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State/Territory Name: Nevada

State Plan Amendment (SPA) #: NV-22-0018

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850

Children and Adults Health Programs Group

February 13, 2023

Suzanne Bierman
Medicaid Administrator
Division of Health Care Financing and Policy
Las Vegas Medicaid District Office
1210 S. Valley View, Suite 104
Las Vegas, NV 89102

Dear Ms. Bierman:

Your title XXI Children's Health Insurance Program (CHIP) state plan amendment (SPA), NV-22-0018, submitted on September 14, 2022, has been approved. This SPA has an effective date of July 21, 2022.

SPA NV-20-0010 was previously approved to provide the following flexibilities through the duration of the federally-declared COVID-19 public health emergency (PHE):

- Waive the collection of premiums;
- Suspend disenrollment for failure to pay premiums; and,
- Suspend the premium lock-out policy.

This amendment extends the state's authority to implement these flexibilities after the end of the federally-declared COVID-19 PHE and through the unwinding period.

In addition, this SPA provides Nevada with the authority to make the aforementioned temporary policy adjustments, as well as the flexibility to delay the timely processing of renewals and applications, for its CHIP program during any future Governor or federally-declared emergency upon notification to CMS. The notification must include the effective dates and duration that the flexibilities will be implemented, and a list of applicable Governor or federally-declared disaster or emergency areas.

Your Project Officer is Ms. Joyce Jordan. She is available to answer your questions concerning this amendment and other CHIP-related matters. Her contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, MD 21244-1850
Telephone: 410-786-3413
E-mail: Joyce.Jordan@cms.hhs.gov

If you have any questions, please contact Meg Barry, Division Director, Division of State Coverage Programs, at (410) 786-1536. We look forward to continuing to work with you and your staff.

Sincerely,
/Signed by Sarah deLone/

Sarah deLone
Director

Guidance: The effective date as specified below is defined as the date on which the State begins to incur costs to implement its State plan or amendment. (42 CFR 457.65) The implementation date is defined as the date the State begins to provide services; or, the date on which the State puts into practice the new policy described in the State plan or amendment. For example, in a State that has increased eligibility, this is the date on which the State begins to provide coverage to enrollees (and not the date the State begins outreach or accepting applications).

1.4. Provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this SPA (42 CFR 457.65). A SPA may only have one effective date, but provisions within the SPA may have different implementation dates that must be after the effective date.

Effective Date: July 21, 2022

Proposed Implementation Date: August 1, 2022

SPA # 22-0018 Purpose of SPA: Evergreen Disaster Relief SPA

To implement provisions for temporary adjustments to enrollment and redetermination polices and cost sharing requirements for children in families living and/or working in state or federally declared disaster areas. In the event of a disaster, the state will notify CMS that it intends to provide temporary adjustments to its enrollment and/or redetermination policies and cost sharing requirements, the effective and duration date of such adjustments and the applicable state or federally declared disaster areas.

Effective date: January 27, 2020

Proposed Implementation Date: April 1, 2020

SPA # 20-0010 Purpose of SPA: Disaster Relief Plan due to COVID-19 Pandemic

Effective April 1, 2020, Nevada added provisions to provide temporary adjustments to tribal consultation, redetermination and premium policies, during the Federal COVID-19 public health emergency.

Original Plan
Effective Date: September 1, 2008

Implementation Date: September 1, 2008

SPA #19-0006 Purpose of SPA: Compliance with the Medicaid Managed Care Final Rule

Proposed effective date: July 1, 2018

Proposed implementation date: July 1, 2018

1.4- TC **Tribal Consultation** (Section 2107(e)(1)(C)) Describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.

A tribal consultation letter was sent to the tribes on June 17, 2022 and consultation was not requested; however, a tribal consultation meeting was still held on July 20, 2022, to discuss other agenda items. No comment specific this SPA update was received after dissemination of the tribal consultation letter or during the tribal consultation meeting.

A tribal consultation letter was sent to the tribes on June 19, 2019 and consultation was not requested; however, the DHCFP tribal liaison was able to add the NV CHIP SPA to the July 9, 2019 tribal consultation meeting agenda. Theresa Carsten, Chief of the Managed Care and Quality Assurance Unit provided an update on the SPA revisions and the only concern noted by members was to ensure that tribal members remained voluntarily enrolled into the managed care benefit plan.

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 is determined through the completion of an application form which includes the following information:

1) Name, date of birth, resident address, gender, Social Security Number, citizenship status, age, ethnicity (optional) and relationship to applicant of all children in the household who are seeking enrollment;
2) Name of person(s) responsible for health care costs of a child;
3) All sources of income as defined in 4.1.3 from all persons residing in the household and contributing to or benefiting from the support of the household;
4) All adults residing in the household;
5) Insurance status, including whether a child is currently or has been insured within the last six months; and
6) If determined eligible: children declared to be citizens will be enrolled.

In addition, the applicant/participant must provide proof of income for each household member. Proof of income may include but is not limited to copies of two current pay stubs from each job dated within 90 days prior to the eligibility determination. For newly hired employees, a signed statement from their employer may be accepted. If self-employed, the applicant may be required to submit a copy of the most recently filed federal/state income tax return.

NCU may accept a client statement of income to determine eligibility for newborns.

Nevada Check Up (NCU) may require additional documentation to determine projected gross annual income from self-employment (including but not limited to bank statements and information about household expenses).

The applications are processed and those individuals found eligible are enrolled. If the family is found to have a prior unpaid premium balance, an approval letter is sent requesting the past due balance be paid, at which time the child will be enrolled. For those individuals found eligible without past due balances, an enrollment letter is sent along with an invoice for the first premium (which may be an amount sufficient to cover one, two or three months, depending on the date enrollment begins). Program enrollment begins on the first day of the next administrative month.

The enrollment letter includes the following information:

- Household Nevada Check Up ID number;
- Names of eligible children and their ID numbers;
- Name of health plan (Managed Care Organization (MCO) or Fee for Service (FFS));
- Effective month of enrollment; and
- The current amount due and the quarterly premium amount.

Native Americans who are members of federally recognized Tribes and Alaska Natives are exempt from premium payment.

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 meet all eligibility requirements. If necessary, the applicant is sent a letter requesting additional or missing information.

Enrollees are required to notify Nevada Check Up immediately with any changes to their address and/or telephone number. Any mail returned indicating the family is no longer at the address may cause disenrollment due to "Loss of Contact".

During a state or federally-declared disaster and at the state's discretion, the state may implement the following changes to its enrollment and redetermination policies for beneficiaries living and/or working in a state or federally-declared disaster areas:

- The state will temporarily use the regulatory timeliness exception for timely processing of CHIP applications under 42 CFR 457.340(d)(1).
- The state will temporarily use the regulatory timeliness exception for timely processing of CHIP renewals under 42 CFR 457.340(d)(1).

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))

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

Nevada Check Up will monitor the status of available State and Federal SCHIP funds. An enrollment cap will be placed on the number of new enrollees if it is necessary for the program to stay within available funds. Prior to implementation of an enrollment cap and waiting list, pursuant to NRS 422.2368, the State will provide 30 days of public notice and will conduct a public hearing. The State also will provide notification to CMS.

The enrollment cap may be set above or below current enrollment. If the cap is set below current enrollment levels, enrollment will be closed until the level of the cap is reached. If the cap is set above current enrollment levels, enrollment may continue until the cap is reached, and then enrollment will be closed. Once enrollment is closed, new applications will continue to be accepted through the normal process. NCU eligibility would be run on all applications. The applications of individuals that appear to be eligible for Medicaid would be forwarded to Medicaid for eligibility determination. Those applicants not eligible for Nevada Check Up will be denied with the appropriate reason. The applicants that are eligible for Nevada Check Up but are not able to be enrolled due to the enrollment

cap will be denied utilizing the standard program denial process. Their denial reason will be, “denied enrollment due to enrollment cap.” These applicants will be notified of the waitlist process. They will also be notified that their child/ren may be eligible for Medicaid if their circumstances change while they are on the waitlist. They will be put on the wait list with a waitlist date equal to the date when Nevada Check Up received the completed application.

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 state's 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 8.8.

8.2. Describe the amount of cost-sharing and any sliding scale based on income, the group or groups of enrollees that may be subject to the charge and the service for which the charge is imposed or time period for the charge, as appropriate.
(Section 2103(e)(1)(A))(42CFR 457.505(a), 457.510(b) & (c), 457.515(a) & (c))

8.2.1. Premiums: A quarterly premium is charged per family based on gross income, except for American Indians who are members of federally recognized Tribes and Alaska Natives, who are exempt from premiums. Starting April 1, 2008, families whose incomes are at or above 176% of FPL, the premium is $80 per quarter ($320 per year). For families whose incomes are at or above 151% FPL but at or below 175% FPL, the premium is $50 per quarter ($200 per year). For families whose incomes are at or above 36% FPL up to 150% FPL, the premium will be $25 per quarter ($100 per year) and these families are offered the option of paying their premium monthly, rather than quarterly. For families whose incomes are below 36% FPL, the premium is zero. These enrollees are either Medicaid referrals or have assets that would preclude their enrollment in Medicaid.

Families whose incomes are at or below 150% FPL are notified on the premium notice that Nevada Check Up premiums may be paid on a monthly basis.

During a state or federally-declared disaster and at the state's discretion, the state may waive premiums for CHIP applicants and/or beneficiaries who reside and/or work in a state or federally-declared disaster areas.

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 changes to those amounts and any differences based on income: (Section 2103(e)) ((1)(B)) (42 CFR 457.505 (b))
The cost sharing information is explained to potential enrollees through the application, which includes a chart of income eligibility and premium payment amounts on its cover. If changes are necessary to the cost sharing requirements of Nevada Check Up, all current enrollees are notified by letter of the changes and effective dates. Public hearings are held to allow the public to comment on any proposed changes to cost sharing in Nevada Check Up

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 are enrolled subject to a full enrollment limitation. Written notice will be provided to families, no later than seven days after the start of the grace period, when the quarterly premium is past due; additionally, a final notice indicating disenrollment will be sent 30 days prior to the potential disenrollment action. (Notices generate at system cutoff approximately five days prior to the end of the month and are mailed the next day allowing at least 30 days' notice) If payment is not received prior to the intended disenrollment date the children will be disenrolled at the end of the two-month grace period. All past due balances must be paid prior to new enrollment. (i.e. Premium request for January/February/March (new coverage period) is mailed November 29, 2011. If payment not received, late notice mailed December 7, 2011. No payment, final notice mailed January 24, 2012, indicating termination effective February 29, 2012. If payment is received by February 24, 2012, coverage will continue.)

American Indians who are members of federally recognized Tribes and Alaska Natives are exempt from paying premiums.

Exception to Disenrollment for Failure to Pay Premiums: During a state or federally-declared disaster and at the state's discretion, as stated in Section 8.2.1, the state may waive premiums for CHIP applicants and/or beneficiaries who reside and/or work in state or federally-declared disaster areas. Therefore, the state will not disenroll beneficiaries for failure to pay premiums. Additionally, the state may waive any unpaid premium balance and waive the premium lock-out period for CHIP beneficiaries who reside and/or work in state or federally- declared disaster areas.

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, co-payments, coinsurance, deductibles, or similar fees prior to disenrollment. (42 CFR 457.570 (a))
- Participating families are always given 30 days written notice of any action that will result in their disenrollment from Nevada Check Up.

☒ 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))
- Families who receive notices of impending disenrollment are encouraged to respond with documentation that will assist eligibility staff to modify their premium and allow their continued enrollment in Nevada Check Up.

☒ 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))

- Nevada Check Up denies enrollment and refers all children to Medicaid who appear to be Medicaid eligible at the time of application. Families who are Medicaid eligible must apply for Medicaid and cooperate with the Medicaid eligibility process. These families are not considered for enrollment in Nevada Check Up until any Medicaid questions have been resolved and/or their circumstances change with the result that they are no longer Medicaid eligible. Cost sharing is always adjusted based on family income.

☒ The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. (42CFR 457.570 (c))

- Nevada Check Up letters always include information on how to request a review of any decision that impacts the family's enrollment.

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)

- The DHCFP ensures that no Federal funds accounts for in any way to make them appear as if they were part of a state match.

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)

- Cost sharing funds received by Nevada Check Up are used only to defray administrative costs of the program.

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))

- Nevada Check Up does not provide insurance to families who have private insurance or have access to affordable private insurance.

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))

- Medicaid eligibility is determined by DWSS eligibility specialists and is in compliance with Federal standards.

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)

- The DHCFP assures that abortion coverage is only that which complies with the rules set forth in the citations listed above.

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

- The DHCFP assures that abortion coverage is only that which complies with the rules set forth in the citations listed above.