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Proposals for Federal Changes & Medicaid

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Department of Health and Human Services

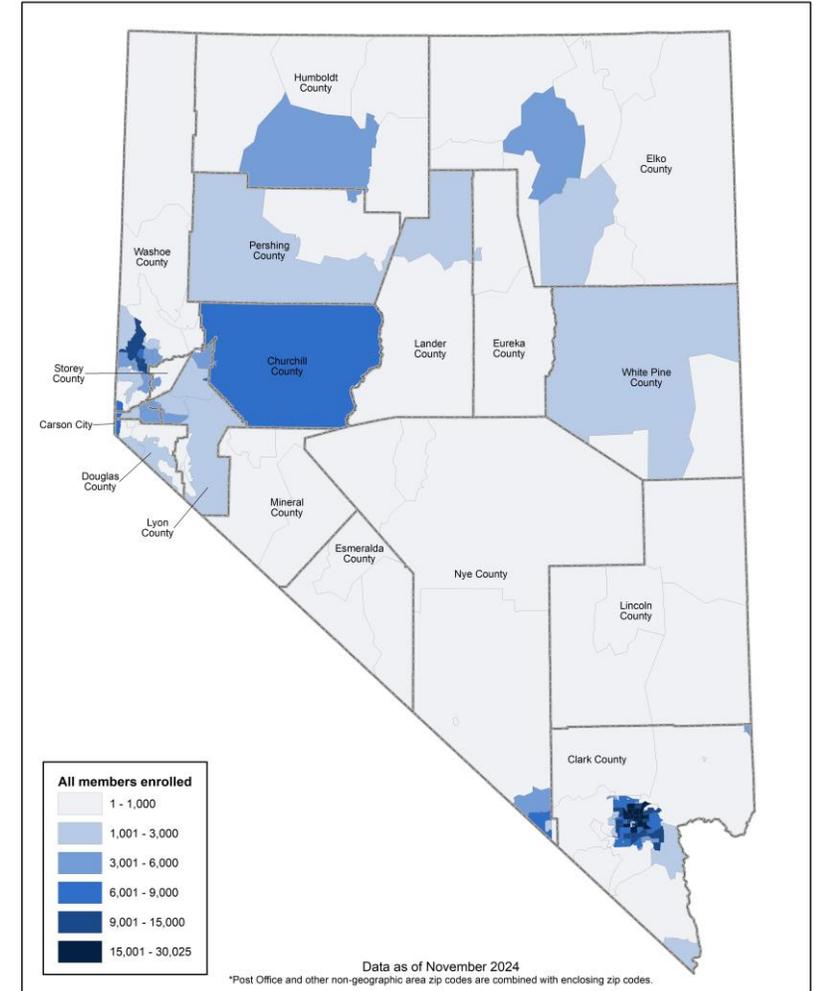
Helping people. It's who we are and what we do.



Nevada Medicaid

| | |
|--------------|---|
| 800,000 | Average number of people covered; 1 in 3 Nevadans; 22% growth pre-COVID |
| \$15 billion | Biennial Spending (state and federal share) |
| 54% | Percentage of births covered by Nevada Medicaid; 1 in 2 births |
| 75% | Recipients served by Medicaid Managed Care Plans |
| 40% | Recipients who are children or youth (0-18) |
| 11% | Dually eligible for Medicare & Medicaid (85,897 individuals) |
| 78% | Recipients who live in Clark County |
| 66% | Percentage of adults enrolled in Medicaid who are employed |
| 71% | Nevadans enrolled in Medicaid who are people of color |
| 57% | Number of nursing facility residents covered by Medicaid |

Nevada Enrolled Medicaid Participants by Zip Code*





Medicaid Financing Recap

- Medicaid is a **state-federal partnership** with federal government sharing a percentage of all costs for the program
- Federal government must pay **at least 50 percent** of all expenditures for eligible populations and services
- **Traditional match** is based on the Federal Medical Assistance Percentage (FMAP)
- **FMAP formula** relies on state economic conditions (per capita income)

Traditional Medicaid Match



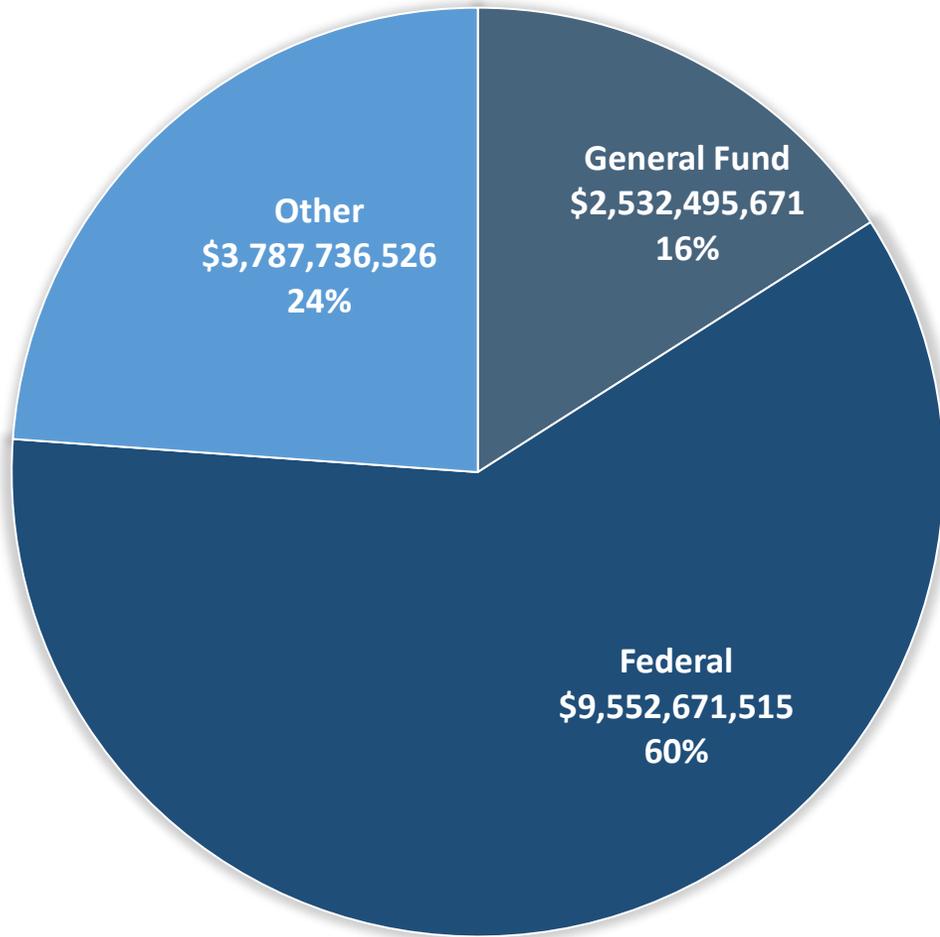
Expansion Medicaid Match





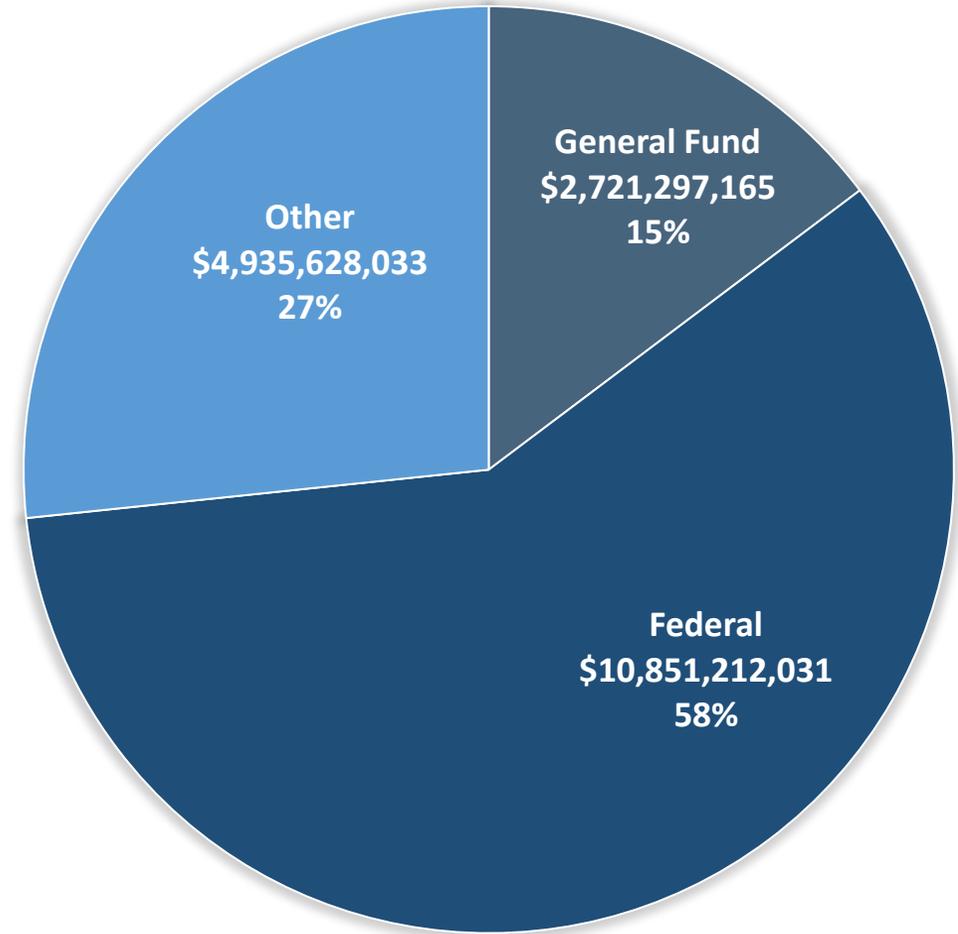
Budgeted Funding Sources

LEGISLATIVE APPROVED FY24-FY25 BIENNIUM



TOTAL: \$15,872,903,712

GOVERNOR RECOMMENDS FY26-FY27 BIENNIUM



TOTAL: \$18,508,137,229



Potential FMAP Changes

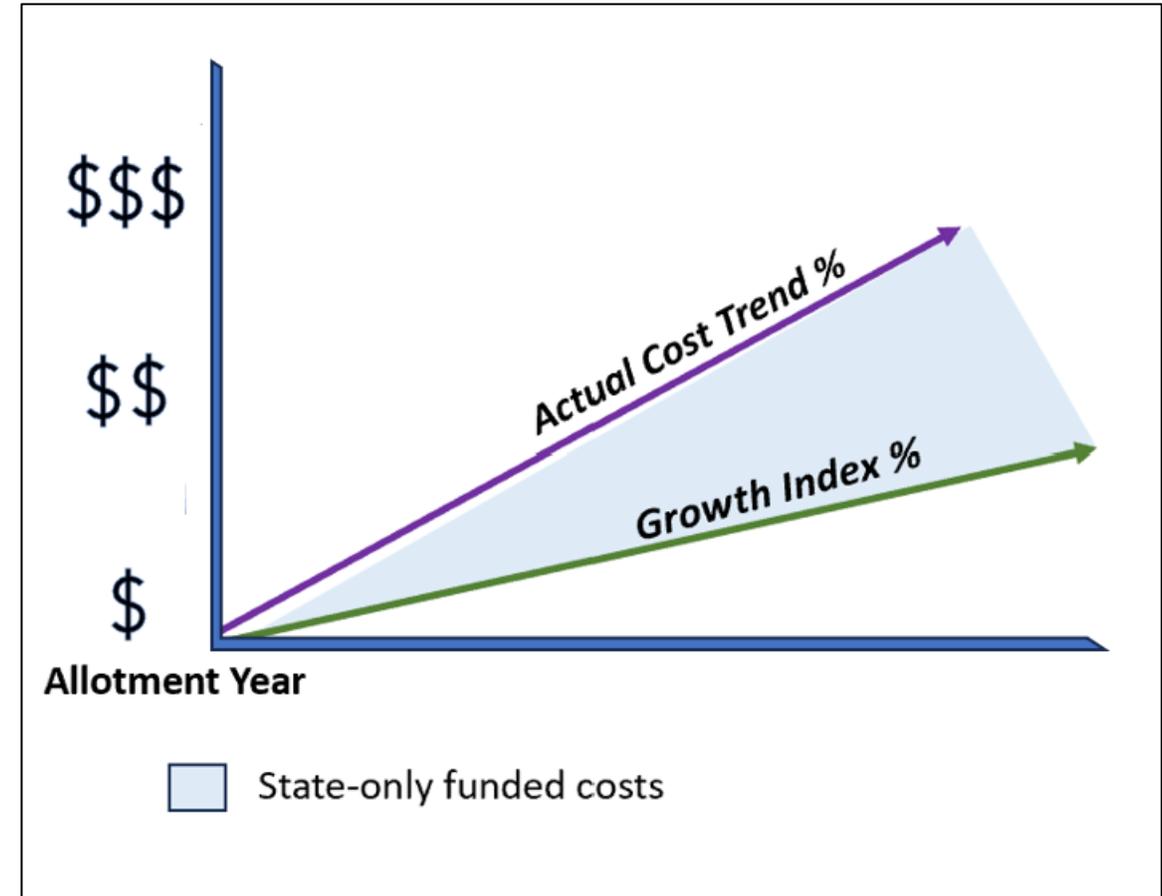
| Proposal | Estimated Impact |
|--|--|
| FMAP Equalization for Expansion: Reduction of 90% FMAP to traditional FMAP | <p>Reduction in federal funds for Nevada of \$1.858 billion over upcoming biennium.</p> <ul style="list-style-type: none">• <u>\$988.9 million</u> of which would be a State General Fund impact for the 300,000 Nevadans covered under expansion.• <u>\$869 million</u> of which would be a loss in federal funds for provider tax and supplemental payment programs |
| Removal of 50% minimum for FMAP for federal share | No impact. |



Potential Federal Funding Model Changes

Per Capita Cap Model

- Federal payment to the state is capped “per capita” (or per “head” or enrollee)
- States bears full risk in unexpected public health crises or pandemic
- Federal funding would no longer be based on percentage of actual costs; instead – federal payment would be based on:
 - Initial Allotment (Base year)
 - Preset growth index (inflation trend factor)
- Previous proposals did not relieve states of federally mandated benefits and populations





Per Capita Cap Scenarios

Scenario A: Lowest Impact

- Allotment Year: 2024
- Growth Index: Medicare Economic Index
- SFY26/27 budget impact: (\$590.2 million)

Scenario B: Highest Impact

- Allotment Year: 2023
- Growth Index: Consumer Price Index – M
- SFY26/27 budget impact: (\$3.153 billion)

Note: If per capita cap is coupled with 90% FMAP equalization, then federal funding losses increase.



Potential Provider Tax Program Changes

Proposal: Reduction in federal tax from **6% to 4% tax** which reduces revenues that are matchable by Medicaid.

• **Private Hospital Tax Program**

- Nevada's current program includes 43 private hospitals
- Proposal estimated to reduce supplemental payments for hospitals by \$693 million over upcoming biennium
- Reduces revenue for children's behavioral health in Medicaid by \$30 million in state revenues over upcoming biennium
- If coupled with 90% FMAP equalization, these reductions would increase to \$1.325 billion.

• **Skilled Nursing Facility Program**

- Nevada's current program serves 57 skilled nursing facilities
- Proposal estimated to reduce supplemental payments for skilled nursing facilities by \$95.5 million over upcoming biennium.
- If coupled with 90% FMAP equalization, these reductions would increase to \$130.2 million.



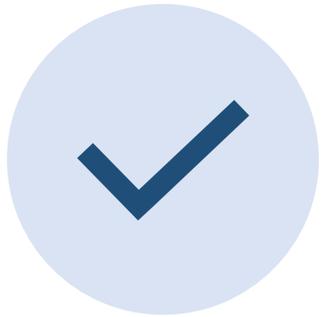
Medicaid Work Requirements

- Details still unknown about exempted populations or requirements
- Generally, these proposals require recipients to demonstrate certain minimum number of employment hours to qualify for coverage
- Based on previous proposals and review of experiences in Arkansas and Georgia, the state's initial estimate shows **70,400 to 112,600 low-income** working age adults' coverage could be affected for total spending reduction of between **\$441 million and \$705.6 million** over upcoming biennium
- Concerns around impact on members with mental illness or substance use, members with certain disabilities, members caring for young children or elderly relatives and those who lose employment/cannot find work
- State flexibilities are key to understanding the full impact.



State Options if there are Federal Reductions

Generally, federal law limits states from cutting certain mandatory services and populations. It also limits states from reducing provider rates in a manner that negatively affects access to care.



Benefit cuts or reductions for optional services only



Eligibility reductions for optional populations only



Provider reimbursement rate reductions (access rule limits)



Generation of state revenue (new fees, taxes, etc.) or Cuts to general fund for non-Medicaid programs



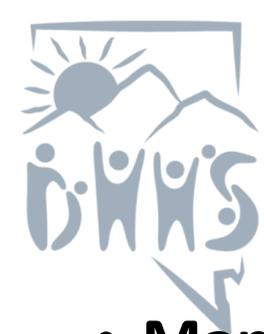
Mandatory v. Optional Benefits

Mandatory Benefits

- Inpatient & outpatient hospital services
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT)
- Nursing facility services
- Home health services
- Physician services
- Rural Health Clinic services
- Federally Qualified Health Center Services
- Laboratory & X-ray services
- Family planning services
- Nurse Midwife services
- Certified Pediatric & Family Nurse Practitioner services
- Freestanding Birth Center services (when licensed/recognized by the state)
- Transportation to medical care
- Tobacco cessation for pregnant women

Optional Benefits

- Prescription drugs
- Clinic services
- Physical, occupational, speech, respiratory therapy
- Diagnostic, screening, preventive, rehab services
- Podiatry services
- Optometry services, Eyeglasses
- Dental services
- Prosthetics
- Chiropractic services for children only
- Other practitioner services
- Private duty nursing services
- Personal care services
- Hospice
- Case management
- HCBS Waiver Services
- Among others...



Mandatory v. Optional Eligibility Groups

- **Mandatory**

- Children and families with incomes at or below 133% of Federal Poverty Level (FPL)
- Pregnant women with incomes at or below 133% FPL
- Seniors (age 65 and older) who receive Medicare and are also low income
- Certain parents or caretakers with very low incomes
- People with disabilities
- Supplemental Security Income recipients (no higher than 75% FPL)
- Non-citizens for limited emergency medical assistance

- **Optional**

- Infants in families with incomes above 185% FPL
- Pregnant women between 133-185% FPL
- Low-income adults without children with incomes (at or below 133% FPL)
- Home and Community Based Services Waiver enrollees
- Katie Beckett children (higher income families with children with disabilities)
- Non-citizens in their first five years of residence

Note: There are mandatory and optional populations under Title XXI CHIP program for children and pregnant women not reflected on this slide.



Questions?



Acronyms

- CHIP – Children’s Health Insurance Program
- FMAP - Federal Medical Assistance Percentage
- FPL - Federal Poverty Level
- MMIS - Medicaid Management Information System