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**Nevada Title XXI State Plan**

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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**

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, (42 CFR 457.40(b))

\_\_\_\_\_  
**Michael J. Willden**  
**Director, Department of Human Resources**

\_\_\_\_\_  
**Date**

(Signature of Governor or designee 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 (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following state officials are responsible for program administration and financial oversight (42 CFR 457.40(c))

Name: Charles Duarte      Position/Title: Administrator, Division of Health Care Financing & Policy (DHCFP)

Name: Mary Wherry      Position/Title: Deputy Administrator, DHCFP

Name: Debra King      Position/Title: Administrative Services Officer IV, DHCFP

**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: CMS, N2-14-26, Baltimore, Maryland 21244**

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

1.1 The state will use funds provided under Title XXI primarily for (check appropriate box (42 CFR457.70) :

1.1.1.  Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (Section 2103); OR

1.1.2.  Providing expanded benefits under the State’s Medicaid plan (Title XIX); OR

1.1.3.  A combination of both of the above.

1.2  Please provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. (42 CFR 457.40(d))

1.3  Please provide an assurance that the state complies with all applicable civil rights requirements, including the title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. (42 CFR 457.130)

1.4.1 Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment (42 CFR 457.65):

Effective date: 8/24/02; Section 4.1.3, page 11 effective October 1, 2002

Implementation date: 8/24/02; Section 4.1.3, page 11, 10-1-02

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**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 42 CFR 457.10). 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). (42 CFR 457.80(a))**

Uninsured Children

Based on the State Demographer's 2002 population estimates, DHCFP has estimated that there are 69,000 children in Nevada who are uninsured living in families with incomes under 200% of poverty. Of these, as many as 50% 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 2000 by the Great Basin Primary Care Association and the State Demographer's 2002 population estimates. The following chart reports on these findings as follows:

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**Number of Uninsured Children in Nevada  
by Region**

<b>Age in Years</b>	<b>Washoe County</b>	<b>Clark County</b>	<b>Rural Counties</b>	<b>Totals</b>
<b>Less than 6</b>	<b>6,988</b>	<b>33,521</b>	<b>5,480</b>	<b>45,989</b>
<b>6 to 18</b>	<b>12,374</b>	<b>44,660</b>	<b>11,899</b>	<b>68,933</b>
<b>TOTAL</b>	<b>19,362</b>	<b>78,181</b>	<b>17,379</b>	<b>114,922</b>

Estimates of Nevada Populations

According to the current Nevada State Demographer's data, Nevada's total population is 2,210,650. Nevada's children age 0-19 comprise the following races by age and sex:

<b>Age in Years</b>	<b>White</b>	<b>Black</b>	<b>American Indian</b>	<b>Asian</b>	<b>Hispanic</b>	<b>Total</b>
<b>&lt;5</b>	<b>103,601</b>	<b>11,157</b>	<b>1,594</b>	<b>9,563</b>	<b>33,471</b>	<b>159, 386</b>
<b>5 to 19</b>	<b>298,148</b>	<b>32, 108</b>	<b>4,587</b>	<b>27,521</b>	<b>96,325</b>	<b>618,075</b>
<b>Total</b>	<b>401,749</b>	<b>43,265</b>	<b>6,181</b>	<b>37,084</b>	<b>129,796</b>	<b>618, 075</b>

Language spoken at home by Nevadans

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According to the 2000 Census Supplementary Survey Summary Tables, Nevada's language spoken at home is as follows:

Nevadans Age >5 years

78% Speak English at home  
5% No English at home  
17% Don't speak English well

No English at Home

14% Speak Spanish at home  
8% 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, TANF and CHAP Medicaid eligible children residing in Clark County are mandatorily enrolled in managed care with the exception of disabled children and those children who reside more than 25 miles from a PCP and participating hospital, pursuant to NAC 695C.160.

Nevada ✓ Check Up

Nevada ✓ Check Up provides access to affordable health insurance to children in working, low-income families. The program features simplified mail-in eligibility applications and low premiums while providing a comprehensive benefits package.

**2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: (Section 2102)(a)(2) (42 CFR 457.80(b))**

**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 outreach and referral services to the Women, Infant, and Children (WIC) centers, Federally Qualified Health Centers (FQHCs), Special Children's 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 in order to provide these outreach and referral services. The description of these programs are as follows:

1. The Medicaid program is administered by the Division of Health Care Financing and Policy and provides health coverage to low-income and

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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 encourages pregnant women and parents in this program to apply for Medicaid or Nevada ✓ Check Up depending on their income level.
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 or Nevada ✓ Check Up:

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. 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 Children's Clinic  
The Nevada Health Division, Special Children's Clinic (SCC) provides direct services to low-income children ages 0-3 under the Maternal and

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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 or Nevada Check Up are encouraged to apply.

5. Baby Your Baby Program

Both the state Title V program and state Medicaid agency support Baby Your Baby (BYB), which is a statewide multi-media bilingual campaign to promote early entry of pregnant women 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. Community Connections/Family to Family Program

The Family to Family program is an initiative aimed at informing new mothers of the services that are available to them and how to access such services. A total of 19 centers have been 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 children, including Medicaid and Nevada ✓ Check Up.

8. Tribal Administrators, Tribal Clinics, and Indian Health Services (IHS)

Nevada ✓ Check Up staff attend and participate in meetings of the Native American Advisory Council, as mandated by Nevada law, in order to share information and receive advice as to the needs of the Native American tribes in Nevada. Application training and program updates are also provided by program staff.

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**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) Describe the procedures the state uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as Title V, that provide health care services for low-income children to increase the number of children with creditable health coverage. (Previously 4.4.5) (Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42 CFR 457.80(c))**

Other than Medicaid, there are no public or private programs providing creditable coverage for low-income children in Nevada. Nevada ✓ Check Up provides information, applications, and technical assistance, as needed, to WIC, Family Resources Centers, Community Connections, and the Welfare Division. The Nevada ✓ Check Up program staff also coordinates with Tribal administrators and clinics as well as city and county agencies interested in assisting families to find affordable insurance.

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### Section 3. Methods of Delivery and Utilization Controls

- 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.** Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. **(Section 2102)(a)(4)** (42 CFR 457.490(a))

The State assures that the delivery of child health assistance using Title XXI funds, will be through a choice of State contracted Managed Care Organizations (MCO) (either HMO or PCCM) primary care providers, or through individually enrolled Medicaid providers where HMOs or PCCMs are not available. In rural areas, services are delivered through Medicaid fee-for-service providers. The State assures that contracts with Managed Care Organizations will comply with all pertinent sections of 1932 and 1903 (m) of the Social Security Act. Contract quality standards will be based on 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 contracted MCOs must develop their own provider networks. The physicians, hospitals and ancillary service providers will deliver a comprehensive benefit package described in Section 6.2. The DHCFP will require MCOs to have a sufficient provider network to serve its enrollees. Managed Care Organizations must offer a contract to Federally Qualified Health Centers (FQHC), Rural Health Centers (RHC), public hospitals, and the University of Nevada School of Medicine at terms that are at least equal to their standard provider contracts. 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 PCCM.

Reimbursement of HMOs will be at a rate determined using actuarial principles. PCCM and other Medicaid providers will be reimbursed using the Medicaid fee-for-service rates.

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**3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the state plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved state plan. (Section 2102)(a)(4) (42 CFR 457.490(b))**

The MCOs which contract with the Nevada ✓ Check Up program are primarily responsible for utilization control and review functions. Nevada ✓ Check Up contract standards require a participating HMO and PCCM to have adequate utilization control and review management staff and procedures to assure that covered services provided to enrollees are medically necessary and appropriate. Before being approved for participation in the program, MCOs 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 established criteria. MCOs also must develop procedures for identifying and correcting patterns of over and under utilization on the part of their enrollees.

Check Up recipients not residing in Managed Care service areas will receive service coverage from individual Medicaid providers who must adhere to Medicaid fee-for-service policies and procedures. Utilization review policies and procedures will follow Medicaid Title XIX practices, including protocols for prior approval and denial of services, hospital discharge planning, physician profiling, and retrospective review of both inpatient and ambulatory claims criteria. Utilization review will be done cooperatively with Nevada Medicaid's Surveillance, Utilization and Review Subsystem (SURS) Unit.

The MCOs may require a prior authorization for a given service. The child's primary care physician (PCP) is responsible for obtaining all necessary prior authorizations. No prior authorization is required 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 include:

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

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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.

Currently in fee-for-service, three (3) treatment areas always require prior authorization. They are:

- 1) Orthodontics – Treatment plan must be submitted to Nevada’s fiscal agent for review and approval by the dental consultant.
- 2) Steel Crowns (more than 7 in a single visit) – Treatment plan must be submitted to Nevada’s fiscal agent
- 3) Admission to Residential Treatment Center (RTC) – Treatment plan must be submitted to Nevada’s Quality Improvement Organization (QIO) for review and approval of proposed mental health services.

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**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)) (42 CFR 457.305 (a) and 457.320 (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 up through the month preceding 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, tips, 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. Government civilian employee or military retirement or pensions or veterans' payments;
6. Private pensions or annuities;
7. Alimony or child support payments;
8. Regular contributions from persons not living in the household;
9. Other cash income. Other cash 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; and,
10. Unemployment Insurance Benefits.

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- 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.
- 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 but will be referred to Medicaid.
- 4.1.7.  **Access to or coverage under other health coverage:** Questions about access to health care coverage, both public and private, are included on the application form. Random checks are conducted by contacting employers for verification of health insurance coverage. A child will be found ineligible if:
- 1) he/she has creditable health insurance;
  - 2) he/she is eligible for health benefits coverage under a State health benefits plan based on a family member's employment with a public agency in the State; or,
  - 3) he/she has had coverage under an employer plan six months prior to the date of 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 applicant's control (e.g., employer discontinues health benefits, applicant was laid off or otherwise terminated, etc.).
- 4.1.8.  **Duration of eligibility:** Once a child has been determined eligible and enrolled, he or she is continuously eligible until the annual eligibility redetermination date, no later than one year from the most recent date of enrollment. The child becomes ineligible on the first day of the next administrative month when:
- 1) the child moves out of state;
  - 2) the child becomes enrolled in Medicaid;
  - 3) the child secures other health insurance;
  - 4) the child turn 19 years old;
  - 5) the child becomes an inmate of a penal institution or an institution for mental diseases;
  - 6) the child dies;
  - 7) the child gets married or becomes emancipated;
  - 8) the parent/guardian fails to pay quarterly premiums; or,
  - 9) the child may also become ineligible if, during the course of a random case audit process, it is determined the family provided

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erroneous information to the state resulting in an incorrect eligibility determination.

A 60 day grace period will be allowed prior to disenrollment for failure to pay the premium. Children 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)) (42 CFR 457.320(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)) (42 CFR 457.350)**

Eligibility will be determined through the completion of an application form which will include the following information:

- 1) Name, , date of birth, age, sex, ethnicity, and relationship to applicant of all children in the household;
- 2) All sources of income, including employment, child support, SSI, and other income;
- 3) Name of person responsible for health care cost of a child, if any;
- 4) Insurance status, including whether insurance is offered through an employer; and,
- 5) 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. If self-employed, the applicant must submit a copy of the most recent federal/state income tax return.

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 the DHCFP. A toll free telephone number has been established and listed on the application as well as on posters and marketing brochures at the above mentioned locations.

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All applications will be considered equally. The applications will be processed and those found eligible will be enrolled, , subject to a full enrollment limitation (see below). Applicants will have a maximum of 120 days to return the enrollment form, including the quarterly premium, and to select a health plan for the child(ren). If the applicant fails to include the premium fee or to select a plan, the form will be returned and the child(ren) will not be enrolled until the premium and selection are received. Native Americans Nativeswho are members of federally recognized tribes and Alaska Natives, are exempt from paying premiums.

Upon receipt of the completed enrollment form and premium, the information will be entered into a database. An approval notice will be sent to the applicant with the following information:

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

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 section 4.1.8. There are no enrollment fees for redeterminations of eligibilty.

#### Application Tracking

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

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 MCO contract also requires the health plans to report updated family information to DHCFP within 7 days of receipt of information.

#### **4.3.1. Describe the state's policies governing enrollment caps and waiting lists (if any). (Section 2106(b)(7)) (42 CFR 457.305(b))**

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Check here if this section does not apply to your state.

**4.4. Describe the procedures which assure:**

**4.4.1. Through the screening procedures used at intake and follow up eligibility determination , including any periodic re-determination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including access to a state health benefits plan) are furnished child health assistance under the state child health plan. (Section 2102)(b)(3)(A)) and 2110(b)(2)(B)) (42 CFR 457.310(b) (42 CFR 457.350(a)(1)) 457.80(c)(3))**

In order to be enrolled in Nevada ✓ Check Up, children must have been without creditable insurance for at least six months prior to the date of application. 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 a substitution for coverage under group health plans.

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 quarterly premiums which are waived for Native American children or Alaska Natives who are members of federally recognized Tribes.

**4.4.2. The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. (Section 2102)(b)(3)(A) and 2110(b)(2)(B)) (42 CFR 457.310(b) (42 CFR, 457.350(a)(1)) and 457.80(c)(3))**

In order to assure that Medicaid eligible children are enrolled in Medicaid, Nevada will take the following steps:

- 1) For families who apply with income below the requirements for Medicaid or, if their income is not more than 25 % above the Medicaid income

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requirement (to account for work expense disregards allowed in the Medicaid eligibility determination), and if the applicant meets the Medicaid assets screen, the Nevada ✓ Check Up application will be considered to be a Medicaid application as well, unless the family has applied for and been denied Medicaid eligibility in the past twelve months for reasons other than non-cooperation. The date of application will be the date received by the State of Nevada.

- 2) If a family has some children who appear, on the basis of the initial screen, to be potentially eligible for Medicaid but the parent/legal guardian nonetheless submits the enrollment form and premium payment, those children would be provisionally enrolled in Nevada ✓ Check Up. Native Americans who are members of federally recognized tribes and Alaska Natives are exempt from paying premiums.
- 3) Any family sent a Medicaid application will have ten working days to return the completed application. If the application is not returned, the family will be sent a notice of denial for Medicaid. The denial notice will allow an additional ten working days to provide all necessary information to DHCFP.
- 4) Nevada ✓ Check Up staff will review all the applications of children who are potentially Medicaid eligible children after one month to determine if the family has filed a Medicaid application. If no application has been filed, the family will be sent a notice of pending disenrollment from Nevada ✓ Check Up. The family will be given 10 days to request a hearing in response to the intended disenrollment decision. If a request for fair hearing is received, the children will be maintained in Nevada ✓ Check Up pending the outcome of the hearing. If no request for hearing is received, the children will be disenrolled on the first day of the next administrative month.
- 5) Once a Medicaid eligibility determination has been made, the family will be notified. Native Americans who are members of federally recognized tribes or Alaska Natives are exempt from paying premiums. In this manner, the federal match rate for such expenses will be the lower Medicaid rate. The family will also be refunded any premiums they paid. If the children are denied eligibility for Medicaid and have not enrolled in Nevada ✓ Check Up, they will be sent another enrollment form for Nevada ✓ Check Up.
- 6) Medicaid enrollees will be compared monthly with the Nevada ✓ Check Up enrollees to ensure that a child is not enrolled in both programs.

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7) Nevada ✓ Check Up will maintain statistics on families applying for the program who meet the income guidelines of Medicaid, including whether they apply for Medicaid, and the disposition of the application.

**4.4.3. The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. (Section 2102(a)(1) and (2) and 2102(c)(2)) (42 CFR 431.636(b)(4))**

A file containing detailed information about children who have been found ineligible for Medicaid is provided electronically to the Nevada ✓ Check Up program. This file will provide information on children that meet the eligibility requirements for Nevada ✓ Check Up. This information is electronically downloaded into the Nevada ✓ Check Up database and these children are enrolled on the first day of the next administrative month following eligibility verification.

**4.4.4. The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the appropriate box. (Section 2102)(b)(3)(C)) (42 CFR 457.805) (42 CFR 457.810 (a) – (c))**

**4.4.4.1.  Coverage provided to children in families at or below 200% FPL:**

Describe the methods of monitoring substitution.

In order to apply for Nevada ✓ Check Up, children generally will have to have been without creditable insurance for at least six months prior to the date of application. 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.

**4.4.4.2.  Coverage provided to children in families over 200% and upto 250% FPL: describe how substitution is monitored and identify specific strategiew to limit substitution if levels become unacceptable.**

**4.4.4.3.  Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution.**

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**4.4.4.4    □    If the state provides coverage under a premium assistance program, describe: The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period. The minimum employer contribution. The cost-effectiveness determination.**

**4.4..    Child health assistance is provided to targeted low-income children in the state who are Native American and Alaska Native (Section 2102)(b)(3)(D))    (42 CFR 457.125(a))**

According to the State Demographer, the Native American population in Nevada is 5.4% of the state's total population. There are twenty-six sovereign Tribal governments. The Inter-Tribal Council of Nevada represents the interests of these governmental entities and includes the following programs: Administration on Aging (AOA); Child Care Development Fund (CCDF); Head Start Program; Employment & Training Program; Women, Infants & Children (WIC); and Domestic Violence. There are two Urban Indian Centers in Nevada, one each located in Reno and Las Vegas. The Nevada Indian Commission, a state government policy group, includes a subcommittee known as the Native American Advisory Committee Concerning the Children's Health Insurance Program.

Native American and Alaska Native children will be provided the same opportunity for enrollment as all other children. These children are exempt from cost sharing.

This section was moved to 2.3

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**Section 5. Outreach (Section 2102(c))**

**Describe the procedures used by the state to accomplish: Outreach to families of children likely to be eligible for assistance or other public or private health coverage to inform them of the availability of the programs and to assist them in enrolling their children in such a program: (Section 2102(c)(1)) (42 CFR 457.90)**

Nevada Check Up conducts multifaceted outreach and referral efforts to inform families of the availability of state sponsored health care coverage for children under both Nevada ✓ Check Up and Medicaid. These efforts are supported by the Northern, Southern, and Rural Covering Kids Coalitions and other community partners.

Nevada has established a toll free telephone number for people who want an application form mailed to them. The number is also used for providing assistance in completing the application and answering questions about the program.

Assistance in Enrolling Children

The most important “assistance” provided is the use of a simple application form which enables most parents to submit applications without direct help. The state conducts periodic application training sessions with community based organizations so they are able to assist families in filling out the application and answer questions parent applicants may have about the program.

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**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) ) and 42 CFR 457.420)**

- 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.)

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))

- 6.1.4.1.  Coverage the same as Medicaid State plan
- 6.1.4.2.  Comprehensive coverage for children under a Medicaid  
Section 1115 demonstration project
- 6.1.4.3.  Coverage that either includes the full EPSDT benefit or that  
the state has extended to the entire Medicaid population

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- 6.1.4.4.  Coverage that includes benchmark coverage plus additional coverage
- 6.1.4.5.  Coverage that is the same as defined by an existing comprehensive state-based coverage
- 6.1.4.6.  Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Please provide a sample of how the comparison will be done)
- 6.1.4.7.  Other (Describe)

**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)) (42 CFR 457.490)**

- 6.2.1.  **Inpatient services (Section 2110(a)(1))**  
Inpatient services include 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
- 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))**

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- 20 days of inpatient mental health services are covered with 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. 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 days 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. Orthodontia is a benefit requiring prior authorization.
- 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.
- 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 (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.

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- 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))**

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 provided with the same State Plan benefit package.

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## 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)) (42 CFR 457.495(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 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 recipient and provider complaints and grievances filed with the State Insurance and/or Health Division; and,
- 3) The compilation, review and investigation, where warranted, of 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 enrolled recipients with participating plans. Participating plans are 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

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all recipients 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 (i.e., the Division of Insurance and the Health Division) to ensure 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 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 behalf of all 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 one which is 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 recommended by a recognized Medical Academy and/or required by the the Centers for Medicare and Medicaid Services (CMS) The MCO is responsible for

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implementing 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 children, both male and female, of child bearing age.

4. Dental Services

Standard

Dental services (including orthodontia, if prior authorized) will be provided to Nevada ✓ Check Up eligible recipients.

5. Medical Record Standards

Standard

The MCO must maintain medical records in accordance with Standard XII of the “Guidelines for Internal Quality Assurance Programs” as set forth in the CMS 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 are similar to, or the same as, those currently utilized in the Medicaid Managed Care program.

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

A. Measurement

1) 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, liquidated damages will be calculated based on the initial annual review; that is, twelve (12) months of the contract year.

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

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2) 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 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.

#### B. Method

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

#### C. 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

#### A. Measurement

Documentation showing 90% of Nevada ✓ Check Up eligible non-exempt recipients ages 0 through 2 are appropriately immunized. Documentation showing 95% of Nevada ✓ Check Up eligible non-exempt recipients 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.

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B. Method

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

C. 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

A. Measurement

80% of eligible recipients 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 recipient's record. An action plan will be required if the percent of compliance is less than 80%.

B. Method

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

C. Frequency

DHCFP will generate quarterly reports and an annual cumulative report utilizing encounter data submitted by the 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

A. Measurement

20 percent of its recipients 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 recipient ages 5 to 18 who have been enrolled for twelve (12) months will receive at least one dental visit in the reporting year.

B. Method

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

C. 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

A. Measurement

1) Appointments with Primary Care Providers (PCP):

The 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.

2) Specialty appointments

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

- (a) Same day appointments within twenty-four hours of referrals as in 1) (a) above;

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- (b) Urgent care appointments within three calendar days of referral; and,
- (c) Routine appointments within two weeks

### 3) 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.

### 4) Office Waiting Times

The MCO shall monitor and ensure that a recipient's waiting time at the PCP or specialist's 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.

A Plan of Correction (POC) will be required if the 90% Standard is not met.

#### B. 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.

#### C. Frequency

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

### 6. Medical Records Standards

#### A. 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)

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legibility; 6) allergies; 7) immunizations; 8) medication information; and 9) identification of current problems.

A sample of the MCO's Nevada ✓ Check Up recipients' 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%.

**B. Method**

Medical records will be reviewed.

**C. Frequency**

Record 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 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 enrolled recipients will receive handbooks from their chosen health plan which will describe the benefits provided to enrollees under the program. These materials also describe enrollee 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, enrollee grievance information, and data on financial expenditures. Information will be used by DHCFP to document performance and assure adequate program accountability.

The Division, 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 Plan of

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Correction as is currently similarly required under the Medicaid Voluntary Managed Care program.

7.1.4.  **Quality improvement strategies**

Quality improvement strategies, with which the MCO contractor must comply, 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 enrollees. 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 enrollees;
  - 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 indicated above, where quality standards, consumer satisfaction surveys or performance measurements are below those stated standards;
- 5) In severe or blatant cases of non-compliance, the Division will assess liquidated damages for not meeting performance measures.

**7.2 Describe the methods used, including monitoring, to assure (2102(a)(7)(B)) (42 CFR 457.495)**

- 7.2.1. Access to well – baby care, well – adolescent care and childhood and adolescent immunizations. (Section 2102 (a) (7)) (42 CFR 457.495 (a)). Refer to Section 7.1.1., item 1. & 2. Section 7.1.2., item 1. & 2.

All Nevada ✓ Check Up recipients are authorized to seek well-baby and well-child care. The HMO contracts contain standards for well-baby and well-child visits, along with the immunizations recommended in section 7.1.1., number 2. The HMOs have established records of the visits and immunizations and send out reminder notices to families that a well-child check or immunization is due. FFS providers are expected to comply with the American Academy of Pediatrics periodicity schedule for well-baby and well-child care purposes.

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7.2.2. Access to covered services, including emergency services as defined in 42 CFR 457.10. (Section 2102 (a) (7)) (42 CFR 457.495 (6))

Emergency Services: The MCO cannot require recipients to seek prior authorization for services in a medical or behavioral health emergency. Plans must inform their enrollees that access to covered emergency services is not restricted and that if the recipient 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 recommended or requested follow-up care pursuant to the emergency.

7.2.3. Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. (Section 2102 (a) (7)) (42 CFR 457.495 (c)). Refer to Section 7.1.1., item 6. and Section 7.1.2., item 5.

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

An analysis of access to care will be based on the results of enrollee satisfaction surveys, member complaint data, member and type of PCPs and specialists and appointment scheduling.

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

Telephone Access: The MCO 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 person.

Days to Appointment: The MCO must abide by the following appointment standards:

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- 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.

7.2.4. Decisions related to the prior authorization of health services are completed in accordance with State law or, in accordance with the medical needs of the patient, within 14 days after receipt of request for services (Section 2102 (a) (7)) (42 CFR 457.495 (d))

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 Division of Insurance (DOI). The DOI 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, MCOs 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 enrollees 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 MCO 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. If the MCO is unable to provide the medically necessary covered service within its provider network, it must allow the enrollee to obtain the service through an out-of-network

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provider. The MCO must facilitate the referral to an out-of-network provider on behalf of the enrollee and must reimburse the out-of-network provider at not less than the Medicaid FFS rate for the covered service. The MCO shall not include in their networks any medical provider who has been sanctioned by Medicare or Medicaid.

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**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 based on gross income, except for American Indian who are members of Federally recognized tribes and Alaska Natives, who are exempt from premiums. For families whose income is above 175% of the Federal Poverty Level (FPL) the premium will be \$50.00 per quarter (\$200.00 per year). For families whose income is above 150% FPL but at or below 175% FPL, the premium will be \$25.00 per quarter (\$100.00 per year). For families whose income is above 33% FPL but at or below 150% FPL, the premium will be \$10.00 per quarter (\$10.00 per year). For families whose income is below 33% the premium will be zero.  
**8.2.2. Deductibles:** There are no deductibles.

**8.2.3 Coinsurance:** There is no coinsurance

**8.2.4 Other:**

**8.3 Describe how the public will be notified, including the public schedule, of this cost-sharing (including the cumulative maximum) and any differences based on income:**

The cost sharing information will be explained to potential enrollees through 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 its plan: (Section 2103(e)) ((1)(B)) (42 CFR 457.505 (b))**

- 8.4.1.  Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B)) (42 CFR 457.530)
- 8.4.2.  No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2)) (42 CFR 457.520)

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**8.4.3.**

No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. (Section 2103 (e) (1) (A)) (42 CFR 457.515 (f))

**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 length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a referral given by the State for overpayment by an enrollee: (Section 2103 (e) (3) (B)) (42 CFR 457.560 (b) and 457.505 (e))**

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 for a year would be \$40, leaving \$760.

The State does not impose any other co-payment.

**8.6 Describe the procedures the state will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native Children will be excluded from cost sharing. (Section 2103 (b) (3) (D)) (42 CFR 457.535)**

The instructional section of the application states that premiums are waived for any household with an American Indian or Alaska Native child. Additionally the application includes an ethnicity question and through self declaration, the family indicates each child's ethnicity. This information is utilized to derive the premium notices.

**8.7. Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. (42 CFR 457.570 and 457.505 (c))**

The applications will be processed and those found eligible will be enrolled, subject to a full enrollment limitation. Applicants will have a maximum of 120 days to return the enrollment form, including the quarterly premium, and to select a health plan for the child(ren). If the applicant fails to include the premium fee or to select a plan, the

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form will be returned and the child(ren) will not be enrolled until the premium and selection are received. American Indians or Alaska Natives, who are members of Federally recognized Tribes, are exempt from paying premiums.

**8.7.1 Please provide an assurance that the following disenrollment protections are being applied:**

- State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles, or similar fees prior to disenrollment. (42 CFR 457.570 (a))
- The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non-payment of cost-sharing charges. (42 CFR 457.570 (b))
- In the instance mentioned above, that the state will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. (42 CFR 457.570 (b))
- The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570 (c) )

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

- 8.8.1.  No Federal funds will be used toward State matching requirements. (Section 2105 (c)(4)) (42 CFR 457.220)
- 8.8.2.  No cost-sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward State matching requirements. (Section 2105 (c) (5)) (42 CFR 457.224)
- 8.8.3.  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 this title. (Section 2105 (c)(6)(A)) (42 CFR 457.626 (a)(1))
- 8.8.4.  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)) (42 CFR 457.622(b)(5))
- 8.8.5.  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)) (42 CFR 457.475)
- 8.8.6.  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

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abortion (except as described above). (Section 2105(c)(7)(A)) (42 CFR 457.475)

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**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)) (42 CFR 457.710 (b))**

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 Medicaid 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 children 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)) (42 CFR 457.710(c))**

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 eligibility 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**

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**performance indicators as specified below or other indicators the state develops:  
(Section 2107(a)(4)(A),(B)) (42 CFR 457.710 (d))**

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 regarding 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)) (42 CFR 457.720)

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**9.5  The state assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the state’s plan for these annual assessments and reports. (Section 2107(b)(2)) (42 CFR 457.750)**

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))(42 CFR 457.720) (42 CFR 457.720)**

**9.7.  The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. (42 CFR 457.710 (e)) (42 CFR 457.710(e))**

**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)) (42 CFR 457.135) (42 CFR 457.135)**

**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 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)) (42 CFR 457.120(a) and (b))**

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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 on the DHCFP/Nevada Check Up website.

- 9.9.1. Describe the process used by the State to ensure interaction with Indian Tribes and organizations in the state on the development and implementation of the procedures required in 42 CFR 457.125. (Section 2107(c)) (42 CFR 457.120 (c))

Representatives of Indian Tribal organizations and advocacy groups are members of the Statewide Covering Kids Coalition, which conducts monthly meetings and also includes representatives from Medicaid and Nevada ✓ Check Up.

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Nevada ✓ Check Up employees participate in Native American Advisory Council meetings, as required by state law, to provide information to the council and to receive advice about the effectiveness of certain marketing and training activities. Nevada ✓ Check Up conducts training in application completion, along with the necessary inclusion of required documentation, for Tribal Clinic staff. This training allows the clinics to help their patients complete a Nevada ✓ Check Up application and attach the required documents before it is submitted to the state. This training has reduced the number of applications placed in pending status because of missing information.

Nevada ✓ Check Up staff attends and participates in quarterly Inter-Tribal Council meetings and other events to which invitations are received.

9.9.2. For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), please describe how and when prior public notice was provided as required in 457.65 (b) through (d).

Public notice is provided pursuant to NRS 422.2368. Public Notice was provided for Section 4.1.3 of this State Plan in November 2002. Public Notice for the consolidated state plan amendment is to be published upon the Director’s approval of the amendment.

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

A suggested financial form for the budget is attached. The budget must describe:

- Planned use of funds, including:
  1. Projected amount to be spent on health services.
  2. Projected amount to be spent on administrative costs, such as: outreach, child health initiatives, an evaluation; and
  3. Assumptions on which the budget is based, including cost per child and expected enrollment.
- Projected sources of non-federal plan expenditures, including any requirements for cost sharing by enrollees.

The budget for the Nevada ✓ Check Up program is included below for Federal Fiscal Years (FFY) 2001, 2002, and 2003. 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.

	SFY 2002 Actual	SFY 2002 Cost Per Eligible	** FFY 2003 Estimate
<b>Benefit Costs</b>			
Total Benefit Costs *	\$28,513,011	\$1,272.11	\$36,433,150
Beneficiary Cost Sharing	\$615,152	\$27.44	\$786,025
Net Benefit Costs	\$27,897,859		\$35,647,126

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Administration Costs			
Personnel	\$693,958	\$30.96	\$886,721
General Administration	\$492,787	\$21.99	\$629,670
Claims Processing	\$174,483	\$7.78	\$222,950
Outreach/Marketing	\$74,997	\$3.35	\$95,830
Total Administration Costs	\$1,436,225		\$1,835,170
Federal Share	\$19,557,034		\$24,989,446

Source:

SFY 2002 Expenditures/Cost Sharing is from a 10/29/02 Dawn Download Attached

\* Category 12 Medical Expenditures

\*\* Average cost per eligible for SFY 2002 times the increase in caseload from SFY 2002 to FFY 2003

See attached Caseload Projections

Total SFY 2002 Expenditures	\$29,949,236
SFY 2002 Average Monthly Eligibles	22,414
FFY 2003 Average Monthly Eligibles	28,640
Difference	6,226

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 is known as the Intergovernmental Transfer Account.

	SFY 2002 - 2003 BUDGETED ENROLLMENT (Note 2.)	ACTUAL ENROLLMENT	PROJECTED ENROLLMENT	BUDGET VS. ACTUAL OR PROJECTED ENROLLMENT	MONTHLY GROWTH RATE
SFY 2002					
July	18,534	19,594		-1,060	
August	18,860	20,085		-1,225	2.51%
September	19,191	21,134		-1,943	5.22%
October	19,528	21,844		-2,316	3.36%
November	19,871	22,130		-2,259	1.31%
December	20,219	22,240		-2,021	0.50%
January	20,574	22,850		-2,276	2.74%
February	20,934	23,197		-2,263	1.52%
March	21,301	23,389		-2,088	0.83%
April	21,674	24,255		-2,581	3.70%
May	22,053	24,106		-2,053	-0.61%
June	22,439	24,138		-1,699	0.13%
MONTHLY AVERAGE	20,432		22,414		23.19%
				Average Monthly% Increase	1.93%
SFY 2003					
July	22,562	24,334		-1,772	0.81%
August	22,795		24,577	-1,782	1.00%
September	23,031		24,823	-1,792	1.00%
October	23,268		25,071	-1,803	1.00%

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November	23,508	25,322	-1,814	1.00%
December	23,751	25,575	-1,824	1.00%
January	23,996	25,831	-1,835	1.00%
February	24,243	26,089	-1,846	1.00%
March	24,493	26,350	-1,857	1.00%
April	24,745	26,614	-1,869	1.00%
May	25,000	26,880	-1,880	1.00%
June	25,257	27,149	-1,892	1.00%
MONTHLY AVERAGE	23,887	25,718	-1,831	

SFY 2004

SFY2004

July		27,420		1.00%
August		27,694		1.00%
September		27,971		1.00%
October		28,251		1.00%
November		28,534		1.00%
December		28,819		1.00%
January		29,107		1.00%
February		29,398		1.00%
March		29,692		1.00%
April		29,989		1.00%
May		30,289		1.00%
June		30,592		1.00%
MONTHLY AVERAGE		28,980		

SFY2005

July		30,898		1.00%
August		31,207		1.00%
September		31,519		1.00%
October		31,834		1.00%
November		32,152		1.00%
December		32,474		1.00%
January		32,799		1.00%
February		33,127		1.00%
March		33,458		1.00%
April		33,792		1.00%
May		34,130		1.00%
June		34,472		1.00%
MONTHLY AVERAGE		32,655		

NOTES:

1. Actual figures are shown in bold type.
2. Budgeted enrollment reflects LCB Revision to the Executive Budget, dated 5/15/01.
3. SFY 2003 projected enrollment utilizes the Monthly Rate of Growth as shown in the LCB Revision to the Executive Budget, dated 5/15/01.
4. SFY 2004 and SFY 2005 projected enrollment utilizes the same Monthly Rate of Growth

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as SFY 2003.

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**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)) (42 CFR 457.750)**

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**

10.2.  **The state assures it will comply with future reporting requirements as they are developed. (42 CFR 457.710 (e))**

10.3.  **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.**

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**Section 11. Program Integrity (Section 2101 (a))**

**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 to Section 12.**

**11.1.**  The State assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Section 2101 (a)) (42 CFR 457.940 (b))

**11.2.** 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)) (42 CFR 457.935 (b))

**11.2.1.**  42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents).

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

**11.2.3.**  Section 1126 (relating to disclosure of information about certain convicted individuals).

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

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

**11.2.6.**  Section 1128E (relating to the National health care fraud and abuse data collection program).

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**Section 12. Applicant and enrollee protections (Section 2101 (a))**

- Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**

**Eligibility and Enrollment Matters**

**12.1. Please describe the review process for eligibility and enrollment matters that complies with 42 CFR 457.1120.**

Enrollees and applicants are informed of program eligibility requirements at the time of application and re-enrollment. In addition, they are assured of and informed about timely processing of application requirements. They are informed of their right to request a review for the following adverse actions:

- Denial of eligibility;
- Failure to make a timely determination of eligibility;
- Suspension or termination of enrollment, including disenrollment for failure to pay cost sharing.

Enrollees and applicants are provided a written notice of decision explaining any adverse actions regarding eligibility and enrollment and have the right to request a review, followed by a state fair hearing, regarding such action. In addition, they have the right to request services continue pending the outcome of the review and hearing process. The agency will continue services if the enrollee requests a review and/or hearing in writing within 10 days of the Notice Date.

A review and/or hearing will not be granted if the sole issue is a change in the State Plan, federal or *state* law requiring automatic change in eligibility or a change in the health benefits package that affects all applicants or enrollees or a group of applicants or enrollees without regard to their individual circumstances.

The applicant or enrollee may be granted an opportunity for a review and a fair hearing if a written request for such is submitted within 30 days after the date of the notice of the decision. The review is conducted by a Reviewing Officer (RO) who is the SCHIP Program Chief or his/her designee. The RO must be an impartial party who has not been involved in the investigation or initial determination of the adverse action in question. The RO sets the review on calendar timely, based on the need for a standard review or submitted justification from the health plan or physician for an expedited review. The enrollee or applicant may represent themselves or have a representative(s) of their choosing participate in the review process, which may be conducted in person or telephonically. The enrollee has the right to review their files and other applicable information relevant to the review of the decision.

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The RO prepares a written decision based on documentation in the case file and any supporting documentation or statements provided during the review process. The RO then provides the written decision in a timely manner as per the standard or expedited review mandates. The written decision includes the date of the review, the findings of fact, any conclusions of law, the decision whether to affirm the adverse action, and the enrollee's or applicants right to request a state fair hearing pursuant to state statute.

If the applicant requests a hearing, the request for hearing is referred to the Division Hearings Unit, which will notify the Department of Administration (DOA) to schedule the fair hearing. In providing a Fair Hearing through DOA, the conduct of such is pursuant to Medicaid Services Manual Chapter 3100.

### **Health Services Matter**

#### **12.2. Please describe the review process for health services matters that complies with 42 CFR 457.1120.**

Enrollees are assured of their opportunity for an external review of the following adverse actions:

- Delay, denial, reduction, suspension or termination of a health services, in whole or in part, including a determination about the type or level of services; and
- Failure to approve, furnish, or provide payment for health services in a timely manner.

Enrollees are provided a written notice of decision explaining any adverse actions regarding health services matters and have the right to specifically request an external review, followed by a State fair hearing, regarding such action. In addition, they have the right to have services continue pending the outcome of the review and/or hearing in writing without 10 days of the Notice Date.

A review and/or hearing will not be granted if the sole issue is a change in the State Plan, federal or state law requiring automatic change in eligibility or a change in the health benefits package that affects all applicants or enrollees or a group of applicants or enrollees without regard to their individual circumstances.

The applicant or enrollee may be granted an opportunity for a review and a fair hearing if a written request for such is submitted within 30 days after the date of the notice of the decision. The review is conducted by a Reviewing Officer (RO) who is the SCHIP Program Chief or his/her designee. The RO must be an impartial party who has not been involved in the investigation or initial determination of the adverse action in question. The RO sets the review on calendar timely, based on the need for a standard review or submitted justification from the health plan or physician for an

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expedited review. The enrollee may represent themselves or have a representative(s) of their choosing participate in the review process, which may be conducted in person or telephonically. The enrollee has the right to review their files and other applicable information relevant to the review of the decision. Should the enrollee request an external review, the request for review is forwarded to the Hearings Unit and is calendared timely by the Unit Supervisor or his/her designee.

The RO or Hearings Supervisor prepares a written decision based on documentation in the case file and any supporting documentation or statements provided during the review process. The RO or Hearings Supervisor then provides the written decision in a timely manner as per the standard or expedited review mandates. The written decision includes the date of the review, the findings of fact, any conclusions of law, the decision whether to affirm the adverse action, and the enrollee's right to request a state fair hearing pursuant to state statute.

The request for hearing is referred to the Division Hearings Unit, which will notify the Department of Administration (DOA) to schedule the hearing requested. In providing a Fair Hearing through DOA, the conduct of such a hearing is pursuant to Medicaid Services Manual Chapter 3100.

### **Premium Assistance Programs**

**12.3. If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, please describe how the state will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.**

Not applicable.

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