BRIAN SANDOVAL
Governor

RICHARD WHITLEY, MS
Director

MARTA JENSEN
Acting Administrator

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH CARE FINANCING AND POLICY
1100 E. William St., Suite 101
Carson City, Nevada 89701
Telephone (775) 684-3676 • Fax (775) 687-3893
http://dhcfp.nv.gov

November 30, 2016

Patricia Hansen, Ed.D.
Centers for Medicare & Medicaid Services
State Demonstrations Group (SDG)
7500 Security Blvd.
Baltimore, MD 21244

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

Dear Ms. Hansen:

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 July 1, 2016 – September 30, 2016, or Federal Q4/2016.

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

Enclosures

Cc: Elizabeth Aiello, Deputy Administrator
Gloria Macdonald, Chief, Program, Research and Development

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

Demonstration Year: 3 (7/1/2015 – 6/30/2016)
Federal Fiscal Quarter: 4 (07/01/16 – 09/30/16)

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** (09/30/16)	**Disenrolled in Current Quarter** (09/30/16)	**Current Enrollees** (10/31/16)
Population 1: MAABD	21,606	0	22,050
Population 2: TANF/CHAP	16,696	0	16,876
Total:	38,302	0	38,926

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** (09/30/16)	**Disenrolled in Current Quarter** (09/30/16)	**Current Enrollees** (10/31/16)
Diagnosis 1: Asthma	5,494	0	5,617
Diagnosis 2: Cerebrovascular disease, aneurysm, and epilepsy	3,365	0	3,471
Diagnosis 3: Chronic obstructive pulmonary disease, chronic bronchitis, and emphysema	3,217	0	3,225
Diagnosis 4: Diabetes mellitus	3,787	0	3,845
Diagnosis 5: End stage renal disease and chronic kidney disease	1,392	0	1,389

Note: *

Demonstration-Qualifying Conditions (in person counts)	**Enrolleed in Current Quarter** (09/30/16)	**Disenrolled in Current Quarter** (09/30/16)	**Current Enrollees** (10/31/16)
Diagnosis 6: Heart disease and coronary artery disease	2,413	0	2,452
Diagnosis 7: HIV/AIDS	328	0	328
Diagnosis 8: Mental health	22,594	0	23,013
Diagnosis 9: Musculoskeletal system	7,950	0	8,065
Diagnosis 10: Neoplasm/cancer	251	0	246
Diagnosis 11: Obesity	4,292	0	4,410
Diagnosis 12: Substance use disorder	7,425	0	7,470
Diagnosis 13: Pregnancy	2,774	0	2,894
Diagnosis 14: Complex Condition/High Utilizer	657	0	678

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

Determinations

The following chart reflects data on demonstration eligibility determinations during Q4/2016 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 38,000 enrolled beneficiaries at quarter ending 09/30/16

Disenrollment's

The following chart reflects data on demonstration disenrollments during Q4/2016 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 Q4/2016 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 Q4/2016 with a steady monthly enrollment average of 38,000 members.

Outreach/Innovative Activities

The DHCFP continued CMO outreach activities with AxisPoint Health (APH) during Q4/2016. The following chart lists the outreach activities for Q4/2016.

Date	Outreach Activity	Summary of Activity
July 2, 2016	Elko Bands Council Elko, Nevada	Dr. Thomas McCrorey and AxisPoint Health (APH) staff Roman met with the Elko Bands Council. Dr. McCrorey spoke with Chris Atine, MSW at Bureau of Indian Affairs (BIA) and Larry Clark, YCB. There was discussion regarding collaboration between the Health Care Guidance Program (HCGP) and the Elko Band Social Workers to members who live on federal, sovereign land. There

Date	Outreach Activity	Summary of Activity
		will be a follow up meeting with partners at Indian Health Services once their new community Social Worker has been hired. Next meeting will be 9/16/2016 from 1:30-3:00 at the BIA Conference room or the call in number is 775-450-4461.
July 12, 2016	Douglas County Health Coalition Douglas, Nevada	Dr. Thomas McCrorey met with the Douglas County Health Coalition. There were multiple health care stakeholders present including; Deputy Fire Chief Fogerson, Chief Schreiens from Carson City, and the new County Health Officer Dr. Holman. Multiple reps from Carson Valley Medical Center (CVMC). Dr. McCrorey and Cheri Glockner engaged in a discussion of forming an advisory committee for the public health board which is mostly the sheriff and county commissioners. There was additional discussion regarding the upcoming Flu Vaccine campaign for the fall. There will not be free flu vaccine from the CDC this year. This is due to the fact that everyone is supposed to have insurance now (ACA). So they will need to do insurance verification/billing at any vaccine outreach. Douglas looking at doing it in the 3rd weekend in October. They are talking about a drive thru/stay in car program. This type of program has worked in Utah and is found to be popular with

Date	Outreach Activity	Summary of Activity
		Seniors. There is still the need to work in an insurance card copying system. The program may use volunteer runners. Smart phones can easily work but HIPAA issues are a problem for that. A discussion of pricing took place. The vaccinations are cheaper at some pharmacies but it may be due to them using the trivalent vaccine instead of quadrivalent. Advisory Committee on Immunization Practices (ACIP) recommends 4-valent. Cheri volunteered to help but we might have a Community Health Worker (CHW) that can help by that time. There was discussion regarding the Non Emergency Transportation Provider, Medical Transportation Management (MTM). The Washoe Tribal Clinic Director wanted to know more regarding this program and its options. Chief Schrieiens discussed signing up to be a provider and Cheri and Dr. McCrorey discussed the overall program for the members.
July 20, 2016	Carson Tahoe Regional Medical Center Carson City, Nevada	Dr. Thomas McCrorey and Cheri Glockner had a discussion with stakeholders. There was minimal promotion of the HCGP but Dr. McCrorey and Mrs. Glockner participated in the discussion/ voting of health needs.

Date	Outreach Activity	Summary of Activity
July 28, 2016	Touro University Teleconference	Dr. Thomas McCrorey met telephonically with Patricia Valdovinos. Patricia has questions about the HCGP. Although she had some knowledge of the program, along with previous notes from Dr. Khan visit, there was some concern by doctors (Dr. Carlson specifically) about what the doctors need to do. As the program is mandatory Dr. McCrorey explained the nature of the program. Although it is mandatory for everyone involved there really is no additional work for the doctors, or any of the recipients. Dr. McCrorey talked about meeting with resident receptors. Dr. Carlson is in charge for the residents. Dr. McCrorey proposed a possible residency presentation like the one done in the past for University of Nevada, Reno (UNR) and University of Nevada, Las Vegas (UNLV). Patricia agrees that they would like a residency presentation. A sit down meeting with Dr. McCrorey or one of APH's Las Vegas Care Managers (CM) was also discussed as a possibility. Patricia seemed pretty happy about the discussion.
August 3, 2016	Southern Nevada Adult Mental Health Facility (SNAMHS) Las Vegas, Nevada	Beacon Health Solutions staff members; Lizotte, Tave, Holmes, and Simmons were present for the discussion with Southern Nevada Adult Mental Health (SNAMHS). There was discussion to gather

Date	Outreach Activity	Summary of Activity
		information on Peer Certification and establishing a Nevada Peer Network and a Peer to Peer routine call/meeting.
August 4,5, 2016	New Orleans Conference Center Las Vegas, Nevada	APH's team member White attended the conference. The Forensic Assessment Services Treatment TEAM (FASTT). Discussed how providers are using a Hybrid service that involves a Pre-Arrest program, and a Post booking program that incorporates the best qualities of each to affect a more immediate response to the mental health needs of the community. The FASTT, which is a community based model of service delivery in a correctional setting. Therapists help to deliver mental health services and determine what resources are available to inmates while incarcerated. The Goal of the FASTT is to determine the best to ways to assess, treat, and transfer people with mental illnesses from custody to the community based mental health system to ensure there are adequate services for mental health triage. Early Intervention: WestCare Mobile Outreach: This resource operates in So. Nevada and the intent of the WestCare team is to reduce the imprisonment of local mentally ill citizens while simultaneously increasingly the safety of the public. Northern Nevada Hopes: Began in 1997-Small HIV clinic in Downtown Reno and after

Date	Outreach Activity	Summary of Activity
		extensive research, is designated as a Community Health Center, provides Behavioral Health, outreach to those with HIV/AIDS, and offers integrated BH/substance abuse and community education, Clinical Professional Counselor (CPC), pharmacy, and case management, transportation, and free HIV testing. Services are low barrier and offered on a low sliding fee scale to those that qualify. Co-occurring Disorders and Treatment Options: Treatment for co-occurring disorders should be based on evidence based practices for each disorder with flexibility to modify as treatment advances. The diagnosis for a substance use disorder is based on a pattern of behavior. There are eleven criterion used for identifying and diagnosing a substance use disorder. They are: increased use or quantity of substance, unsuccessful attempts to cease substance use, spending a large amount of time obtaining, using, or recovering from substance use, craving, the inability to fulfill social obligation, continued use despite problems associated with substance use, decrease in activities due to substance use, using the substance when it is physically hazardous, use of a substance despite psychological and physical effects, tolerance and withdrawal. The individual may want to decrease drinking

Date	Outreach Activity	Summary of Activity
		alcohol. For example, they buy a six pack and end up drinking a twelve pack and then some more. This person has impaired control of their substance use. Unsuccessful attempts to cease substance use are also associated with impaired control. The individual constantly fails at repeated attempts to abstain from substance use. The third criterion is spending a large amount of time obtaining, using, or recovering from substance use. For example, some cocaine addicts may work all day or week until pay day. They then take their earnings and spend them on cocaine. They usually gather at a known crack house, where they can be for days. Craving is when an individual is "geeking", or has an intense urge to indulge in a substance. Some people crave a cigarette after dinner or during a hot cup of coffee. The inability to fulfil social obligations can be characterized when an alcoholic is too intoxicated to go to work. Continued use despite the problems, such as occasions and not showing up at work, associated with alcohol is another criterion. Sleeping all day because of an intense hangover or sickness caused by substance use causes a decrease in activities. The board issues mental health licenses and substance abuse treatment licenses (SAMHSA, 2005).

Date	Outreach Activity	Summary of Activity
		It is important to use an integrated approach to treating a client with co-occurring disorders because it promotes the quality of service by decreasing the burdens clients encounter when trying to access services (SAMHSA, 2005). Navigating through multiple service systems may discourage clients from receiving services. Integrating the treatment approach helps the client access services easier. The experience has been productive and I was able to network with some very impressive individuals.
August 5, 2016	Washoe County Senior Service 1155 E 9th Street Reno, Nevada	Beacon Health Solutions staff member Villalvazo met with Social Services Supervisor Trisha Beaupre for the Adult Day Health Care. Adult day care only bills for services provided within daycare. This does not include case management. Trisha will verify Electronic Verification System (EVS) for Care Management Organization (CMO). HCGP eligibility is checked and they then make a referral to HCGP for case management, if appropriate. If referral is made Trisha agreed to notify legal guardian of referral and provide HCGP contact information. Trisha reported the majority of adult day care participants are dual eligible; Medicare/Medicaid.

Date	Outreach Activity	Summary of Activity
August 13, 2016	Huntridge Family Clinic 1830 E Sahara Avenue Suite 201 Las Vegas, Nevada	APH staff member Doss met with the facility. An HCGP introduction on the Provider Manual, and Real Time Referral (RTR). The facility accepts Fee for Service (FFS) and HIV positive beneficiaries. Spoke with Rob Phoenix APRN.
August 15, 2016	Clover Counseling Reno, Nevada	APH staff member Thun met with Patrick Tanner. He is the owner/operator of Clover Counseling. There were two other counselors present; Kirk Fenton, and Deacon. There was a discussion regarding the referral process, and APH was told that the clinic prefers to be called when the HCGP has a referral.
August 17, 2016	Sunrise Hospital Meeting Las Vegas, Nevada	APH staff Dr. McCrorey and Debbi Svab attended meeting with Sherry Siewers (Chief of Case Management), Dr. Jeff Murawsky (Sunrise Chief Medical Officer). Discussion of where we are with getting ADT data from Sunrise facilities. They seemed to think that their corporate offices are the issue in closing this gap as they have to approve the request. Corporate reports having never heard of giving Medicaid this kind of data before and apparently don't make decisions rapidly there. But Mr. Hoffenberg seemed to think they were inclined to grant the approval. Dr. McCrorey pointed out that if they have real trouble with the

Date	Outreach Activity	Summary of Activity
		information sharing they should talk to Medicaid as it is Medicaid's responsibility to get this data to us, according to the contract. Dr. McCrorey gave a brief update/overview about the HCGP. It did not appear they were very familiar with it or even care management, later though Dr. Murawsky showed a great knowledge of population health and care management. He said he is on a Board of health for Nevada. Dr. Murawsky mentioned that Nevada is now 51st in the country for primary care providers per capita. I thought that Idaho was worse but he stated they have been aggressively paying residents to stay in Idaho or come there. So we are now the worst for access. at least for PCPs. We didn't discuss surgical specialties or medicine subspecialties. But Nevada used to be really bad for those too. They felt the main drivers of Sunrise admissions in Medicaid were Etoh intoxication, other substance abuse, and COPD exacerbation. Sherry mentioned some concerns they have. Skilled Nursing Facility (SNF) access is very poor and they end up doing that in house. But don't get paid properly. She mentioned there are not enough Psych beds in the area. Dr. McCrorey mentioned that Medicaid was well aware of this issue, and that hopefully some of that would be alleviated

Date	Outreach Activity	Summary of Activity
		by new psych hospitals in northern and southern Nevada. Dr. McCrorey believes there is a new psych ward opening in one of the general hospitals in LV. Sherry was concerned about what to do about long term Abx use in Medicaid members with osteomyelitis, etc. payment scheme not set up to help people who are not in the hospital but not a reason for long term admission.
August 20, 2016	Western Nevada College (WNC) Gala; Community Event Carson City, Nevada	APH staff Gorden, McCrorey, and Glockner attended the event. There was slight networking involved within interactions with others.
August 20, 2016	Carson Valley Medical Center; Family Health and Wellness Fair and Color 5K Run Gardnerville, Nevada	The Health Care Guidance Program/Beacon Health Care Options participated with Carson Valley Medical Center in Gardnerville, NV for its annual Family Health & Wellness Fair and Color 5K Fun Run on Saturday, August 20th. Our booth offered information and resources to the public, providers and those on FFS Medicaid.
August 23, 2016	Southern DHCFP Meeting Teleconference	Beacon Health staff member Lorna Lizotte attended the quarterly meeting at DHCFP in Las Vegas. Lorna met with Shawn Vollmer and staff (Stephanie, Stephanie, and Phil) Pat Regan (APH) Stephanie White (Beacon) via conference line.

Date	Outreach Activity	Summary of Activity
		Reviewed specific Medicaid / HCGP member cases Discussed Medical Day Treatment provided in Colorado Provider out of state agreements PCA Agency Loving Care that is difficult to contact DHCFP provided a current list of Personal Care Assistants (PCA) agencies and will continue to email list as they are updated. Reviewed an RTR that is outstanding. Next meeting date in October to be scheduled by Lorna.

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.

Operational Developments/Issues

The DHCFP held its Quarterly Health Care Guidance Meeting on July 26, 2016. At the meeting, AxisPoint Health (APH) presented the following:

- Program Updates, presented by Cheri Glocker, HCGP's Executive Director
  - Updated program capacity plan to correlate staffing, enrollment and geographic distribution. Received corporate support and approval to add 10 positions to the HCGP.
  - Continued collaborate effort to calibrate data sets between APH/Milliman (states actuary) and Hewlett Packard Enterprises (HPE, states fiscal agent) to calculate Program Year (PY1) One results.
  - APH worked with Medical Transportation Management (MTM) to ensure a smooth transition of HCGP members.
  - Worked with Division of Healthcare Financing and Policy (DHCFP) to update "serious occurrence" process.
  - Continued to work with Nevada Emergency Medical Services (EMS) providers to integrate HCGP with community Paramedicine.
  - HCGP presented updated organizational chart and update on staffing.
- Quality Module #4, Goal #3 (3.1 and 3.2) and Goal #4 (4.1)
  - HCGP presented on how the program is meeting Objective 3.1: Reduce hospital readmission by 10 percent. Data presented were preliminary results generated by using operational data sets. APH presented on interventions that may have had an impact on any positive trends such as; access to hospital census information (unavailable or inconsistent), to some extent precludes from immediate contact with members during discharge. Challenges APH poses: Inconsistent receipt, and security processes around

risk management are burdensome. Successes: Receiving timely data for largest system (Valley) in the state. In the future APH is looking into obtaining data for the largest hospital (Sunrise) in the state. APH plans to improve the rates for the measures associated with objective 3.1 by expanding access to census data.

- Objective 3.2: Reduce emergency department utilization by 10 percent. Data presented were preliminary results generated by using operational data sets. APH, presented on interventions implemented that may have had an impact on any positive trends such as; improved care manager to member coaching, clinical alerts regarding medication adherence, seasonal IVR programs throughout the year, promotion of Guide Point. APH plan on improving measurement associated with Objectives 3.1 by introduction of ELIZA to reinforce use of Guide Point, across entire program population.
- Objective 4.1: Nevada Comprehensive Care Waiver (NCCW) enrollee satisfaction improves over baseline. The Medicaid pre/post health plan satisfaction survey has been updated to include two questions which focus on program satisfaction. The survey written in English and Spanish and mailed out yearly at the end of July to all beneficiaries enrolled in the program. The 2016 program year 2 will be compared to program year 1 survey 2015 as well as the survey results from the pre-program survey sent in 2014. Below are the survey results:

Year	Response rate
2014	9.0%
2015	9.1%
2016	Responses are being collected

- Dr. Thomas McCrorey, Medical Director for the HCGP provided an update on provider outreach, activities included the following:
  - APH has participated on more than 30 provider outreach events with multiple stakeholders in the medical and public health community
  - 2 formal presentations to Medical Students and Residents at UNR/UNLV
  - Cooperation with Community Paramedicine a focus of several provider meetings
  - Provider Advisory Board – "Medicaid News Updates"
- Other Medical Director Duties:
  - Case review of complex cases; formal monthly meetings with entire team and immediate review of problematic cases as needed.
  - Review of pharmacy alerts (clinical care alerts)
  - Assist in relationships between hospitals, Medicaid/HPE
  - Try to stay abreast of changes in care management and population health/public health
- On September 22–23, 2016, HSAG conducted the annual Performance Measure Validation (PMV) audit. AxisPoint Health (APH) collects and reports and accurate performance measure data for contractually required performance measures. To verify accuracy of reported rates by APH, DHCFP contracted with Health Services Advisory Group, Inc. (HSAG), the States external quality review organization (EQRO), to validate the performance measure rates calculated and reported by APH. To ensure that the PMV activity is performed with industry standards of practice, HSAG validated APH performance using the external quality review (EQR) Protocol $2^{1\text{-}16}$ developed by CMS as its guide. HSAG's PMV activity focused on the following objectives:
  - Assess the accuracy of the required performance measures reported by APH
  - Determine the extent to which the measures calculated by APH follow DHCFP's specifications and reporting requirements.
- HSAG auditors collected information from APH staff members using several methods, which included interviews, system demonstration, review of data output files, primary source

verification, observation of data processing, and review of data reports. The on-site activities included the following:

- **Opening session**— The opening session included introductions of the validation team and key AxisPoint Health staff members involved in the performance measure validation activities. Discussion during the session covered the review purpose, the required documentation, basic meeting logistics, and queries to be performed.
- **Evaluation of system compliance**—The evaluation included a review of the information systems, focusing on the receipt and handling of enrollment and disenrollment data. Additionally, HSAG evaluated the processes used to collect and calculate the performance measures, including accurate numerator and denominator identification, and algorithmic compliance (which evaluated whether rate calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately). Based on the desk review of the Information Systems Capabilities Assessment Tool (ISCAT), HSAG conducted interviews with key AxisPoint Health staff members who were familiar with the processing, monitoring, and calculating performance measures. HSAG used interviews to confirm findings from the documentation review, and clarify outstanding issues.
- **Overview of data integration and control procedures**—The overview included discussion and observation of source code logic, a review of how all data sources were combined, and how the analytic file used for reporting the performance measures was generated. HSAG performed primary source verification queries and a walk-through of source code files to further validate the output files. HSAG also reviewed any supporting documentation provided for data integration.
- **Closing conference**—The closing conference summarized preliminary findings based on the review of the ISCAT and the on-site visit, and reviewed the documentation requirements for any post-on-site activities.
- The PMV audit examined 22 non-P4P measures. All of the measures were determined to be reportable by APH for this year; however, there were several issues identified during the on-site audit. Some measures may need further discussion with DHCFP for future reporting. See attachment titled "2015-2016 Validation of Performance Measures for AxisPoint Health", page 10 for those detailed remedial actions that need to be corrected.

- DHCFP staff worked with HSAG in providing input on activities that took place during State Fiscal Year 2015-2016 for preparation of the annual technical report (see attachment titled NV2015-16_ EQR TechRpt). HSAG provided technical assistance to the DHCFP with activities related to the Nevada Comprehensive Care Waiver (NCCW) program. HSAG's technical assistance activities included:
  - Implementing the NCCW Quality Strategy and developing a set of quality modules that the HCGP vendor must use to guide its quality-related presentations during the quarterly meetings.
  - Tracking the NCCW 1115 Demonstration Evaluation Design Plan.
  - Reviewing the corrective action plans that resulted from the HCGP compliance review, which is presented in Section 8.
  - Performing source code review of the programming code used to calculate pay for performance (P4P) measures used for the NCCW program, which will be calculated by the DHCFP's actuary.
  - Performed performance measure validation audit of non-P4P measures used to monitor the HCGP's progress in achieving the goals and objectives of the NCCW demonstration waiver.
- DHCFP staff, the states actuary Milliman and the HCGP continue to work together in preparation of Program Year 1 (PY1) results. Milliman will be presenting on the PY1 for the Pay for

Performance (P4P) measures and APH will be presenting on the Non Pay for Performance (Non P4P) Measures for PY1 on October 21, 2016.

Care Management Contracting

- Within FFY16 Q4/2016, the DHCFP received approval from CMS on obtaining approval for Amendment #4 Attachment AA. The purpose of Amendment #4 is to update the contract language to match the STC's Attachment B. The DHCFP followed CMS guidance to revise the "Reconciliation Methodology "in Attachment B of the STC's. In addition, the DHCFP amended the following:
    - ICD-9 language to remove the numerical version to avoid additional amendments due to a change in ICD codes.
    - The Nevada Data Extra Table was updated to match the program launch date of June 2014.
    - Removal of procedure codes under "Additional condition inclusion criteria are as follows" to match the STC's.
- The DHCFP continues to work with CMS, and the CMO Vendor on Amendment #5. The purpose of this amendment is to extend the CMO contract term an additional two years ending June 30, 2018 and make minor language updates to Attachment AA.

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

There are no financial developments/issues/problems with accounting or budget neutrality to report for this quarter (Q4/2016).

Member Month Reporting

Demonstration Populations	Month 1 (July 2016)	Month 2 (August 2016)	Month 3 (September 2016)	Total Ending (October 2016)
Population 1: MAABD	21,575	21,615	21,606	22,050
Population 2: TANF/CHAP	16,677	16,882	16,696	16,876
Total:	38,252	38,497	38,302	38,926

Consumer Issues

There are no consumer issues to report for this quarter (Q4/2016).

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 (Q4/2016), 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 submitted revisions to CMS on July 28, 2015. As of today we have not received additional feedback from CMS regarding and/or final approval from CMS regarding the Evaluation Design Plan.

Enclosures/Attachments

- FFY16 QTR 4 Cover Letter
- HCGP Quarterly Minute Meeting 04-26-16 Final
- NV Quarterly Meeting Agenda 07262016 Final
- HCGP Quarterly Meeting Sign In Sheet 072616
- HCGP July 2016 Quarterly Presentation
- APH_rpt_ NV2015-16_PMV
- NV2015-16 EQR TechRept

State Contact(s)

DHCFP staff

Name	Title	Phone #	Fax #	Address
Elizabeth (Betsy) Aiello	Deputy Administrator	775-684-3679	775-684-3774	1100 E. William St. Carson City, NV 89701
Gloria Macdonald, Program Research and Development Unit (PRD)	Chief	775-687-8407	775-684-3643	1100 E William St. Carson City, NV 89701
Gladys Cook, CMO Project- Quality Lead Monitor	Social Services Program Specialist III	775-684-7596	775-684-3643	1100 E. William St. Carson City, NV 89701
Rachel Marchetti CMO Liaison	Social Services Program Specialist II	775-684-3617	775-684-3643	1100 E. William St. Carson City, NV 89701
John Kucera, Operational Analytics and Data Quality	Management Analyst III	775-684-3631	775-684-3643	1100 E. William St. Carson City, NV 89701
Lisa Koehler Contract Manager	Management Analyst III	775-684-3708	775-684-3643	1100 E. William St. Carson City, NV 89701

Date Submitted to CMS

November 30, 2016

State of Nevada
Division of Health Care Financing and Policy

2015-2016 Validation of Performance Measures

for

AxisPoint Health

November 2016

HSAG HEALTH SERVICES ADVISORY GROUP

Contents

1. Validation of Performance Measures

Validation Overview

On April 24, 2012, the State of Nevada Department of Health and Human Services (DHHS), Division of Health Care Financing and Policy (DHCFP) submitted to the Centers for Medicare and Medicaid Services (CMS) a Medicaid section 1115 Research and Demonstration proposal entitled the Nevada Comprehensive Care Waiver (NCCW). The NCCW program is a comprehensive demonstration that seeks to improve the value of the Medicaid delivery system and assist the DHCFP in reaching its goal to expand enrollment of a target population into a managed Fee-for-Service (FFS) system.

In February 2012, the DHCFP issued a request for proposal (RFP) to contract with a care management organization (CMO) to administer care management services to NCCW program enrollees. The NCCW program mandates care management services throughout the state for a subset of high-cost, high-need beneficiaries not served by the existing managed care organizations. The DHCFP awarded a contract to McKesson Health Solutions, which later changed its name to McKesson Technologies, Inc. (McKesson), to serve as the State's CMO. The contract took effect November 12, 2013, and McKesson implemented the Nevada Health Care Guidance Program (HCGP) with a program start date of June 1, 2014. The first day of McKesson's operations, however, was Monday June 2, 2014. On June 2, 2015, Comvest Partners purchased McKesson Technologies, Inc.'s care management business, which is now doing business as AxisPoint Health.

The DHCFP seeks to verify that, on an annual basis, AxisPoint Health collects and reports complete and accurate performance measure data for contractually required performance measures. To verify the accuracy of reported rates by AxisPoint Health, DHCFP contracted with Health Services Advisory Group, Inc. (HSAG), the State's external quality review organization (EQRO), to validate the performance measure rates calculated and reported by AxisPoint Health. To ensure that the performance measure validation (PMV) activity is performed in accordance with industry standards of practice, HSAG validated AxisPoint Health's performance measures using the external quality review (EQR) Protocol 21 developed by CMS as its guide. HSAG's PMV activity focused on the following objectives:

1. Assess the accuracy of the required performance measures reported by AxisPoint Health
2. Determine the extent to which the measures calculated by AxisPoint Health follow DHCFP's specifications and reporting requirements

[1] *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 1, 2012.

Care Management Organization Information

Basic information about AxisPoint Health is shown in Table 1, including the office location(s) involved in the 2016 validation of performance measures activity.

Table 1—AxisPoint Health Information

CMO Location:	11000 Westmoor Circle, Suite 125 Westminster, CO 80021
CMO Contact:	Michelle Searing Outcomes Operations Manager
Contact Telephone Number:	720.598.7100
Contact E-mail Address:	Michelle.searing@axispointhealth.com
On-site Review Date:	September 22–23, 2016

Performance Measures Validated

HSAG validated rates for the following set of performance measures selected by DHCFP for validation. The measures primarily consisted of performance measures that were contractually required by the DHCFP, but not part of the HCGP pay-for-performance (P4P) program. These measures are herein referred to as the non-P4P measures. The DHCFP provided the specifications AxisPoint Health was required to use for calculation of the performance measures in Attachment II of the AxisPoint Health contract (RFP/Contract #1958). Table 2 below lists the performance measures that HSAG validated under the scope of this audit. The measurement period for which the PMV was conducted was identified as Program Period 2 (i.e., June 1, 2015 through May 30, 2016).

Table 2—List of Performance Measures

	Measure ID	Non-P4P Measure Name
1	CCHU.1	Ambulatory Care-Sensitive Condition Hospital Admission
2	CCHU.2	"Avoidable" Emergency Room Visits
3	FUP	Follow-Up with PCP After Hospitalization
4	MRP	Medication Reconciliation Post-Discharge
5	DEM	Cognitive Assessment for Dementia
6	NEUR	Stroke and Stroke Rehabilitations – Discharged on Antithrombotic Therapy
7	CKD	Adult Kidney Disease – Laboratory Testing (Lipid Profile)

Measure ID		Non-P4P Measure Name
8	RA	Disease-modifying Anti-Rheumatic Drug (DMARD) Therapy for Rheumatoid Arthritis
9	OST	Osteoporosis – Pharmacologic therapy for men and women aged 50 years and older
10	OBS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
11	CAP	Children and Adolescents' Access to Primary Care Practitioners
12	W15	Well-Child Visits in the First 15 Months of Life
13	W34	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
14	AWC	Adolescent Well-Care Visits
15	CIS	Childhood Immunization Status
16	PPC	Prenatal and Postpartum Care
17	WOP	Weeks of Pregnancy at Time of Enrollment
18	FPC	Frequency of Ongoing Prenatal Care
19	ABA	Adult BMI Assessment
20	BCS	Breast Cancer Screening
21	CCS	Cervical Cancer Screening
22	COL	Colorectal Cancer Screening

Description of Validation Activities

Pre-audit Strategy

HSAG conducted the PMV activities using aspects of the validation activities that are outlined in the CMS performance measure validation protocol. HSAG obtained a list of the performance measures that were selected by DHCFP for validation. HSAG assembled a validation team based on the full complement of skills required for validating the specific performance measures and conducting the information system review. The team was composed of a lead auditor and several team members. HSAG provided technical assistance to AxisPoint Health staff throughout the audit process.

HSAG prepared and sent a documentation request letter to AxisPoint Health, which outlined the steps in the PMV process. The document request letter included a request for source code for each performance measure, a completed Information Systems Capabilities Assessment Tool (ISCAT), any additional supporting documentation necessary to complete the audit, and a timetable for completion and instructions for submission. The ISCAT was customized to collect information regarding the necessary data that are consistent with the Nevada HCGP and the NCCW special terms and conditions (STCs). HSAG responded to ISCAT-related questions received directly from AxisPoint Health during the pre-on-site phase.

Upon receiving the completed ISCAT and requested supporting documents, HSAG conducted a desk review of all the materials and noted any issues or items that required further follow-up. An agenda associated with the on-site visit was then sent to AxisPoint Health on August 29, 2016. The agenda described the on-site activities and indicated the type of staff AxisPoint Health would need to make available for interviews for each session. In addition, staff members from HSAG, DHCFP, and AxisPoint Health participated in a kick-off conference call on August 30, 2016 to discuss issues identified from the ISCAT desk review, and to discuss the on-site visit agenda, logistics and expectations, as well as important deadlines. HSAG also requested that the preliminary rates be provided by AxisPoint Health before the on-site audit. AxisPoint Health provided the preliminary rates on September 19, 2016.

Prior to the on-site visit, HSAG also conducted an extensive review of AxisPoint Health's source code used to calculate the non-P4P measures. HSAG source code reviewers performed a line-by-line review on the source codes to assess whether the codes were developed according to the non-P4P measure specifications detailed in AxisPoint Health's contract with the DHCFP. Findings of the source code review were provided to AxisPoint Health, and all issues were resolved prior to the on-site audit. Following the approval of the source code, the preliminary rates were calculated by AxisPoint Health and provided to HSAG. This strategy allowed HSAG to review numerators, denominators and rates to tailor the on-site review around any potential issues identified with the calculations.

Validation Team

The HSAG PMV team was assembled based on the full complement of skills required for the validation and requirements for this PMV activity. The validation team roles, skills, and expertise are detailed below in Table 3.

Table 3—Validation Team

Name and Role	Skills and Expertise
Mariyah Badani, JD, MBA, CHCA *Director, Audits/State & Corporate Services*	Management of audit department, Certified HEDIS Compliance Auditor (CHCA) with multiple years of auditing experience, data integration, systems review, and analysis.
David Mabb, MS, CHCA *Lead Auditor*	CHCA, performance measure knowledge, source code/programming knowledge, and statistics and analysis expertise.
Timea, Jonas, CHCA	CHCA with multiple years of auditing experience, data integration, systems review, and analysis.
Tammy GianFrancisco *Project Manager, Audits/State & Corporate Services; Source Code Review Manager*	Coordinator for the audit department, liaison between the audit team and clients, manages source code review activities, and manages deliverables and timelines.
Dan Moore, MPA *Source Code Reviewer*	Source code/programming knowledge.

Technical Methods of Data Collection and Analysis

The CMS PMV protocol identifies key types of data that should be reviewed as part of the validation process. The following list describes the type of data collected and how HSAG conducted an analysis of these data:

- **Information Systems Capabilities Assessment Tool (ISCAT)**—AxisPoint Health was required to submit an ISCAT prior to the on-site audit. The ISCAT was customized to collect information regarding the data necessary for reporting the performance measures. HSAG responded to ISCAT-related questions received directly from AxisPoint Health during the pre-on-site phase.
- **Source code (programming language) for performance measures**— AxisPoint Health wrote the programming source code used for 2016 calculation and reporting. All performance measures under the scope of this review were reviewed and approved by HSAG source code reviewers. HSAG auditors also reviewed source code on-site for measures with rates that appeared suspect.
- **Prior Years' Validation of Performance Measures reports**—HSAG reviewed previous years' reports to assess for trending patterns, appropriate populations, and rate reasonability.

On-Site Activities

On September 22–23, 2016, HSAG conducted the on-site visit with AxisPoint Health. HSAG auditors collected information from AxisPoint Health staff members using several methods, which included interviews, system demonstration, review of data output files, primary source verification, observation of data processing, and review of data reports. The on-site activities included the following:

- **Opening session**—The opening session included introductions of the validation team and key AxisPoint Health staff members involved in the performance measure validation activities. Discussion during the session covered the review purpose, the required documentation, basic meeting logistics, and queries to be performed.
- **Evaluation of system compliance**—The evaluation included a review of the information systems, focusing on the receipt and handling of enrollment and disenrollment data. Additionally, HSAG evaluated the processes used to collect and calculate the performance measures, including accurate numerator and denominator identification, and algorithmic compliance (which evaluated whether rate calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately). Based on the desk review of the ISCAT, HSAG conducted interviews with key AxisPoint Health staff members who were familiar with the processing, monitoring, and calculating performance measures. HSAG used interviews to confirm findings from the documentation review, and clarify outstanding issues.
- **Overview of data integration and control procedures**—The overview included discussion and observation of source code logic, a review of how all data sources were combined, and how the analytic file used for reporting the performance measures was generated. HSAG performed primary source verification queries and a walk-through of source code files to further validate the output files. HSAG also reviewed any supporting documentation provided for data integration.
- **Closing conference**—The closing conference summarized preliminary findings based on the review of the ISCAT and the on-site visit, and reviewed the documentation requirements for any post-on-site activities.

HSAG conducted several interviews with key AxisPoint Health staff members who were involved with any aspect of performance measure reporting. Table 4 displays a list of AxisPoint Health attendees, along with the Nevada DHCFP representative:

Table 4—List of AxisPoint Health Interviewees

Name	Title
Cheri Glockner	Executive Director, Health Care Guidance Program (APH)
Stuart Rogers	Business/Systems Analyst (APH)
Huilin Feng	Senior Clinical Data Analyst (APH)
Mary Jane Konstantin	Senior Vice President, Clinical Operations (APH)

Name	Title
Michelle Searing	Outsource Operations Manager, Health Care Guidance Program (APH)
Shawn Donnelly	Actuarial Director (APH)
John Kucera	Analyst (DHCFP)

Post-On-Site Activities

During the on-site visit, HSAG auditors identified several items that required follow-up from AxisPoint Health, including revision of some source code for several measures. AxisPoint Health submitted the revised source code, along with revised non-P4P performance measure rates. Upon resolving all outstanding items, HSAG auditors reviewed the revised rates provided by AxisPoint Health before issuing this report.

Validation Results

Several aspects involved in the calculation of performance measures are crucial to the validation process. These include data retrieval, integration, data control, and source code development and documentation of performance measure calculations. A description for each of these activities is provided below.

Data Retrieval

HSAG reviewed the processes AxisPoint Health used to receive, transfer, and store the source data used for calculating the measures, which included staff interview and discussion of the data flow for the various sources of data. Overall, HSAG determined that the data integration processes in place at AxisPoint Health were adequate.

Data Integration

HSAG reviewed the data integration process used by AxisPoint Health, which included a review of file consolidations or extracts, data integration documentation, source code, and linking mechanisms. Overall, HSAG determined that the data integration processes in place at AxisPoint Health were adequate.

Data Control

HSAG reviewed the data control processes used by AxisPoint Health, which included a review of the data flow process, disaster recovery procedures, data backup protocols, and related policies and

procedures. Overall, the audit team determined that the data control processes in place at AxisPoint Health were adequate.

Source Code Development and Performance Measure Documentation

HSAG conducted a line-by-line source code review for all measures and reviewed related documentation, which included the completed ISCAT, computer programming code, output files, work flow diagrams, and narrative descriptions of performance measure calculations. All applicable source code was approved prior to the on-site visit. HSAG also determined that the documentation of performance measure calculations by AxisPoint Health was adequate.

Performance Measure Validation Results

HSAG received the final performance measure results generated by AxisPoint Health based on latest receipt of all applicable monthly operational files on October 18, 2016. Table 5 below displays the measure-specific validation results for AxisPoint Health for program period 2 (June 1, 2015 through May 30, 2016). The rates for program periods 1 and 2 are displayed in Appendix A.

Table 5—Measure-Specific Validation Results for AxisPoint Health

Measure ID		Non-P4P Measure Name	Audit Validation Results
1	CCHU.1	Ambulatory Care-Sensitive Condition Hospital Admission	Reportable
2	CCHU.2	"Avoidable" Emergency Room Visits	Reportable
3	FUP	Follow-Up with PCP After Hospitalization	Reportable
4	MRP	Medication Reconciliation Post-Discharge	Reportable
5	DEM	Cognitive Assessment for Dementia	Reportable
6	NEUR	Stroke and Stroke Rehabilitations – Discharged on Antithrombotic Therapy	Reportable
7	CKD	Adult Kidney Disease – Laboratory Testing (Lipid Profile)	Reportable
8	RA	Disease-modifying Anti-Rheumatic Drug (DMARD) Therapy for Rheumatoid Arthritis	Reportable
9	OST	Osteoporosis – Pharmacologic therapy for men and women aged 50 years and older	Reportable
10	OBS	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Reportable
11	CAP	Children and Adolescents' Access to Primary Care Practitioners	Reportable

Measure ID		Non-P4P Measure Name	Audit Validation Results
12	W15	Well-Child Visits in the First 15 Months of Life	Reportable
13	W34	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Reportable
14	AWC	Adolescent Well-Care Visits	Reportable
15	CIS	Childhood Immunization Status	Reportable
16	PPC	Prenatal and Postpartum Care	Reportable
17	WOP	Weeks of Pregnancy at Time of Enrollment	Reportable
18	FPC	Frequency of Ongoing Prenatal Care	Reportable
19	ABA	Adult BMI Assessment	Reportable
20	BCS	Breast Cancer Screening	Reportable
21	CCS	Cervical Cancer Screening	Reportable
22	COL	Colorectal Cancer Screening	Reportable

Summary of Findings

This audit examined 22 non-P4P measures. All of the measures have been determined to be reportable by AxisPoint Health for this year; however, there were several issues identified during the on-site audit. Some measures may need further discussion with DHCFP for future reporting. The following audit findings examines the issues identified, along with any remedial actions taken to correct the measures for reporting.

During the audit for the first program period (June 1, 2014 through May 30, 2015), it was determined that all of the indicators (numerators) for the *Childhood Immunization Status* measure were underreported based solely on administrative data. Without immunization data from the State registry or medical record review, the *Childhood Immunization Status* measure rates were too low to derive any effective conclusion or impact AxisPoint Health may have had on this population. Based on the first year findings, the State provided the immunization registry data to AxisPoint Health for both program periods. AxisPoint Health calculated the current program period immunization rates and recalculated the rates for the first program period. Initially the *Childhood Immunization Status* measure rates for combinations 2 through 10 appeared to be over-reported. Additional source code review conducted by the auditors on-site discovered the issue and the code was corrected. The rates for both program periods were approved.

For the *Stroke and Stroke Rehabilitations – Discharged on Antithrombotic Therapy (NEUR)* measure, the denominator remains low. The technical specifications use 11 months of continuous enrollment, but this appears to not be needed and, in fact, impacts the denominator for this measure. Any member meeting the event criteria must continue to be in the program the entire period to count towards this measure. However, the numerator only needs the member to be discharged on antithrombotic therapy to count, so there is no real purpose for continuous enrollment throughout the program period. HSAG recommends DHCFP examine this measure and update it, if necessary.

The *Adult Kidney Disease – Laboratory Testing (CKD)* measure evaluates if the member with kidney disease had a fasting lipid profile completed during the year. The initial rate provided by AxisPoint Health was 0.00 percent. A line-by-line evaluation of the source code during the on-site visit determined the source code aligned with the technical specifications; however, the auditors determined the technical specifications left out the most common CPT code (80061) used for the fasting lipid profile. Adding this CPT code increased the rate to over 77 percent. HSAG recommends adding this CPT code to the technical specifications. In addition, there may be a few other codes used by laboratories for billing fasting lipid profiles. HSAG recommends reviewing the available codes and adding the appropriate fasting lipid profiles codes to enhance the technical specifications for this measure. It was also noted by the auditors that the rates produced by Milliman for the *CKD* measure are low and may need to be revised, assuming DHCFP incorporates the additional CPT codes.

Last year, for the *Cognitive Assessment for Dementia (DEM)* measure, AxisPoint Health was not able to fully identify the denominator. The changes to the denominator code allowed by the State to improve the identification of dementia now appears to capture the appropriate population; however, the numerator for this measure continues to be problematic for AxisPoint Health. The providers are not submitting

claims that incorporate the CPT code for the assessment. Since the members have been identified with dementia, it is likely the majority have had an assessment completed. This measure will require additional provider training and/or additional compensation provided for completed assessments to capture this information administratively. DHCFP should also evaluate the purpose of this measure; it may be more beneficial to determine what services were provided to these members after they were identified with dementia, than to evaluate if the member was assessed for dementia (since the ICD-9 and ICD-10 codes have already identified the member has dementia).

The weight assessment body mass index (BMI) component of the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children Adolescents (OBS)* measure for both age groups (3-11 and 12-18 years) has no administrative data and was reported as 0.0 percent. The source code appeared to be correct for this measure; however, 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. This was corrected on-site and the new rates are considered reportable. It was also noted by the auditors that the rates produced by Milliman are low and may also need to be reviewed for this measure.

As identified in last year's report, the rates for *Timeliness of Prenatal Care*, *Postpartum Care*, and *Frequency of Ongoing Prenatal Care*, are very low compared to national percentiles. These rates may be impacted by global billing practices. Global billing is the submission of a single claim for a fixed fee that covers all care related to a certain condition over a particular period of time, such as billing for prenatal and postpartum care visits in conjunction with the delivery. Since generally only global billing is submitted for the duration of the woman's pregnancy, performance measures could be underreported without medical record abstraction to augment the numerator compliance. *Timeliness of Prenatal Care*, *Postpartum Care*, and *Frequency of Ongoing Prenatal Care* rates are considered reportable since the calculation of the measures met the technical specifications, and a true underreported bias cannot be ascertained at this time.

Based on the audit findings, HSAG recommends that the technical specifications for all measures be reviewed annually, or at least every other year in order to ensure the codes for the measures are still valid, and add additional or missing codes (e.g., new ICD-10 or CPT codes) if appropriate. It is also common for measures to be revised based on findings, as well as medical and/or clinical practices. Reviewing the measures allows the technical specifications to incorporate these current practices.

Measure Number	Measure Description (Use numerator description)	Age Group	Program Year 1 (2015)			Program Year 2 (2016)			Corresponding Objective
			Numerator	Denominator	Rate (Percent)	Numerator	Denominator	Rate (Percent)	
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	2017	55405	3640.47	2713	60781	4463.57	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	15863	59066	26.9%	20332	62881	32.3%	3.2
FUP	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	1646	5991	27.5%	1706	5337	32.0%	3.1
FUP	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	3094	5991	51.6%	3017	5337	56.5%	3.1
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	57	5991	1.0%	54	5337	1.0%	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	3	184	1.6%	8	349	2.3%	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+	23	183	12.6%	8	83	9.6%	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+	0	733	0.0%	0	549	0.0%	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+	142	213	66.7%	142	208	68.3%	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+	21	376	5.6%	19	436	4.4%	2.4
OBS	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	0	9707	0.0%	0	9927	0.0%	2.1
OBS	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	12-17 years	74	5828	1.3%	114	6255	1.8%	2.1

Measure Number	Measure Description (Use numerator description)	Age Group	Program Year 1 (2015)			Program Year 2 (2016)			Corresponding Objective
			Numerator	Denominator	Rate (Percent)	Numerator	Denominator	Rate (Percent)	
OBS	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	184	9707	1.9%	237	9927	2.4%	2.1
OBS	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	113	5828	1.9%	151	6255	2.4%	2.1
OBS	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	109	9707	1.1%	54	9927	0.5%	2.1
OBS	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	64	5828	1.1%	44	6255	0.7%	2.1
CAP	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	887	1001	88.6%	958	1081	88.6%	2.1
CAP	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	5146	6732	76.4%	5193	6951	74.7%	2.1
CAP	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	6647	7764	85.6%	7051	8374	84.2%	2.1
CAP	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	9196	10837	84.9%	10065	12140	82.9%	2.1
W15	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 measure-ment year	172	996	17.3%	186	1067	17.4%	2.1
W15	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 measure-ment year	112	996	11.2%	112	1067	10.5%	2.1
W15	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 measure-ment year	125	996	12.6%	111	1067	10.4%	2.1

Measure Number	Measure Description (Use numerator description)	Age Group	Program Year 1 (2015)			Program Year 2 (2016)			Corresponding Objective
			Numerator	Denominator	Rate (Percent)	Numerator	Denominator	Rate (Percent)	
W15	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 measure-ment year	121	996	12.1%	108	1067	10.1%	2.1
W15	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 measure-ment year	123	996	12.3%	120	1067	11.2%	2.1
W15	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 measure-ment year	113	996	11.3%	119	1067	11.2%	2.1
W15	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 measure-ment year	230	996	23.1%	311	1067	29.1%	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	2348	5707	41.1%	2398	5902	40.6%	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	2878	12519	23.0%	3227	13868	23.3%	2.1
CIS	Percentage of children 2 years of age who had four DTaP vaccines by their second birthday.	2 years	616	1105	55.7%	612	1139	53.7%	2.1
CIS	Percentage of children 2 years of age who had three IPV vaccines by their second birthday.	2 years	787	1105	71.2%	832	1139	73.0%	2.1
CIS	Percentage of children 2 years of age who had one MMR vaccine by their second birthday.	2 years	801	1105	72.5%	815	1139	71.6%	2.1
CIS	Percentage of children 2 years of age who had three HiB vaccines by their second birthday.	2 years	773	1105	70.0%	799	1139	70.1%	2.1
CIS	Percentage of children 2 years of age who had three HepB vaccines by their second birthday.	2 years	806	1105	72.9%	829	1139	72.8%	2.1
CIS	Percentage of children 2 years of age who had one VZV (varicella) vaccine by their second birthday.	2 years	804	1105	72.8%	807	1139	70.9%	2.2
CIS	Percentage of children 2 years of age who had four PCV vaccines by their second birthday.	2 years	632	1105	57.2%	622	1139	54.6%	2.3
CIS	Percentage of children 2 years of age who had one HepA vaccine by their second birthday.	2 years	798	1105	72.2%	817	1139	71.7%	2.4
CIS	Percentage of children 2 years of age who had two or three RV vaccines by their second birthday.	2 years	748	1105	67.7%	771	1139	67.7%	2.5
CIS	Percentage of children 2 years of age who had two flu vaccines by their second birthday.	2 years	403	1105	36.5%	333	1139	29.2%	2.6
CIS	Percentage of children 2 years of age who had Combination #2 vaccines by their second birthday.	2 years	547	1105	49.5%	583	1139	51.2%	2.6
CIS	Percentage of children 2 years of age who had Combination #3 vaccines by their second birthday.	2 years	531	1105	48.1%	531	1139	46.6%	2.6
CIS	Percentage of children 2 years of age who had Combination #4 vaccines by their second birthday.	2 years	526	1105	47.6%	531	1139	46.6%	2.6
CIS	Percentage of children 2 years of age who had Combination #5 vaccines by their second birthday.	2 years	481	1105	43.5%	477	1139	41.9%	2.6
CIS	Percentage of children 2 years of age who had Combination #6 vaccines by their second birthday.	2 years	293	1105	26.5%	241	1139	21.2%	2.6

Measure Number	Measure Description (Use numerator description)	Age Group	Program Year 1 (2015)			Program Year 2 (2016)			Corresponding Objective
			Numerator	Denominator	Rate (Percent)	Numerator	Denominator	Rate (Percent)	
CIS	Percentage of children 2 years of age who had Combination #7 vaccines by their second birthday.	2 years	477	1105	43.2%	477	1139	41.9%	2.6
CIS	Percentage of children 2 years of age who had Combination #8 vaccines by their second birthday.	2 years	290	1105	26.2%	241	1139	21.2%	2.6
CIS	Percentage of children 2 years of age who had Combination #9 vaccines by their second birthday.	2 years	261	1105	23.6%	211	1139	18.5%	2.6
CIS	Percentage of children 2 years of age who had Combination #10 vaccines by their second birthday.	2 years	258	1105	23.3%	211	1139	18.5%	2.6
PPC	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	219	931	23.5%	234	856	27.3%	N/A
PPC	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	119	931	12.8%	116	856	13.6%	N/A
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	576	931	61.9%	541	856	63.2%	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	231	931	24.8%	181	856	21.1%	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	70	931	7.5%	91	856	10.6%	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	34	931	3.7%	23	856	2.7%	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	20	931	2.1%	20	856	2.3%	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	2389	20886	11.4%	2859	23466	12.2%	2.1
BCS	Percentage of women 40-69 years of age who had a mammogram to screen for breast cancer.	42-69 years	2912	9052	32.2%	3138	9980	31.4%	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	5542	17224	32.2%	5579	18409	30.3%	2.1
COL	The percentage of members 50-75 years of age who had appropriate screening for colorectal cancer.	51-75 years	1890	10037	18.8%	2444	11765	20.8%	2.1
WOP	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	180	1522	11.8%	140	1321	10.6%	N/A
WOP	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	507	1522	33.3%	424	1321	32.1%	N/A

Measure Number	Measure Description (Use numerator description)	Age Group	Program Year 1 (2015)			Program Year 2 (2016)			Corresponding Objective
			Numerator	Denominator	Rate (Percent)	Numerator	Denominator	Rate (Percent)	
WOP	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	667	1522	43.8%	610	1321	46.2%	N/A
WOP	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	93	1522	6.1%	83	1321	6.3%	N/A
WOP	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	75	1522	4.9%	64	1321	4.8%	N/A

State of Nevada

Division of Health Care Financing and Policy

State Fiscal Year 2015–2016 External Quality Review Technical Report

October 2016

HSAG HEALTH SERVICES ADVISORY GROUP

3133 East Camelback Road, Suite 100 ◆ Phoenix, AZ 85016

Phone 602.264.6382 ◆ Fax 602.241.0757

HSAG HEALTH SERVICES ADVISORY GROUP

CONTENTS

ACKNOWLEDGMENTS AND COPYRIGHTS

Overview of the SFY 2015–2016 External Quality Review

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, requires states to prepare an annual technical report that describes the manner in which data were aggregated and analyzed and how conclusions were drawn as to the quality and timeliness of, and access to, care and services furnished by the states' managed care organizations (MCOs). The data come from activities conducted in accordance with the Code of Federal Regulations (CFR) at 42 CFR §438.358. To meet these requirements, the State of Nevada, Department of Health and Human Services, Division of Health Care Financing and Policy (the DHCFP), contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO). HSAG has served as the EQRO for the DHCFP since 2000.

The goal of the managed care program is to maintain a successful partnership with quality health plans to provide care to recipients while focusing on continual quality improvement. The Nevada-enrolled recipient population encompasses the Family Medical Coverage (FMC), Temporary Assistance for Needy Families (TANF), and Child Health Assurance Program (CHAP) assistance groups as well as the Children's Health Insurance Program (CHIP) population, which is referred to as Nevada Check Up.

The Nevada Medicaid MCOs included in the state fiscal year (SFY) 2015–2016 external quality review (EQR) were **Amerigroup Nevada, Inc.** (**Amerigroup**), and **Health Plan of Nevada** (**HPN**), which operate in both Clark and Washoe counties. Effective January 1, 2014, Nevada expanded its Medicaid program to allow persons with incomes up to 138 percent of the federal poverty level to enroll in Medicaid. Since the majority of persons in the newly eligible population reside in managed care catchment areas, many persons eligible as a result of Medicaid expansion have enrolled with one of the two MCOs offered in the Nevada Medicaid managed care program.

The SFY 2015–2016 EQR Technical Report includes a review of recipients' access to care and the quality of services received by recipients of Title XIX, Medicaid, and Title XXI, CHIP. In addition, the report focuses on the three federally mandated EQR activities. As described in 42 CFR §438.358, these activities are:

- Compliance monitoring evaluation.
- Validation of performance measures.
- Validation of performance improvement projects (PIPs).

In addition to the mandatory activities, HSAG performed the following activities at the request of the DHCFP:

- Evaluated the State's quality strategy and the managed care program's achievement of the goals and objectives identified in the strategy. HSAG's evaluation of the activities that occurred in support of the State's quality strategy is presented in Section 2.

- Provided an analysis of the results of CAHPS activities conducted by the MCOs, which is presented in Section 7.
- Provided technical assistance to the DHCFP with activities related to the Nevada Comprehensive Care Waiver (NCCW) program, the fee-for-service care management program that resulted from Nevada's section 1115(a) Medicaid research and demonstration waiver approved by CMS. The DHCFP contracted with a care management organization (CMO) to provide care management services to the enrolled population. The CMO's care management program is called the Health Care Guidance Program (HCGP). HSAG's technical assistance activities included:
  - Implementing the NCCW Quality Strategy and developing a set of quality modules that the HCGP vendor must use to guide its quality-related presentations during the quarterly meetings.
  - Tracking the NCCW 1115 Demonstration Evaluation Design Plan.
  - Reviewing the corrective action plans that resulted from the HCGP compliance review, which is presented in Section 8.
  - Performing source code review of the programming code used to calculate pay for performance (P4P) measures used for the NCCW program, which will be calculated by the DHCFP's actuary.
- Performed performance measure validation audit of non-P4P measures used to monitor the HCGP's progress in achieving the goals and objectives of the NCCW demonstration waiver, which is presented in Section 9.

In accordance with 42 CFR §438.364, this report includes the following information for each activity conducted:

- Activity objectives
- Technical methods of data collection and analysis (Appendix A)
- Descriptions of data obtained
- Conclusions drawn from the data

The report also includes an assessment of the MCOs' strengths and weaknesses, as well as recommendations for improvement and a comparison of the two health plans that operate in the Nevada Medicaid managed care program.

Since SFY 2014–2015 served as the baseline collection period for the With Medicaid Expansion Included performance measure rates, no specific recommendations were made for the rates reported for this population in the SFY 2014–2015 EQR Technical Report. SFY 2015–2016 was the first year that a comparison could be performed (between HEDIS 2015 and HEDIS 2016 rates) for the With Medicaid Expansion Included population; therefore, an assessment of the degree to which each MCO has effectively addressed recommendations for quality improvement made by HSAG will be reported in the SFY 2016–2017 EQR Technical Report. Similarly, the SFY 2016–2017 EQR Technical Report will contain an assessment of the degree to which each MCO and the PCCM has effectively addressed performance improvement recommendations made by HSAG in this technical report and throughout the state fiscal year.

Findings and Recommendations about the Quality and Timeliness of, and Access to, Care

Overall, both **Amerigroup** and **HPN** have demonstrated strengths and opportunities for improvement related to access, timeliness, and quality of care provided to Nevada Medicaid and Nevada Check Up populations. HSAG encourages MCOs to incorporate rapid-cycle improvement (RCI) concepts acquired from the newly required RCI PIP framework to improve performance measure rates. The approach uses resources more efficiently and implements improvement interventions that have the can bring about real improvement. Further, HSAG recommends the continued use of collaborative meetings between the DHCFP and the MCOs to continually assess MCO performance and the Medicaid and Nevada Check Up programs' achievement of the goals and objectives identified in the State's quality strategy.

Internal Quality Assurance Program—Corrective Action Plan Review

SFY 2015–2016 was the second year of the three-year cycle of reviews for Nevada. HSAG reviewed each of the corrective action plans that resulted from the compliance review activities and assisted the DHCFP staff with clarifying program requirements for the MCOs. The DHCFP approved the MCOs' corrective action plans. No further action was required by the MCOs or HSAG.

Validation of Performance Measures—NCQA HEDIS Compliance Audits

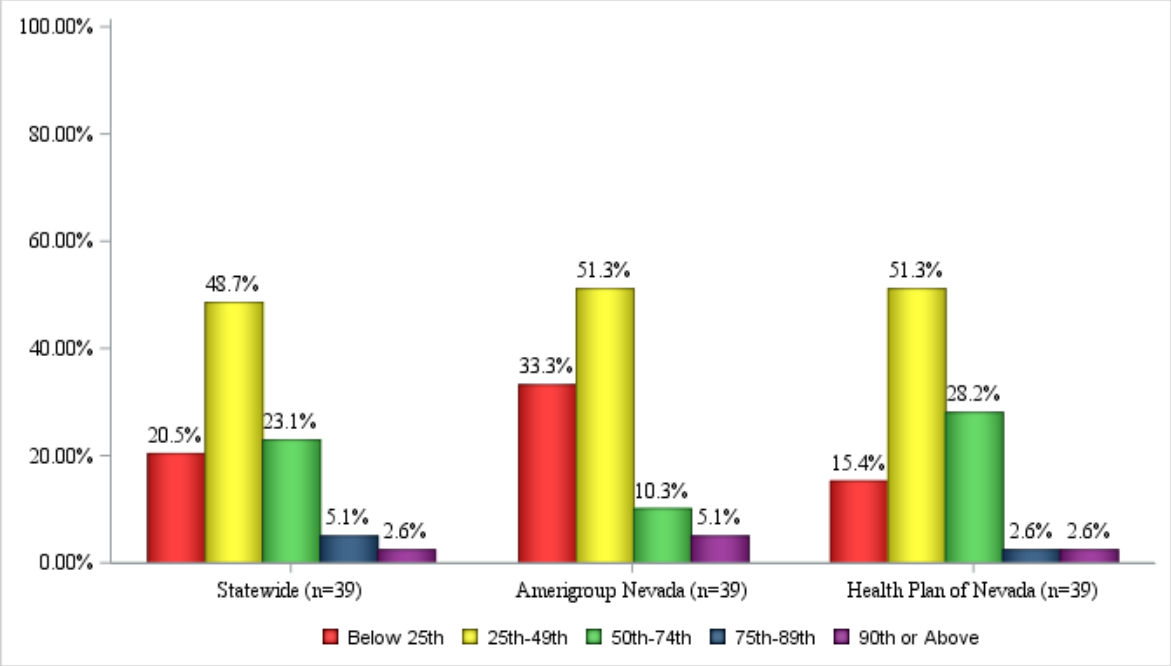
HSAG conducted an NCQA HEDIS Compliance Audit to assess **HPN** and **Amerigroup** performance with respect to the *HEDIS 2016 Technical Specifications* and to review the MCOs' performance on the HEDIS measures. For HEDIS 2016, the MCOs were required to report 19 measures with a total of 50 measure indicator rates for the Medicaid population and 15 measures with a total of 35 measure indicator rates for the Nevada Check Up population. HSAG validated all measures reported by the MCOs.

The NCQA HEDIS Compliance Audit demonstrated that both MCOs had strong policies and procedures in place to collect, process, and report HEDIS data for the Medicaid and Nevada Check Up populations, and both MCOs were in full compliance with the *HEDIS 2016 Technical Specifications*. The claims and encounter data systems employed by the MCOs used sophisticated scanning processes and advanced software to ensure accurate data processing. Both MCOs used software, the source code of which was certified by NCQA, to generate HEDIS measures. This ensured accurate measure calculation.

Medicaid Findings

Figure 1-1 shows the percentage of Medicaid population rates for HEDIS 2016 for the statewide weighted average, **Amerigroup**, and **HPN** compared to the NCQA HEDIS 2015 Audit Means and Percentiles national Medicaid benchmarks.

Figure 1-1—Percentage of HEDIS 2016 Performance Measures Rates for Medicaid Population Compared to HEDIS Medicaid National Percentiles



Thirty-nine of **Amerigroup**'s and **HPN**'s Medicaid HEDIS 2016 rates were evaluated and compared to national Medicaid benchmarks. **Amerigroup** reported two rates (approximately 5 percent) that ranked at or above the 90th percentile and 13 measure indicator rates (approximately 33 percent) that fell below the 25th percentile. **HPN** reported one rate (approximately 3 percent) that ranked at or above the 90th percentile and six measure indicator rates (approximately 15 percent) that fell below the 25th percentile.

Table 1-1 presents the HEDIS 2016 MCO-specific rates and the statewide weighted average Medicaid rates along with star ratings based on rate comparisons to the NCQA HEDIS 2015 Audit Means and Percentiles national Medicaid benchmarks. Measure results were compared to benchmarks and rated using the following star ratings:

★ = Below the national Medicaid 25th percentile

★★ = At or above the national Medicaid 25th percentile but below the 50th percentile

★★★ = At or above the national Medicaid 50th percentile but below the 75th percentile

★★★★ = At or above the national Medicaid 75th percentile but below the 90th percentile

★★★★★ = At or above the national Medicaid 90th percentile

Table 1-1—HEDIS 2016 Results for Medicaid			
HEDIS Measure	**HPN**	**AGP**	**Medicaid**
Access to Care			
Children and Adolescents' Access to Primary Care Practitioners			
Ages 12–24 Months	94.80% ★★	94.15% ★	94.48% ★★
Ages 25 Months–6 Years	84.29% ★	83.55% ★	83.93% ★
Ages 7–11 Years	87.36% ★	87.12% ★	87.26% ★
Ages 12–19 Years	85.21% ★	83.76% ★	84.67% ★
Annual Dental Visit			
Total	55.03% ★★★	53.21% ★★	54.25% ★★
Children's Preventive Care			
Adolescent Well-Care Visits			
Adolescent Well-Care Visits	44.04% ★★	38.43% ★	41.89% ★★
Childhood Immunization Status			
Combination 2	74.94% ★★	73.15% ★★	74.04% ★★
Combination 3	70.32% ★★	66.67% ★★	68.48% ★★
Combination 4	70.07% ★★★	65.28% ★★	67.65% ★★★
Combination 5	55.72% ★★	57.18% ★★	56.45% ★★
Combination 6	38.44% ★★	32.41% ★	35.40% ★
Combination 7	55.72% ★★★	56.48% ★★★	56.10% ★★★
Combination 8	38.44% ★★	32.41% ★	35.40% ★★
Combination 9	31.14% ★★	29.63% ★★	30.38% ★★
Combination 10	31.14% ★★	29.63% ★★	30.38% ★★
Immunizations for Adolescents			
Combination 1 (Meningococcal, Tdap/Td)	79.81% ★★★	71.93% ★★	76.80% ★★★
Well-Child Visits in the First 15 Months of Life			
Six or More Well-Child Visits	53.77% ★★	52.78% ★★	53.26% ★★
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life			
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	64.48% ★	66.33% ★★	65.36% ★

Table 1-1—HEDIS 2016 Results for Medicaid			
HEDIS Measure	**HPN**	**AGP**	**Medicaid**
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Percentile—Total	70.32% ★★★	64.12% ★★	67.74% ★★★
Counseling for Nutrition—Total	57.91% ★★	54.40% ★★	56.45% ★★
Counseling for Physical Activity—Total	52.07% ★★	43.75% ★	48.61% ★★
Human Papillomavirus Vaccine for Female Adolescents			
Human Papillomavirus Vaccine for Female Adolescents	29.68% ★★★★	24.59% ★★★	27.74% ★★★★
Maternity Care			
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	73.97% ★	75.41% ★	74.67% ★
Postpartum Care	57.18% ★★	53.16% ★	55.22% ★
Frequency of Ongoing Prenatal Care			
*<21 Percent of Expected Visits**	14.60% ★★	17.80% ★	16.16% ★
≥81 Percent of Expected Visits	52.07% ★★	56.44% ★★	54.20% ★★
Care for Chronic Conditions			
Comprehensive Diabetes Care			
Hemoglobin A1c (HbA1c) Testing	85.64% ★★	79.63% ★	83.34% ★★
*HbA1c Poor Control (>9.0%)**	45.74% ★★	46.76% ★★	46.13% ★★
Blood Pressure Control (<140/90 mm Hg)	60.83% ★★	55.32% ★	58.71% ★★
Eye Exam (Retinal) Performed	56.93% ★★★	55.09% ★★★	56.23% ★★★
Medical Attention for Nephropathy	92.21% ★★★★★	89.58% ★★★★★	91.20% ★★★★★
HbA1c Control (<8.0%)	46.47% ★★	46.30% ★★	46.40% ★★
Medication Management for People With Asthma			
Medication Compliance 50%—Total	46.96% ★	50.22% ★★	48.14% ★★
Medication Compliance 75%—Total	24.14% ★★	26.84% ★★	25.12% ★★
Behavioral Health			
Follow-Up After Hospitalization for Mental Illness			
7-Day Follow-Up	56.51% ★★★	52.99% ★★★	54.56% ★★★
30-Day Follow-Up	69.41% ★★★	64.55% ★★	66.72% ★★★

Table 1-1—HEDIS 2016 Results for Medicaid			
HEDIS Measure	**HPN**	**AGP**	**Medicaid**
Follow-Up Care for Children Prescribed ADHD Medication			
Initiation Phase	46.65% ★★★	36.68% ★★	42.15% ★★★
Continuation and Maintenance Phase	58.02% ★★★	40.91% ★★	52.00% ★★★
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*			
Total	1.80% ★★★	0.00% ★★★★★	1.02% ★★★★
Utilization and Diversity of Membership			
Mental Health Utilization—Total			
Any Service—Total	5.90% NC	7.21% NC	6.47% NC
Inpatient—Total	0.77% NC	1.18% NC	0.95% NC
Intensive Outpatient or Partial Hospitalization—Total	0.23% NC	0.28% NC	0.25% NC
Outpatient or Emergency Department—Total	5.67% NC	7.01% NC	6.25% NC
Ambulatory Care—Total			
*Emergency Department (ED) Visits—Total**	49.39 NC	55.08 NC	51.85 NC
Outpatient Visits—Total	292.44 NC	294.01 NC	293.12 NC
Weeks of Pregnancy at Time of Enrollment			
Prior to 0 Weeks	33.27% NC	26.39% NC	32.80% NC
1–12 Weeks	12.99% NC	12.50% NC	12.96% NC
13–27 Weeks	28.38% NC	41.44% NC	29.26% NC
28 or More Weeks of Pregnancy	21.28% NC	19.68% NC	21.17% NC
Unknown	4.09% NC	0.00% NC	3.81% NC

* A lower rate indicates better performances for this measure.

NC indicates the HEDIS 2016 rate was not compared to benchmarks either because data were not available or because a measure is informational only and comparisons to benchmarks are not appropriate.

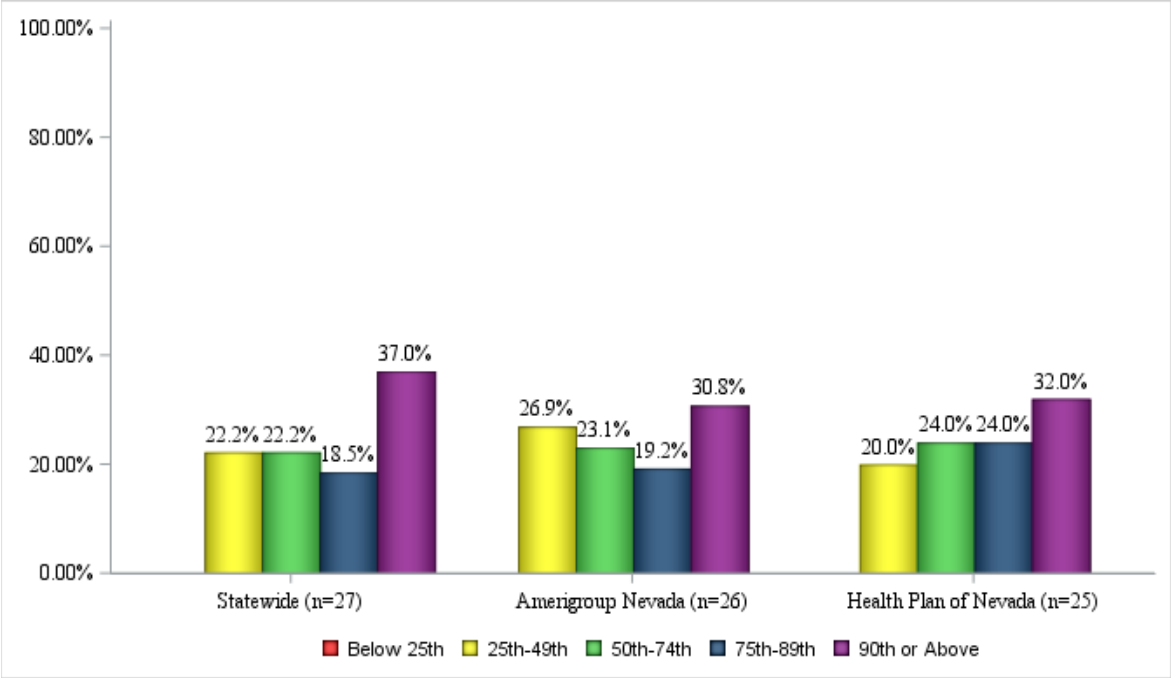
NA indicates the denominator for the measure was too small to report (less than 30).

Most of the statewide weighted average Medicaid population rates fell below the national 50th percentile. However, statewide weighted averages for *Human Papillomavirus Vaccine for Female Adolescents* and *Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total* ranked at or above the national 75th percentile but below the 90th percentile, and the rate for *Comprehensive Diabetes Care—Medical Attention for Nephropathy* ranked at or above the national 90th percentile, indicating performance strengths.

Nevada Check Up Findings

Figure 1-2 shows the percentage of Nevada Check Up population rates for HEDIS 2016 for the statewide weighted average, **Amerigroup**, and **HPN** as compared to the NCQA HEDIS 2015 Audit Means and Percentiles national Medicaid benchmarks.[1-1]

Figure 1-2—Percentage of HEDIS 2016 Performance Measures Rates for Nevada Check Up Population Compared to HEDIS Medicaid National Percentiles



Twenty-six of **Amerigroup**'s Nevada Check Up HEDIS 2016 rates were evaluated as compared to national Medicaid benchmarks, of which eight rates (approximately 31 percent) ranked at or above the 90th percentile and none of the measure indicator rates fell below the 25th percentile. Twenty-five of **HPN**'s Nevada Check Up HEDIS 2016 rates were evaluated as compared to national Medicaid benchmarks, of which eight rates (approximately 32 percent) ranked at or above the 90th percentile and none of the measure indicator rates fell below the 25th percentile.

Table 1-2 presents the HEDIS 2016 MCO-specific rates and the statewide weighted average Nevada Check Up rates along with star ratings based on comparisons of the rates to the NCQA HEDIS 2015 Audit Means and Percentiles national Medicaid benchmarks.

[1-1] Because NCQA HEDIS 2015 Audit Means and Percentiles benchmarks are not available for the Children's Health Insurance Program (CHIP) population, comparisons of Nevada's Check Up population measure indicator rates to the national Medicaid benchmarks should be interpreted with caution.

Table 1-2—HEDIS 2016 Results for Nevada Check Up			
HEDIS Measure	**HPN**	**AGP**	**Nevada Check Up**
Access to Care			
Children and Adolescents' Access to Primary Care Practitioners			
Ages 12–24 Months	99.48% ★★★★★	98.73% ★★★★★	99.15% ★★★★★
Ages 25 Months–6 Years	89.55% ★★★	89.53% ★★★	89.54% ★★★
Ages 7–11 Years	93.54% ★★★	92.91% ★★★	93.32% ★★★
Ages 12–19 Years	90.78% ★★★	88.95% ★★	90.18% ★★★
Annual Dental Visit			
Total	70.11% ★★★★★	67.05% ★★★★★	68.96% ★★★★★
Children's Preventive Care			
Adolescent Well-Care Visits			
Adolescent Well-Care Visits	52.83% ★★★	56.34% ★★★	54.04% ★★★
Childhood Immunization Status			
Combination 2	87.93% ★★★★★	85.90% ★★★★★	86.97% ★★★★★
Combination 3	84.48% ★★★★★	78.21% ★★★★	81.52% ★★★★★
Combination 4	83.91% ★★★★★	77.56% ★★★★	80.92% ★★★★★
Combination 5	79.89% ★★★★★	68.59% ★★★★	74.56% ★★★★★
Combination 6	52.30% ★★★★	46.79% ★★★	49.70% ★★★
Combination 7	79.31% ★★★★★	67.95% ★★★★★	73.96% ★★★★★
Combination 8	51.72% ★★★★	46.79% ★★★	49.40% ★★★★
Combination 9	50.00% ★★★★	42.95% ★★★	46.68% ★★★★
Combination 10	49.43% ★★★★	42.95% ★★★★	46.37% ★★★★
Immunizations for Adolescents			
Combination 1 (Meningococcal, Tdap/Td)	87.35% ★★★★	81.61% ★★★★	85.33% ★★★★
Well-Child Visits in the First 15 Months of Life			
Six or More Well-Child Visits	68.00% ★★★★	78.05% ★★★★★	72.53% ★★★★

Table 1-2—HEDIS 2016 Results for Nevada Check Up			
HEDIS Measure	**HPN**	**AGP**	**Nevada Check Up**
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life			
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	70.13% ★★	70.28% ★★	70.19% ★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Percentile—Total	72.02% ★★★	62.04% ★★	68.43% ★★★
Counseling for Nutrition—Total	60.34% ★★	55.56% ★★	58.62% ★★
Counseling for Physical Activity—Total	57.18% ★★★	47.69% ★★	53.77% ★★
Human Papillomavirus Vaccine for Female Adolescents			
Human Papillomavirus Vaccine for Female Adolescents	42.62% ★★★★★	34.11% ★★★★★	39.68% ★★★★★
Care for Chronic Conditions			
Medication Management for People With Asthma			
Medication Compliance 50%—Total	47.62% ★★	47.76% ★★	47.67% ★★
Medication Compliance 75%—Total	26.98% ★★	26.87% ★★	26.94% ★★
Behavioral Health			
Follow-Up After Hospitalization for Mental Illness			
7-Day Follow-Up	NA	84.85% ★★★★★	83.33% ★★★★★
30-Day Follow-Up	NA	93.94% ★★★★★	89.58% ★★★★★
Follow-Up Care for Children Prescribed ADHD Medication			
Initiation Phase	39.53% ★★	NA	35.21% ★★
Continuation and Maintenance Phase	NA	NA	NA
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*			
Total	NA	NA	NA
Utilization and Diversity of Membership			
Mental Health Utilization—Total			
Any Service—Total	4.71% NC	5.76% NC	5.12% NC
Inpatient—Total	0.14% NC	0.46% NC	0.26% NC
Intensive Outpatient or Partial Hospitalization—Total	0.55% NC	0.32% NC	0.46% NC
Outpatient or Emergency Department—Total	4.67% NC	5.69% NC	5.07% NC

Table 1-2—HEDIS 2016 Results for Nevada Check Up			
HEDIS Measure	**HPN**	**AGP**	**Nevada Check Up**
Ambulatory Care—Total			
*Emergency Department (ED) Visits—Total**	21.00 NC	26.14 NC	23.00 NC
Outpatient Visits—Total	259.29 NC	263.50 NC	260.93 NC

* A lower rate indicates better performances for this measure.

NC indicates the HEDIS 2016 rate was not compared to benchmarks either because data were not available or because a measure is informational only and comparisons to benchmarks are not appropriate.

NA indicates the denominator for the measure was too small to report (less than 30).

For the statewide weighted average results for Nevada Check Up, most of the rates ranked at or above the national 75th percentile. However, statewide weighted averages for the following measures fell at or above the national 25th percentile but below the 50th percentile, indicating opportunities for improvement: *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*; *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total,* and *Counseling for Physical Activity—Total*; *Medication Management for People With Asthma—Medication Compliance 50%—Total,* and *Medication Compliance 75%—Total*; and *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*. As mentioned above, comparisons of Nevada's Check Up population measure indicator rates to the national Medicaid benchmarks should be interpreted with caution.

Conclusions and Recommendations

The HEDIS audit demonstrated that both MCOs had adequate policies and procedures in place to collect, prepare, process, and report HEDIS data and were fully compliant with each of the seven NCQA-specified IS standards. Both MCOs continued to use FACETS to process their claims. Data entry processes were efficient and ensured timely and accurate entry into the system. Only standard codes were accepted and the standard HIPAA 837 file format was used. Both MCOs applied several validation checks to ensure accurate information processing, and both had appropriate processes in place for the ICD-9 to ICD-10 transition and did not experience any data concerns.

Most of the MCOs' performance measure rates from HEDIS 2015 to HEDIS 2016 remained relatively stable from year-to-year for Medicaid. As evidenced by the comparisons of the rates to national Medicaid benchmarks, HSAG suggests that the MCOs focus efforts on improving children and adolescents' access to primary care practitioners. Further, HSAG recommends that the MCOs analyze any improvement strategies that can be linked to the overall success of the measure, counseling children/adolescents for nutrition and physical activity, and improvement interventions that were implemented to improve well child visits. HSAG also recommends that the MCOs monitor performance with regard to maternity care, managing medications for asthmatic members, and appropriate testing and control of HbA1c levels and controlling blood pressure for diabetic members. The areas recommended for improvement are based on rates that mostly ranked below the national Medicaid 50th percentile. Additionally, for the Nevada Check Up population, the MCOs are urged to focus efforts on improving counseling for nutrition and physical activity provided to

children and adolescents and analyze strategies that could be linked to increased rates of well-care visits for adolescents and asthma medication compliance for asthmatic members. Although none of the Nevada Check Up population rates showed declines from 2015 to 2016, rates in these areas fell below the national Medicaid 50th percentile, indicating opportunities for improvement.

For each measure requiring improvement, HSAG recommends that each MCO conduct a thorough analysis of the root cause of poor performance for each measure and identify provider, member, and systems interventions that can be implemented to improve performance measure rates in each area. Similar to the RCI approach required by PIPs, MCOs should test changes on a small scale, using a series of plan, do, study, act (PDSA) cycles and applying rapid-cycle learning principles over the course of the improvement project to adjust intervention strategies so that improvement can occur more efficiently and lead to long-term sustainability.

Validation of Performance Improvement Projects (PIPs)

In July 2014, HSAG developed a new PIP framework based on a modified version of the Model for Improvement developed by Associates in Process Improvement and modified by the Institute for Healthcare Improvement. The redesigned methodology is intended to improve processes and outcomes of healthcare by way of continuous quality improvement. The redesigned framework redirects MCOs to focus on small tests of change in order to determine which interventions have the greatest impact and can bring about real improvement.

HSAG presented the crosswalk and new PIP framework components to CMS to demonstrate how the framework aligned with the CMS validation protocols. CMS agreed that, with the pace of quality improvement science development and the prolific use of PDSA cycles in modern improvement projects within healthcare settings, a new approach was needed. After meeting with DHCFP and HSAG staff members to discuss the topics and approach, CMS gave approval for DHCFP to implement this new PIP approach in Nevada.

In SFY 2015–2016, the DHCFP selected two PIP topics for the MCOs: *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents*, and *Behavioral Health Hospital Readmissions*. The topics addressed CMS requirements related to quality outcomes, specifically the quality and timeliness of and access to care and services.

Table 1-3—PIP Results

PIP Title	Amerigroup PIP Module Results	HPN PIP Module Results
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Module 1: *Achieved* Module 2: *Achieved* Module 3: *Achieved*	Module 1: *Achieved* Module 2: *Achieved* Module 3: *Achieved*
Behavioral Health Hospital Readmissions	Module 1: *Achieved* Module 2: *Achieved* Module 3: *Achieved*	Module 1: *Achieved* Module 2: *Achieved* Module 3: *Achieved*

Recommendations

Since the MCOs were allowed to resubmit PIP modules and incorporate HSAG recommendations in each resubmission, HSAG does not have recommendations for the first three PIP modules that were submitted and approved. For future module submissions, HSAG offers the following recommendations:

- As each MCO moves through the quality improvement process and conducts PDSA cycles, each MCO's PIP team should ensure that it is communicating the MCO's reasons for making changes to intervention strategies and how those changes will lead to improvement. Without a common understanding and agreement about the causes that affect improvement, the MCO's PIP team might misdirect resources and improvement activities toward changes that do not lead to improvement.
- When planning a test of change, each MCO should be proactive with the intervention (i.e., scaling/ramping up to build confidence in the change, and eventually implementing policy to sustain changes).
- When testing an intervention, each MCO should conduct a series of thoughtful and incremental PDSA cycles to accelerate the rate of improvement.
- As each MCO tests new interventions, it should ensure it is making a prediction in each step of the PDSA cycle and discussing the basis for the prediction. This will help keep the theory for improvement in the project in the forefront for everyone involved.
- When developing the intervention testing methodology, the MCOs should determine the best method for identifying the intended effect of an intervention prior to testing. The intended effect should be known up front to help determine which data need to be collected.
- When testing an intervention, the MCOs should collect detailed, process-level data to ensure they collect enough data to illustrate the effects of the intervention.
- The key driver diagram and failure modes and effects analysis (FMEA) for all PIPs should be updated as each MCO progresses through its PDSA cycles.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Surveys

The populations surveyed for **HPN** and **Amerigroup** were adult Medicaid, child Medicaid, and Nevada Check Up. DSS Research, an NCQA-certified vendor, administered the 2016 CAHPS surveys for both **HPN** and **Amerigroup**.

For each of the four global ratings, the percentage of respondents who chose the top satisfaction ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. This percentage is referred to as a question summary rate (or top-box response).

For each of the five composite scores and children with chronic conditions (CCC) composite measures/items, the percentage of respondents who chose a positive response was calculated. CAHPS composite question response choices fell into one of two categories: (1) Never, Sometimes, Usually, or Always; or (2) No or Yes. A positive or top-box response for the composites and CCC composites/items was defined as a response of Usually/Always or Yes. The percentage of top-box responses is referred to as a global proportion for the composite scores and CCC composite

measures/items. For the Effectiveness of Care measures, responses of Always/Usually/Sometimes were used to determine if the respondent qualified for inclusion in the numerator. NCQA's methodology for calculating a rolling average using the current and prior years' results was followed. A substantial increase or decrease is denoted by a change of 5 percentage points or more.

Amerigroup Findings

In 2016, a total of 2,499 adult members were sent a survey and 469 completed a survey.[1-2] After ineligible members were excluded, the response rate was 19.3 percent. In 2015, the average NCQA response rate for the adult Medicaid population was 27.2 percent, which was higher than **Amerigroup**'s response rate.[1-3] **Amerigroup**'s rates decreased between 2015 and 2016 for five of 12 measures: *Getting Needed Care*, *Customer Service*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*. **Amerigroup**'s rates increased between 2015 and 2016 for seven measures: *Getting Care Quickly*, *How Well Doctors Communicate*, *Shared Decision Making*, *Rating of Specialist Seen Most Often*, *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*. Of these, the 2016 *Discussing Cessation Medications* measure rate was at least 5 percentage points greater than the 2015 rate.

In 2016, a total of 4,066 general child members were sent a survey and 686 completed a survey.[1-4] After ineligible members were excluded, the response rate was 17.9 percent. In 2015, the average NCQA response rate for the general child Medicaid population was 25.2 percent, which was higher than **Amerigroup**'s response rate.[1-5] **Amerigroup**'s rates increased between 2015 and 2016 for four measures: *Customer Service*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*. Of these, *Customer Service* and *Rating of All Health Care* showed a substantial increase of more than 5 percentage points. **Amerigroup**'s rates decreased between 2015 and 2016 for four measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Shared Decision Making*. Of these, *Getting Needed Care* showed a substantial decrease of more than 5 percentage points.

In 2016, a total of 236 child members with a chronic condition completed a survey.[1-6] **Amerigroup**'s rates increased between 2015 and 2016 for four reportable measures: *Getting Needed Care*, *Rating of All Health Care*, *Rating of Health Plan*, and *Family Centered Care (FCC): Personal Doctor Who Knows Child*. **Amerigroup**'s rates decreased between 2015 and 2016 for five reportable measures: *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of Personal Doctor*, *Access to Prescription Medicines*, and *FCC: Getting Needed Information*. Of these, *Getting Care Quickly* showed a substantial decrease of more than 5 percentage points.

[1-2] The total number of members surveyed and who completed surveys is based on **Amerigroup**'s adult CAHPS sample only.

[1-3] The 2016 NCQA national response rate information for the CAHPS 5.0 Adult Medicaid Survey was not available at the time this report was produced.

[1-4] The total number of members surveyed and who completed surveys is based on **Amerigroup**'s general child CAHPS sample only (i.e., does not include the CCC supplemental sample of members who were surveyed).

[1-5] The 2015 NCQA national response rate information for the CAHPS 5.0 Child Medicaid with CCC Survey was not available at the time this report was produced.

[1-6] The total number of members who completed surveys is based on **Amerigroup**'s CCC supplemental CAHPS sample only.

In 2016, a total of 1,605 Nevada Check Up general child members were sent a survey and 409 completed a survey.[1-7] After ineligible members were excluded, the response rate was 28.8 percent. **Amerigroup**'s rates decreased between 2015 and 2016 for four measures: *Getting Needed Care*, *Getting Care Quickly*, *Customer Service*, and *Rating of All Health Care*. The rates for three measures increased between 2015 and 2016: *How Well Doctors Communicate*, *Rating of Personal Doctor*, and *Rating of Health Plan*. Of these, *Rating of Personal Doctor* showed a substantial increase of more than 5 percentage points.

In 2016, a total of 80 Nevada Check Up child members with a chronic condition completed a survey.[1-8] **Amerigroup**'s 2015 and 2016 rates could not be reported for the Nevada Check Up CCC population, since all measures did not meet the minimum number of responses.

HPN Findings

In 2016, a total of 1,899 adult members were surveyed and 271 completed a survey.[1-9] After ineligible members were excluded, the response rate was 14.4 percent. In 2015, the average NCQA response rate for the adult Medicaid population was 27.2 percent, higher than **HPN**'s response rate.[1-10] **HPN**'s rates decreased between 2015 and 2016 for eight of nine reportable measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Health Plan*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*. Of these, three measures showed a substantial decrease of more than 5 percentage points: *Getting Care Quickly*, *Rating of All Health Care*, and *Rating of Personal Doctor*. One measure, *Advising Smokers and Tobacco Users to Quit*, increased between 2015 and 2016. The increase was more than 5 percentage points.

In 2016, a total of 2,372 general child members were surveyed and 466 completed a survey.[1-11] After ineligible members were excluded, the response rate for the general child population was 20.4 percent. In 2015, the average NCQA response rate for the child Medicaid population was 25.2 percent, higher than **HPN**'s 2016 response rate.[1-12] **HPN**'s rates decreased between 2015 and 2016 for one of the six reportable measures: *How Well Doctors Communicate*. **HPN**'s rates increased between 2015 and 2016 for five measures: *Getting Needed Care*, *Getting Care Quickly*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*. Further, one measure, *Rating of all Health Care*, showed a substantial increase of at least 5 percentage points.

In 2016, a total of 267 child members with a chronic condition completed a survey.[1-13] **HPN**'s rates decreased between 2015 and 2016 for two measures: *Getting Needed Care* and *Shared Decision*

[1-7] The total number of members surveyed and who completed surveys is based on **Amerigroup**'s Nevada Check Up general child CAHPS sample only.
[1-8] The total number of members who completed surveys is based on **Amerigroup**'s Nevada Check Up CCC supplemental CAHPS sample only.
[1-9] The total number of members surveyed and who completed surveys is based on **HPN**'s adult CAHPS sample only.
[1-10] The 2015 NCQA national response rate information for the CAHPS 5.0 Adult Medicaid Survey was not available at the time this report was produced.
[1-11] The total number of members surveyed and who completed surveys is based on **HPN**'s general child CAHPS sample (i.e., does not include the CCC supplemental sample of members who were surveyed).
[1-12] The 2015 NCQA national response rate information for the CAHPS 5.0 Child Medicaid with CCC Survey was not available at the time this report was produced.
[1-13] The total number of members who completed surveys is based on **HPN**'s CCC supplemental CAHPS sample only.

Making. **HPN**'s rates substantially increased between 2015 and 2016 for four measures: *Getting Care Quickly*, *Rating of All Health Care*, *FCC: Personal Doctor Who Knows Child*, and *Coordination of Care for Children with Chronic Conditions.*

In 2016, a total of 2,352 Nevada Check Up general child members were surveyed and 538 completed a survey.[1-14] For the general child population, **HPN**'s 2016 Nevada Check Up CAHPS scores were below the 2015 Nevada Check Up CAHPS scores for four composite measures: *Getting Needed Care*, *How Well Doctors Communicate*, *Customer Service*, and *Shared Decision Making*. **HPN**'s rates increased between 2015 and 2016 for the remaining four reportable measures: *Getting Care Quickly*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*.

In 2016, 244 Nevada Check Up child members with a chronic condition completed a survey.[1-15] For the CCC population, **HPN**'s 2016 Nevada Check Up CAHPS scores were below the 2015 Nevada Check Up CAHPS scores for three measures: *Getting Needed Care*, *Access to Prescription Medicines*, and *FCC: Getting Needed Information*. **HPN**'s rates increased between 2015 and 2016 for five measures: *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *FCC: Personal Doctor Who Knows Child.*

Recommendations

Overall, HSAG recommends the following:

- Each MCO should continue to work with its CAHPS vendor to ensure that a sufficient number of completed surveys is obtained to enable reporting of all CAHPS measures. NCQA recommends targeting 411 completed surveys per survey administration. **Amerigroup** had measures that did not meet the minimum number of responses (i.e., 100 responses) for the CCC Medicaid population, Nevada Check Up general child population, and Nevada Check Up CCC population. **HPN** had measures that did not meet the minimum number of responses for the adult Medicaid population, general child and CCC Medicaid populations, and the CCC Nevada Check Up population. Without sufficient responses, MCOs lack information that can be critical to designing and implementing targeted interventions that can improve access to, and the quality and timeliness of, care.
- For the adult population, HSAG recommends that **Amerigroup** focus quality improvement initiatives on enhancing members' experiences with *Getting Needed Care*, *Customer Service*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*, since these rates were lower than the 2015 adult CAHPS results and fell below NCQA's 2015 CAHPS adult Medicaid national averages. For the general child Medicaid population, **Amerigroup** should focus its efforts on improving *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Shared Decision Making*, since the rates for these measures were lower than the 2015 general child CAHPS results and fell below NCQA's 2015 CAHPS child Medicaid national averages. For the CCC Medicaid population, **Amerigroup** should focus its efforts on improving *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of Personal Doctor*,

[1-14] The total number of members surveyed and who completed surveys is based on **HPN**'s general child CAHPS sample only (i.e., does not include the CCC supplemental sample of members who were surveyed).
[1-15] The total number of members who completed surveys is based on **HPN**'s Nevada Check Up CCC supplemental CAHPS sample only.

Access to Prescription Medicines, and *FCC: Getting Needed Information*, since the rates for these reportable measures were lower than the 2015 CCC child CAHPS results and fell below NCQA's 2015 CAHPS CCC child national averages. For the Nevada Check Up population, HSAG recommends that **Amerigroup** focus quality improvement initiatives on enhancing members' experiences with *Getting Needed Care*, *Getting Care Quickly*, *Customer Service*, and *Rating of All Health Care*, since the 2016 rates for these reportable measures were lower than the 2015 rates.

- HSAG recommends that **HPN** focus quality improvement initiatives on enhancing members' experiences with *Getting Needed Care*, *Getting Care Quickly*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Health Plan*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies* for the adult Medicaid population, since these rates were lower than the 2015 adult CAHPS results and fell below NCQA's 2015 CAHPS adult Medicaid national averages. For the general child Medicaid population, **HPN** should focus on improving *How Well Doctors Communicate*, since the rate for this composite measure was lower than the 2015 child CAHPS result and fell below NCQA's 2015 CAHPS child Medicaid national average. For the CCC child Medicaid population, **HPN** should focus on improving *Getting Needed Care* and *Shared Decision Making*, since the rates for these measures fell below the 2015 CAHPS results and were substantially lower than the 2015 NCQA CCC child Medicaid national averages. For the Nevada Check Up population, quality improvement efforts should be focused on *Shared Decision Making*, since this measure showed a substantial decrease from 2015 to 2016. For the CCC Nevada Check Up population, **HPN** should improve the *Getting Needed Care*, *Access to Prescription Medicines*, and *FCC: Getting Needed Information*, since the rates for these measures decreased from 2015 to 2016.

Health Care Guidance Program (HCGP) Corrective Action Plan Review

In SFY 2014–2015, HSAG conducted an interim assessment of **McKesson Technologies, Inc**.'s (**McKesson**'s) compliance with its contract six months after **McKesson**'s HCGP operations began in June 2014. Out of 12 standards reviewed during the compliance review, seven were found to be deficient. HSAG recommended that **McKesson**, doing business as **AxisPoint Health** (**APH**), submit to DHCFP a corrective action plan to remedy all deficiencies that resulted from the compliance review. **APH** was responsible for developing the CAP, obtaining DHCFP approval of the CAP, and implementing the strategies outlined in the DHCFP-approved CAP.

CAP Review Findings

In SFY 2015–2016, HSAG worked with the DHCFP staff to review the CAPs submitted by **APH** and give DHCFP feedback regarding the feasibility that the strategies proposed by **APH** would remedy the deficiencies noted in the compliance review. Several of the responses submitted by **APH** were not acceptable to the DHCFP, which issued a closeout letter to **McKesson** in July 2015 citing the items that were not acceptable. During SFY 2015–2016, HSAG worked with the DHCFP staff to review additional strategies that **APH** proposed to remedy outstanding deficiencies. Of the seven corrective action plans initially submitted, DHCFP fully accepted only two and partly accepted one. As a result of DHCFP's initial feedback, **APH** was required to resubmit corrective action plans until DHCFP fully accepted them. DHCFP monitored the deficient standards until it

fully accepted all plans submitted by **APH**. The last one was approved by DHCFP on March 15, 2016.

Recommendations

Although, there are no additional recommendations as a result of the corrective action plan review, HSAG recommends that DHCFP require future plans be submitted and resolved more timely so that **APH** does not remain out of compliance with contractual elements longer than necessary.

HCGP Performance Measure Validation (PMV)

To verify the accuracy of **APH**'s reported rates, DHCFP contracted with HSAG, the State's EQRO, to validate the performance measure rates calculated and reported by **APH**. To ensure that the PMV activity was performed in accordance with industry standards of practice, HSAG validated **APH**'s performance measures using the external quality review (EQR) Protocol 2[1-16] developed by CMS as its guide. HSAG's PMV activity focused on the following objectives:

1. Assess the accuracy of the required performance measures reported by **APH**.
2. Determine the extent to which the measures calculated by **APH** followed DHCFP's specifications and reporting requirements.

Performance Measure Validation Findings

HSAG examined 24 measures with a total of 63 indicators, or individual rates. Of the 63 indicators, 26 were Not Completed (NC). The rates for the other 37 indicators appeared to be appropriately calculated and reported by **APH**.

Recommendations

As a result of the HCGP performance measure validation, HSAG made several recommendations to DHCFP and **APH** so that measures could be fully reported. Bulleted below are HSAG's recommendations as well as a status update for those recommendations.

- **APH** should work to obtain WebIZ supplemental immunization registry data in order to calculate a rate for the *Childhood Immunization* Status measures.
  - **Update: APH** secured the necessary access to obtain WebIZ supplemental immunization registry data in the spring 2016.
- DHCFP should revisit the care transition measures, CCHU 3-7, to determine the likelihood that data can be obtained to report the measures. If data cannot be obtained, then the measures should be omitted or replaced with other measures.
  - **Update:** DHCFP and HSAG staff members worked to replace the CCHU 3-7 measures with measures that could be calculated by **APH**. The new measures are *Follow-Up with PCP After Hospitalization—7 days* and *30 days* and *Medication Reconciliation Post-Discharge*.

[1-16] *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 1, 2012.

- For the *Cognitive Assessment for Dementia* measure, DHCFP should consider modifying the specifications so the denominator can be identified by **APH**.
  - **Update:** DHCFP and HSAG staff members worked to modify the codes used to specify the denominator so it could be identified by **APH** and a rate could be generated.
- DHCFP should consider replacing or removing the measure *Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor Positive Breast Cancer (CAN)*, since CPT II codes cannot be collected.
  - **Update:** DHCFP removed the measure *Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor Positive Breast Cancer (CAN)* from the suite of non-P4P performance measures, since CPT II codes could not be collected.

2. Overview of Nevada Managed Care Program

History of Nevada State Managed Care Program

Nevada was the first state to use a state plan amendment (SPA) to develop a mandatory Medicaid managed care program. Under the terms of a SPA, a state ensures that individuals will have a choice of at least two health maintenance organizations (HMOs) in each geographic area. When fewer than two HMOs are available, the managed care program must be voluntary. In Nevada, there are two geographic areas, Clark and Washoe counties, covered by mandatory managed care. HMOs are referred to as managed care organizations, or MCOs, in this report.

In April 1992, Nevada Medicaid initiated a limited enrollment primary care case management (PCCM) program, the first managed care program in Nevada. The State implemented the PCCM program voluntarily. Nevada contracted with **University Medical Center** (**UMC**), **Nevada Health Solutions**, and **Community Health Center** in both Clark County (Las Vegas) and Washoe County (Reno) for managed care services. The PCCM contract with **UMC** was terminated in the first quarter of 1997, and the remaining PCCM contracts were phased out per legislation in July 1999. In April 1997, voluntary managed care became effective with several vendors. Nevada contracted with **HPN** and **Amil International** (**Amil**) to provide services in Clark County, and with **Hometown Health Plan** for services in Washoe County. Voluntary managed care for most recipients was discontinued in December 1998; however, these health plans continued to provide services to Nevada recipients when the Nevada Legislature passed Senate Bill 559, requiring that Nevada Medicaid develop a mandatory managed care program. Mandatory managed care Medicaid contracts remained in effect, with several renewals, through 2001.

In 2002, contracts were procured again with **Nevada Health Solutions** and **HPN** in both Clark and Washoe counties. **Anthem** and **HPN** won the contracts when Medicaid procured them again in November 2006. **Anthem** left the Nevada market in January 2009 and was replaced by **Amerigroup**. In 2012, the DHCFP re-procured the managed care contracts, with services to begin on July 1, 2013. Both **HPN** and **Amerigroup** were selected to serve as the MCOs in Clark and Washoe counties and remain as the current MCOs for the State.

The State of Nevada managed care program requires the enrollment of recipients found eligible for Medicaid coverage under the family medical coverage (FMC). Applications for medical assistance under the modified adjusted gross income (MAGI) medical eligibility group includes the following aid categories:

- AM—Parents and Caretakers
- AM1—Expanded Parent and Caretakers
- CH—Poverty Level Children and Pregnant Women
- CH1—Expanded Children's Group Ages 6–18 Years
- CH5—Omnibus Budget Reconciliation Act (OBRA)
- CA—Childless Adults, Without Dependents, Ages 19–64 Years
- TR—Transitional Medicaid

- PM—Post Medical
- NC—Nevada Check Up–State CHIP Program for Children Under 19 Years

The managed care program allows voluntary enrollment for the following recipients (these categories of enrollees are not subject to mandatory lock-in enrollment provisions):

- Native Americans who are members of federally recognized tribes except when the MCO is the Indian Health Service, an Indian health program, or urban Indian program operated by a tribe or tribal organization under a contract, grant, cooperative agreement, or compact with the Indian Health Service.
- Children younger than 19 years of age who are receiving services through a family-centered, community-based, coordinated care system that receives grant funds under Section 501(a)(1)(D) of Title V and is defined by the State in terms of either program participation or special health care needs (also known as children with special health care needs—CSHCN).
- FMC adults diagnosed as seriously mentally ill (SMI). Newly eligible SMI adults are enrolled in an MCO if they reside within the managed care geographic service area and cannot opt out of managed care, where available, based on a determination of SMI.
- FMC children diagnosed as severely emotionally disturbed (SED).

Effective January 1, 2014, Nevada expanded its Medicaid program to allow persons with incomes up to 138 percent of the federal poverty level to enroll in Medicaid. Since the majority of persons in the newly eligible population reside in managed care catchment areas, persons eligible as a result of Medicaid expansion have enrolled with one of the two MCOs offered in the Nevada Medicaid managed care program.

Demographics of Nevada State Managed Care Program

The Division of Welfare and Supportive Services carries out the eligibility and aid code determination functions for the Medicaid and Nevada Check Up applicant and eligible population. In January 2014, the DHCFP expanded Medicaid coverage to persons with incomes up to 138 percent of the federal poverty level, which was allowed under the Affordable Care Act. The number of persons who enrolled in Medicaid as a result of the expansion greatly exceeded the DHCFP's original expectations. The majority of newly eligible persons reside in the managed care catchment areas; therefore, both MCOs experienced significant increases in enrollment compared to prior years.

Table 2-1 presents the gender and age bands of Nevada Medicaid- and CHIP-enrolled recipients as of June 2016. The majority of members for both Medicaid and CHIP were children between 3 and 14 years of age.

Table 2-1—Nevada Medicaid and CHIP Managed Care Demographics

Gender/Age Band	June 2016 Members
Males and Females <1 Year of Age	21,695
Males and Females 1–2 Years of Age	33,869
Males and Females 3–14 Years of Age	180,668
Females 15–18 Years of Age	21,088
Males 15–18 Years of Age	21,027
Females 19–34 Years of Age	84,344
Males 19–34 Years of Age	52,270
Females 35+ Years of Age	119,233
Males 35+ Years of Age	90,608
Total Medicaid	**624,802**
Males and Females <1 Year of Age	186
Males and Females 1–2 Years of Age	1,526
Males and Females 3–14 Years of Age	17,093
Females 15–18 Years of Age	2,435
Males 15–18 Years of Age	2,515
Total CHIP	**23,755**
Total Medicaid and CHIP	**648,557**

Table 2-2 presents enrollment of Medicaid recipients by MCO and county for June 2016.

Table 2-2—June 2016 Nevada MCO Medicaid Recipients		
MCO	Total Eligible Clark County	Total Eligible Washoe County
HPN	214,243	34,643
Amerigroup	156,416	23,830
Total	**370,659**	**58,473**

Table 2-3 presents enrollment of CHIP recipients in the Nevada Check Up program by MCO and by county for June 2016.

Table 2-3—June 2016 Nevada MCO CHIP (Nevada Check Up) Recipients		
MCO	Total Eligible Clark County	Total Eligible Washoe County
HPN	10,313	2,717
Amerigroup	6,808	1,414
Total	**17,121**	**4,131**

Table 2-4 presents the ethnic composition of Nevada MCO Medicaid recipients in June 2016.

Table 2-4—June 2016 Nevada MCO Medicaid Ethnic Composition		
Ethnicity	Total Eligible Clark County	Total Eligible Washoe County
Asian or Pacific Islander Non-Hispanic	14,070	1,591
Black Non-Hispanic	86,841	2,909
Hispanic	25	17
Am Indian/Alaskan Non-Hispanic	1,290	621
Am Indian/Alaskan and White	386	152
Asian and White	1,257	203
Black African Am and White	3,062	452
Am Indian/Alaskan and Black	1,079	118
Other Non-Hispanic	28,689	3,244
Asian/Pacific Islander Hispanic	926	182
Black Hispanic	1,390	105
Am Indian/Alaskan Hispanic	188	42
White Hispanic	127,967	19,649
White Non-Hispanic	103,489	29,188
Total	**370,659**	**58,473**

Table 2-5 presents the ethnic composition of CHIP recipients in the Nevada Check Up program for June 2016.

Table 2-5—June 2015 Nevada MCO CHIP (Nevada Check Up) Ethnic Composition

Ethnicity	Total Enrolled Clark County	Total Enrolled Washoe County
Asian or Pacific Islander Non-Hispanic	747	96
Black Non-Hispanic	1,500	54
Hispanic	0	2
Am Indian/Alaskan Non-Hispanic	26	57
Am Indian/Alaskan and White	12	2
Asian and White	66	19
Black African Am and White	123	19
Am Indian/Alaskan and Black	58	6
Other Non-Hispanic	1,389	200
Asian/Pacific Islander Hispanic	42	17
Black Hispanic	58	4
Am Indian/Alaskan Hispanic	9	9
White Hispanic	9,902	2,642
White Non-Hispanic	3,189	1,004
Total	**17,121**	**4,131**

Network Capacity Analysis

In SFY 2014–2015, at the request of the DHCFP, HSAG conducted an evaluation of Nevada's Medicaid provider network. The purpose of the analysis was to review the provider network capacity, geographic distribution, and appointment availability of the MCOs' and fee for service (FFS) networks. The analysis evaluated three dimensions of access and availability:

- **Capacity—**provider-to-recipient ratios for Nevada's provider networks.
- **Geographic Network Distribution—**time/distance analysis for applicable provider specialties and average distance (miles) to the closest provider.
- **Appointment Availability—**average length of time (number of days) to see a provider for MCOs and FFS.

The network analysis was based on comparative evaluations of both Nevada Medicaid recipients and the providers who serve them. Additionally, comparison groups, or populations, of Nevada residents and providers were defined to evaluate network performance relative to the general population in Nevada. The study represented one of many ongoing attempts to capture, report, monitor, and explore the experience of Medicaid recipients' access to health care services. The study also enabled DHCFP to establish baseline network capacity and distance results so that results

from future studies may be compared to the SFY 2014–2015 results to determine what changes, if any, have occurred to the network. This will be especially helpful with the addition of new network monitoring requirements from CMS for both the fee-for-service (FFS) and managed care provider networks. Those new requirements included:

- **Access Monitoring Review Plan**—CMS issued a final rule to allow states and CMS to make better informed, data-driven decisions when considering whether proposed changes to Medicaid fee-for-service payment rates are sufficient to ensure that Medicaid beneficiaries have access to covered Medicaid services. In order to improve the data with which states and CMS monitor access, the regulation requires states to submit access monitoring review plans. The plans must specify data sources that will support a finding of sufficient beneficiary access and will address:
  - The extent to which beneficiary needs are met.
  - The availability of care and providers.
  - Changes in beneficiary service utilization.
  - Comparisons between Medicaid rates and rates paid by other public and private payers.

  The plans must provide for state reviews a core set of five services: primary care, physician specialists, behavioral health, pre- and post-natal obstetrics (including labor and delivery), and home health services. Nevada chose to add a sixth topic, dental, to the list of services reviewed. The DHCFP will evaluate the new Department of Insurance (DOI) network standards once developed.
- **Availability of Services, Assurances of Adequate Capacity and Services, and Network Adequacy Standards**—CMS required states to set standards to ensure ongoing state assessment and certification of MCO, prepaid inpatient health plan, and prepaid ambulatory health plan networks; set threshold standards to establish network adequacy measures for a specified set of providers; establish criteria to develop network adequacy standards for managed long term services and supports programs; and ensure the transparency of network adequacy standards. The rule stipulates that states must establish time and distance standards for the following network provider types: primary care (adult and pediatric); obstetricians/gynecologists; behavioral health; specialist (adult and pediatric); hospital; pharmacy; pediatric dental; and additional provider types when they promote the objectives of the Medicaid program for the provider type to be subject to such time and distance standards.

Nevada State Quality Strategy

The U.S. Department of Health and Human Services (HHS) Centers for Medicare & Medicaid Services (CMS) Medicaid managed care regulations at 42 CFR §438.200 and §438.202, which implement Section 1932(c)(1) of the Social Security Act, define certain Medicaid state agency responsibilities. The regulations require Medicaid state agencies that operate Medicaid managed care programs to develop and implement a written Quality Assessment and Performance Improvement Strategy (herein referred to as "Quality Strategy") to assess and improve the quality of health care services offered to their members. The written strategy must describe the standards that the state and its contracted MCOs and prepaid inpatient health plans must meet. The Medicaid state agency must, in part:

- Conduct periodic reviews to examine the scope and content of its Quality Strategy and evaluate its effectiveness.
- Ensure compliance with standards established by the State that are consistent with federal Medicaid managed care regulations.
- Update the strategy periodically, as needed.
- Submit to CMS a copy of its initial strategy, a copy of the revised strategy whenever significant changes have occurred in the program, and regular reports describing the implementation and effectiveness of the strategy.

An evaluation of the DHCFP's progress in meeting the goals and objectives detailed in the Quality Strategy for SFY 2015–2016 is provided later in this report.

Quality Strategy Goals and Objectives

The DHCFP's mission is to purchase and ensure the provision of quality health care services, including Medicaid services, to low-income Nevadans in the most efficient manner. Furthermore, the DHCFP seeks to promote equal access to health care at an affordable cost to Nevada taxpayers, to restrain the growth of health care costs, and to review Medicaid and other State health care programs to determine the potential to maximize federal revenue opportunities. Further, the DHHS director has identified three priority focus areas for Nevada Medicaid: prevention, early intervention, and quality treatment. Consistent with the State's mission and DHHS priority areas, the purpose of the DHCFP's 2016–2017 Quality Strategy was to:

- Establish a comprehensive quality improvement system that was consistent with the Triple Aim adopted by CMS to achieve better care for patients, better health for communities, and lower costs through improvement in the health care system.
- Provide a framework for the DHCFP to design and implement a coordinated and comprehensive system to proactively drive quality throughout the Nevada Medicaid and Nevada Check Up system. The Quality Strategy promotes the identification of creative initiatives to continually monitor, assess, and improve access to care, clinical quality of care, and health outcomes of the population served.

- Identify opportunities to improve the health status of the enrolled population and improve health and wellness through preventive care services, chronic disease and special needs management, and health promotion.
- Identify opportunities to improve quality of care and quality of service, and implement improvement strategies to ensure Nevada Medicaid and Nevada Check Up recipients have access to high-quality and culturally appropriate care.
- Identify creative and efficient models of care delivery that are steeped in best practice and make health care more affordable for individuals, families, and the state government.
- Improve recipient satisfaction with care and services.

In SFY 2015–2016, HSAG worked with DHCFP staff members to revise the State's quality strategy. Consistent with the national quality strategy, the DHCFP established the following quality goals for the 2016–2017 Quality Strategy to improve the health and wellness of Nevada Medicaid and Nevada Check Up members. Unless otherwise indicated, all objectives will follow the Quality Improvement System for Managed Care (QISMC) methodology to increase rates by 10 percent.

Goal 1: Improve the health and wellness of Nevada's Medicaid and Nevada Check Up population by increasing the use of preventive services.

Objective 1.1a: Increase children and adolescents' access to primary care physicians (PCPs) (12–24 months).

Objective 1.1b: Increase children and adolescents' access to PCPs (25 months–6 years).

Objective 1.1c: Increase children and adolescents' access to PCPs (7–11 years).

Objective 1.1d: Increase children and adolescents' access to PCPs (12–19 years).

Objective 1.2: Increase well-child visits (0–15 months).

Objective 1.3: Increase well-child visits (3–6 years).

Objective 1.4a: Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (body mass index [BMI] percentile).

Objective 1.4b: Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (counseling for nutrition).

Objective 1.4c: Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (counseling for physical activity).

Objective 1.5: Increase immunizations for adolescents.

Objective 1.6: Increase annual dental visits for children.

Objective 1.7: Increase human papillomavirus vaccine for female adolescents.

Objective 1.8: Increase adolescent well-care visits.

Objective 1.9: Increase childhood immunization status (all combos, 2–10).

Goal 2: Increase use of evidence-based practices for members with chronic conditions.

Objective 2.1: Increase rate of HbA1c testing for members with diabetes.

Objective 2.2: Decrease rate of HbA1c poor control (>9.0%) for members with diabetes.**

Objective 2.3: Increase rate of HbA1c good control (<8.0%) for members with diabetes.

Objective 2.4: Increase rate of eye exams performed for members with diabetes.

Objective 2.5: Increase medical attention for nephropathy for members with diabetes.

Objective 2.6: Increase blood pressure control (<140/90 mm Hg) for members with diabetes.

Objective 2.7a: Increase medication management for people with asthma—medication compliance 50 percent.

Objective 2.7b: Increase medication management for people with asthma—medication compliance 75 percent.

Goal 3: Reduce and/or eliminate health care disparities for Medicaid and Nevada Check Up recipients.

Objective 3.1: Ensure that health plans develop, submit for review, and annually revise cultural competency plans.

Objective 3.2: Stratify data for performance measures and avoidable emergency room utilization by race and ethnicity to determine where disparities exist. Continually identify, organize, and target interventions to reduce disparities and improve access to appropriate services for the Medicaid and Nevada Check Up populations.

Objective 3.3: Ensure that each MCO submits an annual evaluation of its cultural competency program to the DHCFP. The MCOs must receive a 100 percent *Met* compliance score for all criteria listed in the MCO contract for cultural competency program development, maintenance, and evaluation.

Goal 4: Improve the health and wellness of new mothers and infants, and increase new-mother education about family planning and newborn health and wellness.

Objective 4.1: Increase the rate of postpartum visits.

Objective 4.2: Increase timeliness of prenatal care.

Objective 4.3: Increase frequency of prenatal care visits (≥ 81 percent of visits).

Objective 4.4: Increase frequency of prenatal care visits (<21 percent of visits).**

Goal 5:	**Increase use of evidence-based practices for members with behavioral health conditions.**
Objective 5.1a:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication—initiation phase.
Objective 5.1b:	Increase follow-up care for children prescribed ADHD medication—continuation and maintenance phase.
Objective 5.2:	Reduce use of multiple concurrent antipsychotics in children and adolescents.**
Objective 5.3:	Reduce behavioral health-related hospital readmissions within 30 days of discharge (improvement based on MCO PIP goals.)
Objective 5.4:	Increase follow-up after hospitalization for mental illness—7 days.
Objective 5.5:	Increase follow-up after hospitalization for mental illness—30 days.
Goal 6:	**Increase reporting of CMS quality measures.**
Objective 6.1:	Increase the number of CMS adult core measures reported to the Medicaid and CHIP Program (MACPro) System.
Objective 6.2:	Increase the number of CMS child core measures reported to MACPro.

***Indicates inverse indicator, wherein a lower rate demonstrates better performance for the measure.*

To establish performance targets, DHCFP uses a QISMC methodology. Performance goals are established by reducing by 10 percent the gap between the performance measure baseline rate and 100 percent. For example, if the baseline rate is 55 percent, the MCO would be expected to improve the rate by 4.5 percentage points, to 59.5 percent. This is calculated as 4.5%= 10% x (100% – 5%). Each measure that shows improvement equal to or greater than the performance target is considered achieved.

To view the State's most recent version of the quality strategy, please see go to the quality strategy link located at: http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Members/BLU/NV2016-17_QAPIS_Report_F1.pdf.

Annual Quality Strategy Evaluation

To continually track the progress of achieving the goals and objectives outlined in the Quality Strategy, the HSAG developed the Quality Strategy Tracking Table as shown in Appendix B. The Quality Strategy Tracking Table lists each of the six goals and the objectives used to measure achievement of the goals. SFY 2014–2015 marked the baseline year of measurement for the 2016–2017 Quality Strategy goals and objectives and also establishes the QISMC goal for each of the objectives.

Table 2-6 shows the MCOs' achievement of goals and objectives in SFY 2015–2016. For additional detail, please see Appendix B of this report.

Table 2-6—2015–2016 Quality Strategy Goals and Objectives Summary of Achievement by MCO*				
Metric	**Amerigroup Medicaid**	**Amerigroup Check Up**	**HPN Medicaid**	**HPN Check Up**
Number of Comparable Rates (Year 1 to Year 2)	32	20	32	20
Number of Rates That Improved	20/32 (63%)	13/20 (65%)	21/32 (66%)	13/20 (65%)
Number of Rates That Stayed the Same	3/32 (9%)	3/20 (15%)	3/32 (9%)	3/20 (15%)
Number of Rates That Achieved QISMC Goal	16/32 (50%)	12/20 (60%)	14/32 (44%)	13/20 (65%)
Number of Rates That Declined	9/32 (28%)	4/20 (20%)	8/32 (25%)	4/20 (20%)
* Note: This table denotes changes in rates from SFY 2014–2015 to SFY 2015–2016 only and does not indicate that changes are statistically significant.				

The DHCFP modifies the performance targets for each of the objectives every two years, thereby raising the performance bar for the MCOs. HSAG will update the tracking table annually and produce the results in each year's annual EQR technical report.

Quality Initiatives and Emerging Practices

Emerging practices can be achieved by incorporating evidence-based guidelines into operational structures, policies, and procedures. Emerging practices are born out of continual quality improvement efforts to improve a particular service, health outcome, systems process, or operational procedure. The goal of these efforts is to improve the quality of and access to services. Only through continual measurement and analyses to determine the efficacy of an intervention can an emerging practice be identified. Therefore, the DHCFP encourages the MCOs to continually track and monitor the effectiveness of quality improvement initiatives and interventions, using a plan do study act (PDSA) cycle, to determine if the benefit of the intervention outweighs the effort and cost.

Another method used by the DHCFP to promote best and emerging practices among the MCOs is to ensure that the State's contractual requirements for the MCOs are at least as stringent as those described in the federal rules and regulations for managed care (42 CFR Part 438—Managed Care). The DHCFP actively promotes the use of nationally recognized protocols, standards of care, and benchmarks by which health plan performance is measured.

MCO-Specific Quality Initiatives

Each health plan is responsible for identifying, through routine data analysis and evaluation, quality improvement initiatives that support improvement in quality, access, and timeliness of services delivered to Medicaid members. By testing the efficacy of these initiatives over time, the MCOs have the ability to determine which initiatives yield the greatest improvement. Listed below is a sampling of the strategic quality initiatives employed by the health plans to improve performance health outcomes.

Health Plan of Nevada (HPN)

Following are some of the strategic quality initiatives **HPN** highlighted as priorities for calendar year 2016:

- **Implemented Now Clinic**, which is a telemedicine service where recipients may see a provider face-to-face through a mobile device.
- **Implemented Medicine on the Move**, which is a mobile medical center unit operated by Southwest Medical.
- **Provided Gaps in Care reports** to provider groups on a monthly basis to show where gaps in care exist.
- **Facilitated HEDIS nurse provider visit** with large provider groups to identify and correct inconsistencies in medical record documentation and increase opportunities for compliance.
- **Issued Citibank cards** to incentivize children to receive well-care visits and seek medical attention at the pediatrician's office.

- **Distributed provider resource sheets** that included the timeline, documentation elements, and tasks that would be considered a missed opportunity for pediatric and adult HEDIS measures so that providers have a better opportunity of ensuring the documentation is correct to receive full credit for the visit.
- **Issued Network Core Reports** to providers to help them identify the member-specific outcomes and whether preventive screenings had occurred for empaneled members.
- **Conducted Follow-up calls and visits to postpartum women** to discuss the importance of postpartum and wellness visits and selecting a pediatrician.
- **Implemented Value-based contracting** to encourage provider engagement through financial incentives and also help increase member engagement.
- **Implemented a Diaper Reward Program** for women who complete postpartum visits.
- **Assigned health care analyst** to analyze data, identify barriers, and assist in implementing solutions to overcome barriers.
- **Access Center/Telephone Advice Nurse (TAN)** is a 24-hour per day clinical access center that continues transitions of care after traditional business hours, weekends, and holidays so the member gets the best possible care and services at all times.
- **Care For Me Program (CFMP)** provides high-touch case management services and care coordination with a single point of contact for hospital discharges and outpatient members in all clinics. The case manager works in collaboration with members, providers and key stakeholders in coordinating healthcare services and referrals.
- **Willing Hands Program** is an 11-bed facility designed to support homeless members' post-discharge care. The program provides home health, a social worker, case manager, and other stakeholders needed to meet the members' needs.

Amerigroup

Following are some of the strategic quality initiatives **Amerigroup** highlighted as priorities for calendar year 2016:

- **Expand the population management programs**, such as the Innovative Healthcare Delivery program, Behavioral Health WellCare Program, and Primary Care Insight.
- **Expand use of data to guide interventions** and evaluate the effectiveness of those interventions.
- **Increase use of technology**, such as electronic data exchange (i2i), Constant Contact® emails to members, and social networking such as Facebook and Twitter.
- **Continue collaboration on quality** across all departments
- **Continue My Advocate Program** used to provide text and verbal messaging as vehicles for proactive and culturally appropriate communication and coaching to pregnant women during their pregnancies.
- **Provide well-child/EPSDT screenings** during health fairs.
- **Facilitate medical director 1:1 meetings with physicians** to talk about missed opportunities and ways to increase performance measure rates.
- **Continue member and provider incentive programs**.

- **Continue Member Meet and Greet** at CVS pharmacies in addition to the meetings held at locations with the top 10 ZIP codes as well as with the highest missed opportunities for health screenings and preventive care.
- **Continue Transition Care Program**, which was implemented as part of a population management program to reduce emergency department use and hospital readmissions within 30 days. For approximately 30 days after a member is discharged from the hospital, the team of nonclinical coordinators serves as surrogate family to individuals who were hospitalized and assists the members with obtaining medications, setting appointments for follow-up care, coordinating transportation, and coordinating housing to promote stabilization after discharge from the hospital.

Collaborative Quality Initiatives—DHCFP and MCOs

The DHCFP established a collaborative environment that promotes sharing of information and emerging practices among the MCOs and external stakeholders through the quarterly on-site MCO meeting. The collaborative sharing among the DHCFP and the MCOs promotes continual quality improvement of the Nevada Medicaid and Nevada Check Up programs, and it has enabled the DHCFP to track progress toward meeting the goals and objectives identified in the DHCFP's Quality Strategy. Some of the collaborative activities are described below.

Improving Access to Care

In response to the results that were presented from the FY 2014–2015 Network Capacity Analysis, The MCOs developed several strategies to remediate the concerns noted in the report. Both MCOs supported the use of outreach mobile units to provide comprehensive exams in the communities they serve. Additionally, both MCOs have increased telemedicine services for urgent and primary care. The MCOs also have staffed nurse community health workers, who provide health services and work with beneficiaries who are homeless. Each health plan is increasing its provider outreach by conducting more on-site visits and providing one-on-one education to providers. Other areas of focus include assisting with non-emergency transportation service arrangements, daycare outreach solutions, and outreach to specialists in Nevada.

Nationwide CAHPS Survey

In the summer of 2014, the DHCFP began working with its subcontractor and CMS in support of the nationwide survey of access to care and experiences of care among adult Medicaid enrollees. The survey was conducted in the fall of 2014. As of the date of this report, CMS has not released the results of the survey. Once the results are released, the DHCFP will use the results from the CMS nationwide survey to determine the types of quality improvement activities that should be incorporated into its next Quality Strategy revision to improve adult Medicaid members' experiences with health care.

MCO Annual Quality Improvement Evaluation

The MCOs are required to submit an annual evaluation of the quality improvement program and activities employed by the MCO for the previous year. The MCOs' annual evaluations include

trends and statistical information that describe and depict the performance for each quality activity and associated indicators developed by the MCO. Annual evaluations also include an analysis and evaluation of clinical and related service areas requiring improvement for each of the quality measures that pertain to the population. The DHCFP requires the MCOs to provide an evaluation of each of the Nevada Medicaid and Nevada Check Up quality measures, which are detailed in the DHCFP Quality Strategy. As part of this effort, the MCOs are required to stratify performance measure rates by race and ethnicity. After stratifying the data, the MCOs are required to identify any health care disparities among the groups and develop a plan targeting interventions to reduce and/or eliminate disparities for members and increase performance measure rates overall. On an annual basis, both MCOs present performance measure data, which is stratified by race and ethnicity for a select set of HEDIS measures. At the end of the second calendar quarter of 2016, the MCOs submitted the required documents (quality description, annual quality work plan, and annual evaluation) to DHCFP for review and approval. DHCFP approved the documents submitted by both MCOs. The MCOs also presented SFY 2015–2016 data during the July 2016 quarterly MCO meeting for the new HEDIS measures adopted by DHCFP in the fall of 2015.

Disparities in Health Care

To comply with the regulatory requirement for State procedures for race, ethnicity, and primary language spoken (CFR §438.206–438.210), the DHCFP requires the MCOs to participate in Nevada's efforts to promote the delivery of service in a culturally competent manner to all recipients, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

The MCOs, in cooperation with the DHCFP, are required to develop and implement cultural CCPs that encourage delivery of services in a culturally competent way to all recipients, including those with limited English proficiency and diverse cultural and ethnic backgrounds. The MCOs are also required to ensure that appropriate foreign language versions of all member materials are developed and available to members, and to provide interpreter services for members whose primary language is not English. The DHCFP reviews and approves all member materials as part of a readiness review for all new MCOs entering the Nevada Medicaid managed care program. During SFY 2015–2016 both MCOs provided evidence that each met the cultural competency objectives identified in the DHCFP Quality Strategy and developed a plan for the following year's cultural competency activities.

As part of their cultural competency initiatives, the MCOs examine disparities through analysis of their performance measures and PIPs. The MCOs also examine indicators used for assessing achievement of the State's Quality Strategy goals and objectives. The MCOs stratify performance measure data by race/ethnicity to identify disparities and opportunities to overcome barriers that impede improvement. Based on their findings, the MCOs incorporate specific interventions for race and ethnicity to improve indicator rates. Furthermore, the MCOs are required to document stratification findings and planned interventions to reduce health care disparities in their annual cultural competency plan evaluation and Quality Strategy evaluation. Both of these documents are submitted to the DHCFP annually for review and approval.

Nevada Medicaid Collaborative Quality Initiatives

The Grants Management Unit of DHCFP has applied for and been awarded several key grants that help the DHCFP achieve its mission and vision for the Medicaid program. As a result of the most recent projects awarded, DHCFP staffs participate in and help support collaborative quality initiatives that span both the fee for service and managed care programs.

State Innovations Model

CMS approved Nevada's State Innovation Model (SIM) Round Two application to improve population health in Nevada. The State was awarded $2 million to design SIM. The grant period began February 1, 2015, and ran for 12 months. The grant provides financial and technical support to DHCFP for the design of multipayer health care payment and service delivery models that will accomplish the CMS Triple Aim.

Nevada is seeking broad, statewide support from health care providers, public health officials, industry associations, consumer advocacy groups, and others to address population health issues such as behavioral health, tobacco use, obesity, and diabetes. Nevada's SIM goals align with other CMS initiatives and will consider a full range of regulatory, policy, and rule-making authority to accelerate meaningful delivery system transformation that maximizes the benefits of health information technology such as telehealth. Nevada is committed to continued use and refinement of models after the cooperative agreement period. The DHCFP has received broad and overwhelming stakeholder support for participation.

Balancing Incentive Payments Program

CMS approved the Nevada application for the Balancing Incentive Payment Program (BIPP). The BIPP offers a targeted increase in the federal medical assistance percentage (FMAP) to states that undertake structural reforms to increase access to noninstitutional long term services and supports (LTSS). States in which 25 to 50 percent of the total expenditures for medical assistance under the state Medicaid program are for noninstitutionally-based LTSS are eligible for a 2 percentage point FMAP increase. In 2009, Nevada was at 41.6 percent, according to a CMS report. More recent estimates have been at around 48 percent. Through the BIPP, Nevada could earn up to $6.6 million in additional FMAP to improve its infrastructure for LTSS. Nevada is required to develop a no wrong door/single entry point system for potential participants, a core standardized assessment and a plan for conflict-free case management. This will be accomplished through the 12 Major Objectives outlined in the Comprehensive Project Plan.

Money Follows the Person (MFP)

The MFP Rebalancing Demonstration Program was authorized by Congress in Section 6071 of the Deficit Reduction Act of 2005 and was designed to provide assistance to states to balance their long term care systems and help Medicaid enrollees transition from institutions to the community. The benchmarks include building upon the success of the Facility Oversight and Community Integration Services program to successfully transition eligible individuals in three target groups (65 and older), physically disabled, and intellectually disabled) from qualified institutions to qualified residences. Major goals for the program include:

- Rebalance and redesign the states' long term care systems.
- Effectively transition individuals from qualified institutional settings to qualified residences in communities.
- Accomplish six benchmarks.

  1. Transition a total of 524 individuals.
  2. Increase state Medicaid expenditures for Home and Community-Based Services during each year of the demonstration.
  3. Rebalance Nevada's method of nursing home financing.
  4. Increase participation in self-directed option (individuals control their own services and supports).
  5. Integrate into a single, statewide case management system that supports MFP requirements and quality of care.
  6. Consolidate quality assurance efforts to ensure high-quality service delivery in an efficient and effective manner.

Nevada has already accomplished the following:

- Successfully implemented the launching of the SAMS Case Management System for the DHCFP staff.
- Increased the numbers of successful transitions.
- Significantly increased the funds in the rebalance account.
- Increased collaboration across divisions to improve the quality assurance efforts when conducting program and provider reviews.
- Received approval for all MFP reports and budgets to CMS.
- Received positive feedback from CMS site visit conducted on March 25–27, 2015.
- Submitted MFP Sustainability Plan to CMS on April 28, 2015.

Medicaid Incentives for Prevention of Chronic Diseases (MIPCD)

Section 4108 of the Patient Protection and Affordable Care Act (Pub. L. 111-148) (The Affordable Care Act) authorizes grants to states to provide incentives to Medicaid beneficiaries of all ages who participate in prevention programs and demonstrate changes in health risk and outcomes, including the adoption of healthy behaviors. The initiatives or programs are to be comprehensive, evidence-based, widely available, and easily accessible. The programs must use relevant evidence-based research and resources. Nevada's MIPCD program consists of three major program components:

1. Nesting incentives in the diabetes disease management programs conducted by Nevada's Medicaid MCOs. MCO enrollees with diabetes will be incentivized to receive evidence-based preventive health services known to be effective in improved management of diabetes and covered under the Nevada Medicaid state plan.
2. Linking approximately 600 adults diagnosed with diabetes and 540 adults at risk of developing type 2 diabetes enrolled in fee for service Medicaid with evidence-based programs through the

Lied Clinic Outpatient Facility at University Medical Center of Southern Nevada, the Southern Nevada Health District, or the YMCA of Southern Nevada.

3. Providing support and facilitation of critical behavioral change and risk reduction for 950 children at risk of heart disease in fee for service Medicaid. The support and services are provided through a multidisciplinary evidenced-based program conducted by Nevada's largest pediatric cardiology practice, and a nationally recognized program based on research funded by the National Institute of Health and the Centers for Disease Control. All program participants will receive incentives to demonstrate positive changes and associated health outcomes over time.

The MIPCD participants have gone through the programs, achieved goals, earned points, and redeemed incentives. The Grants Management Unit at DHCFP is in the process of drafting closeout procedures for the grant and summarizing the results of the grant activities.

Health Information Technology

The Nevada Medicaid Incentive Payment Program for electronic health records (EHRs) is an incentive program for Nevada health care providers to receive payments for becoming meaningful users of certified EHR technology. The goal of the Nevada Medicaid Incentive Payment Program is to give providers access to enhanced Medicaid funds to offset the cost of implementing certified EHR technology. This funding is designed to promote the adoption of certified EHR technology and ultimately provide improved quality of care for Medicaid beneficiaries and increased cost efficiencies within the Medicaid enterprise. As of August 5, 2016, 607 providers and 31 hospitals have received more than $49,886,938 in payments from the Nevada Medicaid EHR Incentive Payment Program.

3. Description of EQR Activities

Mandatory Activities

In accordance with 42 CFR §438.356, the DHCFP contracted with HSAG as the EQRO for the State of Nevada to conduct the mandatory EQR activities as set forth in 42 CFR §438.358. In SFY 2015–2016, HSAG conducted the following mandatory EQR activities for the Nevada Medicaid and Nevada Check Up programs:

- **Compliance monitoring evaluation:** SFY 2014–2015 initiated a new three-year review cycle of Internal Quality Assurance Program review of compliance. SFY 2015–2016 was the second year of the cycle. In SFY 2015–2016, HSAG reviewed each of the corrective action plans that resulted from the compliance review activities and assisted the DHCFP staff with clarifying program requirements for the MCOs.
- **Validation of performance measures:** HSAG validated each of the performance measures identified by the State to evaluate their accuracy as reported by, or on behalf of, the MCOs.
- **Validation of PIPs:** HSAG validated the MCOs' PIPs to determine if they were designed to achieve, through ongoing measurement and intervention, significant and sustained improvement in clinical and nonclinical care. HSAG also evaluated if the PIPs would have a favorable effect on health outcomes and enrollee satisfaction.

Optional Activities

HSAG provided technical assistance, upon request, to the DHCFP and the MCOs in areas related to performance measures, PIPs, compliance, and quality improvement. In addition, HSAG performed the following activities at the request of the DHCFP:

- Evaluated the State's Quality Strategy and the managed care program's achievement of the goals and objectives identified in the strategy. HSAG's evaluation of the activities that occurred in support of the State's Quality Strategy is presented in Section 2.
- Provided an analysis of the results of CAHPS activities conducted by the MCOs, which is presented in Section 7.
- Provided technical assistance to the DHCFP with activities related to the Nevada Comprehensive Care Waiver (NCCW) program, which is the fee-for-service care management program that resulted from Nevada's section 1115(a) Medicaid research and demonstration waiver that was approved by CMS. The DHCFP contracted with a care management organization (CMO) to provide care management services to the enrolled population. The CMO's care management program is called the Health Care Guidance Program (HCGP). HSAG's technical assistance activities included:
  - Implementing the NCCW Quality Strategy, which was developed in response to the requirements included in the 1115 Research and Demonstration Waiver special terms and conditions.

- Participating in quarterly meetings with the HCGP vendor to ensure that quality-related activities remain on track. HSAG also developed a set of quality modules that the HCGP vendor must use to guide its quality-related presentations during the quarterly meetings.
- Tracking the NCCW 1115 Demonstration Evaluation Design Plan.
- Reviewing the corrective action plans that resulted from the HCGP compliance review, which is presented in Section 8.
- Performing source code review of the programming code used to calculate pay for performance (P4P) measures used for the NCCW program, which will be calculated by the DHCFP's actuary.
- Performing a performance measure validation audit of non-P4P measures used to monitor the HCGP's progress in achieving the goals and objectives of the NCCW demonstration waiver, which is presented in Section 9.

The DHCFP's EQR contract with HSAG did not require HSAG to conduct or analyze and report results, conclusions, or recommendations from any other CMS-defined optional activities.

4. Internal Quality Assurance Program (IQAP) Review—SFY 2015–2016

Overview

According to 42 CFR §438.358, which describes the activities related to external quality reviews, a state or its EQRO must conduct a review within a three-year period to determine a Medicaid MCO's compliance with federal standards and standards established by the state for access to care, structure and operations, and quality measurement and improvement. In accordance with 42 CFR §438.204(g), these standards must be as stringent as the federal Medicaid managed care standards described in 42 CFR §438. To meet this requirement, the DHCFP contracted with HSAG to perform a comprehensive review of compliance with State and federal standards for **Amerigroup** and **HPN** in SFY 2014–2015, which initiated a new three-year cycle of Internal Quality Assurance Program (IQAP) Review of Compliance.

Follow-Up on Corrective Actions from SFY 2014–2015 IQAP Review

SFY 2015–2016 was the second year of the three-year cycle of reviews for Nevada. HSAG reviewed each of the corrective action plans that resulted from the compliance review activities and assisted the DHCFP staff with clarifying program requirements for the MCOs. DHCFP approved the corrective action plans submitted by the MCOs. No further action was required by the MCOs or HSAG.

5. Validation of Performance Measures—NCQA HEDIS Compliance Audit—SFY 2015–2016

The DHCFP requires the MCOs to submit performance measurement data as part of their quality assessment and performance improvement programs. Validating the MCOs' performance measures is one of the federally required external quality review (EQR) activities described in 42 CFR §438.358(b)(2). To comply with this requirement, the DHCFP contracted with HSAG to validate the performance measures through HEDIS compliance audits. These audits focused on the ability of the MCOs to process claims and encounter data, pharmacy data, laboratory data, enrollment (or membership) data, and provider data accurately. As part of the HEDIS compliance audits, HSAG also explored the issue of completeness of claims and encounter data to improve rates for the performance measures.

For HEDIS 2016, DHCFP required the MCOs to report rates for Medicaid and Nevada Check Up. The MCOs also were required to report seven new measures for HEDIS 2016, one of which replaced a measure retired by NCQA.

The following section provides summary information from the HEDIS compliance audits conducted by HSAG for **HPN** and **Amerigroup**. Further details regarding the results from the 2016 HEDIS compliance audits may be found in the July 2016 HEDIS Compliance Audit Final Report of Findings.

Of note, DHCFP expanded Medicaid coverage in January 2014 to persons with incomes up to 138 percent of the federal poverty level, which was allowed under the Affordable Care Act. The majority of newly eligible persons resided in the managed care catchment areas; therefore, both MCOs experienced significant increases in enrollment since January 2014. To obtain an accurate representation of the HEDIS rates for the Medicaid expansion population and its impact on HEDIS rates, the DHCFP asked the MCOs to report 2015 Medicaid HEDIS rates for the following populations: With Medicaid Expansion Population Included, and Without Medicaid Expansion Population Included. Performance measure rates for both populations were presented in the SFY 2014–2015 technical report to establish a baseline from which future comparisons could be made for the With Medicaid Expansion Population Included group and so that rates could be compared to prior years' performance (i.e., representative of the Without Medicaid Expansion Population Included group). The results presented in this section include the rates for the With Medicaid Expansion Population Included group; therefore, only HEDIS Medicaid 2015 and HEDIS Medicaid 2016 results are presented and discussed, and prior years' rates for the Without Medicaid Expansion Population Included group are not included.

Objectives

The objectives of the HEDIS compliance audit were to assess the performance of the MCOs with respect to the *HEDIS 2016 Technical Specifications* and to review their performance on the HEDIS measures. The audits incorporated two main components:

- A detailed assessment of the MCO's information system (IS) capabilities for collecting, analyzing, and reporting HEDIS information.
- A review of the specific reporting methods used for HEDIS measures, including databases and files used to store HEDIS information; medical record abstraction tools and abstraction procedures used; certified measure status; and any manual processes employed in HEDIS 2016 data production and reporting. The audit included any data collection and reporting processes supplied by vendors, contractors, or third parties, as well as the MCO's oversight of these outsourced functions.

The HEDIS performance review evaluated the strengths and weaknesses of the MCOs in achieving compliance with HEDIS measures.

For HEDIS 2016, the MCOs were required to report 19 measures with a total of 50 measure indicator rates for the Medicaid population. These measures included 16 performance measures and three utilization or diversity of membership measures (*Mental Health Utilization—Total*, *Ambulatory Care—Total*, and *Weeks of Pregnancy at Time of Enrollment*). For the Nevada Check Up population, the MCOs were required to report 13 performance measures and two utilization measures (*Mental Health Utilization—Total* and *Ambulatory Care—Total*), totaling 35 measure indicator rates. Table 5-1 lists the required HEDIS 2016 measures for these two populations.

Table 5-1—Required HEDIS 2016 Measures

Performance Measure	Medicaid Population	Nevada Check Up Population
Access to Care		
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months, 25 Months–6 Years, 7–11 Years, and *12–19 Years*	√	√
Annual Dental Visit—Total	√	√
Children's Preventive Care		
Adolescent Well-Care Visits	√	√
Childhood Immunization Status—Combinations 2–10	√	√
Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap/Td)	√	√
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	√	√
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	√	√
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total, Counseling for Nutrition—Total, and *Counseling for Physical Activity—Total*	√	√
Human Papillomavirus Vaccine for Female Adolescents	√	√
Maternity Care		
Prenatal and Postpartum Care—Timeliness of Prenatal Care and *Postpartum Care*	√	
Frequency of Ongoing Prenatal Care—<21 Percent of Expected Visits and *≥81 Percent of Expected Visits*	√	

Table 5-1—Required HEDIS 2016 Measures		
Performance Measure	**Medicaid Population**	**Nevada Check Up Population**
Care for Chronic Conditions		
Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing, HbA1c Poor Control (>9.0%), Blood Pressure Control (<140/90 mm Hg), Eye Exam (Retinal) Performed, Medical Attention for Nephropathy, and HbA1c Control (<8.0%)	√	
Medication Management for People With Asthma—Medication Compliance 50%—Total and *Medication Compliance 75%—Total*	√	√
Behavioral Health		
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up and *30-Day Follow-Up*	√	√
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase and *Continuation and Maintenance Phase*	√	√
Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total	√	√
Utilization and Diversity of Membership		
Mental Health Utilization—Total—Any Service, Inpatient, Intensive Outpatient or Partial Hospitalization, and *Outpatient or Emergency Department*	√	√
Ambulatory Care—Emergency Department (ED) Visits—Total and Outpatient Visits—Total	√	√
Weeks of Pregnancy at Time of Enrollment—Prior to 0 Weeks, 1–12 Weeks, 13–27 Weeks, 28 or More Weeks of Pregnancy, and *Unknown*	√	

Plan-Specific Findings—Amerigroup

A detailed review of the 2016 performance reports submitted by **Amerigroup** determined that the reports were prepared according to the *HEDIS 2016 Technical Specifications* for all of the audited measures. Audits of IS capabilities for accurate HEDIS reporting found that **Amerigroup** was compliant with the standards assessed, as follows:

- **Amerigroup** was fully compliant with IS 1.0. All claims were received Monday through Friday. **Amerigroup**'s document management group received paper claims, entered them into the system, and sent them to Smart Data Solutions for scanning or keying. Electronic claims were received from four different clearinghouses daily. There were a number of reconciliation processes to monitor and track claims loaded into EDINET, and there were front-end business edits that were performed and that determined claim acceptance or claim rejection. Rejected claims went through a secondary review prior to a final rejection. Once all claims were accepted, they were loaded into Facets for adjudication. Facets captured all medical codes required for HEDIS reporting. There were no nonstandard codes or forms accepted during the measurement year. Implementation of ICD-10 was successful without any identified issues. There were multiple tests performed with Facets to ensure a smooth implementation. The system has the capacity to distinguish ICD-9 and ICD-10 codes, and after October 1, 2015, ICD-9 codes were no longer accepted. An on-site demonstration was performed and the

necessary edits were identified to ensure accuracy. Accuracy results for the measurement year exceeded **Amerigroup**'s established standards and there was no backlog of processing claims during the measurement year. All providers were fee-for-service so data completeness was not a concern. **Amerigroup** received vision data from EyeQuest, pharmacy data from CVS Caremark, and dental data from SCION. Vendor oversight was performed to ensure quality performance and there were no issues during the measurement year. Data were tracked and trended to ensure completeness.

- **Amerigroup** was fully compliant with IS 2.0. Daily enrollment files were received Monday through Friday via secure file transfer protocol from the State. **Amerigroup**'s internal operations staff downloaded the data and validated the record counts to ensure the data received were successfully loaded. A report was generated to ensure validation and a log was used to create reconciliation files. Load reports were generated to ensure complete data loads into Facets. Any identified errors were corrected. Full files were received from the State and reconciliation procedures were performed. Facets contained all of the necessary data elements relevant to enrollment data required for HEDIS reporting. Effective and termination dates were captured and there was no limit to the number of enrollment segments. **Amerigroup** might consider the use of the notification date to determine continuous enrollment. There were no backlogs in processing enrollment data during the measurement year.
- **Amerigroup** was fully compliant with IS 3.0. Provider applications were first received by the local office and reviewed against national credentialing standards. Initial applications were loaded into the MACESS system and then the primary source verification, including board certification, was performed at a corporate level. Data were then entered into Cactus and there was an interface between Cactus and Facets, which loaded the practitioner data into Facets to avoid additional data entry. Any specialty changes were sent to the credentialing department for verification. Systems were reconciled routinely to ensure accuracy. **Amerigroup** used an internal unique common practitioner identification number as well as the National Provider Identifier to identify practitioners. The number of primary care physicians remained stable from the previous measurement year.
- **Amerigroup** was fully compliant with IS standard 4.0. HSAG reviewed **Amerigroup**'s IS 4 Roadmap pertaining to the policies and procedures for IS standards 4.1, 4.2, 4.3, 4.4, and 4.5. The review found these policies and procedures to be consistent with NCQA's current HEDIS Compliance Audit Standard requirements. **Amerigroup** sampled according to the HEDIS sampling guidelines and assigned an appropriate measure-specific oversample. Provider chase logic was reviewed and determined appropriate across all hybrid measures. For HEDIS 2016, **Amerigroup** contracted with a medical record review (MRR) vendor, Health Data Vision, Inc. (HDVI), to procure and abstract medical records. HSAG participated in a live vendor demonstration of the HDVI tools and instructions. All fields, edits, and drop-down boxes were reviewed for accuracy against NCQA's current *HEDIS Volume 2, Technical Specifications for Health Plans*. HSAG reviewed HDVI's training abstraction manual and found no concerns. **Amerigroup** conducted appropriate oversight of its vendor through quality assurance of reviews, including over-reads of all abstractions resulting in a numerator positive or exclusions, and a random sample of numerator negatives. For HEDIS 2016, **Amerigroup** changed its MRR vendor from Inovalon, Inc. to HDVI with different tools, staff, and processes. Since the MRR vendor was responsible for all procurement and abstraction, a full convenience sample was required. HSAG completed the convenience sample review and did not find any issues.
- **Amerigroup** passed the MRRV process for the following measure groups:

- Group A: *Biometrics (BMI, BP) & Maternity—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile*
- Group B: *Anticipatory Guidance & Counseling—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition*
- Group C: *Laboratory—Comprehensive Diabetes Care—HbA1c Control (<8.0%)*
- Group D: *Immunization & Other Screenings—Childhood Immunization Status—Combination 3*
- Group D: *Immunization & Other Screenings—Childhood Immunization Status—Combination 4*
- Group D: *Immunization & Other Screenings—Childhood Immunization Status—Combination 5*
- Group F: Exclusions

- **Amerigroup** was fully compliant with IS 5.0. **Amerigroup** used several sources of standard supplemental data for HEDIS 2016 reporting, including LabCorp; Quest; Clinical Pathology Laboratories (CPL); and Early and Periodic Screening, Diagnosis and Treatment data. Roadmap Section 5 for each supplemental data source was updated prior to finalizing rates. All data sources were tracked and trended throughout the year to ensure data completeness. Consideration should be extended for future reporting years to determine relevant supplemental data sources for measure impact while completing the roadmap. There were no nonstandard data sources used for HEDIS 2016.
- IS 6.0 was not applicable to the scope of the audit, since **Amerigroup** was not required to report the call center measures for Nevada Medicaid and Nevada Check Up.
- **Amerigroup** was fully compliant with IS 7.0. **Amerigroup** continued to use Inovolan's software, Quality Spectrum Insight (QSI), for HEDIS 2016 certified measure production. Monthly, six programmers extracted data from the data warehouse and transferred it to QSI in the required format. Benchmarking data were compiled to check rates for reasonability and ensure data integrity. A uniform format was created for each type of data to avoid data issues during the compilation process and quality controls were in place after file creation to ensure accuracy. The vision, dental, pharmacy, and laboratory results were stored in independent tables within the data warehouse. Comprehensive trending logs were used to monitor all data types and sources. Duplicated claims were identified and no data were excluded. On-site primary source verification was conducted for the CDC, W15, and CAP measures and no issues were identified. On-site queries were conducted and all on-site documentation satisfied the required queries.

Medicaid Results

The Medicaid HEDIS 2015 rates and HEDIS 2016 rates for **Amerigroup** are presented in Table 5-2, along with 2015–2016 rate comparisons. For the measures with lower rates suggesting better performance (i.e., *Frequency of Ongoing Prenatal Care—<21 Percent of Expected Visits; Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*; *Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total*; and *Ambulatory Care—Total—Emergency Department [ED] Visits—Total*), a decrease in the rate from 2015 to 2016 represents improved performance and an increase in the rate from 2015 to 2016 represents a decline in performance.

Since measures in the Utilization and Diversity of Membership measure domain are designed to capture the frequency of services provided by the MCOs and characteristics of the population served by the MCO, higher or lower rates in this domain do not necessarily indicate better or worse performance. These rates are provided for information purposes only.

Table 5-2—Medicaid HEDIS Performance Measures Results for Amerigroup

HEDIS Measure	HEDIS 2015 Rate	HEDIS 2016 Rate	2015–2016 Rate Comparison
Access to Care			
Children and Adolescents' Access to Primary Care Practitioners			
Ages 12–24 Months	91.14%	94.15%	3.01
Ages 25 Months–6 Years	81.30%	83.55%	2.25
Ages 7–11 Years	85.60%	87.12%	1.52
Ages 12–19 Years	81.53%	83.76%	2.23
Annual Dental Visit			
Total	45.62%	53.21%	7.59
Children's Preventive Care			
Adolescent Well-Care Visits			
Adolescent Well-Care Visits	42.13%	38.43%	-3.70
Childhood Immunization Status			
Combination 2	66.20%	73.15%	6.95
Combination 3	60.88%	66.67%	5.79
Combination 4	58.80%	65.28%	6.48
Combination 5	50.23%	57.18%	6.95
Combination 6	33.33%	32.41%	-0.92
Combination 7	48.38%	56.48%	8.10
Combination 8	33.10%	32.41%	-0.69
Combination 9	28.24%	29.63%	1.39
Combination 10	28.01%	29.63%	1.62
Immunizations for Adolescents			
Combination 1 (Meningococcal, Tdap/Td)	—	71.93%	NC
Well-Child Visits in the First 15 Months of Life			
Six or More Well-Child Visits	50.58%	52.78%	2.20
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life			
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	65.66%	66.33%	0.67
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Percentile—Total	—	64.12%	NC
Counseling for Nutrition—Total	—	54.40%	NC
Counseling for Physical Activity—Total[1]	—	43.75%	NC

Table 5-2—Medicaid HEDIS Performance Measures Results for Amerigroup			
HEDIS Measure	**HEDIS 2015 Rate**	**HEDIS 2016 Rate**	**2015–2016 Rate Comparison**
Human Papillomavirus Vaccine for Female Adolescents			
Human Papillomavirus Vaccine for Female Adolescents	—	24.59%	NC
Maternity Care			
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	69.77%	75.41%	5.64
Postpartum Care	46.74%	53.16%	6.42
Frequency of Ongoing Prenatal Care			
*<21 Percent of Expected Visits**	15.81%	17.80%	1.99
≥81 Percent of Expected Visits	52.33%	56.44%	4.11
Care for Chronic Conditions			
Comprehensive Diabetes Care[1]			
Hemoglobin A1c (HbA1c) Testing	81.90%	79.63%	-2.27
*HbA1c Poor Control (>9.0%)**	46.40%	46.76%	0.36
Blood Pressure Control (<140/90 mm Hg)	62.18%	55.32%	-6.86
Eye Exam (Retinal) Performed	55.45%	55.09%	-0.36
Medical Attention for Nephropathy	75.17%	89.58%	14.41
HbA1c Control (<8.0%)	43.16%	46.30%	3.14
Medication Management for People With Asthma			
Medication Compliance 50%—Total	—	50.22%	NC
Medication Compliance 75%—Total	—	26.84%	NC
Behavioral Health			
Follow-Up After Hospitalization for Mental Illness			
7-Day Follow-Up	53.02%	52.99%	-0.03
30-Day Follow-Up	63.14%	64.55%	1.41
Follow-Up Care for Children Prescribed ADHD Medication			
Initiation Phase	—	36.68%	NC
Continuation and Maintenance Phase	—	40.91%	NC
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*			
Total	—	0.00%	NC
Utilization and Diversity of Membership			
Mental Health Utilization—Total			
Any Service—Total	—	7.21%	NC
Inpatient—Total	—	1.18%	NC
Intensive Outpatient or Partial Hospitalization—Total	—	0.28%	NC
Outpatient or Emergency Department—Total	—	7.01%	NC
Ambulatory Care—Total			
*Emergency Department (ED) Visits—Total**	—	55.08	NC
Outpatient Visits—Total	—	294.01	NC

Table 5-2—Medicaid HEDIS Performance Measures Results for Amerigroup			
HEDIS Measure	**HEDIS 2015 Rate**	**HEDIS 2016 Rate**	**2015–2016 Rate Comparison**
Weeks of Pregnancy at Time of Enrollment			
Prior to 0 Weeks	—	26.39%	NC
1–12 Weeks	—	12.50%	NC
13–27 Weeks	—	41.44%	NC
28 or More Weeks of Pregnancy	—	19.68%	NC
Unknown	—	0.00%	NC

[1] Due to changes in the technical specifications for this measure, caution should be exercised when comparing rates between 2015 and 2016.

* A lower rate indicates better performances for this measure.

— Indicates the measure was not presented in the previous year's technical report, and therefore a HEDIS 2015 measure rate is not presented in this year's report.

NC indicates the 2015–2016 rate comparison could not be calculated because data were not available for both years or because an increase or decrease in the rate did not necessarily indicate better or worse performance.

NA indicates the denominator for the measure was too small to report (less than 30).

A majority of **Amerigroup**'s measures with rates presented for HEDIS 2015 and HEDIS 2016 for the Medicaid population were stable (i.e., decreased or increased by fewer than 5 percentage points) across all measure domains and several measure rates demonstrated performance improvement. Specifically, **Amerigroup**'s *Annual Dental Visit—Total* measure rate in the Access to Care measure domain increased by more than 7 percentage points from HEDIS 2015 to HEDIS 2016. With regard to Children's Preventive Care, five of the nine *Childhood Immunization Status* measure indicator rates demonstrated improvement, with increases of more than 5 percentage points from HEDIS 2015 to HEDIS 2016. In the Maternity Care measure domain, **Amerigroup**'s *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* rates showed improvement by more than 5 percentage points. **Amerigroup**'s *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure rate increased by more than 14 percentage points from HEDIS 2015 to HEDIS 2016. However, due to changes in HEDIS technical specifications, caution should be exercised when comparing HEDIS 2015 rates to HEDIS 2016 rates for the *Comprehensive Diabetes Care* measure indicators.

Conversely, the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* rate decreased by more than 6 percentage points, indicating performance decline. As mentioned above, caution should be exercised when comparing HEDIS 2015 rates to HEDIS 2016 rates for the *Comprehensive Diabetes Care* measure indicators. Of note, within the Behavioral Health measure domain, the rate for *Use of Multiple Concurrent Antipsychotics in Children and Adolescents* indicated overall positive performance, reporting zero members ages 1–17 who were on two or more concurrent antipsychotic medications.

Nevada Check Up Results

The Nevada Check Up HEDIS 2015 rates and HEDIS 2016 rates for **Amerigroup** are presented in Table 5-3, along with 2015–2016 rate comparisons. For the measures with lower rates suggesting better performance (i.e., *Use of Multiple Concurrent Antipsychotics in Children and Adolescents—*

Total and *Ambulatory Care—Total—Emergency Department [ED] Visits—Total*), a decrease in the rate from 2015 to 2016 represents improved performance and an increase in the rate from 2015 to 2016 represents a decline in performance. Since measures in the Utilization and Diversity of Membership measure domain are designed to capture the frequency of services provided by the MCOs and characteristics of the population served by the MCO, higher or lower rates in this domain do not necessarily indicate better or worse performance. These rates are provided for information purposes only.

Table 5-3—Nevada Check Up HEDIS Performance Measures Results for Amerigroup

HEDIS Measure	HEDIS 2015 Rate	HEDIS 2016 Rate	2015–2016 Rate Comparison
Access to Care			
Children and Adolescents' Access to Primary Care Practitioners			
Ages 12–24 Months	95.83%	98.73%	2.90
Ages 25 Months–6 Years	90.48%	89.53%	-0.95
Ages 7–11 Years	92.62%	92.91%	0.29
Ages 12–19 Years	92.18%	88.95%	-3.23
Annual Dental Visit			
Total	64.48%	67.05%	2.57
Children's Preventive Care			
Adolescent Well-Care Visits			
Adolescent Well-Care Visits	56.48%	56.34%	-0.14
Childhood Immunization Status			
Combination 2	74.55%	85.90%	11.35
Combination 3	73.64%	78.21%	4.57
Combination 4	73.64%	77.56%	3.92
Combination 5	54.55%	68.59%	14.04
Combination 6	45.45%	46.79%	1.34
Combination 7	54.55%	67.95%	13.40
Combination 8	45.45%	46.79%	1.34
Combination 9	32.73%	42.95%	10.22
Combination 10	32.73%	42.95%	10.22
Immunizations for Adolescents			
Combination 1 (Meningococcal, Tdap/Td)	—	81.61%	NC
Well-Child Visits in the First 15 Months of Life			
Six or More Well-Child Visits	70.37%	78.05%	7.68
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life			
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	71.30%	70.28%	-1.02
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Percentile—Total	—	62.04%	NC
Counseling for Nutrition—Total	—	55.56%	NC
Counseling for Physical Activity—Total[1]	—	47.69%	NC

Table 5-3—Nevada Check Up HEDIS Performance Measures Results for Amerigroup			
HEDIS Measure	**HEDIS 2015 Rate**	**HEDIS 2016 Rate**	**2015–2016 Rate Comparison**
Human Papillomavirus Vaccine for Female Adolescents			
Human Papillomavirus Vaccine for Female Adolescents	—	34.11%	NC
Care for Chronic Conditions			
Medication Management for People With Asthma			
Medication Compliance 50%—Total	—	47.76%	NC
Medication Compliance 75%—Total	—	26.87%	NC
Behavioral Health			
Follow-Up After Hospitalization for Mental Illness			
7-Day Follow-Up	NA	84.85%	NC
30-Day Follow-Up	NA	93.94%	NC
Follow-Up Care for Children Prescribed ADHD Medication			
Initiation Phase	—	NA	NC
Continuation and Maintenance Phase	—	NA	NC
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*			
Total	—	NA	NC
Utilization and Diversity of Membership			
Mental Health Utilization—Total			
Any Service—Total	—	5.76%	NC
Inpatient—Total	—	0.46%	NC
Intensive Outpatient or Partial Hospitalization—Total	—	0.32%	NC
Outpatient or Emergency Department—Total	—	5.69%	NC
Ambulatory Care—Total			
*Emergency Department (ED) Visits—Total**	—	26.14	NC
Outpatient Visits—Total	—	263.50	NC

[1] Due to changes in the technical specifications for this measure, caution should be exercised when comparing rates between 2015 and 2016.

* A lower rate indicates better performances for this measure.

— Indicates the measure was not presented in previous year's technical report, and therefore a HEDIS 2015 measure rate is not presented in this year's report.

NC indicates the 2015–2016 rate comparison could not be calculated because data were not available for both years or because an increase or decrease in the rate did not necessarily indicate better or worse performance.

NA indicates the denominator for the measure was too small to report (less than 30).

Analogous to the Medicaid population's rates, **Amerigroup**'s rates for the Nevada Check Up population also remained stable from HEDIS 2015 to HEDIS 2016, with several Children's Preventive Care rates indicating performance improvement. Five of the nine *Childhood Immunization Status* measure indicator rates increased by more than 10 percentage points from HEDIS 2015 to HEDIS 2016, demonstrating improved reporting of immunizations for children. Further, **Amerigroup**'s rate for W*ell-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* increased from HEDIS 2015 to HEDIS 2016 by more than 7 percentage points.

None of the rates reported for the Nevada Check Up population demonstrated a decline in performance of greater than 5 percentage points from HEDIS 2015 to HEDIS 2016.

Summary of Amerigroup Emerging Improvement

The following Medicaid performance measure indicators were identified as emerging improvement for **Amerigroup** based on rate improvements greater than 5 percentage points from HEDIS 2015 to HEDIS 2016:

- *Annual Dental Visit—Total*
- *Childhood Immunization Status—Combinations 2, 3, 4, 5, 7*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*[5-1]

The following Nevada Check Up performance measure indicators were identified as emerging improvement for **Amerigroup** based on rate improvements greater than 5 percentage points from HEDIS 2015 to HEDIS 2016:

- *Childhood Immunization Status—Combinations 2, 5, 7, 9, and 10*
- *Well-Child Visits in the First 15 Months of Life—Six or More Visits*

Summary of Amerigroup Opportunities for Improvement

The following Medicaid performance measure indicator was identified as an opportunity for improvement for **Amerigroup** based on a decline in performance of greater than 5 percentage points from HEDIS 2015 to HEDIS 2016.

- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*[5-2]

None of the Nevada Check Up performance measure indicators for **Amerigroup** had a decline in performance by greater than 5 percentage points from HEDIS 2015 to HEDIS 2016.

[5-1] Due to changes in the technical specifications for this measure, caution should be exercised when comparing rates between 2015 and 2016.
[5-2] Ibid.

Plan-Specific Findings—HPN

A detailed review of the 2016 performance reports submitted by **HPN** determined that the reports were prepared according to the *HEDIS 2016 Technical Specifications* for all of the audited measures, which are listed in Appendix A. Audits of IS capabilities for accurate HEDIS reporting found that **HPN** was compliant with the standards assessed, as follows:

- **HPN** was fully compliant with IS Standard 1.0 for medical services data and continued to use the Facets system for claims processing. Data entry processes were effective and efficient, and they assured timely, accurate entry into the system. Only standard codes were accepted, and approximately 75 percent of the claims and encounters were auto-adjudicated. The Facets system captured the rendering provider, even for claims submitted from federally qualified health centers (FQHCs), and enforced ICD-9 coding specificity, as required. As of October 1, 2015, **HPN** no longer accepted ICD-9 codes and transitioned to ICD-10 codes. This transition was well-planned and appeared to be seamless. There was no noticeable reduction in claims or diagnoses codes submitted. Most claims received by **HPN** were electronic claims (electronic data interchange [EDI]). **HPN** had appropriate procedures to receive and monitor the EDI submissions. The **HPN** staff monitored and trended volume on a routine basis to ensure data completeness. In addition to monitoring data completeness, **HPN** had appropriate validation processes to ensure accurate claims and encounter data submission. Pharmacy data were obtained from Optum Rx, while lab data came from Quest. **HPN** also had appropriate processes in place to oversee these vendors, which included review of submitted data and monitoring contract standards. There were no issues identified with the medical services data.
- **HPN** was fully compliant with IS Standard 2.0 for enrollment data. Membership data were received by **HPN** from the State's vendor and were fully reconciled each month. **HPN** had processes in place to assure timely and accurate loading of these data. **HPN** tracked members using the system-issued number. This allowed linkage of data if a member lost and regained eligibility. **HPN** also had the ability to link members who switched product lines. For newborns, the State initially provided a file with the mother and an unborn baby identified for enrollment. Once the baby's birth was reported, the new enrollment file was updated to include the baby's new ID. There appeared to be no issues with linking the appropriate claims back to the newborn's record using the system ID. The State encountered a technical issue with the enrollment files that caused some members to drop off of the enrollment files in 2015. As a result, **HPN** manually corrected approximately 800 to 1,000 member enrollments each month. The issue has not yet been corrected by the State. **HPN** continues to work these adjustments manually each month; therefore, there was no impact to the HEDIS eligible populations.
- **HPN** was fully compliant with IS Standard 3.0 for practitioner data. All of the provider-related data elements required for the Medicaid HEDIS measures under the scope of the audit were captured and verified within the systems. **HPN** continued to use the Cactus software for provider credentialing and to determine provider types and specialties. The credentialing data were directly entered into Facets and then verified against the source data (Cactus). There were no issues identified, and **HPN** was able to distinguish provider types and specialties as required for HEDIS reporting. Since the Board Certification measure was not included in the scope of the audit, credentialing and recredentialing were not reviewed.

- **HPN** was fully compliant with the IS standard 4.0 requirements. HSAG reviewed **HPN**'s IS 4 Roadmap pertaining to the policies and procedures for IS standards 4.1, 4.2, 4.3, 4.4, and 4.5. The roadmap review found these policies and procedures to be consistent with the NCQA *HEDIS 2016, Volume 5, HEDIS Compliance Audit: Standards, Policies and Procedures*. **HPN** sampled according to the HEDIS sampling guidelines and assigned an appropriate measure-specific oversample. Provider chase logic was reviewed and determined appropriate across all hybrid measures. **HPN**'s staff used Verisk hybrid medical record abstraction tools. HSAG participated in a live vendor demonstration of the Verisk tools and instructions. All fields, edits, and drop-down boxes were reviewed for accuracy against the NCQA *HEDIS 2016, Volume 2, Technical Specifications for Health Plans*. HSAG reviewed **HPN**'s training abstraction manual and found no concerns. **HPN** used internal staff members to conduct medical record reviews and quality assurance. Staff members were sufficiently qualified and trained in the HEDIS 2016 technical specifications and the use of Verisk's abstraction tools to accurately conduct medical record reviews. Verisk maintained appropriate quality assurance of reviews, including over-reads of all abstractions resulting in numerator positives or exclusions, and a random sample of numerator negatives.
- A convenience sample was required for the *Adolescent Well-Care Visits* measure due to errors found during the 2015 validation. A convenience sample was also required for the following State-required measures: *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, Immunizations for Adolescents*, and *Human Papillomavirus Vaccine for Female Adolescents*. HSAG completed the convenience sample review and did not find any issues.
- **HPN** passed the MRR process for the following measure groups:
  - *Group A: Biometrics (BMI, BP) & Maternity—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile*
  - *Group B: Anticipatory Guidance & Counseling—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity*
  - *Group C: Laboratory—Comprehensive Diabetes Care—HbA1c Control (<8.0%)*
  - *Group C: Laboratory—Comprehensive Diabetes Care—Medical Attention for Nephropathy*
  - *Group C: Laboratory—Comprehensive Diabetes Care—HbA1c Testing*
  - *Group D: Immunization & Other Screenings—Childhood Immunization Status—Combination 3*
  - *Group F: Exclusions*
- **HPN** was fully compliant with IS Standard 5.0 for supplemental data. **HPN** received laboratory data from QUEST and immunization registry data from the State. Both databases were considered external, standard data. **HPN** also identified historical medical record review data as standard data. **HPN** had processes for data receipt, processing, and loading into the HEDIS vendor's software. **HPN** provided all the required supporting documentation for the standard databases. **HPN** also identified a nonstandard database, Touchworks, to use for reporting. This database contained nine members across three different measures. Proof of service was requested and validated for these supplemental data cases. All nine cases were reviewed and passed the data validation process. There were no issues identified with any of the supplemental data and all standard and nonstandard databases were approved for HEDIS 2016 reporting.

- IS 6.0 was not applicable to the scope of the audit since **HPN** was not required to report the call center measures for Nevada Medicaid and Nevada Check Up.
- **HPN** was fully compliant with IS Standard 7.0 for data integration. **HPN** used Verisk for the calculation of its HEDIS rates. The data integration process has been consistent for many years. Data were loaded from Facets and the Corporate Reporting Database (CRD) directly into Kramer, the data warehouse repository. These data were then loaded into Verisk's software. Reports were generated during each load process to ensure accurate and complete data were captured. Additional reports were generated monthly to compare data in Kramer versus data in Verisk, as well as data in Kramer versus data in Facets and CRD. This high-level reporting system helped ensure the appropriateness of the data and the accuracy of the data transfers. Overall, there were no issues identified with the data integration process. Record tracing verification was conducted on-site for 10 measures and no issues were identified. In addition, preliminary rates were reviewed on-site, showing some improvements with *Comprehensive Diabetes Care* (CDC) rates and well-child rates. Rates that appeared low did not yet have medical record data incorporated. In general, Nevada Check-Up rates were higher than the corresponding rates for Nevada Medicaid. A formal preliminary rate review was conducted following the on-site audit and rates appeared reasonable. The final rate review did not identify any issues and the patient level detail file matched the reported rates. Therefore, all of the rates were approved for reporting.

Medicaid Results

The Medicaid HEDIS 2015 rates and HEDIS 2016 rates for **HPN** are presented in Table 5-4, along with 2015–2016 rate comparisons. For the measures with lower rates suggesting better performance (i.e., *Frequency of Ongoing Prenatal Care—<21 Percent of Expected Visits*; *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*; *Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total*; and *Ambulatory Care—Total—Emergency Department [ED] Visits—Total*), a decrease in the rate from 2015 to 2016 represents improved performance and an increase in the rate from 2015 to 2016 represents a decline in performance. Since measures in the Utilization and Diversity of Membership measure domain are designed to capture the frequency of services provided by the MCOs as well as characteristics of the population served by the MCO, higher or lower rates in this domain do not necessarily indicate better or worse performance. These rates are provided for information purposes only.

Table 5-4—Medicaid HEDIS Performance Measures Results for HPN

HEDIS Measure	HEDIS 2015 Rate	HEDIS 2016 Rate	2015–2016 Rate Comparison
Access to Care			
Children and Adolescents' Access to Primary Care Practitioners			
Ages 12–24 Months	91.42%	94.80%	3.38
Ages 25 Months–6 Years	79.24%	84.29%	5.05
Ages 7–11 Years	83.93%	87.36%	3.43
Ages 12–19 Years	80.80%	85.21%	4.41
Annual Dental Visit			
Total	51.12%	55.03%	3.91

Table 5-4—Medicaid HEDIS Performance Measures Results for HPN			
HEDIS Measure	**HEDIS 2015 Rate**	**HEDIS 2016 Rate**	**2015–2016 Rate Comparison**
Children's Preventive Care			
Adolescent Well-Care Visits			
Adolescent Well-Care Visits	37.47%	44.04%	6.57
Childhood Immunization Status			
Combination 2	70.80%	74.94%	4.14
Combination 3	66.18%	70.32%	4.14
Combination 4	66.18%	70.07%	3.89
Combination 5	53.04%	55.72%	2.68
Combination 6	39.42%	38.44%	-0.98
Combination 7	53.04%	55.72%	2.68
Combination 8	39.42%	38.44%	-0.98
Combination 9	32.36%	31.14%	-1.22
Combination 10	32.36%	31.14%	-1.22
Immunizations for Adolescents			
Combination 1 (Meningococcal, Tdap/Td)	—	79.81%	NC
Well-Child Visits in the First 15 Months of Life			
Six or More Well-Child Visits	51.58%	53.77%	2.19
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life			
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	60.83%	64.48%	3.65
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Percentile—Total	—	70.32%	NC
Counseling for Nutrition—Total	—	57.91%	NC
Counseling for Physical Activity—Total[1]	—	52.07%	NC
Human Papillomavirus Vaccine for Female Adolescents			
Human Papillomavirus Vaccine for Female Adolescents	—	29.68%	NC
Maternity Care			
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	77.62%	73.97%	-3.65
Postpartum Care	58.88%	57.18%	-1.70
Frequency of Ongoing Prenatal Care			
*<21 Percent of Expected Visits**	17.03%	14.60%	-2.43
≥81 Percent of Expected Visits	51.34%	52.07%	0.73
Care for Chronic Conditions			
Comprehensive Diabetes Care[1]			
Hemoglobin A1c (HbA1c) Testing	84.18%	85.64%	1.46
*HbA1c Poor Control (>9.0%)**	44.53%	45.74%	1.21
Blood Pressure Control (<140/90 mm Hg)	70.32%	60.83%	-9.49

Table 5-4—Medicaid HEDIS Performance Measures Results for HPN			
HEDIS Measure	**HEDIS 2015 Rate**	**HEDIS 2016 Rate**	**2015–2016 Rate Comparison**
Eye Exam (Retinal) Performed	55.96%	56.93%	0.97
Medical Attention for Nephropathy	82.73%	92.21%	9.48
HbA1c Control (<8.0%)	43.80%	46.47%	2.67
Medication Management for People With Asthma			
Medication Compliance 50%—Total	—	46.96%	NC
Medication Compliance 75%—Total	—	24.14%	NC
Behavioral Health			
Follow-Up After Hospitalization for Mental Illness			
7-Day Follow-Up	48.49%	56.51%	8.02
30-Day Follow-Up	66.89%	69.41%	2.52
Follow-Up Care for Children Prescribed ADHD Medication			
Initiation Phase	—	46.65%	NC
Continuation and Maintenance Phase	—	58.02%	NC
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*			
Total	—	1.80%	NC
Utilization and Diversity of Membership			
Mental Health Utilization—Total			
Any Service—Total	—	5.90%	NC
Inpatient—Total	—	0.77%	NC
Intensive Outpatient or Partial Hospitalization—Total	—	0.23%	NC
Outpatient or Emergency Department—Total	—	5.67%	NC
Ambulatory Care—Total			
*Emergency Department (ED) Visits—Total**	—	49.39	NC
Outpatient Visits—Total	—	292.44	NC
Weeks of Pregnancy at Time of Enrollment			
Prior to 0 Weeks	—	33.27%	NC
1–12 Weeks	—	12.99%	NC
13–27 Weeks	—	28.38%	NC
28 or More Weeks of Pregnancy	—	21.28%	NC
Unknown	—	4.09%	NC

[1] Due to changes in the technical specifications for this measure, caution should be exercised when comparing rates between 2015 and 2016.

* A lower rate indicates better performances for this measure.

— Indicates the measure was not presented in the previous year's technical report and therefore, a HEDIS 2015 measure rate is not presented in this year's report.

NC indicates the 2015–2016 rate comparison could not be calculated because data were not available for both years or because an increase or decrease in the rate does not necessarily indicate better or worse performance.

NA indicates the denominator for the measure was too small to report (less than 30).

Most of **HPN**'s measures with rates presented for HEDIS 2015 and HEDIS 2016 for the Medicaid population were relatively stable across all measure domains, with select measurement areas demonstrating performance changes. Within the Access to Care and Children's Preventive Care measure domains, rates for *Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years,* and for *Adolescent Well-Care Visits,* increased from HEDIS 2015 to HEDIS 2016 by more than 5 percentage points.

With regard to the Care for Chronic Conditions measure domain, **HPN**'s *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure rate demonstrated performance improvement in providing medical attention for nephropathy, with an increase of more than 9 percentage points from HEDIS 2015 to HEDIS 2016. Conversely, the rate for *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* declined by more than 9 percentage points. However, due to changes in the technical specifications for these measures, caution should be exercised when comparing rates between 2015 and 2016.

Within the Behavioral Health measure domain, the rate for *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* increased by more than 8 percentage points from HEDIS 2015 to HEDIS 2016.

Nevada Check Up Results

The Nevada Check Up HEDIS 2015 Rates and HEDIS 2016 Rates for **HPN** are presented in Table 5-5, along with 2015–2016 Rate Comparisons. For the measures with lower rates suggesting better performance (i.e., *Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total* and *Ambulatory Care—Total—Emergency Department [ED] Visits—Total*), please note a decrease in the rate from 2015 to 2016 represents improved performance and an increase in the rate from 2015 to 2016 represents a decline in performance. Since measures in the Utilization and Diversity of Membership measure domain are designed to capture the frequency of services provided by the MCOs and characteristics of the population served by the MCO, higher or lower rates in this domain do not necessarily indicate better or worse performance. These rates are provided for information purposes only.

Table 5-5—Nevada Check Up HEDIS Performance Measures Results for HPN

HEDIS Measure	HEDIS 2015 Rate	HEDIS 2016 Rate	2015–2016 Rate Comparison
Access to Care			
Children and Adolescents' Access to Primary Care Practitioners			
Ages 12–24 Months	94.70%	99.48%	4.78
Ages 25 Months–6 Years	87.20%	89.55%	2.35
Ages 7–11 Years	93.83%	93.54%	-0.29
Ages 12–19 Years	90.79%	90.78%	-0.01
Annual Dental Visit			
Total	69.50%	70.11%	0.61

Table 5-5—Nevada Check Up HEDIS Performance Measures Results for HPN			
HEDIS Measure	**HEDIS 2015 Rate**	**HEDIS 2016 Rate**	**2015–2016 Rate Comparison**
Children's Preventive Care			
Adolescent Well-Care Visits			
Adolescent Well-Care Visits	55.47%	52.83%	-2.64
Childhood Immunization Status			
Combination 2	83.46%	87.93%	4.47
Combination 3	77.17%	84.48%	7.31
Combination 4	76.38%	83.91%	7.53
Combination 5	66.14%	79.89%	13.75
Combination 6	48.03%	52.30%	4.27
Combination 7	65.35%	79.31%	13.96
Combination 8	47.24%	51.72%	4.48
Combination 9	42.52%	50.00%	7.48
Combination 10	41.73%	49.43%	7.70
Immunizations for Adolescents			
Combination 1 (Meningococcal, Tdap/Td)	—	87.35%	NC
Well-Child Visits in the First 15 Months of Life			
Six or More Well-Child Visits	60.00%	68.00%	8.00
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life			
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	71.95%	70.13%	-1.82
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Percentile—Total	—	72.02%	NC
Counseling for Nutrition—Total	—	60.34%	NC
Counseling for Physical Activity—Total[1]	—	57.18%	NC
Human Papillomavirus Vaccine for Female Adolescents			
Human Papillomavirus Vaccine for Female Adolescents	—	42.62%	NC
Care for Chronic Conditions			
Medication Management for People With Asthma			
Medication Compliance 50%—Total	—	47.62%	NC
Medication Compliance 75%—Total	—	26.98%	NC
Behavioral Health			
Follow-Up After Hospitalization for Mental Illness			
7-Day Follow-Up	NA	NA	NC
30-Day Follow-Up	NA	NA	NC
Follow-Up Care for Children Prescribed ADHD Medication			
Initiation Phase	—	39.53%	NC
Continuation and Maintenance Phase	—	NA	NC

Table 5-5—Nevada Check Up HEDIS Performance Measures Results for HPN			
HEDIS Measure	**HEDIS 2015 Rate**	**HEDIS 2016 Rate**	**2015–2016 Rate Comparison**
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*			
Total	—	NA	NC
Utilization and Diversity of Membership			
Mental Health Utilization—Total			
Any Service—Total	—	4.71%	NC
Inpatient—Total	—	0.14%	NC
Intensive Outpatient or Partial Hospitalization—Total	—	0.55%	NC
Outpatient or Emergency Department—Total	—	4.67%	NC
Ambulatory Care—Total			
*Emergency Department (ED) Visits—Total**	—	21.00	NC
Outpatient Visits—Total	—	259.29	NC

[1] Due to changes in the technical specifications for this measure, caution should be exercised when comparing rates between 2015 and 2016.

* A lower rate indicates better performances for this measure.

— Indicates the measure was not presented in the previous year's technical report and therefore, a HEDIS 2015 measure rate is not presented in this year's report.

NC indicates the 2015–2016 rate comparison could not be calculated because data were not available for both years or because an increase or decrease in the rate does not necessarily indicate better or worse performance.

NA indicates the denominator for the measure was too small to report (less than 30).

Performance improvement was limited to rates in the Children's Preventive Care measure domain for **HPN**'s Nevada Check Up population. Of note, six of the nine *Childhood Immunization Status* measure indicator rates demonstrated performance improvement from HEDIS 2015 to HEDIS 2016. Specifically, *Combinations 3, 4, 9,* and *10* increased more than 7 percentage points from HEDIS 2015 to HEDIS 2016, and *Combinations 5* and *7* increased by more than 13 percentage points. Additionally, the *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* rate increased by 8 percentage points from HEDIS 2015 to HEDIS 2016. None of the rates reported by **HPN** for the Nevada Check Up population demonstrated a decline in performance of greater than 5 percentage points from HEDIS 2015 to HEDIS 2016.

Summary of HPN Emerging Improvement

The following Medicaid performance measure indicators were identified as emerging improvement for **HPN** based on rate improvements greater than 5 percentage points from HEDIS 2015 to HEDIS 2016:

- *Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years*
- *Adolescent Well-Care Visits*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*[5-3]
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up*

[5-3] Due to changes in the technical specifications for this measure, caution should be exercised when comparing rates between 2015 and 2016.

The following Nevada Check Up performance measure indicators were identified as emerging improvement for **HPN** based on rate improvements greater than 5 percentage points from HEDIS 2015 to HEDIS 2016:

- *Childhood Immunization Status—Combinations 3, 4, 5, 7, 9, and 10*
- *Well-Child Visits in the First 15 Months of Life—Six or More Visits*

Summary of HPN Opportunities for Improvement

The following Medicaid performance measure indicators were identified as opportunities for improvement for **HPN** based on a decline in performance of greater than 5 percentage points from HEDIS 2015 to HEDIS 2016.

- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*[5-4]

None of the Nevada Check Up performance measure indicators for **HPN** had a decline in performance by greater than 5 percentage points from HEDIS 2015 to HEDIS 2016.

Plan Comparison

The HEDIS 2016 measure rates for **HPN**, **Amerigroup**, and the statewide weighted average results for the Medicaid and Nevada Check Up populations relative to the NCQA HEDIS 2015 Audit Means and Percentiles national Medicaid benchmarks are shown in Table 5-6 and Table 5-8. Measure results were compared to benchmarks and rated using the following star ratings:

★ = Below the national Medicaid 25th percentile
★★ = At or above the national Medicaid 25th percentile but below the 50th percentile
★★★ = At or above the national Medicaid 50th percentile but below the 75th percentile
★★★★ = At or above the national Medicaid 75th percentile but below the 90th percentile
★★★★★ = At or above the national Medicaid 90th percentile

For the measures denoted with an asterisk (*) (i.e., *Frequency of Ongoing Prenatal Care—<21 Percent of Expected Visits*; *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*; *Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total*; and *Ambulatory Care—Total—Emergency Department [ED] Visits—Total*), lower rates indicate better performance. Since measures in the Utilization and Diversity of Membership measure domain are designed to capture the frequency of services provided by the MCOs as well as characteristics of the population served by the MCO, higher or lower rates in this domain do not necessarily indicate better or worse performance. These rates are provided for information purposes only, and comparisons to benchmarks were not conducted.

[5-4] Due to changes in the technical specifications for this measure, caution should be exercised when comparing rates between 2015 and 2016.

Medicaid Results

Table 5-6 presents the HEDIS 2016 MCO-specific rates and the statewide weighted average Medicaid rates along with star ratings based on comparisons of the rates to the NCQA HEDIS 2015 Audit Means and Percentiles national Medicaid benchmarks.

Table 5-6—HEDIS 2016 Results for Medicaid			
HEDIS Measure	**HPN**	**AGP**	**Medicaid**
Access to Care			
Children and Adolescents' Access to Primary Care Practitioners			
Ages 12–24 Months	94.80% ★★	94.15% ★	94.48% ★★
Ages 25 Months–6 Years	84.29% ★	83.55% ★	83.93% ★
Ages 7–11 Years	87.36% ★	87.12% ★	87.26% ★
Ages 12–19 Years	85.21% ★	83.76% ★	84.67% ★
Annual Dental Visit			
Total	55.03% ★★★	53.21% ★★	54.25% ★★
Children's Preventive Care			
Adolescent Well-Care Visits			
Adolescent Well-Care Visits	44.04% ★★	38.43% ★	41.89% ★★
Childhood Immunization Status			
Combination 2	74.94% ★★	73.15% ★★	74.04% ★★
Combination 3	70.32% ★★	66.67% ★★	68.48% ★★
Combination 4	70.07% ★★★	65.28% ★★	67.65% ★★★
Combination 5	55.72% ★★	57.18% ★★	56.45% ★★
Combination 6	38.44% ★★	32.41% ★	35.40% ★
Combination 7	55.72% ★★★	56.48% ★★★	56.10% ★★★
Combination 8	38.44% ★★	32.41% ★	35.40% ★★
Combination 9	31.14% ★★	29.63% ★★	30.38% ★★
Combination 10	31.14% ★★	29.63% ★★	30.38% ★★
Immunizations for Adolescents			
Combination 1 (Meningococcal, Tdap/Td)	79.81% ★★★	71.93% ★★	76.80% ★★★

Table 5-6—HEDIS 2016 Results for Medicaid			
HEDIS Measure	**HPN**	**AGP**	**Medicaid**
Well-Child Visits in the First 15 Months of Life			
Six or More Well-Child Visits	53.77% ★★	52.78% ★★	53.26% ★★
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life			
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	64.48% ★	66.33% ★★	65.36% ★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Percentile—Total	70.32% ★★★	64.12% ★★	67.74% ★★★
Counseling for Nutrition—Total	57.91% ★★	54.40% ★★	56.45% ★★
Counseling for Physical Activity—Total	52.07% ★★	43.75% ★	48.61% ★★
Human Papillomavirus Vaccine for Female Adolescents			
Human Papillomavirus Vaccine for Female Adolescents	29.68% ★★★★	24.59% ★★★	27.74% ★★★★
Maternity Care			
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	73.97% ★	75.41% ★	74.67% ★
Postpartum Care	57.18% ★★	53.16% ★	55.22% ★
Frequency of Ongoing Prenatal Care			
*<21 Percent of Expected Visits**	14.60% ★★	17.80% ★	16.16% ★
≥81 Percent of Expected Visits	52.07% ★★	56.44% ★★	54.20% ★★
Care for Chronic Conditions			
Comprehensive Diabetes Care			
Hemoglobin A1c (HbA1c) Testing	85.64% ★★	79.63% ★	83.34% ★★
*HbA1c Poor Control (>9.0%)**	45.74% ★★	46.76% ★★	46.13% ★★
Blood Pressure Control (<140/90 mm Hg)	60.83% ★★	55.32% ★	58.71% ★★
Eye Exam (Retinal) Performed	56.93% ★★★	55.09% ★★★	56.23% ★★★
Medical Attention for Nephropathy	92.21% ★★★★★	89.58% ★★★★★	91.20% ★★★★★
HbA1c Control (<8.0%)	46.47% ★★	46.30% ★★	46.40% ★★
Medication Management for People With Asthma			
Medication Compliance 50%—Total	46.96% ★	50.22% ★★	48.14% ★★
Medication Compliance 75%—Total	24.14% ★★	26.84% ★★	25.12% ★★

Table 5-6—HEDIS 2016 Results for Medicaid			
HEDIS Measure	**HPN**	**AGP**	**Medicaid**
Behavioral Health			
Follow-Up After Hospitalization for Mental Illness			
7-Day Follow-Up	56.51% ★★★	52.99% ★★★	54.56% ★★★
30-Day Follow-Up	69.41% ★★★	64.55% ★★	66.72% ★★★
Follow-Up Care for Children Prescribed ADHD Medication			
Initiation Phase	46.65% ★★★	36.68% ★★	42.15% ★★★
Continuation and Maintenance Phase	58.02% ★★★	40.91% ★★	52.00% ★★★
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*			
Total	1.80% ★★★	0.00% ★★★★★	1.02% ★★★★
Utilization and Diversity of Membership			
Mental Health Utilization—Total			
Any Service—Total	5.90% NC	7.21% NC	6.47% NC
Inpatient—Total	0.77% NC	1.18% NC	0.95% NC
Intensive Outpatient or Partial Hospitalization—Total	0.23% NC	0.28% NC	0.25% NC
Outpatient or Emergency Department—Total	5.67% NC	7.01% NC	6.25% NC
Ambulatory Care—Total			
*Emergency Department (ED) Visits—Total**	49.39 NC	55.08 NC	51.85 NC
Outpatient Visits—Total	292.44 NC	294.01 NC	293.12 NC
Weeks of Pregnancy at Time of Enrollment			
Prior to 0 Weeks	33.27% NC	26.39% NC	32.80% NC
1–12 Weeks	12.99% NC	12.50% NC	12.96% NC
13–27 Weeks	28.38% NC	41.44% NC	29.26% NC
28 or More Weeks of Pregnancy	21.28% NC	19.68% NC	21.17% NC
Unknown	4.09% NC	0.00% NC	3.81% NC

* A lower rate indicates better performances for this measure.

NC indicates the HEDIS 2016 rate was not compared to benchmarks either because data were not available or because a measure is informational only and comparisons to benchmarks are not appropriate.

NA indicates the denominator for the measure was too small to report (less than 30).

With regard to the statewide weighted average results for Medicaid, most of the rates fell below the national 50th percentile. However, statewide weighted averages for *Human Papillomavirus Vaccine for Female Adolescents* and *Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total* ranked at or above the national 75th percentile but below the 90th percentile, and the rate for *Comprehensive Diabetes Care—Medical Attention for Nephropathy* ranked at or above the national 90th percentile indicating performance strengths.

Overall, **HPN**'s and **Amerigroup**'s HEDIS 2016 rates for the Medicaid population ranked similarly compared to the national benchmarks. Rates across all the measure domains indicated opportunities for improvement for both MCOs. Of the 39 measure rates that were comparable to national benchmarks, 26 of **HPN**'s rates fell below the national 50th percentile (67 percent), and 33 of **Amerigroup**'s rates fell below the national 50th percentile (85 percent).

Within the Access to Care measure domain, **HPN**'s rates ranked slightly higher than **Amerigroup**'s rates only for *Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months* and *Annual Dental Visit—Total*.

For Children's Preventive Care, most of **HPN**'s rates ranked the same as or slightly higher than **Amerigroup**'s rates, with the exception of **Amerigroup**'s *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* rate, which ranked slightly higher than **HPN**'s rate.

Two of the four Maternity Care measure rates reported by **HPN** ranked slightly higher than **Amerigroup**'s rates (i.e., *Prenatal and Postpartum Care—Postpartum Care* and *Frequency of Ongoing Prenatal Care—<21 Percent of Expected Visits*).

With regard to Care for Chronic Conditions, two of the six *Comprehensive Diabetes Care* measure indicators reported by **HPN** ranked slightly higher than **Amerigroup**'s reported rates (i.e., *Hemoglobin A1c [HbA1c] Testing* and *Blood Pressure Control [<140/90 mm Hg]*). Conversely, **Amerigroup**'s *Medication Management for People With Asthma—Medication Compliance 50%—Total* rate ranked slightly higher than **HPN**'s rate. Of note, both MCOs' rates for *Comprehensive Diabetes Care—Medical Attention for Nephropathy* were at or above the national 90th percentile.

Measure indicator rates in the Behavioral Health domain ranked slightly higher for **HPN** than **Amerigroup** for the *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up* and for Follow*-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase* measure indicators. Of note, **Amerigroup**'s reported rate for *Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total* was at or above the national 90th percentile, indicating overall positive performance.

Data Completeness

Table 5-7 provides an estimate of data completeness for the hybrid performance measures. These measures used administrative data (i.e., claims and encounter data) and supplemented the results with medical record review data. Measures that used only administrative data were not included. The table shows the HEDIS 2016 measure rates and the percentage of each reported rate that was determined solely through administrative data for both MCOs. Rates shaded green with one caret (^) indicate that more than 90 percent of the final rate was derived using administrative data. Rates shaded red with two carets (^^) indicate that less than 50 percent of the final rate was derived using administrative data.

Table 5-7—Estimated Encounter Data Completeness for Medicaid Hybrid Measures				
HEDIS Measure	**HPN HEDIS 2016 Rate**	**HPN Percent from Administrative Data**	**AGP HEDIS 2016 Rate**	**AGP Percent from Administrative Data**
Children's Preventive Care				
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	44.04%	92.27%^	38.43%	79.52%
Childhood Immunization Status				
Combination 2	74.94%	85.71%	73.15%	94.94%^
Combination 3	70.32%	84.43%	66.67%	94.10%^
Combination 4	70.07%	84.38%	65.28%	94.33%^
Combination 5	55.72%	82.53%	57.18%	95.14%^
Combination 6	38.44%	78.48%	32.41%	91.43%^
Combination 7	55.72%	82.53%	56.48%	95.49%^
Combination 8	38.44%	78.48%	32.41%	91.43%^
Combination 9	31.14%	76.56%	29.63%	92.19%^
Combination 10	31.14%	76.56%	29.63%	92.19%^
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap/Td)	79.81%	92.68%^	71.93%	96.13%^
Well-Child Visits in the First 15 Months of Life				
Six or More Well-Child Visits	53.77%	88.24%	52.78%	86.84%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	64.48%	96.60%^	66.33%	95.80%^
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total	70.32%	**16.61%^^**	64.12%	**16.61%^^**
Counseling for Nutrition—Total	57.91%	**15.13%^^**	54.40%	**19.57%^^**
Counseling for Physical Activity—Total	52.07%	**8.88%^^**	43.75%	**12.70%^^**
Human Papillomavirus Vaccine for Female Adolescents				
Human Papillomavirus Vaccine for Female Adolescents	29.68%	92.62%^	24.59%	93.40%^
Maternity Care				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	73.97%	66.45%	75.41%	67.70%
Postpartum Care	57.18%	**49.79%^^**	53.16%	64.76%
Frequency of Ongoing Prenatal Care				
<21 Percent of Expected Visits	14.60%	98.33%^	17.80%	90.79%^
≥81 Percent of Expected Visits	52.07%	**33.18%^^**	56.44%	**36.10%^^**

Table 5-7—Estimated Encounter Data Completeness for Medicaid Hybrid Measures				
HEDIS Measure	**HPN HEDIS 2016 Rate**	**HPN Percent from Administrative Data**	**AGP HEDIS 2016 Rate**	**AGP Percent from Administrative Data**
Care for Chronic Conditions				
Comprehensive Diabetes Care				
Hemoglobin A1c (HbA1c) Testing	85.64%	98.58%^	79.63%	98.84%^
HbA1c Poor Control (>9.0%)	45.74%	97.87%^	46.76%	75.74%
Blood Pressure Control (<140/90 mm Hg)	60.83%	**0.40%^^**	55.32%	**0.00%^^**
Eye Exam (Retinal) Performed	56.93%	88.03%	55.09%	88.66%
Medical Attention for Nephropathy	92.21%	99.21%^	89.58%	97.67%^
HbA1c Control (<8.0%)	46.47%	95.29%^	46.30%	**34.00%^^**

Green Shading^ indicates that more than 90 percent of the final rate was derived using administrative data.
Red Shading^^ indicates that 50 percent or less of the final rate was derived using administrative data.

A total of 27 measure indicators were reported by the MCOs for the Medicaid population using the hybrid methodology. Fifteen final measure rates reported by **Amerigroup** were derived using more than 90 percent administrative data, indicating that more than half of **Amerigroup**'s hybrid measures reported demonstrated high levels of encounter data completeness. Nine final measure indicator rates reported by **HPN** were derived using more than 90 percent administrative data, indicating that one-third of **HPN**'s hybrid measure reporting demonstrated high levels of encounter data completeness. For both MCOs, rates were derived using 50 percent or less administrative data, indicating opportunities to improve data completeness, including rates for all three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure indicators, *Frequency of Ongoing Prenatal Care—≥81 Percent of Expected Visits*, and *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*.

Nevada Check Up Results

Table 5-8 presents the HEDIS 2016 MCO-specific rates and the statewide weighted average Nevada Check Up rates along with star ratings based on comparisons of the rates to the NCQA HEDIS 2015 Audit Means and Percentiles national Medicaid benchmarks.[5-5]

[5-5] Because NCQA HEDIS 2015 Audit Means and Percentiles benchmarks are not available for the Children's Health Insurance Program (CHIP) population, comparisons of Nevada's Check Up population measure indicator rates to the national Medicaid benchmarks should be interpreted with caution.

Table 5-8—HEDIS 2016 Results for Nevada Check Up			
HEDIS Measure	**HPN**	**AGP**	**Nevada Check Up**
Access to Care			
Children and Adolescents' Access to Primary Care Practitioners			
Ages 12–24 Months	99.48% ★★★★★	98.73% ★★★★★	99.15% ★★★★★
Ages 25 Months–6 Years	89.55% ★★★	89.53% ★★★	89.54% ★★★
Ages 7–11 Years	93.54% ★★★	92.91% ★★★	93.32% ★★★
Ages 12–19 Years	90.78% ★★★	88.95% ★★	90.18% ★★★
Annual Dental Visit			
Total	70.11% ★★★★★	67.05% ★★★★★	68.96% ★★★★★
Children's Preventive Care			
Adolescent Well-Care Visits			
Adolescent Well-Care Visits	52.83% ★★★	56.34% ★★★	54.04% ★★★
Childhood Immunization Status			
Combination 2	87.93% ★★★★★	85.90% ★★★★★	86.97% ★★★★★
Combination 3	84.48% ★★★★★	78.21% ★★★★	81.52% ★★★★★
Combination 4	83.91% ★★★★★	77.56% ★★★★	80.92% ★★★★★
Combination 5	79.89% ★★★★★	68.59% ★★★★	74.56% ★★★★★
Combination 6	52.30% ★★★★	46.79% ★★★	49.70% ★★★
Combination 7	79.31% ★★★★★	67.95% ★★★★★	73.96% ★★★★★
Combination 8	51.72% ★★★★	46.79% ★★★	49.40% ★★★★
Combination 9	50.00% ★★★★	42.95% ★★★	46.68% ★★★★
Combination 10	49.43% ★★★★	42.95% ★★★★	46.37% ★★★★
Immunizations for Adolescents			
Combination 1 (Meningococcal, Tdap/Td)	87.35% ★★★★	81.61% ★★★★	85.33% ★★★★
Well-Child Visits in the First 15 Months of Life			
Six or More Well-Child Visits	68.00% ★★★★	78.05% ★★★★★	72.53% ★★★★

Table 5-8—HEDIS 2016 Results for Nevada Check Up			
HEDIS Measure	**HPN**	**AGP**	**Nevada Check Up**
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life			
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	70.13% ★★	70.28% ★★	70.19% ★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Percentile—Total	72.02% ★★★	62.04% ★★	68.43% ★★★
Counseling for Nutrition—Total	60.34% ★★	55.56% ★★	58.62% ★★
Counseling for Physical Activity—Total	57.18% ★★★	47.69% ★★	53.77% ★★
Human Papillomavirus Vaccine for Female Adolescents			
Human Papillomavirus Vaccine for Female Adolescents	42.62% ★★★★★	34.11% ★★★★★	39.68% ★★★★★
Care for Chronic Conditions			
Medication Management for People With Asthma			
Medication Compliance 50%—Total	47.62% ★★	47.76% ★★	47.67% ★★
Medication Compliance 75%—Total	26.98% ★★	26.87% ★★	26.94% ★★
Behavioral Health			
Follow-Up After Hospitalization for Mental Illness			
7-Day Follow-Up	NA	84.85% ★★★★★	83.33% ★★★★★
30-Day Follow-Up	NA	93.94% ★★★★★	89.58% ★★★★★
Follow-Up Care for Children Prescribed ADHD Medication			
Initiation Phase	39.53% ★★	NA	35.21% ★★
Continuation and Maintenance Phase	NA	NA	NA
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*			
Total	NA	NA	NA
Utilization and Diversity of Membership			
Mental Health Utilization—Total			
Any Service—Total	4.71% NC	5.76% NC	5.12% NC
Inpatient—Total	0.14% NC	0.46% NC	0.26% NC
Intensive Outpatient or Partial Hospitalization—Total	0.55% NC	0.32% NC	0.46% NC
Outpatient or Emergency Department—Total	4.67% NC	5.69% NC	5.07% NC

Table 5-8—HEDIS 2016 Results for Nevada Check Up			
HEDIS Measure	**HPN**	**AGP**	**Nevada Check Up**
Ambulatory Care—Total			
*Emergency Department (ED) Visits—Total**	21.00 NC	26.14 NC	23.00 NC
Outpatient Visits—Total	259.29 NC	263.50 NC	260.93 NC

* A lower rate indicates better performances for this measure.
NC indicates the HEDIS 2016 rate was not compared to benchmarks either because data were not available or because a measure is informational only and comparisons to benchmarks are not appropriate.
NA indicates the denominator for the measure was too small to report (less than 30).

With regard to the statewide weighted average results for Nevada Check Up, most of the rates ranked at or above the national 75th percentile. However, statewide weighted averages for the following measures fell at or above the national 25th percentile but below the 50th percentile, indicating opportunities for improvement: W*ell-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*; *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total*; *Medication Management for People With Asthma—Medication Compliance 50%—Total*, and *Medication Compliance 75%—Total*; and *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*. As mentioned previously, comparisons of Nevada's Check Up population measure indicator rates to the national Medicaid benchmarks should be interpreted with caution.

Overall, **HPN**'s and **Amerigroup**'s HEDIS 2016 rates for the Nevada Check Up population ranked similarly compared to the national benchmarks. Of the 25 measure rates reported by **HPN** that were comparable to national benchmarks, eight rates ranked at or above the national 90th percentile (32 percent). Of the 26 measure rates reported by **Amerigroup** and that were comparable to national benchmarks, eight rates ranked at or above the national 90th percentile (31 percent).

HPN's and **Amerigroup**'s rates in the Access to Care measure domain ranked the same, with the exception of **HPN**'s C*hildren and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years* rate, which indicated slightly higher performance. **Amerigroup**'s rate for this measure fell at or above the national 25th percentile but below the 50th percentile, indicating opportunity for improvement.

For Children's Preventive Care, most of **HPN**'s rates ranked the same as or slightly higher than **Amerigroup**'s rates, with the exception of **Amerigroup**'s *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* rate, which ranked slightly higher than **HPN**'s rate. Of note, both MCOs' rates for *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life* fell at or above the national 25th percentile but below the 50th percentile. Further, **Amerigroup**'s rates for all three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* indicators fell at or above the national 25th percentile but below the 50th percentile.

Rates indicated opportunities for improvement for both MCOs in the Care for Chronic Conditions measure domain, with **HPN**'s and **Amerigroup**'s rates for the two *Medication Management for People With Asthma* measure indicators falling at or above the national 25th percentile but below the 50th percentile.

In the Behavioral Health measure domain, **HPN**'s reported rate for *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* fell at or above the national 25th percentile but below the 50th percentile, demonstrating an area for improvement with regard to follow-up care for children on ADHD medications. Conversely, both of **Amerigroup**'s rates that were reportable for HEDIS 2016 in the Behavioral Health measure domain, *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up*, ranked at or above the national 90th percentile, indicating **Amerigroup**'s favorable performance in this area.

Data Completeness

Table 5-9 provides an estimate of data completeness for the hybrid performance measures. These measures used administrative data (i.e., claims and encounter data) and supplemented the results with medical record review data. Measures that used only administrative data were not included. The table shows the HEDIS 2016 measure rates and the percentage of each reported rate that was determined solely through administrative data for both MCOs. Rates shaded green with one caret (^) indicate that more than 90 percent of the final rate was derived using administrative data. Rates shaded red with two carets (^^) indicate that less than 50 percent of the final rate was derived using administrative data.

Table 5-9—Estimated Encounter Data Completeness for Nevada Check Up Hybrid Measures

HEDIS Measure	HPN HEDIS 2016 Rate	HPN Percent from Administrative Data	AGP HEDIS 2016 Rate	AGP Percent from Administrative Data
Children's Preventive Care				
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	52.83%	92.09%^	56.34%	88.33%
Childhood Immunization Status				
Combination 2	87.93%	84.97%	85.90%	94.03%^
Combination 3	84.48%	82.99%	78.21%	94.26%^
Combination 4	83.91%	82.88%	77.56%	94.21%^
Combination 5	79.89%	82.01%	68.59%	93.46%^
Combination 6	52.30%	79.12%	46.79%	91.78%^
Combination 7	79.31%	81.88%	67.95%	93.40%^
Combination 8	51.72%	78.89%	46.79%	91.78%^
Combination 9	50.00%	79.31%	42.95%	91.04%^
Combination 10	49.43%	79.07%	42.95%	91.04%^

Table 5-9—Estimated Encounter Data Completeness for Nevada Check Up Hybrid Measures				
HEDIS Measure	**HPN HEDIS 2016 Rate**	**HPN Percent from Administrative Data**	**AGP HEDIS 2016 Rate**	**AGP Percent from Administrative Data**
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap/Td)	87.35%	88.02%	81.61%	94.84%^
Well-Child Visits in the First 15 Months of Life				
Six or More Well-Child Visits	68.00%	86.76%	78.05%	87.50%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	70.13%	97.47%^	70.28%	96.05%^
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total	72.02%	**20.61%^^**	62.04%	**19.03%^^**
Counseling for Nutrition—Total	60.34%	**14.52%^^**	55.56%	**18.75%^^**
Counseling for Physical Activity—Total	57.18%	**10.21%^^**	47.69%	**10.19%^^**
Human Papillomavirus Vaccine for Female Adolescents				
Human Papillomavirus Vaccine for Female Adolescents	42.62%	91.35%^	34.11%	86.36%

Green Shading^ indicates that more than 90 percent of the final rate was derived using administrative data.
Red Shading^^ indicates that 50 percent or less of the final rate was derived using administrative data.

A total of 17 measure indicators were reported by the MCOs for the Nevada Check Up population using hybrid methodology. Only three final measure indicator rates reported by **HPN** were derived using more than 90 percent administrative data, indicating overall low levels of encounter data completeness. Conversely, 11 final measure rates reported by **Amerigroup** were derived using more than 90 percent administrative data, indicating that almost two-thirds of **Amerigroup**'s hybrid measure reporting demonstrated high levels of encounter data completeness. Rates for all three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure indicators for both MCOs were derived using 50 percent or less administrative data, indicating opportunities to improve data completeness.

Conclusions

The HEDIS audit demonstrated that both MCOs had adequate policies and procedures to collect, prepare, process, and report HEDIS data and were in full compliance with each of the seven NCQA-specified IS standards. Both MCOs continued to use Facets to process their claims. Data entry processes were efficient, with the assurance of timely and accurate entry into the system. Only standard codes were accepted and the standard HIPAA 837 file format was used. Both MCOs applied several validation checks to ensure accurate information processing. Both MCOs had appropriate processes in place for the ICD-9 to ICD-10 transition and did not experience any data concerns.

Upon evaluation of the Medicaid population rates, 29 measure indicator rates were comparable from HEDIS 2015 to HEDIS 2016 for **Amerigroup**. The reported rates showed performance improvement (i.e., improved more than 5 percentage points) on nine measure indicator rates (approximately 31 percent) from HEDIS 2015. Conversely, rates declined (i.e., decreased more than 5 percentage points) for one measure rate (approximately 3 percent) from HEDIS 2015 to HEDIS 2016. Thirty-nine of **Amerigroup**'s Medicaid HEDIS 2016 rates were evaluated compared to national Medicaid benchmarks. Two rates (approximately 5 percent) ranked at or above the 90th percentile and 13 measure indicator rates (approximately 33 percent) fell below the 25th percentile.

For **HPN**'s Medicaid population rates, 29 measures were comparable from HEDIS 2015 to HEDIS 2016, and four measure indicator rates (approximately 14 percent) showed improvement from HEDIS 2015. One rate (approximately 3 percent) declined from HEDIS 2015 to HEDIS 2016. Additionally, 39 of **HPN**'s Medicaid HEDIS 2016 rates were evaluated compared to national Medicaid benchmarks: One rate (approximately 3 percent) ranked at or above the 90th percentile and six measure indicator rates (approximately 15 percent) fell below the 25th percentile.

With regard to **Amerigroup**'s Nevada Check Up population, 17 measures were comparable from HEDIS 2015 to HEDIS 2016, and six measure indicator rates (approximately 35 percent) showed improvement from HEDIS 2015. None of the rates declined from HEDIS 2015 to HEDIS 2016. Additionally, 26 of **Amerigroup**'s Nevada Check Up HEDIS 2016 rates were evaluated compared to national Medicaid benchmarks, of which eight rates (approximately 31 percent) ranked at or above the 90th percentile and none of the measure indicator rates fell below the 25th percentile.

For **HPN**'s Nevada Check Up population, 17 measures were comparable from HEDIS 2015 to HEDIS 2016, and seven measure indicator rates (approximately 41 percent) showed improvement from HEDIS 2015. None of the rates declined from HEDIS 2015 to HEDIS 2016. Additionally, 25 of **HPN**'s Nevada Check Up HEDIS 2016 rates were evaluated compared to national Medicaid benchmarks, of which eight rates (approximately 32 percent) ranked at or above the 90th percentile and none of the measure indicator rates fell below the 25th percentile.

Recommendations

As evidenced by the comparisons of the rates to national Medicaid benchmarks, HSAG suggests that the MCOs focus efforts on improving children and adolescents' access to primary care practitioners. HSAG recommends that the MCOs analyze any improvement strategies that could be linked to the overall success of the measure, counseling children/adolescents for nutrition and physical activity, and improvement interventions implemented to improve well-child visits. Further, HSAG recommends that the MCOs monitor performance with regard to maternity care, managing medications for asthmatic members, appropriate testing and control of HbA1c levels, and controlling blood pressure for diabetic members. The areas recommended for improvement are based on rates that mostly ranked below the national Medicaid 50th percentile.

Additionally, for the Nevada Check Up population, the MCOs are urged to focus efforts on improving documentation of counseling for nutrition and physical activity provided to children and adolescents, and to analyze strategies that could be linked to increased rates of well-care visits for adolescents and asthma medication compliance for asthmatic members. Although none of the

Nevada Check Up population rates showed declines from 2015 to 2016, rates in these areas fell below the national Medicaid 50th percentile, indicating opportunities for improvement.

For each measure requiring improvement, HSAG recommends that each MCO conduct a thorough analysis of the root cause of poor performance for each measure and identify provider, member, and systems interventions that can be implemented to improve performance measure rates in each area. Similar to the rapid cycle improvement approach required by PIPs, MCOs should test changes on a small scale, using a series of PDSA cycles and applying rapid-cycle learning principles over the course of the improvement project to adjust intervention strategies so that improvement can occur more efficiently and lead to long-term sustainability.

6. Validation of Performance Improvement Projects—SFY 2015–2016

As described in 42 CFR §438.240 (b)(1), the DHCFP requires MCOs to conduct performance improvement projects (PIPs) in accordance with 42 CFR §438.240(d). PIPs must be designed to achieve significant and sustained improvement in clinical and nonclinical areas of care through ongoing measurement and intervention, and they must be designed to have a favorable effect on health outcomes and member satisfaction.

One of the mandatory EQR activities under the BBA requires the DHCFP to validate PIPs. To meet this validation requirement, the DHCFP contracted with HSAG as the EQRO. The BBA requires HSAG to assess each MCO's "strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients" (42 CFR §438.364 [a][2]).

In July 2014, HSAG developed a new PIP framework based on a modified version of the Model for Improvement developed by Associates in Process Improvement and modified by the Institute for Healthcare Improvement. The redesigned PIP methodology is intended to improve processes and outcomes of healthcare by way of continuous quality improvement. The redesigned framework redirects MCOs to focus on small tests of change in order to determine which interventions have the greatest impact and can bring about real improvement. PIPs must meet CMS requirements; therefore, HSAG completed a crosswalk of this new framework against the Department of Health and Human Services, CMS publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR), Version 2.0*, September 2012.[6-1]

HSAG presented the crosswalk and new PIP framework components to CMS to demonstrate how the new framework aligned with the CMS validation protocols. CMS agreed that, with the pace of quality improvement science development and the prolific use of plan, do, study, act (PDSA) cycles in modern improvement projects within healthcare settings, a new approach was needed. After meeting with the DHCFP and HSAG staff members to discuss the topics and approach, CMS gave approval to the DHCFP to implement this new PIP approach in Nevada.

Objectives

PIPs provide a structured method to assess and improve processes, and thereby outcomes, of care for the population that an MCO serves. This structure facilitates the documentation and evaluation of improvements in care or services. MCOs conduct PIPs to assess and improve the quality of clinical and nonclinical health care and services received by recipients.

The primary objective of PIP validation is to determine compliance with the requirements of 42 CFR §438.240 (b)(1) and 42 CFR §438.240 (d)(1)(1-4), including:

[6-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: Feb 19, 2013.

- Measurement of performance using objective quality indicators.
- Implementation of system interventions to achieve improvement in quality.
- Evaluation of the effectiveness of interventions.
- Planning and initiation of activities to increase or sustain improvement.

For this new PIP framework, HSAG developed five modules with an accompanying companion guide. Prior to issuing each module, HSAG held technical assistance sessions with the MCOs to educate about application of the modules. The PIP modules and associated validation scoring are described in Appendix A, Technical Methods of Data Collection and Analysis.

Plan-Specific Findings—Amerigroup

In SFY 2015–2016, the DHCFP selected two PIP topics for the MCOs: *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)* and *Behavioral Health Hospital Readmissions*. The topics selected by the DHCFP addressed CMS requirements related to quality outcomes—specifically, the quality and timeliness of and access to care and services.

Table 6-1 presents each PIP topic and the SMART Aim statement as stated by the MCO. **Amerigroup** was required to specify the outcome being measured, the baseline value for the outcome measure, a quantifiable goal for the outcome measure, and the target date for attaining the goal.

Table 6-1—PIP Titles and SMART Aim Statements

PIP Title	SMART Aim Statement
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)	By March 31, 2017, the MCO aims to increase the compliance rate for BMI percentile, counseling for nutrition, and counseling for physical activity among children and adolescents 3 to 17 years of age residing in Clark County who are assigned to a Nevada Health Centers practitioner, from 78.24 percent to 88.24 percent, from 58.33 percent to 68.33 percent, and from 57.41 to 67.41 percent, respectively.
Behavioral Health Hospital Readmissions	By March 31, 2017, the MCO aims to reduce the number of inpatient behavioral health readmissions in Clark County by 10 percentage points from 29.07 percent to 19.07 percent.

Amerigroup completed and submitted Modules 1 through 3 for validation. The following section outlines the validation findings for each of these completed modules.

Module 1: PIP Initiation

The objective of Module 1 is for the MCO to ask and answer the first fundamental question, "What are we trying to accomplish?" In this phase, for both PIPs, **Amerigroup** determined its narrowed

focus, developed its PIP team, established external partnerships, determined the Global and SMART Aims, and developed the key driver diagram.

Behavioral Health Hospital Readmissions

Upon initial validation of Module 1 for the *Behavioral Health Hospital Readmissions* PIP, HSAG identified that **Amerigroup**'s Global Aim statement required revisions in order to have an overarching outcome to which the PIP was contributing and that some potential interventions listed in the key driver diagram were not actual interventions but statements. After receiving technical assistance from HSAG, **Amerigroup** made the necessary corrections and resubmitted the module for final validation. For the final validation, the MCO received *Achieved* scores across all evaluation elements for Module 1.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)

Upon initial validation of Module 1 for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)* PIP, HSAG identified that **Amerigroup** needed to include data on all three components of the WCC measure (body mass index [BMI] documentation, referral for physical activity, and referral for nutrition). After receiving technical assistance from HSAG, Amerigroup made the necessary corrections and resubmitted the module for final validation. For the final validation, the MCO received *Achieved* scores across all evaluation elements for Module 1.

Module 2: SMART Aim Data Collection

The objective of Module 2 is for the MCO to ask and answer the question, "How will we know that a change is improvement?" In this phase, for both PIPs, Amerigroup defined how and when it will be evident that improvement is being achieved.

Behavioral Health Hospital Readmissions

Amerigroup defined the SMART Aim measure as:

Numerator: The total number of monthly inpatient behavioral health readmissions within 30 days in Clark County during the measurement month.

Denominator: The total number of monthly inpatient behavioral health admissions in Clark County during the measurement month.

Amerigroup will be using an administrative data collection methodology for this PIP. The administrative and authorization data have a one-to-one relationship; therefore, all paid claims have an authorization. Authorization data is a manual process and uses real-time data. For this project, "readmission" was defined as "any eligible admission to a hospital within 30 days of discharge from a hospital." An "eligible member" was defined as "one being continuously enrolled for 30 days following an admission." Amerigroup's business information consultant will be responsible for

setting up the query to identify all behavioral health readmissions in Clark County. The results will be displayed monthly on the SMART Aim run chart.

Upon initial validation of Module 2 for the *Behavioral Health Hospital Readmissions* PIP, HSAG identified that **Amerigroup** needed to define and support how the administrative claims data would be used to determine when an admission occurred after discharge from an inpatient setting. HSAG made the recommendation that **Amerigroup** make necessary revisions to its SMART Aim measure. After receiving technical assistance from HSAG, **Amerigroup** clarified how it would use prior authorization data to determine the date of admission within 30 days of discharge from an inpatient setting. **Amerigroup** made the necessary corrections and submitted the module for final validation. For the final validation, the MCO received *Achieved* scores across all evaluation elements for Module 2.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)

Amerigroup defined the SMART Aim measure as:

Numerator:

1. All Nevada Health Centers (NVHC) WCC eligible members with a BMI percentile documented within the previous 12 months.
2. All Nevada Health Centers WCC eligible members who have had counseling for nutrition within the previous 12 months.
3. All Nevada Health Centers WCC eligible members who have had counseling for physical activity within the previous 12 months.

Denominator: All WCC eligible members residing in Clark County who are assigned to a Nevada Health Centers practitioner as of the last business day of each measurement month.

On the first business day of the month, **Amerigroup** will generate a list from its Missed Opportunities report for all WCC eligible members residing in Clark County and assigned to a Nevada Health Centers practitioner as of the last business day of the current measurement month. Using this denominator, the MCO will query those WCC eligible members who had a documented BMI percentile, counseling for nutrition, and counseling for physical activity within the previous 12 months. An Excel spreadsheet with a list of the remaining WCC eligible members without a documented BMI percentile, counseling for nutrition, and counseling for physical activity within the previous 12 months will be sent to NVHC via a secure, encrypted email. Throughout the month, an NVHC administrative coordinator will record on the Excel spreadsheet the WCC eligible members with a documented BMI percentile, counseling for nutrition, and counseling for physical activity. On the last business day of the month, NVHC's coordinator will return the list to **Amerigroup** through a secure, encrypted email. The MCO's HEDIS subject matter expert (SME) will coordinate with NVHC to retrieve medical records for the members listed on the Excel spreadsheet. **Amerigroup**'s HEDIS SME will review each medical record for compliance as per the *HEDIS 2016 Technical Specifications*. Once the information on the spreadsheet is verified, the MCO will enter the data and calculate the rate. The rates will be displayed on the SMART Aim run chart.

Upon initial validation of Module 2 for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)* PIP, HSAG identified that **Amerigroup** needed to include an anchor date for the age criteria, include all measure components in the SMART Aim measure, update the spreadsheet to include all measure components, and update the run chart with baseline data for all three measure components. After receiving technical assistance from HSAG, **Amerigroup** made the necessary corrections and submitted the module for final validation. For the final validation, the MCO received *Achieved* scores across all evaluation elements for Module 2.

Module 3: Intervention Determination

Module 3 is the intervention determination phase of the PIP. In this module, the MCO will ask and answer the question, "What changes can we make that will result in improvement?"

Behavioral Health Hospital Readmissions

Amerigroup completed a process map and an FMEA to determine the areas within its process with the greatest need for improvement and which would have the most impact on the intended outcomes. The MCO identified the following four subprocesses on which to focus efforts:

- Emergency department physician-directed medical evaluation to rule out acute medical condition.
- Member does not meet inpatient criteria and is discharged.
- Finalize discharge plan, review with member, and verify member comprehension.
- Transportation assistance.

Using a risk-priority numbering process to prioritize the identified failure modes within these subprocesses, **Amerigroup** determined that its top four failure modes for which to develop interventions and test through the use of PDSA cycles in Module 4 are:

1. Incomplete discharge planning.
2. Amerigroup is not notified of member discharged from facilities.
3. Inconsistent use of the Patient360 system to support collaboration of real-time member information.
4. Member is unable to navigate or obtain services or to access resources identified in the discharge plan.

Upon initial validation of Module 3 for the *Behavioral Health Hospital Readmissions* PIP, HSAG identified that **Amerigroup** needed to revise its process map so that the selected subprocesses in the FMEA aligned with the opportunities for improvement identified in the process map. The MCO also needed to revise its FMEA so that identified failure causes and failure effects aligned with the listed failure mode. In addition, the MCO was required to revise its documentation to ensure that all narrative documentation in the process map and FMEA were consistent. After receiving technical assistance from HSAG, **Amerigroup** made the necessary corrections and submitted the module for

final validation. For the final validation, the MCO received *Achieved* scores across all evaluation elements for Module 3.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)

For its *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)* PIP, **Amerigroup** completed a process map and an FMEA to determine the areas within its process with the greatest need for improvement and which would have the most impact on intended outcomes. The MCO identified the following five subprocesses on which to focus its efforts:

- Scheduler reviews alert screen for WCC visit in current measurement year.
- Physician reviews alert screen for WCC visit in current measurement year.
- Physician documents visit in electronic medical record.
- Medical assistant inputs vitals in electronic medical record.
- Member outreach and education.

Using a risk-priority numbering process to prioritize the identified failure modes within these sub-processes, **Amerigroup** determined that the top three failure modes for which to develop interventions and test through the use of PDSA cycles in Module 4 are:

1. Incomplete coding by physician of the well-child visit.
2. Not all well-child visits are captured.
3. Member education and outreach to schedule well-child visits are not consistent.

Upon initial validation of Module 3 for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)* PIP, HSAG identified that **Amerigroup** needed to revise its process map so that the selected subprocesses in the FMEA aligned with the opportunities for improvement identified in the process map. The MCO also needed to revise its FMEA so that the identified failure causes and failure effects aligned with the listed failure mode. After receiving technical assistance from HSAG, **Amerigroup** made the necessary corrections and submitted the module for final validation. For the final validation, the MCO received *Achieved* scores across all evaluation elements for Module 3.

At the time of this SFY 2015–2016 EQR Technical Report, **Amerigroup** had completed its PIP cycle through Module 3. HSAG will report on each PIP's Modules 4 and 5 in the SFY 2016–2017 EQR Technical Report.

Plan-Specific Findings—HPN

In SFY 2015–2016, the DHCFP selected two PIP topics for the MCOs: *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)* and *Behavioral Health Hospital Readmissions*. The topics selected by the DHCFP addressed CMS requirements

related to quality outcomes—specifically, the quality and timeliness of and access to care and services.

Table 6-2 presents each PIP topic and the SMART Aim statement as stated by the MCO. **HPN** was required to specify the outcome being measured, the baseline value for the outcome measure, a quantifiable goal for the outcome measure, and the target date for attaining the goal.

Table 6-2—PIP Titles and SMART Aim Statements

PIP Title	SMART Aim Statement
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)	By March 31, 2017, HPN aims to increase the WCC compliance rates for children 3–17 years of age assigned to Dr. Veeramachaneni to the following: BMI percentile documentation from 2.13 percent to 10 percent; counseling for nutrition from 4.79 percent to 12 percent; and counseling for physical activity from 2.66 percent to 10 percent.
Behavioral Health Hospital Readmissions	By March 31, 2017, decrease the rate of the identified top 50 utilizers of inpatient substance abuse and/or mental health admissions from 13.8 percent of the total membership's inpatient substance abuse and/or mental health admissions to 12 percent.

HPN completed and submitted Modules 1 through 3 for validation. The following section outlines the validation findings for each of these completed modules.

Module 1: PIP Initiation

The objective of Module 1 is for the MCO to ask and answer the first fundamental question, "What are we trying to accomplish?" In this phase, for both PIPs, **HPN** determined its narrowed focus, developed its PIP team, established external partnerships, determined the Global and SMART Aims, and developed the key driver diagram.

Behavioral Health Hospital Readmissions

Upon initial validation of Module 1 for the *Behavioral Health Hospital Readmissions* PIP, HSAG identified that **HPN** needed to provide both an explanation as to why the baseline data provided covered 10 months and not a full year and clarification as to the targeted focus of the PIP. The MCO also needed to identify the external partners for the PIP and revise its Global Aim and key driver diagram. After receiving technical assistance from HSAG, **HPN** made the necessary corrections and resubmitted the module for final validation. For the final validation, the MCO received *Achieved* scores across all evaluation elements for Module 1.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)

Upon initial validation of Module 1 for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)* PIP, HSAG identified that **HPN** needed to provide its comparative provider data that demonstrated that Dr. Veeramachaneni was a high-volume, low-performing provider relative to the other providers in the network. In addition, the MCO needed to simplify its SMART Aim statement and ensure that the goals set for each measure were reasonable and attainable. **HPN** also needed to revise the key driver diagram so that the documented drivers were truly drivers and not interventions. After receiving technical assistance from HSAG, **HPN** made the necessary corrections and resubmitted the module for final validation. For the final validation, the MCO received *Achieved* scores across all evaluation elements for Module 1.

Module 2: SMART Aim Data Collection

The objective of Module 2 is for the MCO to ask and answer the question, "How will we know that a change is improvement?" In this phase, for both PIPs **HPN** defined how and when it will be evident that improvement is being achieved.

Behavioral Health Hospital Readmissions

HPN defined the SMART Aim measure as:

Numerator: The total number of admissions during the measurement month for the top 50 utilizers. "Admission" is defined as "any inpatient substance abuse and/or mental health admission, regardless of time between the original admission and subsequent admissions or specific diagnosis." The top 50 super utilizers are those members with the most claims for inpatient substance abuse and/or mental health admissions from January 1, 2015, through December 31, 2015.

Denominator: The total number of inpatient substance abuse and/or mental health admissions for all members during the measurement month.

On the fifth business day of the month, the Behavioral Healthcare Options, Inc. clinical administrator will review the daily inpatient utilization spreadsheet and determine the number of admissions that the previously identified top 50 members had for the month and the total number of admissions for the month. This daily utilization spreadsheet will be sent to **HPN**'s associate director of quality and the Behavioral Health Options Medicaid Program utilization manager for review. Once the spreadsheet has been reviewed, the rate will be determined by dividing the numerator by the denominator and then plotting it on the SMART Aim run chart.

Upon initial validation of Module 2 for the *Behavioral Health Hospital Readmissions* PIP, HSAG identified that **HPN** needed to revise its quarterly measurement intervals to monthly intervals. The MCO also documented that it would use a claim query based data collection methodology. HSAG requested that **HPN** provide greater detail and supporting documentation that hospital claims queried will be complete within a 30-day period for monthly data collection. HSAG also identified that the axes for the run chart needed to be rescaled to accurately reflect the data to be collected and

that the data collection tool needed to be revised to reflect monthly data collection rather than quarterly.

After receiving technical assistance from HSAG, **HPN** clarified how it will use real-time inpatient authorization data and hospital admission claims data and that claims lag would not be a factor for this PIP. **HPN** also made all other necessary revisions and resubmitted Module 2 for final validation. For the final validation, the MCO received *Achieved* scores across all evaluation elements for Module 2.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)

HPN defined the SMART Aim measure as:

Numerator: **HPN** children 3 through 17 years of age with an outpatient visit with Dr. Veeramachaneni through March 31, 2017, with the following documentation in the member's medical record:

- Body Mass Index (BMI) percentile
- Counseling or education on nutrition and diet
- Counseling or education on physical activity

Denominator: All **HPN** Temporary Assistance for Needy Families (TANF) and Nevada Check Up children 3 through 17 years of age as of March 31, 2017, who had an outpatient visit with Dr. Veeramachaneni.

On the first business day of the month, **HPN** will query a list of eligible Health Plan of Nevada Child Health Assurance Program (CHAP)-TANF and Nevada Check Up children ages 3 through 17 years who had an outpatient visit with Dr. Veeramachaneni. The associate director of clinical quality will then query the data to identify those children who already had an outpatient visit and had documentation of a BMI percentile, counseling or education on nutrition and diet, and counseling or education on physical activity. A second query will be run to identify those remaining children who had an outpatient visit with Dr. Veeramachaneni and who should have received counseling or education on nutrition and diet, received counseling or education on physical activity, and had a BMI percentile documented. This list will be sent to Dr. Veeramachaneni via a secure encrypted email. Throughout the month, Dr. Veeramachaneni's maternal child LPN supervisor will record the children who did receive the required WCC measure components.

On the last business day of the month, Dr. Veeramachaneni's maternal child LPN supervisor will send the list back to **HPN**, where the data will be entered and the rate calculated by dividing the numerator by the denominator and plotting the rate on the SMART Aim run chart.

Upon initial validation of Module 2 for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)* PIP, HSAG identified that **HPN** documented the annual HEDIS methodology for the numerator and denominator descriptions. These descriptions needed to be modified to align with the monthly rapid-cycle PIP process. In addition, the MCO needed to revise the dates on the SMART Aim run chart *x* axis to go through March 2017. **HPN**

made the necessary corrections and resubmitted the module for final validation. For the final validation, the MCO received *Achieved* scores across all evaluation elements for Module 2.

Module 3: Intervention Determination

Module 3 is the intervention determination phase of the PIP. In this module, the MCO will ask and answer the question, "What changes can we make that will result in improvement?"

Behavioral Health Hospital Readmissions

HPN completed a process map and an FMEA to determine the areas within its process with the greatest need for improvement and which would have the most impact on the intended outcomes. The MCO identified the following three subprocesses on which to focus efforts:

- Members identified as working with outpatient care and services.
- Member outpatient plan in place.
- Member participates in outpatient care and services.

Using a risk-priority numbering process to prioritize the identified failure modes within these sub-processes, **HPN** determined that the top three failure modes for which to develop interventions and test through the use of PDSA cycles in Module 4 are:

1. No plan established, and member does not gain access to care and services.
2. Member is not accessible for outreach outside the hospital.
3. Member is not identified as a frequent utilizer of inpatient services.

Upon initial validation of Module 3 for the *Behavioral Health Hospital Readmissions* PIP, HSAG identified that steps appeared to be missing in the MCO's process map when a member was denied due to medical necessity. After receiving technical assistance from HSAG, **HPN** revised its process map and made the necessary corrections, then resubmitted the module for final validation. For the final validation, the MCO received *Achieved* scores across all evaluation elements for Module 3.

Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)

For its *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)* PIP, **HPN** completed a process map and an FMEA to determine the areas within its processes with the greatest need for improvement and which would have the most impact on intended outcomes. The MCO identified the following three subprocesses on which to focus efforts:

- Member/parent/caregiver understanding the importance of receiving a BMI percentile, counseling for nutrition, and counseling for physical activity
- Provider documentation of BMI percentile, counseling for nutrition, and counseling for physical activity

- Provider billing for each measure (BMI percentile, counseling for nutrition, and counseling for physical activity) in the office visit claim

Using a risk-priority numbering process to prioritize identified failure modes within these subprocesses, **HPN** determined that the top two failure modes for which to develop interventions and test through the use of PDSA cycles in Module 4 are:

- Provider is completing BMI percentile, counseling for nutrition, and counseling for physical activity but not documenting in medical record.
- Provider is completing BMI percentile, counseling for nutrition, and counseling for physical activity but not billing for each submeasure.

Upon initial validation of Module 3 for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)* PIP, **HPN** received *Achieved* scores across all evaluation elements; a resubmission was not required.

At the time of this SFY 2015–2016 EQR Technical Report, **HPN** had completed its PIP cycle through Module 3. HSAG will report on each PIP's Modules 4 and 5 in the SFY 2016–2017 EQR Technical Report.

Plan Comparison

The validation findings showed that both MCOs were able to complete Modules 1 through 3 successfully and attained *Achieved* scores for all modules for both PIPs. Both **HPN** and **Amerigroup** demonstrated their ability to build internal and external quality improvement teams successfully, develop external collaborative partnerships, and use quality improvement science tools both to help identify opportunities for improvement and to develop methodologically sound projects.

Overall Recommendations for Future Module Submissions

Since the MCOs were allowed to resubmit PIP modules and incorporate HSAG recommendations, HSAG does not have recommendations for the PIP modules that were submitted and approved. For future module submissions, HSAG offers the following recommendations:

- As each MCO moves through the quality improvement process and conducts PDSA cycles, each MCO PIP team should ensure that it is communicating the MCO's reasons for making changes to intervention strategies and how these changes will lead to improvement. Without a common understanding and agreement about the causes that effect improvement, the MCO's PIP team may misdirect resources and improvement activities toward changes that do not lead to improvement.
- When planning a test of change, each MCO should be proactive with the intervention (i.e., scaling/ramping up to build confidence in the change, and eventually implementing policy to sustain changes).

- When testing an intervention, each MCO should conduct a series of thoughtful and incremental PDSA cycles to accelerate the rate of improvement.
- As each MCO tests new interventions, it should ensure that it is making a prediction in each step of the PDSA cycle and discussing the basis for the prediction. This will help keep the theory for improvement in the project in the forefront for everyone involved.
- When developing the intervention testing methodology, the MCOs should determine the best method to identify the intended effect of an intervention before testing. The intended effect of the intervention should be known up front to help determine which data need to be collected.
- When testing an intervention, the MCOs should collect detailed, process-level data to ensure collecting enough data to illustrate the effects of the intervention.
- The key driver diagram and FMEA for all PIPs should be updated as each MCO progresses through its PDSA cycles.

The CAHPS surveys ask members to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers, such as the communication skills of providers and the accessibility of services. **HPN** and **Amerigroup** were responsible for obtaining a CAHPS vendor to administer the CAHPS surveys on their behalf.

Objectives

The primary objective of the CAHPS surveys was to effectively and efficiently obtain information on the level of satisfaction that patients have with their health care experiences.

Technical Methods of Data Collection and Analysis

Three populations were surveyed for **HPN** and **Amerigroup**: adult Medicaid, child Medicaid, and Nevada Check Up. DSS Research, an NCQA-certified vendor, administered the 2016 CAHPS surveys for both **HPN** and **Amerigroup**.

The technical method of data collection was through administration of the CAHPS 5.0H Adult Medicaid Health Plan Survey to the adult population, and the CAHPS 5.0H Child Medicaid Health Plan Survey (with the Children with Chronic Conditions [CCC] measurement set) to the child Medicaid and Nevada Check Up populations. **HPN** and **Amerigroup** used a pre-approved enhanced mixed-mode methodology for data collection (i.e., mailed surveys followed by telephone interviews of nonrespondents).

The survey questions were categorized into various measures of satisfaction. These measures included four global ratings, five composite scores, and three Effectiveness of Care measures for the adult population only. Additionally, five CCC composite measures/items were used for CCC eligible population. The global ratings reflected patients' overall satisfaction with their personal doctor, specialist, health plan, and all health care. The composite scores were derived from sets of questions to address different aspects of care (e.g., getting needed care and how well doctors communicate). The CCC composite measures/items evaluated the satisfaction of families with children with chronic conditions accessing various services (e.g., specialized services, prescription medications). The Effectiveness of Care measures assessed the various aspects of providing assistance with smoking and tobacco use cessation. When a minimum of 100 responses for a measure was not achieved, the result was denoted as Not Applicable (NA).

For each of the four global ratings, the percentage of respondents who chose the top satisfaction ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. This percentage is referred to as a question summary rate (or top-box response).

For each of the five composite scores and CCC composite measures/items, the percentage of respondents who chose a positive response was calculated. CAHPS composite question response choices fell into one of two categories: (1) Never, Sometimes, Usually, or Always; or (2) No or Yes.

A positive or top-box response for the composites and CCC composites/items was defined as a response of Usually/Always or Yes. The percentage of top-box responses is referred to as a global proportion for the composite scores and CCC composite measures/items. For the Effectiveness of Care measures, responses of Always/Usually/Sometimes were used to determine if the respondent qualified for inclusion in the numerator. The rates presented follow NCQA's methodology of calculating a rolling average using the current and prior years' results. A substantial increase or decrease is denoted by a change of 5 percentage points or more.

Plan-Specific Findings—Amerigroup

Table 7-1 shows **Amerigroup**'s 2015 and 2016 adult Medicaid CAHPS top-box rates. In 2016, a total of 2,499 adult members were sent a survey and 469 completed a survey.[7-1] After ineligible members were excluded, the response rate was 19.3 percent. In 2015, the average NCQA response rate for the adult Medicaid population was 27.2 percent, which was higher than **Amerigroup**'s response rate.[7-2]

Table 7-1—Amerigroup Adult Medicaid CAHPS Results

	2015 Top-Box Rates	2016 Top-Box Rates
Composite Measures		
Getting Needed Care	78.0%	77.6%
Getting Care Quickly	73.6%	76.4%
How Well Doctors Communicate	87.0%	87.5%
Customer Service	86.0%	84.7%
Shared Decision Making	79.9%	80.0%
Global Ratings		
Rating of All Health Care	45.9%	44.2%
Rating of Personal Doctor	63.3%	58.6%
Rating of Specialist Seen Most Often	55.2%	58.6%
Rating of Health Plan	47.9%	45.9%
Effectiveness of Care*		
Advising Smokers and Tobacco Users to Quit	61.1%	62.6%
Discussing Cessation Medications	28.7%	34.8%
Discussing Cessation Strategies	29.6%	32.6%

A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as Not Applicable (NA).

* These rates follow NCQA's methodology for calculating a rolling two-year average.

Indicates the 2016 rate is at least 5 percentage points greater than the 2015 national average.

Indicates the 2016 rate is at least 5 percentage points less than the 2015 national average.

Amerigroup's rates decreased between 2015 and 2016 for five of the 12 measures: *Getting Needed Care*, *Customer Service*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*. **Amerigroup**'s rates increased between 2015 and 2016 for seven measures: *Getting Care Quickly*, *How Well Doctors Communicate*, *Shared Decision Making*, *Rating of Specialist Seen Most Often*, *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and

[7-1] The total number of members who were sent a survey and who completed a survey is based on **Amerigroup**'s adult CAHPS sample only.

[7-2] 2016 NCQA national response rate information for the CAHPS 5.0 Adult Medicaid Survey was not available at the time this report was produced.

Discussing Cessation Strategies. Of these, the *Discussing Cessation Medications* 2016 measure rate was at least 5 percentage points greater than the 2015 rate.

Amerigroup's 2016 top-box rates for the adult Medicaid population were lower than the 2015 NCQA adult Medicaid national averages for 11 of the 12 measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Rating of Health Plan*, *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*. Of these, seven measures were at least 5 percentage points less than the 2015 national averages: *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Rating of Health Plan*, *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*.

Table 7-2 shows **Amerigroup**'s 2015 and 2016 general child Medicaid CAHPS top-box rates.[7-3] In 2016, a total of 4,066 general child members were sent a survey and 686 completed a survey.[7-4] After ineligible members were excluded, the response rate was 17.9 percent. In 2015, the average NCQA response rate for the child Medicaid population was 25.2 percent, which was higher than **Amerigroup**'s response rate.[7-5]

Table 7-2—Amerigroup General Child Medicaid CAHPS Results

	2015 General Child Top-Box Rates	2016 General Child Top-Box Rates
Composite Measures		
Getting Needed Care	83.1%	77.5%
Getting Care Quickly	83.9%	83.3%
How Well Doctors Communicate	91.6%	88.5%
Customer Service	82.1%	87.2%
Shared Decision Making	79.8%	77.3%
Global Ratings		
Rating of All Health Care	62.2%	68.6%
Rating of Personal Doctor	69.1%	69.2%
Rating of Specialist Seen Most Often	NA	80.0%
Rating of Health Plan	63.5%	64.5%

A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as Not Applicable (NA).

Indicates the 2016 rate is at least 5 percentage points greater than the 2015 national average.

Indicates the 2016 rate is at least 5 percentage points less than the 2015 national average.

[7-3] The child Medicaid CAHPS results presented in Table 7-2 for **Amerigroup** are based on the results of the general child population only.

[7-4] The total number of members who were sent a survey and who completed a survey is based on **Amerigroup**'s general child CAHPS sample only (i.e., does not include the CCC supplemental sample of members who were surveyed).

[7-5] 2016 NCQA national response rate information for the CAHPS 5.0 Child Medicaid with CCC Survey was not available at the time this report was produced.

Amerigroup's rates increased between 2015 and 2016 for four measures: *Customer Service*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*. Of these, *Customer Service* and *Rating of All Health Care* showed a substantial increase of more than 5 percentage points. **Amerigroup**'s rates decreased between 2015 and 2016 for four measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Shared Decision Making*. Of these, *Getting Needed Care* showed a substantial decrease of more than 5 percentage points.

Amerigroup's 2016 top-box rates for the general child Medicaid population were lower than the 2015 NCQA child Medicaid national averages for seven measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, *Shared Decision Making*, *Rating of Personal Doctor*, and *Rating of Health Plan*. Of these, one measure, *Rating of Specialist Seen Most Often*, was at least 5 percentage points greater than the 2015 national average. Three measures were at least 5 percentage points less than the 2015 national averages: *Getting Needed Care*, *Getting Care Quickly*, and *Rating of Personal Doctor*.

Table 7-3 shows **Amerigroup**'s 2015 and 2016 CCC child Medicaid CAHPS top-box rates.[7-6] In 2016, a total of 236 child members with a chronic condition completed a survey.[7-7]

Table 7-3—Amerigroup CCC Medicaid CAHPS Results

	2015 CCC Supplemental Top-Box Rates	2016 CCC Supplemental Top-Box Rates
Composite Measures		
Getting Needed Care	76.8%	79.4%
Getting Care Quickly	88.2%	81.9%
How Well Doctors Communicate	92.0%	89.8%
Customer Service	NA	NA
Shared Decision Making	NA	NA
Global Ratings		
Rating of All Health Care	60.9%	62.6%
Rating of Personal Doctor	71.0%	69.2%
Rating of Specialist Seen Most Often	NA	72.6%
Rating of Health Plan	56.8%	61.4%
CCC Composite Measures/Items		
Access to Specialized Services	58.7%	NA
Family Centered Care (FCC): Personal Doctor Who Knows Child	87.6%	89.7%

7-6 The child Medicaid CAHPS results presented in Table 7-3 for **Amerigroup** are based on the results of the CCC population only.

7-7 The total number of members who completed a survey is based on **Amerigroup**'s CCC supplemental CAHPS sample only.

Table 7-3—Amerigroup CCC Medicaid CAHPS Results		
	2015 CCC Supplemental Top-Box Rates	2016 CCC Supplemental Top-Box Rates
Coordination of Care for Children with Chronic Conditions	NA	NA
Access to Prescription Medicines	80.2%	79.2%
FCC: Getting Needed Information	89.4%	88.5%

A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as Not Applicable (NA).

Indicates the 2016 rate is at least 5 percentage points greater than the 2015 national average.

Indicates the 2016 rate is at least 5 percentage points less than the 2015 national average.

Amerigroup's rates increased between 2015 and 2016 for four reportable measures: *Getting Needed Care*, *Rating of All Health Care*, *Rating of Health Plan*, and *FCC: Personal Doctor Who Knows Child*. **Amerigroup**'s rates decreased between 2015 and 2016 for five reportable measures: *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of Personal Doctor*, *Access to Prescription Medicines*, and *FCC: Getting Needed Information*. Of these, *Getting Care Quickly* showed a substantial decrease of more than 5 percentage points.

Amerigroup's 2016 top-box rates for the CCC child Medicaid population were lower than the 2015 NCQA CCC child Medicaid national averages for eight reportable measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Health Plan*, *Access to Prescription Medicines*, and *FCC: Getting Needed Information*. Of these, three measures were at least 5 percentage points less than the 2015 national averages: *Getting Needed Care*, *Getting Care Quickly*, and *Access to Prescription Medicines*.

Table 7-4 shows **Amerigroup**'s 2015 and 2016 Nevada Check Up CAHPS top-box rates.[7-8] Since NCQA does not publish separate rates for the CHIP program, national comparisons could not be made. In 2016, a total of 1,605 Nevada Check Up general child members were sent a survey and 409 completed a survey.[7-9] After ineligible members were excluded, the response rate was 28.8 percent.

Table 7-4—Amerigroup Nevada Check Up CAHPS Results		
	2015 General Child Top-Box Rates	2016 General Child Top-Box Rates
Composite Measures		
Getting Needed Care	77.5%	76.5%
Getting Care Quickly	82.6%	81.6%
How Well Doctors Communicate	89.9%	90.8%
Customer Service	86.7%	84.5%

7-8 The Nevada Check Up CAHPS results presented in Table 7-4 for **Amerigroup** are based on the results of the general child population only.

7-9 The total number of members surveyed and who completed a survey is based on **Amerigroup**'s Nevada Check Up general child CAHPS sample only.

Table 7-4—Amerigroup Nevada Check Up CAHPS Results		
	2015 General Child Top-Box Rates	2016 General Child Top-Box Rates
Shared Decision Making	NA	78.3%
Global Ratings		
Rating of All Health Care	63.7%	60.3%
Rating of Personal Doctor	66.3%	72.7%
Rating of Specialist Seen Most Often	NA	NA
Rating of Health Plan	65.7%	68.6%
A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as Not Applicable (NA).		

Amerigroup's rates decreased between 2015 and 2016 for four measures: *Getting Needed Care*, *Getting Care Quickly*, *Customer Service*, and *Rating of All Health Care.* The rates for three measures increased between 2015 and 2016: *How Well Doctors Communicate*, *Rating of Personal Doctor*, and *Rating of Health Plan.* Of these, *Rating of Personal Doctor* showed a substantial increase of more than 5 percentage points.

Table 7-5 shows **Amerigroup**'s 2015 and 2016 Nevada Check Up CAHPS top-box rates for the CCC population.[7-10] Since NCQA does not publish separate rates for the CHIP program, national comparisons could not be made. In 2016, a total of 80 Nevada Check Up child members with a chronic condition completed a survey.[7-11]

Table 7-5—Amerigroup CCC Nevada Check Up CAHPS Results		
	2015 CCC Supplemental Top-Box Rates	2016 CCC Supplemental Top-Box Rates
Composite Measures		
Getting Needed Care	NA	NA
Getting Care Quickly	NA	NA
How Well Doctors Communicate	NA	NA
Customer Service	NA	NA
Shared Decision Making	NA	NA
Global Ratings		
Rating of All Health Care	NA	NA
Rating of Personal Doctor	NA	NA
Rating of Specialist Seen Most Often	NA	NA

[7-10] The child Medicaid CAHPS results presented in Table 7-5 for **Amerigroup** are based on the results of the Nevada Check Up CCC population only.
[7-11] The total number of members who completed a survey is based on **Amerigroup**'s Nevada Check Up CCC supplemental CAHPS sample only.

Table 7-5—Amerigroup CCC Nevada Check Up CAHPS Results		
	2015 CCC Supplemental Top-Box Rates	2016 CCC Supplemental Top-Box Rates
Rating of Health Plan	NA	NA
CCC Composite Measures/Items		
Access to Specialized Services	NA	NA
FCC: Personal Doctor Who Knows Child	NA	NA
Coordination of Care for Children with Chronic Conditions	NA	NA
Access to Prescription Medicines	NA	NA
FCC: Getting Needed Information	NA	NA
A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as Not Applicable (NA).		

Amerigroup's 2015 and 2016 rates could not be reported for the Nevada Check Up CCC population, since all measures did not meet the minimum number of responses.

Plan-Specific Findings—HPN

Table 7-6 shows **HPN**'s 2015 and 2016 adult Medicaid CAHPS top-box rates. In 2016, a total of 1,899 members were sent a survey and 271 completed a survey. After ineligible members were excluded, the response rate was 14.4 percent. In 2015, the average NCQA response rate for the adult Medicaid population was 27.2 percent, which was higher than **HPN**'s response rate.[7-12]

Table 7-6—HPN Adult Medicaid CAHPS Results

	2015 Top-Box Rates	2016 Top-Box Rates
Composite Measures		
Getting Needed Care	73.5%	73.1%
Getting Care Quickly	78.0%	70.4%
How Well Doctors Communicate	88.9%	86.5%
Customer Service	87.8%	NA
Shared Decision Making	NA	NA
Global Ratings		
Rating of All Health Care	51.4%	44.6%
Rating of Personal Doctor	61.3%	54.3%
Rating of Specialist Seen Most Often	65.1%	NA
Rating of Health Plan	56.3%	52.5%
Effectiveness of Care*		
Advising Smokers and Tobacco Users to Quit	54.4%	63.1%
Discussing Cessation Medications	28.4%	24.8%
Discussing Cessation Strategies	27.2%	26.8%

A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as Not Applicable (NA).

* These rates follow NCQA's methodology of calculating a rolling two-year average.

Indicates the 2016 rate is at least 5 percentage points greater than the 2015 national average.

Indicates the 2016 rate is at least 5 percentage points less than the 2015 national average.

HPN's rates decreased between 2015 and 2016 for eight of nine reportable measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Health Plan*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*. Of these, three measures showed a substantial decrease of more than 5 percentage points: *Getting Care Quickly*, *Rating of All Health Care*, and *Rating of Personal Doctor*. One measure, *Advising Smokers and Tobacco Users to Quit*, increased between 2015 and 2016. The increase was more than 5 percentage points.

[7-12] 2016 NCQA national response rate information for the CAHPS 5.0 Adult Medicaid Survey was not available at the time this report was produced.

HPN's 2016 top-box rates for the adult Medicaid population were lower than the 2015 NCQA adult Medicaid national averages for all reportable measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Health Plan*, *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies.* Of these, eight measures were at least 5 percentage points less than the 2015 national average: *Getting Needed Care*, *Getting Care Quickly*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Health Plan*, *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies.*

Table 7-7 shows **HPN**'s 2015 and 2016 child Medicaid CAHPS top-box rates.[7-13] In 2016, a total of 2,372 general child members were sent a survey and 466 completed a survey.[7-14] After ineligible members were excluded, the response rate for the general child population was 20.4 percent. In 2015, the average NCQA response rate for the child Medicaid population was 25.2 percent, which was higher than **HPN**'s 2016 response rate.[7-15]

Table 7-7—HPN Child Medicaid CAHPS Results

	2015 General Child Top-Box Rates	2016 General Child Top-Box Rates
Composite Measures		
Getting Needed Care	79.2%	80.6%
Getting Care Quickly	83.7%	85.9%
How Well Doctors Communicate	92.3%	89.5%
Customer Service	NA	90.1%
Shared Decision Making	NA	78.4%
Global Ratings		
Rating of All Health Care	59.7%	68.5%
Rating of Personal Doctor	70.0%	74.4%
Rating of Specialist Seen Most Often	NA	NA
Rating of Health Plan	71.5%	74.9%

A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as Not Applicable (NA).

Indicates the 2016 rate is at least 5 percentage points greater than the 2015 national average.

Indicates the 2016 rate is at least 5 percentage points less than the 2015 national average.

HPN's rates decreased between 2015 and 2016 for one of the six reportable measures, *How Well Doctors Communicate*. **HPN**'s rates increased between 2015 and 2016 for five measures: *Getting Needed Care*, *Getting Care Quickly*, *Rating of All Health Care*, *Rating of Personal Doctor*, and

[7-13] The child Medicaid CAHPS results presented in Table 7-7 for **HPN** are based on the results of the general child population only.

[7-14] The total number of members who were sent a survey and who completed a survey is based on **HPN**'s general child CAHPS sample (i.e., does not include the CCC supplemental sample of members who were sent a survey).

[7-15] 2016 NCQA national response rate information for the CAHPS 5.0 Child Medicaid with CCC Survey was not available at the time this report was produced.

Rating of Health Plan. Further, one measure, *Rating of All Health Care*, showed a substantial increase of more than 5 percentage points.

HPN's 2016 top-box rates for the general child Medicaid population were lower than the 2015 NCQA general child Medicaid national averages for four measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Rating of Personal Doctor*. Four of **HPN**'s 2016 top-box rates for the general child Medicaid population were higher than the 2015 NCQA general child Medicaid national average: *Customer Service*, *Shared Decision Making*, *Rating of All Health Care*, and *Rating of Health Plan*. *Rating of Health Plan* was at least 5 percentage points greater than the 2015 national average.

Table 7-8 shows **HPN**'s 2015 and 2016 CCC child Medicaid CAHPS top-box rates.[7-16] In 2016, a total of 267 child members with a chronic condition completed a survey.[7-17]

Table 7-8—HPN CCC Medicaid CAHPS Results

	2015 CCC Supplemental Top-Box Rates	2016 CCC Supplemental Top-Box Rates
Composite Measures		
Getting Needed Care	79.3%	76.5%
Getting Care Quickly	78.4%	85.0%
How Well Doctors Communicate	88.7%	91.8%
Customer Service	NA	NA
Shared Decision Making	79.0%	78.7%
Global Ratings		
Rating of All Health Care	54.2%	64.9%
Rating of Personal Doctor	64.8%	68.9%
Rating of Specialist Seen Most Often	61.9%	63.2%
Rating of Health Plan	62.0%	66.8%
CCC Composite Measures/Items		
Access to Specialized Services	62.6%	64.7%
FCC: Personal Doctor Who Knows Child	82.6%	88.6%
Coordination of Care for Children with Chronic Conditions	72.8%	78.5%
Access to Prescription Medicines	88.0%	89.1%
FCC: Getting Needed Information	86.3%	87.3%

A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as Not Applicable (NA).

Indicates the 2016 rate is at least 5 percentage points greater than the 2015 national average.

Indicates the 2016 rate is at least 5 percentage points less than the 2015 national average.

[7-16] The child Medicaid CAHPS results presented in Table 7-8 for **HPN** are based on the results of the CCC population only.
[7-17] The total number of members who completed a survey is based on **HPN**'s CCC supplemental CAHPS sample only.

HPN's rates increased between 2015 and 2016 for 11 measures: *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Rating of Health Plan*, *Access to Specialized Services*, *FCC: Personal Doctor Who Knows Child*, *Coordination of Care for Children with Chronic Conditions*, *Access to Prescription Medicines*, and *FCC: Getting Needed Information*. Of these, four measures showed a substantial increase of more than 5 percentage points: *Getting Care Quickly*, *Rating of All Health Care*, *FCC: Personal Doctor Who Knows Child*, and *Coordination of Care for Children with Chronic Conditions*. **HPN**'s rates decreased between 2015 and 2016 for two measures: *Getting Needed Care* and *Shared Decision Making*.

HPN's 2016 top-box rates for the CCC child Medicaid population were lower than the 2015 NCQA CCC child Medicaid national average for 10 measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Shared Decision Making*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Access to Specialized Services*, *FCC: Personal Doctor Who Knows Child*, *Access to Prescription Medicines*, and *FCC: Getting Needed Information*. Two of **HPN**'s 2016 top-box rates for the CCC child Medicaid population, *Rating of All Health Care* and *Rating of Health Plan*, were higher than the 2015 NCQA CCC child Medicaid national average. However, five measures were at least 5 percentage points less than the 2015 national average: *Getting Needed Care*, *Getting Care Quickly*, *Shared Decision Making*, *Rating of Specialist Seen Most Often*, and *Access to Specialized Services*.

Table 7-9 shows **HPN**'s 2015 and 2016 Nevada Check Up CAHPS top-box rates for the general child population.[7-18,7-19] Since NCQA does not publish separate rates for the CHIP program, national comparisons could not be made. In 2016, a total of 2,352 Nevada Check Up general child members were sent a survey and 538 completed a survey.[7-20] After ineligible members were excluded, the response rate was 32.1 percent.

Table 7-9—HPN Nevada Check Up CAHPS Results

	2015 General Child Top-Box Rates	2016 General Child Top-Box Rates
Composite Measures		
Getting Needed Care	80.8%	79.6%
Getting Care Quickly	80.3%	82.2%
How Well Doctors Communicate	90.5%	89.7%
Customer Service	88.4%	85.2%
Shared Decision Making	79.1%	73.8%

[7-18] The Nevada Check Up CAHPS results presented in Table 7-9 for **HPN** are based on the results of the general child population only.
[7-19] Due to changes to the *Shared Decision Making* composite measure, comparisons of the 2015 to 2014 top-box rate could not be performed for this CAHPS measure.
[7-20] The total number of members who were sent a survey and who completed a survey is based on **HPN**'s general child CAHPS sample only (i.e., does not include the CCC supplemental sample of members who were sent a survey).

Table 7-9—HPN Nevada Check Up CAHPS Results		
	2015 General Child Top-Box Rates	2016 General Child Top-Box Rates
Global Ratings		
Rating of All Health Care	66.3%	66.6%
Rating of Personal Doctor	68.3%	73.5%
Rating of Specialist Seen Most Often	NA	68.4%
Rating of Health Plan	72.4%	73.9%
A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as Not Applicable (NA).		

HPN's rates increased between 2015 and 2016 for four measures: *Getting Care Quickly*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*. For the remaining four reportable measures, **HPN**'s rates decreased between 2015 and 2016: *Getting Needed Care*, *How Well Doctors Communicate*, *Customer Service*, and *Shared Decision Making*. Further, one measure, *Shared Decision Making*, showed a substantial decrease of more than 5 percentage points between 2015 and 2016.

Table 7-10 shows **HPN**'s 2015 and 2016 Nevada Check Up CAHPS top-box rates for the CCC population.[7-21] Since NCQA does not publish separate rates for the CHIP program, national comparisons could not be made. In 2016, 244 Nevada Check Up child members with a chronic condition completed a survey.[7-22]

Table 7-10—HPN CCC Nevada Check UP CAHPS Results		
	2015 CCC Supplemental Top-Box Rates	2016 CCC Supplemental Top-Box Rates
Composite Measures		
Getting Needed Care	83.5%	80.9%
Getting Care Quickly	83.7%	84.2%
How Well Doctors Communicate	90.6%	90.7%
Customer Service	NA	NA
Shared Decision Making	NA	NA
Global Ratings		
Rating of All Health Care	63.3%	67.2%
Rating of Personal Doctor	68.3%	73.1%
Rating of Specialist Seen Most Often	NA	70.6%
Rating of Health Plan	67.8%	67.8%

[7-21] The child Medicaid CAHPS results presented in Table 7-10 for **HPN** are based on the results of the Nevada Check Up CCC population only.

[7-22] The total number of members who completed a survey is based on **HPN**'s Nevada Check Up CCC supplemental CAHPS sample only.

Table 7-10—HPN CCC Nevada Check UP CAHPS Results		
	2015 CCC Supplemental Top-Box Rates	2016 CCC Supplemental Top-Box Rates
CCC Composite Measures/Items		
Access to Specialized Services	NA	NA
FCC: Personal Doctor Who Knows Child	84.4%	86.7%
Coordination of Care for Children with Chronic Conditions	NA	NA
Access to Prescription Medicines	91.2%	87.7%
FCC: Getting Needed Information	93.3%	88.4%
A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as Not Applicable (NA).		

HPN's rates increased between 2015 and 2016 for five measures: *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *FCC: Personal Doctor Who Knows Child*. **HPN**'s rates decreased between 2015 and 2016 for three measures: *Getting Needed Care*, *Access to Prescription Medicines*, and *FCC: Getting Needed Information.*

Plan Comparison

Amerigroup's response rate for the adult Medicaid population was lower than the 2015 NCQA adult Medicaid average response rate by 7.9 percentage points. **Amerigroup**'s adult Medicaid CAHPS scores were below the 2015 NCQA adult Medicaid national averages for 11 of the 12 measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Rating of Health Plan*, *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*. **HPN**'s response rate for the 2016 adult Medicaid population was 12.8 percentage points lower than the 2015 NCQA adult Medicaid average response rate. **HPN**'s adult Medicaid CAHPS scores were below the 2015 NCQA adult Medicaid national averages for all reportable measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Health Plan*, *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies.*

Amerigroup's response rate for the general child Medicaid population was 7.3 percentage points lower than the average 2015 NCQA response rate for the general child Medicaid population. **Amerigroup**'s general child Medicaid CAHPS scores were below the 2015 NCQA general child Medicaid national averages for five composite measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, and *Shared Decision Making.* In addition, **Amerigroup**'s general child Medicaid CAHPS scores were below the 2015 NCQA general child Medicaid national averages for two global ratings: *Rating of Personal Doctor* and *Rating of Health Plan*. **HPN**'s response rate for the 2016 general child Medicaid population was lower by 4.8 percentage points than the 2015 NCQA general child Medicaid average response rate. **HPN**'s general child Medicaid CAHPS scores were below the 2015 NCQA general child Medicaid national averages for three reportable composite measures—*Getting Needed Care*, *Getting Care Quickly*, and *How Well Doctors Communicate*—and for one reportable global rating: *Rating of Personal Doctor*.

Amerigroup's CCC child Medicaid CAHPS scores were below the 2015 NCQA CCC child Medicaid national averages for three reportable composite measures: *Getting Needed Care*, *Getting Care Quickly*, and *How Well Doctors Communicate*. In addition, **Amerigroup**'s CCC child Medicaid CAHPS scores were below the 2015 NCQA CCC child Medicaid national averages for three global ratings—*Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*—and for two reportable CCC composite measures: *Access to Prescription Medicines* and *FCC: Getting Needed Information.* **HPN**'s CCC child Medicaid CAHPS scores were below the 2015 NCQA CCC child Medicaid national averages for four reportable composite measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Shared Decision Making.* **HPN**'s CCC child Medicaid CAHPS scores were also below the 2015 NCQA CCC child Medicaid national averages for two reportable global ratings: *Rating of Personal Doctor* and *Rating of Specialist Seen Most Often*. In addition, **HPN**'s CCC child Medicaid CAHPS scores were below the 2015 NCQA CCC child Medicaid national averages for four CCC composite measures: *Access to Specialized Services*, *FCC: Personal Doctor Who Knows Child*, *Access to Prescription Medicines*, and *FCC: Getting Needed Information.*

Amerigroup's 2016 Nevada Check Up CAHPS scores were above the 2015 Nevada Check Up CAHPS scores for three measures for the general child population: *How Well Doctors Communicate*, *Rating of Personal Doctor*, and *Rating of Health Plan*. Since NCQA does not publish separate rates

for the CHIP program, national comparisons could not be made. **HPN**'s 2016 Nevada Check Up CAHPS scores were below the 2015 Nevada Check Up CAHPS score for four composite measures for the general child population: *Getting Needed Care*, *How Well Doctors Communicate*, *Customer Service*, and *Shared Decision Making*.

Amerigroup's 2016 Nevada Check Up CCC CAHPS survey results were lower than the minimum required 100 responses; therefore, the comparisons could not be completed. Additionally, since NCQA does not publish separate rates for the CHIP program, national comparisons could not be made. **HPN**'s 2016 Nevada Check Up CCC CAHPS score was below the 2015 Nevada Check Up CCC CAHPS score for one composite measure: *Getting Needed Care*. **HPN**'s 2016 Nevada Check Up CCC CAHPS score was also below the 2015 Nevada Check Up CCC CAHPS score for two CCC composite measures: *Access to Prescription Medicines* and *FCC: Getting Needed Information.*

Overall Recommendations

HSAG recommends that each MCO continue to work with its CAHPS vendor to ensure that a sufficient number of completed surveys is obtained to enable reporting of all CAHPS measures. NCQA recommends targeting 411 completed surveys per survey administration. **Amerigroup** had measures that did not meet the minimum number of responses (i.e., 100 responses) for the CCC Medicaid population, Nevada Check Up general child population, and Nevada Check Up CCC population. **HPN** had measures that did not meet the minimum number of responses for the adult Medicaid population, general child and CCC Medicaid populations, and the CCC Nevada Check Up population. Without sufficient responses, MCOs lack information that can be critical to designing and implementing targeted interventions that can improve access to, and the quality and timeliness of, care.

For the adult population, HSAG recommends that **Amerigroup** focus quality improvement initiatives on enhancing members' experiences with *Getting Needed Care*, *Customer Service*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*, since these rates were lower than the 2015 adult CAHPS results and fell below NCQA's 2015 CAHPS adult Medicaid national averages. For the general child Medicaid population, **Amerigroup** should focus on improving *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Shared Decision Making*, since the rates for these measures were lower than the 2015 general child CAHPS results and fell below NCQA's 2015 CAHPS child Medicaid national averages. For the CCC Medicaid population, **Amerigroup** should focus on improving *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of Personal Doctor*, *Access to Prescription Medicines*, and *FCC: Getting Needed Information*, since the rates for these reportable measures were lower than the 2015 CCC child CAHPS results and fell below NCQA's 2015 CAHPS CCC child national averages. For the Nevada Check Up population, HSAG recommends that **Amerigroup** focus quality improvement initiatives on enhancing members' experiences with *Getting Needed Care*, *Getting Care Quickly*, *Customer Service*, and *Rating of All Health Care*, since the 2016 rates for these reportable measures were lower than the 2015 rates.

HSAG recommends that **HPN** focus quality improvement initiatives on enhancing members' experiences with *Getting Needed Care*, *Getting Care Quickly*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Health Plan*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies* for the adult Medicaid population, since these rates were lower than the 2015

adult CAHPS results and fell below NCQA's 2015 CAHPS adult Medicaid national averages. For the general child Medicaid population, **HPN** should focus on improving *How Well Doctors Communicate*, since the rate for this composite measure was lower than the 2015 child CAHPS result and fell below NCQA's 2015 CAHPS child Medicaid national average. For the CCC child Medicaid population, **HPN** should focus on improving *Getting Needed Care* and *Shared Decision Making*, since the rates for these measures fell below the 2015 CAHPS results and were substantially lower than the 2015 NCQA CCC child Medicaid national averages. For the Nevada Check Up population, quality improvement efforts should focus on *Shared Decision Making*, since this measure showed a substantial decrease from 2015 to 2016. For the CCC Nevada Check Up population, **HPN** should improve the *Getting Needed Care*, *Access to Prescription Medicines*, and *FCC: Getting Needed Information*, since the rates for these measures decreased from 2015 to 2016.

8. Health Care Guidance Program (HCGP) CAP Review

Background

In February 2012, the State of Nevada Department of Health and Human Services, Division of Health Care Financing and Policy (DHCFP), issued a request for proposal to contract with a care management organization (CMO) to administer care management services to Nevada Comprehensive Care Waiver (NCCW) program enrollees. The NCCW program mandates care management services throughout the state for a subset of high-cost, high-need beneficiaries not served by the existing managed care organizations.

The DHCFP awarded a contract to **McKesson Health Solutions**, which later changed its name to **McKesson Technologies, Inc**. (**McKesson**), to serve as the State's CMO. The contract took effect November 12, 2013, and **McKesson** implemented the Nevada Health Care Guidance Program (HCGP) with a program start date of June 1, 2014. The first day of **McKesson**'s operations, however, was Monday June 2, 2014. On June 2, 2015, **Comvest Partners** purchased **McKesson Technologies, Inc.**'s care management business, which is now doing business as **AxisPoint Health** (**APH**).

DHCFP requested HSAG to conduct an interim assessment of **McKesson**'s compliance with its contract six months after **McKesson**'s HCGP operations began in June 2014. The purpose of the SFY 2014–2015 compliance review was to verify that **McKesson** had operationalized key elements of the program once services commenced. HSAG conducted an on-site compliance review of **McKesson**'s HCGP on December 10–11, 2014.

Out of 12 standards reviewed during the compliance review, seven were found to be deficient. HSAG recommended that **McKesson**, doing business as **APH,** submit to DHCFP a corrective action plan (CAP) to remedy all deficiencies that resulted from the compliance review. **APH** was responsible for developing the CAP, obtaining DHCFP approval of the CAP, and implementing the strategies outlined in the DHCFP-approved CAP.

CAP Review Findings

In SFY 2015–2016, HSAG worked with the DHCFP staff to review several CAPs submitted by **APH** and provide the DHCFP with feedback regarding the feasibility that the **APH** proposed strategies would remedy the deficiencies noted in the compliance review. Several of the responses **APH** submitted were not acceptable to the DHCFP, which issued a closeout letter to **McKesson** in July 2015 citing the items that were not acceptable. During SFY 2015–2016, HSAG worked with the DHCFP staff to review additional strategies proposed by **APH** to remedy outstanding deficiencies.

Table 8-1 shows the standards that required a CAP, whether the DHCFP accepted the first CAP submission, and the date the DHCFP accepted the final CAP.

Table 8-1—CAPs Submitted by APH				
Standard Number	**Standard Name**	**CAP Required**	**First CAP Submission Approved by DHCFP**	**Date CAP Accepted by DHCFP**
I	Stratification of Enrollees	Yes	No	3/15/16
II	Care Management Teams	No	–	–
III	Care Planning	Yes	No	1/13/16
IV	Mental Health Care Management Services	No	–	–
V	Health Education Materials	No	–	–
VI	Nurse Triage and Call Services	Yes	Partial	12/14/15
VII	Emergency Department Redirection	No	–	–
VIII	Stakeholder Outreach and Education	No	–	–
IX	Feedback to Primary Care Providers (PCPs)	Yes	No	1/13/16
X	Provider Services	Yes	Yes	7/15/15
XI	Care Transitions	Yes	Yes	7/15/15
XII	Operational Structure and Reporting	Yes	No	12/14/15
	Total CAPs	**7/12**	**2.5/7**	
A dash "–" indicates that no CAP was required.				

As noted in Table 8-1, the DHCFP monitored the deficient standards until it fully accepted the CAP submitted by **APH**. The DHCFP approved the last CAP on March 15, 2016.

9. Health Care Guidance Program Performance Measure Validation

Background

In February 2012, the State of Nevada Department of Health and Human Services, Division of Health Care Financing and Policy (the DHCFP), issued a request for proposal to contract with a care management organization (CMO) to administer care management services to Nevada Comprehensive Care Waiver (NCCW) program enrollees. The NCCW program mandates care management services throughout the state for a subset of high-cost, high-need beneficiaries not served by the existing managed care organizations.

The DHCFP awarded a contract to **McKesson Health Solutions**, which later changed its name to **McKesson Technologies, Inc**. (**McKesson**), to serve as the State's CMO. The contract took effect November 12, 2013, and **McKesson** implemented the Nevada Health Care Guidance Program (HCGP) with a program start date of June 1, 2014. The first day of **McKesson**'s operations, however, was Monday June 2, 2014. On June 2, 2015, **Comvest Partners** purchased **McKesson Technologies, Inc.**'s care management business, which is now doing business as **AxisPoint Health** (**APH**).

The DHCFP sought to verify that, on an annual basis, **APH** collected and reported complete and accurate performance measure data for contractually required performance measures. To verify the accuracy of **APH**'s reported rates, the DHCFP contracted with Health Services Advisory Group, Inc. (HSAG), the State's external quality review organization (EQRO), to validate the performance measure rates that **APH** calculated and reported. To ensure that the performance measure validation (PMV) activity was performed in accordance with industry standards of practice, HSAG validated **APH**'s performance measures using the external quality review (EQR) Protocol 2[9-1] developed by CMS as its guide. HSAG's PMV activity focused on the following objectives:

1. Assess the accuracy of the required performance measures reported by **APH**.
2. Determine the extent to which the measures calculated by **APH** followed the DHCFP's specifications and reporting requirements.

Performance Measures Validated

HSAG validated a set of performance measures selected by the DHCFP for validation. The measures primarily consisted of performance measures that were contractually required by the DHCFP, but not part of the HCGP pay-for-performance (P4P) program. These measures are herein referred to as the non-P4P measures.

[9-1] *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 1, 2012.

Validation Results

Several aspects involved in the calculation of performance measures are crucial to the validation process. These include data retrieval, integration, data control, and source code development and documentation of performance measure calculations.

Data Retrieval

HSAG reviewed the processes **APH** used to receive, transfer, and store the source data used to calculate the measures, which included staff interview, examination of log files, and participating in a live demonstration of the VITAL system. The VITAL system is a care management workflow system developed by **McKesson Technologies, Inc.** Overall, HSAG determined that the data integration processes in place at **APH** were adequate.

Data Integration

HSAG reviewed the data integration process used by **APH**, which included a review of file consolidations or extracts, source data compared to warehouse files, data integration documentation, source code, production activity logs, and linking mechanisms. Overall, HSAG determined that the data integration processes in place at **APH** were adequate.

Data Control

HSAG reviewed the data control processes used by **APH**, which included a review of disaster recovery procedures, data backup protocols, and related policies and procedures. Overall, the audit team determined that the data control processes in place at **APH** were adequate.

Source Code Development and Performance Measure Documentation

HSAG conducted a line-by-line source code review for all measures except those related to Care Transitions (i.e., CCHU 3-7 and DEM) and reviewed related documentation, which included the completed Information Systems Capabilities Assessment Tool (ISCAT), computer programming code, output files, work flow diagrams, and narrative descriptions of performance measure calculations. All applicable source code was approved prior to the on-site visit. HSAG also determined that **APH**'s documentation of performance measure calculations by was adequate.

Performance Measure-Specific Rates

HSAG received the final performance measure results generated by **APH** based on latest receipt of all applicable monthly operational files on October 9, 2015. All measure results were reviewed for reasonability. Table 9-1 shows the measure-specific rates for **APH.** For several measures (i.e., Care Transitions [CCUH.2-7], Cognitive Assessment for Dementia [DEM], Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer [CAN], and Childhood Immunization Status [CIS]), **APH** did not take the necessary steps or did not

operationalize appropriate protocols/activities to obtain the information necessary to calculate the measures. Therefore, these measures were assigned a "Not Completed" in the Audit Validation Results column.

Table 9-1—Measure-Specific Rates and Validation Results for APH

Measure ID	Measure	Program Period 1 (June 1, 2014–May 30, 2015)			Audit Validation Results
		Num	Den	Rate	
CCHU.1	*Ambulatory Care-Sensitive Condition Hospital Admission (per 100,000 population)*	2408	52575	4580	**Reportable**
CCHU.2	*"Avoidable" ER Visits*	15475	34169	45.3%	**Reportable**
CCHU.3	*Care Transitions—24 hours of discharge*	NC	NC	NC	**Not Completed**
CCHU.4	*Care Transitions—7 days of discharge*	NC	NC	NC	**Not Completed**
CCHU.5	*Care Transitions—30 days of discharge*	NC	NC	NC	**Not Completed**
CCHU.6	*Care Transitions—Receipt of Transition Record to Patient*	NC	NC	NC	**Not Completed**
CCHU.7	*Transition of Care—Reconciled Medication List*	NC	NC	NC	**Not Completed**
DEM	*Cognitive Assessment for Dementia*	NC	NC	NC	**Not Completed**
NEUR	*Stroke and Stroke Rehabilitations—Discharged on Antithrombotic Therapy*	18	165	10.9%	**Reportable**
CKD	*Adult Kidney Disease—Laboratory Testing (Lipid Profile)*	0	699	0.0%	Measure calculated correctly; technical specifications may not fully identify the numerator.
CAN	*Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer*	NC	NC	NC	**Not Completed**
RA	*Disease-modifying Anti-Rheumatic Drug (DMARD) Therapy for Rheumatoid Arthritis*	118	181	65.2%	**Reportable**
OST	*Osteoporosis—Pharmacologic therapy for men and women aged 50 years and older*	228	1972	11.6%	**Reportable**
OBS	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (3–11 Years)*	403	5431	7.4%	**Reportable**
OBS	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (12–17 Years)*	300	3336	9.0%	**Reportable**
CAP	*Children and Adolescents' Access to Primary Care Practitioners (12–24 months)*	504	549	91.8%	**Reportable**
CAP	*Children and Adolescents' Access to Primary Care Practitioners (25 months–6 years)*	2925	3557	82.2%	**Reportable**
CAP	*Children and Adolescents' Access to Primary Care Practitioners (7–11 years)*	3641	4224	86.2%	**Reportable**
CAP	*Children and Adolescents' Access to Primary Care Practitioners (12–19 years)*	4794	5518	86.9%	**Reportable**

Table 9-1—Measure-Specific Rates and Validation Results for APH					
Measure ID	Measure	Program Period 1 (June 1, 2014–May 30, 2015)			Audit Validation Results
		Num	Den	Rate	
W15	*Well-Child Visits in the First 15 Months of Life (0 Visits)*	207	992	20.9%	**Reportable**
W15	*Well-Child Visits in the First 15 Months of Life (1 Visit)*	150	992	15.1%	**Reportable**
W15	*Well-Child Visits in the First 15 Months of Life (2 Visits)*	142	992	14.3%	**Reportable**
W15	*Well-Child Visits in the First 15 Months of Life (3 Visits)*	139	992	14.0%	**Reportable**
W15	*Well-Child Visits in the First 15 Months of Life (4 Visits)*	110	992	11.1%	**Reportable**
W15	*Well-Child Visits in the First 15 Months of Life (5 Visits)*	87	992	8.8%	**Reportable**
W15	*Well-Child Visits in the First 15 Months of Life (6 or more visits)*	157	992	15.8%	**Reportable**
W34	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*	1459	3021	48.3%	**Reportable**
AWC	*Adolescent Well-Care Visits*	1766	6032	29.3%	**Reportable**
CIS	*Childhood Immunization Status (Dtap)*	0	1084	NC	**Not Completed**
CIS	*Childhood Immunization Status (IPV)*	4	1084	NC	**Not Completed**
CIS	*Childhood Immunization Status (MMR)*	0	1084	NC	**Not Completed**
CIS	*Childhood Immunization Status (HiB)*	5	1084	NC	**Not Completed**
CIS	*Childhood Immunization Status (HepB)*	2	1084	NC	**Not Completed**
CIS	*Childhood Immunization Status (VZV)*	3	1084	NC	**Not Completed**
CIS	*Childhood Immunization Status (PCV)*	0	1084	NC	**Not Completed**
CIS	*Childhood Immunization Status (HepA)*	1	1084	NC	**Not Completed**
CIS	*Childhood Immunization Status (Rotavirus)*	2	1084	NC	**Not Completed**
CIS	*Childhood Immunization Status (Influenza)*	0	1084	NC	**Not Completed**
CIS	*Childhood Immunization Status (Combination #2)*	NC	NC	NC	**Not Completed**
CIS	*Childhood Immunization Status (Combination #3)*	NC	NC	NC	**Not Completed**
CIS	*Childhood Immunization Status (Combination #4)*	NC	NC	NC	**Not Completed**
CIS	*Childhood Immunization Status (Combination #5)*	NC	NC	NC	**Not Completed**
CIS	*Childhood Immunization Status (Combination #6)*	NC	NC	NC	**Not Completed**
CIS	*Childhood Immunization Status (Combination #7)*	NC	NC	NC	**Not Completed**
CIS	*Childhood Immunization Status (Combination #8)*	NC	NC	NC	**Not Completed**
CIS	*Childhood Immunization Status (Combination #9)*	NC	NC	NC	**Not Completed**
CIS	*Childhood Immunization Status (Combination #10)*	NC	NC	NC	**Not Completed**

Table 9-1—Measure-Specific Rates and Validation Results for APH					
Measure ID	Measure	Program Period 1 (June 1, 2014–May 30, 2015)			Audit Validation Results
		Num	Den	Rate	
PPC	*Timeliness of Prenatal Care*	267	1122	23.8%	**Reportable**
PPC	*Postpartum Care*	143	1122	12.7%	**Reportable**
WOP	*Weeks of Pregnancy at Time of Enrollment, ≤ 0 weeks (280 days or more prior to delivery)*	262	1451	18.1%	**Reportable**
WOP	*Weeks of Pregnancy at Time of Enrollment, 1–12 weeks (279–196 days prior to delivery)*	229	1451	15.8%	**Reportable**
WOP	*Weeks of Pregnancy at Time of Enrollment, 13–27 weeks (195–91 days prior to delivery)*	580	1451	40.0%	**Reportable**
WOP	*Weeks of Pregnancy at Time of Enrollment, 28 or more weeks (≤90 days prior to delivery)*	311	1451	21.4%	**Reportable**
WOP	*Weeks of Pregnancy at Time of Enrollment, Unknown*	69	1451	4.8%	**Reportable**
FPC	*Frequency of Ongoing Prenatal Care, <21 percent of expected visits*	702	1122	62.6%	**Reportable**
FPC	*Frequency of Ongoing Prenatal Care, 21 percent–40 percent of expected visits*	275	1122	24.5%	**Reportable**
FPC	*Frequency of Ongoing Prenatal Care, 41 percent–60 percent of expected visits*	74	1122	6.6%	**Reportable**
FPC	*Frequency of Ongoing Prenatal Care, 61 percent–80 percent of expected visits*	41	1122	3.7%	**Reportable**
FPC	*Frequency of Ongoing Prenatal Care, ≥81 percent of expected visits*	30	1122	2.7%	**Reportable**
ABA	*Adult BMI Assessment*	1271	12849	9.9%	**Reportable**
BCS	*Breast Cancer Screening*	2303	5431	42.4%	**Reportable**
CCS	*Cervical Cancer Screening*	3047	8753	34.8%	**Reportable**
COL	*Colorectal Cancer Screening*	1118	5977	18.7%	**Reportable**

Summary of Findings

This audit examined 24 measures with a total of 63 indicators, or individual rates. Of the 63 indicators, 26 rates were given a Not Completed. The rates for the other 37 indicators appeared to be appropriately calculated and reported by **APH**.

APH staff members stated that **APH** was unable to report the care transition measures CCHU 3-7 because **APH** could not fully identify the eligible population and the numerator requirements could not be adequately met with their current process. **APH**'s staff reported that **APH** may not be notified or may not receive encounter data for months after an individual's hospitalization. To mitigate this issue, **APH** staff members attempted to monitor hospitalizations for enrollees via **APH**

staffing and established relationships with hospital facilities so the facilities would report to **APH** when an enrollee was hospitalized.

All of the indicators (numerators) for the *Childhood Immunization Status* measure were underreported based solely on administrative data. Without immunization data from the State registry or medical record review, *Childhood Immunization Status* measure rates were too low to derive any effective conclusion or impact **APH** may have had on this population.

The rates for *Cognitive Assessment for Dementia (DEM)* and *Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor Positive Breast Cancer (CAN)* were also given a Not Completed. For the DEM measure, **APH** was not able to fully identify the denominator. The technical specifications for the CAN measure uses CPT II codes; however, the providers do not currently submit CPT II codes in Nevada. Therefore, the CAN measure had no members identified in the denominator and was Not Completed.

For *Timeliness of Prenatal Care*, *Postpartum Care*, and *Frequency of Ongoing Prenatal Care* the rates are very low compared to national percentiles. These rates may have been impacted by global billing practices. Global billing is the submission of a single claim for a fixed fee that covers all care related to a certain condition over a particular period of time, such as billing for prenatal and postpartum care visits in conjunction with the delivery. Since generally, only global billing is submitted for the duration of the woman's pregnancy, performance measures can be underreported without medical record abstraction to augment the numerator compliance. *Timeliness of Prenatal Care*, *Postpartum Care*, and *Frequency of Ongoing Prenatal Care* rates were considered reportable since the calculation of the measures met the technical specifications, and a true underreported bias could not be ascertained at the time.

Overall Recommendations and Status of Recommendations

As a result of the HCGP performance measure validation, HSAG made several recommendations to the DHCFP and **APH** so that measures could be fully reported. Below are the HSAG recommendations as well as a status update for those recommendations.

- **APH** should work to obtain WebIZ supplemental immunization registry data in order to calculate a rate for the *Childhood Immunization Status* measures.
  - **Update: APH** secured the necessary access to obtain WebIZ supplemental immunization registry data in the spring of 2016.
- The DHCFP should revisit the care transition measures, CCHU 3-7, to determine the likelihood that data can be obtained to report the measures. If data cannot be obtained, then the measures should be omitted or replaced with other measures.
  - **Update:** The DHCFP and HSAG staff members worked to replace the CCHU 3-7 measures with measures that **APH** could calculate. The new measures are *Follow-Up with PCP After Hospitalization—7 days* and *30 days* and *Medication Reconciliation Post-Discharge.*
- For the *Cognitive Assessment for Dementia* measure, DHCFP should consider modifying the measure specifications so that **APH** can identify the denominator.

- **Update:** The DHCFP and HSAG staff members worked to modify the codes used to specify the denominator so that it could be identified by **APH** and a rate could be generated.

- DHCFP should consider replacing or removing the measure *Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor Positive Breast Cancer (CAN)*, since CPT II codes cannot be collected.
  - **Update:** The DHCFP removed the measure *Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor Positive Breast Cancer (CAN)* from the suite of non-P4P performance measures, since CPT II codes could not be collected.

Appendix A. Technical Methods of Data Collection and Analysis

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, requires states to prepare an annual technical report that describes the manner in which data were aggregated and analyzed and how conclusions were drawn as to the quality and timeliness of, and access to, care and services furnished by the states' managed care organizations (MCOs). The data come from activities conducted in accordance with the Code of Federal Regulations (CFR) at 42 CFR §438.358. To meet these requirements, the State of Nevada, Department of Health and Human Resources, Division of Health Care Financing and Policy (the DHCFP), contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO). HSAG has served as the EQRO for the DHCFP since 2000.

From all of the data collected, HSAG summarizes each MCO's strengths and weaknesses and provides an overall assessment and evaluation of the quality, timeliness of, and access to, care and services that each MCO provides. The evaluations are based on the following definitions of quality, access, and timeliness:

- ***Quality***—CMS defines quality in the final rule at 42 CFR §438.320 as follows: "Quality, as it pertains to external quality review, means the degree to which an MCO or PIHP increases the likelihood of desired health outcomes of its beneficiaries through its structural and operational characteristics and through provision of health services that are consistent with current professional knowledge."[A-1]
- ***Timeliness***—NCQA defines timeliness relative to utilization decisions as follows: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[A-2] It further discusses the intent of this standard to minimize any disruption in the provision of health care. HSAG extends this definition of timeliness to include other managed care provisions that impact services to members and that require a timely response from the MCO (e.g., processing expedited member appeals and providing timely follow-up care).
- ***Access***—In the preamble to the BBA Rules and Regulations, CMS discusses access and availability of services to Medicaid enrollees as "the degree to which MCOs/PIHPs implement the standards set forth by the state to ensure that all covered services are available to enrollees. Access includes the availability of an adequate and qualified provider network that considers the needs and characteristics of the enrollees served by the MCO or PIHP."[A-3]

This appendix describes the technical methods for data collection and analysis for each of the following activities: Internal Quality Assurance Program compliance review, performance measure validation, validation of performance improvement projects, CAHPS surveys, Health Care

[A-1] Federal Register. *Code of Federal Regulations, Title 42, Volume 3*, October 1, 2005. Available at: http://www.gpo.gov/fdsys/pkg/CFR-2012-title42-vol4/xml/CFR-2012-title42-vol4-sec438-320.xml. Accessed on: September 15, 2014.

[A-2] NCQA. *2014 Standards and Guidelines for the Accreditation of Health Plans.* Available at: https://iss.ncqa.org/RDSat/ATMain.asp?ProductType=License&ProductID=313&activityID=54453. Accessed on: September 15, 2014.

[A-3] Federal Register. *Code of Federal Regulations. Vol. 67, No. 115*, June 14, 2002.

Guidance Program (HCGP) compliance review follow up, and HCGP performance measure validation (PMV). The objectives for each of these activities are described in the respective sections of this report.

Internal Quality Assurance Program (IQAP) Corrective Action Plan Review

The purpose of the *SFY 2014–2015 Internal Quality Assurance Program (IQAP) On-Site Review of Compliance* was to determine each MCO's compliance with federal and State managed care standards. For the *SFY 2014–2015 IQAP On-Site Review of Compliance*, HSAG reviewed each MCO's managed care and quality program activities that occurred during SFY 2013–2014. In SFY 2014–2015, HSAG reviewed the corrective action plans submitted by the MCOs and approved by the DHCFP. HSAG also identified a couple of key contractual requirements that were misinterpreted by the MCOs and made recommendations to the DHCFP as to how these areas could be clarified for the MCOs. HSAG worked with DHCFP to clarify the requirements for the MCOs so that the requirements would not be misinterpreted in the future.

Validation of Performance Improvement Projects (PIPs)

The DHCFP requires its MCOs to conduct PIPs annually. The topics for the SFY 2014–2015 PIP validation cycle were:

- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC).*
- *Behavioral Health Hospital Readmissions*.

Amerigroup and **HPN** conducted each required PIP and submitted documentation to HSAG for validation.

PIP Validation Redesigned

In July 2014, HSAG developed a new PIP framework based on a modified version of the Model for Improvement developed by Associates in Process Improvement and modified by the Institute for Healthcare Improvement. The redesigned PIP methodology was intended to improve processes and outcomes of healthcare by way of continuous quality improvement. The redesigned framework redirects MCOs to focus on small tests of change in order to determine which interventions have the greatest impact and can bring about real improvement. PIPs must meet CMS requirements; therefore, HSAG completed a crosswalk of this new framework against the Department of Health and Human Services, CMS publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.

HSAG presented the crosswalk and new PIP framework components to CMS to demonstrate how the new PIP framework aligned with the CMS validation protocols. CMS agreed that, with the pace of quality improvement science development and the prolific use of plan, do, study, act (PDSA) cycles in modern improvement projects within healthcare settings, a new approach was needed.

After meeting with the DHCFP and HSAG staff members to discuss the topics and approach, CMS gave approval for the DHCFP to implement this new PIP approach in Nevada.

PIP Components and Process

The key concepts of the new PIP framework include forming a PIP team, setting aims or goals, establishing measures, defining interventions, testing interventions, and spreading successful changes. The core component of the new approach involves testing changes on a small scale, using a series of PDSA cycles and applying rapid-cycle learning principles over the course of the improvement project to adjust intervention strategies so that improvement can occur more efficiently and lead to long-term sustainability. The duration of rapid-cycle PIPs using this new framework is 18 months.

For this new PIP framework, HSAG developed five modules with an accompanying companion guide. Prior to issuing each module, HSAG held technical assistance sessions with the MCOs to educate about application of the modules. The five modules are defined as:

- **Module 1—PIP Initiation:** Module 1 outlines the framework for the project. The framework includes the topic rationale and supporting data, building a PIP team, setting aims (Global and SMART), and completing a key driver diagram
- **Module 2—SMART Aim Data Collection:** In Module 2, the SMART Aim measure is operationalized and the data collection methodology is described. SMART Aim data are displayed using a run chart.
- **Module 3—Intervention Determination:** In Module 3, there is increased focus into the quality improvement activities reasonably thought to impact the SMART Aim. Interventions in addition to those in the original key driver diagram are identified using tools such as process mapping, failure modes and effects analysis (FMEA), Pareto charts, and failure mode priority ranking, for testing via PDSA cycles in Module 4.
- **Module 4—Plan-Do-Study-Act:** The interventions selected in Module 3 are tested and evaluated through a thoughtful and incremental series of PDSA cycles.
- **Module 5—PIP Conclusions:** In Module 5, the MCO summarizes key findings and presents comparisons of successful and unsuccessful interventions, outcomes achieved, and lessons learned.

Approach to PIP Validation

In SFY 2015–2016, HSAG obtained the data needed to conduct the PIP validation from the MCO's module submission forms. These forms provided detailed information about each of the PIPs and the activities completed in Modules 1 through 3.

The MCO submitted each module according to the approved timeline. After the initial validation of each module, the MCO received HSAG's feedback and technical assistance and resubmitted the modules until all validation criteria were met. This method ensured that the methodology was sound before the MCO tested interventions. Currently, the MCOs are testing interventions and completing

Module 4. The Module 4 validation findings will be included in the *SFY 2016–2017 EQR Technical Report*.

The goal of HSAG's PIP validation is to ensure that the DHCFP and key stakeholders can have confidence that any reported improvement is related and can be directly linked to the quality improvement strategies and activities the MCO conducted during the life of the PIP. HSAG's scoring methodology evaluates whether the MCO executed a methodologically sound improvement project and confirms that any achieve improvement could be clearly linked to the quality improvement strategies implemented by the MCO.

PIP Validation Scoring

HSAG assigned a score of Achieved or Failed for each of the criteria in Modules 1 through 3. Any validation criteria not applicable (N/A) were not scored. As the PIP progresses, and at the completion of Module 5, HSAG will use the validation findings for Modules 1 through 5 criteria for each PIP to determine a confidence level representing the validity and reliability of the PIP. Using a standardized scoring methodology, HSAG will assign a level of confidence and report the overall validity and reliability of the findings as one of the following:

- ***High confidence*** = The PIP was methodologically sound, achieved the SMART Aim, and the demonstrated improvement could be clearly linked to the quality improvement processes implemented.
- ***Confidence*** = The PIP was methodologically sound, achieved the SMART Aim, and some of the quality improvement processes could be clearly linked to the demonstrated improvement; however, there was not a clear link between all quality improvement processes and the demonstrated improvement.
- ***Low confidence*** = (A) the PIP was methodologically sound; however, the SMART Aim was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and interventions were poorly executed and could not be linked to the improvement.
- ***Reported PIP results were not credible*** = The PIP methodology was not executed as approved.

Performance Measure Validation/HEDIS Audit

HSAG performed an audit of the MCOs' HEDIS reporting for their Medicaid and Nevada Check Up programs. Methods and information sources used by HSAG to conduct the audit included:

- Teleconferences with the MCOs' personnel and vendor representatives, as necessary.
- Detailed review of the MCOs' completed responses to the NCQA Roadmap.
- On-site meetings, including the following:
  - Staff interviews.
  - Live system and procedure demonstration.
  - Documentation review and requests for additional information.
  - Primary HEDIS data source verification.
  - Programming logic review and inspection of dated job logs.

  - Computer database and file structure review.
  - Discussion and feedback sessions.
- Detailed evaluation of computer programming used to access administrative data sets, manipulate medical record review data, and calculate HEDIS measures.
- Detailed evaluation of encounter data completeness.
- Re-abstraction of sample medical records selected by the auditors, with a comparison of results to each MCO's review determinations for the same records, if the hybrid method was used.
- Requests for corrective actions and modifications related to HEDIS data collection and reporting processes and data samples, as necessary, and verification that actions were taken.
- Accuracy checks of the final HEDIS rates completed by the MCOs.
- Interviews with a variety of individuals whose department or responsibilities played a role in the production of HEDIS data. Representatives of vendors who provided or processed HEDIS 2014 (and earlier historical) data may also have been interviewed and asked to provide documentation of their work.

In addition, activities conducted prior to on-site meetings with representatives of **HPN** and **Amerigroup** included written and email correspondence explaining the scope of the audit, methods used, and time frames for major audit activities; a compilation of a standardized set of comprehensive working papers for the audit; a determination of the number of sites and locations for conducting on-site meetings, demonstrations, and interviews with critical personnel; the preparation of an on-site agenda; a review of the certified measures approved by NCQA; and a detailed review of a select set of HEDIS measures required for reporting by the DHCFP.

The IS capabilities assessment consisted of the auditor's findings on IS capabilities, compliance with each IS standard, and any impact on HEDIS reporting. Assessment details included facts on claims and encounter data, enrollment, provider data, medical record review processes, data integration, data control, and measure calculation processes.

To validate the medical record review portion of the audit, NCQA policies and procedures require auditors to perform two steps: First, an audit team review of the medical record review processes employed by the MCOs, including a review of staff qualifications, training, data collection instruments and tools, interrater reliability (IRR) testing, and the method used to combine medical record review data with administrative data; and second, a reabstraction of selected medical records and a comparison of the audit team's results to abstraction results for medical records used in the hybrid data source measures.

The analysis of the validation of performance measures involved tracking and reporting rates for the measures required for reporting by the DHCFP for Medicaid and Nevada Check Up. The audited measures (and the programs to which they apply) are presented in Table A-1.

Table A-1—SFY 2015–2016 Performance Measures for Nevada Medicaid and Nevada Check Up				
Performance Measure		Method	Populations	
			Medicaid	Nevada Check Up
1	*Adolescent Well-Care Visits (AWC)*	Hybrid	✓	✓
2	*Ambulatory Care (AMB)*	Admin	✓	✓
3	*Annual Dental Visit (ADV)*	Admin	✓	✓
4	*Childhood Immunization Status—Combos 2–10 (CIS)*	Hybrid	✓	✓
5	*Children and Adolescents' Access to Primary Care Practitioners (CAP)*	Admin	✓	✓
6	*Comprehensive Diabetes Care—Excluding <7 indicator (CDC)*	Hybrid	✓	
7	*Follow-Up After Hospitalization for Mental Illness (FUH)*	Admin	✓	✓
8	*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity (ADHD) Medication (ADD)*	Admin	✓	✓
9	*Frequency of Ongoing Prenatal Care (FPC)*	Hybrid	✓	
10	*Human Papillomavirus Vaccine for Female Adolescents (HPV)*	Hybrid	✓	✓
11	*Immunizations for Adolescents (IMA)*	Hybrid	✓	✓
12	*Medication Management for People with Asthma (MMA)*	Admin	✓	✓
13	*Mental Health Utilization (MPT)*	Admin	✓	✓
14	*Prenatal and Postpartum Care (PPC)*	Hybrid	✓	
15	*Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)*	Admin	✓	✓
16	*Weeks of Pregnancy at Time of Enrollment (WOP)*	Hybrid	✓	
17	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)*	Hybrid	✓	✓
18	*Well-Child Visits in the First 15 Months of Life (W15)*	Hybrid	✓	✓
19	*Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)*	Hybrid	✓	✓

CAHPS Surveys

Three populations were surveyed for **HPN** and **Amerigroup**: adult Medicaid, child Medicaid, and Nevada Check Up. Decision Support Systems (DSS) Research, an NCQA-certified vendor, administered the 2016 CAHPS surveys for both **HPN** and **Amerigroup**.

The technical method of data collection was through administration of the CAHPS 5.0H Adult Medicaid Health Plan Survey to the adult population, and the CAHPS 5.0H Child Medicaid Health Plan Survey (with the Children with Chronic Conditions [CCC] measurement set) to the child Medicaid and Nevada Check Up populations. **HPN** and **Amerigroup** used a pre-approved enhanced mixed-mode methodology for data collection (i.e., mailed surveys followed by telephone interviews of nonrespondents).

The survey questions were categorized into various measures of satisfaction. These measures included four global ratings, five composite scores, and three Effectiveness of Care measures for the adult population only. Additionally, five CCC composite measures/items were used for CCC eligible population. The global ratings reflected patients' overall satisfaction with their personal doctor, specialist, health plan, and all health care. The composite scores were derived from sets of questions to address different aspects of care (e.g., getting needed care and how well doctors communicate). The CCC composite measures/items evaluated the satisfaction of families with children with chronic conditions accessing various services (e.g., specialized services, prescription medications). The Effectiveness of Care measures assessed the various aspects of providing assistance with smoking and tobacco use cessation. When a minimum of 100 responses for a measure was not achieved, the result was denoted as Not Applicable (NA).

For each of the four global ratings, the percentage of respondents who chose the top satisfaction ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. This percentage is referred to as a question summary rate (or top-box response).

For each of the five composite scores and CCC composite measures/items, the percentage of respondents who chose a positive response was calculated. CAHPS composite question response choices fell into one of two categories: (1) Never, Sometimes, Usually, or Always; or (2) No or Yes. A positive or top-box response for the composites and CCC composites/items was defined as a response of Usually/Always or Yes. The percentage of top-box responses is referred to as a global proportion for the composite scores and CCC composite measures/items. For the Effectiveness of Care measures, responses of Always/Usually/Sometimes were used to determine if the respondent qualified for inclusion in the numerator. The rates presented follow NCQA's methodology of calculating a rolling average using the current and prior years' results. A substantial increase or decrease is denoted by a change of 5 percentage points or more.

Health Care Guidance Program (HCGP) Corrective Action Plan Review

In SFY 2014–2015, HSAG conducted a compliance review of **McKesson**. HSAG performed the review in two phases. Phase I focused on the operational structure of key areas of the program and consisted of a desk review of documentation and information supplied by **McKesson**. Phase II consisted of a two-day on-site review, which occurred December 10–11, 2014, in **McKesson**'s Carson City, Nevada, office. As a result of the two-phase review, **McKesson**, now doing business as **APH**, was required to submit a corrective action plan (CAP) to DHCFP to correct the areas of deficiency noted from the review.

In SFY 2015–2016, HSAG reviewed the CAP submitted by **APH** and provided feedback to DHCFP regarding the areas that met the contractual requirements and those that were still out of compliance.

Health Care Guidance Program (HCGP) Performance Measure Validation

In the fall of 2015, HSAG conducted a performance measure validation (PMV) audit of **APH**, to verify the accuracy of reported rates by **APH**. HSAG validated **APH**'s performance measures using the external quality review (EQR) Protocol 2[A-4] developed by CMS as its guide. HSAG's **APH** activity focused on the following objectives:

1. Assess the accuracy of the required performance measures reported by **APH**
2. Determine the extent to which the measures calculated by **APH** follow DHCFP's specifications and reporting requirements

HSAG validated a set of performance measures selected by DHCFP for validation. The measures primarily consisted of performance measures that were contractually required by the DHCFP, but not part of the HCGP pay-for-performance (P4P) program. These measures are herein referred to as the non-P4P measures. The DHCFP provided the specifications **APH** was required to use for calculation of the performance measures in Attachment II of the **APH** contract (RFP/Contract #1958). Table A-2 below lists the performance measures that HSAG validated under the scope of this audit. The measurement period for which the PMV was conducted was identified as Program Period 1 (i.e., June 1, 2014 through May 30, 2015).

Table A-2—Performance Measures for HCGP

Measure ID	Measure Name
CCHU.1	*Ambulatory Care—Sensitive Condition Hospital Admission*
CCHU.2	*Avoidable Emergency Room Visits*
CCHU.3-5	*Care Transitions—24 Hours, 7 Days, and 30 Days of Discharge*
CCHU.6	*Care Transitions—Receipt of Transition Record to Patient*
CCHU.7	*Transition of Care—Reconciled Medication List*

[A-4] *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 1, 2012.

Table A-2—Performance Measures for HCGP	
Measure ID	**Measure Name**
DEM	*Cognitive Assessment for Dementia*
NEUR	*Stroke and Stroke Rehabilitations—Discharged on Antithrombotic Therapy*
CKD	*Adult Kidney Disease—Laboratory Testing (Lipid Profile)*
CAN	*Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer*
RA	*Disease-modifying Anti-Rheumatic Drug (DMARD) Therapy for Rheumatoid Arthritis*
OST	*Osteoporosis—Pharmacologic therapy for men and women aged 50 years and older*
OBS	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
CAP	*Children and Adolescents' Access to Primary Care Practitioners*
W15	*Well-Child Visits in the First 15 Months of Life*
W34	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
AWC	*Adolescent Well-Care Visits*
CIS	*Childhood Immunization Status*
PPC	*Prenatal and Postpartum Care*
WOP	*Weeks of Pregnancy at Time of Enrollment*
FPC	*Frequency of Ongoing Prenatal Care*
ABA	*Adult BMI Assessment*
BCS	*Breast Cancer Screening*
CCS	*Cervical Cancer Screening*
COL	*Colorectal Cancer Screening*

Pre-audit Strategy

To assist **APH** with the validation process, HSAG provided a technical assistance webinar session to **APH** in March 2015, and provided technical assistance to **APH**'s staff throughout the audit process.

HSAG prepared and sent a documentation request letter to **APH**, which outlined the steps in the PMV process. The letter included a request for source code for each performance measure, a completed Information Systems Capabilities Assessment Tool (ISCAT), any additional supporting documentation necessary to complete the audit, and a timetable for completion and instructions for submission. The ISCAT was customized to collect information regarding the necessary data that were consistent with the Nevada HCGP and the Nevada Comprehensive Care Waiver (NCCW) special terms and conditions. HSAG responded to ISCAT-related questions received directly from **APH** during the pre-on-site phase.

Upon receiving the completed ISCAT and requested supporting documents, HSAG conducted a desk review of all materials and noted any issues or items that required follow-up. HSAG also conducted an extensive review of **APH**'s source code used to calculate the non-P4P measures. HSAG source code reviewers performed a line-by-line review to assess whether the codes were developed according to the non-P4P measure specifications detailed in **APH**'s contract with the DHCFP. HSAG also checked for any inconsistency in measure interpretation between **APH** and Nevada's actuary (Milliman), the entity responsible for calculating the baseline rates for the non-P4P measures. Findings of the source code review were provided to **APH** before final rates were calculated.

On-site Activities

On October 15, 2015, HSAG conducted the on-site visit with **APH**. HSAG auditors collected information from **APH** staff members using several methods that included interviews, system demonstration, review of data output files, primary source verification, observation of data processing, and review of data reports. The on-site activities included:

- Opening session.
- Evaluation of system compliance.
- Overview of data integration and control procedures.
- Closing conference.

HSAG conducted several interviews with key **APH** staff members involved with any aspect of performance measure reporting.

Post-on-site Activities

During the on-site visit, HSAG auditors identified several items that required follow-up from **APH**, including revision of some source code for several measures. **APH** submitted the revised source code along with revised non-P4P performance measure rates. Upon resolving all outstanding items, HSAG auditors reviewed the revised rates provided by **APH** before issuing the final report.

Appendix B. Quality Strategy Goals and Objectives Table

Appendix B, which follows this page, contains the Quality Strategy Goals and Objectives Table.

Nevada 2016–2017 Quality Strategy
Goals and Objectives for Medicaid

Unless otherwise indicated, all objectives will follow the QISMC methodology to increase rates by 10 percent (of the gap between the 2016 rate and 100 percent).

Goal 1:	Improve the health and wellness of Nevada's Medicaid population by increasing the use of preventive services.						
		AGP 2015	QISMC Goal	AGP 2016	HPN 2015	QISMC Goal	HPN 2016
Objective 1.1a:	Increase children and adolescents' access to PCPs (12–24 months).	91.14%	92.03%	94.15%	91.42%	92.28%	94.80%
Objective 1.1b:	Increase children and adolescents' access to PCPs (25 months–6 years).	81.30%	83.17%	83.55%	79.24%	81.32%	84.29%
Objective 1.1c:	Increase children and adolescents' access to PCPs (7–11 years).	85.60%	87.04%	87.12%	83.93%	85.54%	87.36%
Objective 1.1d:	Increase children and adolescents' access to PCPs (12–19 years).	81.53%	83.38%	83.76%	80.80%	82.72%	85.21%
Objective 1.2:	Increase well-child visits (0–15 months).	50.58%	55.52%	52.78%	51.58%	56.42%	53.77%
Objective 1.3:	Increase well-child visits (3–6 years).	65.66%	69.09%	66.33%	60.83%	64.75%	64.48%
Objective 1.4a:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (BMI percentile).	—	NC	64.12%	—	NC	70.32%
Objective 1.4b:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (counseling for nutrition).	—	NC	54.40%	—	NC	57.91%
Objective 1.4c:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (counseling for physical activity).	—	NC	43.75%	—	NC	52.07%
Objective 1.5:	Increase immunizations for adolescents.	—	NC	71.93%	—	NC	79.81%
Objective 1.6:	Increase annual dental visits for children.	45.62%	51.06%	53.21%	51.12%	56.01%	55.03%
Objective 1.7:	Increase human papillomavirus vaccine for female adolescents.	—	NC	24.59%	—	NC	29.68%
Objective 1.8:	Increase adolescent well-care visits.	42.13%	47.92%	38.43%	37.47%	43.72%	44.04%

Goal 1:	Improve the health and wellness of Nevada's Medicaid population by increasing the use of preventive services.						
		AGP 2015	QISMC Goal	AGP 2016	HPN 2015	QISMC Goal	HPN 2016
Objective 1.9a:	Increase childhood immunization status (Combination 2).	66.20%	69.58%	73.15%	70.80%	73.72%	74.94%
Objective 1.9b:	Increase childhood immunization status (Combination 3).	60.88%	64.79%	66.67%	66.18%	69.56%	70.32%
Objective 1.9c:	Increase childhood immunization status (Combination 4).	58.80%	62.92%	65.28%	66.18%	69.56%	70.07%
Objective 1.9d:	Increase childhood immunization status (Combination 5).	50.23%	55.21%	57.18%	53.04%	57.74%	55.72%
Objective 1.9e:	Increase childhood immunization status (Combination 6).	33.33%	40.00%	32.41%	39.42%	45.48%	38.44%
Objective 1.9f:	Increase childhood immunization status (Combination 7).	48.38%	53.54%	56.48%	53.04%	57.74%	55.72%
Objective 1.9g:	Increase childhood immunization status (Combination 8).	33.10%	39.79%	32.41%	39.42%	45.48%	38.44%
Objective 1.9h:	Increase childhood immunization status (Combination 9).	28.24%	35.42%	29.63%	32.36%	39.12%	31.14%
Objective 1.9i:	Increase childhood immunization status (Combination 10).	28.01%	35.21%	29.63%	32.36%	39.12%	31.14%

Goal 2:	Increase use of evidence-based practices for members with chronic conditions.						
		AGP 2015	QISMC Goal	AGP 2016	HPN 2015	QISMC Goal	HPN 2016
Objective 2.1:	Increase rate of HbA1c testing for members with diabetes.	81.90%	83.71%	79.63%	84.18%	85.76%	85.64%
Objective 2.2:	Decrease rate of HbA1c poor control (>9.0%) for members with diabetes. **	46.40%	41.76%	46.76%	44.53%	40.08%	45.74%
Objective 2.3:	Increase rate of HbA1c good control (<8.0%) for members with diabetes.	43.16%	48.84%	46.30%	43.80%	49.42%	46.47%
Objective 2.4:	Increase rate of eye exams performed for members with diabetes.	55.45%	59.91%	55.09%	55.96%	60.36%	56.93%
Objective 2.5:	Increase medical attention for nephropathy for members with diabetes.	75.17%	77.65%	89.58%	82.73%	84.46%	92.21%
Objective 2.6:	Increase blood pressure control (<140/90 mm Hg) for members with diabetes.	62.18%	65.96%	55.32%	70.32%	73.29%	60.83%
Objective 2.7a:	Increase medication management for people with asthma—medication compliance 50 percent.	—	NC	50.22%	—	NC	46.96%

Goal 2:	Increase use of evidence-based practices for members with chronic conditions.						
		AGP 2015	QISMC Goal	AGP 2016	HPN 2015	QISMC Goal	HPN 2016
Objective 2.7b:	Increase medication management for people with asthma—medication compliance 75 percent.	—	NC	26.84%	—	NC	24.14%

Goal 3:	Reduce and/or eliminate health care disparities for Medicaid recipients.						
		AGP 2015	QISMC Goal	AGP 2016	HPN 2015	QISMC Goal	HPN 2016
Objective 3.1:	Ensure that health plans maintain, submit for review, and annually revise cultural competency plans.	Met	Met	Met	Met	Met	Met
Objective 3.2:	Stratify data for performance measures by race and ethnicity to determine where disparities exist. Continually identify, organize, and target interventions to reduce disparities and improve access to appropriate services for the Medicaid and Nevada Check Up population.	Met	Met	Met	Met	Met	Met
Objective 3.3:	Ensure that each MCO submits an annual evaluation of its cultural competency programs to the DHCFP. The MCOs must receive a 100 percent *Met* compliance score for all criteria listed in the MCO contract for cultural competency program development, maintenance, and evaluation.	Met	Met	Met	Met	Met	Met

Goal 4:	Improve the health and wellness of new mothers and infants and increase new-mother education about family planning and newborn health and wellness.						
		AGP 2015	QISMC Goal	AGP 2016	HPN 2015	QISMC Goal	HPN 2016
Objective 4.1:	Increase the rate of postpartum visits.	46.74%	52.07%	53.16%	58.88%	62.99%	57.18%
Objective 4.2:	Increase timeliness of prenatal care.	69.77%	72.79%	75.41%	77.62%	79.86%	73.97%
Objective 4.3:	Increase frequency of prenatal care visits (≥ 81 percent of visits).	52.33%	57.10%	56.44%	51.34%	56.21%	52.07%
Objective 4.4:	Increase frequency of prenatal care visits (<21 percent of visits). **	15.81%	14.23%	17.80%	17.03%	15.33%	14.60%

Goal 5:	Increase use of evidence-based practices for members with behavioral health conditions.						
		AGP 2015	QISMC Goal	AGP 2016	HPN 2015	QISMC Goal	HPN 2016
Objective 5.1a:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication—initiation phase.	—	NC	36.68%	—	NC	46.65%
Objective 5.1b:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication—continuation and maintenance phase.	—	NC	40.91%	—	NC	58.02%
Objective 5.2:	Reduce use of multiple concurrent antipsychotics in children and adolescents. **	—	NC	0.00%	—	NC	1.80%
Objective 5.3:	Reduce behavioral health-related hospital readmissions within 30 days of discharge. (One of MCOs' PIPs. Improvement TBD by MCO PIP goals.)	*N/A	*N/A	*N/A	*N/A	*N/A	*N/A
Objective 5.4:	Increase follow-up after hospitalization for mental illness within 7 days of discharge.	53.02%	57.72%	52.99%	48.49%	53.64%	56.51%
Objective 5.5:	Increase follow-up after hospitalization for mental illness within 30 days of discharge.	63.14%	66.83%	64.55%	66.89%	70.20%	69.41%

Goal 6:	Increase reporting of CMS quality measures			
		DHCFP 2015 Reporting	DHCFP 2016 Reporting	DHCFP 2017 Reporting
Objective 6.1:	Increase number of CMS adult core measures reported to MACPro (non-QISMC).	4	N/A**	
Objective 6.2:	Increase number of CMS child core measures reported to MACPro (non-QISMC).	7	N/A**	

Green shading indicates QISMC goal met.

** Indicates an inverse performance indicator where a lower rate demonstrates better performance for this measure.

*N/A indicates that a rate was not available as the PIP has not progressed to the measurement stage at the time of this report.

N/A** indicates that information was not available at the time of this report.

"—" indicates that the indicator was not required in 2015.

NC indicates that QISMC goal was not calculated because a rate in 2015 was not available.

Nevada 2016–2017 Quality Strategy

Goals and Objectives for Nevada Check Up

Unless otherwise indicated, all objectives will follow the QISMC methodology to increase rates by 10 percent (of the gap between the 2016 rate and 100 percent).

Goal 1:	Improve the health and wellness of the Nevada Check Up population by increasing the use of preventive services.						
		AGP 2015	QISMC Goal	AGP 2016	HPN 2015	QISMC Goal	HPN 2016
Objective 1.1a:	Increase children and adolescents' access to PCPs (12–24 months).	95.83%	96.25%	98.73%	94.70%	95.23%	99.48%
Objective 1.1b:	Increase children and adolescents' access to PCPs (26 months–6 years).	90.48%	91.43%	89.53%	87.20%	88.48%	89.55%
Objective 1.1c:	Increase children and adolescents' access to PCPs (7–11 years).	92.62%	93.36%	92.91%	93.83%	94.45%	93.54%
Objective 1.1d:	Increase children and adolescents' access to PCPs (12–19 years).	92.18%	92.96%	88.95%	90.79%	91.71%	90.78%
Objective 1.2:	Increase well-child visits (0–15 months).	70.37%	73.33%	78.05%	60.00%	64.00%	68.00%
Objective 1.3:	Increase well-child visits (3–6 years).	71.30%	74.17%	70.28%	71.95%	74.76%	70.13%
Objective 1.4a:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (BMI percentile).	—	NC	62.04%	—	NC	72.02%
Objective 1.4b:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (counseling for nutrition).	—	NC	55.56%	—	NC	60.34%
Objective 1.4c:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (counseling for physical activity).	—	NC	47.69%	—	NC	57.18%
Objective 1.5:	Increase immunizations for adolescents.	—	NC	81.61%	—	NC	87.35%
Objective 1.6:	Increase annual dental visits for children.	64.48%	68.03%	67.05%	69.50%	72.55%	70.11%
Objective 1.7:	Increase human papillomavirus vaccine for female adolescents.	—	NC	34.11%	—	NC	42.62%
Objective 1.8:	Increase adolescent well-care visits.	56.48%	60.83%	56.34%	55.47%	59.92%	52.83%

Goal 1:	Improve the health and wellness of the Nevada Check Up population by increasing the use of preventive services.						
		AGP 2015	QISMC Goal	AGP 2016	HPN 2015	QISMC Goal	HPN 2016
Objective 1.9a:	Increase childhood immunization status (Combination 2).	74.55%	77.10%	85.90%	83.46%	85.11%	87.93%
Objective 1.9b:	Increase childhood immunization status (Combination 3).	73.64%	76.28%	78.21%	77.17%	79.45%	84.48%
Objective 1.9c:	Increase childhood immunization status (Combination 4).	73.64%	76.28%	77.56%	76.38%	78.74%	83.91%
Objective 1.9d:	Increase childhood immunization status (Combination 5).	54.55%	59.10%	68.59%	66.14%	69.53%	79.89%
Objective 1.9e:	Increase childhood immunization status (Combination 6).	45.45%	50.91%	46.79%	48.03%	53.23%	52.30%
Objective 1.9f:	Increase childhood immunization status (Combination 7).	54.55%	59.10%	67.95%	65.35%	68.82%	79.31%
Objective 1.9g:	Increase childhood immunization status (Combination 8).	45.45%	50.91%	46.79%	47.24%	52.52%	51.72%
Objective 1.9h:	Increase childhood immunization status (Combination 9).	32.73%	39.46%	42.95%	42.52%	48.27%	50.00%
Objective 1.9i:	Increase childhood immunization status (Combination 10).	32.73%	39.46%	42.95%	41.73%	47.56%	49.43%

Goal 2:	Increase use of evidence-based practices for members with chronic conditions.						
		AGP 2015	QISMC Goal	AGP 2016	HPN 2015	QISMC Goal	HPN 2016
Objective 2.1:	Increase rate of HbA1c testing for members with diabetes.	N/A	N/A	N/A	N/A	N/A	N/A
Objective 2.2:	Decrease rate of HbA1c poor control (>9.0%) for members with diabetes. **	N/A	N/A	N/A	N/A	N/A	N/A
Objective 2.3:	Increase rate of HbA1c good control (<8.0%) for members with diabetes.	N/A	N/A	N/A	N/A	N/A	N/A
Objective 2.4:	Increase rate of eye exams performed for members with diabetes.	N/A	N/A	N/A	N/A	N/A	N/A
Objective 2.5:	Increase medical attention for nephropathy for members with diabetes.	N/A	N/A	N/A	N/A	N/A	N/A
Objective 2.6:	Increase blood pressure control (<140/90 mm Hg) for members with diabetes.	N/A	N/A	N/A	N/A	N/A	N/A
Objective 2.7a:	Increase medication management for people with asthma—medication compliance 50 percent.	—	NC	47.76%	—	NC	47.62%

Goal 2:	Increase use of evidence-based practices for members with chronic conditions.						
		AGP 2015	QISMC Goal	AGP 2016	HPN 2015	QISMC Goal	HPN 2016
Objective 2.7b:	Increase medication management for people with asthma—medication compliance 75 percent.	—	NC	26.87%	—	NC	26.98%

Goal 3:	Reduce and/or eliminate health care disparities for Nevada Check Up recipients.						
		AGP 2015	QISMC Goal	AGP 2016	HPN 2015	QISMC Goal	HPN 2016
Objective 3.1:	Ensure that health plans maintain, submit for review, and annually revise cultural competency plans.	Met	Met	Met	Met	Met	Met
Objective 3.2:	Stratify data for performance measures by race and ethnicity to determine where disparities exist. Continually identify, organize, and target interventions to reduce disparities and improve access to appropriate services for the Medicaid and Nevada Check Up populations.	Met	Met	Met	Met	Met	Met
Objective 3.3:	Ensure that each MCO submits an annual evaluation of its cultural competency programs to the DHCFP. The MCOs must receive a 100 percent *Met* compliance score for all criteria listed in the MCO contract for cultural competency program development, maintenance, and evaluation.	Met	Met	Met	Met	Met	Met

Goal 4:	Improve the health and wellness of new mothers and infants and increase new-mother education about family planning and newborn health and wellness.						
		AGP 2015	QISMC Goal	AGP 2016	HPN 2015	QISMC Goal	HPN 2016
Objective 4.1:	Increase the rate of postpartum visits.	N/A	N/A	N/A	N/A	N/A	N/A
Objective 4.2:	Increase timeliness of prenatal care.	N/A	N/A	N/A	N/A	N/A	N/A
Objective 4.3:	Increase frequency of prenatal care visits (≥ 81 percent of visits).	N/A	N/A	N/A	N/A	N/A	N/A
Objective 4.4:	Increase frequency of prenatal care visits (<21 percent of visits). **	N/A	N/A	N/A	N/A	N/A	N/A

Goal 5:	Increase use of evidence-based practices for members with behavioral health conditions.						
		AGP 2015	QISMC Goal	AGP 2016	HPN 2015	QISMC Goal	HPN 2016
Objective 5.1a:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication—initiation phase.	—	NC	N/A	—	NC	39.53%
Objective 5.1b:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication—continuation and maintenance phase.	—	NC	N/A	—	NC	N/A
Objective 5.2:	Reduce use of multiple concurrent antipsychotics in children and adolescents. **	—	NC	N/A	—	NC	N/A
Objective 5.3:	Reduce behavioral health-related hospital readmissions within 30 days of discharge. (One of MCOs' PIPs. Improvement TBD by MCO PIP goals.)	N/A	NC	N/A	N/A	NC	N/A
Objective 5.4:	Increase follow-up after hospitalization for mental illness within 7 days of discharge.	N/A	NC	84.85%	N/A	NC	N/A
Objective 5.5:	Increase follow-up after hospitalization for mental illness within 30 days of discharge.	N/A	NC	93.94%	N/A	NC	N/A

Goal 6:	Increase reporting of CMS quality measures.			
		DHCFP 2015 Reporting	DHCFP 2016 Reporting	DHCFP 2017 Reporting
Objective 6.1:	Increase number of CMS child core measures reported to MACPro (non-QISMC).	7	N/A**	

Green shading indicates QISMC goal met.

** Indicates an inverse performance indicator where a lower rate demonstrates better performance for this measure.

* N/A indicates that a rate was not available as the PIP has not progressed to the measurement stage at the time of this report.

N/A** indicates that information was not available at the time of this report.

"—" indicates that the indicator was not required in 2015.

NC indicates that QISMC goal was not calculated because a rate in 2015 was not available.

HCGP Quarterly Meeting July 26, 2016

Location: Division of Public & Behavioral Health (DPBH)
4150 Technology Way, Suite 303 (3rd Floor)
Carson City, Nevada 89706
Phone Number: 877-336-1829 Access Code: 8793897

9:00 am – 9:20 am
I. Welcome and Introductions/DHCFP — Gladys Cook, SSPS 3, DHCFP

9:20 am – 9:30 am
II. Approval of Minutes — Gladys Cook, SSPS 3, DHCFP

9:30 am – 10:10 am
III. Program Updates

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

- APH Organization Chart and update on staffing

Progress toward Program Year One results — Tim Moore, Chief Medical Officer, APH

10:10 am – 10:25 am BREAK

10:25 am – 11:10 am
IV. Quality

Module #4, Goal #3 and #4 (3.1, 3.2 and 4.1) — Michelle Searing, Client Program Manager, APH

11:10 am – 11:45 am
V. Provider Outreach — Thomas McCrorey, HCGP Medical Director, APH
VI. Focus for next quarter — Cheri Glockner, HCGP Executive Director, APH

11:45 am – 12:00 pm
VII. New Business — Gladys Cook, SSPS 3, 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.

AXISPOINT HEALTH

Health Care Guidance Program
Coordinating with you for better care!

Health Care Guidance Program

Cheri Glockner
July 26, 2016

AXISPOINT HEALTH

Health Care Guidance Program
Coordinating with you for better care!

AXISPOINT HEALTH

July 2016 Quarterly Review

AXISPOINT HEALTH

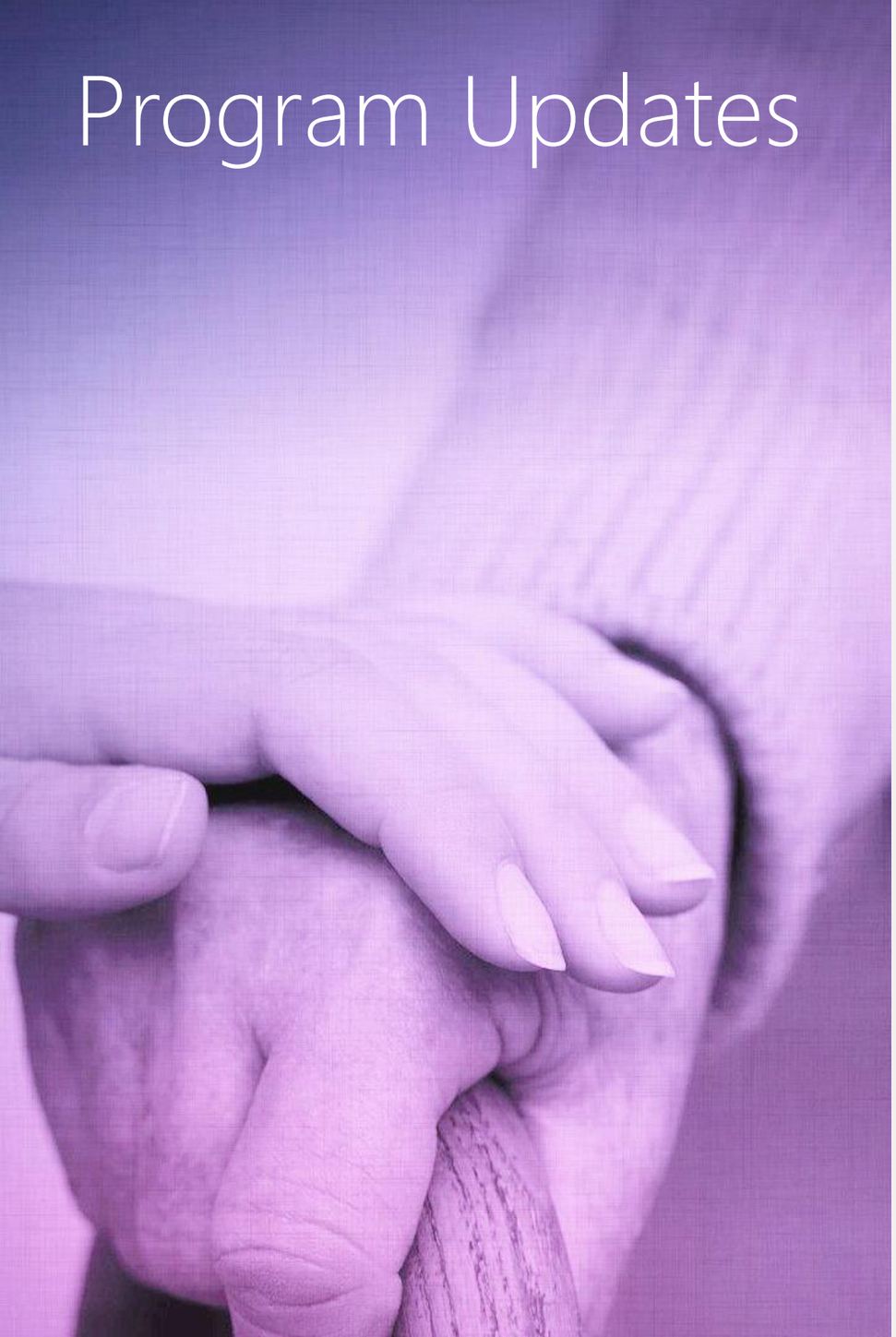
Today's Agenda

9:00 am – 9:20 am	
I. Welcome and Introductions/DHCFP	Gladys Cook, SSPS 3
9:20 am – 9:30 am	
II. Approval of Minutes	Gladys Cook, SSPS 3
9:30 am – 10:10 am	
III. Program Updates	
Executive Director Comments	Cheri Glockner, HCGP Executive Director, APH
APH Organization Chart and update on staffing	
Progress toward Program Year One results	Tim Moore, APH, Chief Medical Officer
10:10 am – 10:25 am BREAK	
10:25 am – 11:10 am	
IV. Quality	
Module #4, Goal #3 and #4 (3.1, 3.2 and 4.1)	Michelle Searing, Client Program Manager, APH
11:10 am – 11:45 am	
V. Provider Outreach	Thomas McCrorey, HCGP, Medical Director
VI. Focus for next quarter	Cheri Glockner, HCGP, Executive Director
11:45 am – 12:00 pm	
New Business	Gladys Cook, SSPS 3

III. Program Updates

Executive Director Comments
APH Organization Charts and Update on Staffing
Progress towards Year One Results

Program Updates



Key Accomplishments

- Focused attention on directive to confirm living conditions of HCGP Members in identified “group home” situations.

- Updated program capacity plan to correlate staffing, enrollment and geographic distribution. Received corporate support and approval to add 10 positions to the HCGP.
- Continued collaborative effort to calibrate data sets between APH/Milliman and HP to calculate Program Year One results.
- Worked with MTM to ensure a smooth transition of HCGP Members.
- Worked with DHCFP to update "serious occurrence" process.
- Continued work with Nevada EMS providers to integrate HCGP with community Paramedicine.

Program Updates

Progress Toward Program Year One Results

Dr. Tim Moore APH, Chief Medical Officer

Program Updates

APH Organization Charts and Update on Staffing

- Organization Charts (see handout)

- Update on Staffing

Status	#
Active Staff	35
In Training	4
Open Requisitions	10

AXISPOINT HEALTH

IV. Quality

Quality Module #4: Goal #3 (3.1, 3.2) and Goal #4 (4.1)

Module #4

Goal #3

Objectives 3.1 and 3.2

Nevada Comprehensive Care Waiver Program

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
- Objective 3.2: Reduce emergency department utilization by 10 percent

Quality Objective 3.1: Reduce hospital readmissions by 10 percent

Health Care Guidance Program
Coordinating with you for better care

PRELIMINARY (INCOMPLETE) RESULTS

NOTE: These preliminary results were generated using Operational data sets.

Measure Description	Measure Category/ Measure #	Baseline	Program Year 1 Preliminary Results	Program Year 2 Preliminary Results
The 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/30 days of discharge.	FUP Follow-up with PCP, 7-days (NP4P) **Revised measure**	TBD Milliman	29.36% 885 / 3014	25.9% 1,783 / 6,885
The 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/30 days of discharge.	FUP Follow-up with PCP, 30-days (NP4P) **Revised measure**	TBD Milliman	51.96% 1,566 / 3014	54.0% 3,715 / 6,885
The 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).	MRP Medication Reconciliation Post-Discharge (NP4P) **Revised measure**	TBD Milliman	1.00% 30 / 3,104	0.9% 63 / 6,885

*This is an exercise of the process only. Note the variances in the populations (denominators) for each measure.

AXISPOINT HEALTH

Quality Objective 3.1: Reduce hospital readmissions by 10 percent

What interventions has AxisPoint Health implemented that may have had an impact on any positive trends?

- Leveraging census information has always played a critical role across the APH Care Management continuum together with our Readmission Reduction program.
- Limited (unavailable or inconsistent) access to hospital census information has, to some extent precluded us from immediate contact with members during discharge.
- Challenges:
  - Inconsistent receipt
  - Security, processes around risk management are burdensome
- Successes:
  - Receiving timely data for largest system (Valley) in the state
  - Very close to obtaining data for largest hospital (Sunrise) in state

What interventions does AxisPoint Health have planned to improve rates for the measures associated with Objectives 3.1?

- Continue to expand access to census data

Quality Objective 3.2: Reduce emergency department utilization by 10 percent

Health Care Guidance Program
Coordinating with you for better care

PRELIMINARY (INCOMPLETE) RESULTS

NOTE: These preliminary results were generated using Operational data sets.

Measure Description	Measure Category/ Measure #	Baseline Preliminary Results Reported July-2015	Program Year 1 Preliminary Results Reported July-2015	Program Year 2 Preliminary Results Reported July-2016
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.	ASM.3 Asthma	13.5% 44 / 325	15.5% 191 / 1,232	9.1% 170 / 1,870
Percent of members with heart failure who had at least one ED visit for acute exacerbation.	HF.2 Heart Failure	61.4% 151 / 428	59.8% 617 / 1,031	64.2% 627 / 977
"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.	CCHU.2 Chronic Condition/ High Utilizer	30.6% 15,787 / 51,556	43.5% 15,536 / 35,697	27.2% 5,484 / 20,126

*This is an exercise of the process only. Note the variances in the populations (denominators) for each measure.

AXISPOINT HEALTH

Quality Objective 3.2: Reduce emergency department utilization by 10 percent

What interventions has AxisPoint Health implemented that may have had an impact on any positive trends?

- Improved Care Manager-to-Member Coaching, clinical content
- Clinical Care Alerts regarding medication adherence
- Seasonal IVR programs throughout the year
- Promotion of GuidePoint

What interventions does AxisPoint Health have planned to improve rates for the measures associated with Objectives 3.1?

- Introduction of ELIZA to reinforce use of GuidePoint, across entire program population

Module #4

Goal #3

Objectives 3.1 and 3.2

Nevada Comprehensive Care Waiver Program

Goal 4: Improve NCCW enrollees' satisfaction with care received

- Objective 4.1: NCCW enrollee satisfaction improves over baseline

Objective 4.1: NCCW enrollee satisfaction improves over baseline

Bi-Lingual Beneficiary Satisfaction Survey

- The Medicaid pre/post health plan satisfaction survey has been updated to include two questions which focus on program satisfaction.
  - The revised survey will be mailed out at the end of July.
  - The 2016 program year 2 will be compared to program year 1 survey 2015 as well as the survey results from the pre-program survey sent in 2014.

Year	Response rate
2014	9.0%
2015	9.1%
2016	Responses are being collected

- A third party is conducting a randomly selected phone survey for the 24-Hour Nurse Advice Line and our Case/Disease Management services.

V. Provider Outreach

Vulnerable Population
Routine Provider Outreach
Other Medical Director Activities
Case Reviews

VI. Provider Outreach

Routine Provider Outreach

- >30 Provider outreach events with multiple stakeholders in medical and public health community
  - 2 formal presentations to Medical Students and Residents at UNR/UNLV
  - Cooperation with Community Paramedicine a focus of several provider meetings
  - Provider Advisory Board –"Medicaid News Updates"

Other Medical Director Duties

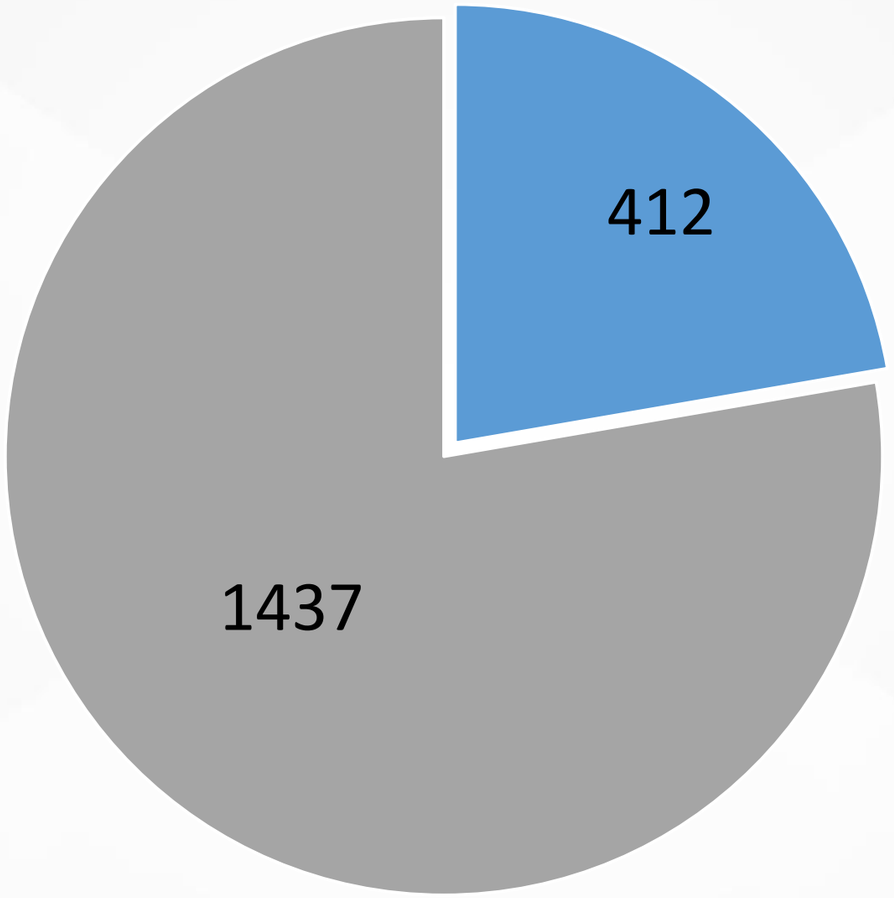
- Case Review of Complex Cases
  - Formal Monthly Meetings with entire team
  - Immediate review of problematic cases as needed.
- Review of Pharmacy Alerts (Clinical Care Alerts)
- Assist in relationships between hospitals, CMs, Medicaid/HPE
- Try to stay abreast of changes in Care Management and Population Health/ Public Health.

VI. Provider Outreach

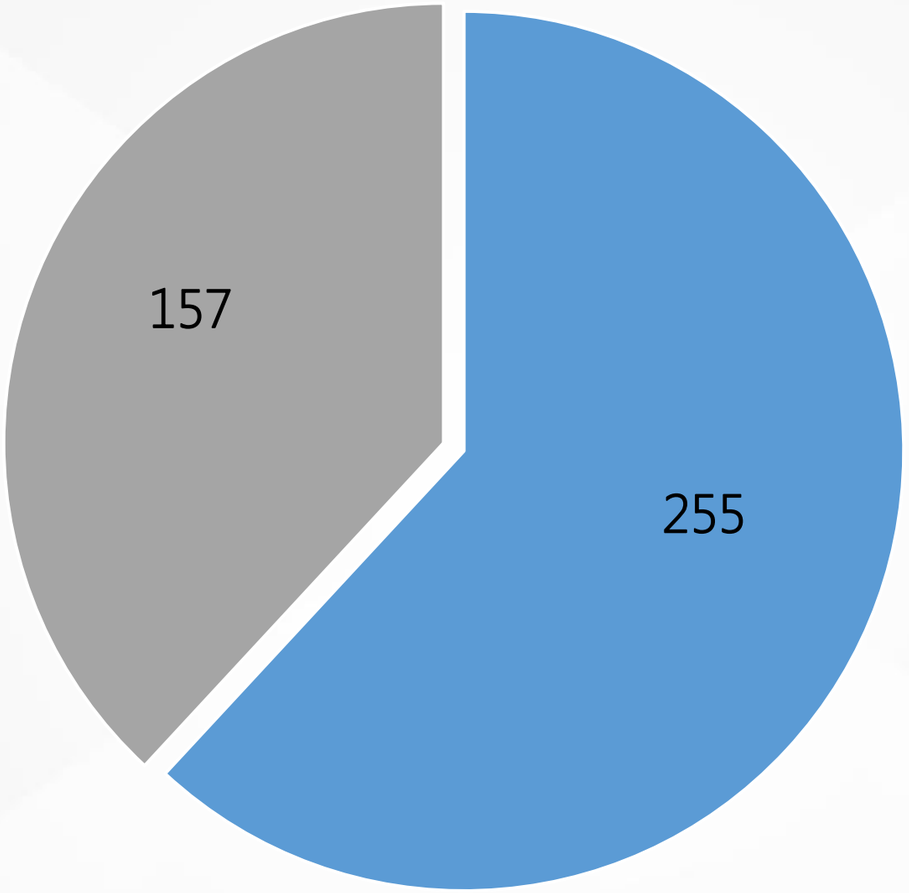
Vulnerable Population Initiative

- Initial request on Mar 31, 2016 from Mr. Whitley via Jennifer Frischmann(chief of LTSS)
- Concern for safety/health of a large Behavioral Health Population
- Shared responsibility for DHHS and HCGP to find members >18 and <65 y/o
  - 1849 members in HCGP identified on DHHS list
- Urgent Meeting with HCGP Behavioral Health Leadership
- Initial focus on most Vulnerable of Members who have not had recent case with us
  - Diagnoses of Schizophrenia, Bipolar and /or Intellectual Disabled
- First 30 days--100% effort of Behavioral Health Team, then 50%

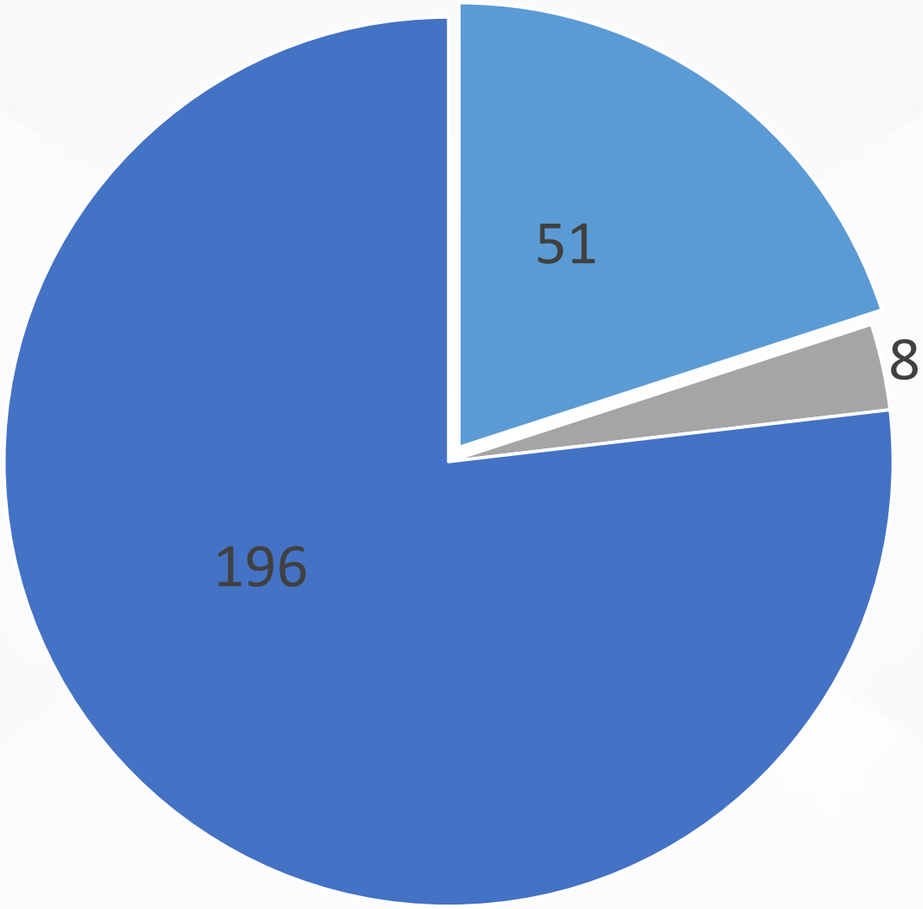
Overall Search Population 1,849



Results of Search (255 total)



RL change after post-evaluation (255 total)



Findings

- Very difficult to locate members even after telephonic contact was made– lots of bogus addresses with no active providers.
- Almost 3% of the population live in the worst neighborhood in the state
- Two of our workers assaulted while visiting a members house
- Members sought but not found were more likely to be young and males
- 66% of the diagnoses are combined Schizophrenia and Bipolar, mutually exclusive diagnoses.
- Search ended on June 23

Case Studies

Gender: Male
Age: 40 years old
Speaks: English
Risk Score: High

Care Plan Problems

- MS, phys. Handicaps, anxiety
- Vision problems
- Rural NV, SSI
- Needs frequent trips to Reno, couldn't afford,
- Difficulty arranging transport due to vision issues

Interventions

- Frequent visits to gain trust
- Assist with DME
- Assist with arrange transport to City
- Found competent provider locally

Outcomes

- Improved visit compliance
- Improved infusion compliance
- Will be able to decrease frequency of CM visits.
- Member states he feels " hope"

Case Studies

Gender: F
Age: 48
Speaks: E
Risk Score: High

Care Plan Problems

Many Significant incl: PTSD, substance abuse

- Recent death of husband
- Trauma history
- Frequent ER/ED visits
- Comprehension difficulty
- Med incompliance
- Weight management
- Missed appointments due to poor transportation

Interventions

- PH/BH collaboration
- Assessments completed
- Outpatient services and medical and equipment coordinated
- Transportation arranged (MTM)
- Medication management and
- BH relapse prevention issues
- addressed-follow up with new
- BH providers

Outcomes

- Increased understanding of
- conditions
- Fall prevention and increased
- in-home ambulation support
- Barriers to working with BH
- provider addressed
- HRQOL improved
- Medication compliance improved
- Increased in-home support for condition management
- Reliable transport to appointments arranged

VI. Focus for Next Quarter

VI. Focus for Next Quarter

- Continue to hire open positions with focus on geographic needs of the program
- Work with DHCFP to finalize and execute contract renewal
- Generate, finalize and deliver PY1 Results
  - Confirm meeting date: September 27, 2016
  - Work with DHCFP to determine stakeholders for further dissemination of results
- Use ADT information to collaborate closely across the state

Health Care Guidance Program
Coordinating with you for better care

AXISPOINT HEALTH

"Thank you!"

Questions?

Health Care Guidance Program Meeting Minutes, Face to Face 04/26/2016				Date:
DHCFP Attendees: Gloria Macdonald, Tracy Palmer, Janice Hadlock-Burnett, Gladys Cook, Rachel Marchetti, John Kucera, Heather Lazarakis, Linda Bowman, Shawna Vollmer, Rochelle van der Poel, Lisa Koehler, Andrew Rico, Margaret Dillon, Raul Martinez				
Organization Attendees: HCGP: Angela Cave Brown, Margaret Flaum, Patricia Regan, Cheri Glockner, Dr. Thomas McCrorey, Dr. Tim Moore, Kris Wilson, Summer Smith, Michelle Searing, Brian Baker, Erin Snell, Dr. Ryan Ley, Mary, Stephanie White, Lorna Lizotte **HSAG:** Gretchen Thompson **MTM:** Stacey Brune				
Topic	**Discussion**	**Recommendation/Action Plan**	**Responsible**	**Due Date**
Welcome and Introductions	**Welcome and Introductions** • Gladys Cook, Social Services Program Specialist III, Program Research & Development (PRD) opened the meeting			
Approval of Minutes	**Approval of Minutes** • There were corrections made and the minutes were approved.			
Program Updates	**Program Updates** • Cheri Glockner, Health Care Guidance Program (HCGP) Executive Director, AxisPoint Health (APH) presented program updates. She called to attention a few things that they have been spending time on as a program. First of which, working with the community paramedicine launch. Cheri and Dr. McCrorey have now met with three departments and they will be meeting with Las Vegas soon. There are still some processes that need to be worked out in particular some of the referral things that will need to occur and the logistics of that. Cheri and Dr. McCrorey have been to two hearings and actually made a suggestion at the last one that was taken into account for the community paramedicine. Secondly, they're pleased and honored to have been asked to work immediately with everyone on the group home initiative which they refer to as the vulnerable population and she thanked Beacon for going out to find the 1,869 people population. Also, they worked with Betsy Aiello and Alexis Tucey on the ED workflow for the behavioral health placing. They worked with the MCOs. Cheri and Dr. McCrorey attended meetings with Alexis and they have two more coming up. Per Gloria's and Betsy's request at the last quarterly, they worked hard on producing some white papers to show outcomes and results which she planned to go over. They worked on the quality assurance report and she thinks that it'll serve as a good road map for them as they move forward. Cheri, Dr. McCrorey and team members did a rural truck and met with providers, hospitals, and case managers. They are getting closer to launching their standalone website			

Health Care Guidance Program Meeting Minutes, Face to Face 04/26/2016				Date:
DHCFP Attendees: Gloria Macdonald, Tracy Palmer, Janice Hadlock-Burnett, Gladys Cook, Rachel Marchetti, John Kucera, Heather Lazarakis, Linda Bowman, Shawna Vollmer, Rochelle van der Poel, Lisa Koehler, Andrew Rico, Margaret Dillon, Raul Martinez				
Organization Attendees: HCGP: Angela Cave Brown, Margaret Flaum, Patricia Regan, Cheri Glockner, Dr. Thomas McCrorey, Dr. Tim Moore, Kris Wilson, Summer Smith, Michelle Searing, Brian Baker, Erin Snell, Dr. Ryan Ley, Mary, Stephanie White, Lorna Lizotte **HSAG:** Gretchen Thompson **MTM:** Stacey Brune				
Topic	**Discussion**	**Recommendation/Action Plan**	**Responsible**	**Due Date**
	for the HCGP. Cheri turned it over to Dr. Tim Moore so he could talk about things that APH is doing, some initiatives that they can maybe bring into the HCGP to help with engagement and some of those things. • Dr. Tim Moore, Chief Medical Officer, APH spoke about using data to figure out for specific people what interventions can drive an outcome and which people you should focus on versus which people you shouldn't focus on. He went on to identify five areas in which they are working on. The first pillar of this is using the data better than they have before and being able to look through data sets to identify who they should focus on. They're working on revamping the whole way that they'll be identifying and focused on people in the future. Secondly, they need to make sure that the people that they identify for intervention are getting the right interventions. The third area is to make sure that people are going to see the person that they connect with the best that will lead to the best outcome. The fourth area, that's really important, is figuring out that people have different ways that they want to connect with them that is through social networks, mobile technology, etc. They are looking at all those different modalities to deliver their services. The fifth area is the whole data analysis side which he admits APH has not been as good as it should have been. He went on to speak about having a primary care team composed of health workers, social workers, nurse generalists, behavioral science and substance abuse because those are the issues that they are dealing with. They also want to have a specialty group that can serve as support to the primary care team that would include specialized nurses for diabetes, cardiac or neonatology problems, pharmacists, and behavioral health specialists just to name a few for example. They're undergoing a lot of these changes right now and they'll start putting the changes into their platform so that they can execute it by the first part of next year. He concluded his presentation.			

Health Care Guidance Program Meeting Minutes, Face to Face 04/26/2016				Date:
DHCFP Attendees: Gloria Macdonald, Tracy Palmer, Janice Hadlock-Burnett, Gladys Cook, Rachel Marchetti, John Kucera, Heather Lazarakis, Linda Bowman, Shawna Vollmer, Rochelle van der Poel, Lisa Koehler, Andrew Rico, Margaret Dillon, Raul Martinez				
Organization Attendees: HCGP: Angela Cave Brown, Margaret Flaum, Patricia Regan, Cheri Glockner, Dr. Thomas McCrorey, Dr. Tim Moore, Kris Wilson, Summer Smith, Michelle Searing, Brian Baker, Erin Snell, Dr. Ryan Ley, Mary, Stephanie White, Lorna Lizotte **HSAG:** Gretchen Thompson **MTM:** Stacey Brune				
Topic	**Discussion**	**Recommendation/Action Plan**	**Responsible**	**Due Date**
Quality	• Gloria Macdonald, Chief , PRD had a question in regards to the primary care team. She asked if the team is going to be focused on level 4? • Dr. Moore responded by saying that the primary care team will be focused on all of the levels and each group would still have a primary care manager, but it would be one that could work with them in the best way to solve their care gap that they have. He also commented that another big change that they are making on their platform is the ability to prioritize all of the people that they page with and manage on a daily basis for who's going to need that call or intervention to deliver the best result because when you are managing thousands of people most of the people on any one day don't need any intervention, but there is always a few people that they need to intervene on that day to help prevent a hospitalization. • Gretchen Thompson, MTM asked Dr. Moore how they are able to identify the members if it's not their claim, would it be through cold calling and reaching out doing an assessment of those people? • Dr. Moore responded that it would be through medical and pharmacy claims, specifically for medication the pharmacy claims will be the richest source of information because the pharmacy claims are the quickest to turn around and the most current anyway. They are also planning to take admission discharge information from hospitals. They're looking at multiple different data sources to help drive these including real time referrals from the provider networks and assessments created by the care manager. **Quality** • Michelle Searing, Client Program Manager, APH gave an update on quality and began her presentation by discussing the Executive Summary which included the latest data from March. She want over the first graph which showed enrollment vs. the minimum and maximum for the waiver and they were very pleased to report that they are above the minimum and			

Health Care Guidance Program Meeting Minutes, Face to Face 04/26/2016				Date:
DHCFP Attendees: Gloria Macdonald, Tracy Palmer, Janice Hadlock-Burnett, Gladys Cook, Rachel Marchetti, John Kucera, Heather Lazarakis, Linda Bowman, Shawna Vollmer, Rochelle van der Poel, Lisa Koehler, Andrew Rico, Margaret Dillon, Raul Martinez				
Organization Attendees: HCGP: Angela Cave Brown, Margaret Flaum, Patricia Regan, Cheri Glockner, Dr. Thomas McCrorey, Dr. Tim Moore, Kris Wilson, Summer Smith, Michelle Searing, Brian Baker, Erin Snell, Dr. Ryan Ley, Mary, Stephanie White, Lorna Lizotte **HSAG:** Gretchen Thompson **MTM:** Stacey Brune				
Topic	**Discussion**	**Recommendation/Action Plan**	**Responsible**	**Due Date**
	have been above the minimum for the past couple of months. She went on to discuss high points of the rest of the data and then was open to questions. • Gladys Cook asked a question, in reference to the Real-time-Referrals (RTR), if they are ineligible are they put aside? Do they go back to into them? Also, on a monthly basis when they stratify the recipients do they check it and see if any of the RTRs are matches? • Michelle responded by stating that they do an immediate check and the RTRs do get put through the identification and stratification process in the next month and then they fall out or in. • John Kucera, Management Analyst III, Data Analytics added to the question by asking if that would be a way to manually put someone on the program? • Michelle responded yes and she concluded the Executive Summary by stating that she is always open to input. • Someone from HCGP asked if the reports are helpful to DHCFP? • John Kucera responded by stating yes, it is a good way to explain to Betsy Aiello, Deputy Administrator, for example. Especially, it gives her information when she has to report on the program to show how they get there. He also thought that it's a positive thing that they're being selective of people that they think they may be able to impact. • Gretchen Thompson expressed concern over the risk level 2 patients. • Michelle went on to speak about the Quality Module #2 by going over the power point slides which they re-presented from the January Quarterly meeting to provide the metrics and charts in exactly the way prescribed. Everyone went into discussion about getting more accurate data in regards to # of Days Enrollment-to-Assessment calculations. John Kucera commented that they aren't terribly picky with what they do as long as it's consistent and it makes sense. If they can pick a			

Health Care Guidance Program Meeting Minutes, Face to Face 04/26/2016				Date:
DHCFP Attendees: Gloria Macdonald, Tracy Palmer, Janice Hadlock-Burnett, Gladys Cook, Rachel Marchetti, John Kucera, Heather Lazarakis, Linda Bowman, Shawna Vollmer, Rochelle van der Poel, Lisa Koehler, Andrew Rico, Margaret Dillon, Raul Martinez				
Organization Attendees: HCGP: Angela Cave Brown, Margaret Flaum, Patricia Regan, Cheri Glockner, Dr. Thomas McCrorey, Dr. Tim Moore, Kris Wilson, Summer Smith, Michelle Searing, Brian Baker, Erin Snell, Dr. Ryan Ley, Mary, Stephanie White, Lorna Lizotte **HSAG:** Gretchen Thompson **MTM:** Stacey Brune				
Topic	**Discussion**	**Recommendation/Action Plan**	**Responsible**	**Due Date**
	method that they can rely on the program and give numbers on and report in a consistent way, that's fine with them. Michelle continued to go over the power point slides. Everyone went into discussion about the measures and how they can be presented more clearly. Gretchen and Gloria provided feedback and made some suggestions in regards to making a spreadsheet that is more easily understood. Michelle agreed and concluded her presentation. • Dr. Thomas McCrorey, HCGP Medical Director, began his presentation on proxy measures. He said these are measures that they presented as a white paper. They have been presented formally to state leadership that was involved with the program. The program was designed to have formal results presented at a delayed period of time and they still do not have that completely done. All the people involved in the program want to have measures showing how effective the program is, interim measures or proxy measures, which are not the same measures as what are going to be formally used by the program per measurements. They produced four different white papers. First of which was the Pharmacy Clinical Care Alerts (CCA). Dr. McCrorey went over graphs that were provided on the power point presentation. Secondly, the Utilization Metrics which are population financial metrics commonly used by payers. Dr. McCrorey went over graphs that were provided on the power point presentation. Third, a small study targeted on the use of Influenza Immunization which is basically an adult and children vaccination program. The fourth and final is a study that looks at those people who have an active cancer treatment (chemotherapy and radiotherapy).			
Contact Compliance Report	**<u>Contact Compliance Report</u>** • John Kucera, Management Analyst III, Data Analytics, presented a contact compliance report in draft form. This report came from two data sources. The first is the monthly stratification report that lists all program members and their			

Health Care Guidance Program Meeting Minutes, Face to Face 04/26/2016				Date:
DHCFP Attendees: Gloria Macdonald, Tracy Palmer, Janice Hadlock-Burnett, Gladys Cook, Rachel Marchetti, John Kucera, Heather Lazarakis, Linda Bowman, Shawna Vollmer, Rochelle van der Poel, Lisa Koehler, Andrew Rico, Margaret Dillon, Raul Martinez				
Organization Attendees: HCGP: Angela Cave Brown, Margaret Flaum, Patricia Regan, Cheri Glockner, Dr. Thomas McCrorey, Dr. Tim Moore, Kris Wilson, Summer Smith, Michelle Searing, Brian Baker, Erin Snell, Dr. Ryan Ley, Mary, Stephanie White, Lorna Lizotte **HSAG:** Gretchen Thompson **MTM:** Stacey Brune				
Topic	**Discussion**	**Recommendation/Action Plan**	**Responsible**	**Due Date**
New Transportation Vendor	both, claims assigned risk level and their user assigned risk level if they're assessed. If it turns out that their assessed risk level is greater or less than their assigned risk level, one of the care managers would change it and that information is reflected on the stratification report. Secondly, on a monthly basis they also receive a raw list of completed members. • Dr. McCrorey commented that they all need to sit down to discuss how they can have accurate measures showing that they are doing the right thing and have a dialogue going forward to have a valuable useful metric that they both agree the methodology on. **New Transportation Vendor** • Rochelle van der Poel, Management Analyst II, Long Term Services & Support, introduced the new non emergency transportation vendor, Medical Transportation Management (MTM), who will replace LogistiCare as of July 1, 2016. • Stacy Brune, Manager, Business Implementation, presented a power point presentation about MTM's history and footprint.			