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August 31, 2017

Emmett Ruff
Division of State Demonstration and Waivers
State Demonstration Group (SDG)
Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Re: Nevada Comprehensive Care Waiver (NCCW), Project Number: 11W-00284/9

Dear Mr. Ruff:

Please accept the following submission requirement: "Quarterly Operational Reports", as outlined in the Special Terms and Condition (STC) 55 of the approved Nevada Comprehensive Care 1115 Research and Demonstration Waiver. Per STC 55, the state must submit progress reports in the format specified in Attachment A, 60 days following the end of each quarter. The attached report is for the period of April 1, 2017 – June 30, 2017, or Federal Q3/2017.

Should you have any questions regarding this submission please contact Gladys Cook, Program Specialist, at (775) 684-7596 or via email at gladys.cook@dhcfp.nv.gov.

We look forward to continuing to work with you and your staff.

Sincerely,

[redacted]

Marta Jensen
Acting Administrator

Cc: Shannon Sprout, Deputy Administrator
Karen Salm, Chief Financial Officer
Gloria Macdonald, Chief of Program, Research and Development

Nevada Comprehensive Care Waiver (NCCW)
Section 1115 Quarterly Report
Demonstration/Quarter Reporting Period:

Demonstration Year 4 (DY4): (7/01/2016 – 6/30/2017)
Federal Fiscal Quarter 3: (4/1/2017 – 6/30/2017)

Introduction

On June 28, 2013, the Nevada Division of Health Care Financing and Policy (DHCFP) received approval for the Nevada Comprehensive Care Waiver (NCCW), (Project Number 11W-00284/9) from the Centers for Medicare & Medicaid Services (CMS) in accordance with section 1115(a) of the Social Security Act. Approval for the NCCW is effective from July 1, 2013 through June 30, 2018.

Under the NCCW, the DHCFP has implemented mandatory care management services throughout the State for a subset of high-cost, high-need beneficiaries not served by the existing Managed Care Organizations (MCOs). This subset of beneficiaries will receive care management services from a Care Management Organization (CMO), named the Health Care Guidance Program (HCGP). This entity will support improved quality of care, which is expected to generate savings/efficiencies for the Medicaid program. Enrollment in the HCGP is mandatory for demonstration eligible Fee-For-Service (FFS) Medicaid beneficiaries with qualifying chronic health conditions. The HCGP launched on June 2, 2014.

The NCCW demonstration will assist the State in its goals and objectives as follows:

Goal 1: Provide care management to high-cost, high-need Medicaid beneficiaries who receive services on a FFS basis.

- **Objective 1.1:** Successfully enroll all Medicaid beneficiaries who qualify for the NCCW program.
- **Objective 1.2:** Stratify all enrollees into case management tiers according to assessed needs.
- **Objective 1.3:** Complete a comprehensive assessment of enrollees with complex or high risk needs.
- **Objective 1.4:** Complete a comprehensive assessment of enrollees with moderate or low risk needs.
- **Objective 1.5:** Increase utilization of primary care, ambulatory care, and outpatient services for members with chronic conditions.

Goal 2: Improve the quality of care that high-cost, high-need Nevada Medicaid beneficiaries in FFS receive through care management and financial incentives such as pay for performance (quality and outcomes).

- **Objective 2.1:** Increase use of preventive services by 10 percent. [1-1]
- **Objective 2.2:** Increase follow-up ambulatory care visit after hospitalization by 10 percent. [1-1]

[1-1] The goal for all measures to increase performance by 10 percent refers to the hybrid Quality Improvement System for Managed Care (QISMC) methodology for reducing the gap between the performance measure rate and 100 percent by 10 percent.

Objective 2.3: Increase patient compliance with anti-depressant medication treatment protocols by 10 percent. [1-1]
Objective 2.4: Increase use of best practice pharmacological treatment for persons with chronic conditions by 10 percent. [1-1]

Goal 3: Establish long-lasting reforms that sustain the improvements in the quality of health and wellness for Nevada Medicaid beneficiaries and provide care in a more cost-efficient manner.

Objective 3.1: Reduce hospital readmissions by 10 percent. [1-1]
Objective 3.2: Reduce emergency department utilization by 10 percent. [1-1]

Goal 4: Improve NCCW enrollee's satisfaction with care received.

Objective 4.1: NCCW enrollee satisfaction improves over baseline.

Enrollment Information

Demonstration Populations (in person counts)	**Enrolled in Current Quarter** (04/30/17)	**Disenrolled in Current Quarter** (04/30/17)	**Current Enrollees** (07/31/17)
Population 1: MAABD	21,837	0	20,988
Population 2: TANF/CHAP	17,070	0	17,195
Total:	38,907	0	38,183

Note: * DHCFP uses the formalized process according to CFR 42 438.56; which states there are two ways in which a disenrollment occurs. The ways in which the disenrollment may be completed are that of the State requesting the disenrollment or the beneficiary submits a request for disenrollment. It is not considered disenrollment when someone is removed from the program due to eligibility status change.

Demonstration-Qualifying Conditions (in person counts)	**Enrolled in Current Quarter** (04/30/17)	**Disenrolled in Current Quarter** (04/30/17)	**Current Enrollees** (07/31/17)
Diagnosis 1: Asthma	5,788	0	6,406
Diagnosis 2: Cerebrovascular disease, aneurysm, and epilepsy	3,208	0	3,045
Diagnosis 3: Chronic obstructive pulmonary disease, chronic bronchitis, and emphysema	2,260	0	2,281
Diagnosis 4: Diabetes mellitus	3,604	0	3,661
Diagnosis 5: End stage renal disease and chronic kidney disease	1,184	0	1,184

Note: *

Demonstration-Qualifying Conditions (in person counts)	**Enrolleed in Current Quarter** (04/30/17)	**Disenrolled in Current Quarter** (04/30/17)	**Current Enrollees** (07/31/17)
Diagnosis 6: Heart disease and coronary artery disease	1,953	0	2,023
Diagnosis 7: HIV/AIDS	304	0	293
Diagnosis 8: Mental health	13,085	0	13,354
Diagnosis 9: Musculoskeletal system	4,542	0	4,585
Diagnosis 10: Neoplasm/cancer	360	0	350
Diagnosis 11: Obesity	4,575	0	4,664
Diagnosis 12: Substance use disorder	7,140	0	7,410
Diagnosis 13: Pregnancy	2,894	0	2,956
Diagnosis 14: Complex Condition/High Utilizer	752	0	750

Note: enrollees may be counted twice due to the ability to fall under multiple diagnoses categories at the same time.

Note: Methodology improved from prior reports to remove duplication of enrollees with multiple diagnoses within the same category. This primarily affects diagnosis categories 8 and 9 and has no effect on categories comprised of a single diagnosis.

<u>Determinations</u>

The following chart reflects data on demonstration eligibility determinations during Q3/2017 as required under STC 26:

# of Determinations (by methodology)	**Determination methodology (in person, telephonic, etc.)**	**Determination outcomes by determination methodology**
Approximately 60,000 eligible members provided to vendor.	Per vendors automated medical claims analysis and stratification	Approximately 38,500 enrolled beneficiaries at quarter ending 07/31/17

<u>Disenrollment's</u>

The following chart reflects data on demonstration disenrollments during Q3/2017 as required under STC 26:

# of disenrollments (by reason)	**Reason(s) for disenrollment**
0	N/A

Note: DHCFP uses the formalized process according to CFR 42 438.56; which states there are two ways in which a disenrollment occurs. The ways in which the disenrollment may be completed are that of the State requesting the disenrollment or the beneficiary submits a request for disenrollment. It is not considered disenrollment when someone is removed from the program due to eligibility status change.

Non-compliance

The following chart reflects data on beneficiaries determined non-compliant during Q3/2017 as required under STC 27:

# of recipients categorized as noncompliant	0

Note: The DHCFP requested guidance regarding the definition of noncompliant. It is the current understanding of the state that it is not considered to be noncompliant when a recipient is no longer enrolled in the program due to relocation or the member is deceased.

# of demonstration-eligible beneficiaries on CMO waiting list	**# added to waiting list since previous quarter**	**# moved from waiting list to enrollment in the CMO**
0	0	0

Enrollment Fluctuations

DHCFP reports the enrollment numbers for Q3/2017 with a steady monthly enrollment average of 38,500 members.

Outreach/Innovative Activities

The DHCFP continued CMO outreach activities with AxisPoint Health (APH) during Q3/2017. The following chart lists the outreach activities for Q3/2017.

Date	Outreach Activity	Summary of Activity
April 18, 2017	Women, Infant, & Children (WIC) Playdate; Springs Preserve Las Vegas, Nevada	AxisPoint Health (APH), staff present for the annual event.
April 19, 2017	Desert Regional Center; 5550 W. Flamingo Rd. Las Vegas, Nevada	Behavioral Health staff with Beacon Health Options explained the Health Care Guidance Program (HCGP) to the front desk receptionist. Provided information on self-mailer

Date	Outreach Activity	Summary of Activity
		brochures, a few business cards, and some flyers.
April 26, 2017	Desert Rose; 4344 W. Cheyenne Avenue Las Vegas, Nevada	AxisPoint Health (APH) met with The Desert Rose facility staff who describes themselves as a specialty mental health provider of acute psychiatric crisis intervention services and trauma oriented psychotherapies. Their mission is to prevent suicides in Nevada, by the intentional use of evidence-based and best practices. The vision of the agency is to become a leading adjunct provider of crisis intervention to city, county, and state entities; in the Western United States. Bianca McCall, is Chief Executor. They service Medicaid Fee-For-Service (FFS) recipients with a documented Severe Emotional Disturbance/Serious Mental Illness (SED/SMI) or a diagnosable disorder, or co-occurring substance abuse or homeless. Their referrals are from the State suicide hotline and at risk populations being discharged from hospitals/jails/shelters. They have 5-7 days to stabilize clients and they can access their properties that can house 15 clients in three homes they own and have a staff member operate. They also extend boarding to those in their Residential

Date	Outreach Activity	Summary of Activity
		Assistant Program of an additional 90 who can act as mentors. They also liaison with other program such as Lovelife for housing resources who also provide Basic Skill Trainer (BST), Psychiatric Rehabilitation (PSR) for Fee-For-Service (FFS) Medicaid recipients. When necessary they utilize substance abuse rehabilitation such as Salvation Army and Westcare. They also informed us they refer to a 30 bed in-patient program; Vitality in Elko, Nevada for their clients. They stated Medical Transportation Management (MTM) provides the transportation to Elko. They also have a Nurse Practitioner in their agency each Wednesday. They stated they conduct an intake that includes a stabilization plan that consists of any documentation that may be needed (like ID) set appointments to assist client become more stable, medication management, psych assessment with a Psychiatrist, assistance with bus passes, job placement (if appropriate), in-patient/out-patient treatment options, case management (but not Targeted Case Management (TCM)) and any assistance with eligibility with Welfare or Social Service needs. They also provide individual and group counseling

Date	Outreach Activity	Summary of Activity
		daily and a final therapy discharge session.
May 3, 2017	Renown Health Population Health Management Team Staff Meeting; 1000 Ryland Street Reno, Nevada	APH staff met with Renown (largest northern hospital system) discharge planning dept. Cover multiple "dropped balls" of our patients discharged from their facility. The Health Care Guidance Program (HCGP) was involved in these discharges but they didn't seem to want to accept the collaboration, with added work and hardship for the members after discharge. The primary purpose for the visit was to discuss several of the HCGP members that had a poor discharge experience. Some individual cases were discussed. Ann Holmes, Del Forge RN knew of a couple and admitted that things weren’t handled well and one already had a quality assessment review done. Our role of course was not to question their outcomes but to plead for a better working relationship so that we can help them in the future. Ms. Holmes promises to work to get us the FFS census. PowerPoint presentation overview of the Health Care Guidance Program was presented and questions were answered.

Date	Outreach Activity	Summary of Activity
		Provided brochures, business cards, Real Time Referral (RTR) forms and HCGP pens. April Steward/Yvonne Delongschamp- HCGP and Beth Mandeville manager of Renown Outpatient Care Coordination team and Chris Needham, Director of Member Health and Wellness were the primary individuals involved in the discussion. Our primary purpose was to present the HCGP, address all questions regarding the program, and explain how to contact and collaborate with us. They were very interested in our Community Health Workers (CHW's) role and are currently trying to implement a similar role.
May 3, 2017	Children's Cabinet Reno, Nevada	Community Health Worker with AxisPoint Health met with Lisa Bonich, Program Coordinator, Family Youth Interventions Department. The purpose of the outreach was to educate her about the HCGP, who we serve, and how we go about it. Provided a letter of authority for Ms. Bonich to share with other departments heads so that we might share demographic information. Ms. Bonich gave me some paperwork about all of the programs Children's Cabinet offers, and will be e-mailing it in

Date	Outreach Activity	Summary of Activity
		PDF form, so that we share the info with the team.
May 4, 2017	Valley Health Systems Las Vegas, Nevada	Cheri Glockner, Executive Director for the HCGP and Tom McCrorey, Medical Director for the HCGP met with Ms. Hensler, a corporate executive who works with all the hospitals in the system. In her role it was important for us to articulate the resources available through the HCGP. We reviewed the program and asked about some corporate Medicaid initiatives that we may be able to assist with. She told us that they struggle with transportation and are developing strategies on their own to manage this issue. Dr. McCrorey told her that MTM should be more helpful and we talked it through with her. We also asked about emergency department issues and discussed ways to work with the system. We told her that to date, Valley is our “best customer” and is the most consistent users of the program. She told us that she has connections at Mountain View hospital and that she would help us get connected on our next trip to Vegas. Meeting with associate administrative /operations officer for the CEO of Valley Health System. Discussion of our program as well as care management in general. Discussion of transportation issues in the state and the Valley

Date	Outreach Activity	Summary of Activity
		approach to dealing with transport problems. She was unaware of MTM and is developing a contract to move people on the Valley Dime. (More than Medicaid but I would imagine mostly Medicaid for Nevada residents). I think we educated her about benefits and reimbursements available that she was unaware of. She also knows the CEO of Mountain View Hospital (HCA system) will let him know we are interested in meeting.
May 4, 2017	Southwest Medical Associates 4475 S Eastern Avenue Las Vegas, Nevada	APH staff met with the Chief of Care Coordination. Presented an overview of the Health Care Guidance Program (HCGP), and sent them an electronic copy as a reference. They have a lot of our members and have had contact with our care managers (CMs). Currently not taking new Fee-for-Fee-Service (FFS) members (my understanding is because they don't have enough providers) but they still have a fair number of ours. Complaints about MTM. Did not feel she needed a follow up visit planned but there would be ongoing communication between her people and HCGP staff.
May 3, 2017	Touro University Clinic Las Vegas, Nevada	Tom McCrorey, Medical Director for the HCGP met with Mr. Henry Johnson Administrator of Touro University Outpatient Clinic. Pretty much a closed

Date	Outreach Activity	Summary of Activity
		clinic at this point without more Primary care staff. May open clinic in summer if the residents are not available will then have more room in staff clinic. Wants us to come back for meeting June 28, 2017 and meet with staff doctors.
May 4, 2017	University of Nevada Las Vegas (UNLV) Community Health Sciences Las Vegas, Nevada	Cheri Glockner, Executive Director for the HCGP and Tom McCrorey, Medical Director for the HCGP met with Jay Shen, PHD, and Chris Cochran, PHD. We had met them prior - 1 year ago, wanted to discuss update of program. An overview of where we are program wise was presented. We have a desire for working with them more closely. They are interested in research opportunities and more data access. They discussed interest in health care financing, predictive analytics, assisting in research to locate members more easily, and possible setting up of internships together. We did not have specifics for proposals but they are going to look at what research proposals they have as well as what their students need to do. They want to get together again in June when I return.

Date	Outreach Activity	Summary of Activity
May 5,2017	Clark County School District Las Vegas, Nevada	AxisPoint Health staff met with the Home Intervention Program team. HCGP information for providers given. Program discussed along with benefits that we can assist Medicaid patients with. Collaboration discussion occurred with the Home Intervention Program. They will call if they are in need of assistance with Medicaid patients and send RTR's. Educated about MTM program for transportation services to include mileage reimbursement, long distance travel and per diem. Discussed several pertinent community resources such as: Green Cross to assure families with medically fragile children in the home do not lose power; the NV Energy Assistance Program for billing credits; and Olive Crest for respite care for moms. The group of five included four teachers who have a maximum caseload of 8 children and a school nurse who does initial evaluation of the enrolled children. The staffs present were very interested and engaged. They believe that we have some members in common and will be able to refer eligible children in their program to us for assistance as needed. Verbalized excitement that they would have resources to turn to besides having to do the leg work themselves. The group was unaware of how hospice/palliative care charges

Date	Outreach Activity	Summary of Activity
		place child at risk of losing valuable services.
May 9, 2017	South Lyon Medical Center (SLMC) Yerington, Nevada	Community Health Worker (CHW) with AxisPoint Health dropped off a Letter of Authority (LOA) to the billing department in hopes to set up a future relationship to get updated member demographics. Staff spoke with h Dalia, Director of Patient Finance, who advised me to email Toni Inserra, Administrator. I emailed Toni attaching our LOA. Toni gave me email addresses for each and directed me to reach out to herself, Dalia, or Holly for any member demographic information we may need in the future. They inquired about our program and were very excited to hear what we do and how we help members. They were very encouraging and helpful. I left them with our HCGP brochure, MTM brochure, a reimbursement form and the HCGP 'provider' office postcards for reference. I let them know that CHW Jennifer may be reaching out for updates as well. I forwarded the contact information to Jennifer for future reference.
June 6, 2017	Partners Allied for Community Excellence (P.A.C.E) Rural Providers Coalition Elko, Nevada	Mental Health, Care Manger with Beacon Health, participated at the Partners Allied for Community Excellence (P.A.C.E), Providers

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		Coalition with Partner where there was an attendance of 38 people: Vicki Salazar, Access to Healthcare Network, Betty Cheney, and Sandra LaPalm, Nevada Early Intervention Services (NEIS), Barbara Barrett, Aging & Disability Services Division (ADSD). Barbara Barrett with Kathy Edwards, The Church of Jesus Christ of Latter Day Saints Humanitarian Specialist,Leslie Goicoechea, Communities in Schools,Francesca Manuel, Consumer Direct,Amy Chimits-Paules, and Rhonda Meyer, Division of Health Care Financing and Policy (DHCFP), Drucilla Gatter, Rhonda Leahy, and Jordan Thuringer, Division of Welfare & Supportive Services (DWSS), Michelle Sandoval, Elko Counseling & Supportive Services, Kassie Antonucci, Elko County Library, Breanna Allen, and Larry Robb, Elko County School District, Mary Pitts: Elko Drug Court, Amanda Leaman, and Sherry Smith, Friends In Service Helping (F.I.S.H.), Malaina Fesenmaier, Head Start of Northeastern Nevada, Samantha Sbriglia, and Antonia Roman, Health Care Guidance Program (HCGP), Margot Teague, Impact Evaluation,Cheryl Atine, and Alice Alexander, Indian Health Service – Southern Bands Health Center, Chela Elliott, Intensive

Date	Outreach Activity	Summary of Activity
		Family Services, Flora Boyer, National Alliance on Mental Illness (NAMI), Jan Brizee, Amelia Marin, Nevada Office of Consumer Health Assistance, Laura L. Oslund, Mary Ann Martinez, Mike Magney, Tami Santistevan, and Peggy Hannum, (P.A.C.E.) Coalition, Rebecca Hepworth, Ruby Mountain Resource Center, Jill Tingey: University of Nevada (UNR), Elko County Cooperative Extension,Theresa Green, and Adriana Ottonelli, Vitality Unlimited, PACE Coalition Director Laura L. Oslund, opened the meeting. Nevada Senator Tick Segerblom is pushing a bill to allow marijuana smoking wherever tobacco smoking is legal, was announced. This makes limiting access to tobacco and, by extension, marijuana even more important. PACE is working on opioid awareness. PACE can’t afford to provide Nalaxone but is working on providing access to Nalaxone where needed and for people to be trained on how to provide it in case people they serve overdose. Members will see more information about some of the projects we will be working on. Those interested in helping with any of the projects can contact Laura. Our strength is in numbers

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		and when we all go in the same direction we can get things done. Laura asked members express concerns they may have so we can work on them together. She was in Eureka recently where residents want to work on Internet safety. There is an app, for example, that almost seems to encourage teen suicide, Laura said. There will be training for parents, care givers, and educators on what's out there, what to look for, and that parents have the right to examine their children's phones. Laura said she is sorry that Peggy Hannum, PACE's bookkeeper, is retiring. She has been a huge help to Laura in keeping things running and because of her many connections to people here. Peggy brought Tammy Santistevan to PACE as her replacement. Peggy and Tammi are both a blessing and help sustain PACE by keeping it fiscally responsible, Laura said. She is thankful to have had Peggy and now Tammi. Leslie Goicoechea, Communities in Schools(CIS) will have a Night at the Races fundraiser on Friday, August 18th, at the Red Lion starting at 6 p.m. They seek attendees, sponsors, and raffle prizes. Those interested in advanced tickets should email Leslie at leslieg@cisnevada.org. CIS also has a job opening.

Date	Outreach Activity	Summary of Activity
		Flora Boyer, National Alliance on Mental Illness (NAMI) will begin a Peer-to-Peer Recovery Class in July. There will be 10, two-hour classes for anyone who is dealing with issues from minor depression to schizophrenia. Classes teach how to deal with being mentally ill in society today. Jill Tingey, UNR Cooperative Extension: Bill AB407 passed the legislature. It will split Cooperative Extension between north and south. Cooperative Extension is usually at Land Grant institutions. It means that CE doesn't know how it will exist if the budget is split. She asked concerned attendees to contact Governor Sandoval's office and let them know they oppose the change. Sandra LaPalm, with NEIS, spoke of her continuing educational pursuits. She brought in printed materials about NEIS and its services. Betty Cheney, Nevada Early Intervention Services: Inaudible. Kathy Edwards, The Church of Jesus Christ of Latter Day Saints: Kathy is the Humanitarian Specialist. She promoted the Just Serve Website, www.justserve.org, where people who wish to volunteer can see what opportunities exist in the community, and organizations

Date	Outreach Activity	Summary of Activity
		needing volunteers can list work. The contact for Just Serve is Gwen Thacker, (775) 340-0870, or ElkoThack@yahoo.com. The church wants to "ramp up" the number of people who are serving in the community. Kassie Antonucci, Elko County Library: The library is taking registrations for its Youth Summer Reading Program, June 18th through July 28th. The registration deadline is June 24th. They are anticipating up to 700 sign-ups. They are also readying their adult program. No registration is required. There will be scrapbooking and wood burning classes. The Holocaust Resource Center for Nevada will offer a Holocaust Book Club. Margot Teague, Impact Evaluations: Margot discussed GBC's Summer Biomedical Workshop. It will be held August 21-24 on the Elko campus. It is designed to: 1) Teach college students about educational and career options with a degree in biology (e.g. graduate school, medical school, research, etc.); 2) Provide students with support and suggestions for successful completion of bachelor's degree in biology; and,

Date	Outreach Activity	Summary of Activity
		3) Visit medical or professional schools, tour labs, meet advisors and grad students In addition to the cohort group and the summer workshop, GBC has purchased some cutting-edge lab equipment. After the first year, one student has been accepted to pharmacy school and another accepted to chiropractic school. Sherry Smith, Friends In Service Helping (F.I.S.H.): The organization's client services hours are now 9 a.m. to 12:30 p.m. Mon., Tue., Thur., and Fri. Store hours remain the same, 9 a.m. – 4 p.m. Monday through Friday. Cheryl Atine, Indian Health Service: Cheryl brought flyers listing the services her office provides. She announced the IHS Tele-Health telemedicine providers operated through the University of New Mexico. I.H.S. currently pays for 23 inpatient residential treatments for youth and adults. Programs can last up to 60 or 180 days for any enrolled member of Federal tribes. Barbara Barrett, Aging & Disability Services: They are awaiting the finalization of the state budgets. Jan Brizee, Office of Consumer Health Assistance: The

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		Affordable Care Act is up in the air, but it looks like changes will not take place until 2020. They are still doing special enrollment periods. The abbreviated general enrollment period will be from Nov. 1 through Dec. 15. They are taking a list for people interested in 2018 enrollment. Chela Elliott, Intensive Family Services intern: She works with two counselors who provide in-home therapeutic services. She is a certified NAMI Family Support Group Facilitator. She announced a train-the-trainer opportunity in Winnemucca on Fri. and Sat., June 15th – 16th, to get more facilitators certified. Attendees will be certified to facilitate Family Support Groups in Elko. The next meeting will be Tuesday, June 20th, at 6 p.m. Those interested should let her know by email. Laura interjected that PACE would send out a flier to the email list regarding the training. Rebecca Hepworth, Ruby Mountain Resources (RMRC's) car wash services are available on Fridays now too. Customers without appointments can call to see if they can be fitted into the schedule. They have started a garden/greenhouse and are producing vegetable and flower plants for sale to the public. Sales

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		support job skills training for clients. Mary Ann Martinez, PACE Coalition, will start a series of free English language diabetes management classes on June 19th. The six, weekly classes are two hours each at Northeastern Nevada Regional Hospital. This course is more interactive than the class previously taught to Spanish speakers. Call Mary Ann to reserve a seat. Class size is limited, but additional classes can be scheduled if needed. Mary Ann will conduct a Safe Talk training at the end of June. The Safe Talk program offers those who are suicidal someone with whom they can speak safely. Mary Ann will become a Notary Public shortly. Laura announced there will be an ASSIST training in August. PACE will send out information closer to the start date of the training. Training program is provided through the Nevada Suicide Prevention Coalition. Michelle Sandoval, CSW III, Children's Program Coordinator for the Nevada Department Health and Human Services, gave the June presentation. She spoke about the Rural Mobile Crisis Response Team program, which can respond rapidly when youth experience a behavioral or mental

Date	Outreach Activity	Summary of Activity
		health crisis. The program seeks to find options that don't require hospital admissions or remove youth from families.
June 7, 2017	Elko Urgent Care Elko, Nevada	AxisPoint Health staff met with the Elko Office Manager. APH introduced the program and discussed ways to support the clinic's efforts to treat Medicaid recipients. The office manager did not recognize the name of the program but once we started providing the overview, she said, "oh yeah, I know our front desk staff is familiar with the help your program provides." The clinic manager told us that while they are an Urgent Care, they do take appointments and are willing to take more Medicaid patients. We showed her how to find our members through the Eligibility Verification System (EVS). We asked her how we could continue to help their clinic. She explained the growth the clinic has been undergoing. We discussed the need for Behavioral health (BH) providers and they told us that they have hired a therapist who will be seeing BH patients one day a week. We told her that we would ask our local staff to drop in often to see how we can support their efforts to treat Medicaid recipients.
June 10, 2017	Tuoro University PA; School Clinic Las Vegas, Nevada	Thomas McCrorey, AxisPoint Health , Medical Director for the Health Care Guidance Program (HCGP), Cheri Glockner,

Date	Outreach Activity	Summary of Activity
		AxisPoint Health, Executive Director for the HCGP and Community Health Worker (CHW), Samantha Sbriglia met with Mr. Henry Jackson, Administrator Clinic RNs. Meeting/ presentation with Touro University District Office and Physicians Assistants school clinic attendant's. Brief discussion of the program (review) and not much discussion as we only had 10 minutes. Did not get the feeling they had any problems with us. The clinic nurse supervisor is familiar with us and contacts our southern supervisor as needed. There are not a lot of patients we have imputed to the clinic, not sure why but could be due to their location in Henderson
June 14, 2017	Southern Bands Clinic Elko, Nevada	AxiPoint Health staff and DHCFP staff met with Andrew McAuliffe, Administrator of Southern Bands Clinic. Provided an overview of the program. The site had a nice IT setup and we were able to give good slide show. Some familiarity but the (CEO) Andrew McAuliffe was new and a full overview was a good idea. They were appreciative of prior assistance and were looking forward to further work with us. Ruth Hawkins with Medical Records wants a list of the shared

Date	Outreach Activity	Summary of Activity
		members. We promised we could do that. Mr. McAuliffe clarified that even if they have excess capacity with behavioral health provider they cannot use him to bill other patients not normally authorized care at Indian Facility. He said they may be working with Vitality (new CCBHC) to cooperate with the Behavioral Health. Will keep ongoing contact with Southern Band Clinic.
June 27, 2017	Lutheran Social Services Las Vegas, Nevada	Monica DeBrest, AxisPoint Health staff, met with Derek the manager at Lutheran Social Services. Received a tour of Clarity Homeless Management Information System. Interfaces with wherever they have the system, goes back years. Can make reports, rates quality of data on member, self reported or not, verified, missing data, etc. Updated when getting food etc., like when you check into medical clinic the receptionist updates information in the computer, the food bank does the same. Variable pricing depending on status of service provider. Incentive from government and the LSS has some pilot project so they are getting a good deal or free.

Date	Outreach Activity	Summary of Activity
		The CEO of Bridges Counseling is wary of the system for use in behavioral health clinics, if they enter a visit into it, it will be seen by "300 food banks" they will know the member has behavioral health issues. But he agreed the value for those providers is good, he wants to use it in a way that his entries could not leave his system. In HCGP we would want access for the social issues, not input medical infrmation, mostly for removing data not otherwise available. Dr. Gurley pointed out this is useful even if the consumer data is mined as this population is least likely to have accurate consumer data. The Lutheran Services has an efficient system for food distribution including online ordering by client/recipient, and credits for food. X amount per month, lower "cost" for healthy foods. So lowest points are for fresh veggies, highest point, candy etc. The ordered can get treats but they have to budget. Derek said they noticed people learned to budget over a few months. Only a few foodbanks nation wide use the system. I am not sure if it is a part of Clarity (add on program) or separate.

Date	Outreach Activity	Summary of Activity
		Food products in the bank are displayed on the monitor, (a picture of the can).Organized by food type and sugar, fat content etc. to comply with diets. A person with a known food restriction will not have the choice to order foods that are not compliant but would need to confirm. Order routed electronically to food volunteer packers. Like a pharmacy, prints out a shopping list and the volunteers fill bags. Keeps track of how much food is left and where to find it. Refrigerated products are selected by participants, rules on the fridge. I imagine there are monitors. Volunteer Dietician involved for consults/teaching. Most food from grocery overage. Get lots of donation after holidays etc.
June 27, 2017	Nevada Rural Health Partners Foundation Washoe Golf Course Reno, Nevada	Tom McCrorey, Medical Director for the HCGP and Cheri Glockner, Executive Director for the HCGP attended the “Annual Networking Event”.
June 27, 2017	Summit Mental Health Las Vegas, Nevada	AxisPoint Health staff met with Cynthia Castillo, Director, going for her CPC, Brandon Lane, CPC Clinical Supervisor. Summit Mental Health Clinic see’s themselves as legitimate providers of health care, in

Date	Outreach Activity	Summary of Activity
		particular the underserved, fell that there are shady providers out there that make it difficult for them to provide Rightful services. Four instance they provide Basic Skills Training (BST) and Psychosocial Rehabilitation (PSR) and feel that in certain populations it is necessary and tends to get cut off too early with severe patients that need it and take a long time to respond that recognize it is abused summit providers visit schizophrenia patients at home that are paranoid of travel fearful of the bus.
June 27, 2017	West Care Reno, Nevada	AxisPoint Health and Beacon Health staff met with Angela (or Amanda) Assistant Director of billing West Care covering Reno. Met with Kevin Morse, VP for Nevada who is charge of all clinics in Reno. Mr. Morse expressed West Care Fairly aware of the HCGP, did not need a general presentation. West Care approved for Certified Community Behavioral Health Clinic (CCBHC) starting July1. Several locations in Nevada, 323 Maryland Parkway is the main one for CCBHC. Also they run a Crisis Treatment Center there for mental health and substance abuse (intoxication) emergencies. 24hrs,3 day stay there. Have nurses and NPS so most people can stay unless ICU etc. or need restraining, physical or chemical.

Date	Outreach Activity	Summary of Activity
		They have admission counselors to see for follow up. They have 51 beds in Las Vegas site and 20 in Reno. Not as much opiates intoxication in Reno as Las Vegas, lots of ETOH (ethyl alcohol) everywhere. About 500 people a month in Las Vegas site. Also aware of cross over issues of billing Targeted Case Management (TCM) claims for members since had discussed with Dr. Stephanie Woodard with Division of Public and Behavioral Health (DPBH). Dr. McCrorey, explained the position over all as care facilitators and managers not providers, that we don’t compete with providers such as their facility. We have a desire to refer members there and make sure they follow their plans. Only overlap on case management. We don’t bill but are considered by Centers for Medicare and Medicaid Services (CMS) to be TCM providers. Discussed the bump out of the program when a TCM claim is dropped. But this might change soon but currently any single T1016 claim will remove patient.They seemed aware and did not want to happen. They are willing to forego billing for TCM services (T1016) if they are in our program. I explained that we did not want to interfere with their

Date	Outreach Activity	Summary of Activity
		efficiency or income but that we did support discussion with our CMs about who would need to do the case management. We were on the same sheet of music about this. The communication is what we both want to set up. It was mentioned that Angela could be the best person for the initial communication to our Care Manager's (CMs) and back to West Care would be the admissions counselors, since they are easiest to reach. They will check EVS for eligibility or send us a message for possible members. I gave her the HCGP Secure email and will check back with her. Provided a copy of the RTR and will set up a format in her health record system. We discussed eligibility and we usually try to call back with a response whether someone is or is not in the program. They also discussed their transport capabilities. They have a fleet of transport vans that bring people to appointments or even from the hospital to home. They do not bill anyone. Or ask for reimbursement from MTM. They looked into MTM and had trouble with them. They were told MTM will not pick up people from Managed Care Organizations (MCOs) only Fee-for- Fee-Services (FFS) and will only work with providers of

Date	Outreach Activity	Summary of Activity
		transport who have over 250 vehicles. Not sure how that happened but they were fairly certain they were given that in a written document. I told them we had heard that before and that we try to assist getting transport issues ironed out, it affects our bottom line.
June 27, 2017	Well Care Services Las Vegas, Nevada	Thomas McCrorey, AxisPoint Health, Medical Director for the HCGP and Monica DeBrest, CHW with AxisPoint Health met with Ms. Paola Sotelo with Well Care Services. Well Care Services is a mental health based clinic with some primary care services. They are not fully staffed on either side yet but will be soon. The currently have two part time psychiatrists and two part time nurse practitioners (NPs) doing mental health. They also have part time family physician (FP). In a couple weeks they will expand to full time presence for both. They are like a Certified Community Behavioral Health Clinic (CCBHC) in that they have not only the clinical mix of mental and physical health, but also have a pharmacy, lab draw station, and in house case management. They only take Amerigroup and FFS Medicaid right now. I don’t believe they are doing case management (CM) for FFS members (that’s what Paola said).

Date	Outreach Activity	Summary of Activity
		They want to get more FFS patients, mental health and primary care. I told Paola that we would probably have one or two of our BH care managers come by for a visit. We can set that up if the southern Beacon team is up for it, unless they have been by before. They have a telemedicine booth they use to contact a FP when the patient is in the clinic but has a medical problem but no primary care is in house. They have a van that will go out and pick up members at their house for appointments. They will go anywhere in the metro area but not Boulder city, Pahrump, Laughlin. etc. They do not bill MTM. I think they bill the insurance companies as part of the visit but I am not sure how that works. The van also goes to the hospital and picks up people that need immediate follow up (for Amerigroup). If the member is homeless and was in the ED or inpatient, and needs housing, the van will pick them up, bring them to assessment at the clinic or if in the night, to the affiliated, but separate building across the parking lot. That is a rest area for Amerigroup homeless members to cool down or warm up, have some food and water, and speak

Date	Outreach Activity	Summary of Activity
		to a homeless coordinator. The coordinator tries to get a place to live long term.
June 28, 2017	Bridge Counseling Las Vegas, Nevada	AxisPoint Health (APH), who handles the Physical Health for the Health Care Guidance Program and Beacon Health who handles the Mental Health for the HCGP met with Mr. David Robeck, CEO,Tabitha Johnson, MFT Assistant, Clinical Director. Provided an over view of program. Not real familiar with HCGP. Their clinic is present over 35 years. A lot of disruption but CEO David Robeck turned it around the past couple years and is proud of their compliance record, and growth. Capacity to take more patients (sounds like it may require discussion to see who is appropriate, mostly focused on SA right now. Lots of contracts for Juvenile court, family court etc. About 40% of the patients are Medicaid. Expect that will go up to 60%.Medicaid insurers: Amerigroup easiest to work with. Credentialing and prior authorizations difficult with Behavioral Health Organization (BHO). Does not do in home visits.

Date	Outreach Activity	Summary of Activity
		Innovative way of dealing with licensing when recruiting out of state. May have someone work as Certified Alcohol and Drug Addiction Counselor (CADAC) first. Then get full certification. Doesn't agree with peer specialists and has trouble with lots of Social Worker's (SWs). Have never done TCM so would be new deal. See that as secondary to their other services. I explained the TCM issues and how we can help. Want to Build a relationship with them; CJ wants to bring Beacon staff back for a tour after they get up and running. CCBHC go live July 1, 2017.

Note: for every provider outreach, team provides tools for immediate services such as; Real Time Referrals (RTR) forms, contact phone numbers to the 24/7 Nurse Advise Line, Enrollee Assessment, Provider Manuals and Access to the Provider Portal.

<u>Operational Developments/Issues</u>

The DHCFP held its Quarterly Health Care Guidance Program (HCGP) Meeting on April 25, 2017. Following the updated Quality Strategy Modules, AxisPoint Health (APH) presented the following:

- Program Updates, presented by; Cheri Glocker, HCGP's Executive Director, and Dr. Tim Moore, CMO APH.
    - Key Accomplishments: APH continues collaboration with the states Medical Transportation Management (MTM) to resolve issues. APH prepared proposal for DHCFP consideration for Amendment #6. APH announced they have executed renewal for Beacon Health Options as subcontractor to the HCGP. Submitted the April 2017 Quarterly P4P/Non-P4P Clinical Rates. Hired more rural staff to increase outreach form Fernley, Nevada to Battle Mountain, Nevada.
- Dr. Tim Moore announced his departure as CEO for AxisPoint Health and welcomed Dr. Virginia Gurley, MD, MPH – Sr. VP, Chief Medical Officer, APH. Dr. Gurley back ground includes preventive medicine and public health specialist with over 20 years of experience in population health program design, health services research, and health plan operations. Dr. Gurley brings special interests in vulnerable populations, social determinants of health, and well-being.

- Dr. Gurley presented on Digital Engagement Campaigns. Digital strategies are targeted, multi-channel campaigns to overcome communication barriers and support adoption of new health behaviors resulting in improved outcomes and experience. With the Digital Engagement Campaigns, three common gaps in care that can be identified via analytics:
    - Refill gaps in guideline recommended medications
    - Missing guideline recommended preventive services
    - Too long since last visit to Medical Home or Specialist

  Analytics flags those members with gaps in care. APH also identifies member appropriate for preventive services: flu shot, PAP, postpartum visit, well child visits. Multi-channel campaigns using SMS, email, IVR and care team to close relevant chronic and preventive services gaps.
- Shawn Donnelly, Actuary, APH, presented internal preliminary Program Year 2 net savings and ROI analysis with six months of claims payment run-out. Final results will include 12 months of payment run-out. Preliminary results, based on claims with 6 months of payment run-out, estimated a savings of $11.1.
- Quality presentation presented by Michelle Searing, Outcomes Operation Manager, APH.
    - Michelle Searing presented on Quality Module #5: Objectives 1.1 and 1.2 and Quality Module #6: Objective 1.5 and Module #7: Objective 2.1 and 2.2.
    - Quality Module #5: Objectives 1.1 and 1.2 are revised graph presenting the new and existing enrollees. Objective 1.1 looks at the total enrollment, new and existing enrollees, and averaging from 500-700 new members every month. New Members defined as never had been in the program. Objective 1.2 looks at the enrolled persons vs. person actively receiving case management (CM) services.
    - Module #6: Objectives 1.5, looks at the trend in rates from baseline to remeasurements 2.2. Presentation displays and discusses the trend in rates from baseline to Program Year 2 (PY2) for the Pay- For-Performance (P4P) measures, which have not reached the performance target. APH, presented on the Quality Improvement (QI) tools used, the identified causes, and what interventions have been identified that, once implemented, will likely improve performance and what is the evaluation plan to establish the effectiveness of those interventions?
    - Module #7: Objective 2.1 Increase use of preventive services by 10%, these are Non Pay-For-Performance (Non P4P) clinical measures which reached the target in Program Year 1 (PY1) then sustained improvement through PY2. APH presented on the interventions that were implemented that positively impacted the P4P measure. Presentation also included Non P4P clinical measures which declined from baseline to PY2 and the QI tools used, the identified causes, what interventions have been identified that, once implemented, will likely improve performance and what is the evaluation plan to establish the effectiveness of those interventions? Objective 2.2 Increase follow-up ambulatory care visit after hospitalization by 10 percent. APH presented on the P4P clinical measures which reached the target and sustained improvement through PY2. The team described the interventions that were implemented that positively impacted the P4P measure. For more detail description on Modules #6 and 7 see attachment titled "NV HCGP APH Quarterly April 2017 final".
- Outreach:
    - Dr. Thomas McCrorey, Medical Director for the HCGP presented on the collaboration between Department of Health Care Financing and Policy (DHCFP) and Department of Health Human Services (DHHS).
        - APH worked with Behavioral Health (BH) section and DHCFP to facilitate care management of members in out of the state Residential Treatment Center's (RTC's).

  - Worked with BH section and DHCFP to collaborate on members in pharmacy lock in program.
  - Collaborate with DHCFP to minimize churn from Targeted Case Management (TCM).
  - Ongoing work with Hewlett Packer Enterprises (HPE state's fiscal agent) to understand impact ED super users in collaboration.
  - Collaborate with inpatient facilities to improve discharge planning and coordination.
  - Assisted DHHS with population profiling.
  - Provider outreach by leaders and case managers
  - Provider Advisory Board Meeting (PAB), June 9, 2017.
- The DHCFP team had the bi-monthly CMS call on April 4, 2017. Introductions took place between the CMS and the DHCFP team. CMS provided to the DHCFP answers regarding the demonstration, questions about the renewal process and questions regarding the incentive payments were answered by CMS. Ms. Juliana Sharp, CMS Technical Director informed the DHCFP that she will be the acting Program Officer for the Nevada Comprehensive Care Waiver (NCCW) until further notice.
- On June 30, 2017, CMS and DHCFP held the bi-monthly call. Introductions took place, the DHCFP informed CMS that the reconciliation methodology for PY2 will begin at the end of the summer beginning of fall. DHCFP continues to have internal discussions about the renewal of the program, still discussing with leadership the direction we are actually going to take, and we are preparing various tasks in preparation for that. DHCFP is interested in finding out about other program authorities, and are considering another new program in addition to the Health Care Guidance Program (HCGP). Mr. John Kucera with the DHCFP acknowledged receipt of email regarding the budget neutrality worksheet with our quarterly submission. Mr. Kucera is currently working with the agency's actuarial team to make sure we match all the methodology.

Care Management Contracting

- The DHCFP continues to work with CMS, and the CMO Vendor on Amendment #6. The purpose of this amendment is to be in compliance with CMS language to Attachment B of the Special Terms and Conditions (STCs) in that it reads "The state must submit a request for an amendment to Attachment B by June 30, 2017 to extend this timeframe if it anticipates that any payment will be made to the CMO's after June 30, 2018". On December 21, 2016, the DHCFP e-mailed CMS asking for guidance as to where the language should be included? To comply with this existing requirement in Attachment B of the STCs, the waiver period will need to be extended to December 2019 to allow for the required amount of claims lag, evaluation, and a potential incentive payment. The state has provided a revised word document of the approved NCCW Attachment B and revisions that will need to be made to "Table 1. Time Frames for State of Nevada Data Extracts" to be in compliance in the event CMS approves the extension. Amendment # 6 will also include updates on the P4P Quality Measures that have been retired and add new Non P4P measures that were identified during the 2015-16 Performance Measure Validation (PMV) Audit as non reportable measures, order of contractual precedence documents, and various revisions to the section of the RFP.

Policy Developments/Issues

On March 6, 2014, the addition of the new Medicaid-eligible Modified Adjusted Gross Income (MAGI) individuals to the CMO-eligible population was discussed with CMS due to the implementation of health care reform. On March 12, 2014, per CMS guidance, the DHCFP submitted a technical correction to the

STCs to address this new Medicaid population and align the eligibility charts (STC 17) with the revised medical assistance AID categories. As of today we have not received any additional feedback and/or final approval from CMS regarding MAGI.

Financial/Budget Neutrality Development/Issues

The DHCFP is submitting an updated budget neutrality work sheet as a requirement to the Special Terms and Conditions (STC's). The DHCFP team would like to bring to CMS attention that the worksheet cannot show any change in PMPM amount quarter-to-quarter due to program design; the program runs on a fixed Per Member Per Month (PMPM) rate of $15.35. The state will find out of the vendor is eligible for an incentive bonus payment after the annual program evaluation is complete, which is the only way the average per member per month cost of the program could change. There has been no incentive payment made from inception of the program to current and, as a result, the PMPM cost of the program in each month of operation has been $15.35.

Member Month Reporting

Demonstration Populations	Month 1 (April 2017)	Month 2 (May 2017)	Month 3 (June 2017)	Total Ending (July 2017)
Population 1: MAABD	21,837	21,860	20,988	20,988
Population 2: TANF/CHAP	17,070	17,059	17,055	17,195
Total:	38,907	38,919	37,761	38,183

Consumer Issues

There are no consumer issues to report for this quarter (Q3/2017).

Quality Assurance/Monitoring Activity

Per STCs 26 & 27, the State is required to report on demonstration eligibility determinations, the number deemed non-compliant and "on demand for noncompliance." For this quarter (Q3/2017), please see table on page 3 for "noncompliance".

The DHCFP reports zero (0) number for those deemed non-compliant and "on demand for noncompliance". The DHCFP sent CMS an e-mail on August 19, 2015 for guidance on the definition of noncompliance to assure reporting is done adequately. The program has been operating since June 2, 2014, and has a zero count. The DHCFP is awaiting the response from CMS to ensure that this measure is being accurately reported.

Demonstration Evaluation

The DHCFP draft Evaluation Design Plan for the NCCW was submitted to CMS on October 14, 2013. On February 2, 2014, DHCFP received feedback from CMS. The DHCFP re-submitted the Evaluation Design Plan for the NCCW to CMS on March 5, 2014, incorporating CMS feedback. On February 24, 2015, the DHCFP received feedback from CMS. The DHCFP received feedback from CMS on January 12, 2017.

CMS has additional has additional questions. The DHCFP submitted responses to CMS questions on January 24, 2017. On January 31, 2017 during the Nevada Comprehensive Care 1115 (a) Demonstration Bi-Monthly Monitoring Call, CMS confirmed receipt of January 24th e-mail. On April 26, 2017 CMS followed up with the DHCFP and request that the state provide an updated evaluation design plan that accurately reflect the current/actual pre-and post analytic methodology and data sources the state is using to measure the impact of the this demonstration.

Enclosures/Attachments

- 2017 Quality Strategy Modules
- 20170818 Updated member months for budget neutrality calculation
- FINAL Budget Neutrality Template for Nevada – Updated Aug 2017
- Fact sheet what is ccbhc final
- HCGP pab 062017
- JUNE 2017 PAB Minutes
- JUNE PAB Agenda
- Minutes for HCGP Quarterly Meeting 01-31-17
- NV HCGP APH Quarterly April 2017 final presentation
- NV Quarterly Meeting Agenda04252017
- Sign in Sheet for HCGP Qrtly Mtg 04252017

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<u>Date Submitted to CMS</u>

August 31, 2017

AXISPOINT HEALTH

Health Care Guidance Program
Coordinating with you for better care!

Health Care Guidance Program

April 25, 2017

AXISPOINT HEALTH

Health Care Guidance Program
Coordinating with you for better care!

AXISPOINT HEALTH

April 2017 Quarterly Review

Today's Agenda

9:00 am – 9:30 am

I. Welcome and Introductions/DHCFP — Gloria Macdonald, Chief, Program Research and Development, DHCFP

Approval of Minutes — Gladys Cook, Social Services Specialist III, DHCFP

II. Program Updates

Executive Director Comments — Cheri Glockner, HCGP Executive Director, APH

AxisPoint Health Update — Dr.'s Tim Moore and Virginia Gurley, CMO, APH

"Preliminary" 12+6 PY2 Results — Shawn Donnelly, APH, Actuary

9:30 am – 10:45 am

III. Quality — Michelle Searing, Outcomes Operations Manager

Module 5: Objectives 1.1 and 1.2

Module 6: Objective 1.5

Module 7: Objectives 2.1 and 2.2

10:45 am – 11:00 am BREAK

11:00 am – 11:30 am

IV. Provider Outreach — Dr. Thomas McCrorey; Medical Director, APH

V. Focus for Next Quarter — Cheri Glockner, HCGP Executive Director, APH

11:30 am – 12:00 pm

VI. New Business — Gladys Cook, Social Services Specialist III, DHCFP

Program Updates

Key Accomplishments

- Continue to work with MTM on meeting Member needs
- Prepared APH proposals for DHCFP consideration for Amendment #6
- Executed renewal for Beacon Health Options as subcontractor to Health Care Guidance Program
- Ongoing support for legislative hearings and inquiries related to HCGP
- Supported operations team as strategies to increase contacts and engagement continue to be deployed
- Hired more rural staff and increased northern Nevada staff to increase outreach from Fernley to Battle Mountain
- April 2017 Quarterly P4P/Non-P4P Clinical Rates
- PY2 Annual Quality Assurance Report

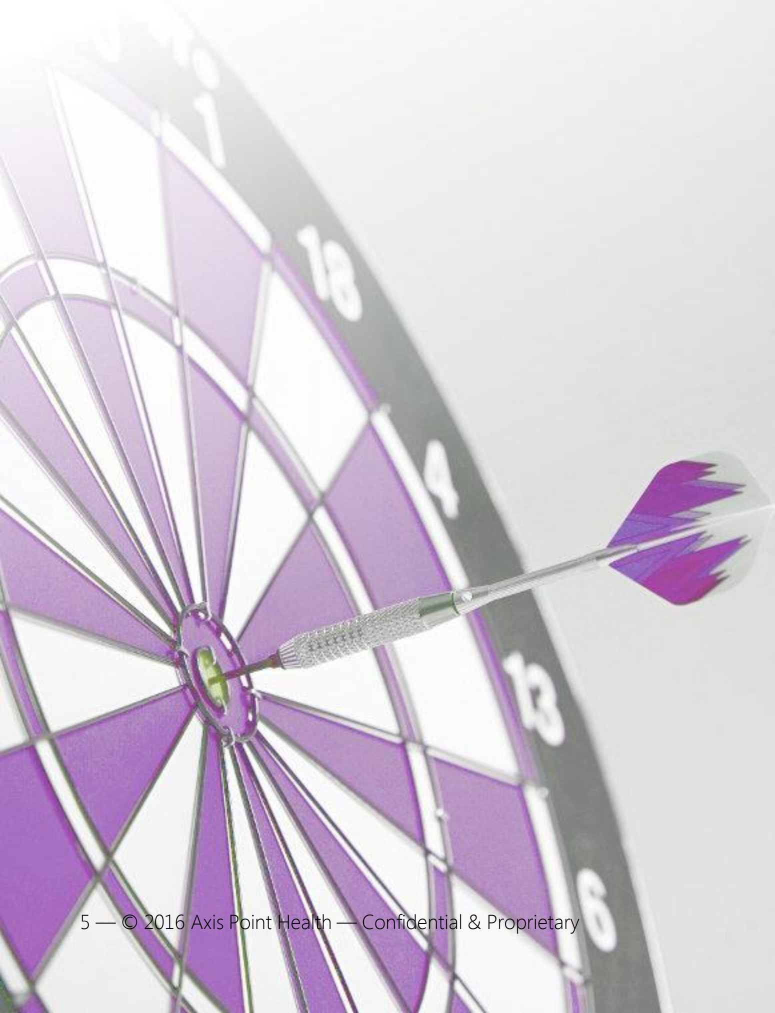
AxisPoint Health

Health Care Guidance Program
Coordinating with you for better care!

AxisPoint Health Business Update

Dr. Virginia Gurley, MD, MPH – Sr VP, Chief Medical Officer, APH

- Preventive medicine & public health specialist
- 20+ years in population health program design, health services research, and health plan operations
- Special interests in vulnerable populations, social determinants of health, and well-being



AXISPOINT HEALTH

Digital Engagement Campaigns

Targeted, multi-channel campaigns overcome communication barriers and support adoption of new health behaviors resulting in improved outcomes and experience

Digital. It's here. It works.

Health Care Guidance Program 1m ago

Salma, Do you have transportation for your doctor visit tomorrow? Reply YES or NO.

Smart Phone Ownership in the United States[1]

Seniors	Adults	Young Adults	Low Income
79%	94%	97%	89%

Text Message Use Read Rates[1]

Read Rate	Read Rate within 3 minutes
98%	95%

1. Cellular Telecommunications Industry Association

Health Care Guidance Program
Coordinating with you for better care!

Actualizing Digital Health Value

Interact

Engaging with the consumer
in the ***right way***,
at the ***right time***.

Engage

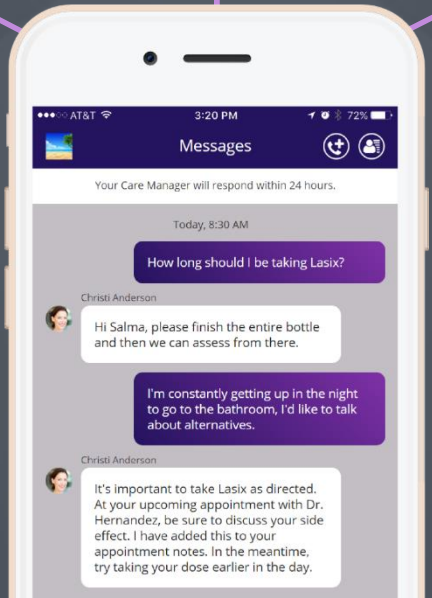
Creating personal, relevant value.

Impact

Achieving success in health goals.

Reaching out to begin interaction

Integrating automated clinical dialogues



Streamlining the consumer experience

Driving engagement; impacting health

AXISPOINT HEALTH

Digital Engagement Campaigns

- Three common gaps in care that can be identified via analytics:
  - Refill gaps in guideline recommended medications
  - Missing guideline recommended preventive services
  - Too long since last visit to Medical Home or Specialist
- Analytics flags those members with gaps in care
- APH also identifies members appropriate for preventive services: flu shot, PAP, postpartum visit, well child visits
- Multi-channel campaigns using SMS, email, IVR and care team to close relevant chronic care and preventive services gaps

Approach

Health Care Guidance Program
Coordinating with you for better care!

Outreach and campaigns using a combination of SMS messaging, IVR and/or email communications to reach members using the communication channels best suited to engaging with them.

- Outreach to confirm whether:
  - Visit to close gap has been scheduled
  - Gap in care has been closed
  - Self-care behavior change has been maintained

Campaigns are refreshed to target those who have not yet closed gap or obtained needed service but have not “opted-out”

- Confirmed gap closure removes from future outreach messaging
- Each outreach followed by educational or motivational messaging, and may include links to community resources
- Telephonic outreach to identify and resolve barriers to gap closure

Ability for patients to connect with a resource who’s focus will be to assist with general care coordination (1-2 contacts with a care coordination resource)

- Find and schedule appointments with providers
- Assist with transportation
- Support question/answer regarding care needs and barriers

AXISPOINT HEALTH

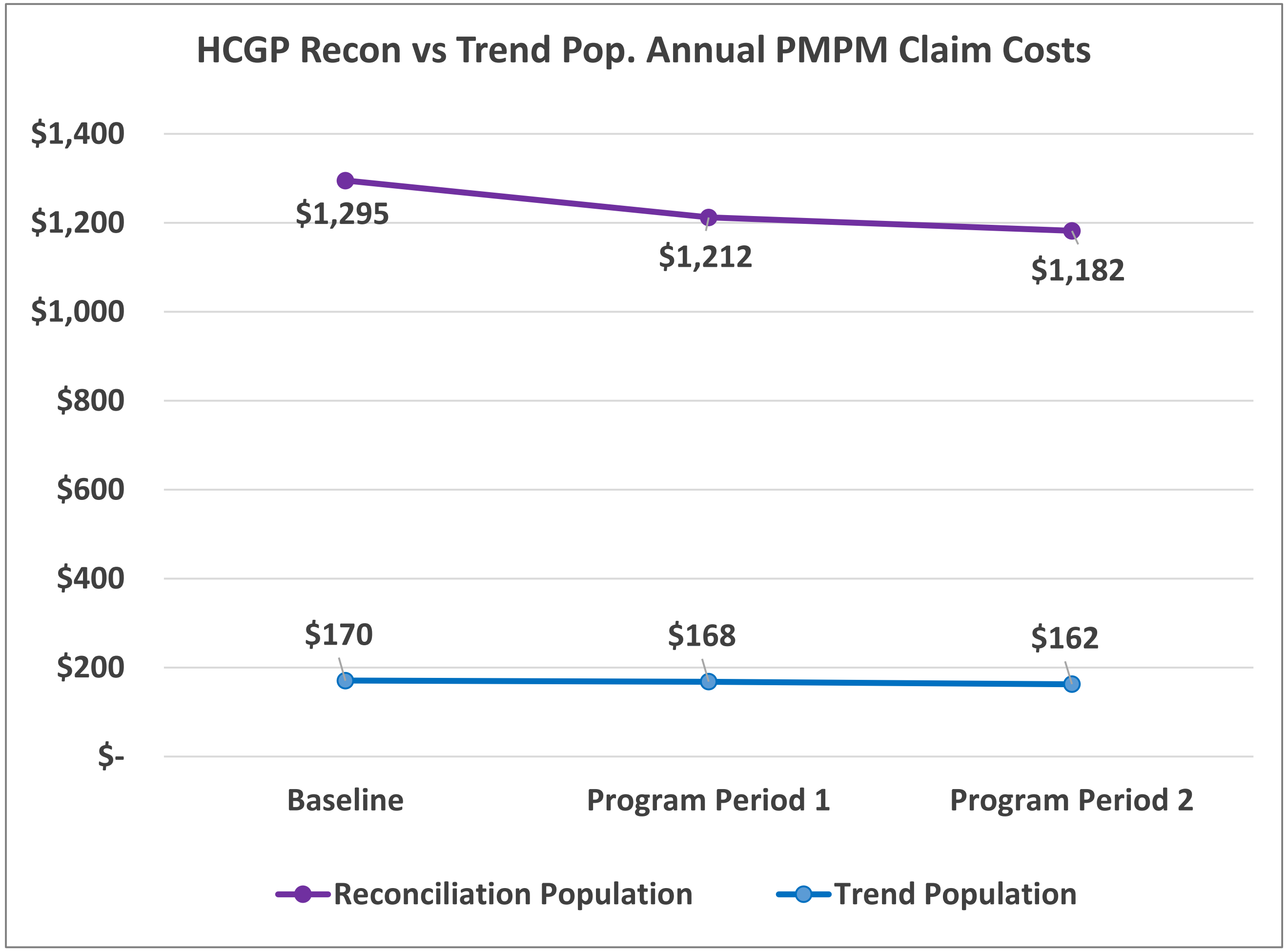
Preliminary PP2 Savings Analysis

AxisPoint Health's Internal Program Period 2 Net Savings and ROI Analysis with six months of claims payment run-out.

APH Net Savings and ROI Analysis - Background

- The APH Team worked closely with the Milliman Team in during each team's year 1 analysis:
  - Milliman shared condition identification SAS Code with APH and APH reviewed and had agreement with Milliman on some specific modifications to this code set.
  - Milliman and APH shared monthly Member ID Lists split by category until both teams had a near match
- Limitations:
  - Milliman and APH had only a 98.6% match on our raw claim paid amount starting points (teams had different sources of their raw claims data)
  - Milliman and APH never compared detailed CDPS Risk Score Results (appears to be a material difference in scores)
- AxisPoint Health internally calculated $19.3 million in Year 1 Gross Savings. Milliman calculated $16.8 million.

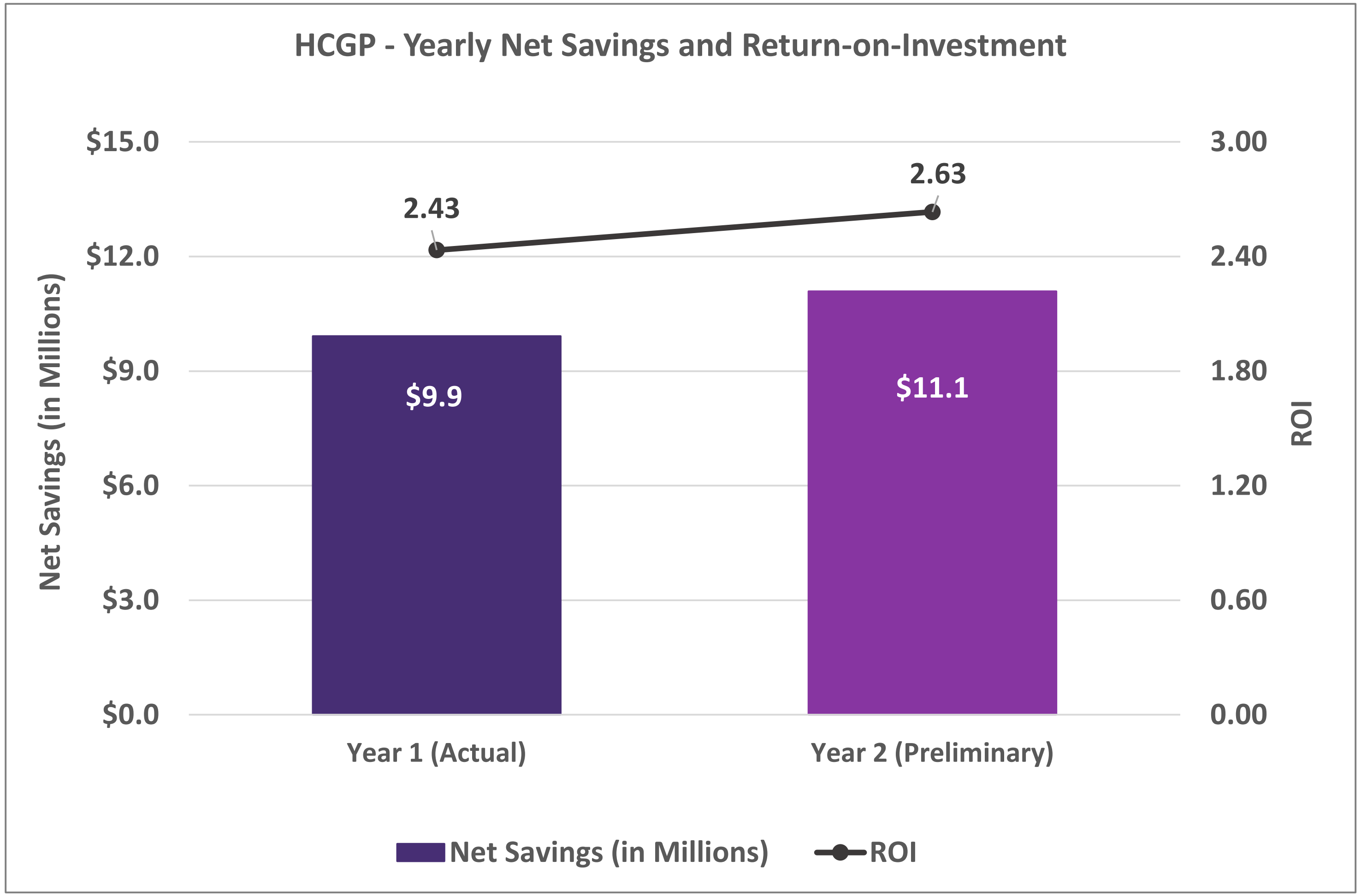
APH Net Savings and ROI Analysis – PMPM Trends



Notes:

- Program Period 2 Results are Preliminary, as they are based on claims with 6 months of payment runout, final results will include 12 months of payment runout.
- All results are based on claims and eligibility data supplied to AxisPoint Health
- Calculations follow the contractual reconciliation methodology
  - Annual Member Claims Costs are capped at $500,000
  - Program Period Reconciliation and Trend Population PMPM Claims Costs have been risk adjusted to match Baseline Risk Levels (i.e. if PP1 average risk is 10% higher than the baseline, the PP1 PMPM is reduced by 10%)
  - Baseline and Program Period 1 Reconciliation and Trend Population PMPM Claims Costs have been adjusted to match the County and Aid Category Distributions of Program Period 2

APH Net Savings and ROI Analysis - Results



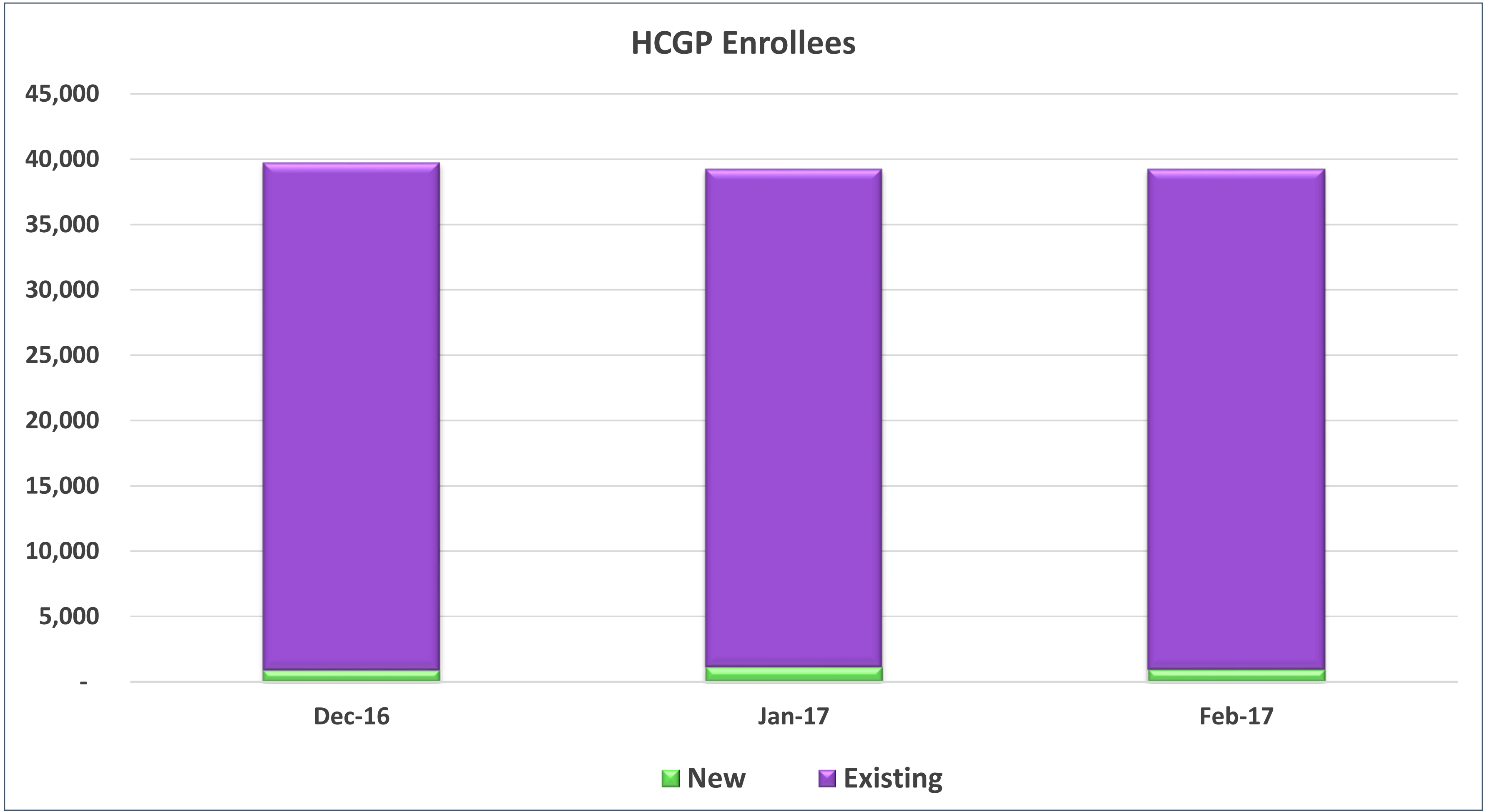
Notes:

- Program Period 2 Results are Preliminary, as they are based on claims with 6 months of payment runout, final results will include 12 months of payment runout.
- Program Period 2 results are based on claims and eligibility data supplied to AxisPoint Health.
- Program Period 1 Results are those presented by Milliman
  - APH's Internal Program Period 1 Results showed a slightly higher Net Savings and ROI

III. Quality

Module 5: Objectives 1.1 and 1.2
Module 6: Objective 1.5
Module 7: Objectives 2.1 and 2.2

Module 5: Objective 1.1 New and Existing Enrollees



Notes/Observations:

- Jan-17 reflected an 8 month high for new enrollees at 1,108. However, that count is pre-TCM lookback.
- On average, over 50% of our new enrollees do not make the final eligibility check due to TCM claims T1016 & T1017.
- An estimated 40% of those would-be members are pulled due to the l T1016 claims code activity.

Module 5: Objective 1.1 New and Existing Enrollees

Health Care Guidance Program
Coordinating with you for better care!

New HCGP Eligible's - *Members who are new to the program in Feb-17*									
	Current Program								
RL	Care Management Interventions	Chronic Kidney Disease Program	Complex Condition Care Management	Disease Management Interventions	Health Care Management	Mental Health Program	Oncology Care Coordination	Pregnancy Care Coordination	Grand Total
4	0	0	3	0	0	0	0	0	3
3	0	1	0	6	4	8	0	12	31
2	1	0	0	3	7	16	0	12	39
1	2	1	0	34	269	94	2	57	459
Grand Total	3	2	3	43	280	118	2	81	532

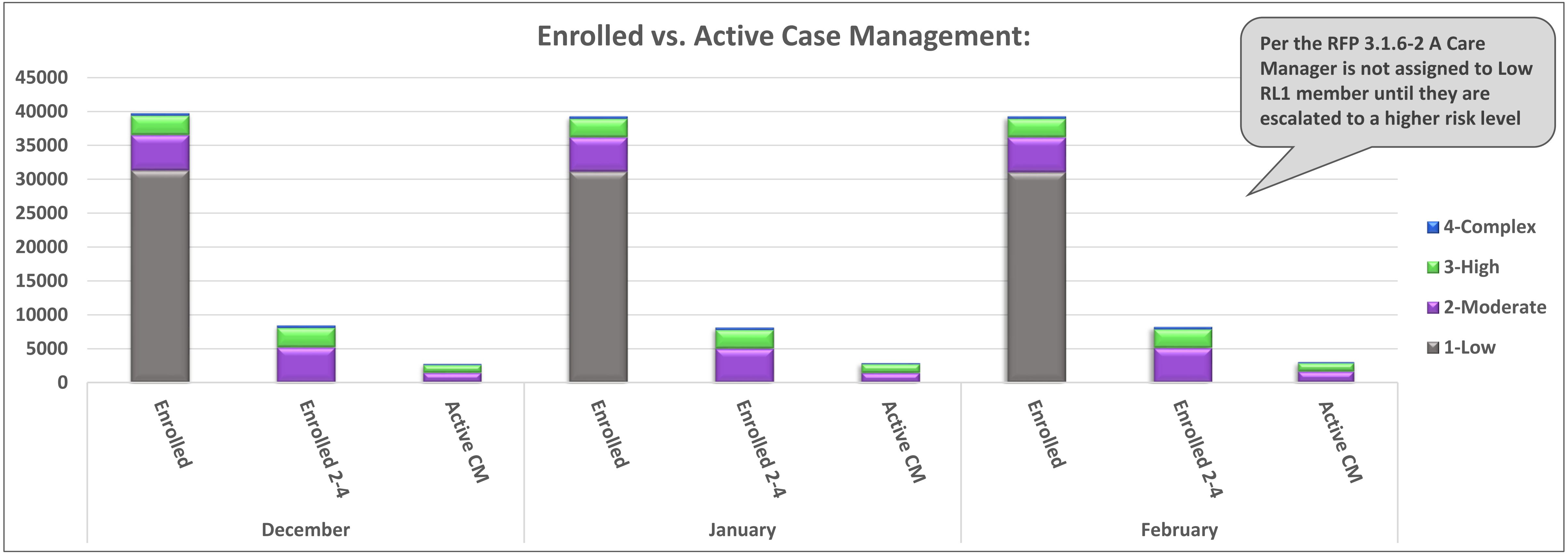
The number of new members in Feb-17 was actually 899, the remaining 40% of new enrollees were deemed ineligible due to TCM claims activity.

Lost HCGP Eligible's - *Members who were eligible in Jan-17 but lost eligibility Feb-17*									
	Current Program								
RL	Care Management Interventions	Chronic Kidney Disease Program	Complex Condition Care Management	Disease Management Interventions	Health Care Management	Mental Health Program	Oncology Care Coordination	Pregnancy Care Coordination	Grand Total
4	0	1	24	0	0	2	0	0	27
3	3	9	4	14	36	78	2	30	176
2	2	5	1	52	61	128	4	14	267
1	17	10	1	144	1,078	488	2	105	1,845
Grand Total	22	25	30	210	1,175	696	8	149	2,315

Members Lost in Feb-17 due to TCM	
RL	TCM
4	11
3	66
2	95
1	358
Grand Total	530

AXISPOINT HEALTH

Module 5: Objective 1.2, Enrolled vs. Persons Actively Receiving Case Management (CM) Services



Observations:

- **Number of enrollees and actively managed month-over-month has been very consistent at an avg. ~ 39,000**

Module 6: Objective 1.5, Trend in rates from Baseline to Remeasurement 2.2

Health Care Guidance Program
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Display and discuss the trend in rates from Baseline to Program Year 2 for the P4P measures, which have not reached the performance target.

Measure Category/ Measure #	Measure Description	*Milliman Baseline (June 2013 – May 2014)*			*Milliman Remeasurement 1 (June 2014 – May 2015) Program Q1-Q4*		
		Num.	Den.	%	Num.	Den.	%
HIV/AIDS: HIV.1	**HIV.1 The percentage of members with a diagnosis of HIV/AIDS with at least one ambulatory care visit in the first half and second half of the measurement period, with a minimum of 60 days between each visit.**	164	262	62.6%	161	280	57.5%
Substance Abuse: SA.1.1	**SA.1.1 Percentage of adolescents and adults members with a new episode of alcohol or other drug (AOD) dependence who received AOD treatment. MH.5.1 – Members with a new episode of AOD who initiated AOD treatment.**	486	1,917	25.4%	539	2,080	25.9%
Substance Abuse: SA.1.2	**SA.1.2 Percentage of adolescents and adults members with a new episode of alcohol or other drug (AOD) dependence who received AOD treatment. MH.5.2 – Members with a new episode of AOD who engaged in AOD treatment.**	264	1,917	13.8%	292	2,080	14.0%

Note: The Milliman rates presented above are currently under review via PMV audit by Health Services Advisory Group

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Module 6: Objective 1.5, Trend in rates from Baseline to Remeasurement 2

Health Care Guidance Program
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Display and discuss the trend in rates from Baseline to Program Year 2 for the P4P measures, which have not reached the performance target.

Measure Category/ Measure #	• The QI Tools used? • The identified causes? • What interventions have been identified that, once implemented, will likely improve performance? • What is the evaluation plan to establish the effectiveness of those interventions?	
HIV/AIDS: HIV.1	The percentage of members with a diagnosis of HIV/AIDS with at least one ambulatory care visit in the first half and second half of the measurement period, with a minimum of 60 days between each visit.	• QI Tools: stratification mapping and case review analysis • Identified Cause(s): HIV/AIDS is not a driver condition which would increase risk level thereby escalating priority for outreach. • Interventions: – ID & Strat identifies a newly eligible member with condition HIV/AIDS – Operations outreach prioritization list is generated – Locate the members and identify needs associated with social determinant of health – Resolve any PCP Visit Compliance barriers and gaps • Evaluation Process: Monitor progress using weekly review of program-specific barriers to care reporting, monthly Gaps-in-Care reporting and quarterly clinical measures review. *Note: The rates reflected on the previous slide are baseline and PY1 rates produced by Milliman. APH Remeasurement 2.2 rate of 75.7% would indicate target achievement.*

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Module 6: Objective 1.5, Trend in rates from Baseline to Remeasurement 2

Display and discuss the trend in rates from Baseline to Program Year 2 for the P4P measures, which have not reached the performance target.

Measure Category/ Measure #		• The QI Tools used? • The identified causes? • What interventions have been identified that, once implemented, will likely improve performance? • What is the evaluation plan to establish the effectiveness of those interventions?
Substance Abuse: SA.1.1	**Percentage of adolescents and adults members with a new episode of alcohol or other drug (AOD) dependence who received AOD treatment. MH.5.1 – The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.**	**• QI Tools: stratification mapping and case review analysis • Identified Cause(s): only 41% of SA members are identified as VITAL-MH program. As a result, the Substance Abuse diagnosis is likely secondary to a combination of physical conditions. • Interventions: – ID & Strat identifies a newly eligible SA/BH member – Outreach Prioritization for all new SA/BH members • Evaluation Process: Monitor progress using weekly review of condition and program-specific barriers to care reporting, monthly Gaps-in-Care reporting and quarterly clinical measures review. *Note: The decline from baseline to Remeasurement 1 is nominal for SA1.1 and measure SA1.2 did not decline. There was an equally nominal increase baseline to Remeasurement 1 for that metric.***
Substance Abuse: SA.1.2	**Percentage of adolescents and adults members with a new episode of alcohol or other drug (AOD) dependence who received AOD treatment. MH.5.2 – The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.**	

Module 7: Objective 2.1 Increase use of preventive services by 10%

Health Care Guidance Program
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Non Pay-For-Performance Clinical Measures which reached the target in Program Year 1 then sustained improvement through PY2

Measure Category/ Measure #	Measure Description	*Milliman Baseline (June 2013 – May 2014)*			*Milliman Remeasurement 1 (June 2014 – May 2015) Program Q1-Q4*			*APH PMV Rates 12+3 operational data (June 2015 – May 2016) Program Q5-Q8*		
		Num.	Den.	%	Num.	Den.	%	Num.	Den.	%
Preventive: CAP.1	**Percentage of members 12 months-19 years of age who had a visit with a Primary Care Practitioner (PCP). The organization reports four separate percentages for each product line. [12-24 months]**	118	134	88.1%	61	65	93.8%	958	1,081	88.6%
Preventive: W15.7	**Percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life: Six well-child visits**	6	197	3.0%	22	57	38.6%	311	1,067	29.1%
Preventive: CIS.2	**Percentage of children 2 years of age who had three IPV vaccines by their second birthday.**	48	171	28.1%	68	109	62.4%	787	1,105	71.2%
Preventive: CIS.11	**Percentage of children 2 years of age who had Combination #2 vaccines by their second birthday.**	35	171	20.5%	47	109	43.1%	583	1,139	51.2%

Note: The Milliman rates presented above are currently under review via PMV audit by Health Services Advisory Group

AXISPOINT HEALTH

Module 7: Objective 2.1 Increase use of preventive services by 10%

Health Care Guidance Program
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Non Pay-For-Performance Clinical Measures which reached the target in Program Year 1 then sustained improvement through PY2

<table>
<tr><th>Measure Category/ Measure #</th><th colspan="2">Please describe the interventions that were implemented that positively impacted the P4P measure.</th></tr>
<tr><td>Preventive: CAP.1</td><td>Percentage of members 12 months-19 years of age who had a visit with a Primary Care Practitioner (PCP). The organization reports four separate percentages for each product line. [age 12-24 months]</td><td rowspan="2">Non-P4P early childhood preventive measures are approached in much the same way; Locate, manage resource needs associated with social determinants “barriers to care” then educate and guide/encourage compliance towards closing the gap in care.
• Interventions:
– Locate the members and identify needs associated with social determinant of health
– Community Outreach to educate on pregnancy and Early Childhood Care
– Resolve any PCP Visit Compliance gaps
• Evaluation Process: Monitor progress using weekly review of program-specific barriers to care reporting, monthly Gaps-in-Care reporting and quarterly clinical measures review.

Note: APH Remeasurement 2.2 reflects continued improvement for measure CAP.1 to a rate of 95.9% and W15.7 to 47.1%</td></tr>
<tr><td>Preventive: W15.7</td><td>Percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life: Six well-child visits</td></tr>
</table>

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Module 7: Objective 2.1 Increase use of preventive services by 10%

Health Care Guidance Program
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Non Pay-For-Performance Clinical Measures which reached the target in Program Year 1 then sustained improvement through PY2

Measure Category/ Measure #	Please describe the interventions that were implemented that positively impacted the P4P measure.	
Preventive: CIS.2	**Percentage of children 2 years of age who had three Inactivated Polio Vaccines by their second birthday.**	**Non-P4P preventive measures are approached in much the same way; Locate, manage resource needs associated with social determinants "barriers to care" then educate and guide/encourage compliance towards closing the gap in care.** • **Interventions:** – **Locate the members and identify needs associated with social determinant of health** – **Community Outreach to educate on Immunizations** – **Resolve any PCP Visit/Immunization Compliance gaps** • **Evaluation Process: Monitor progress using weekly review of program-specific barriers to care reporting, monthly Gaps-in-Care reporting, WebIZ data, and quarterly clinical measures review.** ***Note: APH Remeasurement 2.2 rates reflect continued improvement on CIS.2 and progress consistent with the APH PMV rates for measures CIS.11.***
Preventive: CIS.11	**Percentage of children 2 years of age who had Combination #2 vaccines by their second birthday.**	

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Module 7: Objective 2.1 Increase use of preventive services by 10%

Health Care Guidance Program
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Non Pay-For-Performance Clinical Measures which declined from Baseline to Program Year 2

Measure Category/ Measure #	Measure Description	*Milliman Baseline (June 2013 – May 2014)*			*Milliman Remeasurement 1 (June 2014 – May 2015) Program Q1-Q4*			*APH PMV Rates 12+3 operational data (June 2015 – May 2016) Program Q5-Q8*		
		Num.	Den.	%	Num.	Den.	%	Num.	Den.	%
Preventive: CCS	Percentage of women 21-64 years of age who received one or more Pap tests to screen cervical cancer.	2,587	8,492	30.5%	2,272	6,221	36.5%	5,579	18,409	30.3%
Preventive: OBS.1	Percentage of members whose BMI calculation is documented, and counseling for nutrition and physical activity is provided during the measurement year. Care managers will perform this activity, and it must be documented in the member's care plan. Numerator = BMI	3	4,519	0.1%	160	2,676	6.0%	0	9,927	0.0%
Preventive: CAP.3	Percentage of members 12 months-19 years of age who had a visit with a Primary Care Practitioner (PCP). The organization reports four separate percentages for each product line. [7-11 years.]	1,934	2,293	84.3%	1,950	2,101	92.8%	7,051	8,374	84.2%
Preventive: CAP.2	Percentage of members 12 months-19 years of age who had a visit with a Primary Care Practitioner (PCP). The organization reports four separate percentages for each product line. [25 months-6 years.]	1,220	1,541	79.2%	1,391	1,586	87.7%	5,193	6,951	74.7%
Preventive: AWC	Percentage of enrolled members 12-21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	1,289	5,300	24.3%	1,155	3,543	32.6%	3,227	13,868	23.3%

Note: The Milliman rates presented above are currently under review via PMV audit by Health Services Advisory Group

Module 7: Objective 2.1 Increase use of preventive services by 10%

Health Care Guidance Program
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Non Pay-For-Performance Clinical Measures which declined from Baseline to Program Year 2

Measure Category/ Measure #	Measure Description	*Milliman Baseline (June 2013 – May 2014)*			*Milliman Remeasurement 1 (June 2014 – May 2015) Program Q1-Q4*			*APH PMV Rates 12+3 operational data (June 2015 – May 2016) Program Q5-Q8*		
		Num.	Den.	%	Num.	Den.	%	Num.	Den.	%
Preventive: CIS.10	**Percentage of children 2 years of age who had two flu vaccines by their second birthday.**	**72**	**171**	**42.1%**	**32**	**109**	**29.4%**	**333**	**1,139**	**29.2%**
Pregnancy: FPC.1	**Percentage of Medicaid deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that had the following number of expected prenatal visits: <21 percent of expected visits (Lower rates are better.)**	**328**	**880**	**37.3%**	**146**	**223**	**65.5%**	**541**	**856**	**63.2%**
Pregnancy: FPC.5	**Percentage of Medicaid deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that had the following number of expected prenatal visits: ≥81 percent of expected visits**	**387**	**880**	**44.0%**	**6**	**223**	**2.7%**	**20**	**856**	**2.3%**
Preventive: BCS	**Percentage of women 40-69 years of age who had a mammogram to screen for breast cancer.**	**1,617**	**4,442**	**36.4%**	**1,405**	**3,264**	**43.0%**	**3,138**	**9,980**	**31.4%**

Note: The Milliman rates presented above are currently under review via PMV audit by Health Services Advisory Group

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Module 7: Objective 2.1 Increase use of preventive services by 10%

Health Care Guidance Program
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Non Pay-For-Performance Clinical Measures which declined from Baseline to Program Year 2

Measure Category/ Measure #	• The QI Tools used? • The identified causes? • What interventions have been identified that, once implemented, will likely improve performance? • What is the evaluation plan to establish the effectiveness of those interventions?	
Preventive: CCS	**Percentage of women 21-64 years of age who received one or more Pap tests to screen cervical cancer.**	• **QI Tools: Program-specific stratification review** • **Identified Cause(s): Barriers to Care and Gaps-in-Care (GIC) exist in an inherent hierarchy. Other driver-condition GIC's and Barriers are likely to take precedent in the earlier stages of active management.** • **Interventions:** – **Locate the members and identify needs associated with social determinants of health** – **Work with the member to resolve PCP Visit compliance barriers.** • **Evaluation Process: Monitor progress using weekly review of program-specific barriers to care reporting, monthly Gaps-in-Care reporting, and quarterly clinical measures review.** ***Note: CCS has shown improvement since baseline at 36.9% APH Remeasurement 2.2, which is 0.5% shy of meeting the target 37.4%. As is the case with most of the preventive care metrics, the primary driver for improvement in the rate is by improving PCP visit compliance.***

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Module 7: Objective 2.1 Increase use of preventive services by 10%

Health Care Guidance Program
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Non Pay-For-Performance Clinical Measures which declined from Baseline to Program Year 2		
Measure Category/ Measure #	• The QI Tools used? • The identified causes? • What interventions have been identified that, once implemented, will likely improve performance? • What is the evaluation plan to establish the effectiveness of those interventions?	
Preventive: OBS.1	Percentage of members whose BMI calculation is documented, and counseling for nutrition and physical activity is provided during the measurement year. Care managers will perform this activity, and it must be documented in the member's care plan. -Numerator = BMI	• QI Tools: Program-specific stratification review • Identified Cause(s): Barriers to Care and Gaps-in-Care (GIC) exist in an inherent hierarchy. Other driver-condition GIC's and Barriers are likely to take precedent in the earlier stages of active management. • Interventions: – Locate the members and identify needs associated with social determinants of health – Work with the member to resolve PCP Visit compliance barriers. • Evaluation Process: Monitor progress using weekly review of program-specific barriers to care reporting, monthly Gaps-in-Care reporting, and quarterly clinical measures review. *Note: The 2016 PMV rate reported by APH of 0% was generated prior to the discovery that while source code appeared to be correct for this measure, a review of the value sets (ICD-9, ICD-10, and CPT codes) that count towards the numerator showed that the adult BMI code set was accidentally used in place of the child value set. APH Remeasurement 2.1 and 2.2 reflect rates of 7.1% and 7.3% respectively.*

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Module 7: Objective 2.1 Increase use of preventive services by 10%

Health Care Guidance Program
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Non Pay-For-Performance Clinical Measures which declined from Baseline to Program Year 2

Measure Category/ Measure #	• The QI Tools used? • The identified causes? • What interventions have been identified that, once implemented, will likely improve performance? • What is the evaluation plan to establish the effectiveness of those interventions?	
Preventive: CAP.3	**Percentage of members 12 months-19 years of age who had a visit with a Primary Care Practitioner (PCP). The organization reports four separate percentages for each product line. [Ages 7-11 years]**	• **QI Tools: Demographic-specific stratification review** • **Identified Cause(s): The vast majority of members falling into this age group will be stratified into low risk level 1 VITAL-DM. Prioritization of these lower risk members requires a customized approach to cull them out and outreach accordingly. Often times leveraging existing activities associated with Pregnancy Program outreach.** • **Interventions:** – **Locate the members and identify needs associated with social determinants of health** – **Work with the member to resolve PCP Visit compliance barriers.** • **Evaluation Process: Monitor progress using weekly review of program-specific barriers to care reporting, monthly Gaps-in-Care reporting, and quarterly clinical measures review.** ***Note: Contrary to the preliminary rates generated for the PMV audit (84.2%), APH Remeasurement 2.2 shows CAP.3 has seen improvement since PY1 to a rate of 93.4%. As is the case with most of the metrics related to preventive care, the primary approach to improvement with these metric is by improving visit compliance, and reaching as many people as possible.***

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Module 7: Objective 2.1 Increase use of preventive services by 10%

Health Care Guidance Program
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Non Pay-For-Performance Clinical Measures which declined from Baseline to Program Year 2

Measure Category/ Measure #	• The QI Tools used? • The identified causes? • What interventions have been identified that, once implemented, will likely improve performance? • What is the evaluation plan to establish the effectiveness of those interventions?	
Preventive: CAP.2	**Percentage of members 12 months-19 years of age who had a visit with a Primary Care Practitioner (PCP). The organization reports four separate percentages for each product line. [25mo – 6 years]**	• **QI Tools: Demographic-specific stratification review** • **Identified Cause(s): The vast majority of members falling into this age group will be stratified into low risk level 1 VITAL-DM. Prioritization of these lower risk members requires a customized approach to cull them out and outreach accordingly. Often times leveraging existing activities associated with Pregnancy Program outreach.** • **Interventions:** – **Locate the members and identify needs associated with social determinants of health** – **Resolve any PCP Visit compliance challenges** • **Evaluation Process: Monitor progress using weekly review of program-specific barriers to care reporting, monthly Gaps-in-Care reporting, and quarterly clinical measures review.** ***Note: Contrary to the preliminary rates generated for the PMV audit (74.7%), APH Remeasurement 2.2 shows CAP.2 has seen improvement since PY1 to a rate of 89.6%. As is the case with most of the metrics related to preventive care, the primary way that we improve the metric is by improving visit compliance and reaching as many people as possible.***

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Module 7: Objective 2.1 Increase use of preventive services by 10%

Health Care Guidance Program
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Non Pay-For-Performance Clinical Measures which declined from Baseline to Program Year 2

Measure Category/ Measure #	• The QI Tools used? • The identified causes? • What interventions have been identified that, once implemented, will likely improve performance? • What is the evaluation plan to establish the effectiveness of those interventions?	
Preventive: AWC	**Percentage of enrolled members 12-21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.**	• **QI Tools: Demographic-specific stratification review** • **Identified Cause(s): This measure will be impacted by way of placing emphasis on PCP Visit compliance.** • **Interventions:** – **Locate the members and identify needs associated with social determinants of health** – **Work with the member to resolve PCP Visit compliance barriers.** • **Evaluation Process: Monitor progress using weekly review of program-specific barriers to care reporting, monthly Gaps-in-Care reporting, and quarterly clinical measures review.** **Note:** ***Contrary to the preliminary rates generated for the PMV audit (23.3%), APH Remeasurement 2.2 shows AWC has seen improvement since PY1 to a rate of 34.5%. As is the case with most of the metrics related to preventive care the primary way that we improve the metric is by improving visit compliance and reaching as many people as possible.***

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Module 7: Objective 2.1 Increase use of preventive services by 10%

Health Care Guidance Program
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Non Pay-For-Performance Clinical Measures which declined from Baseline to Program Year 2

Measure Category/ Measure #	• The QI Tools used? • The identified causes? • What interventions have been identified that, once implemented, will likely improve performance? • What is the evaluation plan to establish the effectiveness of those interventions?	
Preventive: CIS.10	**Percentage of children 2 years of age who had two flu vaccines by their second birthday.**	• **QI Tools: Demographic-specific stratification review** • **Identified Cause(s): Non-P4P Preventive measures are approached in much the same way; Locate, manage resource needs associated with social determinants "barriers to care" then educate and guide/encourage compliance towards closing the gap in care.** • **Interventions:** – **Locate the members and identify needs associated with social determinants of health** – **Community Outreach to educate on Immunizations** – **Work with the member to resolve PCP Visit compliance barriers.** • **Evaluation Process: Monitor progress using weekly review of program-specific barriers to care reporting, monthly Gaps-in-Care reporting, WebIZ data, and quarterly clinical measures review.** **Note:** ***Contrary to the preliminary rates generated for the PMV audit (29.2%), APH Remeasurement 2.2 shows CIS.10 has seen improvement since PY1 to a rate of 36.9%. Immunizations will improve with focused attention to visit adherence.***

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Module 7: Objective 2.1 Increase use of preventive services by 10%

Health Care Guidance Program
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Non Pay-For-Performance Clinical Measures which declined from Baseline to Program Year 2

Measure Category/ Measure #		• The QI Tools used? • The identified causes? • What interventions have been identified that, once implemented, will likely improve performance? • What is the evaluation plan to establish the effectiveness of those interventions?
Pregnancy: FPC.1	**Percentage of Medicaid deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that had the following number of expected prenatal visits: <21 percent of expected visits (Lower rates are better.)**	**• QI Tools: Demographic and Program-specific stratification review • Identified Cause(s): Pregnancy prenatal visits have been a priority since the beginning. Prompt identification of a currently pregnant woman is quite difficult due to delayed claims. • Interventions: – Increase staffing allocated to managing pregnancy program members – Locate newly identified rural PCC members Identify and needs associated with social determinants of health – Resolve social determinants needs – Address any Prenatal Visit Compliance gaps • Evaluation Process: Monitor progress using weekly review of program-specific barriers to care reporting, monthly Gaps-in-Care reporting, and quarterly clinical measures review. *NOTE: These rates may be effected by Global Billing submitted for the duration of the pregnancy prenatal and postpartum care visits in conjunction with the delivery which may result in underreporting. Moreover, 70+% of the members sent to APH monthly who are identified as 'newly pregnant' are already in the 2nd – 3rd trimester making timely locate/assessment challenging.***
Pregnancy: FPC.5	**Percentage of Medicaid deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that had the following number of expected prenatal visits: ≥81 percent of expected visits**	

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Module 7: Objective 2.1 Increase use of preventive services by 10%

Health Care Guidance Program
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Non Pay-For-Performance Clinical Measures which declined from Baseline to Program Year 2

Measure Category/ Measure #	• The QI Tools used? • The identified causes? • What interventions have been identified that, once implemented, will likely improve performance? • What is the evaluation plan to establish the effectiveness of those interventions?	
Preventive: BCS	**Percentage of women 40-69 years of age who had a mammogram to screen for breast cancer.**	• **QI Tools: Barriers to Care Analysis** • **Identified Cause(s): Barriers to Care and Gaps-in-Care (GIC) exist in an inherent hierarchy. Other driver-condition GIC's and Barriers are likely to take precedent in the earlier stages of active management.** • **Interventions:** – **Locate the members and identify needs associated with social determinants of health** – **Resolve any PCP Visit Compliance gaps** • **Evaluation Process: Monitor progress using weekly review of program-specific barriers to care reporting, monthly Gaps-in-Care reporting, and quarterly clinical measures review.** ***Note: As is the case with most of the metrics related to preventive care the primary way that we improve the metric is by improving visit compliance, and reaching as many people as possible. Program had met target, but depending on the data measurement and churn may have decreased.***

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Module 7: Objective 2.1 Increase use of preventive services by 10%

Health Care Guidance Program
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Pay-For-Performance Clinical Measures which declined from Baseline to Program Year 2

Measure Category/ Measure #	Measure Description	*Milliman Baseline (June 2013 – May 2014)*			*Milliman Remeasurement 1 (June 2014 – May 2015) Program Q1-Q4*		
		Num.	Den.	%	Num.	Den.	%
Asthma: ASM.2	Percent of patients who have a record of influenza immunization in the past 12 months.	42	723	5.8%	13	599	65.0%
COPD: SPR.2	Percentage of patients aged 18 years and older with a diagnosis of COPD who received influenza immunization in the past 12 months.	176	2,044	8.6%	13	599	2.2%
Diabetes: CDC.3	Percent of members 18 – 75 years of age, with diabetes, who had a nephropathy screening test or evidence of nephropathy.	1,599	2,474	64.6%	1,656	2,679	61.8%
Diabetes: CDC.5	Percent of members 18 – 75 years of age, with diabetes, who received an influenza immunization during the measurement period.	198	2,474	8.0%	204	2,679	7.6%
Diabetes: CDC.6	Percent of members 5 – 17 years of age, with diabetes, who had an HbA1c test performed in the measurement period.	53	69	76.8%	50	83	60.2%

Note: The Milliman rates presented above are currently under review via PMV audit by Health Services Advisory Group

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Module 7: Objective 2.1 Increase use of preventive services by 10%

Health Care Guidance Program
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Pay-For-Performance Clinical Measures which declined from Baseline to Program Year 2

Measure Category/ Measure #	• The QI Tools used? • The identified causes? • What interventions have been identified that, once implemented, will likely improve performance? • What is the evaluation plan to establish the effectiveness of those interventions?	
Asthma: ASM.2	**Percent of patients who have a record of influenza immunization in the past 12 months.**	• **QI Tools: Barriers to Care and PCP Visit compliance** • **Identified Cause(s): Risk-based prioritization for outreach will not result in adequate emphasis for this PCP visit compliance challenge.** • **Interventions:** – **Access to WebIZ data ensures we are accessing the most up to date information/status of immunizations.** – **Locate the member, identify/address social determinant needs** – **Work with the member to resolve PCP Visit/Immunization compliance barriers.** • **Evaluation Process: Monitor progress using weekly review of program-specific barriers to care reporting, monthly Gaps-in-Care reporting, and quarterly clinical measures review.** ***Note: APH Remeasurement 2.2 reflects an ASM.2 rate of 24.6% which would result in target attainment. As with all vaccine measurements, these are supported by increasing visit compliance, automated education campaigns and targeted mailing campaigns to get the vaccine.***

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Module 7: Objective 2.1 Increase use of preventive services by 10%

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Pay-For-Performance Clinical Measures which declined from Baseline to Program Year 2

<table>
<tr><th>Measure Category/ Measure #</th><th colspan="2">

- The QI Tools used?
- The identified causes?
- What interventions have been identified that, once implemented, will likely improve performance?
- What is the evaluation plan to establish the effectiveness of those interventions?

</th></tr>
<tr><td>COPD: SPR.2</td><td>Percentage of patients aged 18 years and older with a diagnosis of COPD who received influenza immunization in the past 12 months.</td><td>

- QI Tools: Barriers to Care and PCP Visit compliance
- Identified Cause(s): Risk-based prioritization for outreach will not result in adequate emphasis for this PCP challenge.
- Interventions:
  - Access to WebIZ data ensures we are accessing the most up to date information/status of immunizations.
  - Locate the member, identify/address social determinant needs
  - Work with the member to resolve PCP Visit/Immunization compliance barriers.
- Evaluation Process: Monitor progress using weekly review of program-specific barriers to care reporting, monthly Gaps-in-Care reporting, and quarterly clinical measures review.

Note: APH Remeasurement 2.2 reflects an SPR.2 rate of 27.0% which would result in target attainment. As is the case with all vaccine measurements these are supported by increasing visit compliance, automated education campaigns and targeted mailing campaigns to get the vaccine.

</td></tr>
</table>

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Module 7: Objective 2.1 Increase use of preventive services by 10%

Health Care Guidance Program
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Pay-For-Performance Clinical Measures which declined from Baseline to Program Year 2

<table>
<tr><th>Measure Category/ Measure #</th><th colspan="2">The QI Tools used?
The identified causes?
What interventions have been identified that, once implemented, will likely improve performance?
What is the evaluation plan to establish the effectiveness of those interventions?</th></tr>
<tr><td>Diabetes: CDC.3</td><td>Percent of members 18 – 75 years of age, with diabetes, who had a nephropathy screening test or evidence of nephropathy.</td><td rowspan="3">QI Tools: Barriers to Care and PCP Visit compliance
Identified Cause(s): Risk-based prioritization for outreach will not result in adequate emphasis for these PCP visit compliance challenges.
Interventions:
Launch of Clinical Care Alerts, DM HGBA1c measured. Alert sent from Beacon CCA based on claims.
Employ advanced Identification & Stratification strategy specifically designed to target members with Med Ad and PCP visit compliance GIC's.
Locate the member, address social determinant needs
Work with the member to resolve PCP Visit/Immunization compliance barriers.
Evaluation Process: Monitor progress using weekly review of program-specific barriers to care reporting, monthly Gaps-in-Care reporting, and quarterly clinical measures review.
Note: APH Remeasurement 2.2 reflects an CDC.3 rate of 71.4%, CDC.5 rate of 24.6% which would result in target attainment.</td></tr>
<tr><td>Diabetes: CDC.5</td><td>Percent of members 18 – 75 years of age, with diabetes, who received an influenza immunization during the measurement period.</td></tr>
<tr><td>Diabetes: CDC.6</td><td>Percent of members 5 – 17 years of age, with diabetes, who had an HbA1c test performed in the measurement period.</td></tr>
</table>

AXISPOINT HEALTH

Module 7: Objective 2.2 Increase follow-up ambulatory care visit after hospitalization by 10 percent.

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Pay-For-Performance Clinical Measures which reached the target and sustained improvement through PY2

Measure Category/ Measure #	Measure Description	*Milliman Baseline (June 2013 – May 2014)*			*Milliman Remeasurement 1 (June 2014 – May 2015) Program Q1-Q4*		
		Num.	Den.	%	Num.	Den.	%
Coronary Artery Disease: CAD.3	**The percentage of discharges for members who were hospitalized with a primary discharge diagnosis of coronary artery disease (CAD) and who had a follow-up, ambulatory care visit within 7 days of discharge.**	**1**	**13**	**7.7%**	**4**	**13**	**30.8%**

Note: The Milliman rates presented above are currently under review via PMV audit by Health Services Advisory Group

AXISPOINT HEALTH

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Pay-For-Performance Clinical Measures which reached the target and sustained improvement through PY2

Measure Category/ Measure #	Please describe the interventions that were implemented that positively impacted the P4P measure.	
Coronary Artery Disease: CAD.3	The percentage of discharges for members who were hospitalized with a primary discharge diagnosis of coronary artery disease (CAD) and who had a follow-up, ambulatory care visit within 7 days of discharge.	7-Day follow up after cardiac admission requires expedient receipt of census/admissions information from NV hospitals. APH has been working on this since launch. Interventions: – Locate the member, identify/address social determinant needs – Work with the member to resolve PCP Visit/Immunization compliance barriers. – Alerts are sent to providers when readmission reduction assessment is initiated by the Care Manager (CM). Although, the alert will be post discharge and a lagging indicator. • Evaluation Process: Monitor progress using weekly review of program-specific barriers to care reporting, monthly Gaps-in-Care reporting and quarterly clinical measures review. *Note: APH Remeasurement 2.2 reflects an CAD.3 rate of 33.3% which reflects continued improvement over PY1 Milliman rates.*

AXISPOINT HEALTH

Module 7: Objective 2.2 Increase follow-up ambulatory care visit after hospitalization by 10 percent.

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Pay-For-Performance Clinical Measures which declined from Baseline to Program Year 1

Measure Category/ Measure #	Measure Description	*Milliman Baseline (June 2013 – May 2014)*			*Milliman Remeasurement 1 (June 2014 – May 2015) Program Q1-Q4*		
		Num.	Den.	%	Num.	Den.	%
COPD: SPR.3	The percentage of discharges for members who were hospitalized with a primary discharge diagnosis of COPD and who had a follow-up, ambulatory care visit within 7 days of discharge.	14	58	24.1%	2	35	5.7%
Heart Failure: HF.4	The percentage of discharges for members who were hospitalized with a primary discharge diagnosis of heart failure (HF) and had a follow-up, ambulatory care visit within 7 days of discharge.	5	23	21.7%	3	20	15.0%
Mental Health: MH.4.1	Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of select mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported: MH.4.1 - percentage of discharges for which the member received follow-up within 30 days of discharge	321	734	43.7%	398	992	40.1%
Mental Health: MH.4.2	See description above. Rate #2 MH.4.2 – the percentage of discharges for which the member received follow-up within 7 days of discharge	219	734	29.8%	254	992	25.6%

Note: The Milliman rates presented above are currently under review via PMV audit by Health Services Advisory Group

Module 7: Objective 2.2 Increase follow-up ambulatory care visit after hospitalization by 10 percent.

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Pay-For-Performance Clinical Measures which declined from Baseline to Program Year 1

Measure Category/ Measure #	• The QI Tools used? • The identified causes? • What interventions have been identified that, once implemented, will likely improve performance? • What is the evaluation plan to establish the effectiveness of those interventions?	
COPD: SPR.3	The percentage of discharges for members who were hospitalized with a primary discharge diagnosis of COPD and who had a follow-up, ambulatory care visit within 7 days of discharge.	• QI Tools: Condition-specific stratification mapping and case review analysis • Identified Cause(s): 7-Day follow up after cardiac admission requires expedient receipt of census/admissions information from NV hospitals. APH has been working on this since launch. • Interventions: – Locate the member, identify/address social determinant needs – Work with the member to resolve PCP Visit/Immunization compliance barriers. – Readmission Reduction Assessment – Alerts are sent to providers when readmission reduction assessment is initiated by the Care Manager (CM). Although, the alert will be post discharge and a lagging indicator. Evaluation Process: Monitor progress using weekly review of program-specific barriers to care reporting, monthly Gaps-in-Care reporting and quarterly clinical measures review. *Note: APH Remeasurement 2.2 reflects an SPR.3 rate of 28.4% which reflects significant improvement over PY1 Milliman rate of 5.7%.*

AXISPOINT HEALTH

Module 7: Objective 2.2 Increase follow-up ambulatory care visit after hospitalization by 10 percent.

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Pay-For-Performance Clinical Measures which declined from Baseline to Program Year 1

Measure Category/ Measure #	• The QI Tools used? • The identified causes? • What interventions have been identified that, once implemented, will likely improve performance? • What is the evaluation plan to establish the effectiveness of those interventions?	

Heart Failure: HF.4	**The percentage of discharges for members who were hospitalized with a primary discharge diagnosis of heart failure (HF) and had a follow-up, ambulatory care visit within 7 days of discharge.**	• **QI Tools: Condition-specific stratification mapping and case review analysis**
		• **Identified Cause(s): 7-Day follow up after cardiac admission requires expedient receipt of census/admissions information from NV hospitals. APH has been working on this since launch.**
		• **Interventions:**
		  – **Locate the member, identify/address social determinant needs**
		  – **Readmission Reduction Assessment**
		  – **Alerts are sent to providers when readmission reduction assessment is initiated by the Care Manager (CM). Although, the alert will be post discharge and a lagging indicator.**
		• **Evaluation Process: Monitor progress using weekly review of program-specific barriers to care reporting, monthly Gaps-in-Care reporting and quarterly clinical measures review.**
		
		Note: APH Remeasurement 2.2 reflects an HF.4 rate of 28.9% which reflects significant improvement over PY1 Milliman rate of 15.0% but remains 0.7% short of the target. Again, prompt access to hospital admission data is the primary barrier to improvement on this measure.

AXISPOINT HEALTH

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Pay-For-Performance Clinical Measures which declined from Baseline to Program Year 1

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Mental Health: MH.4.1	Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of select mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported: MH.4.1 - percentage of discharges for which the member received follow-up within 30 days of discharge	• QI Tools: Condition-specific stratification mapping and case review analysis • Identified Cause(s): 7-Day follow up after cardiac admission requires expedient receipt of census/admissions information from NV hospitals. APH has been working on this since launch. • Interventions: – Locate the member, identify/address social determinant needs – Work with the member to resolve PCP Visit/Immunization compliance barriers. – Readmission Reduction Assessment – Alerts are sent to providers when readmission reduction assessment is initiated by the Care Manager (CM). Although, the alert will be post discharge and a lagging indicator. • Evaluation Process: Monitor progress using weekly review of program-specific barriers to care reporting, monthly Gaps-in-Care reporting and quarterly clinical measures review.
Mental Health: MH.4.2	See description above. Rate #2 MH.4.2 – the percentage of discharges for which the member received follow-up within 7 days of discharge	

AXISPOINT HEALTH

IV. Medical Director

Collaboration with DHCFP/DHHS
In Depth Review of Select Populations
Provider Relations

IV. Medical Director

- Work with Behavioral Health section and DHCFP to facilitate care management of members in out of state RTCs
- Work with Behavioral Health section and DHCFP to collaborate on members in pharmacy lock in program
- Collaborate with DHCFP to minimize churn from TCM
- Ongoing work with HPE to understand and impact ED *Superusers* in collaboration
- Collaborate with inpatient facilities to improve discharge planning and coordination
- Assisted DHHS with population profiling
- Provider Outreach by leaders and CMs
- Provider Advisory Board Meeting

V. Focus for Next Quarter

V. Focus for Next Quarter

- Work with DHCFP staff to finalize Amendment #6
- Continue to work with DHCFP to support legislative inquiries
- Work with DHCFP leadership to produce program information to inform stakeholders of Program Year One/Two results. Stakeholders include:
  - HHS leadership
  - Governor's office
  - Legislature
- Revisit providers – hospitals and clinics – to reinforce program goals and leverage PY1 results to emphasize quality goals.
- Work with APH quality team to incorporate PY1 and PY2 results to ensure program improvement and enhancements

VI. New Business

Health Care Guidance Program
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HCGP Quarterly Meeting April 25th, 2017
Location: Division of Health Care Financing and Policy (DHCFP)
1100 E. William Street (2nd floor conference room)
Carson City, Nevada 89701
Phone Number: 877-336-1829 Access Code: 8793897

9:00 am – 9:30 am

I. Welcome and Introductions/DHCFP — **Gloria Macdonald, Chief, Program Research and Development Unit**

Approval of Minutes — **Gladys Cook, SSPS III, DHCFP**

II. Program Updates

Executive Director Comments — **Cheri Glockner, HCGP Executive Director, APH**
AxisPoint Health Updates — **Dr. Tim Moore, CMO, APH**
"Preliminary" 12+6 PY2 Results — **Shawn Donnelly, APH, Actuary**

9:30 am – 10:45 am

III. Quality

Module 5: Objectives 1.1 and 1.2 — **Michelle Searing, Outcomes Operation Manager, APH**
Module 6: Objective 1.5
Module 7: Objectives 2.1 and 2.2

10:45 am – 11:00 am BREAK

11:00 – 11:30 am

IV. Provider Outreach — **Dr. Thomas McCrorey, Medical Director, APH**

V. Focus for Next Quarter — **Cheri Glockner, HCGP Executive Director, APH**

11:30 am – 12:00 pm

VI. New Business — **Gloria Macdonald, Chief / Gladys Cook, SSPS III DHCFP**

*DIRECTIONS: For those who will be teleconferencing for this meeting, please call at the time scheduled for your agenda item. The dial in number is 877-336-1829. Key in the Pass Code 8793897.

* Should you need assistance during your conference, please press *# for a list of menu options and *0 to obtain Specialist assistance.

Health Care Guidance Program Meeting Minutes, Face to Face				Date: 01/31/2017
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Organization Attendees: DO: Charmaine Yeates, Heather Lazarakis, Shawna Vollmer, Linda Bowman, Kristen Schadegg **HCGP:** Margaret Flaum, Cheri Glockner, Dr. Thomas McCrorey, Dr. Tim Moore, Michelle Searing, Brian Baker, Erin Snell, Dr. Ryan Ley, Lorna Lizotte, Mary Mastrandrea, , **HSAG:** Gretchen Thompson				

Topic	Discussion	Recommendation/Action Plan	Responsible	Due Date
Welcome and Introductions	**<u>Welcome and Introductions</u>** **Gladys Cook**, Social Services Program Specialist III, Program Research & Development (PRD) opened the meeting			
Approval of Minutes	**<u>Approval of Minutes</u>** **Gloria Macdonald** Any comments or changes to the minutes from the last quarterly meeting? **Cheri Glockner** Yes, excellent notes. A couple corrections; name spellings, no additional corrections. One request, please remove Linda Casey, and add Erin Snell, Brian Baker and Mary Mastrandrea . Erin will forward emails to Jessica.			
Program Updates	**<u>Program Updates</u>** **Cheri Glockner** We have had a few accomplishments since the last quarterly in October. We have been drafting information for stakeholders, discussed program yr one results, many questions from legislatures, as well as providers. Team has worked many hours in response to directional letter. Thank you for the signed approval. Worked with Shannon and her team. Opioid strategy- working internally on, Dr. McCrorey also attended Governors' presentation. Cheri attended 4 listening session and is conversing with Navigant, worked with Betsy on this. Worked with HP on their emergency department utilization report, more information to come. Working on strategies to increase contact and engagement. Michelle is an excellent operations manager. Hiring more rural staff, this is an ongoing issue. **John Kucera** One quick question, on the Opioid Issue, we were going to work collaborate with Mary Griffith. Are we doing that? Are we sharing information with you?			

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	Dr. McCrorey Yes, we are working together. We need to go back and make sure we are still tracking. However, Mary agreed to send us her lists every month. **John Kucera** Is there anybody that you would have in the program that you would want on a lock out list? Or are you closing that loop from the information you have with ours? **Dr. McCrorey** I can't answer that question yet. That's a good question. The way that we scan we pick them up before they are forced into that situation, however if the care managers come across someone who needs to be put on that list I do not know the procedure for that. We are trying to prevent people from ending up in this position. **Dr. Moore** AxisPoint business standpoint – launching first clients with care management transformation. Really data driven and care tracked. It is beneficial that we are already using data analytics that we have built for that purpose. It is assistive in figuring out how the members here look from their med adherence part. Can have care managers really focused on those. The second piece is the Care access. Using pieces to augment procedures we are already doing. Building the ability to do 2 way text messaging with members. Should be able to use in Nevada by the 3rd or 4th quarter. Looking at using social determinates of health data and consumer data, and using those to work with another Medicaid health plan to analyze how we can use those data sources and figure out how to better engage people and better approach them. Also obtain much better social mobile phone numbers and email addresses. As well as finding out how receptive a person will be before an introduction, so we can prioritize our patient priorities.			

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	Gloria Macdonald So these are non medical data sources? **Dr. Moore** These are data sources that are non medical, credit card data services, court data sources, mortgage data sources, utilities… **Gloria Macdonald** So do you pay for that? **Dr. Moore** Yes, we are actually looking at three different companies who do those sources now and look at each one to see who has the best data that we can leverages, and then put it together with our medical administrative services. **Gloria Macdonald** So is this like a new thing, or are you seeing this with other companies? **Dr. Moore** A lot of companies use this data source, especially casinos. They use so many data sources to figure out how they can attract people; health care has been way behind. There are a few other health care companies that are starting to leverage it, however I do not know of any that has fully implemented anything. We are just starting this path however anticipate having a few good solid programs in place that we can augment this data source with other data sources. **Gloria Macdonald** So do you have some kind of format, where you look for specific data plans? **Dr. Moore** Our analytics team is looking at many different regression analyses. It's very exciting and by next quarterly we should be able to give a			

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Topic	Discussion	Recommendation/Action Plan	Responsible	Due Date
Quality	report on where we are in the process and with more timelines. **John Kucera** Dr. Moore have you ever heard of the Paris Program? In Washington State it funds federal resources, leverages snap and food stamp benefits programs from other states to see who is receiving the different benefits from multiple states. As an access issue they are looking at veterans benefits. The success stories I have seen are better quality and more state funds. **Dr. Moore** I have not seen that; will have to take a look at that. **<u>Quality</u>** **Michelle Searing** Subset of metrics with revised quality strategy. Objective 1.1 New and existing enrollees. Looks at our total enrollment. Average is 1,000 new members every month New members are defined as those who have never been in the program. **Gloria Macdonald** Do you have corresponding amounts of people going off? **Michelle Searing** We do, we are trying to look more into them to understand why. Asked for permission to look at TCM, so we know when someone is pulled off due to TCM. The TCM piece is non negotiable We lose about 200-250 people actively managed each month, this is heavily weighted towards the TCM members **John Kucera** Do we have opportunity to talk about TCM? History of issue, would like to come up with better methodology for excluding TCM. Currently looking at past 90 days, and anyone			

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Topic	Discussion	Recommendation/Action Plan	Responsible	Due Date
	with certain codes are excluded. However more people are excluded then they should. Propose we adjust that definition similarly to how would work for the P4P, how the diagnosis information is included. To be part of the P4P is increased level of eligibility, last 90 days, we would look at, has it been 3+ instances or TCM from different providers **Dr. McCrorey** We have been looking at this; I think initially we were seeing the same as you. We didn't want to break federal regulations by taking TCM patients in or taking them from their appropriate TCM provider. Looking into the charts, there seems to be two patterns. Looking back through clinical charts, intermittent TCM codes - Not behavioral health related. People aren't aware they're being taken out from the more intense care. John's proposal is a good idea. But there is one issue, CMS allows members to choose a provider and they don't know if someone is a TCM provider. Is there a way to say, this or this to the patients and allow them to know they would lose the HCGP and then allow them to choose, that might make a difference. **Shannon Sprout** That is something we are continuing to evaluate, TCM should be monitored. We are seeing providers billing 30 hrs, having to go back and look at exactly what is occurring and appropriate documentation. Propose a work group who will continue to look at this. **Cheri Glockner** Do you want me to take over that for you Shannon? **Shannon Sprout** Yes, we can work with Tanya to maybe look at scheduling something, and deciding who should be in this work group. What brought this up is when HPE was looking at some of the data, they asked questions such as how can you have 32% of the population			

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Topic	Discussion	Recommendation/Action Plan	Responsible	Due Date
	have good case management but also be a super user of the ER, clearly something isn't happening. **John Kucera** There are several issues; we have a switch on the TCM that removes the person so we need to adjust our automatic methodology. The patient choice piece, if someone doesn't want the HCGP that is the person's choice. **Gladys Cook** Mention of a number of people who fall off due to TCM, have you been able to identify the risk level of each member who is lost. **Michelle Searing** That number turns out to be about 70% of the 200-250 members lost each month, that are lost to TCM. As far as risk levels, since our larger group are 1's a lot of those are 1's. There are some 2s and 3s and very little 4s. I can give you these numbers. **John Kucera** I can do some quick turn around on my side, the fee for service claims information, to look at frequency, distributions, utilization for TCM. I don't have the Medicaid ID's, is it a light lift for you to go back and give me an un duplicated count of members who were excluded due to TCM? **Michelle Searing** I can get that to you. **John Kucera** I would like to look at those people in the last 3, 6, 9 months to see, yes this # had one target case management billing in the last 12 months, which tells me your program will serve these people more. **Michelle Searing** Objective 1.2 looks at enrolled population vs. population under active case management. Looking at Sep through Nov. The bar to			

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Topic	**Discussion**	**Recommendation/Action Plan**	**Responsible**	**Due Date**
	the far left is total enrollment, the bar to the right are active case manager ran members. This tends to remain consistent. The number in each risk level and the number enrolled remain consistent. **Gretchen Thompson** How long do people stay in case management, once the treatment had dissolved and they are under active case management? **Michelle Searing** Age out of cases average about 9 months for risk levels 2 or 3. I can get more accurate report if requested. Case Management/complex/risk level 4 tends to be a little bit longer, just about 12 months. Figure 1.3 and 1.4 touch on how long is it taking us to assess individuals from the time they are enrolled to the day they are assessed. This is presented the way it is prescribed in the data quality strategy. From the left, the categories are typical, complex vs. high, moderate and low. To the right, average number of persons enrolled. To the right of that is the total number or persons who have received an assessment. The numbers are from June 2014 to June 2016. **Gladys Cook** I wanted to see exactly where we stand, with the staff. **Michelle Searing** I can update that and revise, will also discuss at tomorrow's operation's meeting. **Rachel Marchetti** I see the number of days between enrollment and assessment is the lowest for risk level one, is that because you guys attempted or assessed a lower amount since you are required to have a care manager on those, is that why it was such a short distance of time? **Michelle Searing**			

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	Risk level 1, defies logic. By that I mean, you would expect to see a higher value number of days from complex to low, and that's because you would have more claims information complex to low. You would think they would be easier to locate, having more information provided to you, that hasn't always been the case in this program. **Margaret Flaum** There is a good amount of risk level one's that are referred into the program, that's how they get assessed? **Michelle Searing** Most RTR have not been risk level ones. At least for those who are eligible. This is something I want to dig into and understand more. **Erin Snell** We do escalate them if we get an RL 1, so those numbers might be in the 2s and 3s. **Rachel Marchetti** I was just curious because as your typical rule or routine you guys don't seek out level 1s. To have such a low assessment to enrollment ratio when those are the ones that aren't typically on the list to look for. **Michelle Searing** Page 9 of presentation – during 2014 Compliance audit, we only 5 months under our belt, we were tracking to a 72 day average, now at a 51 day average. I am proud of the progress. **Gloria Macdonald** I'm just wondering about the notation regarding addition of community health workers, can you talk about that a little bit. **Michelle Searing** I started thinking about how have we made progress and how do we continue to make progress. Adding those 10 community health			

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	worker's (CHWs), has paid dividends in so many ways. This has tripled the locates from the first 6 months. That is the heart and soul of making this program successful. Every day they are adding to our resource list. We also have community health workers who are finding docs in the rural areas and getting them signed up so they can take our folks. **Cheri Glockner** I love our CHWs, in Reno CHWs going to homeless shelter, getting involved with charities. **Michelle Searing** Page 10 of presentation -People in the program with condition pregnancy, there is all 4 risk levels listed then moving to the right all members ever enrolled and identified with condition pregnancy. And then June to June ever assessed, then average number between enrollment and assessment. Aiming at assessing these members within 30 days. Have taken different approaches; with the added CHWs have 7 dedicated to finding the pregnant women. **Rachel Marchetti** So that was just from the time of enrollment into the program to initial assessment for whatever condition, not necessarily from their condition of pregnancy? **Shannon Sprout** Do you identify from here the impact this could have for those NICU babies, is it shortening in time period, is it lessoning that, do we have data that represents that. A positive impact, to lessen the need for NICU. **Margaret Flaum** We don't look at that as one of the clinical **Cheri Glockner** Not one of our criteria, however it is something I have asked about and am interested in. So is that the HIPPA thing that comes in?			

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Topic	Discussion	Recommendation/Action Plan	Responsible	Due Date
	Shannon Sprout That might be something we can pull from our end. **Dr. McCrorey** Members of the MCOs have the same requirement that we do to find the members and care manage them so you wouldn't have a Comparison Group. **John Kucera** Answer question on HIPAA, any use of the data to better your program is free and available for use; I will confirm that with our compliance group. However that is your only base for medical comparison. **Dr. McCrorey** We would be looking at population data I do not believe that is HIPPA violation. Are we being more effective? We wouldn't be able to compare it; a lot of our members are going into the MCOs. **Gloria Macdonald** The reason the pregnant women are in the program, is they already had an issue is that correct? **Dr. McCrorey** No Pregnancy is a condition so, any fee for service women who become pregnant are enrolled. **Gloria Macdonald** I'm just curious this total number of 6,357 is this a high or low number of people with the moderate/high/complex on top of being pregnant. In addition to being pregnant these people have other medical issues, is this a normal ratio? **Michelle Searing** It's hard to say how many of these woman are actually in the program strictly because they are in the pregnancy care			

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Topic	Discussion	Recommendation/Action Plan	Responsible	Due Date
	coordination (PCC) vital program, in other words they came in for the pregnancy and are likely to roll of after birth. Risk level 4, every one of them had another condition, risk level 2 and 3 I will have to get back to you on those numbers. **Gladys Cook** I think that is a good question, because I know at one point in the program history we wanted all pregnant women to be considered high risk level. **John Kucera** The concern I have, the number I am looking at is risk level 1, we have 60 days to look into this, the majority of pregnant woman. **Cheri Glockner** That's why provider outreach is so critical**.** **Dr. Moore** The risk level is assigned by our regular system, not a pregnancy risk level but a standard risk level. **John Kucera** 87% of your pregnant woman aren't seeing anyone, that's concerning to us. **Michelle Searing** 25% roll into MCO; however we still see your concern and are looking into it. **Dr. McCrorey** Claims submitted after birth, we pick up high risk earlier because things are being billed throughout the pregnancy. **Dr. Moore** If we had the ability to identify a pregnancy at the earliest point in time the best thing we could do is make sure they have care access,			

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Topic	Discussion	Recommendation/Action Plan	Responsible	Due Date
	however so many of these we don't know until after they deliver or complications. **Rachel Marchetti** Risk levels explained in a way not agreed upon before, all pregnant women is risk level 4, once assessed then are put in another risk level. **Dr. McCrorey** All are treated like risk level 4, they get three complex risk managers. **Magaret Flaum** Summarize all this and send that out, so that everyone is clear. **Rachel Marchetti** Greatest issue is not finding out until these woman have already delivered, is there a way for you to break it down, and give us an overall number of how many of those you reached out to have already delivered. Out of those, how long did it take to find out the ones who were never in the program until after they already delivered, had been pregnant and delivered? Did it take you the full 70 days to assess and find that out? **Michelle Searing** Yes **Gloria Macdonald** Question, they are considered level 4 but then you stratify them? **Dr. McCrorey** We treat them all as level 4 which includes complex case management. There is some cross of definitions. There is identified and then treated as. **Rachel Marchetti**			

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Topic	Discussion	Recommendation/Action Plan	Responsible	Due Date
	I think John Whaley just wanted to make sure that every single one of these members were going to be contacted. **Michelle Searing** When I go to vital, there may be a contact with the individual however they may not have been assessed. **Rachel Marchetti** If it took 69 days, to find out that that happened, then I am just trying to figure out the role of the program in that situation. **Margaret Flaum** I think as far as identifying pre term birth is very difficult and other programs have issue with this as well. **Mary Mastrandrea** How is pregnancy billed? **John Kucera** It's a global capitation, it's like a surgical billing. Hospitals were a driver of that. **Gladys Cook** Pregnancy cat 8, is there a way to pull this information. Another concern is if mom loses baby, however if a care manager is already assigned that shouldn't be an issue. **John Kucera** Yes, we have access to all this. And there are specific cat 8 codes in Medicaid. Through welfare if they are eligible. Do you have a mapping with provider type and code itself? I will forward that to you. **Rachel Marchetti** Stratification report also has eligibility codes on it. **John Kucera**			

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	Will get list of pregnancy codes **Gretchen Thompson** Even though not notified until later, is she still getting an assessment and post natal care? **Michelle Searing** There has been an instance, where we have reached out 3 months prior and resources were given however an assessment wasn't made because the mother rejected any services. So I cannot say that every time there is an assessment, if rejected that is documented that way. I can give additional information so we can quantify. **Gretchen Thompson** Global team paid if patient is seen more than 7 times. If less than 7 times, follows fee for service per visit schedule. **Michelle Searing (Pg 11)** Trend in rates to baseline in re-measured 2. 3 Measures specified in quality measures, Milliman vs APH. Important to point out who generated what because it still having conversation around methodology when who is generating these rates. Need to do further review. **Dr. Moore** Suggest bringing this back up for discussion of methodology in April. **John Kucera** We also have some time to figure this out. And it is possible to go back and make these changes that are decided. **Gretchen Thompson** I had a discussion with David Mabb, while we looked up the source code; there have been discussions that may have impacted that code. I would like to recommend that HSAG look at the source code and determining where we see potential risk or problems in			

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Topic	Discussion	Recommendation/Action Plan	Responsible	Due Date
Provider Outreach	possible outcomes. **John Kucera** Ideal outcome, will have to look at financial, however definitely a conversation we would like to have with you. **Gladys Cook** Would like to talk off line regarding this, we can see where we are and discuss finances. **Dr. McCrorey** To briefly go over some of the overall quarter A lot of time spent discussing P4P and Non P4P metrics. We discussed potentially replacing the obsolete measures. Now have formal direction and are requesting replacing 3 obsolete metrics with ones we determined a few weeks ago. **Gloria Macdonald** Had a conference call with a project officer with CMS, suspended animation due to directive from administration. Hope to be able to get feedback in the next 30 to 60 days. **John Kucera** Will this be included in the amendment? Do we want to move forward with having our third party review these measures? **Gretchen Thompson** Thumps up to use measures as substitutes, recommends HEDIS recommendations. All HEDIS measures. **Gloria Macdonald** We can get everything ready **Dr. McCrorey** Cases to review efficiency – TCM claim a much bigger deal than anticipated, need to get a better grip on. Did do a deep dive into, HPE request to look at “Super Users”.			

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Topic	Discussion	Recommendation/Action Plan	Responsible	Due Date
	There is a graph. Over 25 visits per year to ED. Studies have focused on 4 or more, Betsy requested more, 25 visits per year. A lot of movement in and out of program, trying to get a grip on it. Does have to do with TCM. Overview of members – 62 people in HCGP identified as super users. 2,900 people have had more than 4 visits to the ED in a year. When you look at the national data, more looking at 4-25 or more visits, slightly different group. These are any ER visits and they are graded on a scale of 1 to 3, but only ER visits. Some of these people are just plain sick however 25 or more visits they typically are not sick, they are going to the wrong "spot". The next graph shows average number of ED visits in each category, so with 4 groups, main group is the non frequent flyer HCGP members, Next is a control group, Super users are 62 HCGP members. Frequent flyers represent 6% or HCGP and 30% of ER visits for Fee- for -Service. If we could impact this in some way we can make big impact to the HCGP. **Gloria Macdonald** What hospital? **Dr. McCrorey** Misusing outpatient services They all went to different hospitals. Something isn't right with these folks, we want to address their issues but also not agitate the ER. TCM issue is 30% of super users are taken out for recent TCM claims. That's not helpful for efficiently. **Gloria Macdonald** Did you look at age/gender? **Dr. McCrorey** They all went to different hospitals. Yes, however didn't give a lot of information. Age about 40 yrs (17/18 - 50)			

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Topic	Discussion	Recommendation/Action Plan	Responsible	Due Date
	Betsy Aiello These are HCGP members, these members have a diagnosis, and even with the diagnosis and they are super users to the ER, some had no outpatient follow up at all? **Dr. McCrorey** Correct. **John Kucera** How are you defining emergency room visit? **Dr. McCrorey** There are 3 codes. **Erin Snell** Part of that drill down has challenges of locating these people. **Dr. McCrorey** It's hard to go back and track. At some point it may improve or they may burn out, eventually it changes. My idea is to identify who these people are as early as possible. Want to protect these people over ER intervention. We are dedicated to continue to work on these folks. **Dr. Ryan Ley** A lot of these people probably have personality disorders, or have some need for attention. So they go to the ER over and over and over. Some people still think of the ER as primary care, even though it's not. **Gretchen Thompson** Did you look at the time of day of ER visits? Meal times? Follow up care per ER Dr.? **Dr. McCrorey** I don't know if I can see the time they go in. However we have less in Clark county. Very few went to outlying small hospital.			

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Topic	Discussion	Recommendation/Action Plan	Responsible	Due Date
Focus for Next Quarterly	**Erin Snell** One of the practices, the hospitals were not reinforcing with meals. They had to be there for a specific amount of time before they get a meal at the ER. **Rachel Marchetti** To go with Gretchen's thought, they may have a PCP, but sometimes there is a wait for the PCP when they can get immediate care at ER. **Cheri Glockner** Its training **John Kucera** I think this is a super valuable analysis here, I am trying to see the ideal situation if everyone is doing what they should. This looks like an education issue. **Dr. McCrorey** Need to dig and figure out why this group is doing this (more ER visits)? **Margaret Flaum** Slide 18, that graph includes TCM correct? **Dr. McCrorey** Yes, I broke out the TCM from the rest, there were similar findings but somewhat worse.			
New Business	**Cheri Glockner** Thank you for update on CMS, have amendment 6 planned for the next quarter With Legislature, preparing slideshow and will request your review and feedback Do need to start visiting our doctors and do more outreach soon, weather hasn't been great lately			

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Topic	Discussion	Recommendation/Action Plan	Responsible	Due Date
	We are continually looking at program year one results and program year two coming to an end, implementing on quality improvement. **Gloria Macdonald** We received a request from director about the breakdown of conditions, at one point you sent a nice little graph that could be used. Need to talk about worksheet, condition prevalence (10 conditions ranked), not interested in cost. **Dr. McCrorey** We are currently rerunning population profile and will have a lot more data for you soon. This is a population profile. **Gloria Macdonald** Now getting request from directors office to look at populations and what's going on. **Dr. McCrorey** This particular graph was hand done by Dr. Ley and myself, the one they are producing now will have a lot more date. **John Kucera** We're doing same for fee for service as a whole and to be able to do the same thing in an in future all of Medicaid. Currently having a discussion on prevalence. **Dr. Moore** Historically we have always looked at a 24month period. **John Kucera** Fee for service completely different from HCGP **Gloria Macdonald** We are done here.			

Health Care Guidance Program

Coordinating with you for better care!

Provider Advisory Board Agenda

June 9, 2017 12:00-3:00

Attendees:

Thomas McCrorey MD HCGP	Cheri Glockner HCGP
Taylor Ann Johnson APRN, CHA	Virginia Gurley, MD APH
Ryan Ley MD HCGP	Katherine Keely, MD DDS Sunrise Hospital
Summer Smith Admin Assistant	Gladys Cook, DHCFP
Allison Toigo, PharmD Banner C.H.	Racheal Marquette, DHCFP
Michelle Searing, HCGP	Aditi Singh, MD UN School of Medicine
Shannon Sprout, DHCFP	Additional (new) members (pending)
Lisa Durrette, MD Healthy Minds	

Agenda Items:

1200-1215 Call to Order and Introductions	Dr. Thomas McCrorey
1215-1230 Brief Update on the Program and Medicaid	Dr. Thomas McCrorey
1230-100 Discussion of the State of Mental Health Services in the US, and how we got here.	Dr. Ryan Ley
1:00-1:10 Break	
1:10-2:10 The Certified Community Behavioral Health Clinics Project	Dr. Stephanie Woodard
2:10-2:30 Discussion on the CCBHC	I suspect this could be lively as behavioral health care is always of interest to both the primary care docs and the mental health providers.
Other potential topics: The Nevada fight against prescription opioid abuse, Or update on the "ED Superusers" issue Or Overview on Medication adherence issues 3:00 next date sand Adjournment	Waiting on confirmation from Dr. Dimuro, Nevada CMO This would be me—I could discuss next and the problems facing research in this area. This would be me—I have the research done but need to collate and study, make the slides

Health Care Guidance Program

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Provider Advisory Board Minutes

June 9, 2017 12:00-3:00

Attendees:

Thomas McCrorey MD HCGP	Cheri Glockner HCGP
Taylor Ann Johnson APRN, CHA	Virginia Gurley, MD APH (not present)
Ryan Ley MD HCGP	Thomas Hunt, MD (not present)
Katherine Keeley, MD, DDS Sunrise	Gladys Cook, DHCFP
Allison Toigo, PharmD Banner C.H.	Rachel Marchetti, DHCFP
Gina Pierotti-Buthman, RN Valley Health System	Karen Salm, DHCFP
Guest speaker, Stephanie Woodard, PsyD	

Discussion and action items

Call to Order and Introductions	
Brief Update on the Program and Medicaid	Participants thanked Dr. McCrorey for his update, particularly related to legislative action and effect on providers around the state. He discussed the confusion around Managed Care expansion as related to fee-for-service beneficiaries. He told the board that FFS continue to be served in the current model and no decision related to transition is imminent. He asked the Board to help with messaging as there continues to be confusion related to this issue.
Discussion of the State of Mental Health Services in the US, and how we got here.	Presented by Drs. McCrorey, and Dr. Ley Presentation was well received. No questions from the Board
The Certified Community Behavioral Health Clinics Project	Dr. Stephanie Woodard presented to participants.
Discussion on the CCBHC	Participants were enthusiastic about the progress and the opportunity to work with CCBHC's. Dr. Durette asked detailed questions related to formal agreements between providers and the CCBHC's. Dr. Woodard assured her that CCBHC's will work collegially to ensure beneficiary needs are met in a timely, integrated manner, and this has been anticipated in the study design.

Next Meeting – September 7, 2017 Las Vegas DHCFP District Office	
	.

Nevada Health Care Guidance Program Provider Advisory Board Meeting

June 2017

Overview

- Introductions
- Agenda:
- HCGP News
- Medicaid News
- Over view of the Mental Health Resource Shortages
- An Overview of the Certified Behavioral Health Clinics

AXISPOINT HEALTH

HCGP News

- Finished 3 years of program operation!
- Working on PY2 final financial and clinic results
  - (12 month claims runout)
- Ongoing focus on Disease Management and Complex case Management
  - Majority of our engagements involve assisting with social resources
- Program will function for at least 1 more year in the current configuration.
- Likely will continue in some fashion afterwards
- Provider Advisory Board Enlargement
  - Non-provider stakeholders

AXISPOINT HEALTH

Medicaid News –

- Deputy Director Betsy Aiello retired
- New Deputy Director for Medicaid
- Shannon Sprout-was chief of clinical policy
- Marta Jensen remains Acting Director
- Karen Salm, CFO
- Gloria MacDonald Program Research and Development

AXISPOINT HEALTH

Medicaid News – proposed rate and policy changes

Legislature approved or recommended Medicaid funding for:

- Home Health and DME
- Adult non emergency Podiatry
- Dietician services
- Gender Dysphoria surgery

Increased Funding for:

- Adult Day Health Care
- Assisted Living for Behaviorally Complex
- Small hospital swing bed payments
- Pediatric surgery rates

AXISPOINT HEALTH

Medicaid News –Health Bills that passed

- Governors Opiate Abuse Bill (AB 474) passed
  - 14 day supply and < 90 MME/day
  - (Lower limits for Medicaid)
- Pharmacists can dispense opiate antagonist without a prescription
- APRNs can sign a POLST order (AB 199)
- Psychiatric care advance directives and consent (SB50)—signed by governor
- ER visits capped at 150% of Medicare rate (AJR 14) Constitutional amendment– will need to reviewed in next session)
- Funding and requirement DPBH Mobile Mental Health units in Clark and Washoe County to be available from 8 a.m. – 12 a.m., 7 days a week, (SB192) signed by Governor

AXISPOINT HEALTH

Medicaid News –Health Bills that passed

- SB509 authorizes Medicaid to levy a tax on Health facilities-has not been signed by governor yet.
- SB325 waives the wait period for Medicaid eligibility for immigrant children –has not been signed by governor yet.
- AB374 “Medicaid for All” allows state to develop process for people to purchase Medicaid on the market or exchange. Would have same benefits for purchase (except NET) without means tested eligibility-has not been signed by governor.
- Periodic update of Medicaid rates (AB108) every 4 years Medicaid rate comparison to actual cost and propose update in the state Medicaid plan. (has been signed and will be law on July 1)

Budget Neutrality Summary

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	
TANF/CHAP Pop 1	$ 24,235,984	$ 25,205,424	$ 26,213,640	$ 27,262,186	$ 28,352,674	$ 131,269,908
MAABD Pop 2	$ 25,682,887	$ 26,710,202	$ 27,778,610	$ 28,889,755	$ 30,045,345	$ 139,106,799
TOTAL	$ 49,918,871	$ 51,915,626	$ 53,992,251	$ 56,151,941	$ 58,398,018	$ 270,376,706

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	
TANF/CHAP Pop 1	$ 3,069,724	$ 3,395,927	$ 3,234,613	$ 27,261,157	$ 28,351,603	$ 65,313,024
MAABD Pop 2	$ 3,602,584	$ 3,989,741	$ 3,994,853	$ 28,888,664	$ 30,044,211	$ 70,520,053
TOTAL	$ 6,672,307	$ 7,385,668	$ 7,229,466	$ 56,149,821	$ 58,395,814	$ 135,833,077

TOTAL	$ 43,246,564	$ 44,529,958	$ 46,762,784	$ 2,120	$ 2,204	$ 134,543,630

Please provide historical cost and eligibity data on existing Medicaid populations that will be included in the Demor

5 YEARS OF HISTORIC DATA

SPECIFY TIME PERIOD AND ELIGIBILITY GROUP SERVED:

	SFY 2007	SFY 2008	SFY 2009	SFY 2010	SFY 2011	5-YEARS
TANF/CHAP Pop 1						
TOTAL EXPENDITURES	$ 70,654,141	$ 75,689,808	$ 75,582,668	$ 86,563,696	$ 99,096,227	$ 407,586,542
ELIGIBLE MEMBER MONTHS	97,157	120,198	141,620	173,527	197,117	
PMPM COST	$ 727.22	$ 629.71	$ 533.70	$ 498.85	$ 502.73	
TREND RATES			**ANNUAL CHANGE**			**5-YEAR AVERAGE**
TOTAL EXPENDITURE		7.13%	-0.14%	14.53%	14.48%	8.83%
ELIGIBLE MEMBER MONTHS		23.72%	17.82%	22.53%	13.59%	19.35%
PMPM COST		-13.41%	-15.25%	-6.53%	0.78%	-8.82%

	SFY 2007	SFY 2008	SFY 2009	SFY 2010	SFY 2011	5-YEARS
MAABD Pop 2						
TOTAL EXPENDITURES	$ 325,002,881	$ 337,074,721	$ 334,044,247	$ 357,440,867	$ 358,505,007	$ 1,712,067,724
ELIGIBLE MEMBER MONTHS	159,387	174,300	183,712	199,533	208,885	
PMPM COST	$ 2,039.08	$ 1,933.88	$ 1,818.30	$ 1,791.39	$ 1,716.28	
TREND RATES			**ANNUAL CHANGE**			**5-YEAR AVERAGE**
TOTAL EXPENDITURE		3.71%	-0.90%	7.00%	0.30%	2.48%
ELIGIBLE MEMBER MONTHS		9.36%	5.40%	8.61%	4.69%	7.00%
PMPM COST		-5.16%	-5.98%	-1.48%	-4.19%	-4.22%

DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION

MEDICAID POPULATIONS (If no existing Medicaid populations will participate in the demonstration, leave blank.)										
ELIGIBILITY GROUP	**TREND RATE 1**	**MONTHS OF AGING**	**BASE YEAR SFY 2013**	**TREND RATE 2**	**DEMONSTRATION YEARS (DY) SFY 2014**	**SFY 2015**	**SFY 2016**	**SFY 2017**	**SFY 2018**	**TOTAL WOW**
TANF/CHAP Pop 1										
Eligible Member Months	4.00%	24	213,202	4.00%	221,730	230,599	239,823	249,416	259,393	
Care Coordination PMPM Cost	0.00%		$ 20.46	0.00%	$ 109.30	$ 109.30	$ 109.30	$ 109.30	$ 109.30	
Total Expenditure					$ 24,235,984	$ 25,205,424	$ 26,213,640	$ 27,262,186	$ 28,352,674	$ 131,269,908
MAABD Pop 2										
Eligible Member Months	4.00%	24	225,930	4.00%	234,967	244,366	254,141	264,306	274,878	
Coordination PMPM Cost	0.00%		$ 20.46	0.00%	$ 109.30	$ 109.30	$ 109.30	$ 109.30	$ 109.30	
Total Expenditure					$ 25,682,887	$ 26,710,202	$ 27,778,610	$ 28,889,755	$ 30,045,345	$ 139,106,799

NOTES

"Base Year" is the year immediately prior to the planned first year of the demonstration.
"Trend Rate 1" is the trend rate that projects from the last historical year to the Base Year. The default is to use the 5-year historical average trend.
"Months of Aging" equals the number of months of trend factor needed to trend from the last historical year to the Base Year. If the base year is the year immediately following the last historical year, Months of Aging" will be 12.
"Trend Rate 2" is the trend rate that projects all DYs, starting from the Base Year. The default is to use the 5-year historical average trend.
For hypothetical populations, without-waiver estimates are set by default to equal the with-waiver extimates.

DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION

MEDICAID POPULATIONS (Should be blank-filled if no existing Medicaid populations will be in the demonstration.)

ELIGIBILITY GROUP	BASE YEAR SFY 2013	DEMO TREND RATE	DEMONSTRATION YEARS (DY) SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	TOTAL WW
TANF/CHAP Pop 1								
Eligible Member Months	213,202	4.00%	**199,982**	**221,233**	**210,724**	249,416	259,393	
Care Coordination PMPM Cost	$ 20.46	0.00%	**$ 15.35**	**$ 15.35**	**$ 15.35**	$ 109.30	$ 109.30	
Total Expenditure			**$ 3,069,724**	**$ 3,395,927**	**$ 3,234,613**	$ 27,261,157	$ 28,351,603	$ 65,313,024
MAABD Pop 2								
Eligible Member Months	225,930	4.00%	**234,696**	**259,918**	**260,251**	264,306	274,878	
Care Coordination PMPM Cost	$ 20.46	0.00%	**$ 15.35**	**$ 15.35**	**$ 15.35**	$ 109.30	$ 109.30	
Total Expenditure			**$ 3,602,584**	**$ 3,989,741**	**$ 3,994,853**	$ 28,888,664	$ 30,044,211	$ 70,520,053

NOTES

For a per capita budget neutrality model, the trend for member months is the same in the with-waiver projections as in the without-waiver projections. This is the default setting.
New hypothetical populations are shown in both without-waiver and with-waiver projections.
New non-hypothetical populations only appear in the with-waiver projections. The State must show offsetting Medicaid savings to achieve budget neutrality.
Demo Trend Rates' are a blended rate reduction that accounts for Waiver and Non-Waiver polpuation and Waiver Capitation payments to achieve budget nuetrality.

Exhibit 1
Budget Neutrality Evaluation - Comprehensive Care Waiver
Payments to CMO and Cost to State

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	Notes
Overall PMPM	1,108.26	1,102.21	1,096.27	1,090.43	1,084.71	(1)
Savings @ $5.1M	11.17	10.74	10.32	9.93	9.55	(2)
CMO Cost	20.46	20.46	20.46	20.46	20.46	(3)
Assuming 15% Savings						
Gross Savings - PMPM	166.24	165.33	164.44	163.57	162.71	(4)
"Excess" Savings - PMPM	134.61	134.13	133.66	133.18	132.70	(5)
Max Payout - PMPM	88.84	88.53	88.21	87.90	87.58	(6)
PMPM for Budget Neutrality	109.30	108.99	108.67	108.36	108.04	(7)

(1) Current FFS costs, taken from original budget neutrality calculation
(2) Contractually required savings ($5.1M), converted to a PMPM basis
(3) Base PMPM cost paid to CMO, including amount initially withheld
(4) Assumed savings as on a PMPM basis. Calculated as (1) x Savings Percentage
(5) = (4) - (3) - (2)
(6) = 66% x (5), assumes 100% quality score
(7) = (3) + (6)
Represents the "with waiver" cost to be put into the Budget Neutrality calculation

DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION

MEDICAID POPULATIONS (If no existing Medicaid populations will participate in the demonstration, leave blank.)										
ELIGIBILITY GROUP	**TREND RATE 1**	**MONTHS OF AGING**	**BASE YEAR SFY 2013**	**TREND RATE 2**	**DEMONSTRATION YEARS (DY) SFY 2014**	**SFY 2015**	**SFY 2016**	**SFY 2017**	**SFY 2018**	**TOTAL WOW**
TANF/CHAP Pop 1										
Eligible Member Months	4.00%	24	213,202	4.00%	221,730	230,599	239,823	249,416	259,393	
Care Coordination PMPM Cost	0.00%		$ 20.46	0.00%	$ 20.46	$ 20.46	$ 20.46	$ 20.46	$ 20.46	
Total Expenditure					$ 4,536,592	$ 4,718,056	$ 4,906,778	$ 5,103,049	$ 5,307,171	$ 24,571,646
MAABD Pop 2										
Eligible Member Months	4.00%	24	225,930	4.00%	234,967	244,366	254,141	264,306	274,878	
Coordination PMPM Cost	0.00%		$ 20.46	0.00%	$ 20.46	$ 20.46	$ 20.46	$ 20.46	$ 20.46	
Total Expenditure					$ 4,807,429	$ 4,999,727	$ 5,199,716	$ 5,407,704	$ 5,624,012	$ 26,038,588

NOTES

"Base Year" is the year immediately prior to the planned first year of the demonstration.
"Trend Rate 1" is the trend rate that projects from the last historical year to the Base Year. The default is to use the 5-year historical average trend.
"Months of Aging" equals the number of months of trend factor needed to trend from the last historical year to the Base Year. If the base year is the year immediately following the last historical year, Months of Aging" will be 12.
"Trend Rate 2" is the trend rate that projects all DYs, starting from the Base Year. The default is to use the 5-year historical average trend.
For hypothetical populations, without-waiver estimates are set by default to equal the with-waiver extimates.

DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION

MEDICAID POPULATIONS (Should be blank-filled if no existing Medicaid populations will be in the demonstration.)

ELIGIBILITY GROUP	BASE YEAR SFY 2013	DEMO TREND RATE	DEMONSTRATION YEARS (DY) SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	TOTAL WW
TANF/CHAP Pop 1								
Eligible Member Months	213,202	4.00%	221,730	230,599	239,823	249,416	259,393	
Care Coordination PMPM Cost	$ 20.46	0.00%	$ 20.46	$ 20.46	$ 20.46	$ 20.46	$ 20.46	
Total Expenditure			$ 4,536,592	$ 4,718,056	$ 4,906,778	$ 5,103,049	$ 5,307,171	$ 24,571,646
MAABD Pop 2								
Eligible Member Months	225,930	4.00%	234,967	244,366	254,141	264,306	274,878	
Care Coordination PMPM Cost	$ 20.46	0.00%	$ 20.46	$ 20.46	$ 20.46	$ 20.46	$ 20.46	
Total Expenditure			$ 4,807,429	$ 4,999,727	$ 5,199,716	$ 5,407,704	$ 5,624,012	$ 26,038,588

NOTES

For a per capita budget neutrality model, the trend for member months is the same in the with-waiver projections as in the without-waiver projections. This is the default setting.
New hypothetical populations are shown in both without-waiver and with-waiver projections.
New non-hypothetical populations only appear in the with-waiver projections. The State must show offsetting Medicaid savings to achieve budget neutrality.
Demo Trend Rates' are a blended rate reduction that accounts for Waiver and Non-Waiver polpuation and Waiver Capitation payments to achieve budget nuetrality.

Budget Neutrality Summary

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	
TANF/CHAP Pop 1	$ 4,536,592	$ 4,718,056	$ 4,906,778	$ 5,103,049	$ 5,307,171	$ 24,571,646
MAABD Pop 2	$ 4,807,429	$ 4,999,727	$ 5,199,716	$ 5,407,704	$ 5,624,012	$ 26,038,588
TOTAL	$ 9,344,021	$ 9,717,782	$ 10,106,494	$ 10,510,753	$ 10,931,183	$ 50,610,234

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	
TANF/CHAP Pop 1	$ 4,536,592	$ 4,718,056	$ 4,906,778	$ 5,103,049	$ 5,307,171	$ 24,571,646
MAABD Pop 2	$ 4,807,429	$ 4,999,727	$ 5,199,716	$ 5,407,704	$ 5,624,012	$ 26,038,588
TOTAL	$ 9,344,021	$ 9,717,782	$ 10,106,494	$ 10,510,753	$ 10,931,183	$ 50,610,234

TOTAL	$ -	$ -	$ -	$ -	$ -	$ -

DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION

MEDICAID POPULATIONS (If no existing Medicaid populations will participate in the demonstration, leave blank.)										
ELIGIBILITY GROUP	**TREND RATE 1**	**MONTHS OF AGING**	**BASE YEAR SFY 2013**	**TREND RATE 2**	**DEMONSTRATION YEARS (DY) SFY 2014**	**SFY 2015**	**SFY 2016**	**SFY 2017**	**SFY 2018**	**TOTAL WOW**
TANF/CHAP Pop 1										
Eligible Member Months	4.00%	24	213,202	4.00%	221,730	230,599	239,823	249,416	259,393	
PMPM Cost	1.00%		$ 512.83	1.00%	$ 517.96	$ 523.14	$ 528.37	$ 533.65	$ 538.99	
Total Expenditure					$ 114,847,178	$ 120,635,568	$ 126,715,264	$ 133,100,791	$ 139,809,979	$ 635,108,779
MAABD Pop 2										
Eligible Member Months	4.00%	24	225,930	4.00%	234,967	244,366	254,141	264,306	274,878	
PMPM Cost	-1.00%		$ 1,682.13	-1.00%	$ 1,665.31	$ 1,648.66	$ 1,632.17	$ 1,615.85	$ 1,599.69	
Total Expenditure					$ 391,293,262	$ 402,876,301	$ 414,800,575	$ 427,079,121	$ 439,720,251	$ 2,075,769,510

NOTES

"Base Year" is the year immediately prior to the planned first year of the demonstration.

"Trend Rate 1" is the trend rate that projects from the last historical year to the Base Year. The default is to use the 5-year historical average trend.

"Months of Aging" equals the number of months of trend factor needed to trend from the last historical year to the Base Year. If the base year is the year immediately following the last historical year, Months of Aging" will be 12.

"Trend Rate 2" is the trend rate that projects all DYs, starting from the Base Year. The default is to use the 5-year historical average trend.

For hypothetical populations, without-waiver estimates are set by default to equal the with-waiver extimates.

DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION

MEDICAID POPULATIONS (Should be blank-filled if no existing Medicaid populations will be in the demonstration.)

ELIGIBILITY GROUP	**BASE YEAR SFY 2013**	**DEMO TREND RATE**	**DEMONSTRATION YEARS (DY)** SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	**TOTAL WW**
TANF/CHAP Pop 1								
Eligible Member Months	213,202	4.00%	221,730	230,599	239,823	249,416	259,393	
PMPM Cost	$ 512.83	0.00%	$ 512.83	$ 512.83	$ 512.83	$ 512.83	$ 512.83	
Total Expenditure			$ 113,709,704	$ 118,258,092	$ 122,988,415	$ 127,907,952	$ 133,024,270	$ 615,888,433
MAABD Pop 2								
Eligible Member Months	225,930	4.00%	234,967	244,366	254,141	264,306	274,878	
PMPM Cost	$ 1,682.13	-2.00%	$ 1,648.49	$ 1,615.52	$ 1,583.21	$ 1,551.55	$ 1,520.52	
Total Expenditure			$ 387,341,114	$ 394,778,014	$ 402,357,854	$ 410,084,235	$ 417,958,127	$ 2,012,519,344

NOTES

For a per capita budget neutrality model, the trend for member months is the same in the with-waiver projections as in the without-waiver projections. This is the default setting.
New hypothetical populations are shown in both without-waiver and with-waiver projections.
New non-hypothetical populations only appear in the with-waiver projections. The State must show offsetting Medicaid savings to achieve budget neutrality.
Demo Trend Rates' are a blended rate reduction that accounts for Waiver and Non-Waiver polpuation and Waiver Capitation payments to achieve budget nuetrality.

Budget Neutrality Summary

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	
TANF/CHAP Pop 1	$ 114,847,178	$ 120,635,568	$ 126,715,264	$ 133,100,791	$ 139,809,979	$ 635,108,779
MAABD Pop 2	$ 391,293,262	$ 402,876,301	$ 414,800,575	$ 427,079,121	$ 439,720,251	$ 2,075,769,510
TOTAL	$ 506,140,440	$ 523,511,868	$ 541,515,839	$ 560,179,912	$ 579,530,230	$ 2,710,878,289

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	
TANF/CHAP Pop 1	$ 113,709,704	$ 118,258,092	$ 122,988,415	$ 127,907,952	$ 133,024,270	$ 615,888,433
MAABD Pop 2	$ 387,341,114	$ 394,778,014	$ 402,357,854	$ 410,084,235	$ 417,958,127	$ 2,012,519,344
TOTAL	$ 501,050,817	$ 513,036,106	$ 525,346,269	$ 537,992,187	$ 550,982,397	$ 2,628,407,777

TOTAL	$ 5,089,623	$ 10,475,762	$ 16,169,570	$ 22,187,725	$ 28,547,833	$ 82,470,513

CCBHC: Certified Community Behavioral Health Clinics

CCBHC

Are you ready?

What is a CCBHC?

Defined for the first time in the Excellence in Mental Health Act, Certified Community Behavioral Health Clinics (CCBHCs) are designed to provide a comprehensive range of mental health and substance use disorder services, particularly to vulnerable individuals with the most complex needs during a federal demonstration program with participating states.

States must certify that each *CCBHC* offers the following services either directly or through a formal contract with a designated collaborating organization (DCO). Through the demonstration, the following services must be offered and will be paid for even if they are not included in a state's Medicaid plans:

- Crisis mental health services including 24-hour mobile crisis teams, emergency crisis intervention and crisis stabilization*
- Screening, assessment and diagnosis including risk management*
- Patient-centered treatment planning*
- Outpatient mental health and substance use services*
- Primary care screening and monitoring**
- Targeted case-management**
- Psychiatric rehabilitation services**
- Peer support, counseling services, and family support services**
- Services for members of the armed services and veterans**
- Connections with other providers and systems (criminal justice, foster care, child welfare, education, primary care, hospitals, etc.)**

**CCBHC must directly provide*
***May be provided by CCBHC and/or DCO*

Why these services, and why together?

The service array is deliberate. CCBHCs provide the comprehensive array of services that are necessary to create access, stabilize people in crisis, and provide the necessary treatment for those with the most serious, complex mental illnesses and addictions. CCBHCs also integrate additional services to ensure an approach to health care that emphasizes recovery, wellness, trauma-informed care, and physical-behavioral health integration. Highlights regarding this comprehensive array include:

- Easy and welcoming access to services regardless of ability to pay or location of residence to ensure those who need services are able to receive them.
- Immediate screening, assessment, and risk assessment for mental health, addictions, and basic primary care needs to ameliorate the chronic co-morbidities that drive poor health outcomes and high costs for those with behavioral health disorders.
- 24/7/365 crisis services to help people stabilize in the most clinically appropriate, least restrictive, least traumatizing, and most cost-effective settings.
- Full clinical, operational, and financial commitment to peer and family support, recognizing these elements as essential for recovery.
- Tailored emphasis on active and veteran military, who have served our country with honor, to ensure they receive the unique health care support they need.
- Expanded coordination with other health care and social service providers, with a focus on whole health and comprehensive access to a full range of medical, behavioral and supportive services.

Who Do CCBHCs Serve?

In short, CCBHCs serve any individual in need of care, regardless of his or her ability to pay. This includes (but is not limited to):

- Adults with serious mental illness
- Children with serious emotional disturbance
- Those with long-term chronic addiction
- Others with mild or moderate mental illness and substance use disorders
- Underserved individuals and families
- Low income individuals and families
- Those who are insured, uninsured or on Medicaid
- Those with complex health profiles
- Members of our armed services and veterans

What is the CCBHC Demonstration Program?

The Excellence Act provides for a funded demonstration of selected CCBHC projects. The demonstration rolls out in two phases. Phase 1 offers states one-year planning grants to develop their CCBHC program. In October 2015, the Substance Abuse and Mental Health Services Administration (SAMHSA) awarded 24 states grants to plan their CCBHC projects over the next year. States will submit to SAMHSA a program proposal by October 23, 2016. In Phase 2, SAMHSA will select at least eight states to carry out their CCBHC projects. The demonstration project grants will fund the selected CCBHCs for at least two years.

What Happens Afterward?

The Centers for Medicare and Medicaid Services (CMS) has committed to helping states explore options for maintaining CCBHC services through such mechanisms as Section 1115 waivers. Meanwhile, the congressional champions of the Excellence Act and the behavioral health advocacy community are working to expand the demonstration to include more states and to extend for more years.

For more information, please visit the National Council's CCBHC Resource Hub or contact Rebecca Farley at the National Council (RebeccaF@thenationalcouncil.org).

Nevada Division of Health Care Financing and Policy
Health Care Guidance Program
Membership Using STC Criteria

TANF/CHAP

	PY14	PY15	PY16
Current	199,982	221,233	210,724
Prior	221,730	230,599	239,823

ABD

	PY14	PY15	PY16
Current	234,696	259,918	260,251
Prior	234,967	244,366	254,141

Note:
Payment years are June - May
Prior numbers are on a SFY (July-June) basis

Nevada Health Care Guidance Program (HCGP)

2017 Quality Strategy Program Modules

Nevada's Comprehensive Care Waiver (NCCW) program is a comprehensive demonstration that seeks to improve the value of the Medicaid delivery system. Operating the NCCW program as the Health Care Guidance Program (HCGP), the HCGP provides mandatory care management services throughout the State for a subset of high-cost, high-need beneficiaries not served by the existing MCOs. This subset of beneficiaries receives care management services from a care management organization (CMO). The CMO, AxisPoint Health (APH), is expected to support improved quality of care, which is expected to generate savings/efficiencies for the Medicaid program.

The DHCFP established quality goals to improve the health and wellness of NCCW enrollees and ensure they have access to high-quality and culturally competent care. Listed below are the goals and objectives of the HCGP Quality Strategy and program.

Goal 1: Provide care management to high-cost, high-need Medicaid beneficiaries who receive services on a FFS basis.

Objective 1.1: Successfully enroll all Medicaid beneficiaries who qualify for the NCCW program.

Objective 1.2: Stratify all enrollees into case management tier according to assessed needs.

Objective 1.3: Complete a comprehensive assessment of enrollees with complex or high risk needs.

Objective 1.4: Complete a comprehensive assessment of enrollees with moderate or low risk needs.

Objective 1.5: Increase utilization of primary care, ambulatory care, and outpatient services for members with chronic conditions.

Goal 2: Improve the quality of care that high-cost, high-need Nevada Medicaid beneficiaries in FFS receive through care management and financial incentives such as pay for performance (quality and outcomes).

Objective 2.1: Increase use of preventive services by 10 percent. [1-1]

Objective 2.2: Increase follow-up ambulatory care visit after hospitalization by 10 percent.

Objective 2.3: Increase patient compliance with anti-depressant medication treatment protocols by 10 percent.

Objective 2.4: Increase use of best practice pharmacological treatment for persons with chronic conditions by 10 percent.

Goal 3: Establish long-lasting reforms that sustain the improvements in the quality of health and wellness for Nevada Medicaid beneficiaries and provide care in a more cost efficient manner.

Objective 3.1: Reduce hospital readmissions by 10 percent.

[1-1] The goal for all measures to increase performance by 10 percent refers to the hybrid QISMC methodology for reducing the gap between the performance measure rate and 100 percent by 10 percent.

Objective 3.2: Reduce emergency department utilization by 10 percent.

Goal 4: Improve NCCW enrollees' satisfaction with care received.

Objective 4.1: NCCW enrollee satisfaction improves over baseline.

DHCFP expects that APH will achieve significant improvement in each of the objectives that support the program goals. Attachment A contains the DHCFP-defined set of pay for performance (P4P) and non-P4P performance measures that are reviewed to determine if significant improvement was made. These performance measures correspond to a goal and objective enumerated above. While the resulting rates from these performance measures are evaluated annually to determine if APH achieved the goals and objectives of the program, DHCFP expects that APH will monitor these performance measures on an ongoing basis and calculate the rates regularly to determine if any of the interventions used by APH to improve rates are having the desired effect. Further, DHCFP expects that APH will apply a continuous quality improvement approach and conduct barrier analyses on performance measure rates that appear to be stagnant or have declined over time.

Quarterly Quality Meeting

DHCFP augments is ongoing monitoring of the HCGP contractor with a Quarterly Quality Meeting that is attended by DHCFP staff and stakeholders, APH, and DHCFP's external quality review organization (EQRO), Health Services Advisory Group (HSAG). The purpose of the Quarterly Quality Meeting is to discuss the care management and quality improvement efforts implemented by APH to improve the health and wellness of HCGP enrollees and to track APH's progress toward meeting the goals and objectives outlined in the HCGP Quality Strategy. Since the second quarter of the program, staff members from DHCFP, APH, and HSAG have met to discuss the HCGP's progress in meeting the goals and objectives outlined in the quality strategy, as well as the Section 1115 Research and Demonstration Waiver. HSAG and DHCFP have defined a set of modules that APH must follow when presenting quality improvement information during the quarterly meetings. These presentations enable DHCFP staff and meeting attendees to track the progress of APH's performance related to P4P and non-P4P quality indicators and to discuss future interventions APH may employ to improve its performance relative to the quality indicators. The Quality Strategy Modules outlined by DHCFP are described below.

Quality Strategy Modules

It is DHCFP's expectation that APH will achieve meaningful improvement in each of the goals identified for the HCGP. Using the HCGP Quality Strategy as the guide, DHCFP designed a set of modules to ensure that the Quarterly Quality Meetings:

- Support the implementation of the NCCW Quality Strategy.
- Support DHCFP's ongoing monitoring and oversight of the NCCW program.
- Focus on the quality goals and objectives of the NCCW program.
- Provide stakeholders with the opportunity to participate and provide input into the strategic direction of the NCCW quality improvement program.
- Continually review the CMO's enrollee outreach and care management activities and efforts to improve quality of services and health outcomes of NCCW enrollees.

The first set of Quality Modules (Modules 1–4) was developed in 2014 as a guide for the 2015 and 2016 quarterly quality meetings, and is shown in Attachment C. In April 2015, DHCFP provided additional instructions to APH for the Quality Modules. Those instructions are shown in Attachment D.

DHCFP has developed a set of modules for calendar year 2017, which are provided in Attachment B. Continuing the numbering from the first set of modules, the 2017 modules start with Module 5. Each Quarterly Quality Meeting will address the activities and tasks of the corresponding modules and Module 5 will need to be presented at every meeting along with the corresponding quarterly assignment. The contents of each module are dynamic and may be modified at DHCFP's discretion.

Attachment A

P4P and Non-P4P Performance Measures

P4P Performance Measures			
Measure Number	**Measure Description** (Use numerator description)	**Age Group**	**Corresponding Objective**
ASM.1	Percentage of members 5-64 years of age during the measurement period who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement period.	5-64 years	2.4
ASM.2	Percent of patients who have a record of influenza immunization in the past 12 months.	No restrictions	2.1
ASM.3	The percentage of members enrolled during the measurement period with at least one emergency department visit or an urgent care visit for an asthma related event.	No restrictions	3.2
ASM.4	The percentage of discharges for members who were hospitalized with a primary discharge diagnosis of asthma and had a follow-up ambulatory care visit within 7 days of discharge.	No restrictions	2.2
CAD.1	The percentage of members identified with coronary artery disease (CAD) who were prescribed a lipid lowering medication during the measurement period.	No restrictions	2.4
CAD.2	The percentage of members identified with a coronary artery disease (CAD) who had an LDL-C screen performed during the measurement period.	No restrictions	2.1
CAD.3	The percentage of discharges for members who were hospitalized with a primary discharge diagnosis of coronary artery disease (CAD) and who had a follow-up, ambulatory care visit within 7 days of discharge.	No restrictions	2.2
SPR.1	The percentage of members 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis.	40+	2.1
SPR.2	Percentage of patients aged 18 years and older with a diagnosis of COPD who received influenza immunization in the past 12 months.	18+	2.1
SPR.3	The percentage of discharges for members who were hospitalized with a primary discharge diagnosis of COPD and who had a follow-up, ambulatory care visit within 7 days of discharge.	No restrictions	2.2
CDC.1	Percent of members 18 – 75 years of age, with diabetes, who had an HbA1c test performed in the measurement period.	18-75 years	2.1
CDC.2	Percent of members 18 – 75 years of age who with diabetes mellitus (type 1 and type 2) and have had a low-density lipoprotein cholesterol (LDL-C) screening performed in the measurement period.	18-75 years	2.1
CDC.3	Percent of members 18 – 75 years of age, with diabetes, who had a nephropathy screening test or evidence of nephropathy.	18-75 years	2.1
CDC.4	Percent of members 18 – 75 years of age, with diabetes, who had an eye screening for diabetic retinal disease in the measurement period.	18-75 years	2.1
CDC.5	Percent of members 18 – 75 years of age, with diabetes, who received an influenza immunization during the measurement period.	18-75 years	2.1
CDC.6	Percent of members 5 – 17 years of age, with diabetes, who had an HbA1c test performed in the measurement period.	5-17 years	2.1
HF.1	Percent of members 18 years and older who were hospitalized in the intake period with a diagnosis of acute myocardial infarction (AMI) and received persistent beta-blocker treatment for six months after being discharged alive.	18+	2.4
HF.2	Percent of members with heart failure who had at least one ED visit for acute exacerbation. (Lower rate is better.)	No restrictions	3.2
HF.3	Percent of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for ACEIs or ARBs during the measurement period and at least one serum creatinine or blood urea nitrogen therapeutic monitoring test in the measurement period.	18+	2.4
HF.4	The percentage of discharges for members who were hospitalized with a primary discharge diagnosis of heart failure (HF) and had a follow-up, ambulatory care visit within 7 days of discharge.	No restrictions	2.2
HIV.1	The percentage of members with a diagnosis of HIV/AIDS with at least one ambulatory care visit in the first half and second half of the measurement period, with a minimum of 60 days between each visit.	No restrictions	1.5
HPTN.1	The percentage of members with hypertension who were on an anti-hypertension multi-drug therapy regimen, during the measurement period, that included a thiazide diuretic.	No restrictions	2.4
MH.1	The percentage of members with bipolar I disorder treated with mood stabilizers at least 80% of the time during the measurement period.	No restrictions	2.3
MH.2	Percentage of members who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication treatment for at least 84 days.	No restrictions	2.3
MH.3.1	Percentage of members ages 6 and older with schizophrenia who remained on an antipsychotic medication during the measurement period. Two rates are reported: MH.3.1 – rate for 6 months of medication adherence	6+	2.4
MH.3.2	Percentage of members ages 6 and older with schizophrenia who remained on an antipsychotic medication during the measurement period. Two rates are reported: MH.3.2 – rate for one year of medication adherence	6+	2.4

P4P Performance Measures			
Measure Number	**Measure Description** (Use numerator description)	**Age Group**	**Corresponding Objective**
MH.4.1	Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of select mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported: MH.4.1 - percentage of discharges for which the member received follow-up within 30 days of discharge	6+	2.2
MH. 4.2	Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of select mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported: MH.4.2 – the percentage of discharges for which the member received follow-up within 7 days of discharge (used for P4P).	6+	2.2
S.A.1.1	Percentage of adolescents and adults members with a new episode of alcohol or other drug (AOD) dependence who received AOD treatment. Two rates are reported: MH.5.1 – The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.	13+	1.5
S.A.1.2	Percentage of adolescents and adults members with a new episode of alcohol or other drug (AOD) dependence who received AOD treatment. Two rates are reported: MH.5.2 – The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.	13+	1.5

Non-P4P Performance Measures			
Measure Number	**Measure Description** (Use numerator description)	**Age Group**	**Corresponding Objective**
CCHU.1	Age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to the hospital, per 100,000 population under age 75 years. (Lower rates are better.)	<75 years	1.5
CCHU.2	"Avoidable" ER visits are defined as visits with a primary diagnosis that match the avoidable diagnosis codes. The rate of avoidable ER visits used represents the percentage of all ER visits that match the selected "avoidable" diagnosis codes. (Lower rates are better.)	No restrictions	3.2
FUP.1	Percentage of discharges for members who were hospitalized and who had an ambulatory visit with a PCP. The percentage of discharges for which the member received PCP follow-up within 30 days of discharge.	No restrictions	2.2
FUP.2	Percentage of discharges for members who were hospitalized and who had an ambulatory visit with a PCP. The percentage of discharges for which the member received PCP follow-up within 7 days of discharge.	No restrictions	2.2
MRP	Percentage of discharges from January 1–December 1 of the measurement year for members regardless of age for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days).	No restrictions	3.1
DEM	Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least within a 12 month period.	No restrictions	1.3
NEUR	Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or transient ischemic attack (TIA) who were dispensed antithrombotic therapy at discharge.	18+	2.4
CKD	Percentage of patients aged 18 years and older with a diagnosis of CKD (stage 3, 4, or 5, not receiving Renal Replacement Therapy [RRT]) who had a fasting lipid profile performed at least once within a 12-month period.	18+	2.1
RA	Percentage of patients aged 18 years and older who were diagnosed with RA and were dispensed or administered at least one ambulatory prescription for a DMARD.	18+	2.4
OST	Percentage of patients aged 50 years and older with a diagnosis of osteoporosis who were prescribed pharmacologic therapy within 12 months.	50+	2.4
OBS.1	Percentage of members whose BMI calculation is documented, and counseling for nutrition and physical activity is provided during the measurement year. Care managers will perform this activity, and it must be documented in the member's care plan. -Numerator = BMI	3-11 years	2.1
OBS.2	Percentage of members whose BMI calculation is documented, and counseling for nutrition and physical activity is provided during the measurement year. Care managers will perform this activity,	12-17 years	2.1

Non-P4P Performance Measures			
Measure Number	Measure Description (Use numerator description)	Age Group	Corresponding Objective
	and it must be documented in the member's care plan. -Numerator = BMI		
OBS.3	Percentage of members whose BMI calculation is documented, and counseling for nutrition and physical activity is provided during the measurement year. Care managers will perform this activity, and it must be documented in the member's care plan. -Numerator = Counseling for Nutrition	3-11 years	2.1
OBS.4	Percentage of members whose BMI calculation is documented, and counseling for nutrition and physical activity is provided during the measurement year. Care managers will perform this activity, and it must be documented in the member's care plan. -Numerator = Counseling for Nutrition	12-17 years	2.1
OBS.5	Percentage of members whose BMI calculation is documented, and counseling for nutrition and physical activity is provided during the measurement year. Care managers will perform this activity, and it must be documented in the member's care plan. -Numerator = Counseling for Physical Activity	3-11 years	2.1
OBS.6	Percentage of members whose BMI calculation is documented, and counseling for nutrition and physical activity is provided during the measurement year. Care managers will perform this activity, and it must be documented in the member's care plan. -Numerator = Counseling for Physical Activity	12-17 years	2.1
CAP.1	Percentage of members 12 months-19 years of age who had a visit with a Primary Care Practitioner (PCP). The organization reports four separate percentages for each product line.	12-24 months	2.1
CAP.2	Percentage of members 12 months-19 years of age who had a visit with a Primary Care Practitioner (PCP). The organization reports four separate percentages for each product line.	25 months-6 years	2.1
CAP.3	Percentage of members 12 months-19 years of age who had a visit with a Primary Care Practitioner (PCP). The organization reports four separate percentages for each product line.	7-11 years	2.1
CAP.4	Percentage of members 12 months-19 years of age who had a visit with a Primary Care Practitioner (PCP). The organization reports four separate percentages for each product line.	12-19 years	2.1
W15.1	Percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life: No well-child visits (Lower rates are better.)	Turned 15 months old during the measurement year	2.1
W15.2	Percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life: One well-child visit	Turned 15 months old during the measurement year	2.1
W15.3	Percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life: Two well-child visits	Turned 15 months old during the measurement year	2.1
W15.4	Percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life: Three well-child visits	Turned 15 months old during the measurement year	2.1
W15.5	Percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life: Four well-child visits	Turned 15 months old during the measurement year	2.1
W15.6	Percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life: Five well-child visits	Turned 15 months old during the measurement year	2.1
W15.7	Percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life: Six well-child visits	Turned 15 months old during the measurement year	2.1
W34	Percentage of members 3-6 years of age who had one or more well-child visits with a PCP during the measurement year.	3-6 years	2.1
AWC	Percentage of enrolled members 12-21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	12-21 years	2.1
CIS.1	Percentage of children 2 years of age who had four DTaP vaccines by their second birthday.	2 years	2.1
CIS.2	Percentage of children 2 years of age who had three IPV vaccines by their second birthday.	2 years	2.1
CIS.3	Percentage of children 2 years of age who had one MMR vaccine by their second birthday.	2 years	2.1
CIS.4	Percentage of children 2 years of age who had three HiB vaccines by their second birthday.	2 years	2.1
CIS.5	Percentage of children 2 years of age who had three HepB vaccines by their second birthday.	2 years	2.1
CIS.6	Percentage of children 2 years of age who had one VZV (varicella) vaccine by their second birthday.	2 years	2.1
CIS.7	Percentage of children 2 years of age who had four PCV vaccines by their second birthday.	2 years	2.1
CIS.8	Percentage of children 2 years of age who had one HepA vaccine by their second birthday.	2 years	2.1
CIS.9	Percentage of children 2 years of age who had two or three RV vaccines by their second birthday.	2 years	2.1

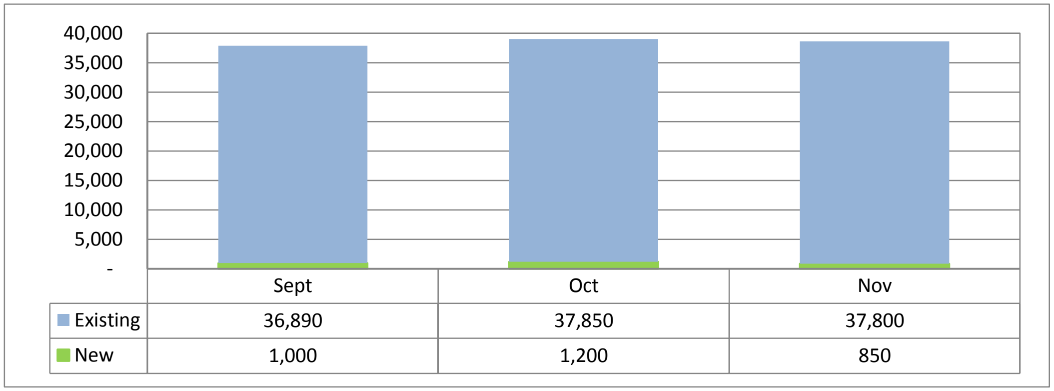
Non-P4P Performance Measures			
Measure Number	**Measure Description** (Use numerator description)	**Age Group**	**Corresponding Objective**
CIS.10	Percentage of children 2 years of age who had two flu vaccines by their second birthday.	2 years	2.1
CIS.11	Percentage of children 2 years of age who had Combination #2 vaccines by their second birthday.	2 years	2.1
CIS.12	Percentage of children 2 years of age who had Combination #3 vaccines by their second birthday.	2 years	2.1
CIS.13	Percentage of children 2 years of age who had Combination #4 vaccines by their second birthday.	2 years	2.1
CIS.14	Percentage of children 2 years of age who had Combination #5 vaccines by their second birthday.	2 years	2.1
CIS.15	Percentage of children 2 years of age who had Combination #6 vaccines by their second birthday.	2 years	2.1
CIS.16	Percentage of children 2 years of age who had Combination #7 vaccines by their second birthday.	2 years	2.1
CIS.17	Percentage of children 2 years of age who had Combination #8 vaccines by their second birthday.	2 years	2.1
CIS.18	Percentage of children 2 years of age who had Combination #9 vaccines by their second birthday.	2 years	2.1
CIS.19	Percentage of children 2 years of age who had Combination #10 vaccines by their second birthday.	2 years	2.1
PPC.1	Percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. Timeliness of Prenatal Care	No restrictions	2.1
PPC.2	Percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. Postpartum Care.	No restrictions	2.1
FPC.1	Percentage of Medicaid deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that had the following number of expected prenatal visits: <21 percent of expected visits (Lower rates are better.)	No restrictions	2.1
FPC.2	Percentage of Medicaid deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that had the following number of expected prenatal visits: 21 percent - 40 percent of expected visits	No restrictions	2.1
FPC.3	Percentage of Medicaid deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that had the following number of expected prenatal visits: 41 percent - 60 percent of expected visits	No restrictions	2.1
FPC.4	Percentage of Medicaid deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that had the following number of expected prenatal visits: 61 percent - 80 percent of expected visits	No restrictions	2.1
FPC.5	Percentage of Medicaid deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that had the following number of expected prenatal visits: ≥81 percent of expected visits	No restrictions	2.1
ABA	Percentage of members 18-74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.	18-74 years	2.1
BCS	Percentage of women 40-69 years of age who had a mammogram to screen for breast cancer.	42-69 years	2.1
CCS	Percentage of women 21-64 years of age who received one or more Pap tests to screen cervical cancer.	22-64 years	2.1
COL	The percentage of members 50-75 years of age who had appropriate screening for colorectal cancer.	51-75 years	2.1
WOP.1	Percentage of women who delivered a live birth during the measurement year by the weeks of pregnancy at the time of their enrollment in the organization. 1-12 weeks (279-196 days prior to delivery)	No restrictions	N/A
WOP.2	Percentage of women who delivered a live birth during the measurement year by the weeks of pregnancy at the time of their enrollment in the organization. 13-27 weeks (195-91 days prior to delivery)	No restrictions	N/A
WOP.3	Percentage of women who delivered a live birth during the measurement year by the weeks of pregnancy at the time of their enrollment in the organization. 28 or more weeks of pregnancy (<=90 days prior to delivery)	No restrictions	N/A
WOP.4	Percentage of women who delivered a live birth during the measurement year by the weeks of pregnancy at the time of their enrollment in the organization. <=0 weeks (280 days or more prior to delivery)	No restrictions	N/A
WOP.5	Percentage of women who delivered a live birth during the measurement year by the weeks of pregnancy at the time of their enrollment in the organization. Unknown	No restrictions	N/A

2017 Quality Strategy Modules

<table>
<tr><th>Module Number and Title</th><th>Quarterly Quality Meeting</th><th>Description of Module and Activities to be Performed
Quarters noted as: Q1: Jun-Aug; Q2: Sept-Nov; Q3: Dec-Feb; Q4: Mar-May</th></tr>
<tr><td>Module 5: Enrollment and Stratification</td><td>To be presented at every meeting, starting January 2017</td><td>

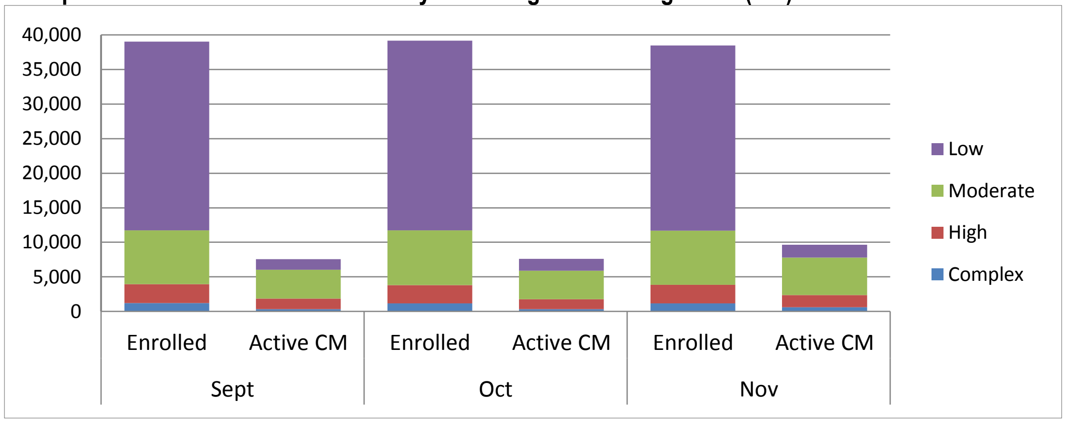
- **Objective 1.1:** Using a stacked bar graph, show the total number of enrollees (new enrollees and existing enrollees) for each month in the previous quarter. (Refer to example 1 below for the preferred method to display the data.)

Example 1: New and Existing HCGP Enrollees



- **Objective 1.2:** Using a stacked bar graph, show the number of enrollees stratified into each of the case management tiers (4 through 1) for each month in the previous quarter. Show how many people are actively receiving case management (assessed and treatment plan developed) for each case management tier. (Refer to example 2 below for the preferred method to display the data.)

Example 2: Enrolled vs. Persons Actively Receiving Case Management (CM) Services



</td></tr>
</table>

Module 6: Enrollment and Stratification	January 2017	(see below)

- **Objective 1.3:** For enrollees with complex (tier 4) and high (tier 3) risk needs, show the average number of days from identification to completing the assessment for all enrollees who were ever enrolled in the program (unduplicated count). Show the subset of enrollees who were pregnant and the average number of days between the date of enrollment to the date of assessment for pregnant enrollees. (Refer to examples 3 and 4 below for the method to display the data.)
- **Objective 1.4:** For enrollees with moderate (tier 2) and low (tier 1) risk needs, show the average number of days from identification to completing the assessment for all enrollees who were ever enrolled in the program (unduplicated count). Show the subset of enrollees who were pregnant and the average number of days between the date of enrollment to the date of assessment for pregnant enrollees. (Refer to examples 3 and 4 below for the method to display the data.)

Example 3: Enrolled vs. Persons Actively Receiving Case Management (CM) Services

Total (Ever) Enrolled and Total (Ever) Assessed June 2014 through June 2016					
CM Tier	Total Number of Persons Ever Enrolled	Percent of Total Enrolled in CM Tier	Total Number of Persons Who Received Assessment	Percent Who Received Assessment	Average Number of Days Between Enrollment and Assessment
Complex (4)	314	0.8%	83	0.2%	57 days
High (3)	2,282	5.8%	451	1.1%	69 days
Moderate (2)	4,696	11.9%	738	1.9%	81 days
Low (1)	32,251	81.5%	556	1.4%	65 days
Total	**39,543**	**100%**	**1,828**	**4.6%**	**Average 72 days**

*Data contained in table is for example only.

Example 4: Pregnant Women Enrolled vs. Pregnant Women Actively Receiving Case Management (CM) Services

Total Pregnant Women (Ever) Enrolled and Total Pregnant Women (Ever) Assessed June 2014 through June 2016			
CM Tier	Total Number of Pregnant Women Enrolled	Total Number of Pregnant Enrollees Assessed	Average Number of Days Between Enrollment and Completed Assessment
Complex (4)	0	0	N/A
High (3)	275	13	72 days
Moderate (2)	50	10	68 days
Low (1)	25	25	52 days
Total	**350**	**48**	**Average 61 days**

*Data contained in table is for example only.

- **Objective 1.5:** Please reference Attachment A. Display and discuss the trend in rates from Baseline to Program Year 2 for the P4P measures, HIV.1, SA.1.1, and SA.1.2, which have not reached the performance target. Please describe the following:
  - The QI tools (e.g., failure mode and effects analysis, process mapping, root cause analysis, fishbone diagram) and techniques that have been used to evaluate the reasons why the measures have not achieved the performance target.

<table>
<tr><th>Module Number and Title</th><th>Quarterly Quality Meeting</th><th>Description of Module and Activities to be Performed
Quarters noted as: Q1: Jun-Aug; Q2: Sept-Nov; Q3: Dec-Feb; Q4: Mar-May</th></tr>
<tr><td></td><td></td><td>▪ What interventions have been identified that, once implemented, will likely improve performance? What interventions have been discontinued due to lack of improvement? What is the evaluation plan to evaluate the effectiveness of the planned intervention to verify that the interventions are having the desired effect?</td></tr>
<tr><td>Module 7: Objectives 2.1 and 2.2</td><td>April 2017</td><td>◆ Objective 2.1: Please reference Attachment A. Display and discuss the Program Year 1 rates and Program Year 2 rates for the measures that correspond to objective 2.1 that reached the performance target and sustained that improvement to Program Year 2. Please describe the interventions that were implemented that positively impacted the following non-P4P performance measures, CAP.1, W15.7 and CIS.2 and CIS.11 (can be presented together).
◆ Objective 2.1: Please reference Attachment A. Several non-P4P measures declined from Baseline to Program Year 2 that correspond to Objective 2.1. Those measures were, OBS.1, CAP.2, CAP.3, AWC, CIS.10, FPC.1, FPC.5, BCS, and CCS. Several P4P measures declined from Baseline to Program Year 1 that correspond to Objective 2.1. Those measures are ASM.2, SPR.2, CDC.3, CDC.5, and CDC.6. For the these P4P and non-P4P measures that declined, please describe the following:
▪ The QI tools (e.g., failure mode and effects analysis, process mapping, root cause analysis, fishbone diagram) and techniques that have been used to evaluate the reasons why measures declined.
▪ The identified causes for the declines.
◆ Objective 2.1: For any P4P and non-P4P rates that declined or did not reach the performance target please describe the following:
▪ What interventions have been identified that, once implemented, will likely improve performance? What interventions have been discontinued due to lack of improvement? What is the evaluation plan to evaluate the effectiveness of the planned intervention to verify that the interventions are having the desired effect?
◆ Objective 2.2: Please reference Attachment A. Display and discuss the Baseline and Program Year 1 rates for the measures that correspond to objective 2.2 that reached the performance target. Please describe the interventions that were implemented that positively impacted the P4P measure, CAD.3.
◆ Objective 2.2: Please reference Attachment A. Several P4P measures declined from Baseline to Program Year 1 that correspond to Objective 2.1. For the measures, SPR.3, HF.4, MH.4.1, and MH.4.2 please describe the following:
▪ The QI tools (e.g., failure mode and effects analysis, process mapping, root cause analysis, fishbone diagram) and techniques that have been used to evaluate the reasons why measures declined.
▪ The identified causes for the declines.
◆ Objective 2.2: For any rates that declined or did not reach the performance target please describe the following:
▪ What interventions have been identified that, once implemented, will likely improve performance? What interventions have been discontinued due to lack of improvement? What is the evaluation plan to evaluate the effectiveness of the planned intervention to verify that the interventions are having the desired effect?</td></tr>
<tr><td>Module 8: Objectives 2.3 and 2.4</td><td>July 2017</td><td>◆ Objective 2.3 and Objective 2.4: Please reference Attachment A. Display and discuss the Program Year 1 rates and Program Year 2 rates for the measures that correspond to objective 2.3 and 2.4 that reached the performance target and sustained that improvement to Program Year 2. Please describe the interventions that were implemented that positively impacted the non-P4P performance measure, RA.</td></tr>
</table>

Module Number and Title	Quarterly Quality Meeting	Description of Module and Activities to be Performed Quarters noted as: Q1: Jun-Aug; Q2: Sept-Nov; Q3: Dec-Feb; Q4: Mar-May
		Please describe the interventions that were implemented that positively impacted the P4P performance measure, HF.1, which reached the performance target in Program Year 1. ◆ **Objective 2.3 and Objective 2.4:** Please reference Attachment A. Several P4P measures **declined** from Baseline to Program Year 1 that correspond to Objective 2.3 and Objective 2.4. For the non-P4P measures, NEUR and OST, and the P4P measures, CAD.1, HPTN.1, MH.1, MH3.1, and MH3.2 that **declined**, please describe the following: ▪ The QI tools (e.g., failure mode and effects analysis, process mapping, root cause analysis, fishbone diagram) and techniques that have been used to evaluate the reasons why measures declined. ▪ The identified causes for the declines. ◆ **Objective 2.3 and Objective 2.4:** Please reference Attachment A. For any rates that **declined or did not reach the performance target** please describe the following: ▪ What interventions have been identified that, once implemented, will likely improve performance? What interventions have been discontinued due to lack of improvement? What is the evaluation plan to evaluate the effectiveness of the planned intervention to verify that the interventions are having the desired effect?
Module 9: Objectives 3.1 and 3.2	October 2017	◆ **Objective 3.2:** Please reference Attachment A. Display and discuss the P4P measure, HF.2, which achieved the performance target from Baseline to Program Year 1. Describe the interventions that were implemented that positively impacted the measure, which led to improvement. ◆ **Objective 3.1 and Objective 3.2:** Please reference Attachment D. Display and discuss the Program Year 1 rates and Program Year 2 rates for the non-P4P measures, CCHU.2 and MRP. The measure, CCHU.2, met the performance target in Program Year 1, but did not achieve the performance target for Program Year 2 (which was set to sustain the Program Year 1 rate). The measure MRP did not achieve the performance target in either program year. The P4P measure, ASM.3 did not achieve the performance target from Baseline to Program Year 1. For these measures that **did not achieve the performance target** (or sustain the performance target once it was achieved), please describe the following: ▪ The QI tools (e.g., failure mode and effects analysis, process mapping, root cause analysis, fishbone diagram) and techniques that have been used to evaluate the reasons why the performance targets have not been achieved. ▪ The identified causes for the declines. ▪ What interventions have been identified that, once implemented, will likely improve performance? What interventions have been discontinued due to lack of improvement? What is the evaluation plan to evaluate the effectiveness of the planned intervention to verify that the interventions are having the desired effect?

2015–2016 Quality Strategy Modules

Module Number and Title	Quarterly Quality Meeting	Description of Module and Activities to be Performed	Person/Entity Responsible
Module 1: NCCW Quality Strategy Overview	Quarter 1: September 22, 2014	Present the NCCW Quality Strategy and provide overview of the NCCW Quality Strategy, including purpose, scope, goals, governance and leadership, quality monitoring activities, and program evaluation. Present the four hypotheses that must be tested (according to Special Terms and Conditions of the NCC Waiver) in evaluating the program.	HSAG – Gretchen Thompson
Module 2: NCCW Goal #1	Quarter 2: January 2015	Presentation/Discussion about Objectives 1.1 through 1.5 (for Goal #1). Present on the following: ◆ **Objective 1.1:** Using a stacked bar graph, show the total number of enrollees (new enrollees and existing enrollees) for each month for June through November 2014. ◆ **Objective 1.2:** Using a stacked bar graph, show the number of enrollees stratified into each of the case management tiers (4 through 1) for each month June through November 2014. Show how many people are currently receiving case management (assessed and treatment plan developed) for each case management tier (stacked bar graph adjacent to the stratification bar graph is preferred.) ◆ **Objective 1.3:** For enrollees with complex (tier 4) and high (tier 3) risk needs, show the average number of days from identification to completing the assessment for each month that enrollees were identified. For example, for all enrollees identified in June (or May), list the average number of days that passed before the assessment was complete. Do the same for each month (June through November) and show pregnant enrollees separate from all other conditions. ◆ **Objective 1.4:** For enrollees with moderate (tier 2) and low (tier 1) risk needs, show the average number of days from identification to completing the assessment for each month that enrollees were identified. For example, for all enrollees identified in June (or May), list the average number of days that passed before the assessment was complete. Do the same for each month (June through November) and show pregnant enrollees separate from all other conditions. ◆ **Objective 1.5:** Discuss what interventions McKesson has put in place to increase utilization of primary care, ambulatory care, and outpatient services for enrollees with chronic conditions. How has McKesson tracked this over time? What results may be shared?	McKesson

Module Number and Title	Quarterly Quality Meeting	Description of Module and Activities to be Performed	Person/Entity Responsible
Module 3: NCCW Goal #2	Quarter 3: April 2015	Presentation/Discussion about Objectives 2.1 through 2.4 (for Goal #2). Present on the following: ◆ **Objective 2.1:** Referencing Table 3-1 and Table 3-2 of the NCCW Quality Strategy, show the trended results for all measures that correspond with Objective 2.1. Show results for June through November 2014. ◆ **Objective 2.2:** Referencing Table 3-1 and Table 3-2 of the NCCW Quality Strategy, show the trended results for all measures that correspond with Objective 2.2. Show results for June through November 2014. ◆ **Objective 2.3:** Referencing Table 3-1 and Table 3-2 of the NCCW Quality Strategy, show the trended results for all measures that correspond with Objective 2.3. Show results for June through November 2014. ◆ **Objective 2.4:** Referencing Table 3-1 and Table 3-2 of the NCCW Quality Strategy, show the trended results for all measures that correspond with Objective 2.4. Show results for June through November 2014. ◆ Summarize any trends noted in the data presented for Objectives 2.1-2.4. What interventions has McKesson implemented that may have had an impact on any positive trends? What interventions does McKesson have planned to improve rates for the measures associated with Objectives 2.1-2.4?	McKesson
Module 4: NCCW Goal #3 and Goal #4.	Quarter 4: July 2015	Presentation/Discussion about Objectives 3.1-3.2 (Goal #3) and 4.1 (Goal #4). Present on the following: ◆ **Objective 3.1:** Referencing Table 3-1 and Table 3-2 of the NCCW Quality Strategy, show the trended results for all measures that correspond with Objective 3.1. Show results for June 2014 through February 2015. ◆ **Objective 3.2:** Referencing Table 3-1 and Table 3-2 of the NCCW Quality Strategy, show the trended results for all measures that correspond with Objective 3.2. Show results for June 2014 through February 2015. ◆ **Objective 4.1:** Show trended results for all satisfaction surveys that have been administered. Has enrollee satisfaction improved over baseline? ◆ Summarize any trends noted in the data presented for Objectives 3.1, 3.2, and 4.1. What interventions has McKesson implemented that may have had an impact on any positive trends? What interventions does McKesson have planned to improve rates for the measures associated with Objectives 3.1, 3.2, and 4.1?	McKesson

Quarterly Quality Meeting Presentation
Instruction Guide *for* April 7, 2015 Meeting

Overview

The intent of this document is to provide McKesson with additional instruction for the Quarterly Quality Meeting presentations McKesson must provide. This document serves as a complement to the document, *Nevada Comprehensive Care Waiver (NCCW) Program, Quality Strategy Implementation and Program Monitoring*, which was provided to McKesson on December 12, 2014 via email. Table 1 of the document, *NCCW Quality Strategy Implementation and Program Monitoring*, which is also attached, lists four Quality Modules that guide the presentations McKesson must provide during the NCCW Quarterly Quality meetings.

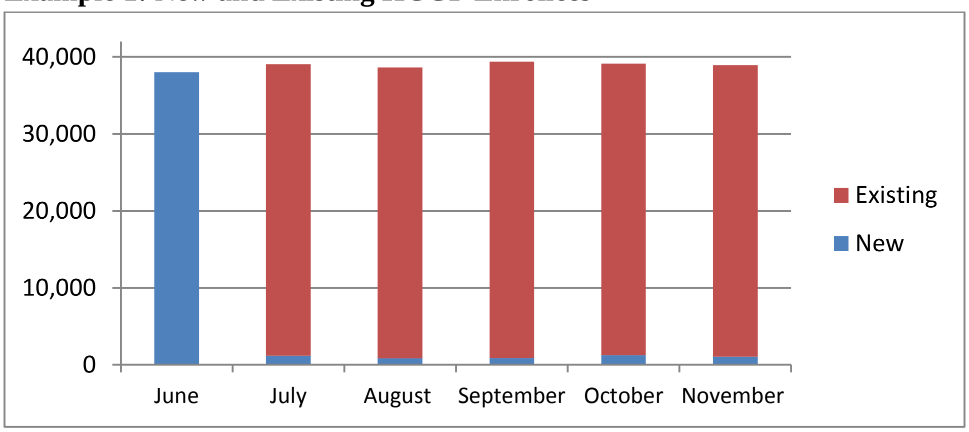
As shown in Table 1 of the *NCCW Quality Strategy Implementation and Program Monitoring* document, Module 1 consisted of the NCCW Quality Strategy presentation, which was provided by Gretchen Thompson of HSAG during the first Quarterly Quality meeting on September 22, 2014. The items in Module 2 were presented by McKesson during the second Quarterly Quality Meeting on January 13, 2015. Although most of the information was presented as required by Module 2, the information was not presented in the manner requested. Specifically, the instructions for producing graphs for Objectives 1.1 and 1.2 were not followed and will need to be part of McKesson's presentation during the third Quarterly Quality Meeting on April 7, 2015.

Instructions for the April 7, 2015 Quarterly Quality Meeting

For the third Quarterly Quality Meeting to be held on April 7, 2015, DHCFP staff asks that McKesson present the following four items:

Item 1. **Present the required information for Objective 1.1** (as indicated in Module 2): Using a stacked bar graph, show the total number of Health Care Guidance Program (HCGP) enrollees (new enrollees and existing enrollees) for each month for June through November 2014. (Please see Example 1 below, which shows six months of fictitious data.)

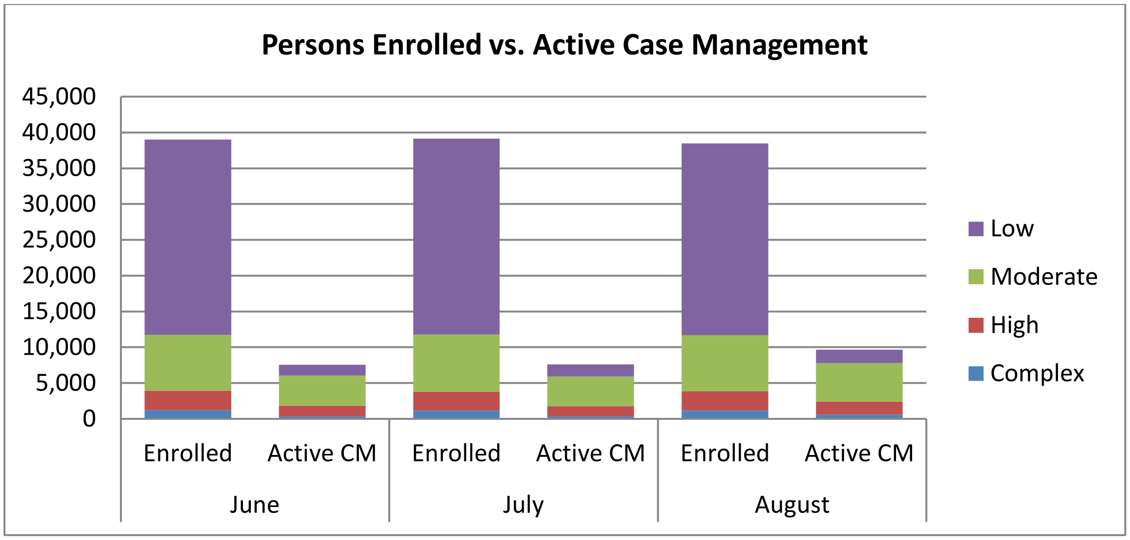
Example 1: New and Existing HCGP Enrollees



Item 2. **Present the required information for Objective 1.2** (as indicated in Module 2): Using a stacked bar graph, show the number of enrollees stratified into each of the case management tiers (4 through 1) for each month June through November 2014. Show the number of people who received case management services (telephonic or face-to-face assessment and treatment

plan developed) for each case management tier. (Please see Example 2 below which shows three months of fictitious data.)

Example 2: Persons Enrolled vs. Persons Actively Receiving Case Management (CM) Services



Item 3. **Present the information outlined in Module 3**. For Module 3, the DHCFP expects that McKesson will demonstrate its capability to collect data and report on the measures listed in Table 3-1 and Table 3-2 of the NCCW Quality Strategy that correspond to the objectives listed for Module 3 (Objectives 2.1, 2.2, 2.3, and 2.4). The NCCW Quality Strategy was presented to McKesson during the September 22, 2014 Quarterly Quality Meeting. A copy of the NCCW Quality Strategy was provided to McKesson in advance of the September 22, 2014 meeting. The DHCFP expects that McKesson will calculate rates for each of the measures for each month, June through November 2014[2], and note any trends in data over time. DHCFP staff understand that the rates reported for each measure for each month will not be the final rates reported by McKesson for the year; however, McKesson should demonstrate its capability to continually track its performance with these measures and show how McKesson's interventions are having a positive effect on the vulnerable population enrolled in the HCGP in relation to these measures. McKesson should include the numerator, denominator, and percentage rate for each performance measure that corresponds to Objectives 2.1, 2.2, 2.3, and 2.4 for each of the months, June, July, August, September, October, and November 2014. Further, McKesson should describe its planned interventions to improve rates for the measures associated with Objectives 2.1, 2.2, 2.3, and 2.4 in future months.

Item 4. **Present information contained in McKesson's FY 2014-15 Compliance Review Corrective Action Plan (CAP) response to DHCFP**. Specifically, please include the tables presented below and describe McKesson's planned approach to improve upon (a) the length of time that passes between identification/enrollment and care treatment plan development,

[2] The *NCCW Quality Strategy Implementation and Program Monitoring* description requests the results for September 2014 through February 2015 for Module 3. To allow McKesson the ability to capture and use all claims (including runout), the dates for reporting have been changed to June through November 2014.

and (b) the number of care management staff that provide care management services to enrollees.

a. Of the 39,543 persons enrolled in the program, 1,828 (4.6 percent) enrollees were served, where an assessment and care management plan were developed. On average, 72 days passed between the enrollment date and the date the enrollee was assessed by McKesson care managers. (Please include and address Tables A-1, A-2, and A-3.)

Table A-1—Persons Enrolled and Served in the HCGP				
Categories	Number of Persons Enrolled	Number of Persons Served	Percent of Total Enrolled Who were Served	Average Number of Days Between Enrollment and Completed Assessment
Complex (4)	314	83	0.2%	57 days
High (3)	2,282	451	1.1%	69 days
Moderate (2)	4,696	738	1.9%	81 days
Low (1)	32,251	556	1.4%	65 days
Total	**39,543**	**1,828**	**4.6%**	**Average 72 days**

Table A-2—Number of Days Between Enrollment and Assessment		
Assessment Completed with X-X Days of Enrollment	Number of Enrollees	Percent of Total Enrollees
0–30 days	427	23%
31–60 days	447	24%
61–90 days	265	14%
Greater than 90 days	689	38%
Total	**1,828**	**100%**

Table A-3—Enrollment for Pregnant Women		
Categories	Number of Pregnant Enrollees	Average Number of Days Between Enrollment and Completed Assessment
Complex (4)	0	N/A
High (3)	13	72 days
Moderate (2)	10	68 days
Low (1)	25	52 days
Total	**48**	**Average 61 days**

b. Please present the following information by risk level. Use the template provided in Table B-2:

   i. Percent of total population enrolled
   ii. Number of members enrolled by risk level
   iii. Number of actual members served by risk level
   iv. Percent of engagement (to include: Complex 50%, High 30%, Moderate 30%) + RTRs for each
   v. Number of Members engaged in HCGP (applying engagement rate)

vi. Proposed case ratios (reduced case ratios, per Betsy): Complex 1:35, High 1:100, Moderate 1:150, Low 1:200
vii. Required number of case managers to maintain CM ratio
viii. Actual Staff
ix. Overage/deficit of staff (after subtracting actual staff from the required number of case managers needed)
x. Actual case manager to actual served ratio

Table B-2 Care Management Program Staffing Explanation and Actual Case Manager Ratios Data as of February 2015										
Case Management (CM) Risk Level	Percent of Population	Max. Number of Enrollees Served by CM Risk Level	Number of Actual Enrollees Served for Feb. 2015	Percent of Members Engaged in Program	Total Number to be Served	Ratio 1 CM to: XX Enrollees	Number of Care Managers to Maintain CM Ratio	Number of Case Managers as of Feb. 2015	Overage/Deficit of Staff Based on Ratios	Actual Ratio of 1 CM to: Enrollees
Complex (4)	3%	1,186		50%	593	35	16.95			
High (3)	7%	2,768		30% + 250 RTR	1,080	100	10.80			
Moderate (2)	20%	7,909		30% + 250 RTR	2,623	150	17.48			
Low (1)	70%	27,680		500	500	200	2.50			
Total	**100%**	**39,543**			**4,796**		**47.73**			

Additional Guidance

DHCFP anticipates that the required information described in Items 1-4 above will require significant time for discussion during the April 7, 2015 Quarterly Quality Meeting. Thus, DHCFP asks that McKesson present Items 1-4 first and if time remains, McKesson may discuss key accomplishments and case studies.