



DEPARTMENT OF HUMAN RESOURCES  
DIVISION OF HEALTH CARE FINANCING AND POLICY

June 17, 1998

Richard Fenton, Deputy Director  
Division of Integrated Health Systems  
Health Care Financing Administration  
Mail Stop C3-20-07  
7500 Security Boulevard  
Baltimore, Maryland 21244-1850

Dear Mr. Fenton:

In your letter dated June 2, 1998, you have raised several additional questions and concerns about Nevada's State Children's Health Insurance Program (Nevada Check Up). Most of these concerns relate to the manner in which Nevada Check Up will coordinate eligibility and enrollment procedures with Medicaid. You have also asked for clarification of the source of funds. These questions and concerns are addressed below.

Eligibility  
You stated that Nevada should... as... and enrollment process as... in [your]... letter of April... Nevada will therefore add... to... that child found to be eligible for medic assistance under the State... Plan under Title XIX are enrolled for such... under such plan. I... included as... A.

our... addition... on how all children who are determined to be Medi eligible will be enrolled in the... aid... as eq... under... 2102(b)(...). For children... identified through the... Check U... to be, ... SSI, ... are therefore automatically eligible... the application form will be considered as a... and Will be forwarded for computer verification of the SSI... and immediate enrollment into... of the automatic... by the gr... requirements of a full application and a pe... int... do... t app... t however that out of more... 4,400 children who have pp... Up so fa none have had SSI. Some families who applied have... on SSI, but all have i... d that the SSI child... receiving Medicaid

I am aware that the concern has been raised by others that... an... opriat... screen and enroll provision, some children could fall through the cracks... coverage. We have taken great strides to ensure that... do not... and the large number of... an possible are... b

providing up to 12 months continuous eligibility, allowing for mail-in applications and removing an assets test in Nevada Check Up. All of these provisions are designed to cover the largest number of children possible.

The biggest problem that could occur if our program is approved is that some children who may be eligible for Medicaid but do not wish to be considered for Medicaid at this time would be enrolled in Nevada Check Up. The children would maintain all rights to apply for Medicaid at any time in the future, but if they are more comfortable with a program in which they "buy" coverage rather than have it given to them, this is not to be discouraged. By allowing enrollment into Nevada Check Up, we assure the children do not fall through the cracks.

In contrast, the biggest problem that will occur if our program is disapproved is that thousands of Nevada children will stay without health insurance of any kind. Additionally, the outreach efforts that the state has embarked upon which provide more information about Medicaid eligibility than has ever before been widely disseminated in Nevada would likely be scaled back if not discontinued.

Intergovernmental Transfers

The Intergovernmental Transfer funds (IGT) are received from the counties or local hospital districts. Assessments are made in accordance with Nevada Revised Statutes section 422.382 (see Attachment B). The law specifies that the entity responsible for the public hospital is the entity that makes the transfer. Where hospital districts have been created, they are the responsible entity for the hospital. Please note that local hospital districts are independent units of government with direct taxing authority, generally covering the same geographic boundaries as counties and run by an elected board. Also please note that no counties have more than one public hospital or one private hospital for which an intergovernmental transfer is made. Below is a listing of entities making payments and the amounts paid in state fiscal year 1997:

	<u>SFY97</u>
Receipt from Counties (Hospital Name)	
Clark County (University Medical Center)	\$43,447,540
Washoe County (Washoe Medical Center)	1,550,000
Nye County (Nye Regional Medical Center)	428,311
	<u>\$45,425,851</u>

Receipt from Hospital Districts (Hospital Name)

Carson City (Carson Tahoe Hospital)	\$ 3,478,788
Elko (Elko General Hospital)	1,310,765
Churchill (Churchill Community Hospital)	1,415,057
Humboldt (Humboldt General Hospital)	231,531
White Pine (Wm. B. Ririe Hospital)	324,669
Mineral (Mt. Grant General Hospital)	198,648
South Lyon (South Lyon Medical Center)	179,445
	<u>\$ 7,138,903</u>

Counties and public hospitals pay intergovernmental transfers out of general revenues. All payments are made in full by the responsible entities; no money is withheld by the counties. The legislature has employed a methodology based on overall equity to all counties within the state in determining these amounts. Washoe County is the only county which has had responsibility for making an intergovernmental transfer on behalf of a private hospital. There has been no evidence that medical care to indigent patients has suffered as a result of Washoe County being released from liability for indigent care as a result of the provisions of NRS 422.382(2).

I sincerely appreciate the efforts of you and other HCFA staff in providing guidance and constructive comments on the Nevada Check Up program. You have an awesome responsibility addressing new and weighty issues with dramatic public policy consequences without benefit of a full regulation hearing process, particularly given the short time frames for approving state plans, which makes me even more appreciative of your willingness to fully discuss and review this issue.

I am confident we will be able to resolve this issue because we share the common goal of providing health care coverage to the greatest number of uninsured low-income children in Nevada.

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 Christopher Thompson, Administrator  
Division of Health Care Financing and Policy

Attachments

cc: Debbie Chang, HCFA  
Richard Chambers, HCFA  
Jim Mulhall, Governor's Office  
Charlotte Crawford, DHR  
Steve Abba, LCB  
Perry Comeaux, Budget

**NEVADA CHECK UP  
POTENTIALLY ELIGIBLE MEDICAID CHILDREN**

In order to assure that Medicaid eligible children are enrolled in Medicaid, Nevada will take the following steps:

- 1) Par families who apply with the current application (which does not include any question on assets), if their income is below the income requirements for Medicaid or if their income is no more than 25% above the Medicaid income requirement (to account for work expense disregards allowed in the Medicaid eligibility determination), their Nevada Check Up application will be considered to be a Medicaid application as well unless the family has applied for and been denied Medicaid eligibility in the past twelve months. The date of application will be the approval date of the Title XXI State Plan or the date received by the State of Nevada, whichever is later.

These families will be sent an enrollment form for Nevada Check Up along with a full Medicaid application. The enrollment form will include an additional question designed to screen individuals who have assets above the Medicaid allowable level.

On or before September 30, 1998, the Nevada Check Up application and/or the Nevada Medicaid application will be redesigned to allow information collected for one program to be used for the other program as well. The revised Nevada Check Up form will include a single assets question to screen out families who do not meet the Medicaid assets requirement. The instructions will note that an applicant is not required to answer the question. If the applicant does not answer the question, he/she will be treated as if the applicant meets the Medicaid assets screen. Once the assets question is added to the application form, only those families meeting both the income and assets test will be sent the Medicaid application.

- 2) An informed consent paragraph will be added to the Nevada Check Up enrollment form which reads as follows:

"I understand that, based on the income reported on my Nevada Check Up application and the assets requirement as explained in the information I received with this form, it is likely that some or all of my children are eligible for Medicaid. I also understand that Medicaid does not charge any premiums, has a somewhat broader benefits package and may pay for medical expenses incurred within the past three months. Nonetheless, I do not wish to apply for Medicaid at this time. (Answering yes to this question will not affect your right to apply for Medicaid at a later time.

**Answering no will not affect your right to enroll in Nevada Check Up now.)"**

**Once the assets question is added to the application, the informed consent paragraph will be revised accordingly.**

- 3) Any family sent a Medicaid application will have two weeks (ten working days) to return the completed application. If the application is not returned, the family will be sent a notice of denial for Medicaid, but the notice will allow an additional two weeks (ten working days) to provide all necessary information to have the application reinstated.**
- 4) In accordance with current Medicaid eligibility rules, a personal interview will be scheduled.**
- 5) Once a Medicaid eligibility determination has been made, the family will be notified. If the children are approved for Medicaid and have previously enrolled in Nevada Check Up, the Medicaid program will reimburse Nevada Check Up for the cost of the premiums paid. In this manner, the federal match rate for such expenses will be the lower Medicaid rate. The family will also be refunded any premiums they paid. If the children are denied eligibility for Medicaid and have not enrolled in Nevada Check Up, they will be sent another enrollment form for Nevada Check Up.**
- 6) Medicaid enrollees will be compared monthly with the Nevada Check Up enrollees to ensure that a child is not enrolled in both programs.**
- 7) Nevada Check Up will maintain statistics on families applying for the program who meet the income guidelines of Medicaid, including whether they apply for Medicaid and the disposition of the applications. Also, if the total number of families who do not follow through with Medicaid applications exceeds 1% of total Nevada Check Up enrollees, the state will survey those families who do not follow through to determine the reasons for not filing a Medicaid application.**

PAYMENTS TO CERTAIN HOSPITALS FOR  
TREATMENT OF INDIGENT PATIENTS

WEST PUBLISHING CO.

Hospitals 13.

WESTLAW Topic No. 204.

C.J.S. Hospitals § 5.

**NRS 422.380 Definitions.** As used in NRS 422.380 to 422.390, inclusive, unless the context otherwise requires:

1. "Hospital" has the meaning ascribed to it in NRS 439B.110 and includes public and private hospitals.

2. "Public hospital" means:

(a) A hospital owned by a state or local government, including, without limitation, a hospital district; or

(b) A hospital that is supported in whole or in part by tax revenue, other than tax revenue received for medical care which is provided to Medicaid patients, indigent patients or other low-income patients.

(Added to NRS by 1991, 2334; A 1993, 1967; 1995, 1427, 1430; 1997, 1243)

**NRS 422.3805 Federal waivers: Duties of administrator.** [Effective until June 30, 1999.] The administrator shall:

1. Apply for all waivers from federal law or regulation which are necessary to carry out the provisions of NRS 422.380 to 422.390, inclusive; and

2. If a waiver is denied or altered, take all appropriate steps to comply with the directives of the Federal Government.

(Added to NRS by 1993, 1966; A 1995, 1430; 1997, 2630)

WEST PUBLISHING CO.

Social Security and Public Welfare 1241.

WESTLAW Topic No. 356A.

C.J.S. Social Security and Public Welfare § 126.

**NRS 422.3805 Federal waivers: Duties of director.** [Effective June 30, 1999.] The director shall:

1. Apply for all waivers from federal law or regulation which are necessary to carry out the provisions of NRS 422.380 to 422.390, inclusive; and

2. If a waiver is denied or altered, take all appropriate steps to comply with the directives of the Federal Government.

(Added to NRS by 1993, 1966; A 1995, 1430; 1997, 2630, effective June 30, 1999)

**NRS 422.382 Transfer to division of health care financing and policy of percentage of amount of payment to hospital. [Effective until June 30, 1999.]**

**1. In a county within which:**

**(a) A public hospital is located, the state or local government or other entity responsible for the public hospital shall transfer an amount equal to 75 percent of the amount of the payment made to the public hospital pursuant to NRS 422.387 less \$50,000 to the division of health care financing and policy.**

**(b) A private hospital which receives a payment pursuant to NRS 422.387 is located, the county shall transfer an amount established by the legislature to the division of health care financing and policy.**

**2. A county that transfers the amount required pursuant to paragraph (b) of subsection 1 to the division of health care financing and policy is discharged of the duty and is released from liability for providing medical treatment for indigent inpatients who are treated in the hospital in the county that receives a payment pursuant to paragraph (b) of subsection 2 of NRS 422.387.**

**3. Any money collected pursuant to subsection 1, including any interest or penalties imposed for a delinquent payment, must be deposited in the state treasury for credit to the intergovernmental transfer account in the state general fund to be administered by the division of health care financing and policy.**

**4. The interest and income earned on money in the intergovernmental transfer account, after deducting any applicable charges, must be credited to the account.**

**(Added to NRS by 1993, 1967; A 1995, 1427, 1430; 1997, 2630)**

**ADMINISTRATIVE REGULATIONS.**

**Interlocal contracts for medical treatment of indigent patients, NAC 422.190**

**WEST PUBLISHING CO.**

**Social Security and Public Welfare 1241.**

**WESTLAW Topic No. 356A.**

**C.J.S. Social Security and Public Welfare § 126.**

**NRS 422.382 Transfer to department of percentage of amount of payment to hospital. [Effective June 30, 1999.]**

**1. In a county within which:**

**(a) A public hospital is located, the state or local government or other entity responsible for the public hospital shall transfer an amount equal to 75 percent of the amount of the payment made to the public hospital pursuant to NRS 422.387 less \$50,000 to the department.**

**(b) A private hospital which receives a payment pursuant to NRS 422.387 is located, the county shall transfer an amount established by the legislature to the department.**

**2. A county that transfers the amount required pursuant to paragraph (b) of subsection 1 to the department is discharged of the duty and is released from liability for providing medical treatment for indigent inpatients who are treated in the hospital in the county that receives a payment pursuant to paragraph (b) of subsection 2 of NRS 422.387.**

3. Any money collected pursuant to subsection 1, including any interest or penalties imposed for a delinquent payment, must be deposited in the state treasury for credit to the intergovernmental transfer account in the state general fund to be administered by the department.

4. The interest and income earned on money in the intergovernmental transfer account, after deducting any applicable charges, must be credited to the account.

(Added to NRS by 1993, 1967; A 1995, 1427, 1430; 1997, 2630, effective

June 30, 1999)

**NRS 422.385 Allocations and payments from Medicaid budget account; transfer of money from intergovernmental transfer account. [Effective until June 30, 1999.]**

1. The allocations and payments required pursuant to NRS 422.387 must be made, to the extent allowed by the state plan for Medicaid, from the Medicaid budget account.

2. Except as otherwise provided in subsection 3, the money in the intergovernmental transfer account must be transferred from that account to the Medicaid budget account to the extent that money is available from the Federal Government for proposed expenditures, including expenditures for administrative costs. If the amount in the account exceeds the amount authorized for expenditure by the division of health care financing and policy for the purposes specified in NRS 422.387, the division of health care financing and policy is authorized to expend the additional revenue in accordance with the provisions of the state plan for Medicaid.

3. If enough money is available to support Medicaid, money in the intergovernmental transfer account may be transferred to an account established for the provision of health care services to uninsured children who are under the age of 13 years pursuant to a federal program in which at least 50 percent of the cost of such services is paid for by the Federal Government, if enough money is available to continue to satisfy existing obligations of the Medicaid program or to carry out the provisions of NRS 439B.350 to 439B.360.

(Added to NRS by 1991, 2335; A 1993, 1969; 1995, 1428, 1430; 1997, 1244, 1546, 2631)

**NRS 422.385 Allocations and payments from Medicaid budget account; transfer of money from intergovernmental transfer account. [Effective**

**June 30, 1999.]**

1. The allocations and payments required pursuant to NRS 422.387 must be made, to the extent allowed by the state plan for Medicaid, from the Medicaid budget account.

2. Except as otherwise provided in subsection 3, the money in the intergovernmental transfer account must be transferred from that account to the Medicaid budget account to the extent that money is available from the Federal Government for proposed expenditures, including expenditures for administrative costs. If the amount in the account exceeds the amount authorized for expenditure by the department for the purposes specified in NRS 422.387, the department is authorized to expend the additional revenue in accordance with the provisions of the state plan for Medicaid.

3. If enough money is available to support Medicaid, money in the intergovernmental transfer account may be transferred to an account established for the provision of health care services to uninsured children who are under the age of 13 years pursuant to a federal program in which at least 50 percent of the cost of such services is paid for by the Federal Government, if enough money is available to continue

to satisfy existing obligations of the Medicaid program or to carry out the provisions of NRS 439B.350 and 439B.360.

[Added to NRS by 1991, 2335; A 1993, 1969; 1995, 1428, 1430 1997, 1244, 1546, 2631, effective June 30, 1999]

**NRS 422.387 Payments to hospitals; allocation for administrative costs; modification of method of establishing rates of payments to hospitals. [Effective until June 30, 1999.]**

1. Before making the payments required or authorized by this section, the division of health care financing and policy shall allocate money for the administrative costs necessary to carry out the provisions of NRS 422.380 to 422.390, inclusive. The amount allocated for administrative costs must not exceed the amount authorized for expenditure by the legislature for this purpose in a fiscal year. The interim finance committee may adjust the amount allowed for administrative costs.

2. The state plan for Medicaid must provide:

(a) For the payment of the maximum amount allowable under federal law and regulations after making a payment, if any, pursuant to paragraph (b), to public hospitals for treating a disproportionate share of Medicaid patients, indigent patients or other low-income patients, unless such payments are subsequently limited by federal law or regulation.

(b) For a payment in an amount approved by the legislature to the private

hospital that provides the largest volume of medical care to Medicaid patients,

indigent patients or other low-income patients in a county that does not have a

public hospital.

The plan must be consistent with the provisions of NRS 422.380 to 422.390, inclusive, and Title XIX of the Social Security Act (42 U.S.C. §§ 1396 et seq.), and the regulations adopted pursuant to those provisions.

3. The division of health care financing and policy may, with the approval of the director, amend the state plan for Medicaid to modify the methodology for establishing the rates of payment to public hospitals for inpatient services, except that such amendments must not reduce the total reimbursements to public hospitals for such services.

(Added to NRS by 1991, 2335; A 1993, 1969; 1995, 1428, 1430; 1997, 1244, 2631)

**REVISER'S NOTE**

Ch. 706, Stats. 1991, the source of this section, contains the following provision not included in NRS:

"Sections 13, 14 and 15 of this act expire by limitation if federal law, regulation or policy causes the department of human resources to be unable to make the payments specified in [NRS 422.387] from the revenue available for that purpose."

**NRS 422.387 Payments to hospitals; allocation for administrative costs; modification of method of establishing rates of payments to hospitals. [Effective June 30, 1999.]**

1. Before making the payments required or authorized by this section, the department shall allocate money for the administrative costs necessary to carry out the provisions of NRS 422.380 to 422.390, inclusive. The amount allocated for administrative costs must not exceed the amount authorized for expenditure by the legislature for this purpose in a fiscal year. The interim finance committee may adjust the amount allowed for administrative costs.

2. The state plan for Medicaid must provide:

(a) For the payment of the maximum amount allowable under federal law and regulations after making a payment, if any, pursuant to paragraph (b), to public hospitals for treating a disproportionate share of Medicaid patients, indigent patients or other low-income patients, unless such payments are subsequently limited by federal law or regulation.

(b) For a payment in an amount approved by the legislature to the private hospital that provides the largest volume of medical care to Medicaid patients, indigent patients or other low-income patients in a county that does not have a public hospital.

The plan must be consistent with the provisions of NRS 422.380 to 422.390, inclusive, and Title XIX of the Social Security Act (42 U.S.C. §§ 1396 et seq.), and the regulations adopted pursuant to those provisions.

3. The department may amend the state plan for Medicaid to modify the methodology for establishing the rates of payment to public hospitals for inpatient services, except that such amendments must not reduce the total reimbursements to public hospitals for such services.

(Added to NRS by 1991, 2335; A 1993, 1969; 1995, 1421,1430; 1997, 1244, 2631, effective June 30, 1999)

**NRS 422.390 Regulations; quarterly report. [Effective until June 30, 1999.]**

1. The division of health care financing and policy shall adopt regulations concerning:

(a) Procedures for the transfer to the division of health care financing and policy of the amount required pursuant to NRS 422.382.

(b) Provisions for the payment of a penalty and interest for a delinquent transfer.

(c) Provisions for the payment of interest by the division of health care financing and policy for late reimbursements to hospitals or other providers of medical care.

2. The division of health care financing and policy shall report to the interim finance committee quarterly concerning the provisions of NRS 422.380 to 422.390, inclusive.

(Added to NRS by 1991, 2337; A 1993, 1970; 1995, 1429; 1997, 2631)

**ADMINISTRATIVE REGULATIONS.**

**Taxes on hospitals, NAC 422.030-422.210**

**NRS 422.390 Regulations; quarterly report. [Effective Juoc 30, 1999.]**

**1. The department, through the welfare division, shall adopt regulations concerning:**

**(a) Procedures for the transfer to the department of the amount required pursuant to NRS 422.382.**

**(b) Provisions for the payment of a penalty and interest for a delinquent transfer.**

**(c) Provisions for the payment of interest by the department for late reimbursements to hospitals or other providers of medical care.**

**2. The department shall report to the interim finance committee quarterly concerning the provisions of NRS 422.380 to 422.390, inclusive.**

**(Added to NRS by 1991, 2337; A 1993, 1970; 1995, 1429; 1997, 2631, effective June 30, 1999)**