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Understanding Medicaid in Nevada

An Overview of the State's Program and Financing, and the Implications of Changes at the Federal Level

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EXECUTIVE SUMMARY

Medicaid spending accounts for nearly one-quarter (24.9 percent) of Nevada's total biennial budget, and in practice, Medicaid covers one in four Nevadans (Division of Health Care Financing and Policy, Nevada Department of Health and Human Services [DHCFP], 2025). Given the impact on Nevada's state budget and insured rates, recent federal changes present questions about how Medicaid is administered at the state level, who is covered, and how federal changes may affect state policies.

This policy brief provides a high-level overview of the complex Medicaid program from national and state governance and funding perspectives. It also explores federal changes and the potential effects on state-level policies.

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KEY TAKEAWAYS

- Medicaid is the health insurer for approximately 1 in 4 Nevadans, nearly half of whom are children.
- Medicaid covers 60 percent of nursing home residents, 39 percent of children, and 42 percent of births in Nevada.
- About 309,000 Nevadans are enrolled through the Patient Protection and Affordable Care Act Medicaid expansion, adopted by Nevada in 2014.
- The One Big Beautiful Bill Act (H.R. 1), passed in July 2025, will affect Nevada's Medicaid program, including provider fees, state-directed payments, and eligibility determinations.

INTRODUCTION

Medicare and Medicaid are the largest health insurance providers in the United States, accounting for nearly $1.5 trillion in health spending in FY 2024 (Congressional Budget Office, 2025). Though not a topic of this paper, Medicare is federally funded health insurance for Americans aged 65 and older and some younger people with disabilities. In contrast, Medicaid covers populations with low income and limited resources.

Medicaid is a joint state and federal program that finances primary and acute medical care and long-term care services for children, adults, pregnant individuals, and the aged, blind, or disabled who meet low-income criteria. It is an entitlement program, meaning that if a person is eligible, they are entitled to services. Theoretically, Medicaid spending has no limit, though policy changes enable the government to control costs as needed.

In July 2025, President Donald J. Trump signed into law the One Big Beautiful Bill Act (H.R. 1)**, which includes significant changes to the federal Medicaid program.** Because states are given some flexibility in administering the program and are funded at different levels, changes to the federal program may affect states differently. To navigate the policy changes at the state level, it is helpful for policymakers to understand the program and its history, how it is funded, and the policy levers available to federal and state policymakers.

MEDICAID: NATIONALLY AND IN NEVADA

PROGRAM BACKGROUND

The Medicaid program was created as part of President Lyndon Johnson's "Great Society" reforms through the Social Security Amendments of 1965, which built on the existing welfare programs from the Social Security Act of 1935. At its inception, Medicaid was designed to provide access to medical services for the elderly, the blind, people with disabilities, and families with dependent children receiving public assistance. In the following decades, Medicaid expanded its covered services (e.g., adding long-term care services) and eligibility criteria (e.g., mandating coverage for pregnant women and children up to age six with household incomes up to 138 percent of the Federal Poverty Level, or FPL).

The Centers for Medicare and Medicaid Services (CMS) is the federal agency tasked with managing the program. Federal law structures Medicaid as a federal-state partnership, both sharing program costs. While state participation is voluntary, all fifty states, the District of Columbia, and the U.S. territories have instituted Medicaid programs.

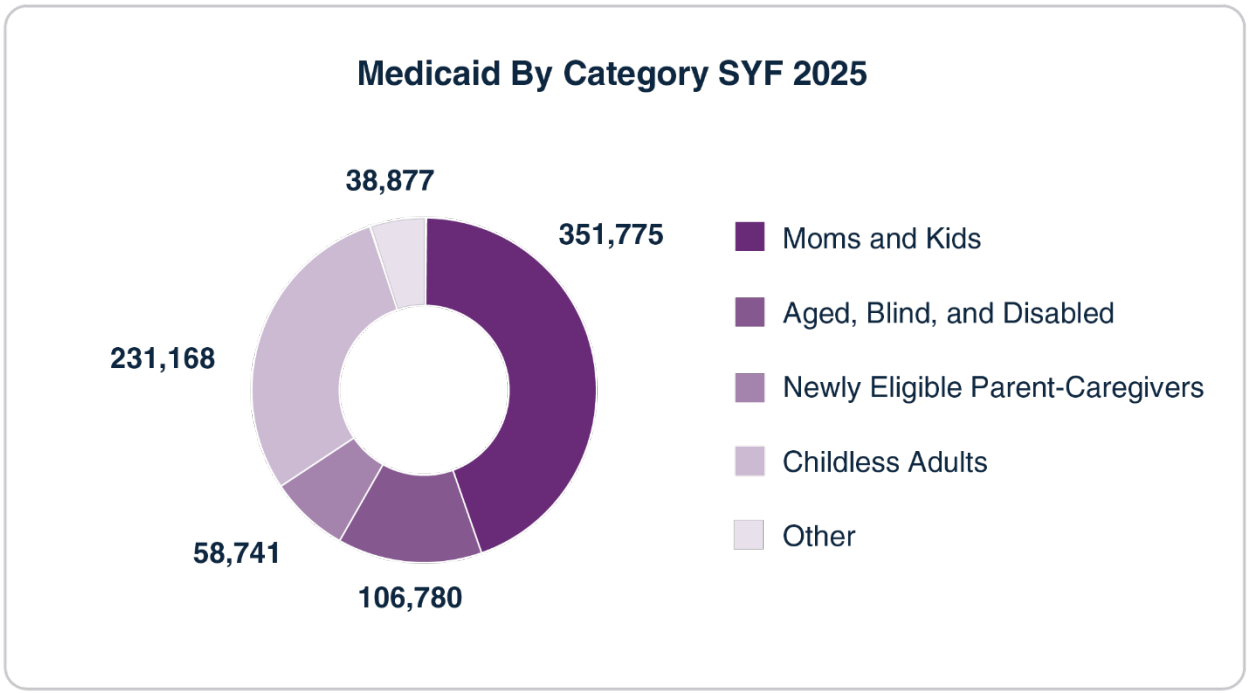
States have discretion in purchasing covered services, using a fee-for-service, or a managed care approach. States also determine the amounts they pay providers. Because of this program flexibility, spending per Medicaid enrollee varies significantly across eligibility groups and states. Spending for older adults and individuals with disabilities may be more than four times that for a typical adult and more than seven times for an average child covered by the program (Rudowitz, R., 2016). Even within a given state and eligibility group, per-enrollee costs may vary significantly, particularly for individuals with disabilities.

MEDICAID IN NEVADA

Nevada started participating in Medicaid in 1967. It offers all required Medicaid services, some optional state plan benefits, and waiver services. Nevada was also an early adopter of the significant Medicaid expansion under the Patient Protection and Affordable Care Act (ACA) in 2014, which broadened eligibility for Medicaid to adults with incomes up to 138 percent of the federal poverty line (FPL). **The program has a significant footprint in the state, with approximately 60 percent of Nevada's nursing home residents, 39 percent of its children, and 42 percent of all births covered by Medicaid (KFF, 2025).**

As of May 2025, the total enrollment in Nevada Medicaid was 784,500 individuals, with an additional 35,230 children receiving coverage from Nevada Check Up, the state's separate Children's Health Insurance Program (CHIP). Of the individuals receiving Medicaid coverage, approximately 45 percent are moms and kids, 29 percent are childless adults, 14 percent are aged, blind, and disabled, 7 percent are newly eligible parent-caregivers, and 5 percent are categorized as other (see Figure 1).

Figure 1: Medicaid Participation by Category for SFY 2025 (Excluding Nevada Check Up)



Source: Nevada Office of Analytics – Data & Reports, "Medicaid Operations Dashboard: Caseloads and Projections – Medicaid by Category."

As shown in Figure 2, in Nevada's urban counties – Carson City, Clark County and Washoe County – approximately 32 percent of the population is on Medicaid, whereas in the remaining rural and frontier counties, approximately 25 percent are enrolled in Medicaid (UNR Med – Office of Statewide Initiatives, 2025).

Nevada's Department of Health and Human Services has historically been designated as the single state agency for the state Medicaid program, with duties split between the Division of Health Care Financing and Policy and the Division of Welfare and Social Services. However, as of July 1, 2025, the Department of Health and Human Services has been restructured into two separate state agencies: the Department of Human Services and the Nevada Health Authority. The Nevada Health Authority will be the single state agency managing the Medicaid program (see Figure 3).

Figure 2: Nevada Medicaid Enrollment by Percent Enrolled and Total Enrollment (2023).

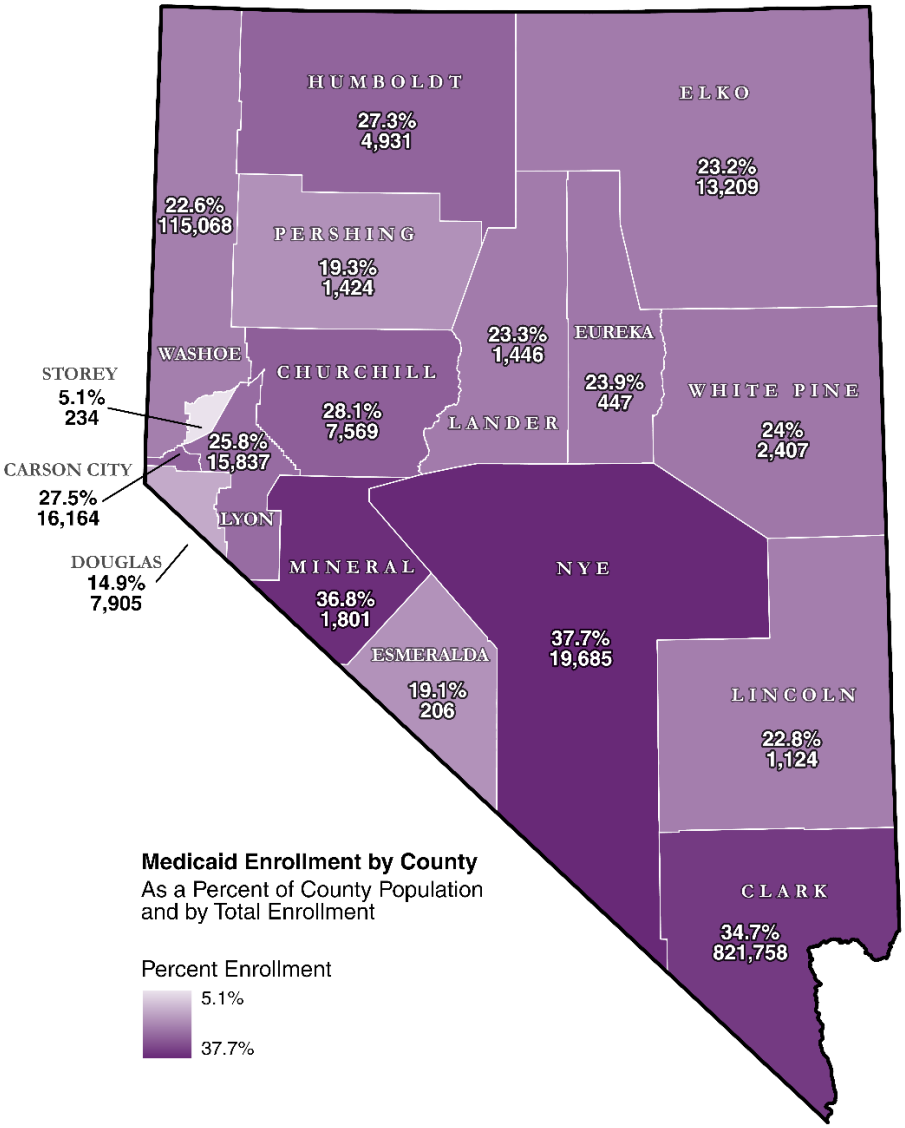
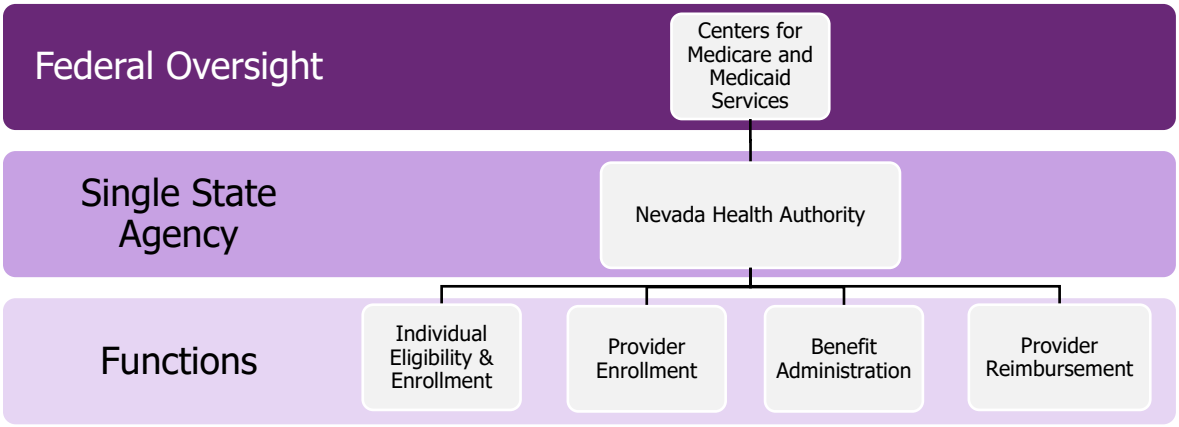


Figure 3: Organization of the Nevada Medicaid Program



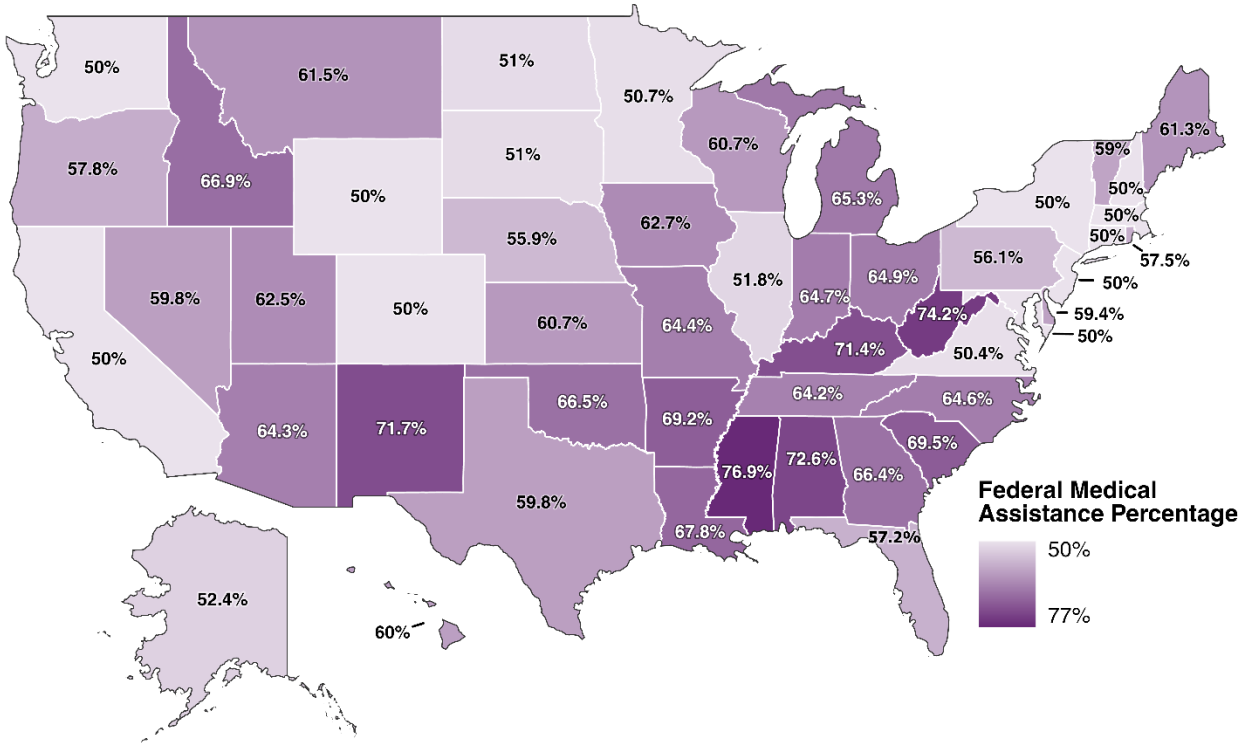
PAYING FOR MEDICAID

The Federal Medical Assistance Percentage (FMAP) drives the financing portion of Medicaid's federal-state partnership. A provider can only be paid using the FMAP if it meets four criteria: (1) the patient is enrolled in Medicaid; (2) the provider is a Medicaid-enrolled provider; (3) the service is a Medicaid-covered service; and (4) the service is medically necessary.

The **Federal Medical Assistance Percentage** is a cost-sharing percentage that varies based on the state's per capita income compared to the national average.

The FMAP is updated every year for each state. By statute, a state's regular Medicaid FMAP cannot be lower than 50 percent or higher than 83 percent. In simplified terms, if the FMAP is set at 60 percent, it would mean that for every $4 paid by the state, the federal government would pay $6. During national economic downturns, Congress has occasionally raised the FMAP for all states. For example, during the COVID-19 pandemic, it was increased by 6.2 percentage points (Congressional Research Service, 2025).

Figure 4: Federal Medical Assistance Percentage by State for Fiscal Year 2026



Source: KFF (2024). *Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier.* https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/

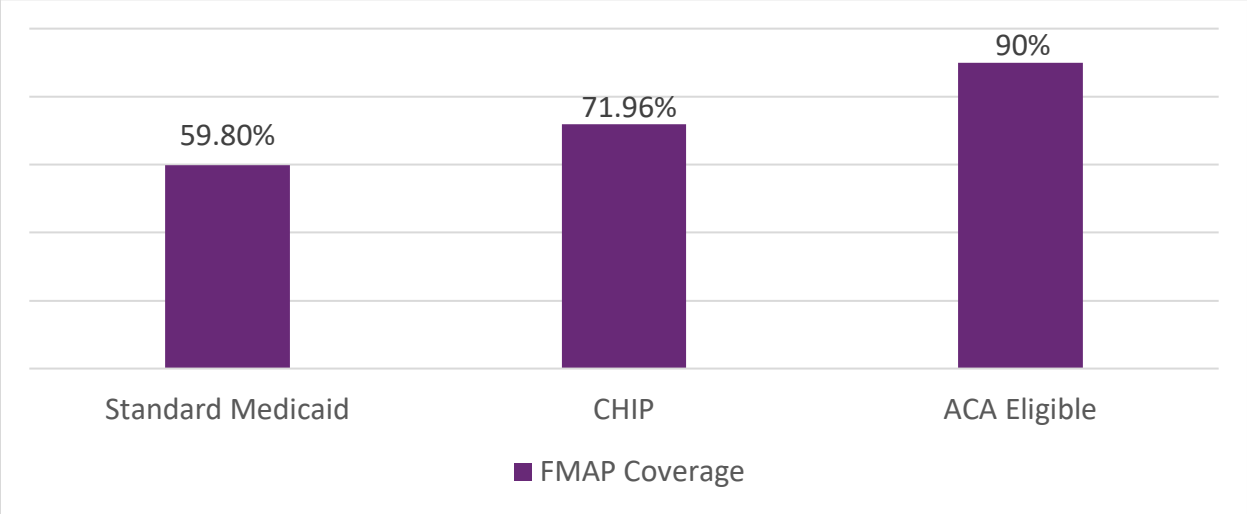
A separate FMAP rate was established in January 2014 when Congress significantly expanded Medicaid eligibility under the ACA. The FMAP for individuals newly eligible under the ACA was initially 100 percent; it gradually decreased to 90 percent by 2020 and remains at this level for all states.

The Children's Health Insurance Program, which is explored in greater detail below, also has an enhanced FMAP rate, typically 5 to 15 percentage points higher than a state's regular FMAP. Other less significant service and expense categories have an enhanced rate. Administrative functions are generally funded at 50 percent (Congressional Research Service, 2025).

To offset uncompensated care costs, the federal government also provides "disproportionate share hospital" (DSH) payments to hospitals that serve Medicaid and low-income uninsured patients. Federal DSH spending is capped for each state and facility, but within those limits, states have considerable discretion in determining the amount of DSH payments to affected hospitals (Rudowitz et al., 2023). In Nevada, counties pay the State's share of DSH payments to hospitals.

Due to the federal matching structure, Medicaid operates in state budgets as both an expenditure item and a source of federal revenue. In FY 2023, Medicaid accounted for 30 percent of total state budgets and 15 percent of expenditures from state funds, second to K–12 education at 23 percent. Medicaid accounted for 57 percent of all state expenditures from federal funds (Rudowitz et al., 2023). States are incentivized to control Medicaid spending because they pay a share of the costs, and research shows that the federal matching dollars positively affect state economies.

Figure 5. Nevada's FMAP Cost-Sharing Percentage Rates for FY 2026



For FY 2023, the Kaiser Family Foundation compiled Medicaid spending data for all states, excluding administrative costs and accounting adjustments. Nevada's spending totaled $5.6 billion, as follows:

Spending	Line Item
$2.68 billion	**Managed care and health plans**, including health maintenance organizations, prepaid health plans, and primary care case management fees.
$1.84 billion	**Fee-for-service acute care**, including inpatient and outpatient care, physician visits, lab tests, prescriptions, mental health care, etc.
$796 million	**Fee-for-service long-term care**, including nursing facilities, home health, personal care services, and intermediate care facilities.
$265 million	**Payments to Medicare**, primarily covering Medicare premiums for Medicaid enrollees.
$22 million	**Disproportionate Share Hospital payments** to offset uncompensated care costs for hospitals that serve many Medicaid and uninsured patients.
$5.6 billion	**FY 2023 TOTAL**

To maximize federal Medicaid reimbursements, states can use local government funding, revenue collected from provider taxes, various fees, and intergovernmental transfers to help finance the state's share of costs. All states except Alaska have at least one provider tax; many states have more than three, and Nevada has two (Burns et al., 2025).

Figure 6. Nevada's Revenue from Provider Taxes

Revenue Source[1]		FY 2024	FY 2025	FY 2026	FY 2027
Long-Term Care Provider Tax	Legislatively Approved	$43,065,365	$43,600,870	$51,909,758	$54,807,632
	Actual	$44,592,153	$45,611,813	$ -	$ -
Private Hospital Assessment[2]	Legislatively Approved	$190,767,099	$381,534,195	$398,615,839	$398,569,709
	Actual	$191,068,912	$397,170,228	$ -	$ -

[1] Beginning July 1, 2025, each of these budget accounts, the "Increased Quality of Nursing Care" and the "Health Care Quality & Access" budget accounts, is included in the Medicaid Division of the Health Authority. Prior to that, each account was included in the Division of Health Care Financing and Policy of the Department of Health and Human Services.

[2] Collection of the Private Hospital Assessment began January 1, 2024.

STATE PLAN SERVICES

Medicaid is also a federal-state partnership in terms of policy. This partnership is underpinned by the Medicaid State Plan, which each state submits for federal approval. State plan services define the core services that must be offered to all eligible individuals statewide. Each state's plan includes mandatory benefits that result in baseline consistency between the states. Additionally, states may choose to provide optional benefits to meet the particular needs of their residents.

These optional state plan services must be made available to all eligible individuals. Nevada Medicaid sets out the guidelines and limitations of the services covered in the Medicaid Services Manual (MSM).

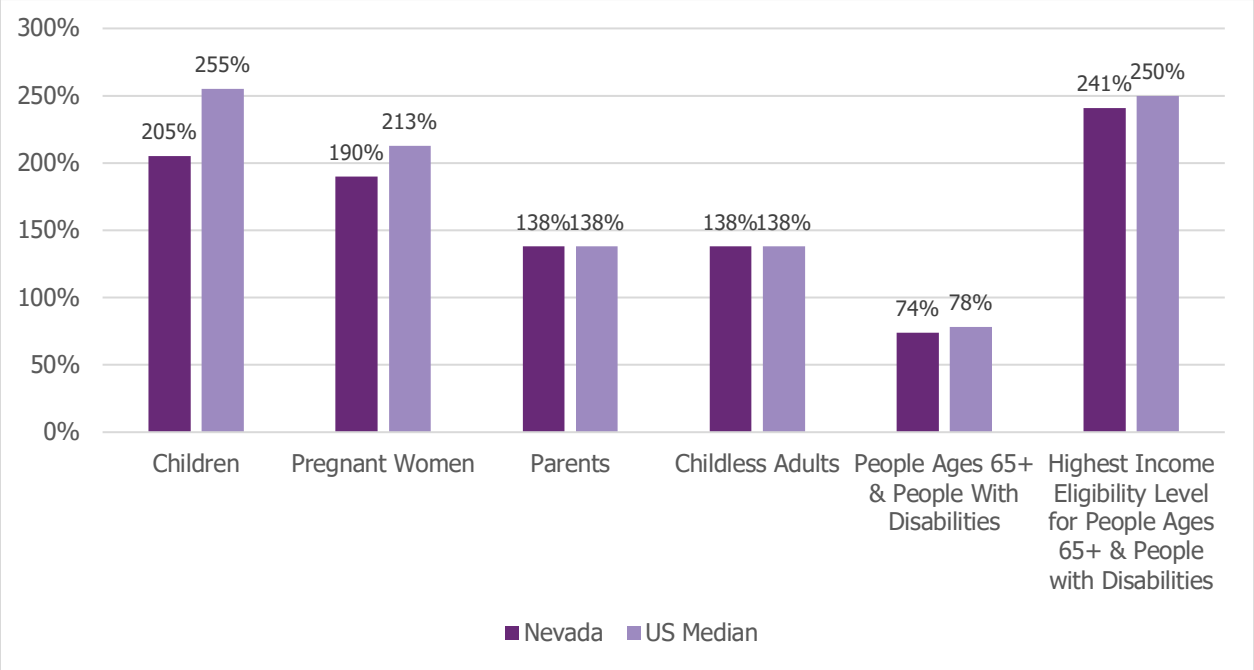
Eligibility is determined by income and family size, as a percentage of the federal poverty line. The FPL is published by the U.S. Department of Health and Human Services, and is standard across all sets except Alaska and Hawaii.

Figure 7: 2025 Federal Poverty Line for the 48 Contiguous States and the District of Columbia

Persons in Household	1	2	3	4	5	6
Annual Income	$15,650	$21,150	$26,650	$32,150	$37,650	$43,150

In Nevada, Medicaid eligibility is determined by income as a percentage of the federal poverty level (FPL). Children under 19 qualify with household incomes at or below 205 percent of the FPL, while pregnant women are eligible if their income is under 165 percent of the FPL. Parents and caretakers, as well as childless adults ages 19–64, qualify with incomes at or below 138 percent of the FPL. Seniors and individuals with disabilities are eligible with incomes at or below 74 percent of the FPL.

Figure 8. Nevada Medicaid Eligibility Limits As Percentage of 2025 Federal Poverty Line, compared to US Median Medicaid Eligibility Limits



Source: KFF, Medicaid in Nevada Factsheet. Available at: https://files.kff.org/attachment/fact-sheet-medicaid-state-NV

Subject to certain limitations, mandatory services include inpatient and outpatient hospital services, doctor visits, laboratory tests and x-rays, nursing home care, home health services, and

others. Optional benefits include dental care, physical and occupational therapy, prescription drugs, prosthetics, and other services (Centers for Medicare and Medicaid Services, 2022).

States may also serve specific optional categories of eligible persons, such as those deemed medically needy, those diagnosed with breast or cervical cancer, elderly and disabled individuals with incomes above federal minimum standards or who receive long-term services and supports in the community, and other groups (Medicaid and CHIP Payment and Access Commission, 2017).

Nevada's current optional benefits include: (1) outpatient prescription drugs; (2) limited adult dental services; (3) physical, occupational, and speech therapy; (4) personal care services for individuals meeting medical necessity criteria; (5) an array of outpatient behavioral health services to address mental health and substance use disorders; and (6) other optional services (DHCFP, 2023). Under Medicaid's optional state plan eligibility categories, Nevada has chosen to serve five of ten optional groups in the "Families and Adults" category, and six of fifteen optional groups in the "Aged, Blind, and Disabled" category (DHCFP, 2025).

Medical necessity is defined by the Nevada Medicaid Services Manual as:

"A health care service or product that is provided for under the Medicaid State Plan and is necessary and consistent with generally accepted professional standards to: diagnose, treat or prevent illness or disease; regain functional capacity; or reduce or ameliorate effects of an illness, injury or disability."

WAIVER SERVICES

Medicaid offers options for states to apply for and receive waivers to Medicaid rules in order to serve specific groups of people, particularly if such waivers will help states to innovate, implement managed care, or help people avoid placement in institutional care (CMS, 2022). There are a variety of waiver types available, as follows:

Waiver Type	Active in Nevada	Purpose	Notes
1115	✓	Allows short-term demonstrations beyond the state plan to test broad program changes.	These waivers enable states to provisionally expand eligibility, provide services not otherwise covered, or utilize new and innovative service delivery systems for Medicaid.

Waiver Type	Active in Nevada	Purpose	Notes
1915(a,b)	✓	1915(a) implements voluntary managed care services and 1915(b) implements mandatory managed care services.	Four types of 1915(b) waivers allow states to: (1) require Medicaid beneficiaries to enroll in managed care plans; (2) allocate savings from managed care to provide additional services not normally covered; (3) use savings to offer additional services; or (4) bypass standard "any willing provider" rules.
1915(c)	✓	Home and Community-Based Services (HCBS) to avoid institutional care.	The services must have adequate and reasonable provider standards and not cost more than institutional care. They cannot be limited to a particular ethnic or racial group, but may be limited geographically, in coverage, or to a particular medical diagnosis. A state can have multiple such waivers.
1915(i)	✓	Provides HCBS via the state plan.	Must be available statewide. Serves people with incomes up to 150 percent of the FPL who do not require institutional care. States can set additional requirements targeting services to groups with specific needs.
1915(j)	✓	Provides self-directed personal assistance services under the state plan or section 1915(c) waivers.	Participation is voluntary, and participants set their provider qualifications, train their providers, and determine their pay rates. States can target people on a 1915(c) waiver, limit the number of participants, or limit the program geographically.
1915(k)	✗	Provides the "Community First Choice" option, allowing states to offer HCBS attendant care to eligible Medicaid enrollees under the state plan.	This option, established under the Affordable Care Act, provides a six-point increase in the FMAP for related services.

Waiver Type	Active in Nevada	Purpose	Notes
1332: State Innovation Waiver	✓	Permits a state to apply for a State Innovation Waiver to pursue creative solutions to improve access to quality, affordable health insurance.	This waiver, established under the Affordable Care Act, is approved by the U.S. Department of Health and Human Services and the Department of the Treasury. For approval, the state must show that the waiver will provide coverage that is as comprehensive, affordable, and widely available as without the waiver. Additionally, the state must show that the waiver will not increase the federal deficit.
Katie Beckett	✓	Home care for children with severe disabilities.	This law allows a state to waive parental income and resource limitations for a disabled child under age 19 who would be eligible for Medicaid in a medical institution. This waiver covers medically necessary costs, which are limited to the cost of institutional care.

All HCBS 1915 waivers are fee-for-service programs, meaning providers are paid for each service the patient receives. Each waiver requires individuals to meet criteria set by the state based on their needed level of care (CMS, 2025). In the 1915(c) category, Nevada operates waivers targeting people with physical disabilities, people with intellectual developmental disabilities, families needing structured caregiving, and frail seniors (CMS, 2022).

Nevada's 1915(b) waiver applies to adult dental services. The state's 1915(i) waivers provide adult day health care services and residential and day habilitation services for people with Traumatic Brain Injuries (DHCFP, 2025).

In January 2025, CMS approved Nevada's State Innovation Waiver under Section 1332 of the Affordable Care Act, allowing the state to introduce new, state-contracted health plans for individuals purchasing coverage through the Silver State Health Insurance Exchange. These plans, known as Battle Born State Plans (BBSPs), will include all essential health benefits and maintain key ACA consumer protections, but will be offered at lower premiums. The waiver also authorizes Nevada to launch a state-based reinsurance program, which will help insurers by subsidizing the cost of high-cost claims. The BBSPs are expected to become available starting in January 2026 (CMS, 2025).

THE CHILDREN'S HEALTH INSURANCE PROGRAM

The Children's Health Insurance Program was created in 1997 to provide health insurance to uninsured children under age 19 whose families earn too much to qualify for Medicaid, but too little to afford private coverage. A CHIP is a separate program from Medicaid, governed by Title XXI of the Social Security Act, but similar to Medicaid, in that it is a federal-state cost-sharing program, with federal law establishing baseline eligibility and benefit standards and states

administering the program. Mandatory benefits include well-baby and well-child visits, dental care, behavioral health services, and vaccines. States can design their CHIP as a separate program, a Medicaid expansion, or both.

If a state chooses to offer a CHIP separate from Medicaid, the coverage must be comparable to one of several benchmarks, such as the insurance provided to state or federal employees. If a state CHIP is structured as a Medicaid expansion, it must provide the same benefit package offered to children under the Medicaid State Plan. It must also provide children and adolescents with the Early and Periodic Screening, Diagnostic, and Treatment benefit (CMS, 2022).

The allowable income for those enrolled in a CHIP varies by state, ranging from 170 percent to 400 percent of the FPL. Subject to limitations, states can require families to share in the cost of their coverage and must ensure that the CHIP does not replace a family's private coverage. Whereas Medicaid is an entitlement, CHIP is a block grant, so states may freeze enrollment or have waiting lists if funding is exhausted (CMS, 2022).

Nevada is one of 38 states that have structured their CHIP program as a combination of Medicaid expansion and a separate program. This means Nevada receives federal funding to implement a Medicaid expansion to cover more children and also operates a separate CHIP program. Nevada Check Up, Nevada's CHIP program, is operated separately from Nevada Medicaid.

Nevada Check Up serves children in households with an annual income of up to 200 percent of the FPL, which translates to $50,200 for a family of four.

The only cost to enrollees is a quarterly premium and there are no co-payments, deductibles, or other charges for covered services. Premiums are determined by family size and income and are either $25, $50, or $80 per family. Enrollees are mandated to receive treatment under a Health Maintenance Organization in the state's urban areas (Nevada Health Link, 2025).

AFFORDABLE CARE ACT EXPANSION

The most significant change since the introduction of Medicaid came in 2010, with the enactment of the ACA. Beginning in 2014, it allowed states to expand coverage to nearly all adults with incomes up to 138 percent of the FPL, approximately $21,600 for an individual in 2025. The federal government offers enhanced federal matching funds to encourage states' participation. The FMAP was initially 100 percent from 2014 to 2016 and was reduced to 90 percent by 2020 for this expanded eligibility cohort. A U.S. Supreme Court ruling in 2012 effectively made the expansion optional for states. As of April 2025, all but ten states have adopted the expansion.

While expansion has led to higher government spending on Medicaid, a large body of literature shows that it has reduced the number of uninsured Americans, increased health care affordability for participants, improved access and health outcomes, and provided economic benefits to states and providers (KFF, 2025). In states that implemented the Medicaid expansion, the uninsured rate dropped by 17 percent compared to pre-expansion levels.

Non-expansion states only saw a 1 percent decrease (NIH, 2019). The expansion enrollees represent nearly a quarter of all national Medicaid enrollment as of March 2024, and made up one-fifth of total Medicaid spending in FY 2023 (Williams et al., 2025).

In addition to adults with incomes marginally higher than the regular Medicaid limit, beneficiaries of the ACA expansion have included former foster youth transitioning into adulthood and individuals with disabilities who were previously ineligible due to income limits. Two percent of expansion enrollees use long-term care services that support activities of daily living, such as eating, bathing, or dressing. Medicaid expansion is also the primary pathway to coverage for people with HIV (Mathers et al., 2025).

Several studies show that states adopting the ACA Medicaid expansion have realized budget savings, revenue gains, overall economic growth, and positive effects on the finances of hospitals and other health care providers (Mathers et al., 2025).

Nevada was an early adopter of the expansion. **For State Fiscal Year 2025, just over 309,000 Nevadans were covered as part of the ACA expansion population** (DHHS Factbook Data Portal, 2025).

CHANGES TO FEDERAL POLICY

HOW WILL CHANGES TO THE FEDERAL PROGRAM AFFECT NEVADA'S MEDICAID POLICIES?

At the end of FY 2024, the U.S. held $28.2 trillion in federal debt, which amounts to approximately $168,000 for every person in the nation's labor force (CBO, 2025; Statista, 2025). In this challenging fiscal environment, some federal policymakers advocate for cuts to government spending, focusing largely on the opportunity for savings in mandatory programs, which constitute 60 percent of the federal budget. Federal mandatory programs include Social Security, Medicare, Medicaid, income security programs, and others. Because these programs reach so many people, reducing federal entitlement spending is a challenging political task.

The Kaiser Family Foundation has analyzed the potential impacts of eliminating the ACA Medicaid expansion. Nationally, it would reduce Medicaid enrollment by 20 million people—a 24 percent reduction—and save $1.7 trillion in federal spending over ten years. Nevada's enrollment reduction would be 42 percent, resulting in approximately 309,000 people losing coverage, or roughly 10 percent of Nevada's population.

The One Big Beautiful Bill Act (H.R. 1), the 2025 Budget Reconciliation Bill, proposed significant cuts to entitlement programs. Passed by Congress on July 3, 2025, and signed into law by President Trump on July 4, 2025, HR 1 does not go as far as to eliminate ACA expansion; however, it does reduce Medicaid spending by $911 billion and will increase the number of uninsured people by 10 million, nationally over the next ten years. As to Nevada specifically, KFF estimates a reduction in federal spending between $6 billion and $11 billion, over the ten-year period (Euhus et al., 2025). Additionally, HR 1 modifies several policy levers that states use to address Medicaid financing and healthcare accessibility.

Policy Levers Altered by the House of Representatives' Budget Bill (HR 1)

The following tables set forth select aspects of the federal Medicaid program that will change under HR 1, impacting Nevada Medicaid's program administration, financing, and Medicaid providers and recipients.

Cost Sharing	
Prior to HR 1	Under HR 1
Federal law allows states to charge premiums and cost-sharing for Medicaid enrollees within federal limits. The limits provide that out-of-pocket costs imposed on enrollees cannot exceed 5 percent of family income, and some services are exempt.	HR 1 imposes co-pays up to $35 per service for expansion adults with incomes 100-138 percent of the Federal Poverty Level (FPL) and maintains the 5 percent of household income cap for adults in the ACA expansion cohort beginning in FY 2029.
HR 1 provides $15 million in implementation funding for FY 2026. Effective: October 1, 2028	

Work Requirements	
Prior to HR 1	Under HR 1
Federal law prohibited states from requiring Medicaid enrollees to participate in the workforce. States could, however, implement such a requirement by submitting a Section 1115 waiver for CMS approval.	HR 1 requires that adults aged 19 to 64 within the ACA expansion eligibility group spend at least 80 hours per month engaged in work or community service activities or meet exemption criteria to enroll in and maintain Medicaid coverage. They would be required to verify that they met this requirement for one or more months, but not more than 3 months, preceding the month of application. Exemptions exist for some adults, including parents of children ages 13 or under.
HR 1 provides $200 million to states for FY 2026 and $200 million to the federal program for support implementation. Effective December 31, 2026, unless an exemption is granted by the Secretary of the U.S. Department of Health and Human Services to extend the effective date to no later than December 31, 2028, upon a demonstration by the state of a good faith effort to comply.	

Two-thirds of Nevada adults on Medicaid are working full- or part-time (KFF 2025). In a presentation to the Nevada Assembly Committee on Health and Human Services, on February 26, 2025, the Division of Health Care Financing and Policy estimated that implementing a work requirement rule in Nevada would affect 70,400 to 112,600 low-income working adults' coverage, with a total spending reduction between $441 million and $705.6 million over the next biennium (Assembly Health and Human Services Meeting, February 26, 2025).

Nationally, among adults under age 65 receiving Medicaid who are not eligible for Social Security Disability Insurance:

- 64 percent work full- or part-time;
- 12 percent are not working due to caregiving responsibilities;
- 10 percent are not working due to illness or disability; and
- 7 percent are not working due to school attendance.

The remaining are retired, unable to find work, or not working for another reason (Hinton & Rudowitz, 2025).

Two states have implemented work requirements: Georgia and Arkansas. Georgia has spent more than $91 million in state and federal funds in the two years since implementing the requirement, $50 million of which was spent on building an eligibility reporting system (Wabe 2025). Arkansas, in implementing its work requirement, observed 18,000 individuals losing Medicaid coverage, with no increase in employment (Hinton & Rudowitz, 2025).

<table>
<tr><th colspan="2">Provider Taxes</th></tr>
<tr><td>Prior to HR 1</td><td>Under HR 1</td></tr>
<tr><td>Provider taxes are assessed on health care providers or services. They can be used to obtain federal Medicaid matching dollars and, in turn, offer enhanced reimbursement to Medicaid providers. Federal rules dictate that provider taxes must be broad-based and applied uniformly to all providers within a specified class, not limited to Medicaid providers. States are prohibited from guaranteeing that providers will receive their revenues back (or be “held harmless). Prior to HR 1, the hold harmless provision did not apply when the tax rate produces revenues less than or equal to 6 percent of net patient revenues from treating patients (referred to as the “safe harbor” limit).</td><td>HR 1 makes significant changes to the use of provider taxes:
It prohibits states from establishing new provider taxes or increasing the rates of existing taxes.
It reduces the “safe harbor” limit for expansion states by 0.5 percent annually starting in FY 2028 until the limit reaches 3.5 percent by FY 2032.</td></tr>
<tr><td colspan="2">Effective upon enactment, but states are given at most three fiscal years to transition out of existing arrangements. HR 1 provides $20 million of implementation funding for FY 2026.</td></tr>
</table>

Nevada Revised Statutes 422.3794 authorizes the state to impose a provider tax “after polling the operators in an operator group and receiving an affirmative vote from at least 67 percent of the operators.” Through this statutory power, and as outlined in the Nevada Medicaid State Plan and a federally approved waiver, Nevada currently imposes the following provider taxes:

- *Nursing Facilities*: All nursing facilities are assessed a 6 percent tax on net revenues. The taxes collected fund enhanced reimbursement to nursing facilities participating in Medicaid.

- *Private Hospitals*: For FY 2025, the provider tax rate is 7.139 percent for inpatient services and 6.809 percent for outpatient services, applied to each private hospital's net patient revenue, excluding Medicare revenue.[1] Nevada law requires that 15 percent of this tax be set aside to assist with the state's shortfall in funding for community-based behavioral health services. The remaining funds are matched by federal funds and used to provide supplemental payments to hospitals providing care to Medicaid enrollees.

State-Directed Payments	
Prior to HR 1	Under HR 1
States, if approved by CMS, could use "state-directed payments" (SDPs) to compel managed care organizations (MCOs) to pay providers specific rates, impose uniform rate increases, or use certain payment models. The upper limit for SDPs is the average commercial rate for hospitals and nursing facilities and is typically higher than the Medicare payments ceiling, which is the metric used for other Medicaid fee-for-service supplemental payments.	Under HR 1, SDPs will be revised to cap the total payment rate for inpatient hospital and nursing facilities at 100 percent of the total published Medicare payment rate for expansion states and at 110 percent of the total published Medicare payment rate for all other states. For SDPs approved before HR 1, the payments will be reduced by 10 percent each year (starting January 1, 2028) until they reach the Medicare payment limit. This provision only applies to SDPs submitted before enactment for rural hospitals and before May 1, 2025, for all other providers.
Effective upon enactment.	

"Medicaid shortfall" refers to the difference between Medicaid payments made to hospitals and the cost of treatment. Hospitals rely on supplemental payments, such as SDPs, to address the shortfall. The revised cap imposed by HR 1 will reduce supplemental payments received by hospitals, thus increasing the financial hardship imposed on hospitals by the Medicaid shortfall.

[1] Neither provider tax assessment rate in Nevada currently produces revenue that exceeds 6 percent of net patient revenues.

Disproportionate Share Hospital Payments	
Prior to HR 1	Under HR 1
Disproportionate share hospital payments (DSH) are supplemental payments made to hospitals that serve a disproportionate share of low-income, uninsured, and Medicaid patients. The ACA sought to reduce federal DSH allotments starting in FY 2014 based on the anticipated reduction in uninsured rates stemming from the ACA implementation; however, the cuts have been delayed several times, currently through September 30, 2025. The slated reductions will impose an $8 billion annual reduction nationwide ($24 billion over three fiscal years).	HR 1 delays DSH reductions through September 30, 2028.
Effective upon enactment.	

DSH allotments are an additional mechanism to address the Medicaid shortfall and the financial stability of safety net hospitals. Each state's allotment is calculated according to federal rules and published annually in the *Federal Register*.

For FY 2025, the total DSH allotment to Nevada was $25,158,225.17 (CMS, 2024).

Eligibility Determinations	
Prior to HR 1	Under HR 1
Previously, states were required to renew eligibility every 12 months for Medicaid enrollees whose eligibility is based on modified adjusted gross income, including children, pregnant individuals, parents, and adults eligible under the ACA expansion.	HR 1 changes this requirement to require states to conduct eligibility redeterminations at least every 6 months for ACA expansion adults.
HR 1 provides $75 million to states for FY 2026 for support implementation. Effective beginning with eligibility determinations set for December 31, 2026; however, states may seek an exemption to delay this requirement going into effect until December 31, 2028.	

Retroactive Coverage	
Prior to HR 1	Under HR 1
Previously, states were required to cover qualified medical expenses incurred up to 90 days prior to the date of Medicaid application.	HR 1 limits retroactive coverage to one month prior to application for the expansion population, and two months prior to application for other enrollees.
HR 1 provides $15 million for implementation in FY 2026. Effective December 31, 2026.	

Coverage for Lawfully Present Immigrant Children and Pregnant People and State Funded Coverage of Undocumented Immigrants	
Prior to HR 1	Under HR 1
Many immigrants must wait five years after gaining qualified status before enrolling in Medicaid, though states have the ability to waive this waiting period for children and pregnant people. Nevada is a state that has waived this waiting period. Undocumented immigrants remain ineligible for Medicaid; however, states can use state-only funds to cover children regardless of status.	HR 1 reduces the expansion match rate from 90 percent to 80 percent for states that provide coverage, including coverage purchased with state-only funds, to purchase health coverage for individuals who do not have a qualified status and who are not lawfully residing children or pregnant adults covered under the Medicaid option for these groups.
Effective October 1, 2027.	

FMAP Percentage for Emergency Medicaid	
Prior to HR 1	Under HR 1
Emergency Medicaid is used to reimburse hospitals for the cost of emergency care rendered to immigrants, both undocumented and some lawfully present, who would qualify for Medicaid if not for their immigration status.	HR 1 limits the FMAP to the state's regular FMAP for Emergency Medicaid for individuals who would be eligible for expansion coverage, if not for their immigration status.
HR 1 provides $1 million for implementation in FY 2026. Effective October 1, 2026.	

Free Choice of Provider	
Prior to HR 1	Under HR 1
States must generally allow beneficiaries to obtain Medicaid services from any qualified provider willing to provide services. Managed care organizations may restrict enrollees to providers in their network, except that such plans cannot limit the free choice of family planning providers.	HR 1 prohibits Medicaid funds from being paid to nonprofit providers offering abortion services. This would affect Planned Parenthood and other Medicaid community providers that also offer family planning, reproductive, or other services.
HR 1 provides $1 million for implementation in FY2026. Effective upon enactment for one year.	

Gender Affirming Care	
Prior to HR 1	Under HR 1
The state plan determines coverage of gender affirming care. Some states have enacted laws prohibiting such care for Medicaid and other payers. Such laws are the subject of ongoing litigation.	HR 1 prohibits the use of FMAP funds for "gender transition procedures" for any individuals enrolled in Medicaid or CHIP.
Effective upon enactment.	

Lastly, HR 1 creates a **Rural Health Transformation Program**, which sets aside $50 billion in grants to be used between fiscal years 2026 and 2030, to promote care, pay for health care services, expand the rural health workforce, and provide technical or operational assistance in rural areas. Fifty percent of the funds will be equally distributed among states with approved applications, while CMS will allocate the remaining funds. The Centers for Medicare and Medicaid Services has not shared guidance on the criteria for how states can apply for and use these funds; however, when awarded, the funds will go to states for program implementation rather than to rural providers directly. The funding will be available in federal fiscal year 2026 (KFF, 2025).

CONSIDERATIONS FOR THE ROAD AHEAD

HR 1 introduces substantial changes to both the financing and administration of Medicaid in Nevada. Although many policy provisions take effect immediately, more than three-quarters of the federal Medicaid spending reductions will occur between 2030 and 2034. This backloaded approach means the full impact of the cuts may take years to materialize, with effects compounding toward the end of the ten-year window. Given the extended timeline, Nevada policymakers may wish to consider the path ahead to address the long-term implications for the state's Medicaid program.

Such policy considerations include:

- **How will Nevada navigate the projected reduction of federal spending of between $6 billion and $11 billion over the next ten years?**

  Nevada's health spending per capita in 2020 was $8,902, ranking 49th among all fifty states and the District of Columbia.[2] Low health spending per capita can represent more efficient health systems with healthier populations. However, the Commonwealth Fund also ranks Nevada 46th in health care quality based on access to care, quality of care, affordability of care, and health outcomes. Taken together, the low health spending per capita indicates an underinvestment in health services.

  The cuts under HR 1 to federal matching funds and state funding mechanisms will further tighten Nevada's ability to fund Medicaid over the next decade and force policymakers to balance maintaining Medicaid coverage against sustaining service funding.

  Policy considerations may include:
  - Creating alternative revenue sources, such as increased taxes;
  - Cutting other state programs; or,
  - Changing program parameters, such as optional benefits and reimbursement rates.

- **How can Nevada reduce the impact on providers, especially rural hospitals, public hospitals, and those serving high numbers of Medicaid patients?**

  Nevada is likely to experience a reduction in SDPs, which help support hospitals that serve a high proportion of Medicaid patients, as well as rural hospitals that often operate on thin financial margins. This challenge will be compounded by the cap on provider taxes, which will lower the cap on Nevada's private hospital tax rate from 6 percent to 3.5 percent by 2032. The resulting revenue loss could influence programmatic decisions at the state level, potentially affecting provider reimbursement rates. Also, the reduction in supplemental payments to safety net hospitals will increase the Medicaid shortfall and reduce access to health care for Medicaid patients.

[2] The CMS Office of the Actuary assesses health spending per capita every five years, looking at spending for all privately and publicly funded personal health care services and products, including hospital care, physician services, nursing home care, prescription drugs, et cetera. The most recent assessment published is for 2020.

Policymakers will need to carefully weigh these revenue constraints against the potential impact on hospitals and providers that primarily serve Medicaid populations.

- **How will Nevada Medicaid shoulder the administrative burden imposed by new changes from HR 1?**

  HR 1 imposes two policy changes that will have a significant administrative burden on the state: (1) a work requirement for the ACA expansion population; and (2) changing the period to renew eligibility for the ACA expansion population from every year, to every six months. Regarding these work requirements, states will need to verify individuals' work or exemption status at the time of application and look back one or more consecutive months, and also every six months after eligibility is granted. In addition to the increase in workload for eligibility determinations, in the event an individual loses eligibility, the State will proceed through the notice of noncompliance, denial, and possible appeal process, for when an individual loses coverage. The new law regarding work requirements will go into effect December 31, 2026; unless Nevada seeks a waiver to extend the effective date to December 31, 2028. To do so, Nevada must demonstrate that the state is undertaking a good-faith effort to comply and submit evidence of progress and barriers to compliance.

- **How will Nevada prepare to implement the new work requirements for ACA expansion populations?**

  Two states – Georgia and Arkansas – received prior approval to implement Medicaid work requirements under section 1115 demonstration waivers. Both states experienced difficulties operationalizing the requirement, and Arkansas's implementation resulted in 18,000 individuals losing Medicaid coverage with no observed increase in employment. Nevada may look to these states for lessons learned and begin considering how it may find and verify work placement for these individuals.

- **How will Nevada absorb the impact of an increase in uninsured populations?**

  An increase in the uninsured population is closely associated with systemic impacts on a community's healthcare spending, economic productivity, and overall health and well-being. Uninsured and underinsured populations either forego or delay care, or rely on hospital emergency rooms for primary care, the most expensive avenue for care. Uncompensated care is displaced onto healthcare providers and consumers through increased insurance premiums. Additionally, untreated illness increases absenteeism at work, reduces productivity, and impacts the economy.

  Nevada may likely need to explore policy opportunities to:
  - Mitigate an increase in the loss of health insurance coverage;
  - Address the costs of healthcare;
  - Reinforce public health infrastructure to address disease prevention; and
  - Focus on early intervention and preventative care.

CONCLUSION

Medicaid eligibility and reimbursement are notoriously complex, with several layers of state and federal compliance and varying calculations to determine a state's FMAP. As an early adopter of the ACA expansion, Nevada has remained innovative over the past decade to maximize federal dollars and policy options to best cover Nevadans. While all policy changes have ripple effects on the affected communities, the changes brought forth by HR 1 will have significant implications on program administration, the number of Nevadans with health insurance, provider reimbursements, and Nevada's overall health care system.

References

1. Arrington, Rep. J. (2025). *Text - H.R.1 - 119th Congress (2025-2026): One Big Beautiful Bill Act.* https://www.congress.gov/bill/119th-congress/house-bill/1/text

2. *Assembly Health and Human Services (HHS) meetings*. (2025, February 26). https://www.leg.state.nv.us/App/NELIS/REL/83rd2025/Committee/433/Meetings

3. Burns, A., Hinton, E., Williams, E., & Rudowitz, R. (2025, March 26). *5 Key facts about Medicaid and provider Taxes | KFF.* KFF. https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-and-provider-taxes/

4. Centers for Medicare and Medicaid Services (CMS). (2022). *Children's Health Insurance Program (CHIP)*. https://www.medicaid.gov/chip

5. Centers for Medicare and Medicaid Services (CMS). (2022). *Home & Community-Based Services 1915(c) | Medicaid.* https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-authorities/home-community-based-services-1915c

6. Centers for Medicare and Medicaid Services (CMS). (2022). Mandatory & Optional Medicaid Benefits. Www.Medicaid.gov. http://www.medicaid.gov/medicaid/benefits/mandatory-optional-medicaid-benefits

7. Center for Medicare & Medicaid Services. (2025, January 10). Nevada: State Innovation Waiver under section 1332 of the ACA (Fact Sheet) [PDF]. U.S. Department of Health & Human Services. https://www.cms.gov/files/document/nevada-section-1332-waiver-fact-sheet.pdf

8. Centers for Medicare & Medicaid Services. (2024, June 13). Nevada State Plan Amendment (SPA) 24-0020: State Plan under Title XIX of the Social Security Act (Effective July 1, 2024). Retrieved from https://www.medicaid.gov/medicaid/spa/downloads/NV-24-0020.pdf

9. Centers for Medicare and Medicaid Services (CMS). (2022). *State Waivers List | Medicaid.* https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list?page=35

10. Centers for Medicare and Medicaid Services (CMS). (2025, February 7). *State Medicaid Plans and Waivers | CMS*. https://www.cms.gov/training-education/partner-outreach-resources/american-indian-alaska-native/ltss-ta-center/information/state-medicaid-plans-and-waivers

11. Congressional Budget Office (CBO). (2025). The Federal Budget in Fiscal Year 2024: An Infographic. https://www.cbo.gov/publication/61181

12. Congressional Research Service (CRS). (2025). Medicaid's Federal Medical Assistance Percentage (FMAP). https://www.congress.gov/crs_external_products/R/PDF/R43847/R43847.12.pdf

13. Department of Health and Human Services. (2024, November 29). Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the

Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2025, Through September 30, 2026 (Notice, 89 Fed. Reg. 94742–94746).

14. DHHS Factbook Data Portal. (2025). *Division of Welfare and Supportive Services (DWSS) Programs*. https://app.powerbigov.us/view?r=eyJrIjoiZDkwNWM0YTktMzNiYi00Yzc2LWE2ZGItZTQ3OTIwZjA1ZTkzIiwidCI6ImU0YTM0MGU2LWI4OWUtNGU2OC04ZWFhLTE1NDRkMjcwMzk4MCJ9

15. Euhus, R., Williams, E., Burns, A., & Rudowitz, R. (2025, July 23). *Allocating CBO's estimates of federal Medicaid spending reductions across the states: Enacted Reconciliation Package | KFF.* KFF. https://www.kff.org/medicaid/issue-brief/allocating-cbos-estimates-of-federal-medicaid-spending-reductions-across-the-states-enacted-reconciliation-package/

16. Griswold, T., Packham, J., Kaur, S., Barboza, A., NEVADA RURAL AND FRONTIER HEALTH, Nevada Health Workforce Research Center, Office of Statewide Initiatives, University of Nevada, Reno School of Medicine, Health Resources and Services Administration, & U.S. Department of Health and Human Services. (2025). *Nevada Rural and Frontier Health Data Book – Twelfth Edition*. https://www.nvpca.org/_files/ugd/5067d7_e069f66ce8e74f5f8c32b5196b7281cd.pdf?index=true

17. Hinton, E., & Rudowitz, R. (2025, February 18). *5 Key Facts About Medicaid Work Requirements*. KFF. https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-work-requirements/

18. KFF. (2024, August 16). *Federal Medicaid Disproportionate Share Hospital (DSH) Allotments | KFF.* https://www.kff.org/medicaid/state-indicator/federal-dsh-allotments/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

19. KFF. (2024, October 30). *Distribution of Medicaid Spending by Service | KFF.* https://www.kff.org/medicaid/state-indicator/distribution-of-medicaid-spending-by-service/

20. KFF. (2025, May 20). *Medicaid State Fact Sheets (Nevada)* | *KFF.* http://kff.org/interactive/medicaid-state-fact-sheets/

21. KFF. (2025, July 8). *Tracking the Medicaid provisions in the 2025 Reconciliation Bill | KFF*. https://www.kff.org/tracking-the-medicaid-provisions-in-the-2025-budget-bill/

22. Mathers, J., Tolbert, J., Chidambaram, P., & Cervantes, S. (2025, April 25). *5 key facts about Medicaid expansion | KFF*. KFF. https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-expansion/

23. Medicaid and CHIP Payment and Access Commission (MACPAC). (2017). *Mandatory and Optional Enrollees and Services in Medicaid*. https://www.macpac.gov/wp-content/uploads/2017/06/Mandatory-and-Optional-Enrollees-and-Services-in-Medicaid.pdf

24. NIH, National Institute on Minority Health and Health Disparities. (2019). *Medicaid Expansion Benefits Young Adults.* https://www.nimhd.nih.gov/news-events/research-spotlight/medicaid-expansion-benefits-young-adults

25. Nevada Division of Health Care Financing and Policy (DHCFP). *LTSSPCS.* https://dhcfp.nv.gov/Pgms/LTSS/LTSSPCS/

26. Nevada Division of Health Care Financing and Policy (DHCFP). (2022). *LTSS Katie Beckett*. https://dhcfp.nv.gov/Pgms/LTSS/LTSSKatieBeckett/

27. Nevada Division of Health Care Financing and Policy (DHCFP). (2022). *What is a Section 1115 Demonstration Waiver?* https://dhcfp.nv.gov/Pgms/Waivers/Home/

28. Nevada Division of Health Care Financing and Policy (DHCFP). (2023). *Medicaid Services Manual.* https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Resources/AdminSupport/Manuals/MSM/Medicaid_Services_Manual_Complete.pdf

29. Nevada Division of Health Care Financing and Policy (DHCFP). 1915(i) Home and Community-Based Services. Retrieved June 19, 2025, from https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Pgms/LTC/1915(i)%20Brochure%20Text.pdf

30. Nevada Division of Health Care Financing and Policy (DHCFP). (2025). *Medicaid Renewals, Total Enrollment January 2015 - Current.* https://app.powerbigov.us/view?r=eyJrIjoiMmY0NzViMTItNjQwZC00ZTBiLThlNzEtOGVmMTE3MGMxNTFhIiwidCI6ImU0YTM0MGU2LWI4OWUtNGU2OC04ZWFhLTE1NDRkMjcwMzk4MCJ9

31. Nevada Division of Health Care Financing and Policy (DHCFP). (2025, May 2). *Nevada State Plan Amendment (SPA) #: 25-0006*. https://www.medicaid.gov/medicaid/spa/downloads/NV-25-0006.pdf

32. Nevada Health Link. *Medicaid Information*. https://www.nevadahealthlink.com/medicaid-information/

33. Rudowitz, R. (2016, December). *Medicaid Financing: The Basics*. Kaiser Family Foundation, The Kaiser Commission on Medicaid and the Uninsured. https://www.thehertelreport.com/wp-content/uploads/2016/12/Issue-Brief-Medicaid-Financing-The-Basics.pdf

34. State of Nevada. (2024). *Executive Budget Overview, 2025-2027 Biennium*. https://www.leg.state.nv.us/App/InterimCommittee/REL/Document/31578

35. Statista. (2025, May 8). *U.S. labor force 1990-2024.* https://www.statista.com/statistics/191750/civilian-labor-force-in-the-us-since-1990/

36. U.S. Department of Health and Human Services, Office of the Secretary. (2023). *Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2024, Through September 30, 2025*. https://www.federalregister.gov/documents/2023/11/21/2023-25636/federal-financial-participation-in-state-assistance-expenditures-federal-matching-shares-for

37. Wabe, J. M. (2025, August 5). Work requirements and red tape ahead for millions on Medicaid - KFF Health News. KFF Health News. https://kffhealthnews.org/news/article/work-requirements-medicaid-georgia-red-tape-eligibility/

38. Williams, E., Burns, A., Euhus, R., & Rudowitz, R. (2025, February 13). *Eliminating the Medicaid expansion Federal Match Rate: State-by-State Estimates | KFF.* KFF. https://www.kff.org/medicaid/issue-brief/eliminating-the-medicaid-expansion-federal-match-rate-state-by-state-estimates/

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