Nevada CARTS FY2020 Report

Welcome!

We already have some information about your state from our records.
If any information is incorrect, please contact the CARTS Help Desk.

1. State or territory name:

Nevada

2. Program type:

- (●) Both Medicaid Expansion CHIP and Separate CHIP
- ( ) Medicaid Expansion CHIP only
- ( ) Separate CHIP only

3. CHIP program name(s):

All

Who should we contact if we have any questions about your report?

4. Contact name:

Cody Phinney

5. Job title:

Deputy Administrator

6. Email:

Cphinney@dhcfp.nv.gov

7. Full mailing address:

Include city, state, and zip code.

1100 East William Street Carson City, NV 89701

8. Phone number:

Some Nevada phone number

PRA Disclosure Statement.
This information is being collected to assist the Centers for Medicare & Medicaid Services (CMS) in partnership with States with the ongoing management of Medicaid and CHIP programs and policies. This mandatory information collection (42 U.S.C. 1397hh) will be used to help each state meet the statutory requirements at section 2108(a) of the Social Security Act to assess the operation of the State child health plan in each Federal fiscal year and to report the results of the assessment including the progress made in reducing the number of uncovered, low-income children. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10398 #1). The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Part 1: Medicaid Expansion CHIP Enrollment Fees, Premiums, and Delivery Systems

1. Does your program charge an enrollment fee?

- ○ Yes
- ◉ No

2. Does your program charge premiums?

- ○ Yes
- ◉ No

3. Is the maximum premium a family would be charged each year tiered by FPL?

- ○ Yes
- ◉ No

3b. What's the maximum premium a family would be charged each year?

$

4. Do premiums differ for different Medicaid Expansion CHIP populations beyond FPL (for example, by eligibility group)? If so, briefly explain the fee structure breakdown.

5. Which delivery system(s) do you use?
Select all that apply.

- ☑ Managed Care
- ☐ Primary Care Case Management
- ☑ Fee for Service

6. Which delivery system(s) are available to which Medicaid Expansion CHIP populations? Indicate whether eligibility status, income level, age range, or other criteria determine which delivery system a population receives.

Part 2: Separate CHIP Enrollment Fees, Premiums, and Delivery Systems

1. Does your program charge an enrollment fee?

- ○ Yes
- ◉ No

2. Does your program charge premiums?

- ◉ Yes

  2a. Are your premiums for one child tiered by Federal Poverty Level (FPL)?

  - ○ Yes
  - ◉ No

  2c. How much is the premium for one child?

  $

- ○ No

3. Is the maximum premium a family would be charged each year tiered by FPL?

◉ Yes

3a. Indicate the range of premiums and corresponding FPL for a family.

Maximum premiums for a family, tiered by FPL

FPL starts at	FPL ends at	Premium starts at	Premium ends at
139	150	$ 25	$ 25
151	175	$ 50	$ 50
176	205	$ 80	$ 80

- ○ No

4. Do your premiums differ for different CHIP populations beyond FPL (for example, by eligibility group)? If so, briefly explain the fee structure breakdown.

No. The only exception is AI/AN children, they are exempt from the quarterly premium

5. Which delivery system(s) do you use?
Select all that apply.

- [x] Managed Care
- [ ] Primary Care Case Management
- [x] Fee for Service

6. Which delivery system(s) are available to which CHIP populations? Indicate whether eligibility status, income level, age range, or other criteria determine which delivery system a population receives.

FFS is used for those living in rural areas and MCO's are used for those living in urban areas.

Part 3: Medicaid Expansion CHIP Program and Policy Changes

Indicate any changes you've made to your Medicaid Expansion CHIP program policies in the past federal fiscal year. Many changes listed in this section require a State Plan Amendment (SPA), while some don't, such as changing outreach efforts or changing the health plan enrollment process. Please submit a SPA to reflect any changes that do require a SPA.

1. Have you made any changes to the eligibility determination process?

- ○ Yes
- ◉ No
- ○ N/A

2. Have you made any changes to the eligibility redetermination process?

- ◉ Yes
- ○ No
- ○ N/A

3. Have you made any changes to the eligibility levels or target populations?
For example: increasing income eligibility levels.

- ○ Yes
- ◉ No
- ○ N/A

4. Have you made any changes to the benefits available to enrollees?
For example: adding benefits or removing benefit limits.

- ○ Yes
- ◉ No
- ○ N/A

5. Have you made any changes to the single streamlined application?

- ○ Yes
- ◉ No
- ○ N/A

6. Have you made any changes to your outreach efforts?
For example: allotting more or less funding for outreach, or changing your target population.

- ○ Yes
- ◉ No
- ○ N/A

7. Have you made any changes to the delivery system(s)?
For example: transitioning from Fee for Service to Managed Care for different Medicaid Expansion CHIP populations.

- ○ Yes
- ◉ No
- ○ N/A

8. Have you made any changes to your cost sharing requirements?
For example: changing amounts, populations, or the collection process.

- ○ Yes
- ◉ No
- ○ N/A

9. Have you made any changes to the substitution of coverage policies?
For example: removing a waiting period.

- ○ Yes
- ◉ No
- ○ N/A

10. Have you made any changes to the enrollment process for health plan selection?

- ○ Yes
- ◉ No
- ○ N/A

11. Have you made any changes to the protections for applicants and enrollees?
For example: changing from the Medicaid Fair Hearing process to the review process used by all health insurance issuers statewide.

- ○ Yes
- ◉ No
- ○ N/A

12. Have you made any changes to premium assistance?
For example: adding premium assistance or changing the population that receives premium assistance.

- ○ Yes
- ◉ No
- ○ N/A

13. Have you made any changes to the methods and procedures for preventing, investigating, or referring fraud or abuse cases?

- ○ Yes
- ◉ No
- ○ N/A

14. Have you made any changes to eligibility for "lawfully residing" pregnant women?

- ○ Yes
- ◉ No
- ○ N/A

15. Have you made any changes to eligibility for "lawfully residing" children?

- ○ Yes
- ◉ No
- ○ N/A

16. Have you made changes to any other policy or program areas?

- (●) Yes
- ( ) No
- ( ) N/A

17. Briefly describe why you made these changes to your Medicaid Expansion CHIP program.

In response to the COVID-19 Public Health Emergency a CHIP Disaster Relief SPA was submitted and approved on 6/4/2020. The SPA authorized the State to make changes to delay processing of renewals and extend deadlines for families to respond to renewal requests, waive the collection of premiums, suspend the premium lock-out policy, and conduct tribal consultation subsequent to the submission of the SPA, as permitted under Section 1135 of the Social Security Act.

18. Have you already submitted a State Plan Amendment (SPA) to reflect any changes that require a SPA?

- (●) Yes
- ( ) No
- ( ) N/A

Part 4: Separate CHIP Program and Policy Changes

Indicate any changes you've made to your Separate CHIP program and policies in the past federal fiscal year. Many changes listed in this section require a State Plan Amendment (SPA), while some don't, such as changing outreach efforts or changing the health plan enrollment process. Please submit a SPA to reflect any changes that do require a SPA.

1. Have you made any changes to the eligibility determination process?

- ○ Yes
- ◉ No
- ○ N/A

2. Have you made any changes to the eligibility redetermination process?

- ◉ Yes
- ○ No
- ○ N/A

3. Have you made any changes to the eligibility levels or target populations?
For example: increasing income eligibility levels.

- ○ Yes
- ◉ No
- ○ N/A

4. Have you made any changes to the benefits available to enrolees?
For example: adding benefits or removing benefit limits.

- ○ Yes
- ◉ No
- ○ N/A

5. Have you made any changes to the single streamlined application?

- ○ Yes
- ◉ No
- ○ N/A

6. Have you made any changes to your outreach efforts?
For example: allotting more or less funding for outreach, or changing your target population.

- ○ Yes
- ◉ No
- ○ N/A

7. Have you made any changes to the delivery system(s)?
For example: transitioning from Fee for Service to Managed Care for different Separate CHIP populations.

- ○ Yes
- ◉ No
- ○ N/A

8. Have you made any changes to your cost sharing requirements?
For example: changing amounts, populations, or the collection process.

- ◉ Yes
- ○ No
- ○ N/A

9. Have you made any changes to substitution of coverage policies?
For example: removing a waiting period.

- ○ Yes
- ◉ No
- ○ N/A

10. Have you made any changes to an enrollment freeze and/or enrollment cap?

- ○ Yes
- ◉ No
- ○ N/A

11. Have you made any changes to the enrollment process for health plan selection?

- ○ Yes
- ◉ No
- ○ N/A

12. Have you made any changes to the protections for applicants and enrollees?
For example: changing from the Medicaid Fair Hearing process to the review process used by all health insurance issuers statewide.

- ○ Yes
- ◉ No
- ○ N/A

13. Have you made any changes to premium assistance?
For example: adding premium assistance or changing the population that receives premium assistance.

- ○ Yes
- ◉ No
- ○ N/A

14. Have you made any changes to the methods and procedures for preventing, investigating, or referring fraud or abuse cases?

- ○ Yes
- ◉ No
- ○ N/A

15. Have you made any changes to your conception to birth expansion (as described in the October 2, 2002 final rule)?
For example: expanding eligibility or changing this population's benefit package.

- ○ Yes
- ◉ No
- ○ N/A

16. Have you made any changes to your Pregnant Women State Plan expansion?
For example: expanding eligibility or changing this population's benefit package.

- ○ Yes
- ◉ No
- ○ N/A

17. Have you made any changes to eligibility for "lawfully residing" pregnant women?

- ○ Yes
- ◉ No
- ○ N/A

18. Have you made any changes to eligibility for "lawfully residing" children?

- ○ Yes
- ◉ No
- ○ N/A

19. Have you made changes to any other policy or program areas?

- (●) Yes
- ( ) No
- ( ) N/A

20. Briefly describe why you made these changes to your Separate CHIP program.

In response to the COVID-19 Public Health Emergency a CHIP Disaster Relief SPA was submitted and approved on 6/4/2020. The SPA authorized the State to make changes to delay processing of renewals and extend deadlines for families to respond to renewal requests, waive the collection of premiums, suspend the premium lock-out policy, and conduct tribal consultation subsequent to the submission of the SPA, as permitted under Section 1135 of the Social Security Act.

21. Have you already submitted a State Plan Amendment (SPA) to reflect any changes that require a SPA?

- (●) Yes
- ( ) No

Part 1: Number of Children Enrolled in CHIP

This table is pre-filled with your SEDS data for the two most recent federal fiscal years (FFY). If the information is inaccurate, adjust your data in SEDS (go to line 7: "Unduplicated Number Ever Enrolled" in your fourth quarter SEDS report) and then refresh this page. If you're adjusting data in SEDS, allow one business day for the CARTS data below to update.

Program	Number of children enrolled in FFY 2019	Number of children enrolled in FFY 2020	Percent change
Medicaid Expansion CHIP	24,079	23,165	-3.796%
Separate CHIP	49,043	42,667	-13.001%

1. If you had more than a 3% percent change from last year, what are some possible reasons why your enrollment numbers changed?

With unemployment rates spiking and the economy seeing a down turn, during the pandemic and since, we saw an increase in eligible participants to CHIP. Additionally The Division of Welfare and Supportive Services has suspended regular enrollee recertification due to the COVID crisis which has led to an increase in Medicaid and NCU enrollment. At this time there is no estimated return to the regular recertification process in the immediate future.

Part 2: Number of Uninsured Children in Your State

This table is pre-filled with data on uninsured children (age 18 and under) who are below 200% of the Federal Poverty Level (FPL) based on annual estimates from the American Community Survey.

Year	Number of uninsured children	Margin of error	Percent of uninsured children (of total children in your state)	Margin of error
2015	33,000	4,000	4.8%	0.6%
2016	31,000	5,000	4.5%	0.7%
2017	31,000	5,000	4.4%	0.7%
2018	28,000	4,000	3.9%	0.6%
2019	29,000	5,000	4.1%	0.6%

Percent change between 2018 and 2019
NaN%

2. Are there any reasons why the American Community Survey estimates wouldn't be a precise representation of the actual number of uninsured children in your state?

- ○ Yes
- ◉ No

3. Do you have any alternate data source(s) or methodology for measuring the number and/or percent of uninsured children in your state?

- ○ Yes
- ◉ No

4. Is there anything else you'd like to add about your enrollment and uninsured data?

5. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Program Outreach

1. Have you changed your outreach methods in the last federal fiscal year?

◉ Yes

1a. What are you doing differently?

While Nevada Health Link's (NVHL) outreach marketing strategies and approach remain largely intact, the tactics used for implementation have been modified this year due to the impact of COVID-19. The biggest impacts were seen in the ability to attend in-person community outreach events that allowed NVHL representatives to engage one-on-one with the Nevadans attending said events, as well as with some sponsorship programs like the Reno Aces baseball team "7th Inning Stretch" program which was intended to engage audiences and build awareness for Nevada Health Link. This said, NVHL worked closely with statewide partners to continue these tactics in the digital/online realm, achieving collaborative success. Some examples of modified outreach and marketing activities include: • NVHL was the presenting sponsor of the Cox Back to School Virtual Fair • Desert View Hospital Drive-thru Back to School Fair • Food Bank of Northern Nevada Family Health Festival • Direct email communication access to partner databases including: The Reno Aces, The Discovery Children's Museum, Immunize Nevada, Nevada Health and Equity Minority Coalition, Las Vegas Chamber and Carson Valley Chamber, etc. Nevada Health Link (NVHL) bolstered outreach exposure by providing hand sanitizer to groups directly involved in combating COVID-19 such as the Southern Nevada Health District, Washoe County Health Department, Cleveland Clinic, UNLV School of Medicine and Roseman University. NVHL also sponsored the One October Memorial Blood Drive in Southern Nevada which attracted hundreds of local-area blood donors. Other digital/online tactics included multiple opportunities to directly or indirectly participate in online webinars and to gain significant exposure through collaborations with Senator Cortez-Masto, Senator Rosen as well as Congresswoman Lee and Congresswoman Titus. It is also worth noting that NVHL's annual Prep Session virtual (Zoom) events, which serve to gather and acquaint relevant stakeholders, community partners and staff about the upcoming Open Enrollment period, were also held online this year garnering record attendance. In summary, while NVHL remains committed to growing its in-person presence in and around target-audience communities, we have successfully demonstrated our ability to adapt and respond to extraordinary circumstances such as COVID-19 that

enables us to continue with imperative outreach and marketing.

○ No

2. Are you targeting specific populations in your outreach efforts?
For example: minorities, immigrants, or children living in rural areas.

◉ Yes

2a. Have these efforts been successful? How have you measured the effectiveness of your outreach efforts?

The majority of NVHL's outreach and marketing exists to support underserved communities throughout Nevada which are punctuated by many minority populations including Hispanics, Asian and Pacific Islanders and African Americans. Culture, family and subsequent beliefs are deeply rooted in these populations and NVHL has come to learn that the foundation to eliciting change and fostering awareness is to build trust. Similar to many other objectives, building trust requires insight and the right combination of resources. This year, Nevada Health Link (NVHL) realized a paradigm shift in the way we target these populations starting with acknowledging not only how we engage but how we are perceived. Thus, we have expanded the collective cultural and ethnic expertise of staff, stakeholders and other partners to strategize a more individualized representation and approach with each of these relevant audiences - including ensuring representatives understand, speak and are of like ethnicity and culture and providing educational materials that reflect relevant images, tone and language. We are consistently streamlining our field tracking and information sharing tactics that allow us to track and measure the momentum we are beginning to build and take it from anecdotal to best practice.

○ No

3. What methods have been most effective in reaching low-income, uninsured children?

For example: TV, school outreach, or word of mouth.

Although many of these types of outreach and marketing activities were modified to an online/digital space or curtailed this year due to COVID-19, Nevada Health Link continues to endorse the strategy that reaching children in targeted uninsured communities affords the opportunity to not only expose them to the Nevada Health Link brand and mission, but to elicit ongoing attempts to change behaviors and attitudes toward the importance of having health insurance and staying healthy and insured. Our methodology includes heavy participation and concentration in events surrounding child-emphasized holidays like Halloween and Dia del Nino and Back to School. Solid material distribution channels with both the Southern Nevada and Washoe County Library systems impart ongoing exposure to children as well. We also closely align with partners Immunize Nevada, Southern Nevada Health District and UNR School of Medicine who directly serve both children and families of low-income and uninsured audiences. With COVID-19 came the unfortunate influx of many family's needs for additional food resources this year. As a result, Nevada Health Link has worked in collaboration with the Food Bank of Northern Nevada and its Family Food Box program of food pantry distribution to elicit further exposure to families and children. These direct efforts are supported through the distribution of child-specific promotional giveaways such as coloring books (in both Spanish and English) which underscore the importance of health and engaging booth activities such as corn hole and ring toss. Fostering behavioral change in younger generations is a long-term effort. Reshaping existing beliefs founded in parental influence, cultural norms and economic circumstances is a marathon, not a sprint. While we extract data such as event demographics, attendance and interactions, the effects of Nevada Health Link's commitment are intended to be measured cumulatively with the ultimate goal of seeing increased enrollment in both children and young adults. To that effort, NVHL remains cognizant of aligning strategies to ensure this goal.

4. Is there anything else you'd like to add about your outreach efforts?

Nevada Health Link continues to maintain a strong commitment to outreach marketing to build and bolster awareness, educate, and be a resource and elicit behavioral change in attitudes and perceptions about the importance of being insured and staying healthy, especially during a global pandemic and public health crisis.

5. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Substitution of Coverage

Substitution of coverage (also known as crowd-out) occurs when someone with private insurance drops their private coverage and substitutes it with publicly funded insurance such as CHIP.

1. Do you track the number of CHIP enrollees who have access to private insurance?

- ○ Yes
- ◉ No
- ○ N/A

2. Do you match prospective CHIP enrollees to a database that details private insurance status?

- ○ Yes
- ◉ No
- ○ N/A

3. What percent of applicants screened for CHIP eligibility cannot be enrolled because they have group health plan coverage?

%

4. If you have a Separate CHIP program, do you require individuals to be uninsured for a minimum amount of time before enrollment ("the waiting period")?

- ○ Yes
- ◉ No
- ○ N/A

5. Is there anything else you'd like to add about substitution of coverage that wasn't already covered? Did you run into any limitations when collecting data?

6. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Renewal, Denials, and Retention

Part 1: Eligibility Renewal and Retention

1. Does your state provide presumptive eligibility, allowing children to access CHIP services pending a final determination of eligibility?
This question should only be answered in respect to Separate CHIP.

- ○ Yes
- ◉ No
- ○ N/A

2. In an effort to retain children in CHIP, do you conduct follow-up communication with families through caseworkers and outreach workers?

- ○ Yes
- ◉ No

3. Do you send renewal reminder notices to families?

- [x] Yes

    3a. How many notices do you send to families before disenrolling a child from the program?

    Anthem sends renewal postcards and HPN sends mailers as a reminder once a month.

    3b. How many days before the end of the eligibility period did you send reminder notices to families?

    The DWSS does not send reminder notices; however, annual redeterminations are sent 60 days prior to the due date, with verifications being due within 30 days.

- [ ] No

4. What else have you done to simplify the eligibility renewal process for families?

Enrollees can create an Access Nevada account online, where they can review an electronic version of their annual redetermination. Requested documentation can be submitted electronically, which has streamlined the application and renewal process.

5. Which retention strategies have you found to be most effective?

6. How do you measure the effectiveness of your retention strategies? What data sources and methodology do you use to track retention?

7. Is there anything else you'd like to add that wasn't already covered?

Telephone calls are also used to remind Managed Care enrollees to complete their annual redetermination.

Part 2: CHIP Eligibility Denials (Not Redetermination)

1. How many applicants were denied CHIP coverage in FFY 2020?
Don't include applicants being considered for redetermination - this data will be collected in Part 3.

21017

2. How many applicants were denied CHIP coverage for procedural reasons?
For example: They were denied because of an incomplete application, missing documentation, or a missing enrollment fee.

0

3. How many applicants were denied CHIP coverage for eligibility reasons?
For example: They were denied because their income was too high or too low, they were determined eligible for Medicaid instead, or they had other coverage available.

0

3a. How many applicants were denied CHIP (Title XXI) coverage and determined eligible for Medicaid (Title XIX) instead?

4. How many applicants were denied CHIP coverage for other reasons?

0

5. Did you have any limitations in collecting this data?

The DWSS does not track procedural and/or eligibility denials separately, so this data cannot be extrapolated. Also, because the Division uses a single streamlined application to determine eligibility, the system does not recognize any application as just CHIP. The household would apply for family medical and then eligibility is determined via an eligibility trickle-down. Because CHIP is the last category on the trickle-down, an applicant would not be denied title XXI and enrolled in XIX. The applicant would be evaluated under XIX first and if ineligible, evaluated for XXI

Table: CHIP Eligibility Denials (Not Redetermination)
This table is auto-populated with the data you entered above.

	Percent
Total denials	100%
Denied for procedural reasons	0%
Denied for eligibility reasons	0%
Denials for other reasons	0%

Part 3: Redetermination in CHIP

Redetermination is the process of redetermining whether a child is eligible to renew in CHIP (Title XXI) every 12 months. This section doesn't apply to any mid-year changes in circumstances that may affect eligibility (for example: income, relocation,

or aging out of the program).

1. How many children were eligible for redetermination in CHIP in FFY 2020?

2. Of the eligible children, how many were then screened for redetermination?

3. How many children were retained in CHIP after redetermination?

4. How many children were disenrolled in CHIP after the redetermination process?
This number should be equal to the total of 4a, 4b, and 4c below.

4a. How many children were disenrolled for procedural reasons?
This could be due to an incomplete application, missing documentation, or a missing enrollment fee.

4b. How many children were disenrolled for eligibility reasons?
This could be due to income that was too high or too low, eligibility in Medicaid (Title XIX) instead, or access to private coverage.

4c. How many children were disenrolled for other reasons?

5. Did you have any limitations in collecting this data?

The DWSS does not have a system indicator that separates RD's from initial applications; therefore, this data cannot be extrapolated.

Table: Redetermination in CHIP
These tables are auto-populated with the data you entered above.

	Percent
Children screened for redetermination	
Children retained after redetermination	
Children disenrolled after redetermination	

Table: Disenrollment in CHIP after Redetermination

	Percent
Children disenrolled after redetermination	
Children disenrolled for procedural reasons	
Children disenrolled for eligibility reasons	
Children disenrolled for other reasons	

Part 4: Redetermination in Medicaid

Redetermination is the process of redetermining whether a child is eligible to renew in Medicaid (Title XIX) every 12 months. This section doesn't apply to any mid-year changes in circumstances that may affect eligibility (for example: income, relocation, or aging out of the program).

1. How many children were eligible for redetermination in Medicaid in FFY 2020?

2. Of the eligible children, how many were then screened for redetermination?

3. How many children were retained in Medicaid after redetermination?

4. How many children were disenrolled in Medicaid after the redetermination process?
This number should be equal to the total of 4a, 4b, and 4c below.

4a. How many children were disenrolled for procedural reasons?
This could be due to an incomplete application, missing documentation, or a missing enrollment fee.

4b. How many children were disenrolled for eligibility reasons?
This could be due to an income that was too high and/or eligibility in CHIP instead.

4c. How many children were disenrolled for other reasons?

5. Did you have any limitations in collecting this data?

The DWSS does not have a system indicator that separates RD's from initial applications; therefore, this data cannot be extrapolated.

Table: Redetermination in Medicaid
These tables are auto-populated with the data you entered above.

	Percent
Children screened for redetermination	
Children retained after redetermination	
Children disenrolled after redetermination	

Table: Disenrollment in Medicaid after Redetermination

	Percent
Children disenrolled after redetermination	
Children disenrolled for procedural reasons	
Children disenrolled for eligibility reasons	
Children disenrolled for other reasons	

Part 5: Tracking a CHIP cohort (Title XXI) over 18 months

Tracking a cohort of children enrolled in CHIP (Title XXI) will indicate how long a specific group of children stays enrolled over an 18-month period. This information is required by Section 402(a) of CHIPRA.
To track your cohort, identify a group of children ages 0 to 16 years who are newly enrolled in CHIP and/or Medicaid as of January through March 2020 (the second quarter of FFY 2020). Children in this cohort must be 16 years and 0 months or

younger when they enroll to ensure they don't age out of the program by the end of the 18-month tracking period.
You'll identify a new cohort every two years. This year you'll report on the number of children at the start of the cohort (Jan - Mar 2020) and six months later (July - Sept 2020). Next year you'll report numbers for the same cohort at 12 months (Jan - Mar 2021) and 18 months later (July - Sept 2021). If data is unknown or unavailable, leave it blank - don't enter a zero unless the data is known to be zero.

Helpful hints on age groups
Children should be in age groups based on their age at the start of the cohort, when they're identified as newly enrolled in January, February, or March of 2020. For example, if a child is four years old when they're newly enrolled, they should continue to be reported in the "ages 1-5" group at 6 months, 12 months, and 18 months later.

The oldest children in the cohort must be no older than 16 years (and 0 months) to ensure they don't age out of the program at the end of the 18-month tracking period. That means children in the "ages 13-16" group who are newly enrolled in January 2020 must be born after January 2004. Similarly, children who are newly enrolled in February 2020 must be born after February 2004, and children newly enrolled in March 2020 must be born after March 2004.

1. How does your state define "newly enrolled" for this cohort?

○ Newly enrolled in CHIP: Children in this cohort weren't enrolled in CHIP (Title XXI) during the previous month. For example: Newly enrolled children in January 2020 weren't enrolled in CHIP in December 2019.

◉ Newly enrolled in CHIP and Medicaid: Children in this cohort weren't enrolled in CHIP (Title XXI) or Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2020 weren't enrolled in CHIP or Medicaid in December 2019.

2. Do you have data for individual age groups?
If not, you'll report the total number for all age groups (0-16 years) instead.

- (●) Yes
- ( ) No

January - March 2020 (start of the cohort)

3. How many children were newly enrolled in CHIP between January and March 2020?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
88	901	2113	1360

July - September 2020 (6 months later)

4. How many children were continuously enrolled in CHIP six months later?
Only include children that didn't have a break in coverage during the six-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
59	771	1797	771

5. How many children had a break in CHIP coverage but were re-enrolled in CHIP six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
<11	19	22	19

6. Of the children who had a break in CHIP coverage (in the previous question), how many were enrolled in Medicaid during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
0	<11	12	<11

7. How many children were no longer enrolled in CHIP six months later?
Possible reasons for no longer being enrolled:
• Transferred to another health insurance program other than CHIP
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
28	111	294	570

8. Of the children who were no longer enrolled in CHIP (in the previous question), how many were enrolled in Medicaid six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
<11	45	126	147

9. Is there anything else you'd like to add about your data?

January - March 2021 (12 months later)
Next year you'll report this data. Leave it blank in the meantime.

10. How many children were continuously enrolled in CHIP 12 months later?
Only include children that didn't have a break in coverage during the 12-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

11. How many children had a break in CHIP coverage but were re-enrolled in CHIP 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

12. Of the children who had a break in CHIP coverage (in the previous question), how many were enrolled in Medicaid during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

13. How many children were no longer enrolled in CHIP 12 months later?
Possible reasons for not being enrolled:
• Transferred to another health insurance program other than CHIP
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

14. Of the children who were no longer enrolled in CHIP (in the previous question), how many were enrolled in Medicaid 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

July - September of 2021 (18 months later)
Next year you'll report this data. Leave it blank in the meantime.

15. How many children were continuously enrolled in CHIP 18 months later? Only include children that didn't have a break in coverage during the 18-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

16. How many children had a break in CHIP coverage but were re-enrolled in CHIP 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

17. Of the children who had a break in CHIP coverage (in the previous question), how many were enrolled in Medicaid during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

18. How many children were no longer enrolled in CHIP 18 months later?
Possible reasons for not being enrolled:
• Transferred to another health insurance program other than CHIP
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

19. Of the children who were no longer enrolled in CHIP (in the previous question), how many were enrolled in Medicaid 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

20. Is there anything else you'd like to add about your data?

Part 6: Tracking a Medicaid (Title XIX) cohort over 18 months

Tracking a cohort of children enrolled in Medicaid (Title XIX) will indicate how long a specific group of children stays enrolled over an 18-month period. This information is required by Section 402(a) of CHIPRA.
To track your cohort, identify a group of children ages 0 to 16 years, who are newly enrolled in Medicaid and/or CHIP as of January through March 2020 (the second quarter of FFY 2020). Children in this cohort must be 16 years and 0 months or younger when they enroll to ensure they don't age out of the program by the end of

the 18-month tracking period.
You'll identify a new cohort every two years. This year you'll report the number of children identified at the start of the cohort (Jan-Mar 2020) and six months later (July-Sept 2020). Next year you'll report numbers for the same cohort at 12 months (Jan-Mar 2021) and 18 months later (July-Sept 2021). If data is unknown or unavailable, leave it blank - don't enter a zero unless the data is known to be zero.

Helpful hints on age groups
Children should be in age groups based on their age at the start of the cohort, when they're identified as newly enrolled in January, February, or March of 2020. For example, if a child is four years old when they're newly enrolled, they should continue to be reported in the "ages 1-5" group at 6 months, 12 months, and 18 months later.

The oldest children in the cohort must be no older than 16 years (and 0 months) to ensure they don't age out of the program at the end of the 18-month tracking period. That means children in the "ages 13-16" group who are newly enrolled in January 2020 must be born after January 2004. Similarly, children who are newly enrolled in February 2020 must be born after February 2004, and children newly enrolled in March 2020 must be born after March 2004.

1. How does your state define "newly enrolled" for this cohort?

○ Newly enrolled in Medicaid: Children in this cohort weren't enrolled in Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2020 weren't enrolled in Medicaid in December 2019.

◉ Newly enrolled in CHIP and Medicaid: Children in this cohort weren't enrolled in CHIP (Title XXI) or Medicaid (Title XIX) during the previous month. For example: Newly enrolled children in January 2020 weren't enrolled in CHIP or Medicaid in December 2019.

2. Do you have data for individual age groups?
If not, you'll report the total number for all age groups (0-16 years) instead.

- (●) Yes
- ( ) No

January - March 2020 (start of the cohort)

3. How many children were newly enrolled in Medicaid between January and March 2020?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
5248	5875	6350	3157

July - September 2020 (6 months later)

4. How many children were continuously enrolled in Medicaid six months later?
Only include children that didn't have a break in coverage during the six-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
4959	5513	6037	2594

5. How many children had a break in Medicaid coverage but were re-enrolled in Medicaid six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
24	49	26	22

6. Of the children who had a break in Medicaid coverage (in the previous question), how many were enrolled in CHIP during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
23	32	27	94

7. How many children were no longer enrolled in Medicaid six months later?
Possible reasons for no longer being enrolled:
• Transferred to another health insurance program other than Medicaid
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
227	282	243	476

8. Of the children who were no longer enrolled in Medicaid (in the previous question), how many were enrolled in CHIP six months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16
21	52	57	87

9. Is there anything else you'd like to add about your data?

January - March 2021 (12 months later)
Next year you'll report this data. Leave it blank in the meantime.

10. How many children were continuously enrolled in Medicaid 12 months later?
Only include children that didn't have a break in coverage during the 12-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

11. How many children had a break in Medicaid coverage but were re-enrolled in Medicaid 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

12. Of the children who had a break in Medicaid coverage (in the previous question), how many were enrolled in CHIP during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

13. How many children were no longer enrolled in Medicaid 12 months later?
Possible reasons for not being enrolled:
• Transferred to another health insurance program other than Medicaid
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

14. Of the children who were no longer enrolled in Medicaid (in the previous question), how many were enrolled in CHIP 12 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

July - September of 2021 (18 months later)
Next year you'll report this data. Leave it blank in the meantime.

15. How many children were continuously enrolled in Medicaid 18 months later? Only include children that didn't have a break in coverage during the 18-month period.

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

16. How many children had a break in Medicaid coverage but were re-enrolled in Medicaid 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

17. Of the children who had a break in Medicaid coverage (in the previous question), how many were enrolled in CHIP during the break?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

18. How many children were no longer enrolled in Medicaid 18 months later?
Possible reasons for not being enrolled:
• Transferred to another health insurance program other than Medicaid
• Didn't meet eligibility criteria anymore
• Didn't complete documentation
• Didn't pay a premium or enrollment fee

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

19. Of the children who were no longer enrolled in Medicaid (in the previous question), how many were enrolled in CHIP 18 months later?

Ages 0-1	Ages 1-5	Ages 6-12	Ages 13-16

20. Is there anything else you'd like to add about your data?

Cost Sharing (Out-of-Pocket Costs)

States can choose whether or not to require cost sharing in their CHIP program. Cost sharing includes payments such as enrollment fees, premiums, deductibles, coinsurance, and copayments.

1. Does your state require cost sharing?

- (●) Yes
- ( ) No

2. Who tracks cost sharing to ensure families don't pay more than the 5% aggregate household income in a year?

- ○ Families ("the shoebox method")
- ○ Health plans
- ○ States
- ○ Third party administrator
- ◉ Other

2b. Who tracks cost sharing?

The premium amounts are set so low, that it is extremely unlikely that families could approach the 5% cap. For a family of two at 150% FPL, the 5% cap is $1293 ($25,860x.05) and the total annual premium is $100. For a family of two at 175% FPL the 5% cap is $1,509 ($30,180x.05) and the total annual premium is $200. For a family of two at 200% FPL, the 5% cap is $1,724 ($34,476x.05) and the annual premium is $320.Families are not required to pay any other out-of-pocket expenses.

3. How are healthcare providers notified that they shouldn't charge families once families have reached the 5% cap?

Nevada's plan only charges premiums (no co-pays or deductibles), so the providers are not allowed to collect any payment from enrollees as stated on the provider contract policies.

4. Approximately how many families exceeded the 5% cap in the last federal fiscal year?

0

5. Have you assessed the effects of charging premiums and enrollment fees on whether eligible families enroll in CHIP?

- ○ Yes
- ◉ No

6. Have you assessed the effects of charging copayments and other out-of-pocket fees on whether enrolled families use CHIP services?

- ○ Yes
- ◉ No

7. You indicated in Section 1 that you changed your cost sharing requirements in the past federal fiscal year. How are you monitoring the impact of these changes on whether families apply, enroll, disenroll, and use CHIP health services? What have you found when monitoring the impact?

Disenrollment has been suspended for the duration of the Public Health Emergency due to COVID-19.

8. Is there anything else you'd like to add that wasn't already covered?

9. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Employer Sponsored Insurance and Premium Assistance

States with a premium assistance program can use CHIP funds to purchase coverage through employer sponsored insurance (ESI) on behalf of eligible children and parents.

1. Does your state offer ESI including a premium assistance program under the CHIP State Plan or a Section 1115 Title XXI demonstration?

- ○ Yes
- ◉ No

Program Integrity

States with a premium assistance program can use CHIP funds to purchase coverage through employer sponsored insurance (ESI) on behalf of eligible children and parents.

1. Do you have a written plan with safeguards and procedures in place for the prevention of fraud and abuse cases?

- (●) Yes
- ( ) No

2. Do you have a written plan with safeguards and procedures in place for the investigation of fraud and abuse cases?

- (●) Yes
- ( ) No

3. Do you have a written plan with safeguards and procedures in place for the referral of fraud and abuse cases?

- (●) Yes
- ( ) No

4. What safeguards and procedures are in place for the prevention, investigation, and referral of fraud and abuse cases?

Nevada Medicaid (DHCFP) Program Integrity consists of two units, Provider Enrollment (PE) and Surveillance & Utilization Review (SUR). Both use written policies and procedures that assure safeguards and methods for prevention, investigation and referral of cases of fraud, waste, abuse and improper payments (FWA). Prevention: PE uses written policies and procedures to ensure that all Affordable Care Act (ACA) initiatives, as stated in 42 CFR 455 subpart B and E for enhanced screening and disclosure information, are being completed. Measures include mandated database checks and pre-enrollment on site visits for moderate and high risk providers. The CMS Fingerprint Based Criminal Background Checks (FCBC) requirement was implemented on 7/1/2017. As a condition of new or continued enrollment, providers shall consent and submit to criminal background checks, including fingerprinting, when required to do so under State law or by the level of screening based on risk of fraud, waste or abuse as determined for the provider. All Medicaid and CHIP providers must complete these processes, regardless of whether they are providing services under fee-for-service (FFS) or solely under a Managed Care Organization (MCO). During the Public Health Emergency (PHE) and by CMS Waiver 1135, all site visits and FCBC requirements are waived.

5. Do the Managed Care plans contracted by your Separate CHIP program have written plans with safeguards and procedures in place?

(●) Yes

5a. What safeguards and procedures do the Managed Care plans have in place?

Our MCO contract requires a written compliance plan, including policies and procedures to assure prevention, investigation and reporting of FWA cases. The contract also requires a Program Integrity Unit (PIU) be established, with the responsibility to implement and annually report on the success of the written plan. Quarterly calls and annual training with DHCFP, MFCU and PIU representatives ensure ongoing communication related to CAF and non-CAF referrals, investigations, and recoveries.

( ) No

( ) N/A

6. How many eligibility denials have been appealed in a fair hearing in FFY 2020?

1671

7. How many cases have been found in favor of the beneficiary in FFY 2020?

<11

8. How many cases related to provider credentialing were investigated in FFY 2020?

6

9. How many cases related to provider credentialing were referred to appropriate law enforcement officials in FFY 2020?

0

10. How many cases related to provider billing were investigated in FFY 2020?

921

11. How many cases were referred to appropriate law enforcement officials in FFY 2020?

51

12. How many cases related to beneficiary eligibility were investigated in FFY 2020?

2810

13. How many cases related to beneficiary eligibility were referred to appropriate law enforcement officials in FFY 2020?

0

14. Does your data for Questions 8-13 include cases for CHIP only or for Medicaid and CHIP combined?

- ○ CHIP only
- ◉ Medicaid and CHIP combined

15. Do you rely on contractors for the prevention, investigation, and referral of fraud and abuse cases?

- ◉ Yes

  15a. How do you provide oversight of the contractors?

  The SUR Unit has direct oversight of the Recovery Audit Contractor (RAC) vendor and CMS has direct oversight of the Unified Program Integrity Contractor (UPIC). The SUR Unit meets semi-monthly with the RAC vendor to discuss scenario development, status updates on active scenarios, cases going to hearing and financial transactions regarding recovery of overpayments. The SUR Unit holds monthly meetings with the UPIC to discuss the status of active cases and ideas for potential audits in areas of concern that the SUR Unit either doesn't have the resources or specific medical expertise to complete a thorough review.

- ○ No

16. Do you contract with Managed Care health plans and/or a third party contractor to provide this oversight?

(●) Yes

16a. What specifically are the contractors responsible for in terms of oversight?

The Division of Health Care Financing and Policy (DHCFP) contracts with the MCOs and they are responsible for providing program integrity oversight of their providers. The DHCFP is not contracted with any other entity specifically for the purpose of conducting program integrity oversight of the MCOs or their associated network providers.

( ) No

17. Is there anything else you'd like to add that wasn't already covered?

18. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Dental Benefits

Tell us about the children receiving dental benefits in your Separate CHIP program. Include children who are receiving full benefits and those who are only receiving supplemental dental benefits. Include the unduplicated number of children enrolled in all types of delivery systems (Managed Care, PCCM, and Fee for Service).

Note on age groups
Children should be in age groups based on their age on September 30th, the end of the federal fiscal year (FFY). For example, if a child turns three years old on September 15th, the child should be included in the "ages 3-5" group. Even if the child received dental services on September 1st while they were still two years old, all dental services should be counted as their age at the end of the FFY.

1. Do you have data for individual age groups?
If not, you'll report the total number for all age groups (0-18 years) instead.

- (●) Yes
- ( ) No

2. How many children were enrolled in Separate CHIP for at least 90 continuous days during FFY 2020?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
94	1828	3729	8985	12201	8022

3. How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received at least one dental care service during FFY 2020?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
<11	419	1619	4884	6502	3539

Dental care service codes and definitions
The dental service must be provided by or under the supervision of a dentist as defined by HCPCS codes D0100-D9999 (or equivalent CDT codes D0100-D9999, or equivalent CPT codes) based on an unduplicated paid, unpaid, or denied claim.

All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

4. How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received at least one preventative dental care service during FFY 2020?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
<11	417	1599	4791	6376	3476

Dental care service codes and definitions
The dental service must be provided by or under the supervision of a dentist as defined by HCPCS codes D0100 - D9999 (or equivalent CDT codes D0100 - D9999, or equivalent CPT codes) based on an unduplicated paid, unpaid, or denied claim.
All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

5. How many children (who were enrolled in Separate CHIP for at least 90 continuous days) received dental treatment services during FFY 2020?
This includes orthodontics, periodontics, implants, oral and maxillofacial surgery, and other treatments.

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
0	40	526	2293	2985	1687

Dental treatment service codes and definitions
The dental service must be provided by or under the supervision of a dentist as defined by HCPCS codes D2000-D9999 (or equivalent CDT codes D2000-D9999 or equivalent CPT codes that involve periodontics, maxillofacial prosthetics, implants, oral and maxillofacial surgery, orthodontics, adjunctive general services) based on an unduplicated paid, unpaid, or denied claim.

All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

6. How many children in the "ages 6-9" group received a sealant on at least one permanent molar tooth during FFY 2020?

2293

Sealant codes and definitions
The sealant on a permanent molar tooth is provided by a dental professional for whom placing a sealant is within their scope of practice. It's defined by HCPCS code D1351 (or equivalent CDT code D1351) based on an unduplicated paid, unpaid, or denied claim. Permanent molars are teeth numbered 2, 3, 14, 15, 18, 19, 30, and 31, and additionally - for states covering sealants on third molars ("wisdom teeth") - teeth numbered 1, 16, 17, and 32.

All data should be based on the definitions in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416).

7. Do you provide supplemental dental coverage?

- ○ Yes
- ◉ No

8. Is there anything else you'd like to add about your dental benefits? If you weren't able to provide data, let us know why.

9. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

CAHPS Survey Results

Children's Health Insurance Program Reauthorization Act (CHIPRA) requires that all CHIP programs submit survey results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS). The survey assesses your CHIP program quality and customer satisfaction.

1. Did you collect the CAHPS survey?

- (●) Yes
  - 1a. Did you submit your CAHPS raw data to the AHRQ CAHPS database?
    - ( ) Yes
    - (●) No
- ( ) No

Part 2: You collected the CAHPS survey

Since you collected the CAHPS survey, please complete Part 2.

1. Upload a summary report of your CAHPS survey results.
This is optional if you already submitted CAHPS raw data to the AHRQ CAHPS database. Submit results only for the CHIP population, not for both Medicaid (Title XIX) and CHIP (Title XXI) together. Your data should represent children enrolled in all types of delivery systems (Managed Care, PCCM, and Fee for Service).

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

2. Which CHIP population did you survey?

- ○ Medicaid Expansion CHIP
- ○ Separate CHIP
- ◉ Both Separate CHIP and Medicaid Expansion CHIP
- ○ Other

3. Which version of the CAHPS survey did you use?

- ○ CAHPS 5.0
- ◉ CAHPS 5.0H
- ○ Other

4. Which supplemental item sets did you include in your survey?
Select all that apply.

- [ ] None
- [x] Children with Chronic Conditions
- [ ] Other

5. Which administrative protocol did you use to administer the survey?
Select all that apply.

- [x] NCQA HEDIS CAHPS 5.0H
- [ ] HRQ CAHPS
- [ ] Other

6. Is there anything else you'd like to add about your CAHPS survey results?

The CAHPS survey report only includes Nevada's Managed Care population which represents 73% of Nevada's total Medicaid population.

Part 3: You didn't collect the CAHPS survey

Health Services Initiative (HSI) Programs

All states with approved HSI program(s) should complete this section.
States can use up to 10% of their fiscal year allotment to develop Health Services Initiatives (HSI) that provide direct services and other public health initiatives for low-income children. [See Section 2105(a)(1)(D)(ii) of the Social Security Act.] States can

only develop HSI programs after funding other costs to administer their CHIP State Plan, as defined in regulations at 42 CFR 457.10.

1. Does your state operate Health Service Initiatives using CHIP (Title XXI) funds?
Even if you're not currently operating the HSI program, if it's in your current approved CHIP State Plan, please answer "yes."

- (●) Yes
- ( ) No

Tell us about your HSI program(s).

1. What is the name of your HSI program?

[ ]

2. Are you currently operating the HSI program, or plan to in the future?

- ( ) Yes
- (●) No

Do you have another HSI Program in this list?

Optional

Part 1: Tell us about your goals and objectives

Tell us about the progress you've made on your performance goals in the past year. The objectives and goals you add to this section should match those reflected in your CHIP State Plan, Section 9. Submit a CHIP State Plan Amendment (SPA) if any of them are different.
Objective 1 is required. We've provided examples for other objectives, but you can edit them so they match the objectives in your CHIP State Plan. You can add additional objectives and goals to fit what's in your CHIP State Plan.

1. Briefly describe your goal for this objective.

For example: In an effort to reduce the number of uninsured children, our goal is to enroll 90% of eligible children in the CHIP program.

Increase enrollment in the CHIP program by 5%.

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children enrolled in CHIP in the last federal fiscal year.

Average monthly CHIP-NCU FFY 2020 enrollment

4. Numerator (total number)

27095

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of eligible children in the last federal fiscal year.

Average monthly CHIP-NCU FFY 2019 enrollment

6. Denominator (total number)

28094

Computed: 96.44%

7. What is the date range of your data?

Start

mm/yyyy

10 / 2019

End

mm/yyyy

09 / 2020

8. Which data source did you use?

- (●) Eligibility or enrollment data
- ( ) Survey data
- ( ) Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

This was a slight decrease over last year.

10. What are you doing to continually make progress towards your goal?

Ensuring that CHIP eligible children are enrolled.

11. Anything else you'd like to tell us about this goal?

The decrease in CHIP enrollment from FFY2019 to FFY2020, may be attributed to the fact that the COVID-19 public health emergency significantly impacted employment and as a result, children that previously qualified for CHIP, may now qualify for Medicaid. - All Goals and Objections in Section 4 are selected to align with the CHIP State Plan Section 9.3 instead of 9.1 and 9.2.

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. Briefly describe your goal for this objective.

For example: In an effort to reduce the number of uninsured children, our goal is to enroll 90% of eligible children in the CHIP program.

Track the enrollment figure for uninsured children who are under age 19, lawfully residing and have not met the 5-year bar that were enrolled in the Medicaid and CHIP program via the CHIPRA Option 214

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children enrolled in CHIP in the last federal fiscal year.

The total number of CHIP enrollees only.

4. Numerator (total number)

128

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of eligible children in the last federal fiscal year.

The Total number of Medicaid and CHIP enrollees.

6. Denominator (total number)

885

Computed: 14.46%

7. What is the date range of your data?

Start

mm/yyyy

10 / 2019

End

mm/yyyy

09 / 2020

8. Which data source did you use?

- (●) Eligibility or enrollment data
- ( ) Survey data
- ( ) Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

This was a slight decrease from last year.

10. What are you doing to continually make progress towards your goal?

Continue to enroll children that qualify under this group

11. Anything else you'd like to tell us about this goal?

The Slight reduction may represent the "cooling effect" of Public Charge. There is fear in the immigrant community that receiving public assistance may affect their immigration status.

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another Goal in this list?

Optional

1. What is the next objective listed in your CHIP State Plan?

You can edit the suggested objective so it matches what's in your CHIP State Plan.

Improve the Health and Wellness of Nevada's Medicaid Population by Increasing Access to and the Use of Preventive Services.

1. Briefly describe your goal for this objective.

For example: In an effort to increase access to care, our goal is to increase the number of children who have visited a primary care physician by 5%.

Increase well-child visits 0-15 months (W15) The DHCFP has set performance targets in managed care, using a Quality Improvement System for Managed Care (QISMC) methodology. Performance goals are established by reducing by 10 percent the gap between the performance measure baseline rate and 100 percent. For example, if the baseline rate was 55 percent, the MCO would be expected to improve the rate by 4.5 percentage points to 59.5 percent. This is calculated as 4.5%= 10% x (100% - 55%). Each measure that shows improvement equal to or greater than the performance target is considered achieved.

2. What type of goal is it?

- (●) New goal
- ( ) Continuing goal
- ( ) Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children enrolled in CHIP who visited a primary care physician in the last federal fiscal year.

Percentage of children who turned 15 months old during the measurement year and who had six or more well-child visits with a primary care practitioner (PCP) during their first 15 months of life.

4. Numerator (total number)

0

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of children enrolled in CHIP in the last federal fiscal year.

A sample size of the eligible population. Eligible population includes children who turn 15 months old during the measurement year with no more than one gap in enrollment of up to 45 days during the continuous enrollment period.

6. Denominator (total number)

482

Computed: 0%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2019

End

mm/yyyy

12 / 2019

8. Which data source did you use?

- (●) Eligibility or enrollment data
- ( ) Survey data
- ( ) Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

The statewide weighted average exceeded the minimum performance standard by 3.12%.

10. What are you doing to continually make progress towards your goal?

A quarterly meeting is held with all the MCO partners led by the Health Services Advisory Group to continually discuss what measures are being met and what measures that need to be prioritized. This is also an avenue to collaborate and discuss challenges and barriers across meeting the measures. This goal is planned to be consistent year over year with the exception of new criteria and or measures that are required or recommended from CMS or from our partners at the Health Services Advisory Group.

11. Anything else you'd like to tell us about this goal?

This is a hybrid measure validated and calculated by the state's EQRO. The EQRO does not provide the numerator for hybrid measures, only the indicator-specific combined sample size and the rate; therefore, the numerator is entered as zero. The rate is: 80.5% which can be found in the EQR Tech Report attached in Section 3H.

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. Briefly describe your goal for this objective.

For example: In an effort to increase access to care, our goal is to increase the number of children who have visited a primary care physician by 5%.

Increase well-child visits 3-6 years (W34) The DHCFP has set performance targets in managed care, using a Quality Improvement System for Managed Care (QISMC) methodology. Performance goals are established by reducing by 10 percent the gap between the performance measure baseline rate and 100 percent. For example, if the baseline rate was 55 percent, the MCO would be expected to improve the rate by 4.5 percentage points to 59.5 percent. This is calculated as 4.5%= 10% x (100% - 55%). Each measure that shows improvement equal to or greater than the performance target is considered achieved.

2. What type of goal is it?

- (●) New goal
- ( ) Continuing goal
- ( ) Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children enrolled in CHIP who visited a primary care physician in the last federal fiscal year.

Percentage of children ages 3 to 6 who had one or more well-child visits with a primary care practitioner (PCP) during the measurement year.

4. Numerator (total number)

0

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of children enrolled in CHIP in the last federal fiscal year.

A sample size of the eligible population. Eligible population includes children ages 3 - 6 as of the measurement year with no more than one gap in enrollment of up to 45 days during the continuous enrollment period.

6. Denominator (total number)

1005

Computed: 0%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2019

End

mm/yyyy

12 / 2019

8. Which data source did you use?

- (●) Eligibility or enrollment data
- ( ) Survey data
- ( ) Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

The statewide weighted average was slightly below the minimum performance standard by 0.32%

10. What are you doing to continually make progress towards your goal?

A quarterly meeting is held with all the MCO partners led by the Health Services Advisory Group to continually discuss what measures are being met and what measures that need to be prioritized. This is also an avenue to collaborate and discuss challenges and barriers across meeting the measures This goal is planned to be consistent year over year with the exception of new criteria and or measures that are required or recommended from CMS or from our partners at the Health Services Advisory Group

11. Anything else you'd like to tell us about this goal?

This is a hybrid measure validated and calculated by the state's EQRO. The EQRO does not provide the numerator for hybrid measures, only the indicator-specific combined sample size and the rate; therefore, the numerator is entered as zero. The rate is: 77.31% which can be found in the EQR Tech Report attached in Section 3H.

12. Do you have any supporting documentation?
Optional

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Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another Goal in this list?

Optional

1. What is the next objective listed in your CHIP State Plan?

You can edit the suggested objective to match what's in your CHIP State Plan.

Increasing the use of preventative care by Adolescent well-care visits, Immunizations and Mental health follow-up.

1. Briefly describe your goal for this objective.

For example: In an effort to increase the use of preventative care, our goal is to increase the number of children who receive one or more well child visits by 5%.

Increase immunizations for adolescents (IMA)-Meningococcal, Tdap The DHCFP has set performance targets in managed care, using a Quality Improvement System for Managed Care (QISMC) methodology. Performance goals are established by reducing by 10 percent the gap between the performance measure baseline rate and 100 percent. For example, if the baseline rate was 55 percent, the MCO would be expected to improve the rate by 4.5 percentage points to 59.5 percent. This is calculated as 4.5%= 10% x (100% - 55%). Each measure that shows improvement equal to or greater than the performance target is considered achieved.

2. What type of goal is it?

- (●) New goal
- ( ) Continuing goal
- ( ) Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children who received one or more well child visits in the last federal fiscal year.

Percentage of adolescents age 13 who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine. This measure calculates a rate for each vaccine and two combination rates.

4. Numerator (total number)

0

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of children enrolled in CHIP in the last federal fiscal year.

A sample size of the eligible population. Eligible population includes ages 12 - 21 during the measurement year with no more than one gap in enrollment of up to 45 days during the continuous enrollment period.

6. Denominator (total number)

885

Computed: 0%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2019

End

mm/yyyy

12 / 2019

8. Which data source did you use?

- (●) Eligibility or enrollment data
- ( ) Survey data
- ( ) Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

The statewide weighted average was slightly below the minimum performance standard by 3.66%

10. What are you doing to continually make progress towards your goal?

A quarterly meeting is held with all the MCO partners led by the Health Services Advisory Group to continually discuss what measures are being met and what measures that need to be prioritized. This is also an avenue to collaborate and discuss challenges and barriers across meeting the measures. This goal is planned to be consistent year over year with the exception of new criteria and or measures that are required or recommended from CMS or from our partners at the Health Services Advisory Group.

11. Anything else you'd like to tell us about this goal?

This is a hybrid measure validated and calculated by the state's EQRO. The EQRO does not provide the numerator for hybrid measures, only the indicator-specific combined sample size and the rate; therefore, the numerator is entered as zero. The rate is: 95.52% which can be found in the EQR Tech Report attached in Section 3H.

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. Briefly describe your goal for this objective.

For example: In an effort to increase the use of preventative care, our goal is to increase the number of children who receive one or more well child visits by 5%.

Increase immunizations for adolescents (IMA)-Meningococcal, Tdap, HPV The DHCFP has set performance targets in managed care, using a Quality Improvement System for Managed Care (QISMC) methodology. Performance goals are established by reducing by 10 percent the gap between the performance measure baseline rate and 100 percent. For example, if the baseline rate was 55 percent, the MCO would be expected to improve the rate by 4.5 percentage points to 59.5 percent. This is calculated as 4.5%= 10% x (100% - 55%). Each measure that shows improvement equal to or greater than the performance target is considered achieved.

2. What type of goal is it?

- (●) New goal
- ( ) Continuing goal
- ( ) Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children who received one or more well child visits in the last federal fiscal year.

Percentage of adolescents age 13 who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. This measure calculates a rate for each vaccine and two combination rates.

4. Numerator (total number)

0

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of children enrolled in CHIP in the last federal fiscal year.

A sample size of the eligible population. Eligible population includes ages 12 - 21 during the measurement year with no more than one gap in enrollment of up to 45 days during the continuous enrollment period.

6. Denominator (total number)

885

Computed: 0%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2019

End

mm/yyyy

12 / 2019

8. Which data source did you use?

- (●) Eligibility or enrollment data
- ( ) Survey data
- ( ) Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

The statewide weighted average was slightly below the minimum performance standard by 3.66%

10. What are you doing to continually make progress towards your goal?

A quarterly meeting is held with all the MCO partners led by the Health Services Advisory Group to continually discuss what measures are being met and what measures that need to be prioritized. This is also an avenue to collaborate and discuss challenges and barriers across meeting the measures. This goal is planned to be consistent year over year with the exception of new criteria and or measures that are required or recommended from CMS or from our partners at the Health Services Advisory Group.

11. Anything else you'd like to tell us about this goal?

This is a hybrid measure validated and calculated by the state's EQRO. The EQRO does not provide the numerator for hybrid measures, only the indicator-specific combined sample size and the rate; therefore, the numerator is entered as zero. The rate is: 53.88% which can be found in the EQR Tech Report attached in Section 3H.

12. Do you have any supporting documentation?
Optional

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Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. Briefly describe your goal for this objective.

For example: In an effort to increase the use of preventative care, our goal is to increase the number of children who receive one or more well child visits by 5%.

Increase childhood immunization status (CIS)-Combination 2 The DHCFP has set performance targets in managed care, using a Quality Improvement System for Managed Care (QISMC) methodology. Performance goals are established by reducing by 10 percent the gap between the performance measure baseline rate and 100 percent. For example, if the baseline rate was 55 percent, the MCO would be expected to improve the rate by 4.5 percentage points to 59.5 percent. This is calculated as 4.5%= 10% x (100% - 55%). Each measure that shows improvement equal to or greater than the performance target is considered achieved.

2. What type of goal is it?

- (●) New goal
- ( ) Continuing goal
- ( ) Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children who received one or more well child visits in the last federal fiscal year.

Percentage of adolescents age 13 who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday.

4. Numerator (total number)

0

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of children enrolled in CHIP in the last federal fiscal year.

A sample size of the eligible population. Eligible population includes ages 12 - 21 during the measurement year with no more than one gap in enrollment of up to 45 days during the continuous enrollment period.

6. Denominator (total number)

567

Computed: 0%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2019

End

mm/yyyy

12 / 2019

8. Which data source did you use?

- (●) Eligibility or enrollment data
- ( ) Survey data
- ( ) Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

The statewide weighted average was slightly below the minimum performance standard by 3.66%

10. What are you doing to continually make progress towards your goal?

A quarterly meeting is held with all the MCO partners led by the Health Services Advisory Group to continually discuss what measures are being met and what measures that need to be prioritized. This is also an avenue to collaborate and discuss challenges and barriers across meeting the measures. This goal is planned to be consistent year over year with the exception of new criteria and or measures that are required or recommended from CMS or from our partners at the Health Services Advisory Group.

11. Anything else you'd like to tell us about this goal?

This is a hybrid measure validated and calculated by the state's EQRO. The EQRO does not provide the numerator for hybrid measures, only the indicator-specific combined sample size and the rate; therefore, the numerator is entered as zero. The rate is: 85.71% which can be found in the EQR Tech Report attached in Section 3H.

12. Do you have any supporting documentation?
Optional

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Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. Briefly describe your goal for this objective.

For example: In an effort to increase the use of preventative care, our goal is to increase the number of children who receive one or more well child visits by 5%.

Increase childhood immunization status (CIS)-Combination 3

2. What type of goal is it?

- (●) New goal
- ( ) Continuing goal
- ( ) Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children who received one or more well child visits in the last federal fiscal year.

Percentage of children age 2 who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (Hep B), one chicken pox (VZV); four pneumococcal conjugate (PCV) by their second birthday.

4. Numerator (total number)

0

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of children enrolled in CHIP in the last federal fiscal year.

A sample size of the eligible population. Eligible population includes Children who turn age 2 during the measurement year with no more than one gap in enrollment of up to 45 days during the continuous enrollment period.

6. Denominator (total number)

567

Computed: 0%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2019

End

mm/yyyy

12 / 2019

8. Which data source did you use?

- (●) Eligibility or enrollment data
- ( ) Survey data
- ( ) Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

The statewide weighted average exceeded the minimum performance standard by 0.14%.

10. What are you doing to continually make progress towards your goal?

A quarterly meeting is held with all the MCO partners led by the Health Services Advisory Group to continually discuss what measures are being met and what measures that need to be prioritized. This is also an avenue to collaborate and discuss challenges and barriers across meeting the measures. This goal is planned to be consistent year over year with the exception of new criteria and or measures that are required or recommended from CMS or from our partners at the Health Services Advisory Group.

11. Anything else you'd like to tell us about this goal?

This is a hybrid measure validated and calculated by the state's EQRO. The EQRO does not provide the numerator for hybrid measures, only the indicator-specific combined sample size and the rate; therefore, the numerator is entered as zero. The rate is: 83.60% which can be found in the EQR Tech Report attached in Section 3H.

12. Do you have any supporting documentation?
Optional

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Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. Briefly describe your goal for this objective.

For example: In an effort to increase the use of preventative care, our goal is to increase the number of children who receive one or more well child visits by 5%.

Increase childhood immunization status (CIS)-Combination 4 The DHCFP has set performance targets in managed care, using a Quality Improvement System for Managed Care (QISMC) methodology. Performance goals are established by reducing by 10 percent the gap between the performance measure baseline rate and 100 percent. For example, if the baseline rate was 55 percent, the MCO would be expected to improve the rate by 4.5 percentage points to 59.5 percent. This is calculated as 4.5%= 10% x (100% - 55%). Each measure that shows improvement equal to or greater than the performance target is considered achieved.

2. What type of goal is it?

- (●) New goal
- ( ) Continuing goal
- ( ) Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children who received one or more well child visits in the last federal fiscal year.

Percentage of children age 2 who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (Hep B), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA) by their second birthday.

4. Numerator (total number)

0

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of children enrolled in CHIP in the last federal fiscal year.

A sample size of the eligible population. Eligible population includes Children who turn age 2 during the measurement year with no more than one gap in enrollment of up to 45 days during the continuous enrollment period.

6. Denominator (total number)

567

Computed: 0%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2019

End

mm/yyyy

12 / 2019

8. Which data source did you use?

- (●) Eligibility or enrollment data
- ( ) Survey data
- ( ) Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

The statewide weighted average was slightly below the minimum performance standard by 0.04%

10. What are you doing to continually make progress towards your goal?

A quarterly meeting is held with all the MCO partners led by the Health Services Advisory Group to continually discuss what measures are being met and what measures that need to be prioritized. This is also an avenue to collaborate and discuss challenges and barriers across meeting the measures. This goal is planned to be consistent year over year with the exception of new criteria and or measures that are required or recommended from CMS or from our partners at the Health Services Advisory Group.

11. Anything else you'd like to tell us about this goal?

This is a hybrid measure validated and calculated by the state's EQRO. The EQRO does not provide the numerator for hybrid measures, only the indicator-specific combined sample size and the rate; therefore, the numerator is entered as zero. The rate is: 83.42% which can be found in the EQR Tech Report attached in Section 3H.

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. Briefly describe your goal for this objective.

For example: In an effort to increase the use of preventative care, our goal is to increase the number of children who receive one or more well child visits by 5%.

Increase childhood immunization status (CIS)-Combination 5 The DHCFP has set performance targets in managed care, using a Quality Improvement System for Managed Care (QISMC) methodology. Performance goals are established by reducing by 10 percent the gap between the performance measure baseline rate and 100 percent. For example, if the baseline rate was 55 percent, the MCO would be expected to improve the rate by 4.5 percentage points to 59.5 percent. This is calculated as 4.5%= 10% x (100% - 55%). Each measure that shows improvement equal to or greater than the performance target is considered achieved.

2. What type of goal is it?

- (●) New goal
- ( ) Continuing goal
- ( ) Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children who received one or more well child visits in the last federal fiscal year.

Percentage of children age 2 who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (Hep B), one chicken pox (VZV); four pneumococcal conjugate (PCV); and two or three rotavirus (RV) by their second birthday.

4. Numerator (total number)

0

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of children enrolled in CHIP in the last federal fiscal year.

A sample size of the eligible population. Eligible population includes Children who turn age 2 during the measurement year with no more than one gap in enrollment of up to 45 days during the continuous enrollment period.

6. Denominator (total number)

567

Computed: 0%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2019

End

mm/yyyy

12 / 2019

8. Which data source did you use?

- (●) Eligibility or enrollment data
- ( ) Survey data
- ( ) Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

The statewide weighted average was slightly below the minimum performance standard by 1.84%

10. What are you doing to continually make progress towards your goal?

A quarterly meeting is held with all the MCO partners led by the Health Services Advisory Group to continually discuss what measures are being met and what measures that need to be prioritized. This is also an avenue to collaborate and discuss challenges and barriers across meeting the measures. This goal is planned to be consistent year over year with the exception of new criteria and or measures that are required or recommended from CMS or from our partners at the Health Services Advisory Group.

11. Anything else you'd like to tell us about this goal?

This is a hybrid measure validated and calculated by the state's EQRO. The EQRO does not provide the numerator for hybrid measures, only the indicator-specific combined sample size and the rate; therefore, the numerator is entered as zero. The rate is: 75.49% which can be found in the EQR Tech Report attached in Section 3H.

12. Do you have any supporting documentation?
Optional

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Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. Briefly describe your goal for this objective.

For example: In an effort to increase the use of preventative care, our goal is to increase the number of children who receive one or more well child visits by 5%.

Increase childhood immunization status (CIS)-Combination 6

2. What type of goal is it?

- (●) New goal
- ( ) Continuing goal
- ( ) Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children who received one or more well child visits in the last federal fiscal year.

Percentage of children age 2 who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (Hep B), one chicken pox (VZV); four pneumococcal conjugate (PCV); and two influenza (flu) vaccines by their second birthday.

4. Numerator (total number)

0

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of children enrolled in CHIP in the last federal fiscal year.

A sample size of the eligible population. Eligible population includes Children who turn age 2 during the measurement year with no more than one gap in enrollment of up to 45 days during the continuous enrollment period.

6. Denominator (total number)

567

Computed: 0%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2019

End

mm/yyyy

12 / 2019

8. Which data source did you use?

- (●) Eligibility or enrollment data
- ( ) Survey data
- ( ) Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

The statewide weighted average exceeded the minimum performance standard by 1.81%.

10. What are you doing to continually make progress towards your goal?

A quarterly meeting is held with all the MCO partners led by the Health Services Advisory Group to continually discuss what measures are being met and what measures that need to be prioritized. This is also an avenue to collaborate and discuss challenges and barriers across meeting the measures. This goal is planned to be consistent year over year with the exception of new criteria and or measures that are required or recommended from CMS or from our partners at the Health Services Advisory Group.

11. Anything else you'd like to tell us about this goal?

This is a hybrid measure validated and calculated by the state's EQRO. The EQRO does not provide the numerator for hybrid measures, only the indicator-specific combined sample size and the rate; therefore, the numerator is entered as zero. The rate is: 49.21% which can be found in the EQR Tech Report attached in Section 3H.

12. Do you have any supporting documentation?
Optional

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Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. Briefly describe your goal for this objective.

For example: In an effort to increase the use of preventative care, our goal is to increase the number of children who receive one or more well child visits by 5%.

Increase childhood immunization status (CIS)-Combination 7 The DHCFP has set performance targets in managed care, using a Quality Improvement System for Managed Care (QISMC) methodology. Performance goals are established by reducing by 10 percent the gap between the performance measure baseline rate and 100 percent. For example, if the baseline rate was 55 percent, the MCO would be expected to improve the rate by 4.5 percentage points to 59.5 percent. This is calculated as 4.5%= 10% x (100% - 55%). Each measure that shows improvement equal to or greater than the performance target is considered achieved.

2. What type of goal is it?

- (●) New goal
- ( ) Continuing goal
- ( ) Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children who received one or more well child visits in the last federal fiscal year.

Percentage of children age 2 who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (Hep B), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); vaccines by their second birthday.

4. Numerator (total number)

0

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of children enrolled in CHIP in the last federal fiscal year.

A sample size of the eligible population. Eligible population includes Children who turn age 2 during the measurement year with no more than one gap in enrollment of up to 45 days during the continuous enrollment period.

6. Denominator (total number)

567

Computed: 0%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2019

End

mm/yyyy

12 / 2019

8. Which data source did you use?

- (●) Eligibility or enrollment data
- ( ) Survey data
- ( ) Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

The statewide weighted average was slightly below the minimum performance standard by 2.02%.

10. What are you doing to continually make progress towards your goal?

A quarterly meeting is held with all the MCO partners led by the Health Services Advisory Group to continually discuss what measures are being met and what measures that need to be prioritized. This is also an avenue to collaborate and discuss challenges and barriers across meeting the measures. This goal is planned to be consistent year over year with the exception of new criteria and or measures that are required or recommended from CMS or from our partners at the Health Services Advisory Group.

11. Anything else you'd like to tell us about this goal?

This is a hybrid measure validated and calculated by the state's EQRO. The EQRO does not provide the numerator for hybrid measures, only the indicator-specific combined sample size and the rate; therefore, the numerator is entered as zero. The rate is: 75.31% which can be found in the EQR Tech Report attached in Section 3H.

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. Briefly describe your goal for this objective.

For example: In an effort to increase the use of preventative care, our goal is to increase the number of children who receive one or more well child visits by 5%.

Increase childhood immunization status (CIS)-Combination 8 The DHCFP has set performance targets in managed care, using a Quality Improvement System for Managed Care (QISMC) methodology. Performance goals are established by reducing by 10 percent the gap between the performance measure baseline rate and 100 percent. For example, if the baseline rate was 55 percent, the MCO would be expected to improve the rate by 4.5 percentage points to 59.5 percent. This is calculated as 4.5%= 10% x (100% - 55%). Each measure that shows improvement equal to or greater than the performance target is considered achieved.

2. What type of goal is it?

- (●) New goal
- ( ) Continuing goal
- ( ) Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children who received one or more well child visits in the last federal fiscal year.

Percentage of children age 2 who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (Hep B), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); and two influenza (flu) vaccines by their second birthday.

4. Numerator (total number)

0

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of children enrolled in CHIP in the last federal fiscal year.

A sample size of the eligible population. Eligible population includes Children who turn age 2 during the measurement year with no more than one gap in enrollment of up to 45 days during the continuous enrollment period.

6. Denominator (total number)

567

Computed: 0%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2019

End

mm/yyyy

12 / 2019

8. Which data source did you use?

- (●) Eligibility or enrollment data
- ( ) Survey data
- ( ) Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

The statewide weighted average exceeded the minimum performance standard by 1.81%.

10. What are you doing to continually make progress towards your goal?

A quarterly meeting is held with all the MCO partners led by the Health Services Advisory Group to continually discuss what measures are being met and what measures that need to be prioritized. This is also an avenue to collaborate and discuss challenges and barriers across meeting the measures. This goal is planned to be consistent year over year with the exception of new criteria and or measures that are required or recommended from CMS or from our partners at the Health Services Advisory Group.

11. Anything else you'd like to tell us about this goal?

This is a hybrid measure validated and calculated by the state's EQRO. The EQRO does not provide the numerator for hybrid measures, only the indicator-specific combined sample size and the rate; therefore, the numerator is entered as zero. The rate is: 49.21% which can be found in the EQR Tech Report attached in Section 3H.

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. Briefly describe your goal for this objective.

For example: In an effort to increase the use of preventative care, our goal is to increase the number of children who receive one or more well child visits by 5%.

Increase childhood immunization status (CIS)-Combination 9 The DHCFP has set performance targets in managed care, using a Quality Improvement System for Managed Care (QISMC) methodology. Performance goals are established by reducing by 10 percent the gap between the performance measure baseline rate and 100 percent. For example, if the baseline rate was 55 percent, the MCO would be expected to improve the rate by 4.5 percentage points to 59.5 percent. This is calculated as 4.5%= 10% x (100% - 55%). Each measure that shows improvement equal to or greater than the performance target is considered achieved.

2. What type of goal is it?

- (●) New goal
- ( ) Continuing goal
- ( ) Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children who received one or more well child visits in the last federal fiscal year.

Percentage of children age 2 who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (Hep B), one chicken pox (VZV); four pneumococcal conjugate (PCV); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.

4. Numerator (total number)

0

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of children enrolled in CHIP in the last federal fiscal year.

A sample size of the eligible population. Eligible population includes Children who turn age 2 during the measurement year with no more than one gap in enrollment of up to 45 days during the continuous enrollment period.

6. Denominator (total number)

567

Computed: 0%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2019

End

mm/yyyy

12 / 2019

8. Which data source did you use?

- (●) Eligibility or enrollment data
- ( ) Survey data
- ( ) Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

The statewide weighted average exceeded the minimum performance standard by 0.95%.

10. What are you doing to continually make progress towards your goal?

A quarterly meeting is held with all the MCO partners led by the Health Services Advisory Group to continually discuss what measures are being met and what measures that need to be prioritized. This is also an avenue to collaborate and discuss challenges and barriers across meeting the measures. This goal is planned to be consistent year over year with the exception of new criteria and or measures that are required or recommended from CMS or from our partners at the Health Services Advisory Group.

11. Anything else you'd like to tell us about this goal?

This is a hybrid measure validated and calculated by the state's EQRO. The EQRO does not provide the numerator for hybrid measures, only the indicator-specific combined sample size and the rate; therefore, the numerator is entered as zero. The rate is: 45.86% which can be found in the EQR Tech Report attached in Section 3H.

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. Briefly describe your goal for this objective.

For example: In an effort to increase the use of preventative care, our goal is to increase the number of children who receive one or more well child visits by 5%.

Increase childhood immunization status (CIS)-Combination 10 The DHCFP has set performance targets in managed care, using a Quality Improvement System for Managed Care (QISMC) methodology. Performance goals are established by reducing by 10 percent the gap between the performance measure baseline rate and 100 percent. For example, if the baseline rate was 55 percent, the MCO would be expected to improve the rate by 4.5 percentage points to 59.5 percent. This is calculated as 4.5%= 10% x (100% - 55%). Each measure that shows improvement equal to or greater than the performance target is considered achieved.

2. What type of goal is it?

- (●) New goal
- ( ) Continuing goal
- ( ) Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children who received one or more well child visits in the last federal fiscal year.

Percentage of children age 2 who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (Hep B), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.

4. Numerator (total number)

0

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of children enrolled in CHIP in the last federal fiscal year.

A sample size of the eligible population. Eligible population includes Children who turn age 2 during the measurement year with no more than one gap in enrollment of up to 45 days during the continuous enrollment period.

6. Denominator (total number)

567

Computed: 0%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2019

End

mm/yyyy

12 / 2019

8. Which data source did you use?

- (●) Eligibility or enrollment data
- ( ) Survey data
- ( ) Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

The statewide weighted average exceeded the minimum performance standard by 0.95%.

10. What are you doing to continually make progress towards your goal?

A quarterly meeting is held with all the MCO partners led by the Health Services Advisory Group to continually discuss what measures are being met and what measures that need to be prioritized. This is also an avenue to collaborate and discuss challenges and barriers across meeting the measures. This goal is planned to be consistent year over year with the exception of new criteria and or measures that are required or recommended from CMS or from our partners at the Health Services Advisory Group.

11. Anything else you'd like to tell us about this goal?

This is a hybrid measure validated and calculated by the state's EQRO. The EQRO does not provide the numerator for hybrid measures, only the indicator-specific combined sample size and the rate; therefore, the numerator is entered as zero. The rate is: 45.86% which can be found in the EQR Tech Report attached in Section 3H.

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. Briefly describe your goal for this objective.

For example: In an effort to increase the use of preventative care, our goal is to increase the number of children who receive one or more well child visits by 5%.

Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication (ADD)-initiation phase The DHCFP has set performance targets in managed care, using a Quality Improvement System for Managed Care (QISMC) methodology. Performance goals are established by reducing by 10 percent the gap between the performance measure baseline rate and 100 percent. For example, if the baseline rate was 55 percent, the MCO would be expected to improve the rate by 4.5 percentage points to 59.5 percent. This is calculated as 4.5%= 10% x (100% - 55%). Each measure that shows improvement equal to or greater than the performance target is considered achieved.

2. What type of goal is it?

- (●) New goal
- ( ) Continuing goal
- ( ) Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children who received one or more well child visits in the last federal fiscal year.

Percentage of children ages 6 to 12 as of the Index Prescription Start Date (IPSD) with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.

4. Numerator (total number)

69

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of children enrolled in CHIP in the last federal fiscal year.

Children in the specified age range who were dispensed an ADHD medication during the 12-month Intake Period with no more than one gap in enrollment of up to 45 days during the continuous enrollment period.

6. Denominator (total number)

123

Computed: 56.1%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2019

End

mm/yyyy

12 / 2019

8. Which data source did you use?

- (●) Eligibility or enrollment data
- ( ) Survey data
- ( ) Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

The statewide weighted average exceeded the minimum performance standard by 0.10%.

10. What are you doing to continually make progress towards your goal?

A quarterly meeting is held with all the MCO partners led by the Health Services Advisory Group to continually discuss what measures are being met and what measures that need to be prioritized. This is also an avenue to collaborate and discuss challenges and barriers across meeting the measures. This goal is planned to be consistent year over year with the exception of new criteria and or measures that are required or recommended from CMS or from our partners at the Health Services Advisory Group.

11. Anything else you'd like to tell us about this goal?

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. Briefly describe your goal for this objective.

For example: In an effort to increase the use of preventative care, our goal is to increase the number of children who receive one or more well child visits by 5%.

Increase follow-up after hospitalization for mental illness (FUH)-7-day The DHCFP has set performance targets in managed care, using a Quality Improvement System for Managed Care (QISMC) methodology. Performance goals are established by reducing by 10 percent the gap between the performance measure baseline rate and 100 percent. For example, if the baseline rate was 55 percent, the MCO would be expected to improve the rate by 4.5 percentage points to 59.5 percent. This is calculated as 4.5%= 10% x (100% - 55%). Each measure that shows improvement equal to or greater than the performance target is considered achieved.

2. What type of goal is it?

- (●) New goal
- ( ) Continuing goal
- ( ) Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children who received one or more well child visits in the last federal fiscal year.

Percentage of discharges for children ages 6 to 17 who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner for which the child received follow-up within 7 days after discharge.

4. Numerator (total number)

29

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of children enrolled in CHIP in the last federal fiscal year.

Percentage of discharges for children ages 6 to 17 who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner with no more than one gap in enrollment of up to 45 days during the continuous enrollment period.

6. Denominator (total number)

65

Computed: 44.62%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2019

End

mm/yyyy

12 / 2019

8. Which data source did you use?

- (●) Eligibility or enrollment data
- ( ) Survey data
- ( ) Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

The statewide weighted average is below the minimum performance standard by 21.58%.

10. What are you doing to continually make progress towards your goal?

A quarterly meeting is held with all the MCO partners led by the Health Services Advisory Group to continually discuss what measures are being met and what measures that need to be prioritized. This is also an avenue to collaborate and discuss challenges and barriers across meeting the measures. This goal is planned to be consistent year over year with the exception of new criteria and or measures that are required or recommended from CMS or from our partners at the Health Services Advisory Group.

11. Anything else you'd like to tell us about this goal?

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. Briefly describe your goal for this objective.

For example: In an effort to increase the use of preventative care, our goal is to increase the number of children who receive one or more well child visits by 5%.

Increase follow-up after hospitalization for mental illness (FUH)-30-day The DHCFP has set performance targets in managed care, using a Quality Improvement System for Managed Care (QISMC) methodology. Performance goals are established by reducing by 10 percent the gap between the performance measure baseline rate and 100 percent. For example, if the baseline rate was 55 percent, the MCO would be expected to improve the rate by 4.5 percentage points to 59.5 percent. This is calculated as 4.5%= 10% x (100% - 55%). Each measure that shows improvement equal to or greater than the performance target is considered achieved.

2. What type of goal is it?

- (●) New goal
- ( ) Continuing goal
- ( ) Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children who received one or more well child visits in the last federal fiscal year.

Percentage of discharges for children ages 6 to 17 who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health practitioner for which the child received follow-up within 30 days after discharge.

4. Numerator (total number)

48

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of children enrolled in CHIP in the last federal fiscal year.

Percentage of discharges for children ages 6 to 17 who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses with no more than one gap in enrollment of up to 45 days during the continuous enrollment period.

6. Denominator (total number)

65

Computed: 73.85%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2019

End

mm/yyyy

12 / 2019

8. Which data source did you use?

- (●) Eligibility or enrollment data
- ( ) Survey data
- ( ) Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

The statewide weighted average is below the minimum performance standard by 5.34%.

10. What are you doing to continually make progress towards your goal?

A quarterly meeting is held with all the MCO partners led by the Health Services Advisory Group to continually discuss what measures are being met and what measures that need to be prioritized. This is also an avenue to collaborate and discuss challenges and barriers across meeting the measures. This goal is planned to be consistent year over year with the exception of new criteria and or measures that are required or recommended from CMS or from our partners at the Health Services Advisory Group.

11. Anything else you'd like to tell us about this goal?

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

1. Briefly describe your goal for this objective.

For example: In an effort to increase the use of preventative care, our goal is to increase the number of children who receive one or more well child visits by 5%.

Increase adolescent well-care visits (AWC) The DHCFP has set performance targets in managed care, using a Quality Improvement System for Managed Care (QISMC) methodology. Performance goals are established by reducing by 10 percent the gap between the performance measure baseline rate and 100 percent. For example, if the baseline rate was 55 percent, the MCO would be expected to improve the rate by 4.5 percentage points to 59.5 percent. This is calculated as 4.5%= 10% x (100% - 55%). Each measure that shows improvement equal to or greater than the performance target is considered achieved.

2. What type of goal is it?

- (●) New goal
- ( ) Continuing goal
- ( ) Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

For example: The number of children who received one or more well child visits in the last federal fiscal year.

Percentage of adolescents ages 12 to 21 who had at least one comprehensive well-care visit with a primary care practitioner (PCP) or an obstetrician/ gynecologist (OB/GYN) during the measurement year.

4. Numerator (total number)

0

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

For example: The total number of children enrolled in CHIP in the last federal fiscal year.

A sample size of the eligible population. Eligible population includes ages 12 - 21 during the measurement year with no more than one gap in enrollment of up to 45 days during the continuous enrollment period.

6. Denominator (total number)

1233

Computed: 0%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2019

End

mm/yyyy

12 / 2019

8. Which data source did you use?

- (●) Eligibility or enrollment data
- ( ) Survey data
- ( ) Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

The statewide weighted average met the minimum performance standard.

10. What are you doing to continually make progress towards your goal?

A quarterly meeting is held with all the MCO partners led by the Health Services Advisory Group to continually discuss what measures are being met and what measures that need to be prioritized. This is also an avenue to collaborate and discuss challenges and barriers across meeting the measures. This goal is planned to be consistent year over year with the exception of new criteria and or measures that are required or recommended from CMS or from our partners at the Health Services Advisory Group.

11. Anything else you'd like to tell us about this goal?

This is a hybrid measure validated and calculated by the state's EQRO. The EQRO does not provide the numerator for hybrid measures, only the indicator-specific combined sample size and the rate; therefore, the numerator is entered as zero. The rate is: 65.46% which can be found in the EQR Tech Report attached in Section 3H.

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another Goal in this list?

Optional

1. What is the next objective listed in your CHIP State Plan?

Increase Medicaid enrollment

1. Briefly describe your goal for this objective.

Maintain or increase enrollment from previous year.

2. What type of goal is it?

- ○ New goal
- ◉ Continuing goal
- ○ Discontinued goal

Define the numerator you're measuring

3. Which population are you measuring in the numerator?

Average Medicaid enrollment in FFY 2020.

4. Numerator (total number)

677249

Define the denominator you're measuring

5. Which population are you measuring in the denominator?

Average Medicaid enrollment in FFY 2019.

6. Denominator (total number)

650782

Computed: 104.07%

7. What is the date range of your data?

Start

mm/yyyy

10 / 2019

End

mm/yyyy

09 / 2020

8. Which data source did you use?

- (●) Eligibility or enrollment data
- ( ) Survey data
- ( ) Another data source

9. How did your progress towards your goal last year compare to your previous year's progress?

Yes, enrollment increased by 26,467 over last year.

10. What are you doing to continually make progress towards your goal?

Enroll all eligible children.

11. Anything else you'd like to tell us about this goal?

A portion of this increase may be due to the MOE requirement under Families First Coronavirus Recovery Act (FFCRA).

12. Do you have any supporting documentation?
Optional

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Do you have another Goal in this list?

Optional

Do you have another objective in your State Plan?

Optional

Part 2: Additional questions

1. Do you have other strategies for measuring and reporting on your performance goals? What are these strategies, and what information have you found through this research?

No

2. Do you plan to add new strategies for measuring and reporting on your goals and objectives? What do you plan to do, and when will this data become available?

No

3. Have you conducted any focused studies on your CHIP population? (For example: studies on adolescents, attention deficit disorder, substance use, special healthcare needs, or other emerging healthcare needs.) What have you discovered through this research?

No

4. Optional: Attach any additional documents here.
For example: studies, analyses, or any other documents that address your performance goals.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

Browse...

Tell us how much you spent on your CHIP program in FFY 2020, and how much you anticipate spending in FFY 2021 and 2022.

Part 1: Benefit Costs

Please type your answers in only. Do not copy and paste your answers.

Combine your costs for both Medicaid Expansion CHIP and Separate CHIP programs into one budget.

1. How much did you spend on Managed Care in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 52,030,780	**$** 48,908,864.62	**$** 51,716,376.43

2. How much did you spend on Fee for Service in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 18,116,309	**$** 9,806,986.20	**$** 9,863,734.82

3. How much did you spend on anything else related to benefit costs in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 0	**$** 0	**$** 0

4. How much did you receive in cost sharing from beneficiaries to offset your costs in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 2,511,637	**$** 2,337,934.97	**$** 2,511,244.19

Table 1: Benefits Costs
This table is auto-populated with the data you entered above.

	FFY 2020	FFY 2021	FFY 2022
Managed Care	52030780.00	48908864.62	51716376.43
Fee for Service	18116309	9806986.20	9863734.82
Other benefit costs	0	0	0
Cost sharing payments from beneficiaries	2511637	2337934.97	2511244.19
Total benefit costs	72658726	61053785.78999999	64091355.44

Part 2: Administrative Costs

Please type your answers in only. Do not copy and paste your answers.

1. How much did you spend on personnel in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?
This includes wages, salaries, and other employee costs.

2020	2021	2022
$ 826,649.53	**$** 826,649.53	**$** 826,649.53

2. How much did you spend on general administration in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 2,722,913.47	**$** 937,813.85	**$** 1,069,818.97

3. How much did you spend on contractors and brokers, such as enrollment contractors in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 0	**$** 0	**$** 0

4. How much did you spend on claims processing in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 0	**$** 0	**$** 0

5. How much did you spend on outreach and marketing in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 0	**$** 0	**$** 0

6. How much did you spend on your Health Services Initiatives (HSI) if you had any in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 0	**$** 0	**$** 0

7. How much did you spend on anything else related to administrative costs in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

2020	2021	2022
$ 0	**$** 0	**$** 0

Table 2: Administrative Costs
This table is auto-populated with the data you entered above.
Your total administrative costs cannot be more than 10% of your total CHIP program costs (the sum of your benefit and administrative costs). The 10% administrative cap is calculated by dividing the total benefit costs by 9.

	FFY 2020	FFY 2021	FFY 2022
Personnel	826649.53	826649.53	826649.53
General administration	2722913.47	937813.85	1069818.97
Contractors and brokers	0	0	0
Claims processing	0	0	0
Outreach and marketing	0	0	0
Health Services Initiatives (HSI)	0	0	0
Other administrative costs	0	0	0
Total administrative costs	3549563	1764463.38	1896468.5
10% administrative cap	7515050.22	6264212.87	6563207.45

Table 3: Federal and State Shares

CHIP is funded by federal and state budgets. The federal share of funding is calculated by multiplying your state's Federal Medical Assistance Percentage (eFMAP) by your total program costs (the sum of your benefit and administrative costs). The remaining amount of your total program costs is covered by your state share of funding.

This table is auto-calculated using the data you entered above. The federal and state shares for FFY 2022 will be calculated once the eFMAP rate for 2022 becomes available. In the meantime, these values will be blank.

	FFY 2020	**FFY 2021**	**FFY 2022**
Total program costs	76208289	62818249.17	65987823.94
eFMAP	86.25	74.31	73.81
Federal share	65729649.26	46680240.96	48705612.85
State share	10478639.74	16138008.21	17282211.09

8. What were your state funding sources in FFY 2020?
Select all that apply.

- [x] State appropriations
- [x] County/local funds
- [ ] Employer contributions
- [ ] Foundation grants
- [ ] Private donations
- [ ] Tobacco settlement
- [ ] Other

9. Did you experience a shortfall in federal CHIP funds this year?

- ( ) Yes
- (•) No

Part 3: Managed Care Costs

Complete this section only if you have a Managed Care delivery system.

1. How many children were eligible for Managed Care in FFY 2020? How many do you anticipate will be eligible in FFY 2021 and 2022?

2020	2021	2022
34019	37228	37608

2. What was your per member per month (PMPM) cost based on the number of children eligible for Managed Care in FFY 2020? What is your projected PMPM cost for FFY 2021 and 2022?
Round to the nearest whole number.

2020	2021	2022
$ 122	**$** 111	**$** 116

	FFY 2020	**FFY 2021**	**FFY 2022**
PMPM cost	122	111	116

Part 4: Fee for Service Costs

Complete this section only if you have a Fee for Service delivery system.

1. How many children were eligible for Fee for Service in FFY 2020? How many do you anticipate will be eligible in FFY 2021 and 2022?

2020	2021	2022
4364	5008	5061

2. What was your per member per month (PMPM) cost based on the number of children eligible for Fee For Service in FFY 2020? What is your projected PMPM cost for FFY 2021 and 2022?
The per member per month cost will be the average cost per month to provide services to these enrollees. Round to the nearest whole number.

2020	2021	2022
$ 208	**$** 194	**$** 197

	FFY 2020	**FFY 2021**	**FFY 2022**
PMPM cost	208	194	197

1. Is there anything else you'd like to add about your program finances that wasn't already covered?

A blended FMAP was used for the EFMAP calculation due to the Covid Enhanced FMAP running from 12/01/2020 to 03/31/2020.

2. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
Files must be in one of these formats: PDF, Word, Excel, or a valid image (jpg or png).

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1. How has your state's political and fiscal environment affected your ability to provide healthcare to low-income children and families?

The State of Nevada was one of the hardest hit states when it relates to the fiscal impact due to the pandemic. In November, Nevada's total Medicaid caseload reached 765,057. The Total Medicaid caseload increased by 121,376 recipients since February 2020, an 18.9% increase. The total Medicaid plus check up caseload was 791,708 in Nov 2020 which is approximately 25% if the state's population (1 in 4 Nevadans) receive their health coverage through one of these programs. Previous to the pandemic; the Nevada Checkup recipients that left the program, were no longer enrolled in any Medicaid program. Following the start of the pandemic, most recipients leaving Check Up moved onto Medicaid due to declining household incomes. Overall, all medical systems within the State of Nevada continue to be overwhelmed with patients and remain fiscally challenged. The Division has been able to hold off on any reductions to services; however Assembly Bill 3 from Nevada's 31st special session has outlined a 6% rate cut pending CMS approval.

2. What's the greatest challenge your CHIP program has faced in FFY 2020?

The greatest challenge this year has been the COVID-19 public health emergency (PHE). Not only has the PHE significantly impacted Nevada's caseloads, case processing and procedures, but the PHE has also impacted DHCFP and DWSS personnel. The PHE has brought about a lot of uncertainty and adjustments to standard business practices evolve from day to day. These changes have required DWSS policy staff to issue and re-issue immediate guidance pertaining to eligibility. In turn, DWSS eligibility staff have become adaptable to accommodate the quickly changing policies and procedures that affect case processing. Additionally, to ensure the Division's compliance with the CDC recommended social distancing guidelines, approximately 75% of DWSS staff began working from home in March of this year. Working remotely has been an adjustment for staff and when first implemented, we encountered our fair share of challenges, most of which were related to connectivity issues. These issues have been resolved and our staff have managed to continue to complete their tasks in a timely manner. The DWSS and DHCFP have faced and continue to face these challenges together to ensure that health and welfare of our staff and fellow Nevadans is at the forefront of all that we do.

3. What are some of the greatest accomplishments your CHIP program has experienced in FFY 2020?

Despite the ongoing PHE, Nevada has risen to the occasion and continues to provide vital services to thousands of Nevadans during this time of uncertainty. The DWSS not only determines eligibility for Medical program such as Medicaid and CHIP, but also determines eligibility for Temporary Assistance for Needy Families (TANF) and SNAP (Supplemental Nutrition Assistance Program). These benefits have provided a lifeline for thousands of Nevadans that have been negatively impacted by this unforeseen emergency. The DWSS and DHCFP continue to collaborate and work side by side as the uncertainty surrounding this pandemic unfolds. Both Divisions remain flexible and committed to facing these challenges together, for the benefit of all those that we serve.

4. What changes have you made to your CHIP program in FFY 2020 or plan to make in FFY 2021? Why have you decided to make these changes?

Nevada has adopted several premium flexibilities i.e., waive premiums for those that indicate an inability to pay due to a COVID related financial hardship, suspension of the premium lock-out period and suspension of disenrollments due to non-payment of premium. These flexibilities were adopted in response to the COVID-19 PHE, via a CHIP Disaster SPA, which was approved by CMS on 6/4/2020.

5. Is there anything else you'd like to add about your state's challenges and accomplishments?

The Check Up Program continues to work internally with technical systems to make vast improvements on their ability to invoice out and collect premiums. The State of Nevada is also working on improving collection and reporting of HEDIS measure relevant to children and adolescents younger than 19.

6. Optional: Attach any additional documents here.

Click Choose Files and make your selection(s) then click Upload to attach your files. Click View Uploaded to see a list of all files attached here.
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