FRAMEWORK FOR THE ANNUAL REPORT OF THE CHILDREN’S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

Preamble

Section 2108(a) and Section 2108(e) of the Social Security Act (the Act) provide that each state and territory* must assess the operation of its state child health plan in each federal fiscal year and report to the Secretary, by January 1 following the end of the federal fiscal year, on the results of the assessment. In addition, this section of the Act provides that the state must assess the progress made in reducing the number of uncovered, low-income children. The state is out of compliance with CHIP statute and regulations if the report is not submitted by January 1. The state is also out of compliance if any section of this report relevant to the state’s program is incomplete.

The framework is designed to:

- Recognize the **diversity** of state approaches to CHIP and allow states **flexibility** to highlight key accomplishments and progress of their CHIP programs, **AND**
- Provide **consistency** across states in the structure, content, and format of the report, **AND**
- Build on data **already collected** by CMS quarterly enrollment and expenditure reports, **AND**
- Enhance **accessibility** of information to stakeholders on the achievements under Title XXI

The CHIP Annual Report Template System (CARTS) is organized as follows:

- Section I: Snapshot of CHIP Programs and Changes
- Section II: Program’s Performance Measurement and Progress
- Section III: Assessment of State Plan and Program Operation
- Section IV: Program Financing for State Plan
- Section V: Program Challenges and Accomplishments

* - When “state” is referenced throughout this template it is defined as either a state or a territory.
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DO NOT CERTIFY YOUR REPORT UNTIL ALL SECTIONS ARE COMPLETE.
State/Territory: NV

Name of State/Territory

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a) and Section 2108(e)).

Signature: Cody Phinney, Acting Administrator

CHIP Program Name(s): All, Nevada

CHIP Program Type:
- [ ] CHIP Medicaid Expansion Only
- [ ] Separate Child Health Program Only
- [x] Combination of the above

Reporting Period: 2018 (Note: Federal Fiscal Year 2018 starts 10/1/2017 and ends 9/30/2018)

Contact Person/Title: Russ Carpenter / Management Analyst III

Address: 1100 E. William St.

City: Carson City State: NV Zip: 89701

Phone: 775-684-3721 Fax: 775-687-8724

Email: rcarpenter@dhcfp.nv.gov

Submission Date: 6/20/2019

(Due to your CMS Regional Contact and Central Office Project Officer by January 1st of each year)
Section I. Snapshot of CHIP Program and Changes

1) To provide a summary at-a-glance of your CHIP program, please provide the following information. If you would like to make any comments on your responses, please explain in the narrative section below this table.

☑ Provide an assurance that your state’s CHIP program eligibility criteria as set forth in the CHIP state plan in section 4, inclusive of PDF pages related to Modified Adjusted Gross Income eligibility, is accurate as of the date of this report.

Please note that the numbers in brackets, e.g., [500] are character limits in the Children’s Health Insurance Program (CHIP) Annual Report Template System (CARTS). You will not be able to enter responses with characters greater than the limit indicated in the brackets.

CHIP Medicaid Expansion Program

Upper % of FPL (federal poverty level) fields are defined as Up to and Including.

Does your program require premiums or an enrollment fee?
☑ NO
☐ YES
☐ N/A

Enrollment fee amount:
Premium fee amount:
If premiums are tiered by FPL, please breakout by FPL.

<table>
<thead>
<tr>
<th>Premium Amount From ($)</th>
<th>Premium Amount To ($)</th>
<th>From % of FPL</th>
<th>Up to % of FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Yearly Maximum Premium Amount per Family: $

If premiums are tiered by FPL, please breakout by FPL.

<table>
<thead>
<tr>
<th>Premium Amount From ($)</th>
<th>Premium Amount To ($)</th>
<th>From % of FPL</th>
<th>Up to % of FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
If yes, briefly explain fee structure: [500]

Which delivery system(s) does your program use?

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

Please describe which groups receive which delivery system: [500]

**Separate Child Health Program**

Upper % of FPL (federal poverty level) fields are defined as Up to and Including

Does your program require premiums or an enrollment fee?

- ☒ NO
- ☐ YES
- ☐ N/A

Enrollment fee amount:
Premium fee amount:
If premiums are tiered by FPL, please breakout by FPL.

<table>
<thead>
<tr>
<th>Premium Amount From ($)</th>
<th>Premium Amount To ($)</th>
<th>From % of FPL</th>
<th>Up to % of FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>25</td>
<td>139</td>
<td>150</td>
<td></td>
</tr>
<tr>
<td>50</td>
<td>151</td>
<td>175</td>
<td></td>
</tr>
<tr>
<td>80</td>
<td>176</td>
<td>205</td>
<td></td>
</tr>
</tbody>
</table>

Yearly Maximum Premium Amount per Family: $100

If premiums are tiered by FPL, please breakout by FPL.

<table>
<thead>
<tr>
<th>Premium Amount From ($)</th>
<th>Premium Amount To ($)</th>
<th>From % of FPL</th>
<th>Up to % of FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>25</td>
<td>139</td>
<td>150</td>
<td></td>
</tr>
<tr>
<td>Premium Amount From ($)</td>
<td>Premium Amount To ($)</td>
<td>From % of FPL</td>
<td>Up to % of FPL</td>
</tr>
<tr>
<td>------------------------</td>
<td>-----------------------</td>
<td>---------------</td>
<td>---------------</td>
</tr>
<tr>
<td>50</td>
<td></td>
<td>151</td>
<td>175</td>
</tr>
<tr>
<td>80</td>
<td></td>
<td>176</td>
<td>205</td>
</tr>
</tbody>
</table>

If yes, briefly explain fee structure: [500]

Premium has been broken down by tiered FPL as outlined above.

Which delivery system(s) does your program use?

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

Please describe which groups receive which delivery system: [500]
Individuals residing in Urban areas are enrolled in Managed Care and individuals residing in Rural areas are enrolled in fee for services.

2) Have you made changes to any of the following policy or program areas during the reporting period? Please indicate “yes” or “no change” by marking the appropriate column.

For FFY 2018, please include only the program changes that are in addition to and/or beyond those required by the Affordable Care Act.

<table>
<thead>
<tr>
<th>Medicaid Expansion CHIP Program</th>
<th>Separate Child Health Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No Change</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

a) Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)

b) Application

c) Benefits

d) Cost sharing (including amounts, populations, & collection process)

e) Crowd out policies

f) Delivery system

g) Eligibility determination process
h) Implementing an enrollment freeze and/or cap
   - Yes: ☐
   - No Change: ☒
   - N/A: ☐

i) Eligibility levels / target population
   - Yes: ☐
   - No Change: ☒
   - N/A: ☐

j) Eligibility redetermination process
   - Yes: ☐
   - No Change: ☒
   - N/A: ☐

k) Enrollment process for health plan selection
   - Yes: ☐
   - No Change: ☒
   - N/A: ☐

l) Outreach (e.g., decrease funds, target outreach)
   - Yes: ☐
   - No Change: ☒
   - N/A: ☐

m) Premium assistance
   - Yes: ☐
   - No Change: ☒
   - N/A: ☐

n) Prenatal care eligibility expansion (Sections 457.10, 457.350(b)(2),
   457.622(c)(5), and 457.626(a)(3) as described in the October 2, 2002 Final
   Rule)
   - Yes: ☐
   - No Change: ☒
   - N/A: ☐

o) Expansion to “Lawfully Residing” children
   - Yes: ☐
   - No Change: ☒
   - N/A: ☐

p) Expansion to “Lawfully Residing” pregnant women
   - Yes: ☐
   - No Change: ☒
   - N/A: ☐

q) Pregnant Women state plan expansion
   - Yes: ☐
   - No Change: ☒
   - N/A: ☐

r) Methods and procedures for prevention, investigation, and referral of cases
   of fraud and abuse
   - Yes: ☐
   - No Change: ☒
   - N/A: ☐

s) Other – please specify
   - a) ☐
   - b) ☒
   - c) ☐

3) For each topic you responded “yes” to above, please explain the change and why the change
   was made, below:

<table>
<thead>
<tr>
<th>Topic</th>
<th>Medicaid Expansion CHIP Program</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>List change and why the change was made</td>
</tr>
<tr>
<td>a)</td>
<td>Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)</td>
</tr>
<tr>
<td>b)</td>
<td>Application</td>
</tr>
<tr>
<td>c)</td>
<td>Benefits</td>
</tr>
<tr>
<td>Topic</td>
<td>List change and why the change was made</td>
</tr>
<tr>
<td>-------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td>d) Cost sharing (including amounts, populations, &amp; collection process)</td>
<td></td>
</tr>
<tr>
<td>e) Crowd out policies</td>
<td></td>
</tr>
<tr>
<td>f) Delivery system</td>
<td></td>
</tr>
<tr>
<td>g) Eligibility determination process</td>
<td></td>
</tr>
<tr>
<td>h) Implementing an enrollment freeze and/or cap</td>
<td></td>
</tr>
<tr>
<td>i) Eligibility levels / target population</td>
<td>Effective Feb.1st, 2018, CHIPRA Option 214 was implemented - DWSS began enrolling several categories of lawfully residing immigrants.</td>
</tr>
<tr>
<td>j) Eligibility redetermination process</td>
<td></td>
</tr>
<tr>
<td>k) Enrollment process for health plan selection</td>
<td></td>
</tr>
<tr>
<td>l) Outreach</td>
<td></td>
</tr>
<tr>
<td>m) Premium assistance</td>
<td></td>
</tr>
<tr>
<td>n) Prenatal care eligibility expansion (Sections 457.10, 457.350(b)(2), 457.622(c)(5), and 457.626(a)(3) as described in the October 2, 2002 Final Rule)</td>
<td></td>
</tr>
<tr>
<td>o) Expansion to “Lawfully Residing” children</td>
<td>Effective Feb.1st, 2018, CHIPRA Option 214 was implemented - DWSS began enrolling several categories of lawfully residing immigrants.</td>
</tr>
<tr>
<td>p) Expansion to “Lawfully Residing” pregnant women</td>
<td></td>
</tr>
<tr>
<td>q) Pregnant Women State Plan Expansion</td>
<td></td>
</tr>
<tr>
<td>r) Methods and procedures for prevention, investigation, and referral of cases of fraud and abuse</td>
<td></td>
</tr>
<tr>
<td>s) Other – please specify</td>
<td>a)</td>
</tr>
<tr>
<td></td>
<td>b)</td>
</tr>
<tr>
<td></td>
<td>c)</td>
</tr>
</tbody>
</table>
## Separate Child Health Program

<table>
<thead>
<tr>
<th>Topic</th>
<th>List change and why the change was made</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Applicant and enrollee protections</td>
<td>(e.g., changed from the Medicaid Fair Hearing Process to State Law)</td>
</tr>
<tr>
<td>b) Application</td>
<td></td>
</tr>
<tr>
<td>c) Benefits</td>
<td></td>
</tr>
<tr>
<td>d) Cost sharing (including amounts, populations, &amp; collection process)</td>
<td></td>
</tr>
<tr>
<td>e) Crowd out policies</td>
<td></td>
</tr>
<tr>
<td>f) Delivery system</td>
<td></td>
</tr>
<tr>
<td>g) Eligibility determination process</td>
<td></td>
</tr>
<tr>
<td>h) Implementing an enrollment freeze and/or cap</td>
<td></td>
</tr>
<tr>
<td>i) Eligibility levels / target population</td>
<td>Effective Feb. 1st, 2018, CHIPRA Option 214 was implemented - DWSS began enrolling several categories of lawfully residing immigrants.</td>
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<tr>
<td>j) Eligibility redetermination process</td>
<td></td>
</tr>
<tr>
<td>k) Enrollment process for health plan selection</td>
<td></td>
</tr>
<tr>
<td>l) Outreach</td>
<td></td>
</tr>
<tr>
<td>m) Premium assistance</td>
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</tr>
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<td>List change and why the change was made</td>
</tr>
<tr>
<td>-------</td>
<td>-----------------------------------------</td>
</tr>
<tr>
<td>r) Methods and procedures for prevention, investigation, and referral of cases of fraud and abuse</td>
<td></td>
</tr>
<tr>
<td>s) Other – please specify</td>
<td></td>
</tr>
<tr>
<td>a)</td>
<td></td>
</tr>
<tr>
<td>b)</td>
<td></td>
</tr>
<tr>
<td>c)</td>
<td></td>
</tr>
</tbody>
</table>

Enter any Narrative text related to Section I below. [7500]
Section II  Program’s Performance Measurement and Progress

This section consists of two subsections that gather information about the CHIP and/or Medicaid program. Section IIA captures your enrollment progress as well as changes in the number and/or rate of uninsured children in your state. Section IIB captures progress towards meeting your state’s general strategic objectives and performance goals.

Section IIA: Enrollment And Uninsured Data

1. The information in the table below is the Unduplicated Number of Children Ever Enrolled in CHIP in your state for the two most recent reporting periods. The enrollment numbers reported below should correspond to line 7 (Unduplicated # Ever Enrolled Year) in your state’s 4th quarter data report (submitted in October) in the CHIP Statistical Enrollment Data System (SEDS). The percent change column reflects the percent change in enrollment over the two-year period. If the percent change exceeds 10 percent (increase or decrease), please explain in letter A below any factors that may account for these changes (such as decreases due to elimination of outreach or increases due to program expansions). This information will be filled in automatically by CARTS through a link to SEDS. Please wait until you have an enrollment number from SEDS before you complete this response. If the information displayed in the table below is inaccurate, please make any needed updates to the data in SEDS and then refresh this page in CARTS to reflect the updated data.

<table>
<thead>
<tr>
<th>Program</th>
<th>FFY 2017</th>
<th>FFY 2018</th>
<th>Percent change FFY 2017-2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHIP Medicaid Expansion Program</td>
<td>29849</td>
<td>23667</td>
<td>-20.71</td>
</tr>
<tr>
<td>Separate Child Health Program</td>
<td>50493</td>
<td>48327</td>
<td>-4.29</td>
</tr>
</tbody>
</table>

A. Please explain any factors that may account for enrollment increases or decreases exceeding 10 percent. [7500]
CHIP Medicaid Expansion Program decreased by 20.71%. Nevada's unemployment rate has decreased from January 2016 of 6.2%, January 2017 to 5.3% and in January 2018 to 4.9%. Increasing the number of employed parents with Health Insurance.

2. The tables below show trends in the number and rate of uninsured children in your state. Three year averages in Table 1 are based on the Current Population Survey. The single year estimates in Table 2 are based on the American Community Survey (ACS). CARTS will fill in the single year estimates automatically, and significant changes are denoted with an asterisk (*). If your state uses an alternate data source and/or methodology for measuring change in the number and/or rate of uninsured children, please explain in Question #3.
Table 1: Number and percent of uninsured children under age 19 below 200 percent of poverty, Current Population Survey

<table>
<thead>
<tr>
<th>Period</th>
<th>Uninsured Children Under Age 19 Below 200 Percent of Poverty</th>
<th>Uninsured Children Under Age 19 Below 200 Percent of Poverty as a Percent of Total Children Under Age 19</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number (In Thousands)</td>
<td>Std. Error</td>
</tr>
<tr>
<td>1996 - 1998</td>
<td>62</td>
<td>10.9</td>
</tr>
<tr>
<td>1998 - 2000</td>
<td>67</td>
<td>11.3</td>
</tr>
<tr>
<td>2000 - 2002</td>
<td>66</td>
<td>8.2</td>
</tr>
<tr>
<td>2002 - 2004</td>
<td>72</td>
<td>8.6</td>
</tr>
<tr>
<td>2003 - 2005</td>
<td>63</td>
<td>10.0</td>
</tr>
<tr>
<td>2004 - 2006</td>
<td>63</td>
<td>11.0</td>
</tr>
<tr>
<td>2005 - 2007</td>
<td>64</td>
<td>11.0</td>
</tr>
<tr>
<td>2006 - 2008</td>
<td>73</td>
<td>11.0</td>
</tr>
<tr>
<td>2007 - 2009</td>
<td>72</td>
<td>12.0</td>
</tr>
<tr>
<td>2008 - 2010</td>
<td>74</td>
<td>8.0</td>
</tr>
<tr>
<td>2009 - 2011</td>
<td>82</td>
<td>6.0</td>
</tr>
<tr>
<td>2010 - 2012</td>
<td>92</td>
<td>8.0</td>
</tr>
</tbody>
</table>

Table 2: Number and percent of uninsured children under age 19 below 200 percent of poverty, American Community Survey

<table>
<thead>
<tr>
<th>Period</th>
<th>Uninsured Children Under Age 19 Below 200 Percent of Poverty</th>
<th>Uninsured Children Under Age 19 Below 200 Percent of Poverty as a Percent of Total Children Under Age 19</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number (In Thousands)</td>
<td>Margin of Error</td>
</tr>
<tr>
<td>2013</td>
<td>71</td>
<td>7.0</td>
</tr>
<tr>
<td>2014</td>
<td>43</td>
<td>5.0</td>
</tr>
<tr>
<td>2015</td>
<td>33</td>
<td>4.0</td>
</tr>
<tr>
<td>2016</td>
<td>31</td>
<td>5.0</td>
</tr>
<tr>
<td>2017</td>
<td>31</td>
<td>5.0</td>
</tr>
<tr>
<td>Percent change 2016 vs. 2017</td>
<td>0%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

A. Please explain any activities or factors that may account for increases or decreases in your number and/or rate of uninsured children. [7500] Effective Feb.1st,2018, CHIPRA Option 214 was implemented-DWSS began enrolling several categories of lawfully residing immigrants. Nevada has also worked with sister agency outreach with Connecting Kids to Care and the Managed Care Organizations.

B. Please note any comments here concerning ACS data limitations that may affect the reliability or precision of these estimates. [7500]
3. Please indicate by checking the box below whether your state has an alternate data source and/or methodology for measuring the change in the number and/or rate of uninsured children.

☐ Yes (please report your data in the table below)
☒ No (skip to Question #4)

Please report your alternate data in the table below. Data are required for two or more points in time to demonstrate change (or lack of change). Please be as specific and detailed as possible about the method used to measure progress toward covering the uninsured.

<table>
<thead>
<tr>
<th>Topic</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data source(s)</td>
<td></td>
</tr>
<tr>
<td>Reporting period (2 or more points in time)</td>
<td></td>
</tr>
<tr>
<td>Methodology</td>
<td></td>
</tr>
<tr>
<td>Population (Please include ages and income levels)</td>
<td></td>
</tr>
<tr>
<td>Sample sizes</td>
<td></td>
</tr>
<tr>
<td>Number and/or rate for two or more points in time</td>
<td></td>
</tr>
<tr>
<td>Statistical significance of results</td>
<td></td>
</tr>
</tbody>
</table>

A. Please explain why your state chose to adopt a different methodology to measure changes in the number and/or rate of uninsured children.

[7500]

B. What is your state’s assessment of the reliability of the estimate? Please provide standard errors, confidence intervals, and/or p-values if available.

[7500]

C. What are the limitations of the data or estimation methodology?

[7500]

D. How does your state use this alternate data source in CHIP program planning?

[7500]

Enter any Narrative text related to Section IIA below. [7500]
Section IIB: State Strategic Objectives And Performance Goals

This subsection gathers information on your state’s general strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your CHIP state plan. (If your goals reported in the annual report now differ from Section 9 of your CHIP state plan, please indicate how they differ in “Other Comments on Measure.” Also, the state plan should be amended to reconcile these differences). The format of this section provides your state with an opportunity to track progress over time. This section contains templates for reporting performance measurement data for each of five categories of strategic objectives, related to:

- Reducing the number of uninsured children
- CHIP enrollment
- Medicaid enrollment
- Increasing access to care
- Use of preventative care (immunizations, well child care)

Please report performance measurement data for the three most recent years for which data are available (to the extent that data are available). In the first two columns, data from the previous two years’ annual reports (FFY 2016 and FFY 2017) will be populated with data from previously reported data in CARTS. If you reported data in the two previous years’ reports and you want to update/change the data, please enter that data. If you reported no data for either of those two years, but you now have data available for them, please enter the data. In the third column, please report the most recent data available at the time you are submitting the current annual report (FFY 2018).

In this section, the term performance measure is used to refer to any data your state provides as evidence towards a particular goal within a strategic objective. For the purpose of this section, “objectives” refer to the five broad categories listed above, while “goals” are state-specific, and should be listed in the appropriate subsections within the space provided for each objective.

NOTES: Please do not reference attachments in this section. If details about a particular measure are located in an attachment, please summarize the relevant information from the attachment in the space provided for each measure.

In addition, please do not report the same data that were reported for Child Core Set reporting. The intent of this section is to capture goals and measures that your state did not report elsewhere. As a reminder, Child Core Set reporting migrated to MACPRO in December 2015. Historical data are still available for viewing in CARTS.

Additional instructions for completing each row of the table are provided below.

A. Goal:

For each objective, space has been provided to report up to three goals. Use this section to provide a brief description of each goal you are reporting within a given strategic objective. **All new goals should include a direction and a target. For clarification only, an example goal would be:** "Increase (direction) by 5 percent (target) the number of CHIP beneficiaries who turned 13 years old during the measurement year who had a second dose of MMR, three hepatitis B vaccinations and one varicella vaccination by their 13th birthday."

B. Type of Goal:

For each goal you are reporting within a given strategic objective, please indicate the type of goal, as follows:
• **New/revised:** Check this box if you have revised or added a goal. Please explain how and why the goal was revised.

• **Continuing:** Check this box if the goal you are reporting is the same one you have reported in previous annual reports.

• **Discontinued:** Check this box if you have met your goal and/or are discontinuing a goal. Please explain why the goal was discontinued.

**C. Status of Data Reported:**

Please indicate the status of the data you are reporting for each goal, as follows:

• **Provisional:** Check this box if you are reporting performance measure data for a goal, but the data are currently being modified, verified, or may change in any other way before you finalize them for FFY 2018.

  **Explanation of Provisional Data** – When the value of the Status of Data Reported field is selected as “Provisional”, the state must specify why the data are provisional and when the state expects the data will be final.

• **Final:** Check this box if the data you are reporting are considered final for FFY 2018.

• **Same data as reported in a previous year’s annual report:** Check this box if the data you are reporting are the same data that your state reported for the goal in another annual report. Indicate in which year’s annual report you previously reported the data.

**D. Measurement Specification:**

This section is included for only two of the objectives—objectives related to increasing access to care, and objectives related to use of preventative care—because these are the two objectives for which states may report using the HEDIS® measurement specification. In this section, for each goal, please indicate the measurement specification used to calculate your performance measure data (i.e., were the measures calculated using the HEDIS® specifications or some other method unrelated to HEDIS®).

Please indicate whether the measure is based on HEDIS® technical specifications or another source. If HEDIS® is selected, the HEDIS® Version field must be completed. If “Other” measurement specification is selected, the explanation field must be completed.

**HEDIS® Version:**

Please specify HEDIS® Version (example 2016). This field must be completed only when a user selects the HEDIS® measurement specification.

**“Other” measurement specification explanation:**

If “Other”, measurement specification is selected, please complete the explanation of the “Other” measurement specification. The explanation field must be completed when “Other” measurement specification has been selected.

**E. Data Source:**

For each performance measure, please indicate the source of data. The categories provided in this section vary by objective. For the objectives related to reducing the number of uninsured children and CHIP or Medicaid enrollment, please indicate whether you have used eligibility/enrollment data, survey data (specify the survey used), or other source (specify the other source). For the objectives related to access to care and use of preventative care, please indicate whether you used administrative data (claims) (specify the kind of administrative data used), hybrid data (claims and medical records) (specify how the two were used to create the data source), survey data (specify the survey used), or other source (specify the other source). In all cases, if another data source was used, please explain the source.
F. Definition of Population Included in Measure:

Numerator: Please indicate the definition of the population included in the numerator for each measure (such as the number of visits required for inclusion, e.g., one or more visits in the past year).

Denominator: Please indicate the definition of the population included in the denominator for each measure.

For measures related to increasing access to care and use of preventative care, please

• Check one box to indicate whether the data are for the CHIP population only, or include both CHIP and Medicaid (Title XIX) children combined.
• If the denominator reported is not fully representative of the population defined above (the CHIP population only, or the CHIP and Medicaid (Title XIX) populations combined), please further define the denominator. For example, denominator includes only children enrolled in managed care in certain counties, technological limitations preventing reporting on the full population defined, etc.). Please report information on exclusions in the definition of the denominator (including the proportion of children excluded). The provision of this information is important and will provide CMS with a context so that comparability of denominators across the states and over time can occur.

G. Deviations from Measure Specification

For the measures related to increasing access to care and use of preventative care.

If the data provided for a measure deviates from the measure specification, please select the type(s) of measure specification deviation. The types of deviation parallel the measure specification categories for each measure. Each type of deviation is accompanied by a comment field that states must use to explain in greater detail or further specify the deviation when a deviation(s) from a measure is selected.

The five types (and examples) of deviations are:

• Year of Data (e.g., partial year),
• Data Source (e.g., use of different data sources among health plans or delivery systems),
• Numerator (e.g., coding issues),
• Denominator (e.g., exclusion of MCOs, different age groups, definition of continuous enrollment),
• Other.

When one or more of the types are selected, states are required to provide an explanation.

Please report the year of data for each performance measure. The year (or months) should correspond to the period in which enrollment or utilization took place. Do not report the year in which data were collected for the measure, or the version of HEDIS® used to calculate the measure, both of which may be different from the period corresponding to enrollment or utilization of services.

H. Date Range: available for 2018 CARTS reporting period.

Please define the date range for the reporting period based on the “From” time period as the month and year which corresponds to the beginning period in which utilization took place and please report the “To” time period as the month and year which corresponds to the end period in which utilization took place. Do not report the year in which data were collected for the measure, or the version of HEDIS® used to calculate the measure, both of which may be different from the period corresponding to utilization of services.

I. Performance Measurement Data (HEDIS® or Other):

In this section, please report the numerators and denominators, rates for each measure (or component). The template provides two sections for entering the performance measurement data, depending on
whether you are reporting using HEDIS® or other methodologies. The form fields have been set up to facilitate entering numerators and denominators for each measure. If the form fields do not give you enough space to fully report on the measure, please use the “additional notes” section.

The preferred method is to calculate a “weighted rate” by summing the numerators and denominators across plans, and then deriving a single state-level rate based on the ratio of the numerator to the denominator). The reporting unit for each measure is the state as a whole. If states calculate rates for multiple reporting units (e.g., individual health plans, different health care delivery systems), states must aggregate data from all these sources into one state rate before reporting the data to CMS. In the situation where a state combines data across multiple reporting units, all or some of which use the hybrid method to calculate the rates, the state should enter zeroes in the “Numerator” and “Denominator” fields. In these cases, it should report the state-level rate in the “Rate” field and, when possible, include individual reporting unit numerators, denominators, and rates in the field labeled “Additional Notes on Measure,” along with a description of the method used to derive the state-level rate.

J. Explanation of Progress:

The intent of this section is to allow your state to highlight progress and describe any quality-improvement activities that may have contributed to your progress. Any quality-improvement activity described should involve the CHIP program, benefit CHIP enrollees, and relate to the performance measure and your progress. An example of a quality-improvement activity is a state-wide initiative to inform individual families directly of their children’s immunization status with the goal of increasing immunization rates. CHIP would either be the primary lead or substantially involved in the project. If improvement has not occurred over time, this section can be used to discuss potential reasons for why progress was not seen and to describe future quality-improvement plans. In this section, your state is also asked to set annual performance objectives for FFY 2019, 2020 and 2021. Based on your recent performance on the measure (from FFY 2016 through 2018), use a combination of expert opinion and “best guesses” to set objectives for the next three years. Please explain your rationale for setting these objectives. For example, if your rate has been increasing by 3 or 4 percentage points per year, you might project future increases at a similar rate. On the other hand, if your rate has been stable over time, you might set a target that projects a small increase over time. If the rate has been fluctuating over time, you might look more closely at the data to ensure that the fluctuations are not an artifact of the data or the methods used to construct a rate. You might set an initial target that is an average of the recent rates, with slight increases in subsequent years. In future annual reports, you will be asked to comment on how your actual performance compares to the objective your state set for the year, as well as any quality-improvement activities that have helped or could help your state meet future objectives.

K. Other Comments on Measure:

Please use this section to provide any other comments on the measure, such as data limitations, plans to report on a measure in the future, or differences between performance measures reported here and those discussed in Section 9 of the CHIP state plan.
<table>
<thead>
<tr>
<th><strong>Objectives Related to Reducing the Number of Uninsured Children (Do not report data that was reported in Section IIA, Questions 2 and 3)</strong></th>
<th><strong>FFY 2016</strong></th>
<th><strong>FFY 2017</strong></th>
<th><strong>FFY 2018</strong></th>
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<tbody>
<tr>
<td><strong>Goal #1</strong> (Describe)</td>
<td><strong>Goal #1</strong> (Describe)</td>
<td><strong>Goal #1</strong> (Describe)</td>
<td>To Maintain or exceed the 8% of people that get disenrolled during the redetermination process by utilizing the MCO's monthly calls to NCU and Medicaid beneficiaries.</td>
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<tr>
<td><strong>Type of Goal:</strong></td>
<td><strong>Type of Goal:</strong></td>
<td><strong>Type of Goal:</strong></td>
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<td>[ ] New/revised. Explain:</td>
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<td><strong>Definition of Population Included in the Measure:</strong></td>
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<td>Definition of denominator:</td>
<td>Definition of denominator: Nevada maintains a single application process. The denominator is the average monthly redeterminations for both CHIP-NCU and Medicaid recipients.</td>
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<td>Definition of numerator:</td>
<td>Definition of numerator: Average monthly number of redeterminations that resulted in CHIP-NCU and Medicaid eligibility who remained enrolled.</td>
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### FFY 2016

**Additional notes on measure:**

**Explanation of Progress:**

How did your performance in 2016 compare with the Annual Performance Objective documented in your 2015 Annual Report?

What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?

Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.

Annual Performance Objective for FFY 2017:

Annual Performance Objective for FFY 2018:

Annual Performance Objective for FFY 2019:

**Explain how these objectives were set:**

**Other Comments on Measure:**

---

### FFY 2017

**Additional notes on measure:**

**Explanation of Progress:**

How did your performance in 2017 compare with the Annual Performance Objective documented in your 2016 Annual Report?

What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?

Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.

Annual Performance Objective for FFY 2017:

Annual Performance Objective for FFY 2018:

Annual Performance Objective for FFY 2019:

**Explain how these objectives were set:**

**Other Comments on Measure:**

---

### FFY 2018

**Additional notes/comments on measure:**

**Explanation of Progress:**

How did your performance in 2018 compare with the Annual Performance Objective documented in your 2017 Annual Report? In FFY 2017, Nevada reported a 90.6% and a slight decrease in FFY 2018 of 90.1%.

What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal? Nevada was slightly affected by the unknown factors of the CHIP reauthorization reported by media. Nevada has continued to assure CHIP program availability. Nevada has also started to increase their quality CHIP core set measures.

Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.

Annual Performance Objective for FFY 2017:

Annual Performance Objective for FFY 2018:

Annual Performance Objective for FFY 2019:

Annual Performance Objective for FFY 2020:

**Explain how these objectives were set:**

**Other Comments on Measure:**
Objectives Related to Reducing the Number of Uninsured Children (Do not report data that was reported in Section IIA, Questions 2 and 3) (Continued)

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<td>FFY 2016</td>
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<tr>
<td>Goal #2 (Describe)</td>
<td>Attain an enrollment baseline number that consists of unduplicated, uninsured children under age 19 lawfully residing and fall under the 5 year waiting period enrolled in a Medicaid program.</td>
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<td>Explain:</td>
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<td>Additional notes/comments on measure:</td>
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<td><strong>Explanation of Progress:</strong> How did your performance in 2016 compare with the Annual Performance Objective documented in your 2015 Annual Report?</td>
<td><strong>Explanation of Progress:</strong> How did your performance in 2017 compare with the Annual Performance Objective documented in your 2016 Annual Report?</td>
<td><strong>Explanation of Progress:</strong> How did your performance in 2018 compare with the Annual Performance Objective documented in your 2017 Annual Report? This is a new goal established due to Nevada passed Senate Bill 325, to insure the uninsured children under age 19, waiting the 5 year period.</td>
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<td>What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?</td>
<td>What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?</td>
<td>What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal? To decrease the number of uninsured, increase quality of health.</td>
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<td>Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data. Annual Performance Objective for FFY 2017:</td>
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**Objectives Related to Reducing the Number of Uninsured Children (Do not report data that was reported in Section IIA, Questions 2 and 3) (Continued)**

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## Objectives Related to CHIP Enrollment

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<td>In FFY 2017, Nevada increased by 11.3% and in FFY 2018 Nevada increased by 10.5%.</td>
<td>Nevada had a slight decrease and believe this is the result of an increase in employment opportunities, unknow factors of CHIP program.</td>
<td>Nevada DHCFP works collaboratively with Welfare (DWSS) to collect this data. Nevada had a slight decrease and believe this is the result of increase in employment opportunities, unknow factors of CHIP program.</td>
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<td><strong>Goal #2 (Describe)</strong></td>
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**Type of Goal:**
- ☐ New/revised. Explain:
- ☑ Continuing.
- ☐ Discontinued. Explain:

**Status of Data Reported:**
- ☐ Provisional. Explanation of Provisional Data:
- ☑ Final.

**Data Source:**
- ☐ Eligibility/Enrollment data.
- ☐ Survey data. Specify:
- ☐ Other. Specify:

**Definition of Population Included in the Measure:**
- Definition of denominator:
- Definition of numerator:

**Date Range:**
- From: (mm/yyyy) To: (mm/yyyy)

**Performance Measurement Data:**
- Described what is being measured:
  - Numerator:
  - Denominator:
  - Rate:

**Additional notes on measure:**

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**Goal #2 (Describe):**
Maintain or exceed application turn around time within agency process of the required Federal regulation of 45 days.

**Type of Goal:**
- ☐ New/revised. Explain:
- ☑ Continuing.
- ☑ Discontinued. Explain:

**Status of Data Reported:**
- ☐ Provisional. Explanation of Provisional Data:
- ☑ Final.

**Data Source:**
- ☐ Eligibility/Enrollment data.
- ☐ Survey data. Specify:
- ☐ Other. Specify:

**Definition of Population Included in the Measure:**
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**Date Range:**
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**Performance Measurement Data:**
- Described what is being measured:
  - Numerator:
  - Denominator:
  - Rate:

**Additional notes on measure:**
Calculation for this goal is a percentage as calculated above a rate.  
$119/12 = 9.917$ days
Under 10 days as an average turnaround time.
<table>
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<tr>
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<tbody>
<tr>
<td><strong>Explanation of Progress:</strong>&lt;br&gt;How did your performance in 2016 compare with the Annual Performance Objective documented in your 2015 Annual Report?</td>
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<tr>
<td>In FFY 2017 Nevada's turn around time was 12 and half days. For FFY 2018, Nevada's turn around time is an average slightly under 10 days.</td>
<td></td>
<td>The Nevada Welfare Division (DWSS) continues to refine their new application processing structure. The DWSS also maintains the additional eligibility workers for case processing.</td>
</tr>
<tr>
<td><strong>Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.</strong> Annual Performance Objective for FFY 2017: Annual Performance Objective for FFY 2018: Annual Performance Objective for FFY 2019:</td>
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**CHIP Annual Report Template – FFY 2018**
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<td><strong>Goal #3 (Describe)</strong></td>
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**Type of Goal:**
- [ ] New/revised. *Explain:*
- [ ] Continuing.
- [ ] Discontinued. *Explain:*

**Status of Data Reported:**
- [ ] Provisional. *Explanation of Provisional Data:*
- [ ] Final.
- [ ] Same data as reported in a previous year’s annual report. *Specify year of annual report in which data previously reported:*

**Data Source:**
- [ ] Eligibility/Enrollment data.
- [ ] Survey data. *Specify:*
- [ ] Other. *Specify:*

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**Additional notes on measure:**

**Other Performance Measurement Data:**  
*(If reporting with another methodology)*

Numerator: 402  
Denominator: 700  
Rate: 57.4  

Additional notes on measure: The MCO combined results divided by total provides rate of 57.4%
### Explanation of Progress:

How did your performance in 2016 compare with the Annual Performance Objective documented in your 2015 Annual Report?

What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?

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**Annual Performance Objective for FFY 2017:**
- Annual Performance Objective for FFY 2018:
- Annual Performance Objective for FFY 2019:

**Explain how these objectives were set:**

Other Comments on Measure:

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### FFY 2017

How did your performance in 2017 compare with the Annual Performance Objective documented in your 2016 Annual Report?

What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?

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**Annual Performance Objective for FFY 2018:**
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- Annual Performance Objective for FFY 2020:

**Explain how these objectives were set:**

Other Comments on Measure:

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### FFY 2018

How did your performance in 2018 compare with the Annual Performance Objective documented in your 2017 Annual Report? In FFY 2017, Nevada had a performance measure rate of 79.3%. In FFY 2018 Nevada experienced a significant decrease with a rate of $57.4. Nevada added a third managed care and removed dental services from managed care contract.

What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal? Nevada has recommended the managed care health plans focus on developing performance improvement projects surrounding access-related needs.

Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.

**Annual Performance Objective for FFY 2019:**
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**Explain how these objectives were set:**

Other Comments on Measure:
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<td>From: (mm/yyyy) To: (mm/yyyy)</td>
<td>From: (mm/yyyy) 10/2017 To: (mm/yyyy) 09/2018</td>
</tr>
</tbody>
</table>

**Nevada clarified provider type 20 and specialty code 139, and has added the increase by 2% each FFY to the continuous pediatric provider measure.**

**Measurement Specification:**
- HEDIS. Specify version of HEDIS® Version used:
- Other. Specify: Pediatric providers' that fall under PT20/specialty code 139 enrolled in each Federal Fiscal Year.

**Definition of Population Included in the Measure:**
- Denominator includes CHIP population only.
- Denominator includes CHIP and Medicaid (Title XIX). If denominator is a subset of the definition selected above, please further define the Denominator, please indicate the number of children excluded.
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<th><strong>FY 2018</strong></th>
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</thead>
</table>
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(If reporting with HEDIS/HEDIS-like methodology) | **HEDIS Performance Measurement Data:**  
(If reporting with HEDIS) | **HEDIS Performance Measurement Data:**  
(If reporting with HEDIS) |
| Numerator: | Numerator: | Numerator: |
| Denominator: | Denominator: | Denominator: |
| Rate: | Rate: | Rate: |
| **Deviations from Measure Specifications:**  
☐ Year of Data, Explain. | **Deviations from Measure Specifications:**  
☐ Year of Data, Explain. | **Deviations from Measure Specifications:**  
☐ Year of Data, Explain. |
| ☐ Data Source, Explain. | ☐ Data Source, Explain. | ☐ Data Source, Explain. |
| ☐ Denominator, Explain. | ☐ Denominator, Explain. | ☐ Denominator, Explain. |
| ☐ Other, Explain. | ☐ Other, Explain. | ☐ Other, Explain. |
| **Additional notes on measure:** | **Additional notes on measure:** | **Additional note/comments on measure:** |

**Other Performance Measurement Data:**  
(If reporting with another methodology)  
Numerator:  
Denominator:  
Rate:  
Additional notes on measure:  

**Other Performance Measurement Data:**  
(If reporting with another methodology)  
Numerator:  
Denominator:  
Rate:  
Additional notes on measure:  

**Other Performance Measurement Data:**  
(If reporting with another methodology)  
Numerator: 1182  
Denominator: 1124  
Rate: 5.1  
Additional notes on measure: This goal is to measure the number of Pediatric providers for Nevada Medicaid and CHIP enrolled members.
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<tbody>
<tr>
<td><strong>Explanation of Progress:</strong></td>
<td><strong>Explanation of Progress:</strong></td>
<td><strong>Explanation of Progress:</strong></td>
</tr>
</tbody>
</table>
In FFY 2017 Nevada had a rate of 11.8%. In FFY 2018, Nevada has a rate of 5.1% increase. Achieving the goal to increase Pediatric providers each FFY by 2%. |
| What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal? | What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal? | What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?  
Managed care health plans and Nevada's Fiscal Agent work collaboratively to enroll additional Pediatric providers and outreach for specialty provider in the pediatric field. |
| Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.  
Annual Performance Objective for FFY 2017:  
Annual Performance Objective for FFY 2018:  
Annual Performance Objective for FFY 2019: | Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.  
Annual Performance Objective for FFY 2018:  
Annual Performance Objective for FFY 2019:  
Annual Performance Objective for FFY 2020: | Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.  
Annual Performance Objective for FFY 2019:  
CMS/CMCS can continue to support and assist by providing other state initiatives on maintaining/increase Pediatric provider enrollment.  
Annual Performance Objective for FFY 2020:  
CMS/CMCS can continue to support and assist by providing other state initiatives on maintaining/increase Pediatric provider enrollment.  
Annual Performance Objective for FFY 2021:  
CMS/CMCS can continue to support and assist by providing other state initiatives on maintaining/increase Pediatric provider enrollment.  
Webinars on increase in Pediatric providers align with the increase of quality measures. |

**Explain how these objectives were set:**

**Other Comments on Measure:**

**Explain how these objectives were set:**

**Other Comments on Measure:**

**Explain how these objectives were set:**

**Other Comments on Measure:**

CHIP Annual Report Template – FFY 2018
### Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need) (Continued)

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**Goal #3 (Describe)**

To maintain or increase the use of Telemedicine used by Medicaid and CHIP enrollees by 5% each Federal Fiscal Year (FFY).
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<thead>
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<th>FFY 2017</th>
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<tbody>
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Additional notes on measure:

Other Performance Measurement Data:

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<td>Rate:</td>
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</table>

Additional notes on measure:

Explanation of Progress:

How did your performance in 2016 compare with the Annual Performance Objective documented in your 2015 Annual Report?

What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?

How did your performance in 2017 compare with the Annual Performance Objective documented in your 2016 Annual Report?

What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?

How did your performance in 2018 compare with the Annual Performance Objective documented in your 2017 Annual Report? In FFY 2017 Nevada had a 27% count increase of use from FFY 2016. In FFY 2018, Nevada increased to a 76% increase of use.

What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal? Nevada developed training and education via provider webinars. Training tools were posted via the DHCFP website and with states Fiscal Agent.

Additional notes/comments on measure:

Other Performance Measurement Data:

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Additional notes on measure: FFY 2017 count was adjusted to reflect an actual count with variation from count of use not included in the reporting time of data pull in FFY 2017 CHIP report. (11,050) to (11247).
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**Explain how these objectives were set:**

**Other Comments on Measure:**
Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)

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- **Other, Explain.**

### Additional notes on measure:

### Other Performance Measurement Data:
(If reporting with another methodology)
- **Numerator:**
- **Denominator:**
- **Rate:**

### Explanation of Progress:
- **How did your performance in 2016 compare with the Annual Performance Objective documented in your 2015 Annual Report?**
- **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**

### Additional notes on measure:

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- **Numerator:**
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- **Rate:**

### Explanation of Progress:
- **How did your performance in 2017 compare with the Annual Performance Objective documented in your 2016 Annual Report?**
- **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?**

### Additional notes on measure:

### Other Performance Measurement Data:
(If reporting with another methodology)
- **Numerator:**
- **Denominator:**
- **Rate:**

### Explanation of Progress:
- **How did your performance in 2018 compare with the Annual Performance Objective documented in your 2017 Annual Report?** In FFY 2017 Nevada's achieved rate was 9.02%. In FFY 2018 Nevada increased their counseling for nutrition rate of 13.3%.
- **What quality improvement activities that involve the CHIP program and benefit CHIP enrollees help enhance your ability to report on this measure, improve your results for this measure, or make progress toward your goal?** The managed care health plans worked with the state to develop a focus on the WCC HEDIS measure. Managed care health plan offers nutrition workshops for Medicaid and CHIP enrollees and with pediatric services on nutrition focused initiatives.
Please indicate how CMS might be of assistance in improving the completeness or accuracy of your reporting of the data.

Annual Performance Objective for FFY 2017:
Annual Performance Objective for FFY 2018:
Annual Performance Objective for FFY 2019:

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Annual Performance Objective for FFY 2020:

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Annual Performance Objective for FFY 2019:
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Annual Performance Objective for FFY 2020:
CMS/CMCS can continue to support and assist by providing other state initiatives on maintaining/increase counseling for nutrition.
Annual Performance Objective for FFY 2021:
*Explain how these objectives were set:* These objectives were in line with Quality measures but not reported in MACPro.

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*Explain how these objectives were set:*
### Objectives Related to Use of Preventative Care (Immunizations, Well Child Care) (Continued)

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1. What other strategies does your state use to measure and report on access to, quality, or outcomes of care received by your CHIP population? What have you found? [7500]

The DHCFP continues to adopt a multidisciplinary approach to developing, reviewing, and revising the Quality Strategy. The approach involves the public, provider stakeholders, recipient advocates, and outside partners who have a direct concern for—and impact on—access, quality of care, and quality of service. All stakeholders have the opportunity to comment on the development of quality goals and objectives highlighted in the Quality Strategy.

The methods employed by the DHCFP to achieve these goals include:

Developing and maintaining collaborative strategies among State agencies and external partners to improve health education and health outcomes, manage vulnerable and at-risk members, and improve access to services for all Nevada Medicaid and Nevada Check Up recipients.

Using additional performance measures, performance improvement projects, contract compliance monitoring, and emerging practice activities to drive improvement in member health care outcomes.

Strengthening evidence-based prevention, wellness, and health management initiatives to improve members’ health status and achievement of personal health goals.

Enhancing member services and member satisfaction with services.

Improving health information technology to ensure that information retrieval and reporting are timely, accurate, and complete.

Working collaboratively with other Department of Health divisions and community resources to improve access to and quality of care and health outcomes of the populations served by Medicaid.

The DHCFP uses HEDIS data whenever possible to measure the MCOs’ performance with specific guides of quality, timeliness, and access to care. The DHCFP’s EQRO conducts HEDIS compliance audits of the MCOs on an annual basis and reports the HEDIS results to DHCFP as well as to NCQA. As part of the EQR Annual Technical Report, the EQRO performs a comparison of the rates between the MCOs and also compares the individual health plan and aggregate rates with available Medicaid percentile data published by NCQA.

In addition, DHCFP continues to monitor access to care through enrollee and provider feedback and develop innovative ways to expand availability of services.

Findings for FFY 2018: Of the three areas most critical to external quality review as stated in the federal regulations—access to and timeliness and quality of care furnished by the MCOs—the MCOs demonstrated mixed results with performance measures that fell within all three domains. For two of the MCOs, the most notable differences in rates from baseline to the HEDIS 2018 was with the measure, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents. In SFY 2016–2017, this measure served as the foundation of one of the MCO’s required PIPs. The intervention strategies that each MCO employed to improve the rates associated with the previous year’s PIP, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, likely had residual beneficial effects that continued to affect the performance measure’s rates.

2. What strategies does your CHIP program have for future measurement and reporting on access to, quality, or outcomes of care received by your CHIP population? When will data be available? [7500]

DHCFP will report on the same set of measures listed above for the CHIP population as 2017, with additional CHIP goals not outlined in the MACPro CHIP core set measures. The CAHPS measures will follow the CAHPS 5.0H 2018 measurement year and specifications. The CAHPS survey includes Child Medicaid and CHIP Children with Chronic Conditions (CCC).

The DHCFP submitted the Access to Care Monitoring Review Plan (ACMRP) in 2016 and has continued to update the ACMRP for the Medicaid and CHIP-FFS population. The goal is to establish methods and procedures that will ensure the fee for service Medicaid beneficiaries can access services to at least the same extent as the general population in the same geographic area. Program changes and trend analysis will continue to guide ACMRP updates. The ACMRP revised version with outcomes is required to CMS every 3 years; September of 2019.

Nevada plans to increase the CHIP core set measures by 2024, reporting all 26 core set measures. Section 3003 of the Healthy Kids Act and section 50102 of the ACCESS Act extend federal funding for the Pediatric Quality Measures Program in order to support the Federal
regulation. Section 50102 of the ACCESS Act mandates reporting on the Child Core Set of measures beginning with the annual State report in FY 2024.

3. Have you conducted any focused quality studies on your CHIP population, e.g., adolescents, attention deficit disorder, substance abuse, special health care needs or other emerging health care needs? What have you found? [7500]

For FFY 2018, Nevada focused on the implementation of Senate Bill (SB) 325, approved during our FFY 2017 legislative session. The Children’s Health Insurance Program (CHIP)- Nevada Check Up State Plan, Section 4.1, Section 4.4.2, “Eligibility Standards and Methodology” and Section 5 “Outreach” were reviewed and approved by CMCS to update Nevada’s State Plan to reflect compliance with Centers for Medicare and Medicaid and CHIP Services requirements in Section 214 of Children’s Health Insurance Program Reauthorization Act (CHIPRA). The passage of SB 325 during the 2017 Nevada Legislative session changes reflect the provision of health coverage to otherwise eligible children without the five year waiting periods who are aliens lawfully residing in the United States. Nevada developed a new goal under the objectives related to reducing the number of uninsured children.

In March 2017, the State of Nevada, Purchasing Division, on behalf of the DHCFP, solicited responses from qualified vendors to provide risk-based capitated prepaid ambulatory health plan (PAHP) services designed in support of the Title XIX (Medicaid) and Title XXI Child Health Insurance Program (CHIP, also known as “Nevada Check Up”) dental assistance programs. In response to request for proposal (RFP) 3425, one PAHP was selected by the DHCFP to provide dental benefits administrator (DBA) services to Medicaid and CHIP-Nevada Check Up. The CHIP core set quality measure for dental services will be able to provide a full 12 month report in FFY 2019 for SFY 2018.

4. Please attach any additional studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your CHIP program’s performance. Please include any analyses or descriptions of any efforts designed to reduce the number of uncovered children in the state through a state health insurance connector program or support for innovative private health coverage initiatives. [7500]

1. 2018 EQR Technical Report (Including CAHPS and Performance Improvement Projects(PIP) reports)

The Nevada Quality Strategy Plan is currently updating their Quality Assessment and Performance Improvement Strategy (QAPIS) plan. Nevada updates their QAPIS plan every two years even though the requirement is every three years.

Enter any Narrative text related to Section IIB below. [7500]

In FFY 2018, Nevada worked with their EQRO to conduct a Fee for Servie (FFS) child Medicaid CAHPS survey. The CAHPS survey was supported through CMS Access to Care Monitoring Review plan (CMS-2328-FC). The CAHPS survey included child Medicaid FFS members and did not focus soley on CHIP population but Medicaid and CHIP in the rural areas.
Section III: Assessment of State Plan and Program Operation

Please reference and summarize attachments that are relevant to specific questions

Please note that the numbers in brackets, e.g., [7500] are character limits in the State Annual Report Template System (CARTS). You will not be able to enter responses with characters greater than the limit indicated in the brackets.

Section IIIA: Outreach

1. How have you redirected/changed your outreach strategies during the reporting period? [7500]

   Nevada continues to work directly with the Silver State Health Insurance Exchange’s (Exchange) outreach strategy and has not changed substantially during the reporting period. Outreach continues to be a critical component in the Exchange’s communications strategy; the Exchange has been in close contact with stakeholder groups statewide, and continues to expand and sharpen mechanisms to identify key influencers and community partnerships statewide in order to pursue cross promotional opportunities. This includes scheduling meetings with various non-profit organizations throughout the state and discovering ways we can cross promote each agency’s messaging and materials to educate consumers on the resources we provide.

   The Exchange carefully considers and strategizes outreach and event attendance opportunities to maximize exposure to potentially eligible consumers. The Exchange develops creative content and prints educational literature, aligned with Open Enrollment messaging. The Exchange is fortunate to have had various opportunities to provide email communications to all Chamber members as well as school district listservs. The Exchange works with The LV Metro Chamber, the Latin Chamber, Carson Valley Chamber, and Reno Sparks Chamber, to name a few. We also have made great inroads with Carson City School District, Washoe County School District, and areas of Clark County School District, as well as the Universities. This gives the Exchange a chance to provide messaging and updates on the Exchange to people we have not been able to communicate to in years past. These are just some examples of the inroads the Exchange has made with community partners statewide.

   Nevada’s Connecting to Kids grant finalized their awardee report. Throughout the grant period, implementation of an internal referral process within each organization was determined to be one of the most effective strategies. This strategy was utilized for both new enrollments and renewals. Each organization implemented this method based on internal program organization and is described as follows:

   At LSSN, case managers identified clients who needed to submit new enrollment and renewal applications and referred them to one of their CHWs. Once the CHW received a referral, they would schedule an office-based appointment to complete the application. At the Children’s Cabinet, their CHWs provided information on the NV-CKC Program by providing flyers during the parenting classes conducted at their sites. In addition, the Children’s Cabinet collaborated with all other programs offered at their sites, such as the Home Instruction for Parents of Preschool Youngsters (HIPPY) Program, the Children’s Health & Education Reinforced in Supportive Homes (CHERISH) Program, and other Youth and Family Programs to refer clients to the NV-CKC Program internally.

   At HOPES, the intake department and front desk staff have collaborated to filter their patients that qualify for Nevada Medicaid and NCU and help these clients to schedule an office-based appointment with their CHW.
2. What methods have you found most effective in reaching low-income, uninsured children (e.g., T.V., school outreach, word-of-mouth)? How have you measured effectiveness? [7500]

While the Exchange’s outreach is not tailored specifically towards low-income, uninsured children, the Exchange’s outreach and marketing is geared towards the parents and families of low-income, uninsured children. The Exchange’s advertising campaign and outreach strategies include images of children in print, TV, and social media advertising; and the Exchange utilizes school outreach, cross marketing through partner organizations (e.g., community centers and federally qualified health centers), and family-oriented events (e.g., family fairs, festivals, events) to promote Qualified Health Plans (QHPs) sold on the Exchange that can insure low-income, uninsured children and their families.

Again, while targeting low-income, uninsured children is not the primary focus of the Exchange, the Exchange can measure effectiveness through tracking enrollment numbers through publicly available post-open enrollment public reporting. Data on the Exchange’s under 18 year old population may be found here: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/2018_Open_Enrollment.html

The most cost-effective strategy in reaching low-income through Nevada’s Connecting to Kids was the establishment of a cohesive internal and external referral process was the most cost-effective strategy as it concurrently allowed for the greatest reach with the least amount of funding. Once each organization established an internal referral process, it did not require any additional resources to expand their reach within their organization as they were leveraging existing resources (other employees). Similarly, establishing a relationship with individuals or organizations who can refer eligible clients to the CKC program is a cost-effective strategy as it leverages other resources for no additional costs.

3. Which of the methods described in Question 2 would you consider a best practice(s)? [7500]

The most effective way to directly reach low-income, uninsured children for SSHX is through grassroots outreach and education as well as marketing through the school districts statewide, including attending and presenting at the Back to School Nights.

All organizations who participated in the Nevada Connecting to Kids for Care (NV-CKC) Program are planning on continuing their efforts for outreach and education if any additional funding becomes available in the future.

4. Is your state targeting outreach to specific populations (e.g., minorities, immigrants, and children living in rural areas)?

☐ Yes
☐ No

Have these efforts been successful, and how have you measured effectiveness? [7500]

In 2017, Nevada's Legislative session approved eligibility for Medicaid and CHIP enrollees that normally would not qualify based on not meeting the lawfully residing, under 19 and waiting the 5 year sit out period. Nevada developed and implemented policy, procedures and have tracked enrollment since the effective date of February 2018. a new goal was developed to monitor improvement in decreasing uninsured population in Nevada.

Nevada Health Link continues to expand its outreach presence by attending more off-season events than in years past.

5. What percentage of children below 200 percent of the federal poverty level (FPL) who are eligible for Medicaid or CHIP have been enrolled in those programs? [5] 97.9

(Identify the data source used). [7500]

Nevada used the most recent "Current Population Survey" U.S. Census Bureau, 2017 American Community Survey which estimates about 298,000 children under age 19 are at or below 200%
Federal Poverty Level (FPL). The combined Child Medicaid and CHIP monthly average enrollment at 304,117 represents 102% of the total population of children under 19 that are at or below 200% of the FPL. This number of enrollees include Nevada's CHIP and Medicaid programs that allow enrollment above 205% of FPL which also includes the 1950(c) Home and Community Based waiver (HCB). Nevada has been successful in enrolling low-income children into health care programs.

Enter any Narrative text related to Section IIIA below. [7500]

Based on DPBH Connecting Kids Project; Cumulative number of children enrolled or renewed, as a direct result of substantial interactive assistance given between the start of the grant through the final reporting period, July 1, 2016 to June 30, 2018: Newly enrolled-469, Renewed-252 and the total of 721.

**Section IIIB: Substitution of Coverage (Crowd-out)**

All states should answer the following questions. Please include percent calculations in your responses when applicable and requested.

1. Does your program require a child to be uninsured for a minimum amount of time prior to enrollment (waiting period)?
   - ☒ No
   - ☐ Yes
   - ☐ N/A

   If no, skip to question 5. If yes, answer questions 2-4:

2. How many months does your program require a child to be uninsured prior to enrollment?

3. To which groups (including FPL levels) does the period of uninsurance apply? [1000]

4. List all exemptions to imposing the period of uninsurance [1000]

5. Does your program match prospective enrollees to a database that details private insurance status?
   - ☒ No
   - ☐ Yes
   - ☐ N/A

6. If answered yes to question 5, what database? [1000]

7. What percent of individuals screened for CHIP eligibility cannot be enrolled because they have group health plan coverage? [5]
   
   a. Of those found to have had employer sponsored insurance and have been uninsured for only a portion of the state’s waiting period, what percent meet the state’s exemptions and federally required exemptions to the waiting period ((# individuals subject to the waiting period (# of individuals subject to the waiting period)*100)? [5]

8. Do you track the number of individuals who have access to private insurance?
   - ☐ Yes
   - ☒ No
9. If yes to question 8, what percent of individuals that enrolled in CHIP had access to private health insurance at the time of application during the last federal fiscal year \( \frac{(\# \text{ of individuals that had access to private health insurance})}{(\text{total \# of individuals enrolled in CHIP})} \times 100 \)? [5]

Enter any Narrative text related to Section IIIB below. [7500]

**Section IIIC: Eligibility**

This subsection should be completed by all states. Medicaid Expansion states should complete applicable responses and indicate those questions that are non-applicable with N/A.

**Section IIIC: Subpart A: Eligibility Renewal and Retention**

1. Do you have authority in your CHIP state plan to provide for presumptive eligibility, and have you implemented this?
   - [ ] Yes
   - [x] No

   If yes,
   a. What percent of children are presumptively enrolled in CHIP pending a full eligibility determination? [5]
   b. Of those children who are presumptively enrolled, what percent of those children are determined eligible and enrolled upon completion of the full eligibility determination? [5]

2. Select the measures from those below that your state employs to simplify an eligibility renewal and retain eligible children in CHIP.
   - [ ] Conducts follow-up with clients through caseworkers/outreach workers
   - [x] Sends renewal reminder notices to all families

   - How many notices are sent to the family prior to disenrolling the child from the program? [500]
     Two notifications are sent to the family prior to disenrollment.

   - At what intervals are reminder notices sent to families (e.g., how many weeks before the end of the current eligibility period is a follow-up letter sent if the renewal has not been received by the state?) [500]
     A redetermination packet is sent 6 days prior to the actual disenrollment effective date. A termination notice is sent 30 days prior to the closure date but information must be received 13 days prior to closure.

   - [x] Other, please explain: [500]
     Telephone calls are used to remind Managed Care Organization enrollees.

3. Which of the above strategies appear to be the most effective? Have you evaluated the effectiveness of any strategies? If so, please describe the evaluation, including data sources and methodology. [7500]

   The second notification mailed of case being closed connected to the managed care telephone reminders. Nevada has maintained and show an increase in redetermination submissions in line with the above activities.
Section IIIIC: Subpart B: Eligibility Data

Table 1. Data on Denials of Title XXI Coverage in FFY 2018

States are required to report on all questions (1, 1.a., 1.b., and 1.c) in FFY 2018. Please enter the data requested in the table below and the template will tabulate the requested percentages. If you are unable to provide data in this section due to the single streamlined application, please note this in the response to question 2.

<table>
<thead>
<tr>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Total number of denials of title XXI coverage</td>
</tr>
<tr>
<td>a. Total number of procedural denials</td>
</tr>
<tr>
<td>b. Total number of eligibility denials</td>
</tr>
<tr>
<td>i. Total number of applicants denied for title XXI and enrolled in title XIX</td>
</tr>
<tr>
<td>(Check here if there are no additional categories)</td>
</tr>
<tr>
<td>c. Total number of applicants denied for other reasons Please indicate:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>19859</td>
<td>100</td>
</tr>
</tbody>
</table>

2. Please describe any limitations or restrictions on the data used in this table:

   The DWSS does not track procedural and/or eligibility denials. Also, because the Division uses a single streamlined application to determine eligibility, the system does not recognize any application as just CHIP. The family would apply for family medical and 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.

Definitions:

1. The “the total number of denials of title XXI coverage” is defined as the total number of applicants that have had an eligibility decision made for title XXI and denied enrollment for title XXI in FFY 2018. This definition only includes denials for title XXI at the time of initial application (not redetermination).

   a. The “total number of procedural denials” is defined as the total number of applicants denied for title XXI procedural reasons in FFY 2018 (i.e., incomplete application, missing documentation, missing enrollment fee, etc.).

   b. The “total number of eligibility denials” is defined as the total number of applicants denied for title XXI eligibility reasons in FFY 2018 (i.e., income too high, income too low for title XXI referred for Medicaid eligibility determination/determined Medicaid eligible, obtained private coverage or if applicable, had access to private coverage during your state’s specified waiting period, etc.)

   i. The total number of applicants that are denied eligibility for title XXI and determined eligible for title XIX.

   c. The “total number of applicants denied for other reasons” is defined as any other type of denial that does not fall into 2a or 2b. Please check the box provided if there are no additional categories.
Table 2. Redetermination Status of Children

For tables 2a and 2b, reporting is required for FFY 2018.

Table 2a. Redetermination Status of Children Enrolled in Title XXI

Please enter the data requested in the table below in the “Number” column, and the template will automatically tabulate the percentages.

<table>
<thead>
<tr>
<th>Description</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Total number of children who are enrolled in title XXI and eligible to be redetermined</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>2. Total number of children screened for redetermination for title XXI</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>3. Total number of children retained in title XXI after the redetermination process</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Total number of children disenrolled from title XXI after the redetermination process</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>a. Total number of children disenrolled from title XXI for failure to comply with procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Total number of children disenrolled from title XXI for failure to meet eligibility criteria</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>i. Disenrolled from title XXI because income too high for title XXI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(If unable to provide the data, check here)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ii. Disenrolled from title XXI because income too low for title XXI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(If unable to provide the data, check here)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>iii. Disenrolled from title XXI because application indicated access to private coverage or obtained private coverage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(If unable to provide the data or if you have a title XXI Medicaid Expansion and this data is not relevant check here)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>iv. Disenrolled from title XXI for other eligibility reason(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Please indicate:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(If unable to provide the data check here)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Total number of children disenrolled from title XXI for other reason(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Please indicate:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Check here if there are no additional categories)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. If relevant, please describe any limitations or restrictions on the data entered into this table. Please describe any state policies or procedures that may have impacted the redetermination outcomes data [7500].

The DWSS does not have a system indicator that separate’s RD’s from initial applications.

Definitions:
1. The “total number of children who are eligible to be redetermined” is defined as the total number of children due to renew their eligibility in federal fiscal year (FFY) 2018, and did not age out (did not exceed the program’s maximum age requirement) of the program by or before redetermination. This total number may include those children who are eligible to renew prior to their 12 month eligibility redetermination anniversary date. This total must include ex parte redeterminations, the process when a state uses information available to it through other databases, such as wage and labor records, to verify ongoing eligibility. This total number must also include children whose eligibility can be renewed through administrative redeterminations, whereby the state sends the family a renewal form that is pre-populated with eligibility information already available through program records and requires the family to report any changes.
2. The “total number of children screened for redetermination” is defined as the total number of children that were screened by the state for redetermination in FFY 2018 (i.e., ex parte redeterminations and administrative redeterminations, as well as those children whose families have returned redetermination forms to the state).

3. The “total number of children retained after the redetermination process” is defined as the total number of children who were found eligible and remained in the program after the redetermination process in FFY 2018.

4. The “total number of children disenrolled from title XXI after the redetermination process” is defined as the total number of children who are disenrolled from title XXI following the redetermination process in FFY 2018. This includes those children that states may define as “transferred” to Medicaid for title XIX eligibility screening.
   a. The “total number of children disenrolled for failure to comply with procedures” is defined as the total number of children disenrolled from title XXI for failure to successfully complete the redetermination process in FFY 2018 (i.e., families that failed to submit a complete application, failed to provide complete documentation, failed to pay premium or enrollment fee, etc.).
   b. The “total number of children disenrolled for failure to meet eligibility criteria” is defined as the total number of children disenrolled from title XXI for no longer meeting one or more of their state’s CHIP eligibility criteria (i.e., income too low, income too high, obtained private coverage or if applicable, had access to private coverage during your state’s specified waiting period, etc.). If possible, please break out the reasons for failure to meet eligibility criteria in i.-iv.
   c. The “total number of children disenrolled for other reason(s)” is defined as the total number of children disenrolled from title XXI for a reason other than failure to comply with procedures or failure to meet eligibility criteria, and are not already captured in 4.a. or 4.b.

The data entered in 4.a., 4.b., and 4.c. should sum to the total number of children disenrolled from title XXI (line 4).

Table 2b. Redetermination Status of Children Enrolled in Title XIX.

Please enter the data requested in the table below in the “Number” column, and the template will automatically tabulate the percentages.

<table>
<thead>
<tr>
<th>Description</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Total number of children who are enrolled in title XIX and eligible to be</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>redetermined</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Total number of children screened for redetermination for title XIX</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>3. Total number of children retained in title XIX after the redetermination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>process</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Total number of children disenrolled from title XIX after the redetermination</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>process</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Total number of children disenrolled from title XIX for failure to comply</td>
<td></td>
<td></td>
</tr>
<tr>
<td>with procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Total number of children disenrolled from title XIX for failure to meet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>eligibility criteria</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>i. Disenrolled from title XIX because income too high for title XIX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(If unable to provide the data, check here)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ii. Disenrolled from title XIX for other eligibility reason(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Please indicate:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(If unable to provide the data check here)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Total number of children disenrolled from title XIX for other reason(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Please indicate:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Check here if there are no additional categories)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. If relevant, please describe any limitations or restrictions on the data entered into this table. Please describe any state policies or procedures that may have impacted the redetermination outcomes data [7500].

The DWSS does not have a system indicator that separate’s RD’s from initial applications.

Definitions:
1. The “total number of children who are eligible to be redetermined” is defined as the total number of children due to renew their eligibility in federal fiscal year (FFY) 2018, and did not age out (did not exceed the program’s maximum age requirement) of the program by or before redetermination. This total number may include those children...
who are eligible to renew prior to their 12 month eligibility redetermination anniversary date. This total must include ex parte redeterminations, the process when a state uses information available to it through other databases, such as wage and labor records, to verify ongoing eligibility. This total number must also include children whose eligibility can be renewed through administrative redeterminations, whereby the state sends the family a renewal form that is pre-populated with eligibility information already available through program records and requires the family to report any changes.

2. The “total number of children screened for redetermination” is defined as the total number of children that were screened by the state for redetermination in FFY 2018 (i.e., ex parte redeterminations and administrative redeterminations, as well as those children whose families have returned redetermination forms to the state).

3. The “total number of children retained after the redetermination process” is defined as the total number of children who were found eligible and remained in the program after the redetermination process in FFY 2018.

4. The “total number of children disenrolled from title XIX after the redetermination process” is defined as the total number of children who are disenrolled from title XIX following the redetermination process in FFY 2018. This includes those children that states may define as “transferred” to CHIP for title XXI eligibility screening.
   a. The “total number of children disenrolled for failure to comply with procedures” is defined as the total number of children disenrolled from title XIX for failure to successfully complete the redetermination process in FFY 2018 (i.e., families that failed to submit a complete application, failed to provide complete documentation, failed to pay premium or enrollment fee, etc.).
   b. The “total number of children disenrolled for failure to meet eligibility criteria” is defined as the total number of children disenrolled from title XIX for no longer meeting one or more of their state’s Medicaid eligibility criteria (i.e., income too high, etc.).
   c. The “total number of children disenrolled for other reason(s)” is defined as the total number of children disenrolled from title XIX for a reason other than failure to comply with procedures or failure to meet eligibility criteria, and are not already captured in 4.a. or 4.b.

The data entered in 4.a., 4.b., and 4.c. should sum to the total number of children disenrolled from title XIX (line 4).
Table 3. Duration Measure of Selected Children, Ages 0-16, Enrolled in Title XIX and Title XXI, Second Quarter FFY 2018

The purpose of tables 3a and 3b is to measure the duration, or continuity, of Medicaid and CHIP enrollees’ coverage. This information is required by Section 402(a) of CHIPRA. **Reporting on this table is required.**

Because the measure is designed to capture continuity of coverage in title XIX and title XXI beyond one year of enrollment, the measure collects data for 18 months of enrollment. This means that reporting spans two CARTS reports over two years. The duration measure uses a cohort of children and follows the enrollment of the same cohort of children for 18 months to measure continuity of coverage. **States identify a new cohort of children every two years. States identify newly enrolled children in the second quarter of FFY 2018 (January, February, and March of 2018) for the FFY 2018 CARTS report. This same cohort of children will be reported on in the FFY 2019 CARTS report for the 12 and 18 month status of children newly identified in quarter 2 of FFY 2018.** If your eligibility system already has the capability to track a cohort of enrollees over time, an additional “flag” or unique identifier may not be necessary.

The FFY 2018 CARTS report is the first year of reporting in the cycle of two CARTS reports on the cohort of children identified in the second quarter of FFY 2018. For the FFY 2018 report, States will only report on lines 1-4a of the tables. States will continue to report on the same table in the FFY 2019 CARTS report. In the FFY 2019 report, no updates will be made to lines 1-4a. For the FFY 2019 report, data will be added to lines 5-10a. The next cohort of children will be identified in the second quarter of the FFY 2020 (January, February and March of 2020).

**Instructions:** For this measure, please identify newly enrolled children in both title XIX (for Table 3a) and title XXI (for Table 3b) in the second quarter of FFY 2018, ages 0 months to 16 years at time of enrollment. Children enrolled in January 2018 must have birthdates after July 2001 (e.g., children must be younger than 16 years and 5 months) to ensure that they will not age out of the program at the 18th month of coverage. Similarly, children enrolled in February 2018 must have birthdates after August 2001, and children enrolled in March 2018 must have birthdates after September 2001. Each child newly enrolled during this time frame needs a unique identifier or “flag” so that the cohort can be tracked over time. If your eligibility system already has the capability to track a cohort of enrollees over time, an additional “flag” or unique identifier may not be necessary. Please follow the child based on the child’s age category at the time of enrollment (e.g., the child’s age at enrollment creates an age cohort that does not change over the 18 month time span).

Please enter the data requested in the tables below, and the template will tabulate the percentages. In the FFY 2018 report you will only enter data on line 1 about the total children newly enrolled, and lines 2-4a related to the 6-month enrollment status of children identified on line 1. Line 1 should be populated with data on the children newly-enrolled in January, February, and March 2018. Lines 2-4a of the tables should also be populated with information about these same children 6 months later (as of June 2018 for children first identified as newly enrolled in January 2018, as of July 2018 for children identified as newly enrolled in February 2018, and as of August 2018 for children identified as newly enrolled in March 2018). Only enter a “0” (zero) if the data are known to be zero. If data are unknown or unavailable, leave the field blank.

**Note that all data must sum correctly in order to save and move to the next page.** The data in each individual row must add across to sum to the total in the “All Children Ages 0-16” column for that row. And in each column, the data within each time period (6, 12 and 18 months) must each sum up to the data in row 1, which is the number of children in the cohort. This means that in each column, rows 2, 3 and 4 must sum to the total in row 1; rows 5, 6 and 7 must sum to the row 1; and rows 8, 9 and 10 must sum to row 1. These tables track a child’s enrollment status over time, so for data reported at each milestone (6, 12, and 18 months), there should always be the same total number of children accounted for. That is, regardless of how the enrollment numbers are distributed between line 2-10 in the continuously enrolled, break in coverage but re-enrolled, and disenrolled categories and across the age category columns at each time period, the total number of children accounted for in each time period should add up to the number in line 1, column 2 “All Children Ages 0-16.”
Rows numbered with an “a” (e.g., rows 3a and 4a) are excluded from the totals because they are subsets of their respective rows. The system will not move to the next section of the report until all applicable sections of the table for the reporting year are complete and sum correctly to line 1.

Table 3 a. Duration Measure of Children Enrolled in Title XIX

☐ Not Previously Enrolled in CHIP or Medicaid—“Newly enrolled” is defined as not enrolled in either title XXI or title XIX in the month before enrollment (i.e., for a child enrolled in January 2018, he/she would not be enrolled in either title XXI or title XIX in December 2017, etc.)

☐ Not Previously Enrolled in Medicaid—“Newly enrolled” is defined as not enrolled in title XIX in the month before enrollment (i.e., for a child enrolled in January 2018, he/she would not be enrolled in title XIX in December 2017, etc.)

<table>
<thead>
<tr>
<th>Table 3a. Duration Measure, Title XIX</th>
<th>All Children Ages 0-16</th>
<th>Age Less than 12 months</th>
<th>Ages 1-5</th>
<th>Ages 6-12</th>
<th>Ages 13-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of children newly enrolled in title XIX in the second quarter of FFY 2018</td>
<td>18224</td>
<td>100%</td>
<td>629</td>
<td>100%</td>
<td>6617</td>
</tr>
<tr>
<td>Enrollment status 6 months later</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total number of children continuously enrolled in title XIX</td>
<td>16253</td>
<td>89.18</td>
<td>548</td>
<td>87.12</td>
<td>5916</td>
</tr>
<tr>
<td>Total number of children with a break in title XIX coverage but re-enrolled in title XIX</td>
<td>375</td>
<td>2.06</td>
<td>15</td>
<td>2.38</td>
<td>116</td>
</tr>
<tr>
<td>3.a. Total number of children enrolled in CHIP (title XXI) during title XIX coverage break (If unable to provide the data, check here ☐)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total number of children disenrolled from title XIX</td>
<td>1596</td>
<td>8.76</td>
<td>66</td>
<td>10.49</td>
<td>585</td>
</tr>
<tr>
<td>4.a. Total number of children enrolled in CHIP (title XXI) after being disenrolled from title XIX (If unable to provide the data, check here ☐)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enrollment status 12 months later</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total number of children continuously enrolled in title XIX</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total number of children with a break in title XIX coverage but re-enrolled in title XIX</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.a. Total number of children enrolled in CHIP (title XXI) during title XIX coverage break (If unable to provide the data, check here ☐)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total number of children disenrolled from title XIX</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.a. Total number of children enrolled in CHIP (title XXI) after being disenrolled from title XIX (If unable to provide the data, check here ☐)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Table 3a. Duration Measure, Title XIX

<table>
<thead>
<tr>
<th>Enrollment status 18 months later</th>
<th>All Children Ages 0-16</th>
<th>Age Less than 12 months</th>
<th>Ages 1-5</th>
<th>Ages 6-12</th>
<th>Ages 13-16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
</tr>
</tbody>
</table>

8. Total number of children continuously enrolled in title XIX

9. Total number of children with a break in title XIX coverage but re-enrolled in title XIX
   9.a. Total number of children enrolled in CHIP (title XXI) during title XIX coverage break
   (If unable to provide the data, check here ☐)

10. Total number of children disenrolled from title XIX

10.a. Total number of children enrolled in CHIP (title XXI) after being disenrolled from title XIX
   (If unable to provide the data, check here ☐)

---

### Definitions:

1. The “total number of children newly enrolled in title XIX in the second quarter of FFY 2018” is defined as those children either new to public coverage or new to title XIX, in the month before enrollment. Please define your population of “newly enrolled” in the Instructions section.

2. The total number of children that were continuously enrolled in title XIX for 6 months is defined as the sum of:
   - the number of children with birthdates after July 2001, who were newly enrolled in January 2018 and who were continuously enrolled through the end of June 2018
   + the number of children with birthdates after August 2001, who were newly enrolled in February 2018 and who were continuously enrolled through the end of July 2018
   + the number of children with birthdates after September 2001, who were newly enrolled in March 2018 and who were continuously enrolled through the end of August 2018

3. The total number who had a break in title XIX coverage during 6 months of enrollment (regardless of the number of breaks in coverage) but were re-enrolled in title XIX by the end of the 6 months, is defined as the sum of:
   - the number of children with birthdates after July 2001, who were newly enrolled in January 2018 and who disenrolled and re-enrolled in title XIX by the end of June 2018
   + the number of children with birthdates after August 2001, who were newly enrolled in February 2018 and who disenrolled and re-enrolled in title XIX by the end of July 2018
   + the number of children with birthdates after September 2001, who were newly enrolled in March 2018 and who disenrolled and re-enrolled in title XIX by the end of August 2018
   3.a. From the population in #3, provide the total number of children who were enrolled in title XXI during their break in coverage.

4. The total number who disenrolled from title XIX, 6 months after their enrollment month is defined as the sum of:
   - the number of children with birthdates after July 2001, who were newly enrolled in January 2018 and were disenrolled by the end of June 2018
   + the number of children with birthdates after August 2001, who were newly enrolled in February 2018 and were disenrolled by the end of July 2018
   + the number of children with birthdates after September 2001, who were newly enrolled in March 2018 and were disenrolled by the end of August 2018
   4.a. From the population in #4, provide the total number of children who were enrolled in title XXI in the month after their disenrollment from title XIX.

5. The total number of children who were continuously enrolled in title XIX for 12 months is defined as the sum of:
   - the number of children with birthdates after July 2001, who were newly enrolled in January 2018 and were continuously enrolled through the end of December 2018
   + the number of children with birthdates after August 2001, who were newly enrolled in February 2018 and were continuously enrolled through the end of January 2019
   + the number of children with birthdates after September 2001, who were newly enrolled in March 2018 and were continuously enrolled through the end of February 2019
6. The total number of children who had a break in title XIX coverage during 12 months of enrollment (regardless of the number of breaks in coverage), but were re-enrolled in title XIX by the end of the 12 months, is defined as the sum of:
   - the number of children with birthdates after July 2001, who were newly enrolled in January 2018 and who disenrolled and then re-enrolled in title XIX by the end of December 2018
   + the number of children with birthdates after August 2001, who were newly enrolled in February 2018 and who disenrolled and then re-enrolled in title XIX by the end of January 2019
   + the number of children with birthdates after September 2001 who were newly enrolled in March 2018 and who disenrolled and then re-enrolled in title XIX by the end of February 2019
   6.a. From the population in #6, provide the total number of children who were enrolled in title XXI during their break in coverage.

7. The total number of children who disenrolled from title XIX 12 months after their enrollment month is defined as the sum of:
   - the number of children with birthdates after July 2001, who were enrolled in January 2018 and were disenrolled by the end of December 2018
   + the number of children with birthdates after August 2001, who were enrolled in February 2018 and were disenrolled by the end of January 2019
   + the number of children with birthdates after September 2001, who were enrolled in March 2018 and were disenrolled by the end of February 2019
   7.a. From the population in #7, provide the total number of children, who were enrolled in title XXI in the month after their disenrollment from title XIX.

8. The total number of children who were continuously enrolled in title XIX for 18 months is defined as the sum of:
   - the number of children with birthdates after July 2001, who were newly enrolled in January 2018 and were continuously enrolled through the end of June 2019
   + the number of children with birthdates after August 2001, who were newly enrolled in February 2018 and were continuously enrolled through the end of July 2019
   + the number of children with birthdates after September 2001, who were newly enrolled in March 2018 and were continuously enrolled through the end of August 2019
   8.a. From the population in #8, provide the total number of children who were enrolled in title XIX during their 18 months of enrollment (regardless of the number of breaks in coverage), but were re-enrolled in title XIX by the end of the 18 months.

9. The total number of children who had a break in title XIX coverage during 18 months of enrollment (regardless of the number of breaks in coverage), but were re-enrolled in title XIX by the end of the 18 months, is defined as the sum of:
   - the number of children with birthdates after July 2001, who were newly enrolled in January 2018 and who disenrolled and re-enrolled in title XIX by the end of June 2019
   + the number of children with birthdates after August 2001, who were newly enrolled in February 2018 and who disenrolled and re-enrolled in title XIX by the end of July 2019
   + the number of children with birthdates after September 2001, who were newly enrolled in March 2018 and who disenrolled and re-enrolled in title XIX by the end of August 2019
   9.a. From the population in #9, provide the total number of children who were enrolled in title XXI during their break in coverage.

10. The total number of children who were disenrolled from title XIX 18 months after their enrollment month is defined as the sum of:
    - the number of children with birthdates after July 2001, who were newly enrolled in January 2018 and were disenrolled by the end of December 2018
    + the number of children with birthdates after August 2001, who were newly enrolled in February 2018 and were disenrolled by the end of January 2019
    + the number of children with birthdates after September 2001, who were newly enrolled in March 2018 and were disenrolled by the end of February 2019
    10.a. From the population in #10, provide the total number of children who were enrolled in title XXI (CHIP) in the month after their disenrollment from XIX.

Table 3b. Duration Measure of Children Enrolled in Title XXI

Specify how your “newly enrolled” population is defined:

☐ Not Previously Enrolled in CHIP or Medicaid—“Newly enrolled” is defined as not enrolled in either title XXI or title XIX in the month before enrollment (i.e., for a child enrolled in January 2018, he/she would not be enrolled in either title XXI or title XIX in December 2017, etc.)

☐ Not Previously Enrolled in CHIP—“Newly enrolled” is defined as not enrolled in title XXI in the month before enrollment (i.e., for a child enrolled in January 2018, he/she would not be enrolled in title XXI in December 2017, etc.)

<table>
<thead>
<tr>
<th>Table 3b. Duration Measure, Title XXI</th>
<th>All Children Ages 0-16</th>
<th>Age Less than 12 months</th>
<th>Ages 1-5</th>
<th>Ages 6-12</th>
<th>Ages 13-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Total number of children newly enrolled in title XXI in the second quarter of FFY 2018</td>
<td>8688  100%</td>
<td>109  100%</td>
<td>2106  100%</td>
<td>4641  100%</td>
<td>1832  100%</td>
</tr>
</tbody>
</table>

CHIP Annual Report Template – FFY 2018 66
### Table 3b. Duration Measure, Title XXI

<table>
<thead>
<tr>
<th>Enrollment status 6 months later</th>
<th>All Children Ages 0-16</th>
<th>Age Less than 12 months</th>
<th>Ages 1-5</th>
<th>Ages 6-12</th>
<th>Ages 13-16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
</tr>
<tr>
<td>2. Total number of children continuously enrolled in title XXI</td>
<td>4888</td>
<td>56.26</td>
<td>58</td>
<td>53.21</td>
<td>1144</td>
</tr>
<tr>
<td>3. Total number of children with a break in title XXI coverage but re-enrolled in title XXI</td>
<td>315</td>
<td>3.63</td>
<td>6</td>
<td>5.5</td>
<td>78</td>
</tr>
<tr>
<td>3.a. Total number of children enrolled in Medicaid (title XIX) during title XXI coverage break</td>
<td>(If unable to provide the data, check here ☐)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Total number of children disenrolled from title XXI</td>
<td>3485</td>
<td>40.11</td>
<td>45</td>
<td>41.28</td>
<td>884</td>
</tr>
<tr>
<td>4.a. Total number of children enrolled in Medicaid (title XIX) after being disenrolled from title XXI</td>
<td>(If unable to provide the data, check here ☐)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Enrollment status 12 months later

<table>
<thead>
<tr>
<th>Enrollment status 12 months later</th>
<th>All Children Ages 0-16</th>
<th>Age Less than 12 months</th>
<th>Ages 1-5</th>
<th>Ages 6-12</th>
<th>Ages 13-16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
</tr>
<tr>
<td>5. Total number of children continuously enrolled in title XXI</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Total number of children with a break in title XXI coverage but re-enrolled in title XXI</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.a. Total number of children enrolled in Medicaid (title XIX) during title XXI coverage break</td>
<td>(If unable to provide the data, check here ☐)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Total number of children disenrolled from title XXI</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.a. Total number of children enrolled in Medicaid (title XIX) after being disenrolled from title XXI</td>
<td>(If unable to provide the data, check here ☐)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Enrollment status 18 months later

<table>
<thead>
<tr>
<th>Enrollment status 18 months later</th>
<th>All Children Ages 0-16</th>
<th>Age Less than 12 months</th>
<th>Ages 1-5</th>
<th>Ages 6-12</th>
<th>Ages 13-16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
<td>Percent</td>
<td>Number</td>
</tr>
<tr>
<td>8. Total number of children continuously enrolled in title XXI</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Total number of children with a break in title XXI coverage but re-enrolled in title XXI</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.a. Total number of children enrolled in Medicaid (title XIX) during title XXI coverage break</td>
<td>(If unable to provide the data, check here ☐)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Total number of children disenrolled from title XXI</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.a. Total number of children enrolled in Medicaid (title XIX) after being disenrolled from title XXI</td>
<td>(If unable to provide the data, check here ☐)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Definitions:

1. The “total number of children newly enrolled in title XXI in the second quarter of FFY 2018” is defined as those children either new to public coverage or new to title XXI, in the month before enrollment. Please define your population of “newly enrolled” in the Instructions section.
2. The total number of children that were continuously enrolled in title XXI for 6 months is defined as the sum of:
   the number of children with birthdates after July 2001, who were newly enrolled in January 2018 and who were continuously enrolled through the end of June 2018
   + the number of children with birthdates after August 2001, who were newly enrolled in February 2018 and who were continuously enrolled through the end of July 2018
   + the number of children with birthdates after September 2001, who were newly enrolled in March 2018 and who were continuously enrolled through the end of August 2018

3. The total number who had a break in title XXI coverage during 6 months of enrollment (regardless of the number of breaks in coverage) but were re-enrolled in title XXI by the end of the 6 months, is defined as the sum of:
   the number of children with birthdates after July 2001, who were newly enrolled in January 2018 and who disenrolled and re-enrolled in title XXI by the end of June 2018
   + the number of children with birthdates after August 2001, who were newly enrolled in February 2018 and who disenrolled and re-enrolled in title XXI by the end of July 2018
   + the number of children with birthdates after September 2001, who were newly enrolled in March 2018 and who disenrolled and re-enrolled in title XXI by the end of August 2018
   3.a. From the population in #3, provide the total number of children who were enrolled in title XIX during their break in coverage.

4. The total number who disenrolled from title XXI, 6 months after their enrollment month is defined as the sum of:
   the number of children with birthdates after July 2007, who were newly enrolled in January 2018 and were disenrolled by the end of June 2018
   + the number of children with birthdates after August 2001, who were newly enrolled in February 2018 and were disenrolled by the end of July 2018
   + the number of children with birthdates after September 2001, who were newly enrolled in March 2018 and were disenrolled by the end of August 2018
   4.a. From the population in #4, provide the total number of children who were enrolled in title XIX in the month after their disenrollment from title XXI.

5. The total number of children who were continuously enrolled in title XXI for 12 months is defined as the sum of:
   the number of children with birthdates after July 2001, who were newly enrolled in January 2018 and were continuously enrolled through the end of December 2018
   + the number of children with birthdates after August 2001, who were newly enrolled in February 2018 and were continuously enrolled through the end of January 2019
   + the number of children with birthdates after September 2001, who were newly enrolled in March 2018 and were continuously enrolled through the end of February 2019

6. The total number of children who had a break in title XXI coverage during 12 months of enrollment (regardless of the number of breaks in coverage), but were re-enrolled in title XXI by the end of the 12 months, is defined as the sum of:
   the number of children with birthdates after July 2001, who were newly enrolled in January 2018 and who disenrolled and then re-enrolled in title XXI by the end of December 2018
   + the number of children with birthdates after August 2001, who were newly enrolled in February 2018 and who disenrolled and then re-enrolled in title XXI by the end of January 2019
   + the number of children with birthdates after September 2001, who were newly enrolled in March 2018 and who disenrolled and then re-enrolled in title XXI by the end of February 2019
   6.a. From the population in #6, provide the total number of children who were enrolled in title XIX during their break in coverage.

7. The total number of children who disenrolled from title XXI 12 months after their enrollment month is defined as the sum of:
   the number of children with birthdates after July 2001, who were enrolled in January 2018 and were disenrolled by the end of December 2018
   + the number of children with birthdates after August 2001, who were enrolled in February 2018 and were disenrolled by the end of January 2019
   + the number of children with birthdates after September 2001, who were enrolled in March 2018 and were disenrolled by the end of February 2019
   7.a. From the population in #7, provide the total number of children, who were enrolled in title XIX in the month after their disenrollment from title XXI.

8. The total number of children who were continuously enrolled in title XXI for 18 months is defined as the sum of:
   the number of children with birthdates after July 2001, who were newly enrolled in January 2018 and were continuously enrolled through the end of June 2019
   + the number of children with birthdates after August 2001, who were newly enrolled in February 2018 and were continuously enrolled through the end of July 2019
   + the number of children with birthdates after September 2001, who were newly enrolled in March 2018 and were continuously enrolled through the end of August 2019

9. The total number of children who had a break in title XXI coverage during 18 months of enrollment (regardless of the number of breaks in coverage), but were re-enrolled in title XXI by the end of the 18 months, is defined as the sum of:
   the number of children with birthdates after July 2001, who were newly enrolled in January 2018 and who disenrolled and re-enrolled in title XXI by the end of June 2019
   + the number of children with birthdates after August 2001, who were newly enrolled in February 2018 and who disenrolled and re-enrolled in title XXI by the end of July 2019
   + the number of children with birthdates after September 2001, who were newly enrolled in March 2018 and who disenrolled and re-enrolled in title XXI by the end of August 2019
   9.a. From the population in #9, provide the total number of children who were enrolled in title XIX during their break in coverage.
10. The total number of children who were disenrolled from title XXI 18 months after their enrollment month is defined as the sum of:
   the number of children with birthdates after July 2001, who were newly enrolled in January 2018 and disenrolled by the end of June 2019
   + the number of children with birthdates after August 2001, who were newly enrolled in February 2018 and disenrolled by the end of July 2019
   + the number of children with birthdates after September 2001, who were newly enrolled in March 2018 and disenrolled by the end of August 2019

10.a. From the population in #10, provide the total number of children who were enrolled in title XIX (Medicaid) in the month after their disenrollment from XXI.

Enter any Narrative text related to Section IIIC below. [7500]
Section III D: Cost Sharing

1. Describe how the state tracks cost sharing to ensure enrollees do not pay more than 5 percent aggregate maximum in the year?

   a. Cost sharing is tracked by:

   □ Enrollees (shoebox method)

   If the state uses the shoebox method, please describe informational tools provided to enrollees to track cost sharing. [7500]

   □ Health Plan(s)
   □ State
   □ Third Party Administrator
   □ N/A (No cost sharing required)
   □ Other, please explain. [7500]

   The cost sharing requirements are set at very low levels so it is extremely unlikely that families could approach the 5% cap. For a family of two at 150% of FPL, the 5% cap is $1,235 ($24,696X.05); the total NCU annual premium is $100. For a family of two at 175% FPL, the 5% cap is $1,544 ($30,876X.05); the total NCU annual premium is $200. For a family of two at 200% of FPL, the 5% cap is $1,687 ($33,744X.05); the total NCU annual premium is $320.

2. When the family reaches the 5% cap, are premiums, copayments and other cost sharing ceased?
   □ Yes
   □ No

3. Please describe how providers are notified that no cost sharing should be charged to enrollees exceeding the 5% cap. [7500]

   Nevada’s plan only charges premiums, so the providers are not allowed to collect any payment from recipients as stated on the provided contract policies.

4. Please provide an estimate of the number of children that exceeded the 5 percent cap in the state’s CHIP program during the federal fiscal year. [500]

   0

5. Has your state undertaken any assessment of the effects of premiums/enrollment fees on participation in CHIP?

   □ Yes
   □ No If so, what have you found? [7500]

6. Has your state undertaken any assessment of the effects of cost sharing on utilization of health services in CHIP?

   □ Yes
   □ No If so, what have you found? [7500]
7. If your state has increased or decreased cost sharing in the past federal fiscal year, how is the state monitoring the impact of these changes on application, enrollment, disenrollment, and utilization of children’s health services in CHIP. If so, what have you found? [7500]

There are no changes to report.

Enter any Narrative text related to Section IIID below. [7500]

Section IIIE: Employer sponsored insurance Program (including Premium Assistance)

1. Does your state offer an employer sponsored insurance program (including a premium assistance program under the CHIP State Plan or a Section 1115 Title XXI Demonstration) for children and/or adults using Title XXI funds?
   - Yes, please answer questions below.
   - No, skip to Program Integrity subsection.

Children
   - Yes, Check all that apply and complete each question for each authority
     - Purchase of Family Coverage under the CHIP state plan (2105(c)(3))
     - Additional Premium Assistance Option under CHIP state plan (2105(c)(10))
     - Section 1115 Demonstration (Title XXI)

Adults
   - Yes, Check all that apply and complete each question for each authority.
     - Purchase of Family Coverage under the CHIP state plan (2105(c)(10))
     - Section 1115 demonstration (Title XXI)

2. Please indicate which adults your state covers with premium assistance. (Check all that apply.)
   - Parents and Caretaker Relatives
   - Pregnant Women

3. Briefly describe how your program operates (e.g., is your program an employer sponsored insurance program or a premium assistance program, how do you coordinate assistance between the state and/or employer, who receives the subsidy if a subsidy is provided, etc.) [7500]

4. What benefit package does the ESI program use? [7500]

5. Are there any minimum coverage requirements for the benefit package?
   - Yes
   - No
6. Does the program provide wrap-around coverage for benefits?
   - Yes
   - No

7. Are there limits on cost sharing for children in your ESI program?
   - Yes
   - No

8. Are there any limits on cost sharing for adults in your ESI program?
   - Yes
   - No

9. Are there protections on cost sharing for children (e.g., the 5 percent out-of-pocket maximum) in your premium assistance program?
   - Yes
   - No

   If yes, how is the cost sharing tracked to ensure it remains within the 5 percent yearly aggregate maximum [7500]? [7500]

10. Identify the total number of children and adults enrolled in the ESI program for whom Title XXI funds are used during the reporting period (provide the number of adults enrolled in this program even if they were covered incidentally, i.e., not explicitly covered through a demonstration).

   Number of childless adults ever-enrolled during the reporting period
   Number of adults ever-enrolled during the reporting period
   Number of children ever-enrolled during the reporting period

11. Provide the average monthly enrollment of children and parents ever enrolled in the premium assistance program during FFY 2018.

   Children
   Parents

12. During the reporting period, what has been the greatest challenge your ESI program has experienced? [7500]

13. During the reporting period, what accomplishments have been achieved in your ESI program? [7500]

14. What changes have you made or are planning to make in your ESI program during the next fiscal year? Please comment on why the changes are planned. [7500]

15. What do you estimate is the impact of your ESI program (including premium assistance) on enrollment and retention of children? How was this measured? [7500]
16. Provide the average amount each entity pays towards coverage of the dependent child/parent under your ESI program:

<table>
<thead>
<tr>
<th>Population</th>
<th>State</th>
<th>Employer</th>
<th>Employee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

17. Indicate the range in the average monthly dollar amount of premium assistance provided by the state on behalf of a child or parent.

<table>
<thead>
<tr>
<th></th>
<th>Low</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

18. If you offer a premium assistance program, what, if any, is the minimum employer contribution? [500]

19. Please provide the income levels of the children or families provided premium assistance.

<table>
<thead>
<tr>
<th>Income level of</th>
<th>From</th>
<th>To</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents</td>
<td>% of FPL [5]</td>
<td>% of FPL [5]</td>
</tr>
</tbody>
</table>

20. Is there a required period of uninsurance before enrolling in premium assistance?
   - [ ] Yes
   - [ ] No

   If yes, what is the period of uninsurance? [500]

21. Do you have a waiting list for your program?
   - [ ] Yes
   - [ ] No

22. Can you cap enrollment for your program?
   - [ ] Yes
   - [ ] No

23. What strategies has the state found to be effective in reducing administrative barriers to the provision of premium assistance in ESI? [7500]
Section IIIF: Program Integrity

COMPLETE ONLY WITH REGARD TO SEPARATE CHIP PROGRAMS, I.E., THOSE THAT ARE NOT MEDICAID EXPANSIONS)

1. Does your state have a written plan that has safeguards and establishes methods and procedures for:

   (1) prevention:
      ☑ Yes
      ☐ No

   (2) investigation:
      ☑ Yes
      ☐ No

   (3) referral of cases of fraud and abuse?
      ☑ Yes
      ☐ No

Please explain: [7500]

Prevention: The Provider Enrollment Unit (PEU) ensures 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 announced/unannounced site visits for moderate and high risk providers. The Fingerprint Based Criminal Background Checks (FCBC) requirement is currently being addressed with a CMS-approved July 1, 2017 implementation date. 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).

The Surveillance and Utilization Review (SUR) Unit educates providers on improper billing; makes referrals to the PEU for provider terminations; makes referrals to policy staff for policy changes or clarifications; and makes referrals to the Business Process Management Unit (BPMU) for claims processing edits.

Investigation: The Surveillance and Utilization Review (SUR) Unit reviews fee-for-service (FFS) claims and identifies, prevents, and recovers overpayments to providers due to fraud, waste, abuse, and improper payments. The SUR Unit 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.

Referral: The SUR Unit is the point of contact with the MFCU. Credible Allegation of Fraud (CAF) within the Nevada Medicaid and CHIP programs are referred first to the SUR Unit. Each MCO does their own preliminary investigation to ascertain whether it is a CAF, and makes the referral to the SUR Unit. All other allegations received by the SUR Unit are evaluated for a CAF by the SUR Unit. All CAFs are referred to the MFCU. The MFCU has conducted training with the SUR Unit and the Special Investigations Units (SIU) of each MCO regarding what they would like to see in a referral. The SUR Unit meets monthly with the MFCU, and the MFCU also participates in the quarterly PI meetings with the MCOs.
Do managed health care plans with which your program contracts have written plans?

☑ Yes
☐ No

Please Explain: [500]

Each MCO has an internal Special Investigations Unit (SIU) which works to identify fraud, waste, abuse and improper payments as they pertain to Nevada Medicaid and CHIP. Each MCO will be required to establish and maintain a distinct Program Integrity Unit (PIU) whose responsibilities will include the identification, review, recovery, and reporting of improper Medicaid and CHIP payments, including fraud, waste and abuse activities.

2. For the reporting period, please report the

219 Number of fair hearing appeals of eligibility denials
0 Number of cases found in favor of beneficiary

3. For the reporting period, please indicate the number of cases investigated, and cases referred, regarding fraud and abuse in the following areas:

Provider Credentialing
52 Number of cases investigated
6 Number of cases referred to appropriate law enforcement officials

Provider Billing
1728 Number of cases investigated
229 Number of cases referred to appropriate law enforcement officials

Beneficiary Eligibility
12 Number of cases investigated
0 Number of cases referred to appropriate law enforcement officials

Are these cases for:

CHIP ☐

Medicaid and CHIP Combined ☑

4. Does your state rely on contractors to perform the above functions?

☑ Yes, please answer question below.
☐ No

5. If your state relies on contractors to perform the above functions, how does your state provide oversight of those contractors? Please explain: [7500]

The SUR Unit has direct oversight of the Recovery Audit Contractor (RAC) vendor and CMS has direct oversight of the Medicaid Integrity Contractor (MIC). 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 overpayment recoveries. The SUR Unit holds monthly meetings with the MIC 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.
6. Do you contract with managed care health plans and/or a third party contractor to provide this oversight?

☑ Yes
☐ No

Please Explain: [500]

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. DHCFP oversight of MCO program integrity is one of the initiatives the DHCFP is looking forward to expanding once the new contracts go into effect July 1, 2017.

Enter any Narrative text related to Section IIIF below. [7500]

Nevada SUR unit consist of three main areas for review: Prevention, Investigation and Referral.
Section IIIG: Dental Benefits:

Please ONLY report data in this section for children in Separate CHIP programs and the Separate CHIP part of Combination programs. Reporting is required for all states with Separate CHIP programs and Combination programs. If your state has a Combination program or a Separate CHIP program but you are not reporting data in this section on children in the Separate CHIP part of your program, please explain why. Explain: [7500]

Data for this table are based on the definitions provided on the Early Periodic Screening, Diagnostic and Treatment (EPSDT) Report (Form CMS-416).

1. Information on Dental Care for Children in Separate CHIP Programs (including children in the Separate CHIP part of Combination programs). Include all delivery system types, e.g. MCO, PCCM, FFS.

Data for this table are based on the definitions provided on the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form CMS-416)

   a. Annual Dental Participation Table for Children Enrolled in Separate CHIP programs and the Separate CHIP part of Combination programs (for Separate CHIP programs, please include ONLY children receiving full CHIP benefits and supplemental benefits).

<table>
<thead>
<tr>
<th>FFY 2018</th>
<th>Total (All age groups)</th>
<th>&lt;1 year</th>
<th>1 – 2 years</th>
<th>3 – 5 years</th>
<th>6 – 9 years</th>
<th>10–14 years</th>
<th>15–18 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Individuals Enrolled for at Least 90 Continuous Days¹</td>
<td>38381</td>
<td>143</td>
<td>2155</td>
<td>4268</td>
<td>9995</td>
<td>13321</td>
<td>8499</td>
</tr>
<tr>
<td>Total Enrollees Receiving Any Dental Services² [7]</td>
<td>19077</td>
<td>3</td>
<td>557</td>
<td>1938</td>
<td>5579</td>
<td>7278</td>
<td>3722</td>
</tr>
<tr>
<td>Total Enrollees Receiving Preventive Dental Services³ [7]</td>
<td>18769</td>
<td>3</td>
<td>527</td>
<td>1894</td>
<td>5497</td>
<td>7209</td>
<td>3639</td>
</tr>
</tbody>
</table>

¹ Total Individuals Enrolled for at Least 90 Continuous Days – Enter the total unduplicated number of children who have been continuously enrolled in a separate CHIP program or the separate CHIP part of a combination program for at least 90 continuous days in the federal fiscal year, distributed by age. For example, if a child was enrolled January 1st to March 31st, this child is considered continuously enrolled for at least 90 continuous days in the federal fiscal year. If a child was enrolled from August 1st to September 30th and from October 1st to November 30th, the child would not be considered to have been enrolled for 90 continuous days in the federal fiscal year. Children should be counted in age groupings based on their age at the end of the fiscal year. For example, if a child turned 3 on September 15th, the child should be counted in the 3-6 age grouping.

² Total Enrollees Receiving Any Dental Services - Enter the unduplicated number of children enrolled in a separate CHIP program or the separate CHIP part of a combination program for at least 90 continuous days who received at least one dental service 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.

³ Total Enrollees Receiving Preventive Dental Services - Enter the unduplicated number of children enrolled in a separate CHIP program or the separate CHIP part of a combination program for at least 90 continuous days who received at least one preventive dental service by or under the supervision of a dentist as defined by HCPCS codes D1000 - D1999 or equivalent CDT codes D1000 - D1999 or equivalent CPT codes, that is, only those CPT codes that indicate preventive dental services.
b. For the age grouping that includes children 8 years of age, what is the number of such children who have received a sealant on at least one permanent molar tooth? [7]

1767

2. Does the state provide supplemental dental coverage?

☐ Yes
☐ No

If yes, how many children are enrolled? [7]

What percent of the total number of enrolled children have supplemental dental coverage? [5]

Enter any Narrative text related to Section IIIG below. [7500]

that are for preventive dental services and only if provided by or under the supervision of a dentist), based on an unduplicated paid, unpaid, or denied claim.

4 Total Enrollees Receiving Dental Treatment Services - Enter the unduplicated number of children enrolled in a separate CHIP program or the separate CHIP part of a combination program for at least 90 continuous days who received at least one treatment service 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 is, only those CPT codes that involve periodontics, maxillofacial prosthetics, implants, oral and maxillofacial surgery, orthodontics, adjunctive general services, and only if provided by or under the supervision of a dentist), based on an unduplicated paid, unpaid, or denied claim.

Report all dental services data in the age category reflecting the child’s age at the end of the federal fiscal year even if the child received services while in two age categories. For example, if a child turned 10 on September 1st, but had a cleaning in April and a cavity filled in September, both the cleaning and the filling would be counted in the 10-14 age category.

5 Receiving a Sealant on a Permanent Molar Tooth -- Enter the unduplicated number of children enrolled in a separate CHIP program or the separate CHIP part of a combination program for 90 continuous days and in the age category of 6-9 who received a sealant on a permanent molar tooth, as defined by HCPCS code D1351 (or equivalent CDT code D1351), based on an unduplicated paid, unpaid, or denied claim. For this line, include sealants placed by any dental professional for whom placing a sealant is within his or her scope of practice. Permanent molars are teeth numbered 2, 3, 14, 15, 18, 19, 30, 31, and additionally, for those states that cover sealants on third molars, also known as wisdom teeth, the teeth numbered 1, 16, 17, 32.

Report all sealant data in the age category reflecting the child’s age at the end of the federal fiscal year even if the child was factually a different age on the date of service. For example, if a child turned 6 on September 1st, but had a sealant applied in July, the sealant would be counted in the age 6-9 category.
Section IIIH: CHIPRA CAHPS Requirement:

CHIPRA section 402(a)(2), which amends reporting requirements in section 2108 of the Social Security Act, requires Title XXI Programs (i.e., CHIP Medicaid Expansion programs, Separate Child Health Programs, or a combination of the two) to report CAHPS results to CMS starting December 2013. While Title XXI Programs may select any CAHPS survey to fulfill this requirement, CMS encourages these programs to align with the CAHPS measure in the Children’s Core Set of Health Care Quality Measures for Medicaid and CHIP (Child Core Set). Starting in 2013, Title XXI Programs should submit summary level information from the CAHPS survey to CMS via the CARTS attachment facility. We also encourage states to submit raw data to the Agency for Healthcare Research and Quality’s CAHPS Database. More information is available in the Technical Assistance fact sheet, Collecting and Reporting the CAHPS Survey as Required Under the CHIPRA: https://www.medicaid.gov/medicaid/quality-of-care/downloads/cahpsfactsheet.pdf

If a state would like to provide CAHPS data on both Medicaid and CHIP enrollees, the agency must sample Title XIX (Medicaid) and Title XXI (CHIP) programs separately and submit separate results to CMS to fulfill the CHIPRA Requirement.

Did you Collect this Survey in Order to Meet the CHIPRA CAHPS Requirement?
☑ Yes
☐ No

If Yes, How Did you Report this Survey (select all that apply):
☐ Submitted raw data to AHRQ (CAHPS Database)
☒ Submitted a summary report to CMS using the CARTS attachment facility (NOTE: do not submit raw CAHPS data to CMS)
☐ Other. Explain:

If No, Explain Why:
Select all that apply (Must select at least one):

☐ Service not covered
☐ Population not covered
☐ Entire population not covered
☐ Partial population not covered

Explain the partial population not covered:

☐ Data not available

Explain why data not available
☐ Budget constraints
☐ Staff constraints
☐ Data inconsistencies/accuracy

Please explain:
☐ Data source not easily accessible

Select all that apply:
☐ Requires medical record review
☐ Requires data linkage which does not currently exist
☐ Other:
Information not collected. Select all that apply:
- Not collected by provider (hospital/health plan)
- Other:

- Small sample size (less than 30) Enter specific sample size:
- Other. Explain:

Definition of Population Included in the Survey Sample:

Definition of population included in the survey sample:
- Denominator includes CHIP (Title XXI) population only.
  - Survey sample includes CHIP Medicaid Expansion population.
  - Survey sample includes Separate CHIP population.
  - Survey sample includes Combination CHIP population.

If the denominator is a subset of the definition selected above, please further define the denominator, and indicate the number of children excluded:

Which Version of the CAHPS® Survey was Used?
- CAHPS® 5.0.
- CAHPS® 5.0H.
- Other. Explain:

Which Supplemental Item Sets were Included in the Survey?
- No supplemental item sets were included
- CAHPS Item Set for Children with Chronic Conditions
- Other CAHPS Item Set. Explain:

Which Administrative Protocol was Used to Administer the Survey?
- NCQA HEDIS CAHPS 5.0H administrative protocol
- HRQ CAHPS administrative protocol
- Other administrative protocol. Explain:

Enter any Narrative text related to Section IIIH below. [7500]
Attached EQR Technical Report with included CAHPS results.
Section III I: Health Service Initiatives (HSI) Under the CHIP State Plan

Pursuant to Section 2105(a)(1)(D)(ii) of the Social Security Act, states have the option to use up to 10 percent of actual or estimated Federal expenditures to develop state-designed Health Services Initiatives (HSI) (after first funding costs associated with administration of the CHIP state plan), as defined in regulations at 42 CFR 457.10, to improve the health of low-income children.

1) Does your state operate HSI(s) to provide direct services or implement public health initiatives using Title XXI funds?
   - Yes, please answer questions below.
   - No, please skip to Section IV.

2) In the table below, please provide a brief description of each HSI program operated in the state in the first column. In the second column, please list the populations served by each HSI program. In the third column, provide estimates of the number of children served by each HSI program. In the fourth column, provide the percentage of the population served by the HSI who are children below your state’s CHIP FPL eligibility threshold.

<table>
<thead>
<tr>
<th>HSI Program</th>
<th>Population Served by HSI Program</th>
<th>Number of Children Served by HSI Program</th>
<th>Percent of Low-income Children Served by HSI Program ≤ CHIP FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resources for the Early Advancement of Child Health (REACH) program into after school programs serving the highest risk schools in Nevada that will be prioritized by the mandated environmental scan. The implementation of these innovative changes supports Nevada children in achieving a physical and emotionally safe environment by incorporating the REACH pilot project within the targeted schools. REACH is based on available funding and the individualized schools needs.</td>
<td>Nevada is specifically looking at our “at risk and low income children and youth” populations: Ages 10-12 and 13-18. Reaching our children/youth before they have a behavioral health issues supporting those that have been exposed to a number of traumatic events due to the effects of poverty. The scope of services will target early intervention services, mental health resources, and create support environments for parents focusing on formal and informal links within their community.</td>
<td>728</td>
<td>82%</td>
</tr>
</tbody>
</table>

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6 The percent of children served by the HSI program who are below the CHIP FPL threshold in your state should be reported in this column.
3) Please define a metric for each of your state’s HSI programs that is used to measure the program’s impact on improving the health of low-income children. In the table below, please list the HSI program title in the first column, and include a metric used to measure that program’s impact in the second column. In the third column, please provide the outcomes for metrics reported in the second column. Reporting on outcomes is optional as states work to develop metrics and collect outcome data. States that are already reporting to CMS on such measures related to their HSI program(s) do not need to replicate that reporting here and may skip to Section IV.

<table>
<thead>
<tr>
<th>HSI Program</th>
<th>Metric</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resources for the Early Advancement of Child Health (REACH) program</td>
<td>The REACH program has completed nine, six-week sessions with continued success and 100% participation, youth and their parents/guardians. All children are provided preventative services for those that participate in this prevention program. Two areas of direct increase in pre/post test results that identified an average increase within the post scores by 35%. Referrals will be monitored, while receiving further behavioral health services they are immediately enrolled for supportive intervention.</td>
<td>The Early Advancement of Child Health (REACH) program, funded by CHIP, Health Services Initiative (HSI). The implementation of preventative behavioral health changes supports Nevada in achieving a physical and emotionally safe environment. An Average of 65% improvement.</td>
</tr>
<tr>
<td>HSI Program</td>
<td>Metric</td>
<td>Outcome</td>
</tr>
<tr>
<td>-------------</td>
<td>--------</td>
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</tr>
</tbody>
</table>

Enter any Narrative text related to Section III I below. [7500]
Section IV. Program financing for State Plan

1. Please complete the following table to provide budget information. Describe in narrative any details of your planned use of funds below, including the assumptions on which this budget was based (per member/per month rate, estimated enrollment and source of non-federal funds). (Note: This reporting period equals federal fiscal year 2018. If you have a combination program you need only submit one budget; programs do not need to be reported separately.)

COST OF APPROVED CHIP PLAN

<table>
<thead>
<tr>
<th>Benefit Costs</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance payments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Managed Care</td>
<td>50668555</td>
<td>61002847</td>
<td>48642095</td>
</tr>
<tr>
<td>Fee for Service</td>
<td>23603803</td>
<td>13189488</td>
<td>11073484</td>
</tr>
<tr>
<td>Total Benefit Costs</td>
<td>74272358</td>
<td>74192335</td>
<td>59715579</td>
</tr>
<tr>
<td>(Offsetting beneficiary cost sharing payments)</td>
<td>-2699620</td>
<td>-1678580</td>
<td>-1760493</td>
</tr>
<tr>
<td>Net Benefit Costs</td>
<td>71572738</td>
<td>72513755</td>
<td>57955086</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Administration Costs</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personnel</td>
<td>347895</td>
<td>419245</td>
<td>430972</td>
</tr>
<tr>
<td>General Administration</td>
<td>2186380</td>
<td>2215539</td>
<td>2277509</td>
</tr>
<tr>
<td>Contractors/Brokers (e.g., enrollment contractors)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Claims Processing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outreach/Marketing costs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (e.g., indirect costs)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Services Initiatives</td>
<td>354410</td>
<td>354410</td>
<td>354410</td>
</tr>
<tr>
<td>Total Administration Costs</td>
<td>2888685</td>
<td>2989194</td>
<td>3062891</td>
</tr>
<tr>
<td>10% Administrative Cap (net benefit costs ÷ 9)</td>
<td>7952526</td>
<td>8057084</td>
<td>6439454</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal Title XXI Share</td>
<td>73277486</td>
<td>74302452</td>
<td>60047791</td>
</tr>
<tr>
<td>State Share</td>
<td>1183937</td>
<td>1200497</td>
<td>970186</td>
</tr>
<tr>
<td>TOTAL COSTS OF APPROVED CHIP PLAN</td>
<td>74461423</td>
<td>75502949</td>
<td>61017977</td>
</tr>
</tbody>
</table>

2. What were the sources of non-federal funding used for state match during the reporting period?

- [ ] State appropriations
- [ ] County/local funds
- [ ] Employer contributions
- [ ] Foundation grants
- [ ] Private donations
- [ ] Tobacco settlement
- [ ] Other (specify) [500]

3. Did you experience a short fall in CHIP funds this year? If so, what is your analysis for why there were not enough federal CHIP funds for your program? [1500]
Yes, CHIP was not reauthorized during Sept. 2017-Feb.2019.

4. In the tables below, enter 1) number of eligibles used to determine per member per month costs for the current year and estimates for the next two years; and, 2) per member per month (PMPM) cost rounded to a whole number. If you have CHIP enrollees in a fee for service program, per member per month cost will be the average cost per month to provide services to these enrollees.

### A. Managed Care

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Eligibles</th>
<th>PMPM ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>34286</td>
<td>$111</td>
</tr>
<tr>
<td>2019</td>
<td>35220</td>
<td>$126</td>
</tr>
<tr>
<td>2020</td>
<td>25922</td>
<td>$108</td>
</tr>
</tbody>
</table>

### A. Fee For Service

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Eligibles</th>
<th>PMPM ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>5090</td>
<td>$345</td>
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<tr>
<td>2019</td>
<td>4957</td>
<td>$201</td>
</tr>
<tr>
<td>2020</td>
<td>11161</td>
<td>$110</td>
</tr>
</tbody>
</table>

Enter any Narrative text related to Section IV below. [7500]
Nevada anticipates the increase in enrollment for 2020 based on the newly Senate Bill 325.
Section V: Program Challenges and Accomplishments

1. For the reporting period, please provide an overview of your state’s political and fiscal environment as it relates to health care for low income, uninsured children and families, and how this environment impacted CHIP. [7500]

When the CHIP Program’s future looked uncertain in Congress, it was estimated that Nevada’s funding would end by mid-December 2017. Nevada received a portion of the redistributed funds which kept the program afloat until CHIP funding was reauthorized by Congress. Nevada had a termination plan ready in case the reauthorization bill did not pass. Approximately 26,000 children would be directed to the Nevada Silver State Health Exchange (SSHX) but funds were not budgeted to support outreach and special enrollment in the health exchange. The Division of Health Care Financing and Policy (DHCFP) was working with CMS/CMCS and the Division of Welfare and Support Services (DWSS) to define the multiple termination steps for Nevada’s CHIP program; Nevada Check Up. Steps included, but not limited to disenroll recipients, remove the CHIP State Plan and update Medicaid Modernization Information System (MMIS) in case the funding was not reauthorized before the state ran out of funds. The Maintenance of Effort (MOE) requirements would have forced Nevada to use other state funds to cover the expanded populations through 9/30/2019.

With the implementation of Senate Bill 325, Nevada was able to ensure enrollment of children who had lawfully resided in the state for less than 5 years, decreasing the number of uninsured children in the state.

The Nevada Silver State Health Exchange was not affected by the state’s Medicaid political or fiscal environment. Potentially, the SSHX would have been impacted by several factors’ such as the shortened federal open enrollment, cuts to marketing and outreach, rate increases as a result of federal policy instability, and instability in the federal marketplace. However, as the federally facilitated states saw declines in their enrollment, Nevada increased enrollment by 2.2 percent.

2. During the reporting period, what has been the greatest challenge your program has experienced? [7500]

Preparing for the possible termination of the CHIP program and coordinating with all agencies involved was one of the greatest challenges while the CHIPRA’s future was undecided. Nevada’s rate of uninsured children is currently between 6% and 8%, which is higher than the national average of 5%. The passage of Senate Bill 325 has helped decrease the number of uninsured children as it allowed children who had lawfully resided in the state for less than 5 years to be eligible for CHIP/Medicaid.

Nevada’s Tribal population would have been severely impacted by the termination of the CHIP program. Those enrolled in the current health plans would have been transitioned to the health exchange, resulting in substantial monthly premium increases, or they would have become uninsured. Nevada was in contact with the tribal leaders to minimize the public reaction. As a result of the CHIPRA re-authorization, the tribal community was not impacted and there were no disruptions in access to care and services.

The Connecting Kids to Coverage (CKC) has had its own challenges. Working with partner organizations has provided access to a greater population of potential recipients. Community Health Workers (CHW) helped to provide feedback to improve data collections systems to better suit the needs of the CKC program. Increasing enrollment has been a challenge. Funding has been difficult to obtain for the CKC program and Nevada’s large rural populations rely heavily on the referral process for quality providers. Integrating CHWs that the community trusts into the
rural areas has helped to overcome some of these challenges and enroll children and families that are otherwise reluctant to receive government assistance outside of Tribal clinics.

The greatest challenge to the Nevada Silver State Health Exchange was the threat of repeal and replace of the Affordable Care Act (ACA) during the reporting period and instability within the marketplace from federal policy. This would have had an impact in the number of children covered by policies on the exchange as these are who don’t meet the requirements to be covered by the CHIP program.

3. During the reporting period, what accomplishments have been achieved in your program? [7500]

From September 2017 to February 2018, Nevada was able to maintain CHIP enrollment. Additional procedures were put in place depending on the outcome of the CHIP Reauthorization. The implementation of Senate Bill 325 has helped decrease the number of uninsured children in Nevada as it allowed children who had lawfully resided here for less than 5 years to be eligible for CHIP/Medicaid.

The CKC program also helped to enroll uninsured children, especially in the rural areas of the state by integrating CHWs in the rural communities. The children affected by Senate Bill 325 and the CKC program now have access to see a provider for preventive care and are less likely to utilize urgent care and emergency rooms for preventive care thus reducing the fiscal impact to the CHIP program.

The Nevada Silver State Health Exchange saw an increase in enrollment of 2.2%. The exchange does not administer or connect uninsured children to the CHIP program, but the increase means that more of Nevada’s children are being insured by policies purchased on the exchange. With the reversal of the Individual Mandate of the ACA, the expectation was the decline in enrollment due to consumers no longer being required to maintain insurance. Instead, Nevada’s enrollment increased showing the success of the grassroots outreach and education as well as marketing through the school districts statewide.

4. What changes have you made or are planning to make in your CHIP program during the next fiscal year? Please comment on why the changes are planned. [7500]

Gathering data has been difficult in getting the information to correlate to certain child core set measures. Nevada is currently in the process of modernization of the MMIS system, resulting in improving the ability to collect data, analyze and apply the data to improve the Medicaid Child and CHIP core set measures.

The Bipartisan Budget Act changes in Section 53102 will affect recipients in the CHIP program. The DHCFP is collaborating with DWSS to implement system edits that will honor the recipient’s other insurance until time of redetermination. The recipients will be able to maintain coverage through CHIP and maintain TPL coverage until renewal or required re-assessment period. If the recipients still have other insurance at that time, they will become ineligible for the CHIP program.

The Mental Health Parity section of the CHIP State Plan is currently in the process of being reviewed and approved through CMCS Mental Health Parity team.
Based on Section 50102 and 50103 of the BBA of 2018, Nevada will be increasing the Medicaid and CHIP child core set measures during the FFY 2019-2020. Currently the focus is on gaining core set measures for Contraceptive Care for Women Ages 15-20 and Live Birth Weights of Less Than 2,500 Grams. Once these measures are in place, Nevada’s focus will then shift to data collecting of Contraceptive Care for Postpartum Women Ages 15-20 and Audiological Diagnosis No Later Than 3 Months of Age. Nevada is working hard to meet the goals of mandatory participation in all 26 measures for both Medicaid Child and CHIP prior to the FFY 2024 deadline.

Nevada’s goal of standardizing common definitions for the hearings process between Medicaid/CHIP and health insurance policies purchased on the exchange are being collaboratively developed. Nevada’s use of acronyms and the procedures for filing appeals and grievances are in alignment with those used within the commercial insurance industry.

Enter any Narrative text related to Section V below. [7500]
Nevada is currently working with CHIP-MHPAEA team to approve MHPAEA section. Nevada is also working on CHIP-Managed Care state plan compliance.