enrolled in the Children's Health Insurance Program.

§ 422.2749. Custody, use, preservation and confidentiality of records, files and communications concerning applicants for and recipients of public assistance or assistance pursuant to Children's Health Insurance Program.

1. To restrict the use or disclosure of any information concerning applicants for and recipients of public assistance or assistance pursuant to the Children's Health Insurance Program to purposes directly connected to the administration of this chapter, and to provide safeguards therefor, under the applicable provisions of the Social Security Act, the Division shall establish and enforce reasonable regulations governing the custody, use and preservation of any records, files and communications filed with the Division.

2. If, pursuant to a specific statute or a regulation of the Division, names and addresses of, or information concerning, applicants for and recipients of assistance, including, without limitation, assistance pursuant to

the Children's Health Insurance Program, are furnished to or held by any other agency or department of government, such agency or department of government is bound by the regulations of the Division prohibiting the publication of lists and records thereof or their use for purposes not directly connected with the administration of this chapter.

3. Except for purposes directly connected with the administration of this chapter, no person may publish, disclose or use, or permit or cause to be published, disclosed or used, any confidential information pertaining to a recipient of assistance, including, without limitation, a recipient of assistance pursuant to the Children's Health Insurance Program, under the provisions of this chapter.

§ 422.27495. Contracts for provision of certain transportation services for recipients of Medicaid and recipients of services pursuant to Children's Health Insurance Program.

1. The Department shall, to the extent authorized by federal law, contract with a common motor carrier, a contract motor carrier or a broker for the provision of transportation services to recipients of Medicaid traveling to and returning from providers of services under the State Plan for Medicaid.

2. The Department may, to the extent authorized by federal law, contract with a common motor carrier, a contract motor carrier or a broker for the provision of transportation services to recipients of services pursuant to the Children's Health Insurance Program traveling to and returning from providers of services under the Children's Health Insurance Program.

3. The Director may adopt regulations concerning the qualifications of persons who may contract with the Department to provide transportation services pursuant to this section.

4. The Director shall:

(a) Require each motor carrier that has contracted with the Department to provide transportation services pursuant to this section to submit proof to the Department of a liability insurance policy, certificate of insurance or surety which is substantially equivalent in form to and is in the same amount or in a greater amount than the policy, certificate or surety required by the Department of Motor Vehicles pursuant to NRS 706.291 for a similarly situated motor carrier; and

(b) Establish a program, with the assistance of the Nevada Transportation Authority of the Department of Business and Industry, to inspect the vehicles which are used to provide transportation services pursuant to this section to ensure that the vehicles and their operation are safe.

5. As used in this section:

(a) "Broker" has the meaning ascribed to it in NRS 706.021.

(b) "Common motor carrier" has the meaning ascribed to it in NRS 706.036.

(c) "Contract motor carrier" has the meaning ascribed to it in NRS 706.051.