Nevada CARTS FY2021 Report

Welcome!

We already have some information about your state from our records. If any information is incorrect, please contact the mdct_help@cms.hhs.gov.

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):

Nevada Check Up

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

4. Contact name:

Sandie Ruybalid

5. Job title:

Deputy Administrator

6. Email:

sruybalid@dhcfp.nv.gov

7. Full mailing address:

Include city, state, and zip code.

Nevada Department of Health and Human Services Division of Health Care Financing and Policy 1100 E. William Street, Suite 101 Carson City, NV 89701

8. Phone number:

(775) 684-3676

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 CHIP premiums.

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 (PHE) 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. The PHE is currently ongoing as a 90 day extension was granted on October 15th, 2021.

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

- (●) Yes
- ( ) No

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

In response to the COVID-19 Public Health Emergency (PHE) 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. The PHE is currently ongoing as a 90-day extension was granted on October 15th, 2021.

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 2020	Number of children enrolled in FFY 2021	Percent change
Medicaid Expansion CHIP	23,165	75,759	227.041%
Separate CHIP	42,667	108,116	153.395%

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 downturn, during the pandemic and since, we have seen an increase in eligible participants to CHIP and children enrolled in the Medicaid Expansion program. Additionally, the Division of Welfare and Supportive Services has suspended regular enrollee recertification due to the COVID crisis which has also contributed to the increase in enrollment for both programs. 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. Due to the impacts of the COVID-19 PHE on collection of ACS data, the 2020 children's uninsurance rates are currently unavailable. Please skip to Question 3.

Year	Number of uninsured children	Margin of error	Percent of uninsured children (of total children in your state)	Margin of error
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%
2020	Not Available	Not Available	Not Available	Not Available

Percent change between 2019 and 2020
Not Available

1. What are some reasons why the number and/or percent of uninsured children has changed?

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?

No.

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?

With the introduction of vaccines and the establishment of a new, socially-distanced normality, Nevada Health Link has been able to increase the number of in-person outreach events from the previous year. Additionally, the focus has been on partnering with elected officials and government agencies (e.g., parks & recreation departments, city governments) who represent districts with high concentrations of our target populations. Some successful examples of these partnerships include: ● Joint events with the Regional Transportation Commission in Clark County anchored around their 'Beat the Heat' summer ridership campaign, ● Tabling at popular Hispanic grocery stores at peak times with Esta en tus Manos and the Southern Nevada Health District, ● Marketing banners placed at the City of Sparks Golden Eagle Sports Complex. ● Tabling at Washoe County Sheriff's Department 'Faith in Blue' Cornhole Tournament

( ) 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?

A large portion of Nevada Health Link's outreach efforts are focused on targeting the uninsured populations throughout the state of Nevada with a specific emphasis on minority populations including Hispanic/Latinx, African-American, Asian American and Pacific Islander communities. We also work cooperatively with the sovereign tribal nations in Nevada to support their tribal members. While a disparity in uninsured rates between white and minority communities remains a reality, we continue to engage these communities in our outreach and marketing efforts to provide access to quality, affordable insurance through Nevada Health Link. TAA & NVHL continue to capture data on demographics from certified NVHL enrollment assisters, or navigators at community events to reach the target demographics and utilize this information to refine and improve all outreach efforts on a continuing basis.

( ) No

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

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

The Abbi Agency and Nevada Health Link (NVHL) have worked diligently to reach uninsured children and their caregivers to ensure that they have the opportunity to access quality, affordable insurance offered through Nevada Health Link. In particular, NVHL partnered with community organizations to sponsor and/or participate in community events designed to reach children in our target demographics, with a specific emphasis on milestone moments for children throughout the year, including Back-to-School and Halloween events. Some examples of this outreach include: ● Family Health Festivals organized by Northern Nevada Food Bank, ● City of North Las Vegas Movie Madness series, ● Toy Drive with Las Vegas Councilmember Olivia Diaz ● Ward 5 (Las Vegas) Summer Splash ● Nevada Partners Back to School Fair ● Washoe County Sheriff's Department Christmas in July Back to School event ● Back to School Backpack Giveaway with Las Vegas Councilmember William McCurdy. ● Las Vegas PBS 'Be My Neighbor' Day. Nevada Health Link closely tracks the estimated number of event attendees as well as the number of interactions that our Navigators have with event attendees. Through our community event outreach we have spread our message to tens of thousands of Nevadans.

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

Nevada Health Link has had strong success reaching the uninsured populations throughout the state. During the Open Enrollment Period and Special Enrollment Periods covered in this time frame, Nevada Health Link enrolled nearly 90,000 Nevadans in coverage

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?

No

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?

◉ 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. Also, if an enrollee elects electronic communications, they can receive emails or text messages notifying them that there is information regarding their annual redetermination to review in their Access Nevada account.

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?

This data is not tracked

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

Managed Care enrollees are contacted by telephone to remind them to complete their annual redetermination.

Part 2: CHIP Eligibility Denials (Not Redetermination)

1. How many applicants were denied CHIP coverage in FFY 2021?
Don't include applicants being considered for redetermination - this data will be collected in Part 3.

17099

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.

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.

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?

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	
Denied for eligibility reasons	
Denials for other reasons	

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 2021?

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 2021?

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?

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 last year you reported on the number of children at the start of the cohort (Jan - Mar 2020) and six months later (July - Sept 2020). This year you'll report on 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): included in 2020 report.
You completed this section in your 2020 CARTS Report. Please refer to that report to assist in filling out this section if needed.

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): included in 2020 report.

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?

See technical notes.

January - March 2021 (12 months later): to be completed this year.
This year, please report data about your cohort for this section

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
36	609	1584	425

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
11	57	118	214

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
12	105	95	131

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
41	235	411	721

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
<11	120	245	56

July - September of 2021 (18 months later): to be completed this year
This year, please report data about your cohort for this section.

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
29	306	475	786

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
35	148	332	506

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
32	108	225	337

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
24	447	1306	68

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
12	267	589	38

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

See technical notes.

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 last year you reported the number of children identified at the start of the cohort (Jan-Mar 2020) and six months later (July-Sept 2020). This 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 2021. 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 2021 must be born after January 2004. Similarly, children who are newly enrolled in February 2021 must be born after February 2004, and children newly enrolled in March 2021 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): included in 2020 report
You completed this section in your 2020 CARTS Report. Please refer to that report to assist in filling out this section if needed.

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): included in 2020 report
You completed this section in your 2020 CARTS report. Please refer to that report to assist in filling out this section if needed.

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): to be completed this year
This year, please report data about your cohort for this section.

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
5008	4194	3955	1776

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
147	393	586	247

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
21	132	130	125

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
20	1288	1809	1134

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
<11	103	232	107

July - September of 2021 (18 months later): to be completed next year
This year, please report data about your cohort for this section.

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
4482	3908	3656	1043

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
46	835	1348	2066

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
12	56	45	89

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
720	1132	1346	48

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
18	225	345	142

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

Technical Notes: The Division of Health Care Financing and Policy (DHCFP) data warehouse is comprised of claims data submitted by over 35,000 Medicaid providers from within Nevada and across the country. While DHCFP staff conscientiously make every effort to validate these data through continuous provider education and the use of highly experienced audit staff, the Division relies heavily on providers to submit accurate and complete information on Medicaid patients. It should therefore be understood by the users of DHCFP reports on disease morbidity and patient health that the data source for these reports are based solely on patient claims data and may not be a complete and comprehensive health record. The data for this report is procured from databases that are currently being modernized from their legacy versions. Considering the unpredictable technical challenges that may arise during the migration of data from legacy to modernized versions of the databases, it is advised to use the data with caution. Due to changes in methodology, rates for subgroups published in this edition may not match or be directly comparable to past years, and should be used with caution when compared to other published rates. Monthly enrollment data for this reporting was gathered from Nevada Medicaid Data Warehouse DSS. Nevada Medicaid and Nevada Check Up enrollees are included. Medicaid and Nevada Check Up were defined using the benefit plan field. The report was produced to report each individual month an enrollee is covered. Nevada Medicaid enrollment is determined on a monthly basis.

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?

Their 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 calculated at $2178.00 x 12 = ($26,136 x.05) = $1306.80 and the total annual premium is $100.00. For a family of two at 175% FPL the 5% cap is calculated at $2541.00 x 12 ($30,492 x .05) = $1524.60 and the total annual premium is $200.00. For a family of two at 200% FPL, the 5% cap is calculated at $2904.00 x 12 ($34,848 x .05) = $1742.40 and the total annual premium is $320.00.

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

Nevada's State 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?

Terminations for non-payment of premium has been suspended for the duration of the Public Health Emergency (PHE) due to COVID-19. A 90-day extension of the PHE was authorized on 10/15/2021. By suspending terminations for non-payment of premiums the Agency has provided continuity of care to ensure CHIP enrollees received all necessary health care services during the PHE.

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.
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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. SUR likewise uses its written policies and procedures to: • educate providers on improper billing; • make referrals to the PE for provider terminations; • make referrals to policy staff for policy changes or clarifications; and • make referrals to the Business Process Management Unit (BPMU) for claims processing edits Investigation: SUR also has written policies and procedures that cover reviews of fee-for-service (FFS) claims and identifies, prevents, and recovers overpayments to providers due to fraud, waste, abuse, and improper payments. SUR conducts reviews based on tips, complaints and referrals received from various sources including the Managed Care Organizations (MCOs), recipients, providers, the general public, the Medicaid Fraud Control Unit (MFCU), and other State agencies. Data mining and analytics are also utilized to identify potential provider fraud, waste, abuse and improper payments. 4. Referral: In addition to the referrals outlined above, SUR is the point of contact for the Medicaid Fraud Control Unit (MFCU), in large part to process Credible Allegations of Fraud (CAFs). Written policies and procedures include those for CAFs within the Nevada Medicaid and CHIP programs, which are referred to SUR. When SUR identifies a CAF, a referral is sent to the MFCU. The MFCU meets monthly with SUR, and has

conducted multiple trainings regarding what they would look for in a quality CAF referral.

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 2021?

1964

7. How many cases have been found in favor of the beneficiary in FFY 2021?

<11

8. How many cases related to provider credentialing were investigated in FFY 2021?

0

9. How many cases related to provider credentialing were referred to appropriate law enforcement officials in FFY 2021?

0

10. How many cases related to provider billing were investigated in FFY 2021?

2353

11. How many cases were referred to appropriate law enforcement officials in FFY 2021?

50

12. How many cases related to beneficiary eligibility were investigated in FFY 2021?

1230

13. How many cases related to beneficiary eligibility were referred to appropriate law enforcement officials in FFY 2021?

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 to conduct 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?

No.

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 2021?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
227	1681	3184	8115	10676	6457

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 2021?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
0	289	1454	4383	6028	3722

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 2021?

Ages 0-1	Ages 1-2	Ages 3-5	Ages 6-9	Ages 10-14	Ages 15-18
0	271	1362	4148	5696	3367

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 2021?
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	63	638	2638	3649	2295

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 2021?

1203

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. For the 2021 CARTS report, we highly encourage states to report all raw CAHPS data to the Agency for Healthcare Research and Quality (AHRQ) CAHPS Database instead of reporting a summary of the data via CARTS. For 2022, the only option for reporting CAHPS results will be through the submission of raw data to ARHQ.

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?

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?

Resources for the Early Advancement of Child Health (REACH)

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 the percentage of children enrolled in Nevada Check Up by 5% annually, thus decreasing overall uninsured child rates in Nevada

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 2021 enrollment

4. Numerator (total number)

25725

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 2020 enrollment

6. Denominator (total number)

27095

Computed: 94.94%

7. What is the date range of your data?

Start

mm/yyyy

10 / 2020

End

mm/yyyy

09 / 2021

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?

Due to the ongoing Pandemic our conclusion is that individuals are still unemployed or working lower wage jobs, thus making individuals eligible for Medicaid. As a result, the enrollment figures for CHIP have actually decreased.

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?

Yes, once employment rates increase our expectation is that more children will transition off of Medicaid into CHIP.

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 (W30-CH) 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 who visited a primary care physician in the last federal fiscal year.

This population includes a unique count of eligible enrollees who visited a PCP at least 6 times from birth to 15 month of age.

4. Numerator (total number)

13

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.

The population includes all Nevada resident enrollees with continuous enrollment who turned 15 months of age with less than one month gap in enrollment from birth to 15 months of age.

6. Denominator (total number)

627

Computed: 2.07%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2020

End

mm/yyyy

12 / 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 is a new goal.

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?

Data gathered for this measure are defined by the well-care visits value set provided on the 'Child Value Sets to Codes' tab of this workbook. Visits were calculated using a unique count of service dates indicated on the header of a claim. Rate 1: Visits incurred from birth to 15 months of age of children who turned 15 months during the measurement period were reported. Rate 2: Visits incurred from 15 months and 1 day of age of children who turned 30 months during the measurement period were reported. Claims paid at the header and detail level are used for this reporting. Denied claims have been excluded. The calculations in this measure adhere to the HEDIS 14-Day Rule which specified that well-child visits must occur 14 days apart to avoid double counting events. Beneficiaries in hospice are excluded from the eligible population. - Please see Technical Notes.

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 15-30 months (W30-CH) 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 who visited a primary care physician in the last federal fiscal year.

This population includes a unique count of eligible enrollees who visited a PCP at least 2 times from 15 months and 1 day of age to 30 months of age

4. Numerator (total number)

236

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.

This population includes all Nevada resident enrollees with continuous enrollment who turned 30 months of age with less than one month gap in enrollment from 15 months and 1 day of age to 30 months.

6. Denominator (total number)

1018

Computed: 23.18%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2020

End

mm/yyyy

12 / 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 is a new measure.

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?

Data gathered for this measure are defined by the well-care visits value set provided on the 'Child Value Sets to Codes' tab of this workbook. Visits were calculated using a unique count of service dates indicated on the header of a claim. Rate 1: Visits incurred from birth to 15 months of age of children who turned 15 months during the measurement period were reported. Rate 2: Visits incurred from 15 months and 1 day of age of children who turned 30 months during the measurement period were reported. Claims paid at the header and detail level are used for this reporting. Denied claims have been excluded. The calculations in this measure adhere to the HEDIS 14-Day Rule which specified that well-child visits must occur 14 days apart to avoid double counting events. Beneficiaries in hospice are excluded from the eligible population. Please see Technical Notes.

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%.

In an effort to increase access to care, our goal is to increase child and adolescent well-care visits (WCV-CH) 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 who visited a primary care physician in the last federal fiscal year.

The population includes a unique count of eligible enrollees who visited a PCP or an OB/GYN for a well care visit at least one time during the measurement year. The well-child visit occurred with a PCP or OB/GYN; however, the PCP or OB/GYN may not have been the practitioner assigned to the child.

4. Numerator (total number)

6823

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.

The population includes all Nevada resident enrollees with continuous enrollment who were 3 to 21 years old of age as of December 31 of the measurement year. Ages have been broken down into three stratifications: 3-11, 12-17, and 18-21 years of age.

6. Denominator (total number)

17423

Computed: 39.16%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2020

End

mm/yyyy

12 / 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 is a new measure.

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?

Data gathered for this measure are defined by the well-care visits value set provided on the 'Child Value Sets to Codes' tab of this workbook. Visits were calculated using a unique count of service dates indicated on the header of a claim. Claims paid at the header and detail level are used for this reporting. Denied claims have been excluded. Please see Technical Notes

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%.

In an effort to increase the use of preventative care, our goal is to increase immunizations for adolescents (IMA-CH) for Meningococcal rate 11th - 13th birthday 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 who visited a primary care physician in the last federal fiscal year.

This population is a unique count of eligible enrollees who received a Meningococcal serogroups A, C, W, Y vaccine on or between the adolescent's 11th and 13th birthdays.

4. Numerator (total number)

411

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.

The population includes all Nevada resident enrollees with continuous enrollment who turned 13 years old during the measurement year. Ages have been broken down into three stratifications: 3-11, 12-17, and 18-21 years.

6. Denominator (total number)

1535

Computed: 26.78%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2020

End

mm/yyyy

12 / 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 is a new measure.

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?

Data gathered for this measure are defined by the designated vaccine value sets provided on the 'Child Value Sets to Codes' tab of this workbook. Enrollment and claims data were gathered from the Nevada Medicaid Data Warehouse for this reporting. The WebIZ Immunization Database was not used to gather the data for this measurement period. Beneficiaries in hospice are excluded from the eligible population. There were no additional exclusions considered for this reporting. See Technical Notes.

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%.

In an effort to increase the use of preventative care, our goal is to increase immunizations for adolescents (IMA-CH) for Meningococcal rate 11th - 13th birthday 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 who visited a primary care physician in the last federal fiscal year.

This population is a unique count of eligible enrollees who received a tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccine on or between the adolescent's 10th and 13th birthdays.

4. Numerator (total number)

392

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.

The population includes all Nevada resident enrollees with continuous enrollment who turned 13 years old during the measurement year. Ages have been broken down into three stratifications: 3-11, 12-17, and 18-21 years.

6. Denominator (total number)

1535

Computed: 25.54%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2020

End

mm/yyyy

12 / 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 is a new measure.

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?

Data gathered for this measure are defined by the designated vaccine value sets provided on the 'Child Value Sets to Codes' tab of this workbook. Enrollment and claims data were gathered from the Nevada Medicaid Data Warehouse for this reporting. The WebIZ Immunization Database was not used to gather the data for this measurement period. Beneficiaries in hospice are excluded from the eligible population. There were no additional exclusions considered for this reporting. See Technical Notes.

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%.

In an effort to increase the use of preventative care, our goal is to increase immunizations for adolescents (IMA-CH) for Meningococcal rate 11th - 13th birthday 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 who visited a primary care physician in the last federal fiscal year.

This population is a unique count of eligible enrollees who received at least two Human papillomavirus (HPV) vaccines at least 146 days apart on or between the adolescent's 9th and 13th birthday or at least three HPV vaccines on three different dates on or between the adolescent's 9th and 13th birthdays.

4. Numerator (total number)

155

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.

The population includes all Nevada resident enrollees with continuous enrollment who turned 13 years old during the measurement year. Ages have been broken down into three stratifications: 3-11, 12-17, and 18-21 years.

6. Denominator (total number)

1535

Computed: 10.1%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2020

End

mm/yyyy

12 / 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 is a new measure.

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?

Data gathered for this measure are defined by the designated vaccine value sets provided on the 'Child Value Sets to Codes' tab of this workbook. Enrollment and claims data were gathered from the Nevada Medicaid Data Warehouse for this reporting. The WebIZ Immunization Database was not used to gather the data for this measurement period. Beneficiaries in hospice are excluded from the eligible population. There were no additional exclusions considered for this reporting. See Technical Notes.

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%.

In an effort to increase the use of preventative care, our goal is to increase immunizations for adolescents (IMA-CH) for Meningococcal rate 11th - 13th birthday 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 who visited a primary care physician in the last federal fiscal year.

The population includes a unique count of eligible enrollees who received both the meningococcal and Tdap vaccines.

4. Numerator (total number)

362

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.

The population includes all Nevada resident enrollees with continuous enrollment who turned 13 years old during the measurement year. Ages have been broken down into three stratifications: 3-11, 12-17, and 18-21 years.

6. Denominator (total number)

1535

Computed: 23.58%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2020

End

mm/yyyy

12 / 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 s a new measure.

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?

Data gathered for this measure are defined by the designated vaccine value sets provided on the 'Child Value Sets to Codes' tab of this workbook. Enrollment and claims data were gathered from the Nevada Medicaid Data Warehouse for this reporting. The WebIZ Immunization Database was not used to gather the data for this measurement period. Beneficiaries in hospice are excluded from the eligible population. There were no additional exclusions considered for this reporting. See Technical Notes.

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%.

In an effort to increase the use of preventative care, our goal is to increase immunizations for adolescents (IMA-CH) for Meningococcal rate 11th - 13th birthday 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 who visited a primary care physician in the last federal fiscal year.

The population includes a unique count of eligible enrollees who received both the meningococcal and Tdap vaccines. Rate 5: The population includes a unique count of eligible enrollees who received the meningococcal, Tdap and HPV vaccines.

4. Numerator (total number)

123

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.

The population includes all Nevada resident enrollees with continuous enrollment who turned 13 years old during the measurement year. Ages have been broken down into three stratifications: 3-11, 12-17, and 18-21 years.

6. Denominator (total number)

1535

Computed: 8.01%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2020

End

mm/yyyy

12 / 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 is a new measure.

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?

Data gathered for this measure are defined by the designated vaccine value sets provided on the 'Child Value Sets to Codes' tab of this workbook. Enrollment and claims data were gathered from the Nevada Medicaid Data Warehouse for this reporting. The WebIZ Immunization Database was not used to gather the data for this measurement period. Beneficiaries in hospice are excluded from the eligible population. There were no additional exclusions considered for this reporting. See Technical Notes.

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 follow-up after hospitalization for mental illness (FUH) 7-Day.

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.

The number of follow-up visits with a mental health provider within 7 days after discharge

4. Numerator (total number)

10

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.

The number of discharges are determined using the population of all Nevada resident enrollees with continuous enrollment who were aged 6 - 17 years with an acute inpatient discharge that includes a principal diagnosis of mental illness or intentional self harm on or between January 1 and December 1 of the measurement year.

6. Denominator (total number)

33

Computed: 30.3%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2020

End

mm/yyyy

12 / 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 is a new measure.

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?

See Technical Notes.

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 follow-up after hospitalization for mental illness (FUH) 30-Day.

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.

The number of follow-up visits with a mental health provider within 30 days after discharge.

4. Numerator (total number)

12

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.

The number of discharges are determined using the population of all Nevada resident enrollees with continuous enrollment who were aged 6 - 17 years with an acute inpatient discharge that includes a principal diagnosis of mental illness or intentional self harm on or between January 1 and December 1 of the measurement year.

6. Denominator (total number)

33

Computed: 36.36%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2020

End

mm/yyyy

12 / 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 is a new measure.

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?

See Technical Notes.

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 Developmental Screening (DEV) in the first three years of life.

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.

Children who had a claim with CPT code 96110 before or on their first birthday.

4. Numerator (total number)

7

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.

The children in the eligible population who turned 1 during the measurement year.

6. Denominator (total number)

425

Computed: 1.65%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2020

End

mm/yyyy

12 / 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 is a new measure.

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 access to care, our goal is to increase the number of children who have visited a primary care physician by 5%.

Increase Developmental Screening (DEV) in the first three years of life.

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.

Children who had a claim with CPT code 96110 after their first and before or on their second birthdays.

4. Numerator (total number)

257

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.

The children in the eligible population who turned 2 during the measurement year.

6. Denominator (total number)

874

Computed: 29.41%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2020

End

mm/yyyy

12 / 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 is a new measure.

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

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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 access to care, our goal is to increase the number of children who have visited a primary care physician by 5%.

Increase Developmental Screening (DEV) in the first three years of life.

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.

Children in Denominator 3 who had a claim with CPT code 96110 after their second and before or on their third birthdays.

4. Numerator (total number)

276

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.

The children in the eligible population who turned 3 during the measurement year.

6. Denominator (total number)

925

Computed: 29.84%

7. What is the date range of your data?

Start

mm/yyyy

01 / 2020

End

mm/yyyy

12 / 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 is a new measure.

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...

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?

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?

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?

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 2021, and how much you anticipate spending in FFY 2022 and 2023.

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 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021	2022	2023
$ 60,757,879	**$** 58,805,049	**$** 55,362,707

2. How much did you spend on Fee for Service in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021	2022	2023
$ 14,483,599	**$** 11,757,858	**$** 10,315,168

3. How much did you spend on anything else related to benefit costs in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021	2022	2023
$ 0	**$** 0	**$** 0

4. How much did you receive in cost sharing from beneficiaries to offset your costs in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021	2022	2023
$ 2,095,190	**$** 2,337,934	**$** 2,551,244

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

	FFY 2021	FFY 2022	FFY 2023
Managed Care	60757879	58805049	55362707
Fee for Service	14483599	11757858	10315168
Other benefit costs	0	0	0
Cost sharing payments from beneficiaries	2095190	2337934	2551244
Total benefit costs	77336668	72900841	68229119

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 2021? How much do you anticipate spending in FFY 2022 and 2023?
This includes wages, salaries, and other employee costs.

2021	2022	2023
$ 826,649	**$** 826,649	**$** 826,649

2. How much did you spend on general administration in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021	2022	2023
$ 2,290,961	**$** 1,173,215	**$** 1,283,332

3. How much did you spend on contractors and brokers, such as enrollment contractors in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021	2022	2023
$ 0	**$** 0	**$** 0

4. How much did you spend on claims processing in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021	2022	2023
$ 0	**$** 0	**$** 0

5. How much did you spend on outreach and marketing in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021	2022	2023
$ 0	**$** 0	**$** 0

6. How much did you spend on your Health Services Initiatives (HSI) if you had any in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021	2022	2023
$ 0	**$** 0	**$** 0

7. How much did you spend on anything else related to administrative costs in FFY 2021? How much do you anticipate spending in FFY 2022 and 2023?

2021	2022	2023
$ 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 2021	FFY 2022	FFY 2023
Personnel	826649	826649	826649
General administration	2290961	1173215	1283332
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	3117610	1999864	2109981
10% administrative cap	8127365.33	7580552.56	7014070.11

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 2023 will be calculated once the eFMAP rate for 2023 becomes available. In the meantime, these values will be blank.

FMAP Table	FFY 2021	FFY 2022	FFY 2023
Total program costs	80454278	74900705	70339100
eFMAP	74.31	73.81	73.86
Federal share	59785573.98	55284210.36	51952459.26
State share	20668704.02	19616494.64	18386640.74

8. What were your state funding sources in FFY 2021?
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 2021? How many do you anticipate will be eligible in FFY 2022 and 2023?

2021	2022	2023
41241	37228	37608

2. What was your per member per month (PMPM) cost based on the number of children eligible for Managed Care in FFY 2021? What is your projected PMPM cost for FFY 2022 and 2023?
Round to the nearest whole number.

2021	2022	2023
$ 122	**$** 145	**$** 116

	FFY 2021	**FFY 2022**	**FFY 2023**
PMPM cost	122	145	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 2021? How many do you anticipate will be eligible in FFY 2022 and 2023?

2021	2022	2023
4577	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 2021? What is your projected PMPM cost for FFY 2022 and 2023?
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.

2021	2022	2023
$ 208	**$** 380	**$** 197

	FFY 2021	**FFY 2022**	**FFY 2023**
PMPM cost	208	380	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 03/31/2021.

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.
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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 continues to be one of the hardest hit states when it relates to the fiscal impact due to the pandemic. In October 2021, Nevada's total Medicaid caseload reached 852,673 surpassing October 2020's case load of 765,057. This remains approximately 25% if the state's population (1 in 4 Nevadans) receive their health coverage through one of these programs. Nevada's medical systems within the State continue to be overwhelmed with patients and remain fiscally challenged. Nevada has seen a decrease in available providers and often here about wait lists to see a specialist. The Division overall was able to hold off on any reductions to services including the proposed 6% rate cut to providers prior to the American Rescue Plan.

2. What's the greatest challenge your CHIP program has faced in FFY 2021?

One of the greatest challenges has been adjusting to the policy and case processing flexibilities that were adopted due to the PHE; however, DWSS eligibility staff have continued to be productive. While a majority of DWSS field staff have returned to the office, a portion of staff are still working from home. DWSS staff that have been transitioned back into the office are still required to adhere to the CDC social distancing guidelines and are required to wear facial coverings, even when vaccinated. Additionally, it has been a challenge to ensure that Outreach staff maintain health and safety as they are regularly exposed to the virus in the natural course their duties. All State of Nevada employees are now required to be vaccinated or receive weekly COVID testing. This has required a significant amount of coordination between medical professionals conducting the tests and various agency Division Administrators and HR staff. In spite of all the challenges faced within the last several months, DWSS and DHCFP continue to provide exceptional customer service to the citizens of the great State of Nevada.

3. What are some of the greatest accomplishments your CHIP program has experienced in FFY 2021?

Due to the ongoing PHE, the Medicaid and CHIP program has continued to utilize the flexibilities that were adopted due to the PHE i.e., suspension of terminations for non-payment of premiums, suspension of the 90-day sit out, delaying the processing of renewals, etc. This has provided a continuity of care for both Medicaid and CHIP enrollees. Medicaid enrollment in October of 2021 was 852,673, while CHIP enrollment was 23,643. Coverage for these individuals ensures that those in our community can receive the health care they need during this ongoing pandemic and these times of uncertainty.

4. What changes have you made to your CHIP program in FFY 2021 or plan to make in FFY 2022? Why have you decided to make these changes?

In FFY 2021, Nevada still had an approved Disaster Relief SPA which allowed the state to make changes to delay the 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 after the submission of the SPA, as permitted under Section 1135 of the Social Security Act. Nevada continues to work under these flexibilities and will continue to do so, until the PHE is officially declared over. In FFY 2022, if the PHE is declared over, agencies will begin the unwinding of all the flexibilities implemented during the PHE. This will require coordination amongst CMS, agency Administrators, Office Managers, Supervisors, Policy and Field staff. The DWSS and DHCFP continue to work with CMS regarding the unwinding of the PHE, review the guidance provided and plan accordingly to ensure a smooth transition forward.

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

Nevada Medicaid was able to open Tobacco Cessation coverage for all residents. This had previously been available to pregnant women only.

6. Optional: Attach any additional documents here.

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