

March \_\_\_\_\_, 1998

Nancy-Ann Min DeParle  
Administrator  
Health Care Financing Administration  
7500 Security Blvd.  
Baltimore, Maryland 21244

Attn: Family & Children's Health Programs Group  
Center for Medicaid and State Operations  
Mail Stop - C4-14-16

Dear Ms. DeParle:

The Governor of the State of Nevada has designated the Department of Human Resources (DHR), Division of Health Care Financing and Policy (DHCFP), as the state agency responsible for implementing the Children's Health Insurance Program under Title XXI of the Social Security Act. Nevada is honored to submit to the Health Care Financing Administration (HCFA) our Title XXI State Plan.

We believe this plan offers comprehensive health coverage for Nevada's uninsured children below the 200 percent Federal Poverty Level. The program is called Nevada ✓ Check Up and is to be implemented on July 1, 1998. Questions about the Nevada State Plan may be directed to Christopher Thompson, CPA/Administrator of DHCFP. He may be reached by phone at (702) 687-4176 ext 247 or by fax at (702) 684-8792.

Thank you for your consideration of Nevada's Title XXI State Plan application. We look forward to working with HCFA in the implementation of our plan to provide comprehensive health care to children of low-income, working families who do not qualify for Medicaid.

Sincerely,

Charlotte Crawford  
Director

CC/lmt

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**STATE CHILD HEALTH PLAN  
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT  
STATE CHILDREN'S HEALTH INSURANCE PROGRAM**

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

**State/Territory:**     *Nevada State*

**Organization:**     *Nevada State Department of Human Resources*

**Address:**            *505 E. King Street, Suite 600  
Capitol Complex  
Carson City, Nevada 89710*

**Supervising  
Official:**            *Christopher Thompson, Administrator  
Division of Health Care Financing and Policy*

As a condition for receipt of Federal funds under Title XXI of the Social Security Act,

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Bob Miller, Governor

Date

(Signature of Governor of State/Territory, Date Signed)

submits the following State Child Health Plan for the State Children's Health Program and hereby agrees to administer the program in accordance with the provisions of the State Child Health Plan, the requirements of Title XXI and XIX of the Act and all applicable Federal regulations and other official issuances of the Department.

**According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0707. The time required to complete this information collection is estimated to average 160 hours (or minutes) per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: HCFA, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.**

**Section 1. General Description and Purpose of the State Child Health Plans (Section 2101)**

The state will use funds provided under Title XXI primarily for (check appropriate box):

- 1.1.  **Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (Section 2103); OR**
- 1.2.  **Providing expanded benefits under the State's Medicaid plan (Title XIX); OR**
- 1.3.  **A combination of both of the above.**

**Introduction:**

Nevada submits its Title XXI State Plan to expand uninsured children's access to health coverage by implementing a new statewide program to provide comprehensive medical services to children of low-income families. Nevada's Title XXI program will be called Nevada Check Up, to be administered by the Department of Human Resources (DHR), Division of Health Care Financing and Policy (DHCFFP). Health Maintenance Organizations (HMOs) and other state qualified health care organizations, if any, will deliver the benefit packet as described in Section 6.2 of this plan.

The 1997 Nevada Legislature passed Senate Bill (SB) 470 to create a state program to increase awareness of health care programs for children and to encourage enrollment in Medicaid or other health programs for eligible children. (See Attachment A.)

The mission of Nevada ✓ Check Up is to provide health insurance to uninsured children (birth to 18 years of age) of Nevada working families who are not covered either by private health insurance or Medicaid while:

- promoting health care coverage for children;
- encouraging individual responsibility; and
- partnering with public and private health care providers.

Nevada ✓ Check Up will be for children ages 0 to 18 in families with annual gross incomes at or below 200% of federal poverty level. The first period of enrollment will be July 1, 1998 through July 30, 1999. As many as 45,000 children could be enrolled.

In the Title XXI insurance program, children will receive a health benefit package which is available to the commercial population of Nevada's largest HMO. They will also receive vision, pharmacy, hearing, and dental coverage for minimal co-payments. This comprehensive benefits package provides children with quality health care including preventive services which will help promote healthier children for the state of Nevada.

Nevada's goal is to ensure that children's health plans become their medical manager by emphasizing preventive services, coordinating with programs that currently serve the uninsured, and assuring quality of care by establishing specific performance measures in the health plan contract.

Like all working beneficiaries of health insurance, eligible families are expected to participate in the support of the program through an enrollment fee, quarterly premiums, and minimal co-payments for families' prescriptions, dental, vision and hearing services. No co-payments will be charged for preventive services, immunizations or emergency services and no co-payments will be charged to children in families at or below 150% of poverty. The annual maximum cost sharing for a family will be below 5% of the families' gross annual income. Cost sharing will give families personal responsibility and choices in the management of the health of their children.

Eligibility will be determined through a simple one page form which includes demographic, income, and insurance information on families. Once families are found eligible, they will be sent an enrollment form providing them with information on their choice of plans. This form will be returned to the state along with the enrollment fee and the family will be enrolled in their plan of choice at the beginning of the next month.

The program has been developed by the Nevada DHCFP including input from the public and oversight of the Legislative Committee on Health Care. Both DHCFP and the Legislative Committee on Health Care will continue to hold public hearings to evaluate the program and to consider ways to improve it.

**Section 2. General Background and Description of State Approach to Child Health Coverage**  
 (Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

**2.1 Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in section 2110(c)(2)). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (see Section 10 for annual report requirements).**

Uninsured Children

DHCFP has estimated that there are 60,000 children in Nevada who are uninsured living in families with incomes under 200% of poverty. Of these, as many as 12,000 to 20,000 may be eligible for Medicaid. These numbers are based on limited and sometimes seemingly contradictory data.

For example, the U.S. Census Bureau estimates that for 1996, there were 45,000 uninsured children under 200% of poverty in Nevada, but also estimated that there were 77,000 uninsured at all income levels. This would mean that less than 60% of all uninsured would be under 200% of poverty. The national average is 73%. Only five other states (Alaska, Massachusetts, Vermont, Hawaii, and New Jersey) are under 60%, all of whom have significantly higher Medicaid eligibility levels than Nevada, resulting in a greater level of coverage for low-income children.

With regard to demographic data, the best information comes from a survey of the uninsured in Nevada completed in June 1992. This study focused on all uninsured (not just children). Among its findings were that:

Number of Uninsured Children in Nevada  
by Region

	North	South	Rural	Total
Less than 6	6,830	14,350	2,921	24,101
6 to 18	9,018	27,089	6,555	42,662
	15,848	41,439	9,476	66,763

Due to the sketchy information, Nevada is undertaking a new survey on the uninsured with a particular focus on children. Results from this study are expected to be available in the latter half of 1998. This survey will establish baseline data for evaluating Nevada ✓ Check Up.

Health Insurance Coverage

Based on the U.S. Census data (three year average 1993-1995) 69.5% of children in Nevada under the age of 19 and under 200% of federal poverty level are insured, leaving 30.5%

uninsured. Of the insured children, an estimated 36.6% are covered by employer sponsored insurance, 5.4% have other coverage, and 25.1% are covered by Medicaid. The amount for Medicaid would appear to be understated as Nevada had 55,640 children enrolled in the program in 1996 (average monthly eligibles). This would represent 28.3% of the 196,676 children under 200% of poverty. (Essentially all children on Nevada Medicaid are under 200% of poverty. Nevada has no public health insurance programs for children other than Medicaid.)

Estimates of Nevada Populations

According to the 1996 U.S. Census Bureau data released on December 18, 1997, Nevada’s total population is 1,603,162. Nevada’s children age 0-19 comprise the following races by age and sex:

Age/Sex	White	Black	American Indian	Asian	Hispanic	Total
<5						
M	41,091	4,916	829	2,757	13,887	
F	38,497	3,811	829	2,560	11,071	120,248
5 to 19						
M	106,891	14,076	2,659	6,172	29,915	
F	101,527	11,526	2,903	5,998	27,916	309,583
Total	288,006	34,329	7,220	17,487	82,789	429,831

The Nevada State Demographer estimates 1,688,140, approximately 5% higher. (See Attachment B “Population characteristics: Official Nevada Estimate (1996) and Projections (1997+).”)

Language spoken at home by Nevadans

According to the 1990 U.S. Census data, Nevadan’s language spoken at home is as follows:

Nevadans Age >5

- 86.8% Speak English at home
- 7.6% No English at home
- 5.6% Don’t speak English well

No English at Home

- 58.5% Speak Spanish at home
- 41.5% Speak language other than English or Spanish

Public Health Insurance Coverage

Medicaid is Nevada’s major public health insurance program. In 1967, Nevada implemented the Medicaid program for the Aid to Families with Dependent Children (AFDC) now Temporary Assistance for Needy Families (TANF), Child Welfare, Aged, Blind, and Disabled populations, and in 1985 implemented the Child Health Assurance Program (CHAP) for pregnant women and later for pregnant women with children. Nevada is at the federal minimums for eligibility, 133% of the federal poverty level (FPL) for children up to age six and 100% of FPL for children six and older born on or after October 1, 1983. Currently most TANF and CHAP children on Medicaid have a choice of fee for service or managed care (except disabled children and children in rural areas).

Medicaid's two voluntary managed care programs include the primary care case management (PCCM) program which began in November 1983, and the health maintenance organization (HMO) program which began in April 1997.

Both managed care programs are capitated. The PCCM program provides the following services: All physician services; outpatient radiology and clinical laboratory services; and outpatient prescribed drugs. The HMO program provides fully capitated comprehensive services with some carve outs such as non-emergency medical transportation and dental services.

As of January 1, 1998, the total Temporary Assistance for Needy Families (TANF)/ Childrens Health Assurance Program (CHAP) enrollment for both managed care programs is 32,213 or 60.6% out of a total eligible population of 53,194. Enrollment by program is as follows:

PCCM: 24,042 enrollees out of a total eligible population of 53,194 or 45.2%;

HMO: 8,171 enrollees out of a total eligible population of 53,194 or 15.4%.

Beginning in October 1998, Medicaid will implement a mandatory, fully capitated managed care program in northern and southern Nevada and phase out the PCCM.

#### Nevada ✓ Check Up

Nevada ✓ Check Up will provide access to affordable health insurance to children in working, low-income families. The program will feature simplified mail-in eligibility and low premiums and co-payments while providing a comprehensive benefits package.

Between Medicaid and Nevada ✓ Check Up, Nevada could cover nearly 100,000 children by 1999.

## **2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: (Section 2102)(a)(2)**

### **2.2.1 The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e. Medicaid and state-only child health insurance):**

Nevada currently has several initiatives to enroll children in Medicaid. These include the Women, Infant, and Children (WIC) centers, Federally Qualified Health Centers (FQHCs), Special Children Clinic (SCC), Baby Your Baby program (BYB), Family Resource Centers (FRCs), and the Family to Family program. In addition, outstationed eligibility workers are in certain public hospitals and federally qualified health centers.

1. Medicaid administered by the Department of Health Care Financing and Policy, provides health coverage to low-income and disabled Nevada children. Nevada takes the following steps to enroll children in Medicaid:

- a. Nevada State Welfare District Offices located throughout the state determine a person's eligibility for TANF, CHAP, and Medicaid.
  - b. Outstationed sites (FQHCs, county hospitals, and local county health departments) help people apply for Medicaid and send their applications and eligibility determination to the local Nevada State Welfare District Office. Local public health agencies identify low income, uninsured children through referrals from a variety of sources including: WIC, child health and immunization clinics, community health and social services agencies, and schools.
2. Women, Infants and Children (WIC) provides nutritious food to supplement the regular diet of pregnant women, infants, and children under age five who meet state income standards. Women and children under five years old qualify if the combined family income is at or below 185% of the federal poverty level. WIC staff encourage pregnant women and parents in this program to apply for Medicaid.
  3. Federally Qualified Health Centers offer health care to low-income people. Nevada has three (3) federally qualified community health centers. The centers provide primary care services including care for acute and chronic illness, injuries, emergency care, diagnostic services and prescriptions.

Community Health Centers take the following steps to enroll children in Medicaid:

1. Provide a financial screen for each new patient or family
2. Provide information on and explanation of the program(s) for which family members may be eligible.
3. Assist with completing applications and collecting required documentation.
4. Determine eligibility on-site or forward applications to the determining agency and communicate with family about eligibility status.

If a patient/family is not eligible for any program, the Community Health Center will provide the health care services and will use its sliding fee scale according to family size and income to determine the fee.

4. Special Childrens Clinic  
The Nevada Health Division, Special Children's Clinic (SCC) provides direct services to low-income children ages 0-3 under the Maternal and Child Health Block Grant (Title V). Services include well child clinic services, including developmental and physical assessments and immunizations. Children who appear to qualify for Medicaid are encouraged to apply for Medicaid.
5. Baby Your Baby Program  
Both the state Title V program and state Medicaid agency support Baby Your Baby (BYB), a statewide multi-media bilingual campaign to promote early entry into prenatal care. In its first year of operation, BYB achieved 80% name recognition with new mothers. In 1996, 7,194 people were served by BYB representing 29.5% of live births (24,384) in Nevada. Over half (55%) of the pregnant women who called the information and referral line or sent in a participation card indicated they were self-pay

or did not know how they would pay for prenatal care. All of these women were referred to Medicaid and Title V prenatal care programs.

6. Family Resource Centers

A total of 36 Family Resource Centers (FRCs) have been established in high risk neighborhoods throughout Nevada, and an additional 2 are scheduled to open in the next year. The FRCs are community based centers run by not-for-profit organizations with state grants and private contributions. Their aim is to provide information about available social services including Medicaid, and how to access those services. Sites also provide some services (e.g. child care) based on the need of the community.

7. Family to Family Program

The Family to Family program is a new major initiative aimed at informing new mothers of the services that are available to them and how to access such services. A total of 22 centers will be established throughout the state. These centers will be community based and operated as public private partnerships. New mothers will be able to receive a home visit, get questions answered about parenting issues and services available to aid them in raising their child, including Medicaid.

**2.2.2 The steps this state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership.**

There are no public-private partnerships in Nevada offering health insurance to low-income children.

**2.3. Describe how the new State Title XXI program(s) is(are) designed to be coordinated with such efforts to increase the number of children with creditable health coverage so that only eligible targeted low-income children are covered: (Section 2102)(a)(3)**

Information about Nevada ✓ Check Up will be distributed to all of the entities listed above. Families that apply for Medicaid but are found ineligible will be provided information on Nevada ✓ Check Up. The state also intends to provide information about Nevada ✓ Check Up to families who are coming off Medicaid in advance of their Medicaid eligibility lapsing. (Due to programming constraints, this process will not be operational until approximately November 1998.)

Information packets for Nevada ✓ Check Up will also include information on Medicaid eligibility. Differences between the two programs will be shown including the cost sharing applicable to Nevada ✓ Check Up but not Medicaid.

Nevada ✓ Check Up applicants will be screened against Medicaid eligibles and will be denied if they are on Medicaid. Enrollee lists for the two programs will be compared monthly. Anyone found to be on both programs will be immediately disenrolled from Nevada ✓ Check Up.

**Section 3. General Contents of State Child Health Plan (Section 2102)(a)(4)**

**Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the states Medicaid plan, and continue on to Section 4.**

**3.1 Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children: (Section 2102)(a)(4)**

Services under Nevada ✓ Check Up will be delivered through Managed Care Organizations (MCOs). Nevada ✓ Check Up will set forth the benefits package, rates, provider network standards, quality of care, access standards, member rights, grievance procedures, financial solvency, and other requirements through a contract.

Any MCO that has all necessary approvals from the Nevada Division of Insurance (DOI) to provide such coverage will be allowed to participate. It is likely that most, if not all, MCOs will be HMOs.

It is also possible that in some remote areas of Nevada no MCOs will elect to provide coverage. In that case, a fee for service program will be offered.

DHCFP will review the policies and procedures as they relate to Nevada ✓ Check Up. MCOs who are included in the voluntary Medicaid managed care program may use the same policies and procedures for Nevada ✓ Check Up.

HMOs or MCOs

There are thirteen (13) HMOs or MCOs licensed by the Division of Insurance (DOI) to do business in Nevada, of which four (4) are contracted with Medicaid. These HMOs or MCOs will be eligible to service Nevada ✓ Check Up children. If a child loses Medicaid coverage and becomes eligible for Nevada ✓ Check Up, the child will be able to remain with the same HMO or MCO. The Nevada ✓ Check Up HMO or MCO contract will address the following areas: enrollment, marketing, benefits, co-payments, provider network, utilization management, quality of care, access to care, member rights, and grievance procedures. Contract standards will be based on a review of standards from the following sources: National Association of Insurance Commissioners (NAIC) Model Acts, National Committee for Quality Assurance (NCQA) Accreditation Standards, and Quality Improvement System for Managed Care (QISMC) Standards.

The DOI grants HMO or MCO licenses based on a review of financial stability, adequate provider subcontracts, access to care and quality of care. The DOI subcontracts the quality and access review to the Nevada Health Division. When a licensed plan applies for a Medicaid contract, DHCFP reviews several aspects of the plan's operation including provider network, utilization, management, access to care, quality improvement and grievance procedures.

Nevada ✓ Check Up Provider Network

The MCOs must develop their own provider network. The physicians, hospitals and ancillary service providers will deliver the Nevada ✓ Check Up comprehensive benefit package described in Section 6.2. DHCFP will require MCOs to have a sufficient provider network to serve its enrollees. The MCOs must offer a contract to federally qualified health centers, rural health centers, public

hospitals, and the University of Nevada School of Medicine at terms that are at least equal to their standard provider contracts.

**Primary Care:** Nevada ✓ Check Up will use the participating HMOs' physician network to provide routine care.

**Immunizations:** Nevada ✓ Check Up plans will educate and encourage the parent to immunize their child.

**Well Baby and Well Child:** Nevada ✓ Check Up plans will educate the child's parent about these programs and encourage them to have their child undergo a diagnostic evaluation.

**Specialty Care:** Nevada ✓ Check Up plans must allow for referrals to appropriate specialists for necessary medical care.

**Hospital Benefits:** The MCOs are required to have a contract with at least one hospital in each geographic service area and are required to offer contracts to public hospitals at terms that are at least equal to their standard hospital contract in that area.

**Pharmaceuticals:** Pharmaceutical benefits will be available to members through the MCO's pharmacy network. The majority of Nevada's pharmacies contract with MCOs.

**3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children: (Section 2102)(a)(4)**

The MCOs who contract with the Nevada ✓ Check Up program are primarily responsible for utilization management functions. Nevada ✓ Check Up contract standards require a participating MCO to have adequate utilization management staff and procedures to assure that services provided to enrollees are medically necessary and appropriate. Before being approved for participation in the program, health plans must develop and have in place utilization review policies and procedures that include protocols for prior approval and denial of services, hospital discharge planning, physician profiling, and retrospective review of both inpatient and ambulatory claims meeting pre-defined criteria. Plans also must develop procedures for identifying and correcting patterns of over and under utilization on the part of their enrollees.

Prior Authorizations

The health plans may require a prior authorizations for a given service. The child's Primary Care Physician (PCP) is responsible for obtaining all necessary prior authorizations. Services requiring prior authorizations may include, but are not limited to:

- All outpatient therapies including physical therapy, speech therapy, and occupational therapy
- Services performed by a provider outside the plan's network
- Home health care
- Hospice care

- Inpatient and outpatient surgery
- Some diagnostic tests

No prior authorization is allowed for emergency care or preventive services.

MCO compliance with utilization management contracts standards will be monitored by DHCFP staff and/or an external quality review organization (EQRO). To the extent feasible, compliance monitoring will be combined for Medicaid and Nevada ✓ Check Up.

Managed care plans will be contractually required to track the utilization of benefit services and to submit said data to DHCFP on a monthly and/or quarterly basis. Examples of the data includes:

- hospital admissions: diagnosis, length of stay
- ambulatory services - visits to primary care physicians and specialists
- drugs

The data collected will be analyzed by DHCFP and/or the EQRO to identify utilization issues. Said entities will work with the health plans as necessary to resolve identified problems. More information can be found on utilization control in Section 7 - Quality and Appropriateness of Care.

#### Grievance Procedures

The MCO must have a process to resolve Nevada ✓ Check Up participant grievances.

The process must be in writing and submitted to DHCFP for review and approval at the time the MCO Policies and Procedures are submitted. The process must include, but is not limited to:

- 1) the MCO's final decision is issued no later than thirty (30) days after the participant files the grievance; and
- 2) a written record in the form of a file or log is kept of the grievance to include the nature of the complaint, date filed, current status, dates and nature of actions taken and final resolution.

Within twenty (20) days of receipt of the MCO's final decision, a participant may request a review by DHCFP. Upon receipt of the request, DHCFP will request the record of the grievance from the MCOs. The MCO must send the record to DHCFP within five (5) working days upon receipt of the request by DHCFP. DHCFP will review the record and issue a decision within fifteen (15) working days of receipt of the record. The participant and the MCO will be notified of the finding and the required MCO action, if any.

In addition, periodically DHCFP will review the number and content of complaints and grievances filed regarding each MCO.

Provider Protest: The MCO must have a process to resolve provider protests related to payment for and services provided or requested for Nevada ✓ Check Up participants. The written procedures must be submitted to DHCFP for review and approval at the time the Policies and Procedures are submitted. The process must include, but is not limited to:

- 1) The MCO's final decision is issued no later than thirty (30) days after the provider files the protest ; and
- 2) A written record in the form of a file or log is kept of the protest to include the nature of it, date filed, dates and nature of actions taken and final resolution.

**Section 4. Eligibility Standards and Methodology.** (Section 2102(b))

- Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 5.

**4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard.** (Section 2102)(b)(1)(A))

- 4.1.1  **Geographic area served by the Plan:** The plan is available statewide, in all 17 Nevada Counties.
- 4.1.2  **Age:** The plan is available to children 0 through 18 years of age. This age criteria allows a family to apply for up to one full year's coverage up to the month before the child's 18<sup>th</sup> birthday, and the child can receive coverage through the month before the child's 19<sup>th</sup> birthday.
- 4.1.3  **Income:** Eligible children are from families whose gross annual incomes are at or below 200% of the federal poverty level. Income for the purposes of this plan means gross income before deduction of income taxes, employees' social security taxes, insurance premiums, bonds, etc. Income includes the following:
1. Monetary compensation for services, including wages, salary, commissions or fees;
  2. Net income from farm employment;
  3. Social Security;
  4. Dividends or interest on savings bonds, income from estates or trusts, or net rental income;
  5. Unemployment compensation;
  6. Government civilian employee or military retirement or pensions or veterans' payments;
  7. Private pensions or annuities;
  8. Alimony or child support payments;
  9. Regular contributions from persons not living in the household;
  10. Other cash income. Other case income includes but is not limited to: cash amounts received or withdrawn from any source including savings, investments, trust accounts, and other resources which are readily available to the family.
- 4.1.4  **Resources (including any standards relating to spend downs and disposition of resources):** The Title XXI program has no resource requirements.
- 4.1.5  **Residency:** Nevada residency is required. A resident is anyone who has their primary residence in Nevada for six months prior to the date of enrollment.

- 4.1.6.  **Disability Status (so long as any standard relating to disability status does not restrict eligibility):** No child is denied eligibility based on disability status. If the child receives SSI and is eligible for Medicaid, the child will not be enrolled in Nevada ✓ Check Up and will be referred to Medicaid.
- 4.1.7  **Access to or coverage under other health coverage:** The application form asks questions about all access to health care coverage, both public and private, on the application form before the child is enrolled in the program.  
 Random checks will be done by contacting employers for verification of health insurance coverage . A child will be found ineligible 1) if a child has creditable health insurance; 2) is eligible for health benefits coverage under a State health benefits plan based on a family members' employment with a public agency in the State; or 3) has had coverage under an employer plan on or after January 1, 1998, or for applications submitted after July 1, 1998, six months prior to application. The six month waiting period may be waived if the applicant provides evidence that the loss of insurance was due to actions outside the applicants control (e.g., employer discontinues health benefits).
- 4.1.8.  **Duration of eligibility:** Once a child has been accepted, he or she is continuously eligible in the health plan until the annual eligibility redetermination date, July 1 of each year unless the child moves out of state; becomes enrolled in Medicaid; secures other health insurance; becomes an inmate of penal institution or an institution for mental diseases; dies; or fails to pay quarterly premiums. A 60 day grace period will be allowed prior to disenrollment for failure to pay the premium. Families can remain in the program from year to year if they continue to meet the eligibility criteria.
- 4.1.9  Other standards (identify and describe):

**4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102)(b)(1)(B))**

- 4.2.1.  These standards do not discriminate on the basis of diagnosis.
- 4.2.2.  Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.
- 4.2.3  These standards do not deny eligibility based on a child having a pre-existing medical condition.

**4.3. Describe the methods of establishing eligibility and continuing enrollment. (Section 2102)(b)(2))**

Eligibility will be determined through a one page two-sided application form which will include the following information:

Name, social security number, date of birth, age, sex, ethnicity, and relationship to applicant of all children in the household;  
 All sources of income, including employment, child support, SSI, and other income;

Name of person responsible for health care cost of a child, if any;  
Insurance status, including whether insurance is offered through an employer; and,  
Citizenship and residency.

In addition, the applicant must provide proof of income by submitting copies of the two most current pay stubs from each job and their 1997 federal income tax return

Eligibility applications will be made available statewide through schools, child care facilities, family resource centers, social service agencies, and other locations where eligible children and/or their parents frequent. The applications will be completed and returned to a central processing facility of DHCFP in Carson City, Nevada. An 800 number has been established and listed on the application as well as on posters and marketing brochures at the above mentioned locations. A copy of the application package is included as Attachment D.

The initial application open enrollment period will run from March 15, 1998 through April 30, 1998. All applications filed on or before April 30, 1998, will be considered equally. The applications will be processed and those found eligible will be sent enrollment forms, subject to a full enrollment limitation (see below). Parents will have up to 60 days to return the enrollment form (including an enrollment fee) and to select a health plan for the child(ren). If the applicant fails to include the enrollment fee or to select a plan, the form will be returned and the child(ren) will not be enrolled until the fee and selection are received.

Upon receipt of the completed enrollment form and fee, the information will be entered into a data base. An approval notice will be sent to the family with the following information:

- Household Nevada ✓ Check Up ID number;
- Names of eligible children;
- Name of Health Plan;
- Effective month of enrollment;
- The amount and due dates of the quarterly premium

#### Full Enrollment Limitation

The program will be able to enroll at least 40,000 children (the exact amount will be determined based on the total \$42,000,000 divided by the annual cost per child) and it is unlikely that the state will reach that level, particularly in the initial application period. Nonetheless, if applications exceed the available money, the families with the highest income levels would be put on a waiting list.

If necessary, up to Five percent (5%) of available funds will be set aside for children with financial hardship (those coming off of Medicaid and children in families at or below \$15,000 per year who are not found to be eligible for Medicaid) to ensure that they can be immediately enrolled in Nevada ✓ Check Up.

If sufficient money is not available to enroll all eligible children in the initial phase, children in families with the highest gross family incomes will be put onto a waiting list. Additionally, any families who make application after the program is fully subscribed will be placed on a waiting list. Families on the waiting list will be sent enrollment forms when sufficient slots are available based on the lowest family gross income. Slots can become available because enrollment forms are not returned, children drop off the program, or additional funds become available.

Once enrolled, child(ren) will remain on the program (except as noted below) until the next eligibility determination date. This date will be June 30, 1999, and each subsequent year. Waiting lists will be used through April 1, 1999, and then redone through the eligibility determination process (open-enrollment period). Children will be disenrolled immediately (usually the first of the following month) for the following circumstances:

- a) The child enrolls in Medicaid (A monthly match will be performed between Medicaid and Nevada ✓ Check Up to ensure no duplications);
- b) The child gets other creditable insurance coverage;
- c) The child moves out of state or out of the home;
- d) The child becomes an inmate of a public institution;
- e) The child becomes a patient in an institution for mental diseases (for more than 30 days);
- f) The child dies;
- g) The family does not pay the quarterly premium (there will be notification and a 60 day grace period for payment);
- h) Child turns 19; or
- i) Child gets married or becomes emancipated.

For subsequent eligibility determinations, all children enrolled in the program will stay in the program as long as the family income is below the program maximum and they are not found to meet the circumstances listed in 4.3 a) through i). There will not be an enrollment fee for redeterminations of eligibility. All other applicants will be ranked based on gross family income, and made eligible within available funds. A new waiting list will be established, if necessary.

#### Management Information Systems Support

All paper flow into and out of central office will be tracked on a newly designed database. This information system will contain a fully automated capitation payments system and a series of tracking records which mirror the handling of paper membership applications from the moment they are received by mail to when the completed application is filed and the family receives its official enrollment notice.

Application and member tracking within the Nevada ✓ Check Up information system will include the determination of member-file status, application processing, eligibility determination, enrollment and the storage of enrollment data for active members. The majority of applicant data is stored in five primary tables: file tracking, application,

member's family information and financial information, and enrollment. Tracking will be linked by a family identifier assigned at the time of entry into the tracking system by the child's social security number and/or a unique identification number. Capitation payment to the MCO will be linked to the member's identification number.

#### Application Tracking

File folders are assembled with the last name of the parent, the postmark date of the application, application tracking record, and all application documentation for each application received. Families will be sent a letter requesting additional or missing information if necessary. The applicant will have 30 days to provide said information.

Application information is entered into the data system and a unique family ID is generated at the time of entry for the purpose of linking related records within the system.

Enrollees are required to notify DHCFP, within 30 days, if their circumstances change and when they are no longer eligible for Nevada ✓ Check Up. The contract also requires the health plans to report said information to DHCFP within 7 days of receipt of information.

#### **4.4. Describe the procedures that assure:**

##### **4.4.1. Through intake and follow up screening, that only targeted low-income children are furnished child health assistance under the state child health plan. (Section 2102)(b)(3)(A))**

Families who apply will be asked about insurance coverage for each child. If a child is currently covered, or was covered at any time since January 1, 1998, by private (creditable) insurance, the child will be ineligible for Nevada ✓ Check Up. Children will be eligible to apply only after six months without creditable insurance. The six month waiting period does not apply to children coming off of Medicaid, and may be waived for families who lose insurance for circumstances outside of their control (e.g., employer drops dependant health care coverage). Random verification of income and children's health insurance status through contact with employers and other means will be done.

Information in the application packet includes Medicaid eligibility criteria and how to apply for Medicaid as well as information on differences between Medicaid and Nevada ✓ Check Up. In particular, Medicaid has no cost sharing while Nevada ✓ Check Up has an enrollment fee and quarterly premiums. When the application is submitted, reported income will be screened and any family that reports income lower than the Medicaid threshold for a child on the application will be sent a further notice about the potential Medicaid eligibility and the lack of any cost sharing. This information will also include the address and phone number of the nearest Welfare Division Office where they can apply for Medicaid.

If the family applies for Medicaid first and is determined to be ineligible, they will be encouraged to complete the enrollment package for Nevada ✓ Check Up. Nevada ✓ Check Up application packets will be available at all Welfare offices.

Because Medicaid has a resource test but Nevada ✓ Check Up does not, Nevada ✓ Check Up will be unable to determine if a child is Medicaid eligible. It is inappropriate to require more information for lower income applicants than for relatively higher income applicants and would be contrary to the assurance under 4.2.2. For this reason, Nevada will enroll applicants in Nevada ✓ Check Up after the family:

- Has been provided with Medicaid eligibility information in the application packet;
- Has been provided with specific information- that their income as reported is within the Medicaid limit -on how and when to apply for Medicaid and- information that Medicaid does not charge an enrollment fee; and
- Has paid the enrollment fee to enroll in Nevada ✓ Check Up.

Medicaid rolls will be reviewed monthly through data system interface to ensure that children are not in both programs.

**4.4.2. That children found through the screening to be eligible for medical assistance under the state Medicaid plan under Title XIX are enrolled for such assistance under such plan. (Section 2102)(b)(3)(B))**

Because the Nevada Medicaid program in Nevada has resource tests which will not be applied with regard to Nevada ✓ Check Up, generally no definite determination of Medicaid eligibility can be made (children receiving SSI income will not be enrolled because that status would make them eligible for Medicaid). The information packets on Nevada ✓ Check Up will include information regarding Medicaid eligibility and how and where to apply, as well as programmatic advantages of Medicaid, including the lack of an enrollment fee or premiums and a broader benefits package. This will afford families a direct financial incentive to apply for Medicaid.

**4.4.3. That the insurance provided under the state child health plan does not substitute for coverage under group health plans. (Section 2102)(b)(3)(c))**

In order to apply for Nevada ✓ Check Up, children generally will have to have been without creditable insurance for at least six months. This should provide a major disincentive to families to drop current coverage. The exceptions to the six month waiting period are for children coming off of Medicaid and for families who lose insurance due to circumstances beyond their control (e.g., employer drops health insurance coverage for dependents). In those cases, Nevada ✓ Check Up coverage would not be substitution for coverage under group health plans.

DHCFP will closely monitor overall health insurance coverage for children and determine additional steps to be taken if substitution (crowd-out) appears to be taking place. To the extent that such steps include regulations on employers, legislation

would be required. As Nevada has a biennial legislature, any such policies could not be implemented until 1999.

**4.4.4. The provision of child health assistance to targeted low-income children in the state who are Indians (as defined in section 4(c) of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c). (Section 2102)(b)(3)(D))**

According to the State Demographer as of 1997 the Native American population in Nevada is 121,600 or 5.4% of the state's total population. There are twenty-six Tribal Councils and Head Start Programs; an Inter-Tribal Executive Board, and an Indian Commission. In March 1998 DHCFP staff will give an overview of the Nevada ✓ Check Up Program to the Inter-Tribal Council at their monthly meeting and to the Nevada Indian Commission. The director of the Head Start Program has agreed to distribute application packets to each of their Head Start programs.

Native American children will be provided the same opportunity for enrollment as all other children.

**4.4.5. Coordination with other public and private programs providing creditable coverage for low-income children. (Section 2102)(b)(3)(E))**

Other than Medicaid, there are no public or private programs providing creditable coverage for low-income children in Nevada.

## Section 5. Outreach and Coordination (Section 2102(c))

Describe the procedures used by the state to accomplish:

### 5.1 Outreach to families of children likely to be eligible for assistance or under other public or private health coverage to inform them of the availability of, and to assist them in enrolling their children in such a program: (Section 2102(c)(1))

Nevada will perform a multifaceted outreach effort to inform families of the availability of state sponsored health care coverage for children under both Nevada ✓ Check Up and Medicaid. Initially from March through June of 1998 the intent is to make all parents aware of the programs through a blanket distribution of application packets along with press and media coverage on the program roll out. Public service announcements will also be used.

#### Application Packet

The application packet includes a letter from Governor Miller to Nevada parents on the importance of health care insurance coverage in raising children as well as the State's programs to aid low income families to secure the coverage. There is also information on both Medicaid and Nevada ✓ Check Up as well as an explanation of significant differences. A Nevada ✓ Check Up application form is also included. A copy of the packet is included as Attachment C.

DHCFP will print 400,000 copies of the packet which will be produced in both English and Spanish.

#### Distribution

The primary distribution will be through the school system. The seventeen school districts have committed to providing information packets to every child in their schools. This will be supplemented with information in newsletters and other school mailings and during parent/teacher conferences. Nearly 300,000 packets will be disseminated in this manner.

Application packets will also be distributed through the Head Start program, Tribal Councils, child care facilities, Family Resource Centers, State Welfare Offices, the WIC program, employment centers, county social services agencies, county health districts, the State Health Division's Community Health Nursing and Special Children's Clinic programs, the Family to Family program, public libraries, Boys & Girls Clubs, and other program/facilities where parents of potentially eligible children may be reached.

Nevada will also provide application packets, as well as additional information, to other organizations that wish to aid the state in its informational campaign. Public hospitals, FQHCs, and some community based organizations have already expressed interest in such a project. Using health care providers at this stage does not present a problem to direct marketing because the emphasis is outreach and encouraging people to apply and does not relate to selection of a plan.

Finally, Nevada has established an 800 number for people who want an application form mailed to them. The number will also be used for providing assistance in completing the form and other questions about the program.

Through these efforts, the State believes that substantially all eligible families will become aware of the program.

#### Second Phase Outreach

After the initial enrollment phase, demographic information on children who enrolled will be reviewed and compared with information from the survey on the uninsured to determine areas where more targeted outreach efforts are necessary. Outreach strategies will then be developed.

#### Assistance in Enrolling Children

The most important "assistance" provided is the use of a simple application form which will enable most parents to fill out the form without direct help. The state will encourage community based organizations to aid those who may need it. Finally, as previously mentioned, there will be a toll free number for people with questions on how to apply.

Once eligibility has been determined, an enrollment packet will be sent out. This packet will include information on the various managed care choices available to assist families in selecting an MCO.

### **5.2 Coordination of the administration of this program with other public and private health insurance programs: (Section 2102(c)(2))**

Nevada ✓ Check Up will be closely coordinated with the Medicaid program. When families apply, a match will be performed through the data system interface to determine if a child is in Medicaid. Based on the income reported, if a child may qualify for Medicaid, further information will be sent to the family regarding application for Medicaid. Because Nevada ✓ Check Up has an enrollment fee and premiums, there will be an economic incentive for the family to make a Medicaid application for said child(ren). Families who first apply for Medicaid and are determined ineligible will be referred to Nevada ✓ Check Up.

Ongoing on a monthly basis, eligibility roles will be reviewed to ensure that children who have subsequently enrolled in Medicaid are disenrolled from Nevada ✓ Check Up. Additionally, children being disenrolled from Medicaid will be given an opportunity to enroll in Nevada ✓ Check Up without a waiting period.

From a service standpoint, all of the HMOs who provide services in the Medicaid voluntary managed care program have expressed interest in being Nevada ✓ Check Up providers as well. Though not required, DHCFP will encourage providers to be in both programs. Evaluation, oversight, and reporting by MCOs will be coordinated between Medicaid and Nevada ✓ Check Up. If other qualified MCOs participate in Nevada ✓ Check Up, they to will be evaluated and monitored in the same manner as the Medicaid HMOs.

To the extent that the MCOs are in both programs, children moving between programs will be able to maintain their primary care physician. This will improve continuity of care.

Outreach efforts for Medicaid and Nevada ✓ Check Up will be closely coordinated. Demographic data and the surveys on insurance status of children will be used for both programs. Finally, Nevada ✓ Check Up will build on the relationship between Medicaid and other social service organizations (see 2.2.1) in informing eligible individuals about available services.

**Section 6. Coverage Requirements for Children's Health Insurance** (Section 2103)

- Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 7.**

**6.1. The state elects to provide the following forms of coverage to children:**

(Check all that apply.)

- 6.1.1.  **Benchmark coverage;** (Section 2103(a)(1))
- 6.1.1.1.  **FEHBP-equivalent coverage;** (Section 2103(b)(1))  
(If checked, attach copy of the plan.)
- 6.1.1.2.  **State employee coverage;** (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)
- 6.1.1.3.  **HMO or MCO with largest insured commercial enrollment** (Section 2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description.)

Nevada has opted to offer Health Plan of Nevada's (HPN) Sierra Health Care Bronze VI Health Plan for its CHIP program, their most subscribed to plan. In April 1982, HPN became a licensed HMO in Nevada and is federally qualified. HPN is the largest commercial HMO in Nevada. As of January 1, 1998, Health Plan of Nevada had the following enrollee population: Commercial-142,902, Medicare-31,716, and Medicaid-1995, a total of 176,612. In addition, their PPO totals 23,326. Of note, HPN is one of the four Nevada Medicaid HMOs (Refer to Attachment D).

- 6.1.2.  **Benchmark-equivalent coverage;** (Section 2103(a)(2)) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach signed actuarial report that meets the requirements specified in Section 2103(c)(4). **See instructions.**
- 6.1.3.  **Existing Comprehensive State-Based Coverage;** (Section 2103(a)(3)) [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If existing comprehensive state-based coverage is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for existing comprehensive state-based coverage.
- 6.1.4.  **Secretary-Approved Coverage.** (Section 2103(a)(4))

**6.2. The state elects to provide the following forms of coverage to children:  
(Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a))**

- 6.2.1.  **Inpatient services** (Section 2110(a)(1))  
Inpatient services includes all physician, surgical and other services delivered during a hospital stay. Inpatient services covered in full with no co-payments.
- 6.2.2.  **Outpatient services** (Section 2110(a)(2))  
Outpatient services include outpatient surgery – covered in full with no co-payments.
- 6.2.3.  **Physician services** (Section 2110(a)(3))  
Physician services include medical office visits with a physician, mid-level practitioner or specialist. Covered in full with no co-payment. Preventive care and immunizations covered in full with no co-payment.
- 6.2.4.  **Surgical services** (Section 2110(a)(4))  
Covered in full. See 6.2.1 for inpatient surgical services and 6.2.2 for outpatient surgical services.
- 6.2.5.  **Clinic services (including health center services) and other ambulatory health care services.** (Section 2110(a)(5))  
See section 6.2.2.
- 6.2.6.  **Prescription drugs** (Section 2110(a)(6))  
Covered for outpatient prescription drugs with no co-payment for families at or below 150% FPL and \$5 prescription co-payment for families above 150% FPL.
- 6.2.7.  **Over-the-counter medications** (Section 2110(a)(7))
- 6.2.8.  **Laboratory and radiological services** (Section 2110(a)(8))  
Covered in full with no co-payment for physician-ordered services.
- 6.2.9.  **Prenatal care and pre pregnancy family services and supplies** (Section 2110(a)(9))  
Family planning and prenatal maternity care covered in full with no copayment.
- 6.2.10.  **Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services** (Section 2110(a)(10))  
20 days of inpatient mental health services covered. No co-payments.
- 6.2.11.  **Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services** (Section 2110(a)(11))  
Outpatient mental health services covered with a 20 visit limit per year.
- 6.2.12.  **Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices)** (Section 2110(a)(12))

Limited to hearing aids and glasses, each subject to \$10 co-payment for families above 150% FPL and limited to one device every twenty-four (24) months.

- 6.2.13.  **Disposable medical supplies** (Section 2110(a)(13))
- 6.2.14.  **Home and community-based health care services (See instructions)** (Section 2110(a)(14))
- 6.2.15.  **Nursing care services (See instructions)** (Section 2110(a)(15))  
Skilled nursing covered up to 100 day per year; ICF not covered. No co-payment.
- 6.2.16.  **Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest** (Section 2110(a)(16))
- 6.2.17.  **Dental services** (Section 2110(a)(17))  
Coverage for preventive, diagnostic and treatment, and other general dental services and emergency assessments with no co-payment for families at or below 150% FPL and below and \$5 co-payment per visit for families above 150% FPL. Orthodontia services are not covered.
- 6.2.18.  **Inpatient substance abuse treatment services and residential substance abuse treatment services** (Section 2110(a)(18))  
Limited to \$9,000 per year. No co-payment. Lifetime substance abuse rehabilitation limit of \$39,000.
- 6.2.19.  **Outpatient substance abuse treatment services** (Section 2110(a)(19))  
Limited to \$2,500 and lifetime of \$39,000. No co-payment.
- 6.2.20.  **Case management services** (Section 2110(a)(20))
- 6.2.21.  **Care coordination services** (Section 2110(a)(21))
- 6.2.22.  **Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders** (Section 2110(a)(22))  
Short-term Inpatient and Outpatient rehabilitation services limited to 60 consecutive days per condition per lifetime. No co-payment except \$10 for hearing aids for families above 150% FPL.
- 6.2.23.  **Hospice care** (Section 2110(a)(23))  
Covered with no co-payment. Inpatient covered. Inpatient and outpatient limited to \$1,500 per year.
- 6.2.24.  **Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions)** (Section 2110(a)(24))  
Annual vision screening exam and glasses (for \$10 co-payment for families above 150% FPL if medically indicated). Refer to 6.2.22. No co-payment.
- 6.2.25.  **Premiums for private health care insurance coverage** (Section 2110(a)(25))
- 6.2.26.  **Medical transportation** (Section 2110(a)(26))  
Hospital and emergency room transport covered. No co-payment.
- 6.2.27.  **Enabling services (such as transportation, translation, and outreach services (See instructions)** (Section 2110(a)(27))
- 6.2.28.  **Any other health care services or items specified by the Secretary and not included under this section** (Section 2110(a)(28))

Generally, benefits are subject to prior authorization and/or other utilization review controls as established by the plan, except for emergency services. For areas not covered by an MCO, a fee for service benefit will be offered with the same benefit package but without the same prior authorization and/or utilization review controls.

## Section 7. Quality and Appropriateness of Care

- Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 8.

### 7.1 Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (2102(a)(7)(A))

The Division of Health Care Financing and Policy will perform the same readiness review process, less those issues which are specific to Medicaid, prior to allowing the HMO or MCO contractor to deliver services under the Nevada ✓ Check Up program.

Overall program monitoring, to assure quality and appropriateness of care, will be performed on an ongoing basis by the following activities:

- 1) Review and analysis of encounter and financial data;
- 2) Review of client and provider complaints and grievances files with the State Insurance and/or Health Division; and
- 3) The compilation, review and investigation (where warranted or consumer satisfaction data);
- 4) Establishment of quality and performance measures for well baby care, well child care and immunization monitored through encounter data and chart review.

Monitoring of the contractors will be performed through the following actions:

- 1) An annual quality and operational review of each contractor;
- 2) Requiring the same encounter data reporting (in form, format, and periodicity) as required under the Medicaid Voluntary Managed Care program (to the extent that such services are program benefits under the contract);
- 3) Review of the contractors and contract data by an External Quality Review Organization (EQRO);
- 4) Generation of HEDIS reporting, depending on program benefits under the contract, with the same periodicity, form and format as under the Medicaid Voluntary Managed Care program;
- 5) Performing on-site review, if problems of a material nature arise;
- 6) Performance of a yearly member satisfaction survey by DHCFP and/or the MCO contractor with review, analysis and follow-up (as required) by the State.
- 7) Grievances filed by subscribers with participating plans. Participating plans will be contractually required to report grievances on a quarterly basis. These reports will be shared with subscribers who request the information. In addition, DHCFP will track the information on the number and type of grievances filed by all participants enrolled in a plan. Grievance information will be used by DHCFP to identify plan performance needing improvement and to form the basis of future performance standards.
- 8) DHCFP will work with the state's two health insurance industry regulatory entities (Divisions of Insurance and Health) to assure that all publicly available data on health plan performance is known to DHCFP.

Will the state utilize any of the following tools to assure quality?

(Check all that apply and describe the activities for any categories utilized.)

7.1.1  **Quality standards**

The state will utilize quality standards for the Nevada ✓ Check Up program comparable to those currently used under the Medicaid Voluntary Managed Care Program.

The following clinical areas of concern will be monitored:

1. Comprehensive Well Baby and Well Child Periodic and Interperiodic Health

Standard

Well Baby/Well Child screening comprise a comprehensive health and developmental history, unclothed physical exam, and vision, dental, and hearing evaluations with follow-up. When indicated appropriate diagnostic and treatment services must be provided. Periodic screening will be completed on eligible children between the ages of 0 through 18 according to the most current Guidelines from Medicaid (Health Plan Employer Data and Information Set) (HEDIS).

An interperiodic screening is a screening provided at such other intervals, indicated as medically necessary, to determine the existence of physical or mental illnesses, or conditions of concern or to follow up on previously diagnosed health problems. Such screening exams must be provided at the request of a parent, guardian, health or educational professional.

2. Childhood Immunizations

Standard

Age appropriate immunizations will be documented in the medical record unless documentation is provided of exemption due to State law. Age appropriate immunizations required by the State are those immunizations recommended by a recognized Medical Academy and/or required by the Health Care Financing Administration (HCFA). The MCO will be responsible to implement the most recent immunization schedule as endorsed by the American Academy of Pediatrics and the Nevada Health Division.

3. Family Planning

Standard

Family planning services will be provided to Nevada ✓ Check Up eligible clients (both male and female) of child bearing age.

4. Dental Services

Standard

Dental services (excluding orthodontia) will be provided to Nevada ✓  
Check Up eligible participants.

5. Medical Record Standards

Standard

The HMO or MCO must maintain medical records in accordance with  
Standard XII of the "Guidelines for Internal Quality Assurance Programs"  
as set forth in the HCFA Medicaid guidelines.

6. Appointment Standards

Standard

90% of appointments must meet time criteria (both for waiting and for  
number of days between request and appointment).

7.1.2  **Performance measurement**

Performance measurements for each of the Quality Standards noted in 7.1.1  
similar to, or the same as, those currently utilized in the Medicaid Voluntary  
Managed Care program.

1. Comprehensive Well Baby and Well Child Periodic and Interperiodic  
Health Assessments - Periodic screening

Measurement

- a) 80% of Nevada ✓ Check Up eligible children who have been enrolled  
for twelve (12) months must have an age appropriate Periodic  
screening. HMO or MCO compliance will be monitored by a quarterly  
evaluation of encounter data and, if indicated, liquidation damages will  
be calculated based on the initial annual review; that is, twelve (12)  
months of the contract year.

Liquidation Damage: (number of required Periodic screening not  
completed) x (Periodic screening fee) = liquidation damage.

- b) Annually a chart sample of Nevada ✓ Check Up eligible children will  
be reviewed. During chart review, areas of critical concern will be age  
appropriate developmental, dental, vision and hearing screening with  
follow-up, when indicated, by diagnostic and treatment activities  
and/or referrals. The timely scheduling and completion of interperiodic  
screening upon request, accompanied by necessary follow-up activities,  
will be assessed during the chart review.

Corrective action: If the chart reviews suggest poor quality of medical care and/or inadequate follow up activities and treatment, DHCFP may direct the or MCO to conduct a study of particular areas of concern. In cases of immediate concern, a simultaneous referral to the Division of Insurance and Health Division may be initiated for further examination of appropriateness and quality of care within the existing scope of each agency.

Method

Encounter data, chart review, analysis of number and nature of complaint reports, and recipient/guardian surveys will be analyzed and evaluated.

Frequency

DHCFP will generate quarterly reports from encounter data with an annual cumulative report. An annual on-site review with an emphasis on chart review will be conducted by DHCFP and/or an EQRO. Chart review may be conducted more often than annually, if indicated.

2. Childhood Immunizations

Measurement

Documentation showing 90% of Nevada ✓ Check Up eligible non-exempt individuals ages 0 through 2 are appropriately immunized. Documentation showing 95% of Nevada ✓ Check Up eligible non-exempt individuals ages 3 through 18 are appropriately immunized. Nevada ✓ Check Up clients must have been enrolled for 6 months before compliance with required percentages is calculated. Each immunization (vaccine) will be two encounter codes. One code will indicate administration of a specific vaccine by the MCO; the second code will indicate a history of receiving a specific immunization.

An action plan will be required from the MCO if compliance is less than 90% for individuals ages 0 through 2 and/or less than 95 % for individuals 3 through 18.

Method

Encounter data, chart review, and analysis of number and nature of complaints reported.

Frequency

DHCFP will generate quarterly reports from encounter data with an annual cumulative report. An annual review will be conducted by DHCFP and/or an EQRO.

### 3. Family Planning

#### Measurement

80% of eligible clients of child bearing age will receive age appropriate education and services regarding family planning. A chart sample of participants who have been enrolled for at least 6 months will be reviewed for compliance. At a minimum documentation indicating family planning information was offered or provided must be evident in the client's record. An action plan will be required if the percent of compliance is less than 80%.

#### Method

Encounter data, chart review and verification of service from clients whose records were reviewed will be evaluated, analysis of number and nature of complaints reported, and recipient/guardian surveys will be analyzed and evaluated.

#### Frequency

DHCFP will generate quarterly reports and an annual cumulative report utilizing encounter data submitted by the HMO or MCO. DHCFP will conduct an annual review. If the reviewed sample does not meet the minimum percentage criteria, follow-up will be conducted by DHCFP staff.

### 4. Dental Services

#### Measurement

20 percent of its participants ages 3 to 5 who have been enrolled at least twelve (12) months will receive at least one oral health screening, referral and follow-up for necessary diagnostic and preventive services; and, 50 percent of its participant ages 5 to 18 who have been enrolled for twelve (12) months will receive at least one dental visit in the reporting year.

#### Method

Encounter data, chart review and verification of service from participants whose records were reviewed will be evaluated, analysis of number and nature of complaints reported, and recipient/guardian surveys will be analyzed and evaluated.

#### Frequency

DHCFP will generate quarterly reports and an annual cumulative report utilizing encounter data submitted by the HMO or MCO. DHCFP will conduct an annual review. If the reviewed sample does not meet the minimum percentage criteria, follow-up will be conducted by DHCFP and/or EQRO staff.

## 5. Appointment standards

### Measurement

#### Appointments with Primary Care Providers (PCP):

The HMO or MCO shall have procedures in place that ensure:

- (a) Same day primary care provider appointments (e.g., high temperature, persistent vomiting or diarrhea, symptoms which are of sudden or severe onset but which do not require emergency room service) are available the same day;
- (b) Urgent care PCP appointments (e.g., persistent rash, recurring high grade temperature, nonspecific pain, fever) are available within two calendar days; and
- (c) Routine care PCP appointments (e.g., well child/baby exams, routine physical exams) are available within two weeks. This two week standard does not apply to regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits more frequently than once every two weeks.

#### Specialty appointments

For specialty referrals to physicians, therapist and other diagnostic and treatment health care providers the HMO or MCO shall provide:

- (a) Same day appointments within twenty-four hours of referrals as in (a) above;
- (b) Urgent care appointments within three calendar days of referral; and
- (c) Routine appointments within two weeks

#### Dental Appointments

- (a) Initial appointment to a dentist is available within four weeks;
- (b) Follow up appointments according to a plan of care within two weeks;
- (c) Urgent care appointments within one week; and
- (d) Emergency care (severe tooth ache, loss of tooth) within 24 hours.

#### Office Waiting Times

The HMO or MCO shall monitor and ensure that a participant's waiting time at the PCP or specialist office is not more than one hour from the scheduled appointment time, except when the provider is unavailable due to an emergency. Providers can be delayed when they

“work in” urgent cases, when a serious problem is found, or when the patient had an unknown need that requires more services or education than was described at the time the appointment was made.

An action plan will be required if the 90% Standard is not met.

Method

DHCFP and/or an EQRO may validate this annually by means of on-site observations, chart reviews, enrollee satisfaction surveys, review of grievances, and interviews with enrollees.

Frequency

DHCFP and/or an EQRO may conduct reviews of available data not less often than annually.

6. Medical Records Standards

Measurement

Of the 16 elements of medical record keeping, 9 are critical and must be present in each record. The critical items for medical record keeping are as follows: 1) patient identification information; 2) personal/biographical data; 3) entry date; 4) provider identification; 5) legibility; 6) allergies; 7) immunizations; 8) medication information; and 9) identification of current problems.

A sample of the HMO’s Medicaid participants medical records will be reviewed. 90% of records reviewed must contain medical record keeping and patient visit date items indicated as critical. An action plan will be required if the percent meeting standards is less than 90%.

Method

Medical records will be reviewed.

Frequency

Chart reviews will be conducted annually by DHCFP and /or an EQRO. If the reviewed sample does not meet the minimum criteria, a corrective action plan will be required from the HMO or MCO and follow-up will be done by the DHCFP staff.

(Please note that the specific standards may be altered as a result of contract negotiations.)

7.1.3  **Information strategies**

At the time of enrollment notification, DHCFP will mail to the approved applicant information about each health plan available in his/her service area. The information will provide the eligible enrollee general information about

the health plan's organization structure, provider network, and other unique services available through the plan, if any.

All Nevada ✓ Check Up enrollees will receive handbooks from their chosen health plan which will describe the benefits provided to enrollees under the program. These materials also describe members' rights and responsibilities and the specific steps to file a grievance.

DHCFP will collect information from the health plans on a quarterly and annual basis. This reporting provides information on enrollment, demographic, and ethnic characteristics, outreach efforts, use of medical and dental services, member grievance information, and data on financial expenditures. Information will be used by DHCFP to document performance and assure adequate program accountability.

The Division, HMO, MCO and/or the External Quality Review Organization (EQRO) will conduct yearly consumer satisfaction surveys no more than 3 months after the end of the first year of the contract and every year thereafter. This data will be compiled and analyzed. Where areas of concern will be performed and if the area of concern is valid, the MCO will be required to produce a Corrective Action Plan as currently required under the Medicaid Voluntary Managed Care program.

7.1.4.  **Quality improvement strategies**

Quality improvement strategies, which the MCO contractor must comply with, are as follows:

- 1) Requirements for written policies and procedures regarding prior authorization standards and criteria, and for periodic review and updating of said policies and procedures;
- 2) Policies and Procedures regarding Utilization Review activities, including reports to State Agencies on methods from reviewing, and follow-up activities required based on the outcome of the review activities;
- 3) Establishment (including requirements) of a Quality Assurance Program designed to direct, evaluate and monitor the effectiveness of health care services provided to its insureds. The program must include, as defined in the Nevada Statutes, without limitation:
  - a) A method for analyzing the outcomes of health care services;
  - b) Peer review;
  - c) A system to collect and maintain information related to the health care services provided to insureds;
  - d) Recommendations for remedial actions; and
  - e) Written guidelines that set forth the procedures for remedial action when problems related to quality of care are identified.

- 4) Corrective Action Plans will be required as indicted above, where quality standards, consumer satisfaction surveys or performance measurements are below those expected.
- 5) In severe cases, the Division will assess liquidated damages for not meeting performance measures.

**7.2 Describe the methods used, including monitoring, to assure access to covered services, including emergency services. (2102(a)(7)(B))**

State licensed HMOs will be the principal health plan providers for enrollees. Under Nevada Revised Statute 695C, these entities are subject to oversight and regulation by the Insurance Division. The Insurance Division is primarily responsible for monitoring initial capitalization and financial solvency. The Health Division is charged with monitoring quality of care and assuring the availability of and accessibility to health services.

To obtain licensure, certain requirements regarding availability and access must be satisfied by an HMO. These requirements are:

- Coverage for basic health services, including emergency services;
- Provisions for access to primary care physician for each subscriber;
- Evidence of arrangements for the ten most commonly used specialists;
- Policies on obtaining referrals for specialty care;
- Physician and provider network capacities.

Many of these requirements are evaluated initially upon licensure; upon request for service area expansion; and periodically through complaint and grievance monitoring as well as, on-site visits by both Divisions.

To participate in the Nevada ✓ Check Up program, health plans must establish and maintain provider networks with sufficient number of providers in each contracted geographic service area. The MCO's network must contain all provider types necessary to provide to its participants a continuum of services which includes primary and preventive care, and includes the diagnosis, management and treatment of a variety of diseases and conditions, as well as, specialized care to handle complex health problems. The networks must include the provider types necessary to furnish the prepaid benefit package, including; hospitals, physicians (primary care and specialist), mental health and substance abuse providers, nursing homes, and pharmacies. Health plans shall not include in their networks any medical provider who has been sanctioned by Medicare or Medicaid.

Service Accessibility: Health plans must take measures to ensure compliance with the access standards. DHCFP will monitor health plan performance and will take action if problems are identified.

An analysis of access to care will be based on the results of member satisfaction survey, member complaint data, member and type of PCP's and specialists and appointment scheduling.

Twenty-Four (24) Hour Coverage: Health plans must provide health care coverage to its members, twenty-four (24) hours a day and seven (7) days a week. Health plans must instruct their members on how to obtain services after business hours and on weekends.

Telephone Access: Health plans may require their PCPs to have primary responsibility for serving as an after hours "on-call" telephone resource to members with medical problems. Whether or not the plan assigns primary responsibility for after hours telephone access to a PCP, it must have a (24) twenty-four hour toll free telephone number for members to call which is answered by a live voice (answering machines are not acceptable).

Days to Appointment: Health plans must abide by the following appointment standards:

- Urgent medical or behavioral problems within 24 hours;
- Non-urgent "sick visits" within 48 hours, as clinically indicated;
- Routine, non-urgent or preventive care visits within two weeks; and
- In-plan, non-urgent mental health or substance abuse visits within two weeks.

Emergency Services: Health plans cannot require members to seek prior authorization for services in a medical or behavioral health emergency. Plans must inform their members that access to emergency services is not restricted and that if the member experiences a medical or behavioral health emergency, he/she may obtain services from a non-plan physician or other qualified provider, without penalty. However, health plans may deny payment for such a visit should the visit be determined as a non-emergency using a prudent lay person standard. The health plan may require members to obtain prior authorization for any follow-up care delivered pursuant to the emergency.

**Section 8. Cost Sharing and Payment** (Section 2103(e))

Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the states Medicaid plan, and continue on to Section 9.

**8.1. Is cost-sharing imposed on any of the children covered under the plan?**

- 8.1.1.  YES
- 8.1.2.  NO, skip to question 8.5.

**8.2. Describe the amount of cost-sharing and any sliding scale based on income:**

(Section 2103(e)(1)(A))

**8.2.1. Premiums:** A quarterly premium will be charged per family on gross income. (see chart below.) The premium will be due on the first day of each quarter (January 1, April 1, July 1, and October 1). No premium will be charged for the first quarter of coverage, but an enrollment fee will be charged (see below). Families will be informed at the time of enrollment notification of the timing and amount of premiums, and a reminder notice will be sent approximately 3 weeks prior to the due date. Should the family fail to submit premium payment by the 10<sup>th</sup> day of the month the premium is due the health plan will be sent a listing of families who have not paid the quarterly premium. The health plan will be encouraged to contact the family by letter or phone. If payment is not received by the 45<sup>th</sup> day of the quarter, the family will be sent a notice of disenrollment to be effective the first day of the next month.

**8.2.2. Deductibles:** There are no deductibles.

**8.2.3 Coinsurance:** There is a \$5 co-payment required for each drug prescription and dental visit; and a \$10 co-payment for eye glasses and hearing aids for families above 150% of FPL. No other co-payments are allowed. Families with income at or below 150% of FPL are not subject to co-payments.

**8.2.4 Other: Enrollment fee:** This will be in lieu of the first quarterly premium. The fee is based on gross annual income and represents total costs per family.(See below.)

<u>Family of 2</u>	One-time	Quarterly	<u>Family of 3</u>	One-time	Quarterly
	<u>Enrollment Fee</u>	<u>Premiums</u>		<u>Enrollment Fee</u>	<u>Premiums</u>
Up to \$16,000	\$20	\$10	Up to 20,000	\$20	\$10
\$16,001-18,500	\$40	\$20	\$20,001-23,250	\$40	\$20
\$18,501-21,000	\$50	\$50	\$23,251-26,500	\$50	\$50

<u>Family of 4</u>	One-time	Quarterly	<u>Family of 5</u>	One-time	Quarterly
	<u>Enrollment Fee</u>	<u>Premiums</u>		<u>Enrollment Fee</u>	<u>Premiums</u>
Up to \$24,000	\$20	\$10	Up to 28,000	\$20	\$10
\$24,001-28,000	\$40	\$20	\$28,001-32,800	\$40	\$20
\$28,001-32,000	\$50	\$50	\$32,801-37,500	\$50	\$50

These amounts may be revised upward in conjunction with changes in the federal poverty level.

The state will adjust cost sharing payments to a family whenever necessary to assure the families sharing costs are below the levels included under Section 1916(b)(1), calculated on an annual basis. The state will achieve this by first decreasing the amount of the enrollment fee, and then if necessary, the amount of the quarterly premium. Since the total cost of the enrollment fee and premiums would be only \$50 for families under 150 percent of FPL, this would represent less than \$5 per month. If the maximum allowable premiums were lower, the enrollment fees and premiums would be reduced as follows:

<u>Maximum Monthly Fee</u>	<u>Enrollment Fee</u>	<u>Quarterly Premiums</u>
\$4	\$18	\$10
\$3	\$ 6	\$10
\$2	\$ 0	\$ 8
\$1	\$ 0	\$ 4

In the case of a family enrolling for less than a full year period, similar adjustments would be made. In the case of a family disenrolling from Nevada ✓ Check Up prior to the end of a full year (e.g. becomes enrolled in Medicaid), a refund would be sent if the effective monthly charge exceeds the maximum allowed under 1916(b)(1).

**8.3 Describe how the public will be notified of this cost-sharing and any differences based on income:**

The cost sharing information will be explained to potential enrollees through an informational brochure designed by DHCFF, the application, and by health plans. The disseminated information will breakdown the costs by gross income sliding fee scale. (see Attachment C)

**8.4. The state assures that it has made the following findings with respect to the cost sharing and payment aspects of its plan: (Section 2103(e))**

- 8.4.1.  **Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B))**
- 8.4.2.  **No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2))**
- 8.4.3.  **No child in a family with income less than 150% of the Federal Poverty Level will incur cost-sharing that is not permitted under 1916(b)(1).**  
Enrollment fees and/or premiums will be reduced if the total payments for the plan year (July-June) divided by the anticipated number of months on the program exceeds the monthly payment limit permitted. Also, if a family is disenrolled during the year, the enrollment fees and premiums actually paid would be divided by the number of months actually on the program and compared to the monthly payment limit. If it exceeds the limit, a refund will be issued.
- 8.4.4.  **No Federal funds will be used toward state matching requirements. (Section 2105(c)(4))**

- 8.4.5.  **No premiums or cost-sharing will be used toward state matching requirements.** (Section 2105(c)(5))
- 8.4.6.  **No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title.** (Section 2105(c)(6)(A))
- 8.4.7.  **Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997.** (Section 2105(d)(1))
- 8.4.8.  **No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.** (Section 2105(c)(7)(B))
- 8.4.9.  **No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above).** (Section 2105(c)(7)(A))

**8.5 Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family’s annual income for the year involved:** (Section 2103(e)(3)(B))

The cost sharing requirements are set at very low levels so it is extremely unlikely that any families over 150% of FPL could approach the 5 percent cap. For a family of two just above 150% of FPL, the 5 percent cap would represent \$800 (\$16,001 x .05). The total premiums and enrollment fee for a year would be \$100, leaving \$700 for co-payments. In order to exceed this amount, more than 140 prescriptions, dental visits, eyeglasses (count as 2), and hearing aids (count as 2) would have to be accessed by the child within a year. Families will be apprised of the 5 percent cap with their enrollment forms as well as a process for making a claim if they exceed the cap. Additionally, the state will review encounter data annually to determined if any family has sufficient encounters to trigger the 5 percent cap, and will refund any payments in excess of the cap to the family.

**8.6. The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan:**

- 8.6.1.  **The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services** (Section 2102(b)(1)(B)(ii)); **OR**
- 8.6.2.  **The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.3.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA** (Section 2109(a)(1),(2)). **Please describe:** \_\_\_\_\_

## **Section 9. Strategic Objectives and Performance Goals for the Plan Administration** (Section 2107)

### **9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children:** (Section 2107(a)(2))

The strategic objectives for the Nevada ✓ Check Up program are to:

1. Decrease the percentage of children eligible for Medicaid that are not enrolled in the program.
2. Decrease the percentage of children under 200% of poverty that do not have creditable health coverage.
3. Reduce the overall percentage of uninsured in Nevada.
4. Increase availability of managed care in rural Nevada.
5. Limit decrease of private insurance for children under 200% of poverty.

### **9.2 Specify one or more performance goals for each strategic objective identified:** (Section 2107(a)(3))

The following performance goals and measures will be used to evaluate the program's effectiveness:

1. Within one year enroll at least 40% of children under 100% of poverty not currently enrolled in the program. Increase by 5% each year for the next 4 years, such that by 2003, at least 60% of such children are in Medicaid. (Note: Children under 100% of poverty is used as a proxy for Medicaid eligible because there is no current system to specifically track all of the aspects of Medicaid eligibility (e.g. resource test, disability etc.)
2. Within one year, at least 50% of children under 200% of poverty not currently insured should have coverage. Increase percentage 5% each year for 2 years, then maintain at 60%.
3. Overall uninsured rate should decrease by at least one percentage point (e.g. for 17% to 16%) in the first year, then maintain lower level.
4. Managed care enrollment in rural Nevada for private insurance should increase by at least 100% in three years, and 10% per year thereafter.
5. Unfortunately, crowd out will occur to some degree, if only as a result of new employees with less financial incentive to provide insurance for low income workers. For the first year this should be no more than 10% increasing to 20% in the second year and 25% thereafter.

### **9.3 Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance indicators as specified below or other indicators the state develops:** (Section 2107(a)(4)(A),(B))

The primary source for measuring the five performance indicators will be an annual survey of the uninsured. The baseline will be established from a survey currently underway, being performed by the University of Nevada-Las Vegas. A longitudinal study will allow for determining the degree to which these goals are met. Additionally, data from the Bureau of

the Census are poverty and insurance status, data for the Nevada Division of Insurance on health care covered lives and enrollment data for Medicaid and Nevada ✓ Check Up will be used to confirm the data.

**Check the applicable suggested performance measurements listed below that the state plans to use:** (Section 2107(a)(4))

- 9.3.1.  **The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.**
- 9.3.2.  **The reduction in the percentage of uninsured children.**
- 9.3.3.  **The increase in the percentage of children with a usual source of care.**
- 9.3.4.  **The extent to which outcome measures show progress on one or more of the health problems identified by the state.**
- 9.3.5.  **HEDIS Measurement Set relevant to children and adolescents younger than 19.**
- 9.3.6.  **Other child appropriate measurement set. List or describe the set used.**
- 9.3.7.  **If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:**
  - 9.3.7.1.  Immunizations
  - 9.3.7.2.  Well child care
  - 9.3.7.3.  Adolescent well visits
  - 9.3.7.4.  Satisfaction with care
  - 9.3.7.5.  Mental health
  - 9.3.7.6.  Dental care
  - 9.3.7.7.  Other, please list: \_\_\_\_\_
- 9.3.8.  **Performance measures for special targeted populations.**

**9.4  The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires.** (Section 2107(b)(1))

**9.5  The state assures it will comply with the annual assessment and evaluation required under Section 10.1. and 10.2. (See Section 10) Briefly describe the state's plan for these annual assessments and reports.** (Section 2107(b)(2))

The state's plan for the assessments and reports will include an annual update of a survey on insurance coverage for children in Nevada. This survey will initially be used to determine the extent of coverage and related crowd-out issues, but will be designed to allow for additional questions on health status, access to care and other issues as appropriate.

The state will also perform surveys of families on the program regarding access to care, grievance resolution and overall satisfaction. HEDIS reporting will be evaluated for quality of health coverage.

The information will be compiled by state staff and will address each of the performance goals included in Section 9.2. Variances will be addressed and evaluated to determine policies to improve the performance of the program. Also, performance goals will be reevaluated and changes made as appropriate.

9.6.  **The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit.** (Section 2107(b)(3))

9.7.  **The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed.**

9.8. **The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX:** (Section 2107(e))

9.8.1.  **Section 1902(a)(4)(c) (relating to conflict of interest standards)**

9.8.2.  **Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)**

9.8.3.  **Section 1903(w) (relating to limitations on provider donations and taxes)**

9.8.4.  **Section 1115 (relating to waiver authority)**

9.8.5.  **Section 1116 (relating to administrative and judicial review), but only insofar as consistent with Title XXI**

9.8.6.  **Section 1124 (relating to disclosure of ownership and related information)**

9.8.7.  **Section 1126 (relating to disclosure of information about certain convicted Individuals)**

9.8.8.  **Section 1128A (relating to civil monetary penalties)**

9.8.9.  **Section 1128B(d) (relating to criminal penalties for certain additional charges)**

9.8.10.  **Section 1132 (relating to periods within which claims must be filed)**

9.9. **Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement.** (Section 2107(c))

Public input on the design and implementation of the plan has been accomplished through various means:

- a) The Department of Human Resources prepared a four-page outline designed as a program framework. The outline was used to solicit public comment at four public hearings held throughout the state:

October 22, 1997 in Las Vegas

December 4, 1997 in Fallon

December 5, 1997 in Reno

December 10, 1997 in Las Vegas

- b) The Legislative Committee on Health Care is a standing committee of Nevada's Legislature. The Committee has held monthly meetings since October 1997, at which the Nevada ✓ Check Up program has been discussed. In addition to six legislators, approximately 25 other interested parties are also represented including:
- State agencies
  - County agencies
  - Hospitals
  - Labor unions
  - Health Maintenance Organizations (HMOs)
  - Physicians and other health professionals
  - Federally Qualified Health Centers (FQHC)
  - Native American Advocacy Groups
  - American Association of Retired Persons
  - Legal Services Statewide Advocacy Office
  - Children's Advocacy groups

The recommendations of the legislative body as well as the comments from the public and private sectors were taken into consideration in the drafting of the State Plan. Once available for distribution, copies of the State Plan will be mailed to all persons who have requested in writing to have a copy; and to all interested person and entities who have participated in the initial public hearing process previously described. The state plan will also be available through the Internet.

DHCFP will hold a public hearing on the State Plan as submitted, and will also hold public hearings with regard to any amendments in order to solicit public comment. Generally these public hearings require public notice and provide an opportunity for public comment and the proposed policy.

**9.10. Provide a budget for this program. Include details on the planned use of funds and sources of the non-Federal share of plan expenditures. (Section 2107(d))**

The budget for the Nevada ✓ Check Up program is included below for Federal Fiscal Years (FFY) 1998 and 1999. The amounts represent the maximum funding that is being committed to the program, even though full enrollment may not be achieved. Actual cost may be significantly lower.

The source of the non-federal funds for Nevada ✓ Check Up is a dedicated account within the state's general fund which is used as a reserve for potential Medicaid cost overruns. The account (called the intergovernmental transfer account) has a surplus due to lower than anticipated Medicaid enrollment which, in accordance with Senate Bill 470 for the 1997 Nevada Legislature, can be used for a children's health program.

<u>REVENUES</u>	Fiscal Year Ending September 30,	
	1998	1999
State Funds	\$3,057,000	\$16,553,000
Title XXI Funds	5,678,000	30,742,000
Premium/Enrollment Fee	<u>540,000</u>	<u>2,730,000</u>
	<u>\$9,275,000</u>	<u>\$50,025,000</u>
 <u>EXPENSES</u>		
Insurance Payment	\$7,875,000	\$45,675,000
Ongoing Administration	1,000,000	4,000,000
Start Up Administration	<u>400,000</u>	<u>350,000</u>
	<u>\$9,275,000</u>	<u>\$50,025,000</u>

Insurance payments are based on \$1,050 per child per year, for an average of 30,000 children in FFY 1998 (July through September) and 43,500 (maximum enrollment based on the estimated capitated rate) children in FFY 1999. The actual capitation rate has not yet been set.

Premiums and enrollment fees are estimated at \$18 per child for FFY 1998 and \$63 per child for FFY 1999. The estimate is based on a blend of income levels and an average of two(2) children per family.

Start up administration costs of \$750,000 will be incurred in FFY 1998, but due to the 10% administration cost limitation \$350,000 will be deferred and claimed in FFY 1999. The 10% limitation for FFY 1998 is calculated by first applying all enrollment fees against administrative costs. The administrative cost limitation for FFY 1998 is \$873,500 (10% x (\$9,275,000-\$540,000)). Administrative cost claimed is \$860,000 (\$1,400,000-\$540,000).

**Section 10. Annual Reports and Evaluations (Section 2108)**

**10.1 Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: (Section 2108(a)(1),(2))**

10.1.1.  **The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and**

10.1.2.  **Report to the Secretary, January 1 following the end of the fiscal year, on the result of the assessment.**

**10.2.  State Evaluations. The state assures that by March 31, 2000 it will submit to the Secretary an evaluation of each of the items described and listed below: (Section 2108(b)(A)-(H))**

10.2.1.  **An assessment of the effectiveness of the state plan in increasing the number of children with creditable health coverage.**

10.2.2. **A description and analysis of the effectiveness of elements of the state plan, including:**

10.2.2.1.  **The characteristics of the children and families assisted under the state plan including age of the children, family income, and the assisted child's access to or coverage by other health insurance prior to the state plan and after eligibility for the state plan ends;**

10.2.2.2.  **The quality of health coverage provided including the types of benefits provided;**

10.2.2.3.  **The amount and level (including payment of part or all of any premium) of assistance provided by the state;**

10.2.2.4.  **The service area of the state plan;**

10.2.2.5.  **The time limits for coverage of a child under the state plan;**

10.2.2.6.  **The state's choice of health benefits coverage and other methods used for providing child health assistance, and**

10.2.2.7.  **The sources of non-Federal funding used in the state plan.**

10.2.3.  **An assessment of the effectiveness of other public and private programs in the state in increasing the availability of affordable quality individual and family health insurance for children.**

10.2.4.  **A review and assessment of state activities to coordinate the plan under this Title with other public and private programs providing health care and health care financing, including Medicaid and maternal and child health services.**

- 10.2.5.  **An analysis of changes and trends in the state that affect the provision of accessible, affordable, quality health insurance and health care to children.**
- 10.2.6.  **A description of any plans the state has for improving the availability of health insurance and health care for children.**
- 10.2.7.  **Recommendations for improving the program under this Title.**
- 10.2.8.  **Any other matters the state and the Secretary consider appropriate.**
- 10.3.  **The state assures it will comply with future reporting requirements as they are developed.**
- 10.4.  **The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.**