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February 28, 2017

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

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

Dear 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 October 1, 2016 – December 31, 2016, or Federal Q1/2017.

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

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

Sincerely,

[redacted]

Marta Jensen
Acting Administrator

Enclosure

Cc: Elizabeth Aiello, Deputy Administrator, Division of Health Care Financing and Policy (DHCFP)
Gloria Macdonald, Chief, Program, Research and Development, DHCFP

Nevada Comprehensive Care Waiver (NCCW)
Section 1115 Quarterly Report
Demonstration/Quarter Reporting Period:
Demonstration Year: 4 (7/1/2016 – 6/30/2017)
Federal Fiscal Year 17, Quarter: 1 (10/1/2016 – 12/31/2016)

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** (12/31/16)	**Disenrolled in Current Quarter** (12/31/16)	**Current Enrollees** (01/31/17)
Population 1: MAABD	22,453	0	22,397
Population 2: TANF/CHAP	16,795	0	16,856
Total:	39,248	0	39,253

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** (12/31/16)	**Disenrolled in Current Quarter** (12/31/16)	**Current Enrollees** (01/31/17)
Diagnosis 1: Asthma	5,916	0	5,907
Diagnosis 2: Cerebrovascular disease, aneurysm, and epilepsy	3,312	0	3,287
Diagnosis 3: Chronic obstructive pulmonary disease, chronic bronchitis, and emphysema	2,236	0	2,226
Diagnosis 4: Diabetes mellitus	3,698	0	3,699
Diagnosis 5: End stage renal disease and chronic kidney disease	1,181	0	1,182

Note: *

Demonstration-Qualifying Conditions (in person counts)	**Enrolleed in Current Quarter** (12/31/16)	**Disenrolled in Current Quarter** (12/31/16)	**Current Enrollees** (01/31/17)
Diagnosis 6: Heart disease and coronary artery disease	1,930	0	1,961
Diagnosis 7: HIV/AIDS	324	0	325
Diagnosis 8: Mental health	13,124	0	13,149
Diagnosis 9: Musculoskeletal system	4,626	0	4,634
Diagnosis 10: Neoplasm/cancer	346	0	343
Diagnosis 11: Obesity	4,518	0	4,540
Diagnosis 12: Substance use disorder	7,349	0	7,320
Diagnosis 13: Pregnancy	2,810	0	2,860
Diagnosis 14: Complex Condition/High Utilizer	727	0	716

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

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

Determinations

The following chart reflects data on demonstration eligibility determinations during Q1/2017 as required under STC 26:

# of Determinations (by methodology)	**Determination methodology (in person, telephonic, etc.)**	**Determination outcomes by determination methodology**
Approximately 60,000 eligible members provided to vendor.	Per vendors automated medical claims analysis and stratification	Approximately 39,000 enrolled beneficiaries at quarter ending 12/31/16

Disenrollment's

The following chart reflects data on demonstration disenrollments during Q1/2017 as required under STC 26:

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

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

Non-compliance

The following chart reflects data on beneficiaries determined non-compliant during Q1/2017 as required under STC 27:

# of recipients categorized as noncompliant	0

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

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

Enrollment Fluctuations

DHCFP reports the enrollment numbers for Q1/2017 with a steady monthly enrollment average of 39,000 members.

Outreach/Innovative Activities

The DHCFP continued CMO outreach activities with AxisPoint Health (APH) during Q1/2017. The following chart lists the outreach activities for Q1/2017.

Date	Outreach Activity	Summary of Activity
10/3/2017	Elko County Library; Rural Providers Meeting Elko, NV	Beacon Health solutions staff attended ongoing community meeting for Rural Health Providers. This month Partners Allied for Community Excellence (PACE) will resume its monthly newsletter, "Keeping PACE." Maribeth Cassinelli has replaced Cecelia Smith at the Retired Senior Volunteer Program (RSVP) since Cecelia has retired. Friends in Service Helping (FISH) have permanently moved its warming shelter to its facilities at 821 Water St. The entrance is on the parking lot side of the thrift store. When volunteers are

Date	Outreach Activity	Summary of Activity
		needed, FISH will post information on Facebook, as well as sending the information to Dylan at PACE. FISH is also seeking an employee for their Thrift Store. Please contact FISH with inquiries, 775-738-3038. The Heart & Shield Program will hold a stakeholders' meeting Thursday, January 26th, at 1 p.m., at 701 Walnut St. Northeastern Nevada Regional Hospital will incorporate its annual health fair into Ruby Radio Corporation's annual March Health & Fitness Fair at the Elko Convention Center. The hospital's health fair operations will occupy the new Elko Conference Center adjacent to the convention center. Certain blood work will be free to the public on that day. This event will be held March 11 from 9 a.m. - 3 p.m. Elko's National Alliance for Mental Illness (NAMI) Family Support group meets the third Tuesday of each month from 6 - 7:30 p.m. at the Elko County Library. This month the meeting will be January 17th. This is a great opportunity to learn how to support your loved one living with mental illness and to meet others, who have loved ones with similar concerns, or conditions. These meetings are confidential, free, and open to the public, no obligations, or membership needed. For individuals living with a mental health condition or illness:

Date	Outreach Activity	Summary of Activity
		NAMI has two support groups active in Elko at this time. One meets every Thursday night at the First Presbyterian Church, 1559 Sewell Drive, from 5:30 - 7 p.m. There is also a new group meeting at lunch time at Elko Library. Presenter Lidia Cortes president of Justice for Stephanie, a nonprofit organization, which is just a little over a year old. Ms. Cortes shared her daughters story " Our beautiful daughter, Stephanie Gonzalez was one of the several women in our community and surrounding areas who was tragically murdered back in 2011. She was taken from us by her estranged husband. She lived in a domestic violence environment and wanted out of the relationship. "Since Stephanie's murder I have, along with family and friends, advocated against domestic violence. As with many cases, some of us don't get involved until it hits home. Justice for Stephanie was founded at first in the search for justice for our daughter and mom, who leave behind three precious children. It has taken over five and a half years but we now have peace and justice has been served. His sentencing is on January 13th. "Justice for Stephanie's goal and mission is to someday create, "Stephanie's Safe Haven," which is not a shelter. Our organization seeks to provide school students

Date	Outreach Activity	Summary of Activity
		via prevention services that include education of safe relationships and an annual scholarship opportunity. "Program Services for potential victims, survivors and the family members of those involved in the cycle of domestic violence will include peer led support groups in a safe environment, assistance in learning new employment and life skills for survivors. "Stephanie's Safe Haven" seeks to create a safe and welcoming "home-like" environment that can be utilized for many services including an alternative place to have supervised or court order family time. This is not a shelter. I have not spoken to our judges, attorneys, or other agencies about this but I know there is a need for it in our community. It was an idea that came to me from our own personal and tragic experience. "We have also been fortunate to partner with Judy Andreson, Family Resource Director (FRC)".
10/4/2017	Stein Forensic Hospital; 6161 W Charleston Blvd Las Vegas, NV	Beacon Health Solutions staff met with Dr. Shera Bradley, Director of Psychology for the hospital, Sharon, LCSW, LADC, Agency Manager. Collaboration between the Health Care Guidance Program (HCGP) and the hospital was discussed as Stein is a Forensic Hospital and the Health Care Guidance Program's beneficiaries are very difficult to find once they are discharged.

Date	Outreach Activity	Summary of Activity
		Having the ability to complete assessments while they are inpatient means a higher chance of connecting them to resources to decrease recidivism. There are currently three beneficiaries who are inpatient and will be discharged soon from the hospital.
10/4/2017	Southern Nevada Adult Mental Health Services (SNAMHS) Rawson Neal Psychiatric Hospital Las Vegas, NV	Beacon Health Solutions staff met with Dr. Aaron Bomer, Director of Social Services, 8 unit social workers, 2 psychiatrists in treatment team meetings, Alma, R.N., Director of Utilization Review, Carla Henderson, Management Analyst for SNAMHS/Rawson-Neal Hosp. Collaboration between the Health Care Guidance Program and SNMAHS as a community hospital and our beneficiary's are very difficult to find once they are discharged. Having the ability to complete assessments while they are inpatient means that we have higher chances of connecting them to resources to decrease recidivism.
10/4/2017	Annual Nevada Medicaid Conference Sparks, NV	Health Care Guidance Program present for answering questions regarding the program as needed.
10/5/2017	Medical Transportation Management (MTM) Las Vegas, NV	Health Care Guidance Program staff held an in depth discussion about issues with our members getting rides, dropped rides, etc. Sandy from MTM said a lot of the issue is with poor performance from the ride

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		contractors. They are trying to fire those to get more business with the better ones. MTM made a commitment to do better and are trying to get their business improved. Their assumptions for other states are not always valid for Nevada. There are a lot more dropped ride contracts then they have seen before. Contractors don't follow through on their commitments some of the patient reps are poorly informed. Se'Rita will address that on case by case basis. We had a strong feeling that MTM was sincere and did not seem overly defensive. Some of their business practices will need to change, such as how they are notified about dropped rides? Will need to wait and see if this improves.
10/6/2017	Annual Medicaid Conference Las Vegas, NV	Health Care Guidance Program staff present to answer questions regarding the program as needed.
10/7/2017	Valley Health System; Case Management Meeting Las Vegas, NV	Health Care Guidance Program staff met with: Aida Quray. RN Gina Pierotti- Buthman RN about the use of social workers in the program especially in Behavioral Health. Presented the nine page slide overview of the program. Took a long time as Gina (like most Case Management Supervisors) had lots of good questions and understanding of what the program is meant to do. She asked questions of our Case Managers and wanted their input on experiences. Gina seemed

Date	Outreach Activity	Summary of Activity
		pretty excited about the program and seemed very interested in the changes in Medicaid that are proposed. She did not seem up on the latest events or that she and others could give feedback. Notes that was sent out to other stakeholders would be shared with Gina and inform of the chance to give feedback on the MCO expansion proposal. Thank you to the Valley staff for being helpful with the daily reports. Did want to give feedback about the difference in access Beacon has between Desert Springs Hospital (DSH) psych ward and the Valley Med Center psych ward. Although it was our intent to bring up the topic, Gina was the one who initiated the question of how it was working at the facilities. Easy access to DSH psych, Valley MC psych restricted to 1-2 hours / week due to security issues and conflict with patient schedules for therapy and napping. (Previously discussed with Dr. Ley who wasn't sure why the patient day nap times need to be protected.) Gina pointed out that she does not manage the CMs for the psych wards. But she did have some oversight of the processes and was very interested in trying to assist Beacon to get into the facility. Good discussion between her and Erin about the issues. We

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		made it clear that we had a good working relationship with Kelly Mann, head nurse of the Valley Med. Center psych ward, but were being forthright about issues and that we felt if access could improve we could accomplish more for everyone. Everyone agreed that the other hospitals were very welcoming especially DSH, although Velicia pointed out that due to busy work schedules it was difficult to catch individual CMs when visiting a facility. So we agreed that some efficiencies could be improved as we move forward, they will get to know when the CM meetings at individual hospitals, and share cell numbers etc. Unfortunately, Gina mentioned that we will need to get badges for the Valley Health System. She did not know the entire process but said it had to go through their security Vendor. Did not know what the cost would be but said the badges would be good system wide. Although the Northern Nevada people we met with 2 weeks ago were firm that they were not part of the Valley Health System the impression we got was that there are part of the Valley Health System. So there may be some confusion going through some of these processes. Gina was going to set us up with Lita McCaw but we already met

Date	Outreach Activity	Summary of Activity
		with her team. Gina said she had some ideas related to utilization and care management, focusing on the ER. It sounded like she wanted to work out details first with her system then discuss with us. Tentatively will discuss in the next couple months
10/13/2017	National Alliance on Mental Illness (NAMI) Masquerade; Governor's Mansion Carson City, NV	Health Care Guidance Program and Beacon Health Solutions staff present to "network" for the program.
10/17/2017; 10/18/2017	Nevada Health Conference Atlantis Reno, NV	Health Care guidance program staff present for "networking" connections for the program.
10/21/2017	National Association of Social Workers (NASW) Lifestyle Intervention Conference (LIC) Convention Las Vegas, NV	Health Care Guidance Program staff met with Kirk Stein. Hamilton Relay company provides no cost captioned telephones to those that are hard of hearing or deaf.
10/24/2017	A New Day Community Health Center 3085 E. Flamingo Road Las Vegas, NV	Health Care Guidance Program staff provided education and materials regarding the program.
10/26/2017	Renown Case Management with Katie Swint, LSW Chief of Care Transitions Reno, NV	Health Care Guidance Program staff met with some of the Renown Team and passed out cards, contact information and went over how we assist in transitions of care. Dr. Thomas McCrorey arrived and gave the nine slides over view of the program and why it is important for us to get electronic data for Admission Discharge

Date	Outreach Activity	Summary of Activity
		Transfer (ADT). Katie Agreed that it would be useful for both sides. Needed to discuss with her supervisor Teri Howard to proceed. I promised the Letter of Authority (LOA) and letter to hospitals signed by Mrs. Elizabeth (Betsy) Aiello, Deputy Administrator for Division of Health Care Financing and Policy (DHCFP). Promised that we would be able to meet again and discuss further. Will email Teri and discuss ADTs
November 1, 2017	Elko County Library; Partners Allied for Community Excellence (PACE) Coalition Elko, NV	Health Care Guidance Program presents to obtain information and interact regarding resources for the program. Meeting facilitated by Laura Oslund from the Partners Allied for Community Excellence (PACE) Coalition. Speaker: Jan Brizee—State of NV Office of Consumer Health Assistance (Open Enrollment). Main portion of the meeting was regarding Open Enrollment and the services offered by the Consumer Health Assistance Office. Commissioner Androzzi mentioned the need in the future for all provider entities represented at the meeting will need to be involved in a grant that Elko County is applying for regarding the Obesity Epidemic and the secondary conditions caused from it. He will be updating in the PACE Coalition

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		meeting monthly as things develop. It was mentioned during the introduction by HCGP the need for toiletry donations for Medicaid members being seen by the HCGP staff in the Northeastern part of Nevada state. Requesting donation for toilet paper, paper towels, soap, shampoo, razors, shaving cream, feminine products, cleaning supplies to contact one of the local staff. Noted no resources in this area for these items unless a member is homeless. 3 new Elko providers have started practice in Elko recently: Dr. Sharma and Dr. Curtis, Gynecology and Obstetrics; ph# 775-748-0701 They do accept Medicaid. Dr. Sharma sought me out after the PACE Coalition meeting. Both her and Dr. Curtis do high risk OB. They both emphasized they want to build their practice on Women's Health for ALL ages and ALL reasons. Their passion is GYN issues. Their goal is to keep patients close to home as long as possible. They are very aware of several of the high risks in this area and were asking about resources for BH, as well as methadone and suboxone clinics as they have already encountered a few OBs that are addicted to several types of drugs with one in particular

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		Percocet. Dr. Pullin: Orthopedic; ph# 775-777-3535 accepts Medicaid. He left rather quickly to get back to his office. We did not get a chance to talk to him.
November 15, 2017	Project Homelessness Cashman Center Las Vegas, NV	Health Care Guidance Program staff provided HCGP education and "networking" as needed.
November 16, 2017	Amanda Nielsen, Renovation Mental Health Service Reno, NV	Health Care Guidance Program staff presented an overview education on the program. The HCGP staff received facility information. The facility accepts FFS member-resource for BH services.
November 18, 2017	Renown Hospital Reno, NV	Health Care Guidance Program staff met to discuss further cooperation with Renown Medical System about HCGP learning of admissions to hospital. Dr. Thomas McCrorey with HCGP, met with Katie Swint head of discharge planning who supported our active involvement in the admission of our members. But wanted her boss to approve us getting real time notification of admission. Dr. McCrorey emailed Teri Howard about this but she was against the idea. She said they had trouble with sending electronic information to health plans and were working with privacy lawyers and IT people to do this in the future. At

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		the current time they have a type of moratorium on this. Dr. McCrorey wants to speak in person with Ms. Swint to push the issue. Ms. Swint set up a meeting and gave the idea she would consider some other non automated process to cooperate with us. When we met in person she re-iterated her point about not transmitting bulk data to us. Dr. McCrorey described our role and why we would like routine daily information about admission. That their case managers identifying a member who needs a "real time referral (RTR) was not the best plan and that we have added benefits even for members who are not identified by the facility as high need for outpatient support. April, HCGP staff made a strong argument that early notification can make our effectiveness better, as we have time to work on needed support and find follow up. Teri mentioned that getting members follow up care is a difficult area for Renown, and could we help with that. The HCGP staff responded absolutely we can assist with that and it is difficult for us as well but since it is a particular focus of ours we would like to collaborate. We discussed briefly the differences between us and the Managed Care Organizations (MCO) and we do

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		not provide care, run a network or do UM. However Teri seemed to appreciate the benefit of our care navigation, continuity of member contact, advocacy, and coaching that we provide for people with high needs in a very fragmented system. HCGP staff; April, Janine and Dr. Thomas McCrorey pointed out some of the common misconceptions and lack of knowledge in the patient population and gave examples of where we had helped especially connecting to benefits. Teri wondered why the concurrent authorizations that are submitted to Hewlett Packard Enterprise (HPE) are not adequate for this. Dr. McCrorey responded that they are received but delayed. Didn't know what the delay was but that by the time they are in the system they are usually not useful. Dr. McCrorey pointed out that if we could get them sooner that would be awesome but we don't and that we are trying any way we can to find the members. We would still pursue getting that data more timely from HPE. Teri said she would consider giving us information on the FFS Medicaid, such as a hard copy or fax about the members. Janine, HCGP staff discussed how to find if the members are in the program in EVS and also that we could have them fax RTR

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		directly to us for us to bypass the normal process of RTR. That would enable us to know right away when Renown sent the list. Teri with Renown mentioned asking the members if they don't mind calling us. Dr. McCrorey explained in clear terms we have the right to know who is admitted whether they want it or not, they are mandatorily in the program and although we would not force ourselves in their room against their will we didn't need their permission to know their health information. Teri wanted to see our Letter of Authority (LOA) from Medicaid, which we will provide again. We did acknowledge that we will need to comply with their access rules (badging). After Teri looks at the LOA she will discuss this with Renown's privacy team and will also want to discuss with our privacy officer. Then she will work with us and with patient administration dept to determine the best way for us to get the information s. We discussed briefly the ideal of getting bulk electronic data directly to VITAL program. She said they will only be using the Epic Care system going forward. But neither she nor Dr. McCrorey spent a lot of time on this topic.

Date	Outreach Activity	Summary of Activity
		There were several other ideas that HCGP staff; Janine and Teri brought up for ways to get information but it seemed like Teri was not willing to commit until she had our Letter of Authority (LOA) and she had met with the privacy people. It did seem like we would have some routine data sent to us after she had discussed it.
November 19, 2017	Convoy of Hope Las Vegas, NV	Health Care Guidance Program staff on site to provide education and "networking" for the program.
November 23, 2017	Zephyr Wellness 418 Cheney St. Reno, NV	Beacon Health Solutions staff met with Jake Wiskerchen, owner of Zephyr Wellness and his front office manager, and discussed identifying who the CMO members are and how to outreach to us to inform. Zephyr Wellness serves the Medicaid population, including FFS members.
December 2, 2017	Monte Vista Hospital Las Vegas, NV	Health Care Guidance Program staff were present at discussion/ event but did not participate or present.
December 6, 2017	Elko County Library; Rural Providers Coalition Elko, NV	The Health Care Guidance Program staff present in case of questions regarding the program and for "networking." MaryAnn Martinez will be holding a diabetes management class. This class will solely be in Spanish. It is a six-week class that is held once a week for two hours. The dates are February, 1st, 8th,

Date	Outreach Activity	Summary of Activity
		15th, 22nd, March 1st and 8th. The class is held from 9:00am to 11:30am in PACE's Board Room. For more information, please contact MaryAnn Martinez at mary_ann@pacecoalition.org. Chris Pacini has started a new business called Silver State CPR. She teaches first aid and CPR to anyone who is in need of the class. Chris will be getting pet mannequins and can teach Pet CPR as well. Maribeth Cassinelli will be replacing Cecelia Smith at RSVP since Cecelia has retired. FISH is in need of volunteers since they may be opening up the Warming Shelter 12/06/16. The shelter is located 729 Douglas St in Elko. Please call FISH for more information. 775-738-3038. The Heart & Shield Program just finished their fall and winter programming. They will resume programming again in February. Vicki Salazar from Access to Healthcare Network wanted to remind everyone that Medicare part D closes December 7th, 2016. Kathy Edwards from LDS Humanitarian would like to come into contact with organizations and people who need supplies and basic needs. Kathy has a number of quilts she would like to give away. Please contact Kathy for more details at: Kathyedwards4@gmail.com FRC is hosting a Teen Health Program on December 7th & 8th from 3:45pm to 6:00pm for ages

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		13-18. Students will receive a FREE backpack when they complete the free program. Students can earn 2 movie tickets when they have a friend sign up as well. Mary Pitts is the new Coordinator for Elko County Drug Courts. Margo Teague has stepped down from the position; Mary is now the point of contact. The Division of Child and Family Services (DCFS) is in dire need of Social Workers and Foster Parents. Please refer anyone who is looking to become a foster parents or who is interested in a Social Worker Position to the DCFS office, 1010 Ruby Vista Dr. Suite 101. Head start of Northeastern Nevada is always accepting new applications. Justice for Stephanie is in the process of writing grants and has enjoyed attending county and city activities as well as making a positive impact on the community as well as survivors of domestic violence. Nevada IT recycles old computers and gives the recycled computers to nonprofits in the area or people who are in need of a computer. Elko Counseling & Supportive Services has recently changed its name. It is now called, Elko Rural Clinics. Their address and phone number are still the same. Rebecca will be sending out information regarding the Mobile Crisis Response Team. The Mobile Crisis

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		Response Team is there for any person who thinks a child is in danger of harming themselves can call a dispatch number and a crisis team will go to the location of the child to determine what kind of help that child needs. This response team will work with parents or guardians to make sure the child gets the help that they need. Gratitude to those who completed the Coalition Survey. We want to improve and have taken your ideas into consideration. If you have any more ideas to improve our monthly Rural Providers Meeting, please send them to Laura Oslund at laura@pacecoalition.org. Presenter: Zanny Marsh & Bailey Billington with The American Red Cross responds to 70,000 disasters/emergencies per year. The most common disaster response is for home fires. Since Thanksgiving 2015, home fires across North and Northeastern Nevada have nearly doubled in Battle Mountain, Elko, Spring Creek, Ryndon, and Winnemucca. Home Fires occur every month of the year- but are especially common in colder months because of increased time spent indoors, use of space heaters, frozen pipes, and decorating with greenery. There are three things that should occur when you and your family are practicing family preparedness, get a kit (for your pet, kids, and

Date	Outreach Activity	Summary of Activity
		yourself) make a plan, and be informed. Get a Kit: Every human kit should have these essential in it, 1 gal/person per day of water, food, medical supplies, sanitary supplies, cell phone/charger, contact information, emergency blanket, cash, flashlight, batteries, radio, first aid kit, personal documents, maps of the area and any customized supplies as needed. Dog kit essentials should have these items leash, secure kennel and blanket, collar with ID, food/food bowl, water, medication, and sport or hydration towel. Cat kit essential should have these items, kitty litter/litter box, secure carrier and blanket, collar with ID, food/food bowl, water and medication. Vaccination records, microchips and pet first aid kits are advised for all pets. Remember to store a 3-day supply of food and water in a sturdy backpack or duffle if you have to evacuate. Always keep a 2 week supply at home should stores be closed or you cannot leave affected area. Check supplies and rotate every 6 months for freshness. Make a Plan: In this plan include family, household members, neighbors in planning, and discuss how to prepare and respond to emergencies most likely to happen where you live, learn, work and play. Learn how to turn off utilities (if advised) and learn

Date	Outreach Activity	Summary of Activity
		how to identify responsibilities for each member of your household and plan to act as a team. Be Informed: Know and plan for our region's common disasters. Get information- How would you get information during an emergency? Cell phone & charger/two-way radios/even a sharpie and paper! Take action by learning CPR, First Aid and check www.redcross.org for newly-offered classes. Practice, Practice & Practice: Run through a mock evacuation twice/year Make it fun for the kids and include anyone that you may assist (i.e., in-laws, neighbors, grandparents, etc.) Resources: Please visit www.redcross.org or Elko Service Center, 723 Railroad Street Elko, NV 89801 775-856-1000 or American Red Cross of Northern Nevada 4750 Longley Lane, Suite 101 Reno, NV 89502 775-856-1000. Please remember to limit your update to only one minute! We have a limited amount of time and we would LOVE to get everyone's update in. If your update/news is longer than a minute, please sign up for one of our speaker spots. 2016 is all filled up but we have spots in 2017 open. Cancellations do happen so we may contact you if needed. Please contact Dylan dylan@pacecoalition.org to be added to speaker list. Also, please remember to sign in. This is how we keep track of who attended.

Date	Outreach Activity	Summary of Activity
		The next meeting will be January 3rd, 2017 at the Elko County Library at 8:00am. If you would like your events to be included in these minutes, please send them to dylan@pacecoalition.org.
December 7, 2017	Dr. Charles Mahakinan (Psychiatrist) MH 3017 W Charles Las Vegas, NV	Health Care Guidance Program staff provided education, no collaboration discussed working as a team (Dr., Nurse from Summit BH and Doctor BH CM).
December 8, 2017	Dr. Renu Mahajan Las Vegas, NV	Health Care Guidance Program staff provided education, no collaboration just working as a team (Dr., Nurse, Doctor and BH CM). Follow-up meeting TBD.
December 14, 2017	Feeding Families with Catholic Charities St. Vincent's 4th St. Reno , NV	Health Care Guidance Program staff present to "network" and off program resources for identified recipients. Feeding Families is an event that feeds 5,500 families throughout the state of Nevada. We host an event on December 14th where we give out 2,000 filled holiday food bags to families in need. The bags are filled with stuffing, rolls, cranberry sauce, mashed potatoes, a ham, and more. In the past we have not offered any additional services but this year we would like to offer a mini Project Homeless Connect so that families have the opportunity to receive everything they need in one location.

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 Program (HCGP) Meeting on October 21, 2016. Following the Quality Modules, AxisPoint Health (APH) presented the following:

- Program Updates, presented by; Cheri Glocker, HCGP's Executive Director, Dr. Ron Geraty, CEO, APH and Dr. Tim Moore, CMO APH.
    - Cheri Glockner provided update on Key Accomplishments: Continuing to hire open positions in urban and rural Nevada, continued collaborative effort to calibrate data sets between APH and Milliman (states actuary) to calculate Program Year One (PY1) results, Worked with Medical Transportation Management (MTM) to highlight areas of improvement for HCGP members. Scheduled trainings for MTM Staff to understand unique HCGP needs, Reviewed draft of Amendment #5 – program extension, Supported the 2016 Performance Measure Validation (PMV) Audit, Worked with sister agencies to ensure program awareness, Worked with Hewlett- Packard (HP) on Emergency Department Utilization report.
    - Dr. Ron Geraty informed APH is now a separate company from McKesson Technologies.
    - Dr. Tim Moore presented on the approach of moving from the Traditional Core Five to the Care Point approach, including improving medication adherence and care visit access. APH has identified about 19 conditions they feel have a real opportunity to generate savings.
- Quality presentation presented by Michelle Searing, Outcomes Operation Manager, APH.
    - Michelle Searing presented on Quality Module #4; Program Year 2 (PY2) Member and Provider Satisfaction Surveys and Program Dashboard.
      Results for NCCW Enrollee Satisfaction Survey:

Annual Satisfaction Surveys

Member Satisfaction - Annual PY2	2014	2015	2016
Survey Candidates	33,866	34,857	38,554
Survey Completions	3,031	3,205	2,153
Response Rate	9.0%	9.2%	5.6%
Rate HCGP Good or Best Care Possible	0.0%	0.0%	69.5%

Provider Satisfaction – Annual PY2	2015	2016
Survey Recipients	1,185	1,588
Participants	60	46
Response Rate	5.1%	2.9%

Quarterly Satisfaction Surveys

DM Member Satisfaction (Quarterly-Q2)	Q1 2016	Q2 2016
Survey Recipients	1,024	1,458
Participants	236	320
Response Rate	23.0%	22.0%
Satisfaction Rate	90.0%	90.0%

CM Member Satisfaction (Quarterly-Q2)	Q1 2016	Q2 2016
Survey Recipients	695	377
Participants	95	108
Response Rate	13.7%	28.6%
Satisfaction Rate	98.9%	94.4%

For a detail view of the PY2 results please see attachment titled "NV HCGP APH Quarterly 2016 final 10 14 16, pages 21-43"

- HCGP Performance Dashboard presented by Michelle Searing. Topics discussed; Enrollment; APH staff provided a rolling 12 month view enrollment per risk level categories, Staffing Update; APH presented graph to provide an overview at the total

enrollment by risk levels where care managers are assigned, Member Contacts; it was broken down per HCGP's successful contacts for risk level 4 and 3's, Real Time Referrals (RTR's) and Serious Occurrences (SOR's); APH presented on the numbers of RTR's received between October 2015 – September 2016. There was a significant decrease in RT's starting June 2016 attributed to the loss of data received from Renown and Carson Tahoe Hospitals, SOR's; APH had not previously tracked these until January 2016. The DHCFP and APH collaborated and set up a number of workgroups internally to track SOR's. SOR's include; home healthcare-related hospitalizations', any deaths, accidents, falls, allegations of assault, arrest, auto accident, pedestrian accident, Complaints and Compliments; APH informed there has been an increase in member complaints in the month of September 2016 tied to "wrong number". Members are requesting that they be removed from the call list due to "wrong number". Top three complaint categories: Erroneous demographics, providers and transportation vendor.

- Michelle Searing with APH, provided an overview on the HCGP Program Year 2 LessonsLearned: Multi-disciplinary team approach to managing members is critical to success, Data is king: identifying and targeting most impactable members will yield the right results, Care Management is quickly evolving as better data becomes available, Updated Identification and Targeting methodologies translate into "Assertive Rapid Engagement" by meeting our members where they're located, consumer driven communication based upon member preferences, Optimal grassroots member outreach ensures HCGP staff are well connected to community resources to assist in member needs. Better Monitoring of Performance by: Comparing Year-to-date results to the results at that same point the previous year.

- Dr. Thomas McCrorey, Medical Director, APH presented on Provider Outreach.
  - Dr. McCrorey has been working with Top 10 Hospitals in Nevada. The purpose of receiving these reports from the hospitals is to identify when an HCGP member has been admitted to better assist with continuity of care. The below chart provides an overview of the collaboration with these hospitals.

Top 10 Hospital Name	Census data?	Admits
Sunrise Hospital & Medical Center	In process-1	1,267
Valley Hospital Med Ctr	Yes-2	1,197
Renown Regional Medical Center	In process-3	735
North Vista Hospital	No-4	679
University Medical Center	In process-5	674
Montevista Hospital	No-4	573
Mountain View Hospital	In process-1	552
Carson Tahoe Regional Medical Center	Stopped-6	535
Desert Springs Hospital	Yes-2	387
Summerlin Hospital Medical Ctr llc	Yes-2	327

1. Agreed to provide reports months ago, but negotiations ongoing about IT and a HIPAA Business Associates agreement.
2. Valley System provides daily reports
3. Had been receiving census but stopped this year, lots of turnover at Renown. Meeting this month to re-establish reporting
4. Will begin negotiations to receive reports from this facility.
5. UMC has agreed months ago to provide reports, but has not yet.
6. Carson Tahoe had been giving regular reports but stopped this year, above the level of their Case management. Will need to negotiate to get reporting

- DHCFP worked with HSAG with revising the Health Care Guidance Program Quality Strategy 2017-2018. Final document will be provided at the next quarterly report. The purpose of the HCGP Quality Strategy is to:
    - Establish a comprehensive quality improvement system that is consistent with the Triple Aim adopted by CMS (improved care, improved health, and reduced costs) and the goals and objectives identified in the National Quality Strategy.
    - Provide a framework for the DHCFP to design and implement a coordinated and comprehensive system to proactively drive quality throughout the Nevada Medicaid system. The Quality Strategy promotes the identification of initiatives to continuously monitor, assess, and improve access to care, clinical quality of care, and health outcomes of the population served.
    - Identify opportunities for improvement in the health status of the HCGP 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 HCGP enrollees have access to high-quality and culturally appropriate care.
    - Improve HCGP enrollee satisfaction with care and services.
- The states actuary Milliman and AxisPoint Health presented the Program Year 1(PY1) results. Milliman presented on the Pay for Performance (P4P) measures and APH presented on the Non Pay for Performance (Non P4P) Measures for PY1. Results from Milliman's calculation are as followed; in program Year 1 (June 1, 2014 through May 31, 2015), there is no P4P due to the APH. The total impact to cost in PY1, as calculated was a cost reduction of $9,918,243. The overall quality score for PY1 is 2.4%. While an overall cost reduction for the reconciliation population was achieved in PY1, the minimum overall quality score threshold of 50% was not met, resulting in a P4P bonus payment of $0. For detail PY1, P4P calculation report, please see attachment "2016 HCGP Program Year 1 Calculation". For a detail Non-P4P report, please see attachments "HCGP PY1 Non P4P Memo and HCGP PY1 Non P4P Clinical Results 2016 11 04"

Care Management Contracting

- Within FFY16 Q1/2017, the DHCFP received approval from CMS on obtaining approval for Amendment #5 and Attachment AA. The purpose of Amendment #5 is to amend the Nevada Comprehensive Care Waiver (NCCW) – Contract 14983. The contract amendment extends the contract term from November 30, 2017 to June 30, 2018, and made minor language updates to Attachment AA.
- The DHCFP plans on working together with CMS, and the CMO Vendor on Amendment #6. The purpose of this amendment is to be in compliance with CMS language to Attachment B of the STCs in that it reads "The state must submit a request for an amendment to Attachment B by June 30, 2017 to extend this timeframe if it anticipates that any payment will be made to the CMO's after June 30, 2018". On December 21, 2016, the DHCFP e-mailed CMS asking for guidance as to where the language should be included? To comply with this existing requirement in Attachment B of the STCs, the waiver period will need to be extended to December 2019 to allow for the required amount of claims lag, evaluation, and a potential incentive payment. The state has provided a revised word document of the approved NCCW Attachment B and revisions that will need to be made to "Table 1. Time Frames for State of Nevada Data Extracts" to be in compliance in the event CMS approves the extension.

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 (Q1/2017).

Member Month Reporting

Demonstration Populations	Month 1 (October 2016)	Month 2 (November 2016)	Month 3 (December 2016)	Total Ending (January 2017)
Population 1: MAABD	22,050	22,982	22,453	22,397
Population 2: TANF/CHAP	16,876	16,744	16,795	16,856
Total:	38,926	39,726	39,248	39,253

Consumer Issues

There are no consumer issues to report for this quarter (Q1/2017).

Quality Assurance/Monitoring Activity

Per STCs 26 & 27, the State is required to report on demonstration eligibility determinations, the number deemed non-compliant and "on demand for noncompliance." For this quarter (Q1/2017), please see table on page 3 for "noncompliance".

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

Demonstration Evaluation

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

questions on January 24, 2017. On January 31, 2017 during the Nevada Comprehensive Care 115 Demonstration Bi-Monthly Monitoring Call, CMS confirmed receipt of January 24th e-mail. Up to date the DHCFP is waiting for feedback and or final approval from CMS regarding the Evaluation Design Plan.

Enclosures/Attachments

- FFY17 QTR 1 Cover Letter
- NV Quarterly Meeting Agenda 10212016
- HCGP Quarterly Meeting Sign In Sheet 10212016
- NV HCGP APH Quarterly October 2016 final 102016
- Minutes for HCGP Quarterly Meeting 07-26-16
- 2016 HCGP Program Year 1 Calculation
- HCGP PY1 Non P4P Memo
- HCGP PY1 Non P4P Clinical Results
- Health Care Guidance Program Upcoming Quarterly Meetings Schedule 2017

State Contact(s)

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Date Submitted to CMS

February 28, 2017

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November 11, 2016

John Kucera
State of Nevada, DHCFP
1100 East William Street, No. 116
Carson City, NV 89701

Re: Program Year 1 Quality Measures and Savings Calculations

Dear John:

This letter will describe the trend calculation, quality measurements, and pay-for-performance (P4P) bonus calculation for the first program year of Nevada's Health Care Guidance Program (HCGP). Included in this deliverable are quality metrics used in HCGP's P4P program, as well as other quality metrics not evaluated in this program, as required by the HCGP. We have also included exhibits showing the calculation of trends for the chronic and non-chronic populations and how the trend and quality components contribute to the shared savings payout. This letter explains these calculations; it may not be appropriate for other purposes.

Executive Summary

As described in Attachment AA of the Nevada's CMO contract with Access Point Health (APH), a final calculation of the shared savings bonus will be conducted with 12 months of runout. This document and the attached exhibits describe this calculation and its results.

In Program Year 1 (June 1, 2014 through May 31, 2015), there is no P4P bonus payment due to APH. The total impact to cost in Program Year 1, as calculated in Exhibit 3, was a cost reduction of $9,918,243 when accounting for management fees. The overall quality score for

Program Year 1 is 2.4%. While an overall cost reduction for the reconciliation population was achieved in Program Year 1, the minimum overall quality score threshold of 50% was not met, resulting in a P4P bonus payment of $0.

Program trends, quality measures, and savings calculations are detailed in the following exhibits:

- Exhibit 1 shows the development of the Program Year 1 risk adjusted cost trends.
- Exhibit 2 shows the P4P quality measures for the baseline and Program Year 1. It also shows the target Program Year 1 quality measures, calculated per Attachment AA, and indicates whether or not APH has met these targets.
- Exhibit 3 shows the calculation of the pay-for-performance bonus for Program Year 1.
- Exhibit 4 shows the membership and cost basis for our trend development.

Data

The Nevada fee for service (FFS) data used in this calculation was provided by DHCFP. This includes claims incurred from June 1, 2011 through May 31, 2015 and paid through May 31, 2016. Per Attachment AA, this data includes 12 months of runout so no completion adjustment was applied.

Trend Calculation

Membership and risk adjusted cost trends are shown in Exhibit 1. Total combined trends were calculated in addition to the separate trends for the reconciliation and trend populations, as defined in Attachment AA. The membership and cost basis for these can be seen in Exhibit 4.

Risk Adjustment

Risk scores for the population were calculated using the CDPS v6.1 risk adjustment model.

Because CDPS uses separate risk models for adults vs. children and disabled vs. non-disabled, it was necessary to normalize risk scores to the same basis. An average PMPM cost was calculated for each year for each CDPS classification (Adult Disabled, Adult non-Disabled, Child Disabled, Child non-Disabled). Costs for each classification were averaged across the five year period, resulting in a single PMPM cost for each classification. This approach was taken, rather than calculating a single overall average, to ensure that the combination of trend and any shift in population distribution by classification did not impact the classification relativities.

Using Adult non-disabled as the base (i.e. 1.00), relativities were calculated for each classification. The relativities are shown in Table 1 below.

Table 1
CDPS Claim Cost Relativities

Classification	Relativity
Child non-Disabled	0.527
Adult non-Disabled	1.000
Child Disabled	2.210
Adult Disabled	2.344

The risk score for each sub-population (aid category, calendar year, county, adult child status) was multiplied by the appropriate relativity. With this adjustment, the new risk scores were expected to represent accurate relativities to the overall population rather than the individual classifications.

Using these normalized risk scores, annual risk-adjusted PMPMs were calculated separately for each combination of

- Aid category (ABD, non-ABD)
- Program Year
- County (Clark, Washoe, Other)

Overall risk-adjusted PMPMs for each program year were calculated as the weighted average of each county group's risk-adjusted PMPM for that year. The weights used were the county's total member months during the study period (June 1, 2014 through May 31, 2015). By using the same weights in each year, we eliminate any impact geographic population shifts might have on trend

Total risk-adjusted PMPMs for each calendar year were calculated as the weighted average of each aid category's (ABD and non-ABD) risk-adjusted PMPM for that year. The weights used were each aid category's total member months during the study period (June 1, 2014 through May 31, 2015). By using the same weights in each program year, we eliminate any impact on trend due to shifts in each aid category's relative population counts. These total risk-adjusted PMPMs were used to calculate annual trends.

This approach to calculating trend was developed in late 2015 in conjunction with CMS in order to obtain their approval to include a bonus payment in the program.

Quality Measures

Quality Measure Calculation

As per Attachment AA of the contract, an annual pay-for-performance payment will be made based on a net reduction in costs, if the CMO meets the criteria outlined in the contract. These criteria require both a reduction in cost as well as a demonstration of quality of care improvements based on the use of specified quality measures.

Attachment FF and GG of the contract list and define these quality measures. Actual achieved measure values for the baseline and Program Year 1 are shown in Exhibit 2.

The quality measures provided in Exhibit 2 were calculated for the reconciliation population using a process reviewed and approved by the Health Services Advisory Group (HSAG). P4P measures presented in Exhibit 2 use SAS code approved by HSAG in January 2014.

Though this does not impact the Program Year 1 calculation, we have updated our methodology to include ICD-10 diagnosis and procedure codes. Since this does not impact any claims incurred prior to October 1, 2015, there is no impact from ICD-10 conversion.

Quality Improvement Target Calculation

Exhibit 2 shows quality improvement targets for Program Year 1 along with an indication whether that target was achieved. As per Attachment AA, the quality improvement target for each quality measure is calculated as 10 percent of the difference between the optimal quality level and the value of the measurement during the baseline period for the eligible population. Some measures, such as those measuring emergency room visits post-discharge, were targeted to decrease, but most were targeted to increase. Targets were only calculated for measures impacting the P4P calculation.

Pay-for-Performance Bonus Calculation

The trend calculation and the P4P quality measure calculations combine to calculate the P4P bonus payment. Per Attachment AA, the bonus is calculated using this equation:

$$Bonus = Reduction\ in\ Costs \times [50\% - (100\% - Overall\ Quality\ Score)]$$

Where this formula results in a negative number due to an overall quality score less than 50%, a maximum of zero was applied. This calculation is shown in Exhibit 3. Each component of this calculation is defined as follows.

Reduction in costs

The reduction in costs is calculated assuming the difference in trend between the trend and reconciliation populations is due to management by APH. After risk adjustment, the reconciliation population's baseline PMPM is trended forward using the trend population's annual cost trend. This result is then compared to the reconciliation population's actual risk adjusted program year PMPM. After removing care management fees paid to APH, the difference is the calculated reduction in costs.

Overall Quality Score

Each condition receives a condition specific quality score, calculated as the number of "achieved" quality improvement targets divided by the total number of quality improvement measures for that condition. The condition specific quality scores are shown in Exhibit 3.

The overall quality score is the weighted average of each condition specific quality score, based on the number of member months with that condition. Members with multiple conditions are counted multiple times in this calculation.

Caveats & Limitations

In performing our analysis, we relied on data and other information provided to us by DHCFP and its data vendors. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. We are members of the American Academy of Actuaries, and we meet the qualification standards for performing the analysis in this letter.

Please contact us if you have any questions regarding this analysis.

Sincerely,

[redacted]

Robert Bachler, FSA, FCAS, MAAA
Principal and Consulting Actuary

[redacted]

Catherine Lewis, FSA, MAAA
Actuary

cc: Betsy Aiello (DHCFP)
Gladys Cook (DHCFP)
Tom Sargent (DHCFP)
David Allwine (Milliman)
Zachary Zwicker (Milliman)

Exhibit 1
Nevada Department of Health Care Finance and Policy
Health Care Guidance Program
Comparison of Trends
Chronic Condition vs Non Chronic Condition Population

	Total Eligible Population			
	PY2014 [3]	PY2015 [3]	Total	2014-15 [3]
Member Months	672,990	729,458	1,402,448	8.4%
Average Risk Score	1.57	1.54	1.55	-2.4%
Reweighted Paid PMPM [1]	$624.05	$578.68	$600.45	-7.3%
Risk Adjusted PMPM	$396.46	$376.65	$386.16	-5.0%

	Reconciliation Population			
	PY2014 [3]	PY2015 [3]	Total	2014-15 [3]
Member Months	268,343	297,168	565,511	10.7%
Average Risk Score	2.97	2.89	2.93	-2.7%
Reweighted Paid PMPM [1]	$1,325.13	$1,208.35	$1,263.76	-8.8%
Risk Adjusted PMPM	$445.57	$417.66	$430.91	-6.3%

	Trend Population			
	PY2014 [3]	PY2015 [3]	Total	2014-15 [3]
Member Months	404,647	432,290	836,937	6.8%
Average Risk Score	0.65	0.60	0.62	-6.5%
Reweighted Paid PMPM [1]	$159.12	$145.83	$152.25	-8.4%
Risk Adjusted PMPM	$246.46	$241.56	$243.93	-2.0%

Difference in Risk Adjusted Trends [2]	-4.3%

Notes:
(1) PMPM is capped at $500,000 per individual per program year.
(2) Positive number indicates target population > benchmark population
(3) PY14 and PY15 represent the Baseline (Jun 1, 2013 - May 31, 2014) and Program Year 1 (Jun 1, 2014 - May 31, 2015) respectively.

Exhibit 2
Nevada Department of Health Care Finance and Policy
Health Care Guidance Program
P4P Bonus Calculations
Program Year 1 - Measurement Period Ending May 31, 2015

Asthma Measures

				Baseline (PY14)			Target for Program Year 1 (PY15)		Program Year 1 (PY15)			Target Achieved?
Measure	Age Group	Numerator Description	Denominator Description	Numerator	Denominator	Percent	Increase or Decrease?	Percent	Numerator	Denominator	Percent	
Measure ASM.1	5 - 64	Members with persistent asthma that received preferred prescription	Members with persistent asthma	441	694	63.5%	INCREASE	67.2%	373	574	65.0%	NO
Measure ASM.2	All Ages	Members with persistent asthma that received a flu shot	Members with persistent asthma	42	723	5.8%	INCREASE	15.2%	13	599	2.2%	NO
Measure ASM.3	All Ages	Members with persistent asthma with an ED or Urgent Care visit	Members with persistent asthma	104	723	14.4%	DECREASE	12.9%	118	599	19.7%	NO
Measure ASM.4	All Ages	IP asthma discharges with an ambulatory follow up visit	IP asthma discharges	7	24	29.2%	INCREASE	36.3%	6	18	33.3%	NO

Coronary Artery Disease Measures

Measure	Age Group	Numerator Description	Denominator Description	Numerator	Denominator	Percent	Percent	Percent	Numerator	Denominator	Percent	
Measure CAD.1	All Ages	Members with CAD who were prescribed lipid lowering medications	Members with CAD	170	871	19.5%	INCREASE	27.6%	147	928	15.8%	NO
Measure CAD.2	All Ages	Members with CAD with an LDL-C screening	Members with CAD	661	971	68.1%	INCREASE	71.3%	748	1,050	71.2%	NO
Measure CAD.3	All Ages	IP CAD discharges with an ambulatory follow up visit	IP CAD discharges	1	13	7.7%	INCREASE	16.9%	4	13	30.8%	YES

Chronic Obstructive Pulmonary Disease Measures

Measure	Age Group	Numerator Description	Denominator Description	Numerator	Denominator	Percent	Percent	Percent	Numerator	Denominator	Percent	
Measure SPR.1	40 +	Members with a COPD index episode start date receiving a spirometry test	Members with a COPD index episode start date	126	440	28.6%	INCREASE	35.8%	140	459	30.5%	NO
Measure SPR.2	18 +	Members with COPD that received a flu shot	Members with COPD	176	2,044	8.6%	INCREASE	17.7%	162	2,195	7.4%	NO
Measure SPR.3	All Ages	IP COPD discharges with an ambulatory follow up visit	IP COPD discharges	14	58	24.1%	INCREASE	31.7%	2	35	5.7%	NO

Diabetes Measures

Measure	Age Group	Numerator Description	Denominator Description	Numerator	Denominator	Percent	Percent	Percent	Numerator	Denominator	Percent	
Measure CDC.1	18 - 75	Members with diabetes who had an HbA1c test	Members with diabetes	1,731	2,474	70.0%	INCREASE	73.0%	1,904	2,679	71.1%	NO
Measure CDC.2	18 - 75	Members with diabetes who had an LDL-C screening	Members with diabetes	1,698	2,474	68.6%	INCREASE	71.8%	1,836	2,679	68.5%	NO
Measure CDC.3	18 - 75	Members with diabetes who underwent nephropathy screening	Members with diabetes	1,599	2,474	64.6%	INCREASE	68.2%	1,656	2,679	61.8%	NO
Measure CDC.4	18 - 75	Members with diabetes who underwent diabetic retinal screening	Members with diabetes	716	2,474	28.9%	INCREASE	36.0%	801	2,679	29.9%	NO
Measure CDC.5	18 - 75	Members with diabetes who received a flu shot	Members with diabetes	198	2,474	8.0%	INCREASE	17.2%	204	2,679	7.6%	NO
Measure CDC.6	5 - 17	Members with diabetes who had an HbA1c test	Members with diabetes	53	69	76.8%	INCREASE	79.1%	50	83	60.2%	NO

Heart Failure Measures

Measure	Age Group	Numerator Description	Denominator Description	Numerator	Denominator	Percent	Percent	Percent	Numerator	Denominator	Percent	
Measure HF.1	18 +	Members with an IP visit for HF and were dispensed beta blockers	Members with an IP visit for HF	50	91	54.9%	INCREASE	59.5%	57	91	62.6%	YES
Measure HF.2	All Ages	Members with HF who had at least one ED visit	Members with HF	134	357	37.5%	DECREASE	33.8%	127	376	33.8%	YES
Measure HF.3	18 +	Members prescribed ACE inhibitors who received annual monitoring	Members prescribed ACE inhibitors	1,521	1,763	86.3%	INCREASE	87.6%	1,175	1,343	87.5%	NO
Measure HF.4	All Ages	IP discharges for HF with an ambulatory follow up visit	IP discharges for HF	5	23	21.7%	INCREASE	29.6%	3	20	15.0%	NO

HIV / AIDS Measures

Measure	Age Group	Numerator Description	Denominator Description	Numerator	Denominator	Percent	Percent	Percent	Numerator	Denominator	Percent	
Measure HIV.1	All Ages	Members with HIV/AIDS and two ambulatory visits 60 days apart	Members with HIV/AIDS	164	262	62.6%	INCREASE	66.3%	161	280	57.5%	NO

Hypertension Measures

Measure	Age Group	Numerator Description	Denominator Description	Numerator	Denominator	Percent	Percent	Percent	Numerator	Denominator	Percent	
Measure HPTN.1	All Ages	Members with 3 or more hypertension OP visits who received a thiazide diuretic	Members with 3 or more hypertension OP visits	428	2,551	16.8%	INCREASE	25.1%	381	2,699	14.1%	NO

Mental Health and Substance Abuse Measures

Measure	Age Group	Numerator Description	Denominator Description	Numerator	Denominator	Percent	Percent	Percent	Numerator	Denominator	Percent	
Measure MH.1	All Ages	Bipolar members who were prescribed mood stabilizers	Bipolar members	246	457	53.8%	INCREASE	58.4%	246	473	52.0%	NO
Measure MH.2	All Ages	Members with a new episode of major depression with anti-depression meds	Members with a new episode of major depression	324	712	45.5%	INCREASE	51.0%	322	675	47.7%	NO
Measure MH.3.1	6 +	Schizophrenic members with at least 5 months of anti-psychotic medication	Schizophrenic members	783	945	82.9%	INCREASE	84.6%	799	1,008	79.3%	NO
Measure MH.3.2	6 +	Schizophrenic members with at least 11 months of anti-psychotic medication	Schizophrenic members	492	945	52.1%	INCREASE	56.9%	520	1,008	51.6%	NO
Measure MH.4.1	6 +	MH IP discharges who went to a MH practitioner within 30 days	MH IP discharges	321	734	43.7%	INCREASE	49.4%	398	992	40.1%	NO
Measure MH.4.2	6 +	MH IP discharges who went to a MH practitioner within 7 days	MH IP discharges	219	734	29.8%	INCREASE	36.9%	254	992	25.6%	NO
Measure SA.1.1	13+	Members with a new episode of AOD who initiated AOD treatment	Members with a new episode of AOD	486	1,917	25.4%	INCREASE	32.8%	539	2,080	25.9%	NO
Measure SA.1.2	13+	Members with a new episode of AOD who engaged in AOD treatment	Members with a new episode of AOD	264	1,917	13.8%	INCREASE	22.4%	292	2,080	14.0%	NO

Exhibit 3
Nevada Department of Health Care Finance and Policy
Health Care Guidance Program
Quality Score Bonus Calculations
Program Year 1 - Measurement Period Ending May 31, 2015

Step 1: Calculate Reduction in Cost (from page 4 of contract):

Reweighted Baseline Recon (PY14) Population PMPM	$1,325.13	(a) - From Exh 1
Trend this PMPM forward to the appropriate period using the Trend Population's trend		
Trend Factor from Trend Population. This is the risk-adjusted Program Year 1 (PY15) PMPM / risk-adjusted Baseline (PY14) PMPM	0.980	(b)
Trended Baseline PMPM	$1,298.79	(c) = (a) * (b)
Reconciliation Population Program Year 1 (PY15) PMPM costs	$1,208.35	(d) - From Exh 1
Risk Score Trend for Reconciliation Population	0.973	(e)
Trended Program Year 1 (PY15) PMPM	$1,242.12	(f) = (d) / (e)
Program Year 1 (PY15) PMPM Gross Cost Reduction. A positive amount here implies savings	$56.66	(g) = (c) - (f)
Calculate Total Gross Cost Reduction		
Program Year 1 (PY15) Member Months in Target Population	297,168	(h)
Total Gross Cost Reduction	$16,838,806	(i) = (g) * (h)
Calculate Program Period Care Management Fees		
Program Year 1 (PY15) Member Months for Program Eligible Population	450,851	(j)
Program Year 1 (PY15) Program Care Management Fees PMPM, from page 12 of contract	$15.35	(k)
Total Program Year 1 (PY15) Program Care Management Fees	$6,920,563	(l) = (j) * (k)
Total Reduction in Cost. A positive amount here implies savings	**$9,918,243**	(m) = (i) - (l)

Step 2: Overall Quality Score Calculations (from page 10 of contract):

Category	Condition Specific Quality Score	Program Year 1 (PY15) Member Months
Asthma Measures	0%	61,102
Coronary Artery Disease Measures	33%	13,083
Chronic Obstructive Pulmonary Disease Measures	0%	30,440
Diabetes Measures	0%	47,748
Heart Failure Measures	50%	12,527
HIV / AIDS Measures	0%	4,825
Hypertension Measures	0%	39,468
Mental Health and Substance Abuse Measures	0%	235,331
Overall Quality Score	**2.4%**	

Step 3: Final Bonus Calculation

Bonus = Reduction in Costs x [50% - (100% - Overall Quality Score)]	**$ -**	Both Components must be positive

Exhibit 4
Nevada Department of Health Care Finance and Policy
Health Care Guidance Program
Trend and Recon Population PMPM Buildup for PY14 and PY15

	PY14[(1)] Recon Population Basis			PY15[(1)] Recon Population Basis		
ABD Clark	45%	116,360	$433.12	45%	133,802	$422.74
ABD Washoe	8%	21,545	$297.33	8%	24,389	$323.84
ABD Other	10%	28,493	$354.93	10%	29,263	$342.69
TANF Clark	13%	39,459	$646.90	13%	37,966	$550.07
TANF Washoe	3%	9,207	$494.24	3%	9,623	$455.28
TANF Other	21%	53,279	$442.71	21%	62,125	$392.13
Total	100%	268,343	**$445.57**	100%	297,168	**$417.66**

	PY14[(1)] Trend Population Basis			PY15[(1)] Trend Population Basis		
	Weight	MM	PMPM[(2)]	Weight	MM	PMPM[(2)]
ABD Clark	18%	71,916	$265.62	18%	77,057	$286.03
ABD Washoe	3%	11,389	$206.83	3%	11,658	$203.04
ABD Other	3%	15,371	$239.47	3%	14,085	$290.86
TANF Clark	17%	80,473	$300.32	17%	71,549	$260.26
TANF Washoe	5%	25,738	$353.73	5%	23,625	$295.70
TANF Other	54%	199,760	$215.28	54%	234,316	$214.72
Total	100%	404,647	**$246.46**	100%	432,290	**$241.56**

(1) PY14 and PY15 represent the Baseline (Jun 1, 2013 - May 31, 2014) and Program Year 1 (Jun 1, 2014 - May 31, 2015) respectively.
(2) Risk adjusted PMPMs

Date: November 3, 2016

To: Betsy Aiello, Deputy Chief Administrator, Division of Health Care Financing and Policy

From: Cheri Glockner, Executive Director, Health Care Guidance Program
Michelle Searing, Outcomes Operations Manager, AxisPoint Health/HCGP

Re: **HCGP Program Year One – Non Pay-for-Performance Quality Measure Calculation**

MEMO

In accordance with the 2014-2015 Nevada Comprehensive Care Waiver (NCCW) Quality Strategy, pg. 13, AxisPoint Health (APH) respectfully submits Program Year One, June 1, 2014 through May 31, 2015, Non Pay-for-Performance rates and result calculations.

As required by the NCCW Quality Strategy, annual performance measure validation audits (completed in August, 2015 and September, 2016) were conducted by Health Services Advisory Group (HSAG) on AxisPoint Health's processes. These comprehensive audits ensure that the data used to report rates for each measure were generated appropriately. These validation audits also confirm that AxisPoint Health followed the required specifications for each indicator.

The Nevada fee-for-service (FFS) data used in this calculation was provided by the Division of Health Care Financing and Policy. This includes claims incurred from June 1, 2011 through May 31, 2015 and paid through May 31, 2016. Per Attachment AA, this data includes 12-months of runout.

APH appreciates the opportunity to work with DHCFP to disseminate these results and other Program Year One material to interested stakeholders. We are available to answer questions and inquiries that may arise as these results are released to the public.

Program Year 1 Non-P4P Clinical Rate Observations (June 2014 - May 2015)

Condition	Measure Number	Measure Description (Use numerator description)	Age Group	Milliman Baseline Rate (June 1, 2013 - May 31, 2014)				APH Remeasurement (June 1, 2014 - May 31, 2015)			PER CONTRACT Performance Target Met? (Y/N) Millman BL vs APH PY1	Notes:
				Numerator	Denominator	Baseline Rate (Percent)	Performance Target (Year 1)	Numerator	Denominator	PY1 Rate (Percent)		
Chronic Condition/ High Utilizer	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	5,563	28,188	19735.35	17761.81	2,238	37,435	5978.36	Yes	Please see Note.1
	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	15,043	46,157	32.6%	29.3%	13,753	54,451	25.3%	Yes	Please see Note.1
	FUP.1	Percentage of discharges for members who were hospitalized and who had an ambulatory visit with a PCP. The percentage of discharges for which the member received PCP follow-up within 7 days of discharge.	No restrictions	1,332	5,433	24.5%	32.1%	1,425	4,460	32.0%	No	Please see Note.2
	FUP.2	Percentage of discharges for members who were hospitalized and who had an ambulatory visit with a PCP. The percentage of discharges for which the member received PCP follow-up within 30 days of discharge.	No restrictions	2,860	5,433	52.6%	57.4%	2,601	4,460	58.3%	Yes	Please see Note.2
	MRP	Percentage of discharges from January 1–December 1 of the measurement year for members regardless of age for whom medications were reconciled the date of discharge through 30 days after discharge (31 total days).	No restrictions	36	5,780	0.6%	10.6%	48	4,460	1.1%	No	Please see Note.3
Dementia	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	4	161	2.5%	12.2%	3	209	1.4%	No	Please see Note.4
Neurological	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+	192	495	38.8%	44.9%	28	197	14.2%	No	Please see Note.5
Renal	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	634	0.0%	10.0%	0	813	0.0%	No	Please see Note.6

Program Year 1 Non-P4P Clinical Rate Observations (June 2014 - May 2015)

Condition	Measure Number	Measure Description (Use numerator description)	Age Group	Milliman Baseline Rate (June 1, 2013 - May 31, 2014)				APH Remeasurement (June 1, 2014 - May 31, 2015)			PER CONTRACT Performance Target Met? (Y/N) Millman BL vs APH PY1	Notes:
				Numerator	Denominator	Baseline Rate (Percent)	Performance Target (Year 1)	Numerator	Denominator	PY1 Rate (Percent)		
Musculo-skeletal	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+	103	177	58.2%	62.4%	124	187	66.3%	Yes	Please see Note.7
	OST	Percentage of patients aged 50 years and older with a diagnosis of osteoporosis who were prescribed pharmacologic therapy within 12 months.	50+	145	302	48.0%	53.2%	8	288	2.8%	No	Please see Note.8
Obesity	OBS.1	Percentage of members whose BMI calculation is documented, and counseling for nutrition and physical activity is provided during the measurement year. Care managers will perform this activity, and it must be documented in the member's care plan. -Numerator = BMI	3-11 years	3	4,519	0.1%	10.1%	160	2,676	6.0%	No	Please see Note.9
	OBS.2	Percentage of members whose BMI calculation is documented, and counseling for nutrition and physical activity is provided during the measurement year. Care managers will perform this activity, and it must be documented in the member's care plan. -Numerator = BMI	12-17 years	2	3,697	0.1%	10.0%	132	2,245	5.9%	No	Please see Note.9
	OBS.3	Percentage of members whose BMI calculation is documented, and counseling for nutrition and physical activity is provided during the measurement year. Care managers will perform this activity, and it must be documented in the member's care plan. -Numerator = Counseling for Nutrition	3-11 years	43	4,519	1.0%	10.9%	62	2,676	2.3%	No	Please see Note.10
	OBS.4	Percentage of members whose BMI calculation is documented, and counseling for nutrition and physical activity is provided during the measurement year. Care managers will perform this activity, and it must be documented in the member's care plan. -Numerator = Counseling for Nutrition	12-17 years	61	3,697	1.6%	11.5%	52	2,245	2.3%	No	Please see Note.10
	OBS.5	Percentage of members whose BMI calculation is documented, and counseling for nutrition and physical activity is provided during the measurement year. Care managers will perform this activity, and it must be documented in the member's care plan. -Numerator = Counseling for Physical Activity	3-11 years	9	4,519	0.2%	10.2%	37	2,676	1.4%	No	Please see Note.10

Program Year 1 Non-P4P Clinical Rate Observations (June 2014 - May 2015)

Condition	Measure Number	Measure Description (Use numerator description)	Age Group	Milliman Baseline Rate (June 1, 2013 - May 31, 2014)				APH Remeasurement (June 1, 2014 - May 31, 2015)			PER CONTRACT Performance Target Met? (Y/N) Millman BL vs APH PY1	Notes:
				Numerator	Denominator	Baseline Rate (Percent)	Performance Target (Year 1)	Numerator	Denominator	PY1 Rate (Percent)		
	OBS.6	Percentage of members whose BMI calculation is documented, and counseling for nutrition and physical activity is provided during the measurement year. Care managers will perform this activity, and it must be documented in the member's care plan. -Numerator = Counseling for Physical Activity	12-17 years	11	3,697	0.3%	10.3%	28	2,245	1.2%	No	Please see Note.10
Preventative	CAP.1	Percentage of members 12 months-19 years of age who had a visit with a Primary Care Practitioner (PCP). The organization reports four separate percentages for each product line.	12-24 months	118	134	88.1%	89.3%	61	65	93.8%	Yes	N/A
	CAP.2	Percentage of members 12 months-19 years of age who had a visit with a Primary Care Practitioner (PCP). The organization reports four separate percentages for each product line.	25 months-6 years	1,220	1,541	79.2%	81.3%	1,391	1,586	87.7%	Yes	N/A
	CAP.3	Percentage of members 12 months-19 years of age who had a visit with a Primary Care Practitioner (PCP). The organization reports four separate percentages for each product line.	7-11 years	1,934	2,293	84.3%	85.9%	1,950	2,101	92.8%	Yes	N/A
	CAP.4	Percentage of members 12 months-19 years of age who had a visit with a Primary Care Practitioner (PCP). The organization reports four separate percentages for each product line.	12-19 years	2,876	3,471	82.9%	84.6%	3,045	3,313	91.9%	Yes	N/A
	W15.1	Percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life: No well-child visits **(Lower rates are better.)**	Turned 15 months old during the measure-ment year	69	197	35.0%	31.5%	3	57	5.3%	Yes	Please see Note.16
	W15.2	Percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life: One well-child visit	Turned 15 months old during the measure-ment year	51	197	25.9%	33.3%	3	57	8.8%	No	Please see Note.16
	W15.3	Percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life: Two well-child visits	Turned 15 months old during the measure-ment year	31	197	15.7%	24.2%	5	57	8.8%	No	Please see Note.16

Program Year 1 Non-P4P Clinical Rate Observations (June 2014 - May 2015)

Condition	Measure Number	Measure Description (Use numerator description)	Age Group	Milliman Baseline Rate (June 1, 2013 - May 31, 2014)				APH Remeasurement (June 1, 2014 - May 31, 2015)			PER CONTRACT Performance Target Met? (Y/N) Millman BL vs APH PY1	Notes:
				Numerator	Denominator	Baseline Rate (Percent)	Performance Target (Year 1)	Numerator	Denominator	PY1 Rate (Percent)		
	W15.4	Percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life: Three well-child visits	Turned 15 months old during the measure-ment year	15	197	7.6%	16.9%	5	57	22.8%	Yes	Please see Note.16
	W15.5	Percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life: Four well-child visits	Turned 15 months old during the measure-ment year	19	197	9.6%	18.7%	13	57	10.5%	No	Please see Note.16
	W15.6	Percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life: Five well-child visits	Turned 15 months old during the measure-ment year	6	197	3.0%	12.7%	6	57	38.6%	Yes	Please see Note.16
	W15.7	Percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life: Six well-child visits	Turned 15 months old during the measure-ment year	6	197	3.0%	12.7%	22	57	38.6%	Yes	Please see Note.16
	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	537	1,360	39.5%	45.5%	469	912	51.4%	Yes	Please see Note.14
	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	1,289	5,300	24.3%	31.9%	1,155	3,543	32.6%	Yes	Please see Note.15
	CIS.1	Percentage of children 2 years of age who had four DTaP vaccines by their second birthday.	2 years	92	171	53.8%	58.4%	53	109	48.6%	No	Please see Note.11
	CIS.2	Percentage of children 2 years of age who had three IPV vaccines by their second birthday.	2 years	48	171	28.1%	35.3%	68	109	62.4%	Yes	Please see Note.11
	CIS.3	Percentage of children 2 years of age who had one MMR vaccine by their second birthday.	2 years	122	171	71.3%	74.2%	71	109	65.1%	No	Please see Note.11
	CIS.4	Percentage of children 2 years of age who had three HiB vaccines by their second birthday.	2 years	120	171	70.2%	73.2%	69	109	63.3%	No	Please see Note.11
	CIS.5	Percentage of children 2 years of age who had three HepB vaccines by their second birthday.	2 years	120	171	70.2%	73.2%	73	109	67.0%	No	Please see Note.11

Program Year 1 Non-P4P Clinical Rate Observations (June 2014 - May 2015)

Condition	Measure Number	Measure Description (Use numerator description)	Age Group	Milliman Baseline Rate (June 1, 2013 - May 31, 2014)				APH Remeasurement (June 1, 2014 - May 31, 2015)			PER CONTRACT Performance Target Met? (Y/N) Millman BL vs APH PY1	Notes:
				Numerator	Denominator	Baseline Rate (Percent)	Performance Target (Year 1)	Numerator	Denominator	PY1 Rate (Percent)		
	CIS.6	Percentage of children 2 years of age who had one VZV (varicella) vaccine by their second birthday.	2 years	123	171	71.9%	74.7%	72	109	66.1%	No	Please see Note.11
	CIS.7	Percentage of children 2 years of age who had four PCV vaccines by their second birthday.	2 years	103	171	60.2%	64.2%	54	109	49.5%	No	Please see Note.11
	CIS.8	Percentage of children 2 years of age who had one HepA vaccine by their second birthday.	2 years	123	171	71.9%	74.7%	74	109	67.9%	No	Please see Note.11
	CIS.9	Percentage of children 2 years of age who had two or three RV vaccines by their second birthday.	2 years	65	171	38.0%	44.2%	68	109	62.4%	Yes	Please see Note.11
	CIS.10	Percentage of children 2 years of age who had two flu vaccines by their second birthday.	2 years	72	171	42.1%	47.9%	32	109	29.4%	No	Please see Note.11
	CIS.11	Percentage of children 2 years of age who had Combination #2 vaccines by their second birthday.	2 years	35	171	20.5%	28.4%	47	109	43.1%	Yes	N/A
	CIS.12	Percentage of children 2 years of age who had Combination #3 vaccines by their second birthday.	2 years	35	171	20.5%	28.4%	43	109	39.4%	Yes	N/A
	CIS.13	Percentage of children 2 years of age who had Combination #4 vaccines by their second birthday.	2 years	35	171	20.5%	28.4%	43	109	39.4%	Yes	N/A
	CIS.14	Percentage of children 2 years of age who had Combination #5 vaccines by their second birthday.	2 years	18	171	10.5%	19.5%	42	109	38.5%	Yes	N/A
	CIS.15	Percentage of children 2 years of age who had Combination #6 vaccines by their second birthday.	2 years	25	171	14.6%	23.2%	18	109	16.5%	No	N/A
	CIS.16	Percentage of children 2 years of age who had Combination #7 vaccines by their second birthday.	2 years	18	171	10.5%	19.5%	42	109	38.5%	Yes	N/A
	CIS.17	Percentage of children 2 years of age who had Combination #8 vaccines by their second birthday.	2 years	25	171	14.6%	23.2%	18	109	16.5%	No	N/A
	CIS.18	Percentage of children 2 years of age who had Combination #9 vaccines by their second birthday.	2 years	10	171	5.8%	15.3%	17	109	15.6%	Yes	N/A
	CIS.19	Percentage of children 2 years of age who had Combination #10 vaccines by their second birthday.	2 years	10	171	5.8%	15.3%	17	109	15.6%	Yes	N/A
Pregnancy	PPC.1	Percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. Timeliness of Prenatal Care	No restrictions	162	880	18.4%	26.6%	58	223	26.0%	No	Please see Note.17
	PPC.2	Percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. Postpartum Care.	No restrictions	50	880	5.7%	15.1%	31	223	13.9%	No	Please see Note.17

Program Year 1 Non-P4P Clinical Rate Observations (June 2014 - May 2015)

Condition	Measure Number	Measure Description (Use numerator description)	Age Group	Milliman Baseline Rate (June 1, 2013 - May 31, 2014)				APH Remeasurement (June 1, 2014 - May 31, 2015)			PER CONTRACT Performance Target Met? (Y/N) Millman BL vs APH PY1	Notes:
				Numerator	Denominator	Baseline Rate (Percent)	Performance Target (Year 1)	Numerator	Denominator	PY1 Rate (Percent)		
	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	328	880	37.3%	33.5%	146	223	65.5%	No	Please see Note.18
	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	102	880	11.6%	20.4%	51	223	22.9%	Yes	Please see Note.18
	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	39	880	4.4%	14.0%	13	223	5.8%	No	Please see Note.18
	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	24	880	2.7%	12.5%	7	223	3.1%	No	Please see Note.18
	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	387	880	44.0%	49.6%	6	223	2.7%	No	Please see Note.18
Preventative	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	Milliman did not provide a BL rate due to "data deficiencies"				799	6,838	11.7%	NR	Please see Note.13
	BCS	Percentage of women 40-69 years of age who had a mammogram to screen for breast cancer.	42-69 years	1,617	4,442	36.4%	42.8%	1,405	3,264	43.0%	Yes	N/A
	CCS	Percentage of women 21-64 years of age who received one or more Pap tests to screen cervical cancer.	22-64 years	2,587	8,492	30.5%	37.4%	2,272	6,221	36.5%	No	N/A
	COL	The percentage of members 50-75 years of age who had appropriate screening for colorectal cancer.	51-75 years	955	5,020	19.0%	27.1%	1,093	4,398	24.9%	No	N/A

Program Year 1 Non-P4P Clinical Rate Observations (June 2014 - May 2015)

Condition	Measure Number	Measure Description (Use numerator description)	Age Group	Milliman Baseline Rate (June 1, 2013 - May 31, 2014)				APH Remeasurement (June 1, 2014 - May 31, 2015)			PER CONTRACT Performance Target Met? (Y/N) Millman BL vs APH PY1	Notes:
				Numerator	Denominator	Baseline Rate (Percent)	Performance Target (Year 1)	Numerator	Denominator	PY1 Rate (Percent)		
Pregnancy	WOP.1	Percentage of women who delivered a live birth during the measurement year by the weeks of pregnancy at the time of their enrollment in the organization. 1-12 weeks (279-196 days prior to delivery)	No restrictions	555	1,028	54.0%	Not a performance measure. These rates are deemed descriptive statistical measures. As such there are no performance target rates.	25	323	7.7%	Not a performance measure. These rates are deemed descriptive statistical measures. As such there are no performance target rates.	N/A
	WOP.2	Percentage of women who delivered a live birth during the measurement year by the weeks of pregnancy at the time of their enrollment in the organization. 13-27 weeks (195-91 days prior to delivery)	No restrictions	146	1,028	14.2%		58	323	18.0%		N/A
	WOP.3	Percentage of women who delivered a live birth during the measurement year by the weeks of pregnancy at the time of their enrollment in the organization. 28 or more weeks of pregnancy (<=90 days prior to delivery)	No restrictions	172	1,028	16.7%		74	323	22.9%		N/A
	WOP.4	Percentage of women who delivered a live birth during the measurement year by the weeks of pregnancy at the time of their enrollment in the organization. <=0 weeks (280 days or more prior to delivery)	No restrictions	155	1,028	15.1%		154	323	47.7%		N/A
	WOP.5	Percentage of women who delivered a live birth during the measurement year by the weeks of pregnancy at the time of their enrollment in the organization. Unknown	No restrictions	-	1,028	0.0%		12	323	3.7%		N/A

Nevada Comprehensive Care Waiver Program
Health Care Guidance Program
PY1 Final Program Performance Results
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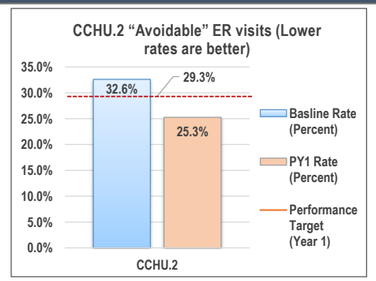
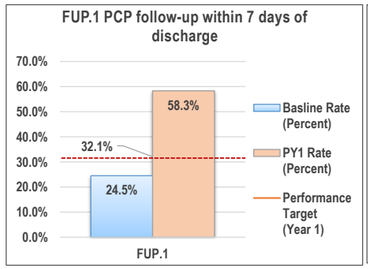
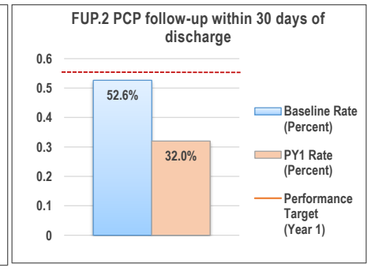
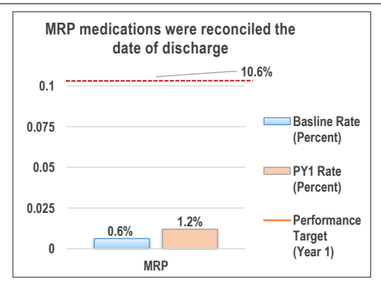
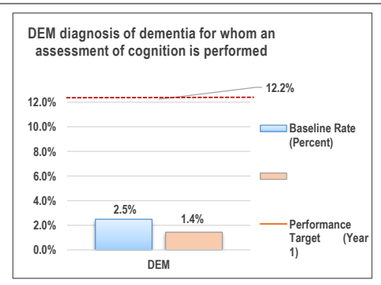
Program Year 1 Non-P4P Clinical Rate Observations (June 2014 - May 2015)

Condition	Notes	General Observations	Analysis	Illustrations	Program Action Plan
Chronic Condition/ High Utilizer	Note.1	CCHU IP Admissions and Avoidable ER rates reflect significant improvement over baseline rates	Improvement can be attributed to implementation of annual ED Reduction campaign via IVR and mailings -and- Readmission Reduction Assessment which focuses on resource and access constraints to ensuring proper post admission/visit follow-up.		- Increased emphasis on obtaining hospital ADT/census information to expedite CMO intervention post-discharge. To this end, requested letter of authority from DHCFP to encourage the timely sharing of member-admission/visit data. - Implemented Readmission Reduction Assessment to drive necessary member behavioral, access and follow-up improvements. - Leveraging the Serious Occurrence and Real-time-referral processes to improve reach-rate with members being seen in the ED and being admitted into facilities across NV. - GuidePoint (a.k.a. Nurse Advice Line) through additional mailings, door hangers, and IVR - Improved member outreach strategy which prioritized member locate activities according to targeted condition, risk, and cost factors.
	Note.2	Post-discharge PCP visit rates within 30 days was achieved with the 7 day measure only 0.1% below target.	The 7-day window for FUP.1 requires prompt receipt of notification that our members are being admitted or in the ED. Need to make any reasonable effort to obtain census data from facilities across NV. Need to identify all potential levers available to us for notification as close to 'real-time' as possible.	 	
	Note.3	MRP Med Reconciliation PY1 performance result was double that or 100% of the baseline rate.	The claims coding used for medication reconciliation is a CPT 2 code which is not used in the state of Nevada. This limits our understanding of true measure/rate performance.		
Dementia	Note.4	PY1 rate for DEM improved slightly as compared to baseline.	DEM source code was updated in 2015 following the PMV Audit to ensure optimal capture of applicable claims. Both the baseline and PY1 rates reflect the inherent challenges. Impactability is limited as this measure captures the assessment and coding practices of PCP's which is not within the CMO's realm of influence.		Understanding the complexities around the assessment and coding practices of PCP's across Nevada APH/HCGP implemented a screening tool (assessment) to the Care Manager workflow for members identified with condition Dementia. This workflow includes collection of additional cognitive inputs to consider for manual adjustments to risk level, as well as, Gaps in Care identified for follow-on coaching with DEM members. Measure DEM will be reviewed further following the 2016 PMV Audit of all Non-P4P measures. This measure numerator is difficult for APH to impact. Options for next steps: 1) Get providers to start coding for the assessments so they appear in claims, 2) Leverage the Cognitive Assessment APH implemented last year in response to the 2015 PMV Audit, or 3) Tie the numerator to the number of members with DEM which are actively managed versus total DEM population enrolled. If updates are necessary, those will likely not be made prior to October 21, 2016.
Neurological	Note.5	Rates reflect the inherent challenge associated with the specifications for this numerator.	NEUR: this rate is determined by claims submitted for anti-thrombotic therapy (blood thinners.) The most common blood thinner for stroke therapy is aspirin, an over-the-counter (OTC) medicine. As OTC's are not commonly captured in claims, the annual performance rates for this measure will be understated.		As this measure is a reflection of inpatient care, impactability is difficult due to lack of direct influence over hospital providers

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Condition	Notes	General Observations	Analysis	Illustrations	Program Action Plan
Renal	Note.6	Inadequate specification for this measure.	CKD is currently under review following the HSAG PMV Audit of all Non-P4P measures Sept-16. APH and Milliman code is written to specifications. However, numerator for this measure is not capturing the lab claims for fasting lipids testing as intended. Codes that are recommended for consideration; 80061, 83700, 83704, and 83721 are not presently included in the measure specifications. HSAG and DHCFP will discuss then APH and Milliman will make those revisions prior to October 21, 2016.		HCGP had a dedicated Complex Case Manager assigned to oversee care management protocols for our CKD members including; member assignment, risk level escalation, Gaps in Care and Cost Savings prioritization. APH/HCGP is confident that once the measure source code is updated to include the appropriate claims codes our performance rates for PY1 will reflect the focused effort being made with our CKD enrollment population.
Musculo-skeletal	Note.7	RA PY1 target rate was met.			Continued improvement becomes more challenging. Impacting medication prescribing practices is more likely in the outpatient setting.
	Note.8	OST PY1 rates reflects a decrease as compared to baseline. There is no logical clinical explanation for this decrease. Need to consider baseline source code issues.	Claims tied to Osteoporosis therapy should reflect the same outcome as the RA measure. However, there is a dramatic decrease in the claims for these medications. There is no clinical reason why this should occur as the recommendations for osteoporosis medications has remained firm. The numerator discrepancy between the baseline (Milliman) data and the PY1 (APH) data is a clear cause for concern. While the APH source code has been validated on two separate occasions by HSAG the explanation for this discrepancy is likely to be another external issue. Perhaps a mistranslation of the HEDIS or Attachment JJ specifications within the Milliman source code.		
Obesity	Note.9	Milliman has the action to update the baseline OBS BMI rates with the changes made during the 2016 PMV audit.	OBS comparison analysis will be completed upon receipt of the baseline rates. The rates for PY1 are noticeably low. Ideally they would be close to 20-30% given the rate of obesity in American children. This is an indicator that it is difficult to impact as it requires the care manager reminding the parent to remind the PCP to counsel the child for being overweight and then code for it. That is somewhat less likely than reminding them to go to the doctor or to get a refill of a life saving medicine.		
	Note.10	Milliman has the action to provide the rates for OBS "Counseling for Nutrition" and "Counseling for Physical Activity"	Comparison analysis will be completed upon receipt of the baseline rates.		
Preventative	Note.11	CIS.1-10 rates met the majority of PY1 targets. One immunization (Hep A) did not meet the goal despite improvement. Given the small sample size, APH would submit that this is likely not statistically significant.	The denominator discrepancy between the baseline (Milliman) data and the PY1 (APH) data is an clear cause for concern. While the APH source code has been validated on two separate occasions by HSAG the explanation for this discrepancy is likely to be another external issue. Perhaps a mistranslation of the HEDIS or Attachment JJ specifications within the Milliman source code.		APH/HCGP works diligently to encourage immunizations through improved coaching workflows and community outreach across the state of Nevada. The program also conducts an annual Influenza immunization IVR campaign reminding members to get their flu shots each fall.
	Note.13	Milliman needs to provide the ABA rate.	Milliman reported insufficient data for this measure. APH ran this rate given the information provided during the 2016 PMV Audit. The assumption being that the updates to the SAS code for this measure was not shared with Milliman. In any event, the PY1 results appear to be inline with expectations from a percentage perspective.		

Nevada Comprehensive Care Waiver Program
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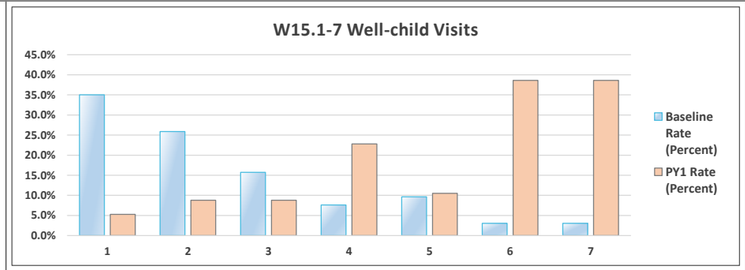
Program Year 1 Non-P4P Clinical Rate Observations (June 2014 - May 2015)					
Condition	**Notes**	**General Observations**	**Analysis**	**Illustrations**	**Program Action Plan**
	Note.14	W34—PY1 data shows reasonable improvement.			
	Note.15	AWC—PY1 data shows significant and reasonable improvement.			HCGP places particular emphasis on care planning for families through dedication of critical resources, support of community events/outreach and locate efforts.
	Note.16	W15 measures; clear improvement across the measurement can be seen.	A consolidated bar graph illustrates improvement with this important measure. HCGP is proud that this measure demonstrates clear success toward a central goal.		
Pregnancy	**Note.17**	The PPC measures show significant improvement (est. 30% and almost 200%) but failed to meet/exceed the rate targets.	The denominator discrepancy between the baseline (Milliman) data and the PY1 (APH) data is a clear cause for concern. While the APH source code has been validated on two separate occasions by HSAG the explanation for this discrepancy is likely to be another external issue. Perhaps a mistranslation of the HEDIS or Attachment JJ specifications within the Milliman source code.		
	Note.18	The FPC measures show a significant worsening of baseline rates across all measures. There is no logical clinical explanation for this decrease.	The denominator discrepancy between the baseline (Milliman) data and the PY1 (APH) data is a clear cause for concern. While the APH source code has been validated on two separate occasions by HSAG the explanation for this discrepancy is likely to be another external issue. Perhaps a mistranslation of the HEDIS or Attachment JJ specifications within the Milliman source code.		

Health Care Guidance Program
Coordinating with you for better care!

HCGP Quarterly Meeting October 21, 2016
Location: Legislative Counsel Bureau (LCB)
301 S. Stewart St. Room 1214
Carson City, Nevada 89701
Phone Number: 877-336-1829 Access Code: 8793897

9:00 am – 9:20 am

I. Welcome and Introduction — **Gloria Macdonald, Chief / Gladys Cook SSPS 3**

Approval of Minutes

9:20 am – 9:45 am

II. Program Updates

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

AxisPoint Health Updates — **Dr. Ron Geraty, CEO, AxisPoint Health, Dr. Tim Moore, CMO, APH**

9:45 am – 10:00 am BREAK

10:00 am – 11:30 am

III. Quality

Program Dashboard with Detailed Data Points: Staffing, GuidePoint, ELIZA Overview — **Michelle Searing, Outcomes Operation Manager, APH**

Member and Provider Satisfaction Survey Results – PY2

Lessons Learned – PY1

11:30 am – 11:45 am

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

Hospitals and ADT's Update

V. Key Accomplishments — **Cheri Glockner, HCGP Executive Director, APH**

11:45 am – 12:00 pm

VI. New Business — **Gloria Macdonald, Chief / Gladys Cook, SSPS 3**

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

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

Health Care Guidance Program Meeting Minutes, Face to Face 07/26/2016				Date:
DHCFP Attendees: Gloria Macdonald, Gladys Cook, Rachel Marchetti, John Kucera, Linda Bowman, Lisa Koehler, Raul Martinez, Betsy Aiello, Linda Bowman, Charmaine Yeates, Marta Jenson				
Organization Attendees: HCGP: Margaret Flaum, Patricia Regan, Cheri Glockner, Dr. Thomas McCrorey, Dr. Tim Moore, Summer Smith, Michelle Searing, Brian Baker, Erin Snell, Dr. Ryan Ley, Stephanie White, Lorna Lizotte, Kris Schadegg, Janine Hansen, Shawn Donnelly **HSAG:** Gretchen Thompson				
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** • The minutes were approved.			
Program Updates	**Program Updates** **CHERI GLOCKNER** • Welcomed Janine Hansen, newly promoted to APH supervisor and Kris Shadegg, Beacon care manager. • Called to attention a few things that they have been spending time on as a program. The first being a project beginning in April; assigned via Jennifer Frischman on behalf of Director Whitley, to help find vulnerable people in program, due to a robust investigation regarding group home situations. Dr. McCrorey will give a detailed update. This project is pretty much finalized. • Looked at compact plan for the program and the enrollment based on geographic demographic of members. Worked with corporate leadership, including Dr. Moore, Mary Jane Konstantine, Margaret, and Dr. Geraty. We looked at how we can really support the members of program given the geographic disruption and the number we have. Did get approval to add ten positions to staff. Have been working on adding those positions since the beginning of May. • Also have continued to work with HP, Milliman, and John to calibrate the data sets in order to finalize the year one results, because of the 12 + 12 run out, it has been a large process, are coming up on it. It will be complete before we meet for the next quarterly. • Very intent on helping members transition from Logisticare to MTM. Have had several trainings for staff. Care managers have become very intent in learning the process, because Logisticare has become such a key component in our tool box			

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Topic	**Discussion**	**Recommendation/Action Plan**	**Responsible**	**Due Date**
	for our members. So very pleased to work closely with MTM with transition, first few weeks went very well, the last week had some things to work through and will continue to work through them. • Worked with Rachel and Gladys to update and come to an agreement on the serious occurrence process with DHCFP offices around the state. Serious occurrence within the DHCFP is different than what we consider a serious occurrence. Different process of information about our members that comes through the DHCFP offices in Las Vegas, California, Reno and trying to work to make sure Rachel has all the information she needs in order to report to CMS. Dr. McCrorey and I sat down with Rachel; Dr. McCrorey is continuing to work with team, as well as Janine and Pat on this. • Still continuing to work on community Paramedicine. Has been a really exciting, fun thing to do because these EMS providers around the state are so on it, they are excited about this initiative and we're looking forward to working with them. We are going out to Winnemucca (Gladys has accepted to go with). Will work with Jared Oscarson in Winnemucca on August 10th for a meeting. The other person within the State that we've been really pleased to work with is Dave Fogerson from Minden, he's been great with us. • That's where our focus has been the last couple months. If there are no questions I will turn it over to Dr. Moore. **DR. MOORE** • Update on where I felt we were in the reconciliation process. On both sides of our teams, I know that Shawn on our team and John on yours has been working a lot with Milliman on this process. One of our challenges a month ago was the fact that as we were looking at the data there was only a 75% match between the reconciliation group of members the operational group of members. Were able to work with Milliman to close that gap and now have a 99.9% alignment between the reconciliation and operations groups and we feel pretty good			

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Topic	Discussion	Recommendation/Action Plan	Responsible	Due Date
	about that. • The next issue we saw was a huge difference in prescription or drug claims that we had with Milliman. We found that there was some reversal logic in the claims processing that we had incorporated that really worked to clean up the differences with that we have about 99.9% match so we feel really comfortable with that. • Recently agreed to use the most recent version of the CDPS, which is a scoring system for risk adjustment for the members they change that periodically, and we want to use the most current version so that's in process now to redo the risk scoring with that more recent tool. • This week, we identified that Milliman had been including about 210 of TCM members in the eligibility pool. We notified Milliman that they should be pulled out, because the decision was to pull them out of both pools. Currently waiting for licensing of the new risk adjustment CBS 6.120 waiting on Milliman's feedback on the TCM exclusions. I would anticipate, after talking to Shawn or John that over the next 2-4 weeks, this will be resolved and the numbers will be run. Milliman has scheduled a meeting for September 27th, to present the report and we're all excited to see what it shows. • Any Questions? **JOHN KUCERA** • I'll just mirror what Dr. Moore said, it is an arduous process and it's tough to know what you don't know quite yet, but as we wade through the process and as we get the bigger pieces out of the way we can focus on some of the smaller details. I think we are right on track to get our preliminary piece out here shortly which is just to make sure our methodology lines up. As soon as that's done, we have our 12 + 12 delivery which was completed last week. I believe all the file counts have lined up so we have all the data we need to do the big final program year one evaluation. I think the end of September is a good goal and of course we will adjust and update everyone as			

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Topic	Discussion	Recommendation/Action Plan	Responsible	Due Date
	needed. Right now I would agree with Dr. Moore's timeline. **MICHELLE SEARING** • So we are still planning on going through with our preliminary? **JOHN KUCERA** • We will certainly go through it, if all of our counts and methodologies work out we will test the final rates, in that case I'm more concerned that our rates line up and less concerned with the actual rates themselves considering we just have a subset of our final data. There is a lot of stuff that can happen in the last 6 months especially with our out of state providers or facilities getting claims in that will both positively impact your preventative rates and could negatively impact cost issues so we want the full picture. So we are more concerned with our rates matching up and our methodology lining up for our preliminary piece to make sure we don't run into these hurdles for the final evaluation. We will do a rate run, match up our base line calculation we will match up all the numbers, we will get your agreement that we are close and then we will move forward with the final piece. **CHERI GLOCKNER** • Update on our org chart, it does seem like there have been a lot of moving parts. This is the same format that you have seen in the past. The things that would be necessary to point out today, outcomes operations manager has been a company decision to allow what was the customer program manager to really have a more oversight of the operations team, because it is a much more efficient and has become an effective way to manage our on the ground staff. So that's the biggest change you'll see of what's reporting up through Michelle all the contractual pieces have been added to this chart, as in the past. Had forwarded to everyone the other day, with no questions, are there any questions now? **GLADYS COOK** • I do have a couple questions now. I know you also presented an organizational chart back on January 26th, and you guys did an			

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Topic	Discussion	Recommendation/Action Plan	Responsible	Due Date
	amazing job. What I would like to see with this one, is you provided a key. Could you do that with this one as well? And let me know what all the colors represent, I assume that all the purple/blue indicate the roles that are contractually required, so if you could do that as well. • Also by comparing the two there are a couple pieces that raised some more questions. There are quite a few names of what I would consider key staff, such as the Behavioral Health Pharmacist. Is that still Norm Smith? **CHERI GLOCKNER** • He's no longer with us. **GLADYS COOK** • Ok so those are changes we would like to know, as of when and who is it now? And also same with, in the past Nevada Manager and I know you updated us with that change. **MICHELLE SEARING** • You want the detailed version. **GLADYS COOK** • I want the detailed version, exactly. **RACHEL MARCHETTI** • My question was to Cheri; you had mentioned you had been approved for your new positions back in May, have we made any progress on that? I still see we still have 10 open requisitions and I know that was the approved amount, so I didn't know if we have made progress on that. **CHERI CLOCKNER** • Some of these are also due to other positions, a resignation here or there. As you know we are focused on getting these rural health workers, and that's what we've been posting all over, I'm actually pretty proud of our recruiters and their ways of getting the word out. 10 are what we have now but with community health workers by summer replacement of these positions as well. **BETSY AIELLO** • Have we tried to link you up to public and behavioral health,			

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	they may be aware of community health workers in this state, because they're very active in the certification? It was Monica but Monica left one or two months ago. **MICHELLE SEARING** • We also have just linked up with the Community Health Workers Association of Nevada and they posted the positions on their website and Facebook page over the last few weeks. **CHERI GLOCKNER** • That association has been very active, they send emails with ideas all the time, are really trying to get boots on the ground to find the real way to leverage community health workers. One of our original community health workers Monica has been chosen to be on the board, so we are very proud of her. I have been trying to get her to come present at one of our quarterly meetings. • Did that answer your questions Rachel? **RACHEL MARCHETTI** • It did. Whenever we do modify the organizational chart, before you would present for us, like where your care managers are, whether or not they were full time, part time, could we add that? **CHERI GLOCKNER** • That's the detailed version, yes. We will make sure you get that before the end of the day. **GLORIA MACDONALD** • Some questions and comments: Gretchen I may need to ask you questions as we go, is that ok? So I'm looking at the page organizational charts and update on staffing. So it's a very brief update on staffing, and I've been reviewing and looking at the various quarterly reports, the difference of compliance reviews, a lot of the communications going back and forth and then talking to Gladys and Rachel, I'm wondering if on a quarterly basis if we could have an ongoing update on the members by risk level and then how many case manager per risk level we have. I know there has been a certain format on all the			

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Quality	quarterly reports, I know that is what have been targeted are the various quality modules but what I was hoping to see are the percent of numbers with active cases. This is the kind of thing I want to see. This update on staffing I'm showing a total of 49, but I don't know if the 4 in training are part of active staff or what that means? And it would be helpful to know, what your ratios are? The notes I have is there should be 1 case manager per 75 members in risk category number 4, those are the kinds of things I want to see. The reason is because we keep racing towards this reconciliation calculation in the fall, but we can't evaluate a program based on one major event, we need to have numbers and we need to have representation of all the components that are working toward how that reconciliation is going to come out. So I would like to see this kind of report at every quarterly meeting updating us on the members by risk category and the case manager allocations. **CHERI GLOCKNER** • For clarification are you ok with us repeating all those same modules or in addition to? **GLADYS COOK** • In addition to. **GRETCHEN THOMPSON** • In previous quarterly meetings we have talked about producing that on a quarterly basis, I'm not sure why we moved away from that. I think that it is important to follow the structure that Gloria is presenting right now, to show the number of members in each category, the number of case managers associated with that, so we don't need the total number of staff. So the number of active case managers within those groupings so that we can confirm that you are in compliance with the case management ratios that were proposed in the last proposal. **GLORIA MACDONALD** • The requests Gladys and Rachel are asking on the org chart are to help us understand leadership, to understand technical assistance, the key positions that are providing professional			

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	expertise on the program. That would be my request in this area. **MICHELLE SEARING** • The great news is everything you ask for exists and we update it monthly, the bad news is that it wasn't on the agenda so I didn't bring it. We should bring it. We go over it once a month. Will provide asap. **DR. TIM MOORE** • This will be a standard agenda item at each quarterly. **BETSY AIELLO** • Staffing is what we need to monitor for Ops, but legislature needs actual outcomes that are statistical measures. **CHERI GLOCKNER** • We're excited about that, and to talk about results and all those things. **Quality** **MICHELLE SEARING** • Reviewing the quality plan, Module 4, goals 3 and 4. Goal 3 reviews objective 3.1 and 3.2 which covers reduction of hospital readmissions and reduction of emergency department utilization. If you go to slide 10, we have our first three preliminary rates. Each of these cover reduction of hospital readmission, these three measures are new. They were revised. Compared to the review of these areas this time last year. We have follow up with PCP, the first cover that area within 7 days following discharge and then within 30 days following discharge. These are now revised to work from claims data vs self recorded or chart audits. This will allow us to use the claims information that we receive through our reconciliation data in order to generate these rates. Because they're new we don't have the baseline information from Milliman yet. Basically what has happened in the last 4 weeks, we've received the revised instructions, we've implemented those changes into our SAS code and these are our first attempt to			

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	run those rates using that new source code. So what we have here are program year one results and then program year two, keep in mind program year one has 6 months of run out included in the rate where as program year two has 0 because program year 2 just ended. So this is all using operational data and is more an exercise than process. **GLORIA MACDONALD** • So what do you mean by that, "more of an exercise than the process?" **MICHELLE SEARING** • When the run out isn't meeting the standard, which is that full year than your really just looking at that preliminary information because we don't have all of the data required yet. **BETSY AIELLO** • This is based on HEDIS guidelines, international guidelines on how you pull your data, so year one is actual HEDIS results it sounds like. **MARGARET FLAUM** • With 6 months of run off **GRETCHEN THOMPSON** • These are modified measures, these aren't direct measures. **BETSY AIELLO** • Oh so these aren't actual HEDIS measures? **MICHELLE SEARING** • The actual HEDIS measures needed to be revised because, there was some consummation around how do we collect the information to understand the impact were making post discharge because it wasn't defined by claims before. There was some assumption you would either be using self-entered data or doing a chart audit. • After the PMV audit last year, your team and HSAG went back to the drawing board to figure out what would be a more well-defined approach to making sure these were as accurate as possible.			

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	BETSY AIELLO • Gretchen does that mean we can't benchmark this against our MCO data to see how the healthcare guidance case management matches. **GRETCHEN THOMPSON** • That is correct. The MCO don't collect on this matter. This measure is based on focusing on follow up after hospitalization, after anyone is discharged from a healthcare inpatient facility, follow up with PCP. We had to do that because the original measures were the transition of care measure and were looking at the discharge records being sent to the PCP. At this point we had difficulty with this information coming through and it wasn't coming through on claims. So HSAG worked with John, Gladys and Rachel and modified the measures to one that could be collected by access point through claims. It could be expenditure managed care program because it is based on claims but it's not currently. **BETSY AIELLO** • One of our long term goals was to be able to help determine delivery models in the state and have things that would be comparable between the programs so if we move away from that we may need to see what there is within the measures because that was one of the original goals, was what is a better delivery model. **GRETCHEN THOMPSON** • We do have some measures still that are comparable. **GLORIA MACDONALD** • So I have some questions about the presentation. Looking at the table I understand that we don't have a baseline yet, but the two columns next to that; program year one preliminary results, program year two, so what I would expect to see there is a period date. What I'm hearing is that in program year one we have a statistic here that must be in and of one by itself that is not comparable to program year two if it's not being calculated			

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	using the same type of data. I think we had this issue last quarter. So these worksheets need to be described better, for instance if I was coming in and was hearing this at a hearing at the legislature. What I'm seeing here is program year one, well what year what does this time frame mean? Also then there's no information on that column that states what specific data is included. For instance looking at the Measure for the FUP (Follow up with PCP after hospitalization) it says the denominator is the eligible population, this leads to more questions: Is this the eligible population for all of fee- for -service? **JOHN KUCERA** • The way the specifications for these HEDIS measures that HSAG put together for us define in really intimate detail the numerator and the denominator population. It says eligible population and then it goes down to define eligible population, using CPT and HTPC codes so it actually looks at anybody who had through claims data one of those hospital facility codes that would indicate a stay that helps define our numerator via the eligible population piece. **BETSY AIELLO** • Right, in that first year they had 3,014 in their case load that were discharged from the hospital with one of those billing codes. **JOHN KUCERA** • It's not on a per person basis its epitomic to if one person had two separate discharges we would be looking at each one of those discharges, and to see if that person had a PCP follow-up within the first 7 or 30 days of that facility stay. **GLORIA MACDONALD** • Probably because these two years are not comparable there's no column talking about percent change, how has this improved or not improved. What this tells us is... **BETSY AIELLO** • There isn't enough time to have the finalized data. But			

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	preliminarily you would say the first one dropped. But because the first year had a longer run out more claims would have come through and would be showing more PCP visits. It takes a longer period of time. Do we know when the TBD or know when Millimans getting the baseline in? **JOHN KUCERA** • As we've been prioritizing Milimans effort on this part, their first priority has been figuring out the underlying data match, because that's the piece we need first to figure out for the preliminary analysis. After that when we figure out all the matches and all our accounts match up, all the methodology is the same. At that point Milliman will recalculate the baseline because we will actually need it to compare our final evaluation to. **BETSY AIELLO** • And by the time we get the final evaluation, I heard you guys are working on a lot of the data, then year one will be final and not preliminary. **MICHELLE SEARING** • And then we will have a target, so the last time we met, we did away with the delta column and replaced it with a target column, I can have both. **GRETCHEN THOMPSON** • I think we need to be wary of saying things are an exercise of cost only simply because the ongoing quality improvement as a state and body is a philosophy for continuous quality improvement, is monitoring just that. Monitoring continuous quality improvement and continues practice improvement. This is something we would expect the vendor is already doing that on an ongoing basis. • My question about program year preliminary results, would you take a look at the data after 180 days of run out, you know the 6 month/9 month run out, to see if there was any variations between that time period and the full year run out. Then to the measured amenity the change, the variance between the two. If			

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	you had, the change was very insignificant. The change was maybe a .01 , perhaps with the program year 2 preliminary results you can have a little more confidence in those after much less run out than a full year. **GLORIA MACDONALD** • This goes back to describing what we're looking at "note the variants in the populations in each measure, ok, so tell me about the significance of that and is that related to what we're talking about. **BETSY AIELLO** • I think this is exciting, it's the first time we I've seen any numbers, so I'm happy about that. Gretchen I have a question, "The quality goals says reduce hospital measures by 10%, I don't know if that's every year".. **GRETCHEN THOMPSON** • This follows the same set up as we have with the MCOs; that they achieve a 10% achievement, basically it's reducing the rate to 100% by 10%. Or choosing that type of improvement. **BETSY AIELLO** • So it is annually then? **GRETCHEN THOMPSON** • Yes. What this program has done, the methodology used for a P4P, is that if a 10% improvement is achieved within the first year, the program year one than it must be sustained in program year two. It is not readjusted though however as the rate goes down. It retains the original goal. **GLORIA MACDONALD** • Did you want to make a comment about telling us to note the variances in the population denominators in each measure? **MICHELLE SEARING** • As I understand, we wouldn't necessarily expect a 2 times the difference in the denominators year over year, that or greater than 2 times. So when you look at 3014 for year 1 and 6885 for year 2, to those in the room that was note worthy, that was interesting to say the lease. What we are hoping will happen			

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	when we run the final rates, is that that will come more similar. **DR. THOMAS MCCROREY** • My concern looking at that when I see that there are twice as many admissions in the second year; even if it's real it makes you wonder about comparing the numerators. So if we're looking at a couple percent differences between one numerator and the next but are looking at a 100% difference in the denominator we're talking about two different things. So it makes me wonder if there really is the same population. It's hard to say what a 51% to a 53% when you have a 100% change in admissions. **BETSY AIELLO** • It makes no sense, especially because you went from about 35,000 to 38,000 so you shouldn't of had that huge of difference, because it looks like the people are actually going to the hospital more. **DR THOMAS MCCROREY** • I would be more concerned with the people that were counted. **BETSY AIELLO** • That's kind of what we would expect you to be guiding through your data and looking at. **GLORIA MACDONALD** • If this is the type of report we would present to the legislature, all of these statements and presentations that lend themselves to lots of questions, it would be a good idea to already answer them. Your presenting the data and pointing out the variances, but you need to take the next step in saying here is what we're thinking, this is what this means. **CHERI GLOCKNER** • I fully respect that, I just want to say I think what we are looking at now this isn't going to be like this next year, where we will have final results in program year one. **BETSY AIELLO** • If we get the baseline in program year one for the legislature and program year two isn't final you would only want to use			

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	those two. But even still I'd be nervous about my program year one data based on what you're seeing for program year two. **MARGARET FLAUM** • And a lot of what you do at this time is what we have been doing is reconciling the data, is really figuring out why is it incomplete, why is it not matching with Milliman or HPE, so we are there now we have reconciled it so I think that's going to help tremendously. I hear what you are all saying on an ongoing basis we are looking at data, but now we have actual reconciliation data that is going to be used to measure the program which is always different than that operational data. **SHAWN DONNELLY** • It is my department that runs claims based measures similar to the one that you are looking at and it's one of our specialties. I feel I need to add a little background as to this process and to answer some of the questions that are coming up. Michelle referred to this as an exercise versus official recording and tracking. There is history behind that and other people involved. When we are required to report these measures at the quarterly meeting and we have not reconciled on the official data set, we are forced to use operational data. Which is not the best data source to record for these measures. Results based on our operational data should not be paired with the legislature, results based on our reconciliation data should be the results that are shared. But until we reach that stage for the first time we won't be able to do that. That is our standard process and we have put in place a quarterly delivery schedule for reconciliation data. Where we would be updating these every quarter and we would be able to compare year over year at certain points of time. We haven't reached that first reconciliation yet, and that is way behind or normal schedule and we would have official quarterly results coming our each quarter and we aren't there yet. John could you share your view of what I just said.			

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	JOHN KUCERA • I have a couple comments, first of all we talked about this vigorously beforehand about quantifying the difference between reconciliation and our operational, the reconciliation is three month data dumps that we give you and give Milliman that make sure were working from the same data sets. At a given time the information you get at the end of the quarter through the reconciliation data set should be exactly the same as your prior three operation pieces. So I would like to formally request that you look at those two pieces and let us know for a given point of time is there a significant magnitude of difference between the operational and the reconciliation piece. We talk abstractly about that but I would like to know, my understanding is at a given point of time if you look at the quarterly delivery and you compare previous operational statements they should be exactly the same aside from timing factors. If there is we really need to know that. • Second, we can't just evaluate the program on an annual basis; we have to look at it regularly. I understand there is one final evaluation, it's very important that Milliman's final evaluation has the same methodology as your final evaluation, but that doesn't tie your hands every month or every quarter to use your own method of data to come up with these regular figures. So to add to Gloria's point, operational data does not include 12 months of standard run out on your operational piece, that's absolutely acceptable and that's expected because we can't tell what's going to come in the future we have to use the monthly pieces we have in front of us. That's what you use I'm sure internally and those are the bread crumbs that we need on a regular monthly, quarterly, six week basis, to not be surprised at what's going to come out of the final evaluation. We don't want to be surprised, we want to know what you're seeing and then when we get to the final piece we can reconcile with Milliman we can figure out all the small details in the baseline pieces. Those intermediate pieces are important. **GRETCHEN THOMPSON**			

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	• It's really important that we look at this on an ongoing basis, because if you wait until the end of the year, you wait until you have 12 months of run out, that ship has sailed you do not have the opportunity to go back and apply any kind of intervention or do anything different for the population or make any changes to your denominator. So if you're not looking at this on an ongoing regular basis, real time regardless if the data is extremely accurate or not you have to view something to know where you are at that period, so you can take a look at this and say wow our denominator is fine. That's the point of this ongoing quarterly check, to see where we are with these measures and is there anything we can do to make this improve before the door gets closed before the end of this program year. **GLORIA MACDONALD** • You are looking at data, you're looking at the internal operational data, you're probably looking at all of these measures and that's what you need to be giving to us because we are the internal partners,because at some point we are all going to have to stand up in front of the decisions makers and if were standing up there with one event, that is not going to play. So we want to have the information brought forward even if it's not the official, it's not the baseline, not the reconciled all of those fancy terms the ongoing regular business model operational data that you look at needs to be shared with us so that we don't have some ugly surprises. **MARGARET FLAUM** • And that makes sense, and we do look at data, Michelle looks at it by the hour, daily, monthly I mean we are constantly looking at data. So we are looking at all of that, so why don't we take this back and really look at what operational data on a ongoing basis we are sharing with you. **BETSY AIELLO** • I know that you guys are convinced that you are successful in making a big impact and we wouldn't want to get rid of something that is successful and making big impact but we			

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	have people telling us they don't think that's the case, so we need to show the impact. It has to be in a data format that's solid and convincing. **CHERI GLOCKNER** • I think we need to restructure our joint ops meetings, make sure that you Gloria can make it, to ease your mind that we are absolutely following these things so that you or Betsy are able to articulate it. **GLORIA MACDONALD** • We're willing to do whatever it takes, and I think the format for helping us have some confidence is in the quality modules, NCCW. You have the format and so we need this data presented to us, and I want it all the way back to the beginning. Even if you're saying okay here is where we started, within the first quarter this is what we saw and this is our preliminary assessment of what we saw and then you march forward, and you say the second quarter we have it again, it's operational. But here is what we're seeing operational, it's so important. **CHERI GLOCKNER** • If you look at slide 11, this just provides a little bit of editorial around two key points; which is part of the quality strategy. You're looking at "Okay what has AxisPoint Health done in recent history to affect the rates we just looked and the second question being, what we are going to do in the future? With reduction and hospital readmission it's all about two things are we admission reduction assessment in our program that we actually use every day and then the other piece is leveraging census information, which has been a bit of a challenge for the program. **BETSY AIELLO** • How often do you get Prior Authorization Data dumps? **MICHELLE SEARING** • We get those once a week. **BETSY AIELLO**			

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	• Because that was part of the reason we arranged prior authorization data dumps is we have concurrent authorization in all acute admits. The idea was you could get it from the hospital itself but the prior authorization data dump was to give real time data because claims are a form of data. So if it was once a week if it would help to be twice a week, we can work with the hospitals to get this done. **GLADYS COOK** • Can you walk me through the process, once you receive your Prior Authorization Data, what do you do? You have a report that gives you information that this person has a prior authorization, so what do you do with it? Do you hold onto it until you receive a real time referral or do you hold on to it until a claim actually comes through? How does that work? What do you do with this information? **MICHELLE SEARING** • Prior Auth Data is fed into VITAL; this is a program the care manager's use. It actually generates alerts to them based on events that are created. Discussed with data team about certain types of Prior Auth, which generate alerts to get to the more meaningful activities and working with them to define which ones we want to trigger alerts that go out to the team. • I'm not sure what that looks like to the care managers, when alerts or reminders come across. **JANINE HANSEN** • In our computer system it's the VITAL system, it generates different kind of service or hospital events, those are loaded every Tuesday. We go in open that event, it identifies the patient and the hospital to which they have been admitted so we reach out to that patient, and if they cannot be reached at home we contact the hospital. **RACHEL MARCHETTI** • What about those recipients that don't actually have a care manager because they are at a lower risk level as they have never actually had the claims data to bump them up to a higher			

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	risk level. Now they've had this hospital admit and they find out they have a huge chunk of health problems that have never been diagnosed, and we get the prior authorization, would they still get the alert to the care managers or would they not because they haven't been assessed or assigned one yet? **MICHELLE SEARING** • As I understand it, alerts come out for anybody that has an event; it's not if they're under an active care plan. That's not what determines an alert. There are alerts/reminders that are sent out to a group of people and I would expect that there is a distribution list that would receive alerts of people who don't have a care manager assigned. So then the questions becomes, what that flow process looks like. **MARGARET FLAUM** • And that's how we do it too, so those people that aren't assigned they would get generated and the nurses would then get those. We will get the details of that process. **GLADYS COOK** • I want to know with the RTRs depending on the severity of where the patient is, I want to be assured that you are reviewing the RTR and you are assessing the member right away versus waiting for the three month lapse of claims to come in. Walk me through the process; How does it work, do you wait for the three months of lag with the claims? **MICHELLE SEARING** • I have to get back to you on the work flow of when an alert or PA comes through for someone that is not assigned a care manager. **PATRICIA REGAN** • Often we will see the unassigned members on the SOR list that comes in weekly. The reports come in on Mondays and Tuesdays. I immediately assign a patient to a nurse and let the nurse know, then it gets picked up by a nurse and the process begins. For the behavioral health ones I would assign them to behavioral health supervisor and then she in turn assign them to			

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Topic	**Discussion**	**Recommendation/Action Plan**	**Responsible**	**Due Date**
Provider Outreach	her staff and then they are processed. So nobody goes unassigned unless we don't know about them. • The process is: it goes to the care manager, the care manager then has responsibility of beginning initial contact with the member within 30 days. If the phone contact is unsuccessful after 4 tries a reminder gets sent to a community health worker who then places the recipient on a locate list, and then goes out to find this person. **MICHELLE SEARING** • Slide 12: covers three different rates, the first two are P4P (Pay for Performance Measure) the third CCHU.2 is a non pay for performance, but they all get at the same topic which is reducing emergency department utilization. For these measures, we actually do have the preliminary baseline that was provided by Milliman this time last year; the challenge will be that it was provided this time last year. The reason that is important is because that was prior to any of us having any population discussions, so it's a preliminary set of rates. • From AxisPoint Health perspective it is important to note the differences in the denominator in particular. It's just interesting and we have work to do to make sure that the work we have been doing with Milliman to agree to our approach and our populations follows through with these measures as well. • Slide 13: very similar to slide 11 where you address two questions, one is what have we been doing in recent history to affect those types of measures speaking to emergency department and what do we plan to do. A few bullet points on what we have been doing would include some improvements to our couching scripts, so how our care managers actually coach their members, on addressing gaps in care, gaps in care due to avoiding ER visits. We added additional clinical and care alert types over time, obviously managing your medications appropriately through things like these alerts, coming through to physicians and helping managers keep them compliant. We have seasonal IVRs tied to things like asthma and promotion of			

Topic	Discussion	Recommendation/Action Plan	Responsible	Due Date
	guide point (nurse advice line). We launched with risk level 1, and had a third of our patients outreached to in the months of May and June, through that phone tree. We get about 600 inbound calls to nurse advice line a month, need to check since Eliza. • Eliza is an interactive voice response system. There is a phone tree that it walks through and verifies that who they reach is the actual member. • This final bullet, we have expanded this outreach to the higher risk levels now too. This helps with better demographics and it also makes them aware that the nurse advice line is available to them. I think we have had very positive success early on with this so we are looking at ways to expand. **GRETCHEN THOMPSON** • We had a similar measure with the MCO with performance improvement project, that they were required to produce some of the items that I wanted to toss out there for consideration including: they looked at the number of ER visits over a course of a 90 day period, if a person had a certain number of visits they automatically went into the care management program. If you are the care management program there would be active outreach to them. The other thing they would do is notify the PCP on records to make them aware that this person is a frequent flyer at the ER so that they can offer the outreach program to that member. **MICHELLE SEARING** • Slide 15 - Goal 4 for enrollee satisfaction portion of the program which launches or is executed on each June/July, over the course of this month we have made the updates to the survey that you requested this time last year. Betsy you had requested that we update the survey because it was really focused on the performance of Medicaid versus the focus of the program. We took a couple questions out that were more getting at demographic types of information and replaced them with questions related to the program. That allows us to capture			

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Topic	**Discussion**	**Recommendation/Action Plan**	**Responsible**	**Due Date**
Focus for the next Quarterly	within the context of that survey a couple bullet points on how the program is performing. So that's being rolled out at the end of this month. We would hope that by this next quarterly we will be reporting on results. • In addition you had asked us, "Aren't there some industry standard types of surveys that we can leverage to understand more about program performance from the members perspective?"There are. There are quarterly surveys that we send out for our DM and case management programs for other programs. So we are launching those for this program and will be reporting on those at the same time when we meet in October. **<u>Provider Outreach</u>** **DR. MCCROREY** • Will talk about provider outreach along with other aspects of what we have done. (Slide 17) Provider outreach is always a focus of the program although it's not as important as the first year, anytime any of our staff outreaches to stakeholders in the community, we consider that a provider outreach. In the past three months we have had over 30 of our named provider outreach events. I would like to mention two of the most laborious ones, formal presentations to medical students and residents, third year medical class, care management in Medicaid, Medicare and care management discussion with medical students. We also presented to the medical MP in Las Vegas. • It is important for people to know that community Paramedicine is community based and different at every fire department that we meet with. • Even though these are people who are dedicated to Medicaid fee-for-service their knowledge of what's happening in Medicaid was minimal. It's interesting to me that they didn't know some basics for Nevada. This is the time the state wants to find out everyone's ideas on the issue, and get their			

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Topic	**Discussion**	**Recommendation/Action Plan**	**Responsible**	**Due Date**
	knowledge, the providers, members, communities, it was kind of shocking that they just though it was a done deal. So I took it upon myself to send an email to the provider advisory board to let them know about some of these things. • The provider advisory board is made up of active providers in the medical community throughout the state; all of them seem to have a particular interest in Fee-for-service. It is about half behavioral health and about half primary care. We're probably going to add a specialist to the group. Behavioral health is very important in our program because a very significant number of our members are in the program because of behavioral health. • The population initiative we're going to present because it was a significant amount of work for our behavioral health team. It initially came out because our group homes were not providing proper care or some weren't getting properly inspected. Mr. Whitley decided along with the department of Health and Human services that they were going to do a safety and health check on a very large section of the behavioral health section of Medicaid. APH had a meeting with the health care guidance program behavioral health leadership, which included Brian, Stephanie and Lorna. We had 1849 of our members who would not be easy to find, so we knew this would take some time and effort, so we needed to prioritize. We took as priority schizophrenia patients, bipolar, and intellectual disability. The first 30 days we had 100% of the teams efforts put into finding these members. • The next slide shows the overall search population of 1849, we were able to get an active search for 412 members. The results of that 412; we did find 259 people, 49% were risk level 1. It turned out that there wasn't a whole lot of concerning behavior going on out there. Unfortunately we were unable to locate 157 of those people and we have basically exhausted our efforts to find these people. • I think we need to spend time researching and educating providers, at the same time talk with Medicaid about some of			

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	the data we are receiving. **BETSY AIELLO** • If you just think someone needs education, because our first hope is maybe the dr. thinks it entitles them to some service, but they don't so would it be better to reach out and educate. **DR. RYAN LEY** • I think it's a systematic issue that underscores the difficulty in treating behavioral health and I don't think there are any. I think there are just times where stuff gets messed up. **DR. MCCROREY** • The assumption is that is if there are multiple providers and they don't know what the other providers are doing, then they would get an alert along with the pharmacies notifying them of the other providers through the alert, if they don't change their behaviors we notify them again and then lock into one pharmacy. • And what Dr. Ley is getting at is we have non-scientific practice, that doesn't mean bad practice. If you have someone that is clearly out of line than you can go into all of that stuff. The bigger picture of the fact is we have lots of providers in this country and others; they're doing what the patient wants. This is another aspect of not having enough providers. So when we notify them the providers may realize "Maybe I need to pay attention to other providers." **MICHELLE SEARING** • I think the case alerts are helping, reviewing those cases, educating the providers; just knowing someone is looking makes a difference. Looking at this list and really evaluating it. **RACHEL MARCHETTI** • Under reporting requirements under 3.9 there is a fraud and abuse report, we have a folder I check on a weekly basis to see if anything comes in. So we can take a look at what we need to pass it to provider support. **<u>Focus for the next Quarterly</u>**			

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	MICHELLE SEARING • We're going to continue to hire these ten open positions and focus on these rural areas. • I'm working on finalizing executing the contract manual. It's a little different in every state. **GLADYS COOK** • It is different in that that it depends on what amendment we are doing, for example amendment number 4 contained a piece that CMS needed to approve before going forward. Once that is said and done then it comes back to us and we start that amendment process. • I would like to focus on number 5, we have had a lot of other priorities with the name change and everything so that took us back a lot. So the next amendment I would like to focus on is the referral (?). Our fiscal services, has stated they do not like the term retarded. However, I realize the next amendment we need to go back and evaluate the now, and the presence of the documents how they are now, this would be amendment number 6. • The term of the renewal would go from Nov 2016 to Nov 2018. **MICHELLE SEARING** • We have helped with waivers and with programs, and have had lots of experience working with the state through CMS, so we are happy to help you if you need, with the waiver, which is 5 years. • Time wise, you think we will be ok? **GLADYS COOK** • Yes I think so; we have already started drafting the paper work. I believe a couple weeks for a draft. **MICHELLE SEARING** • Just so you all know Dr Ley and Dr McCrorey are going to attend Governor Sandoval Prescription Drug Summit, which is the end of August. And I do want to thank everyone for coming today.			

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AXISPOINT HEALTH

Health Care Guidance Program
Coordinating with you for better care

Health Care Guidance Program

Cheri Glockner
October 21, 2016

AXISPOINT HEALTH

Health Care Guidance Program
Coordinating with you for better care!

AXISPOINT HEALTH

October 2016 Quarterly Review

AXISPOINT HEALTH

Today's Agenda

9:00 am – 9:20 am

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

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

II. Program Updates

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

AxisPoint Health Update — Dr. Ron Geraty, CEO, APH and Dr. Tim Moore, CMO, APH

10:00 am - 10:15 am BREAK

10:15 am – 11:30 am

III. Quality — Michelle Searing, Outcomes Operation Manager, APH

Program Dashboard

- Enrollment
- Staffing
- Member Contacts
  - Focused IVR Outreach
  - GuidePoint
- Complaints, Compliments, RTR's and SOR's

Module 4: Goal #4 PY2 Member and Provider Satisfaction Survey Results

Program Year 2 Lessons Learned

11:30 am – 11:45 am

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

Hospitals and ADT's update

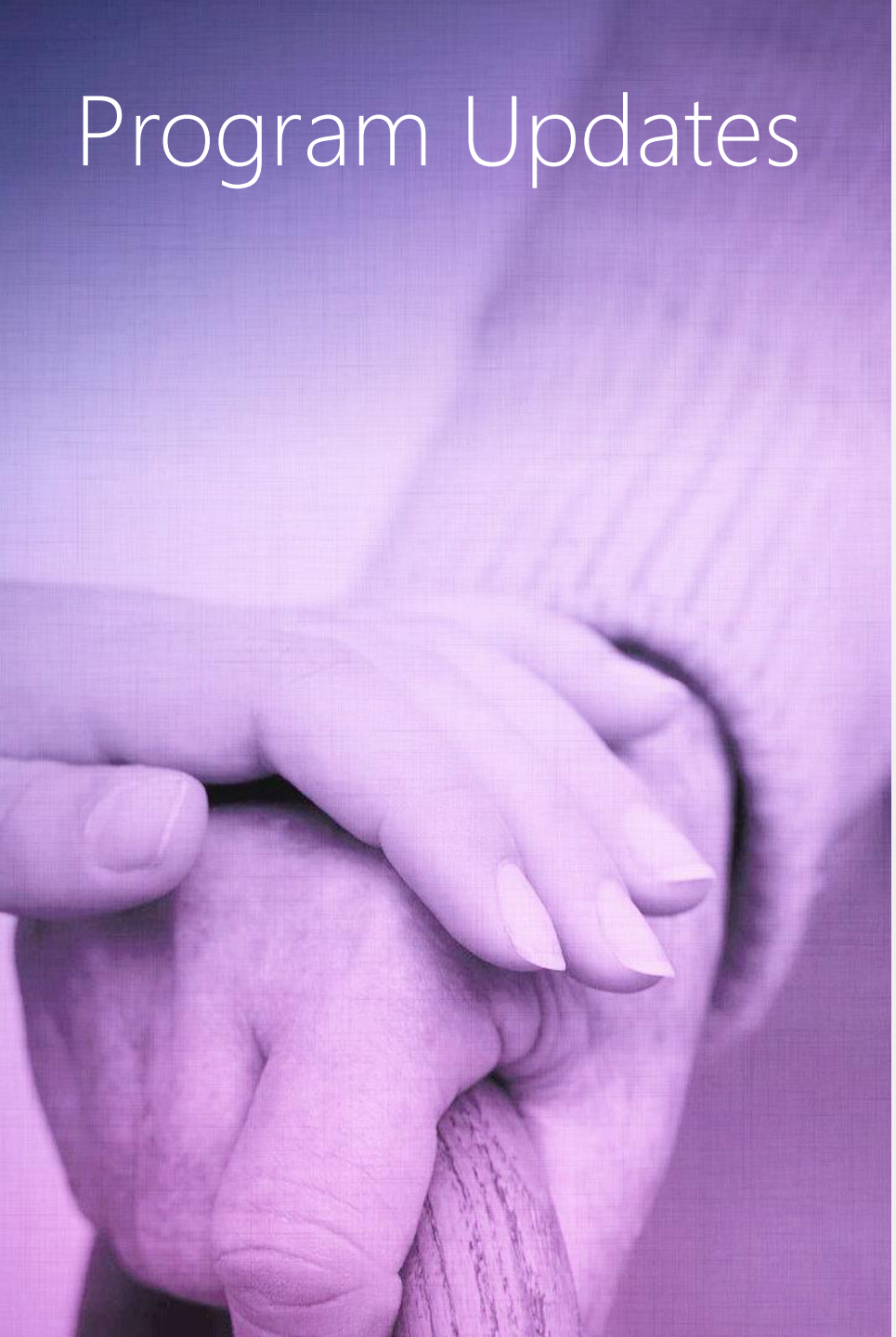
IIV. Focus for Next Quarter — Cheri Glockner, HCGP Executive Director, APH

11:45 am – 12:00 pm

VII. New Business — Gladys Cook, Social Services Specialist II, DHCFP

AXISPOINT HEALTH

Program Updates



Key Accomplishments

- Continuing to hire open positions in urban and rural Nevada
- Continued collaborative effort to calibrate data sets between APH and Milliman to calculate Program Year One results.
- Worked with MTM to highlight areas of improvement for HCGP members. Scheduled trainings for MTM staff to understand unique HCGP needs
- Reviewed draft of Amendment #5 – Program Renewal. Waiting for CMS approval before signature
- Supported the 2016 Performance Measure Validation Audit
- Worked with sister agencies to ensure program awareness
- Worked with HP on Emergency Department Utilization report

AxisPoint Health

AxisPoint Health Business Update

Dr. Ron Geraty, Chief Executive Officer, APH

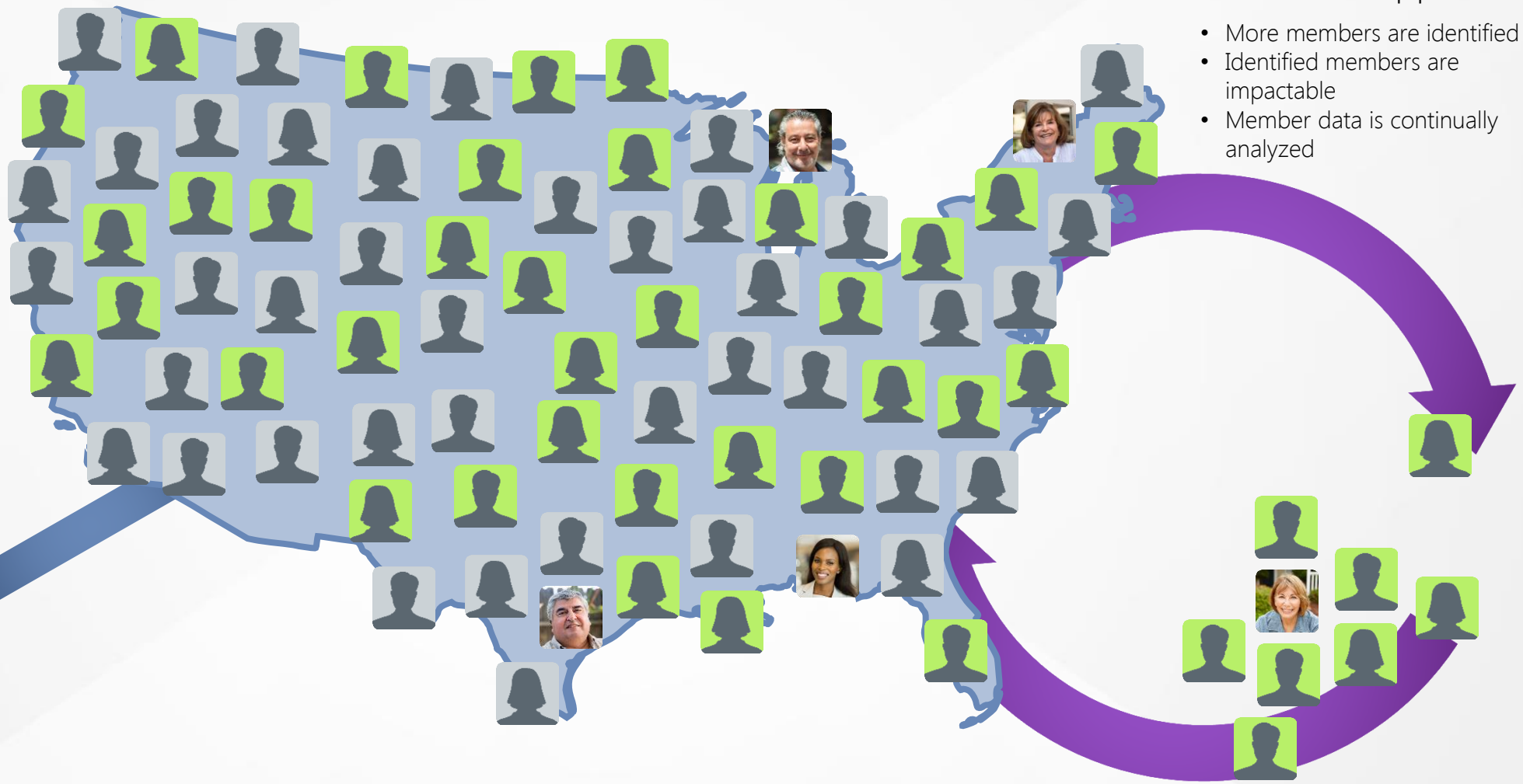
Dr. Tim Moore, Chief Medical Officer, APH

Targeting and Engaging Impactable Members

Impactable

Non-impactable

TOTAL POPULATION



Traditional **Core Five** Approach

Not all identified members are impactable

CarePoint Approach

- More members are identified
- Identified members are impactable
- Member data is continually analyzed

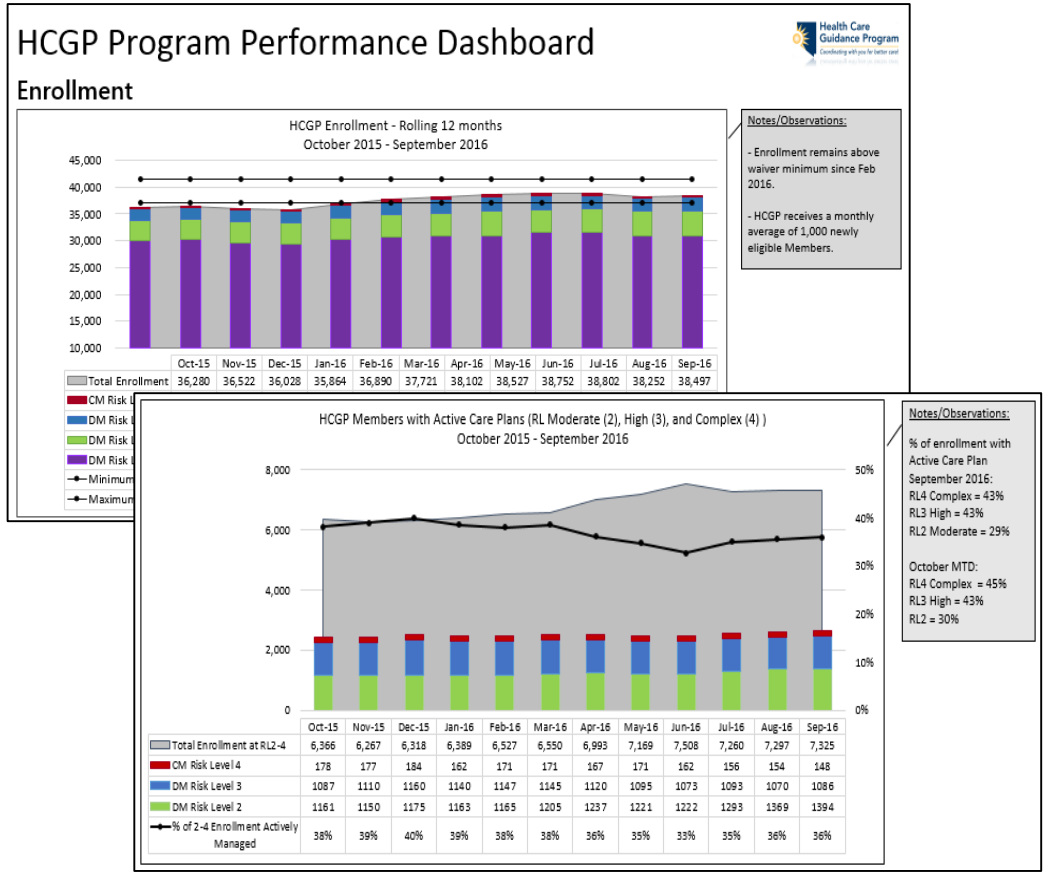
AXISPOINT HEALTH

III. Quality

- Program Dashboard
  - Enrollment
  - Staffing Update
  - Member Contacts
    - Focused IVR Contacts
    - GuidePoint
  - Complaints, Compliments, RTR's and SOR's
- Module 4, Goal 4 Member and Provider Satisfaction Survey
- Program Year 2 Lessons Learned

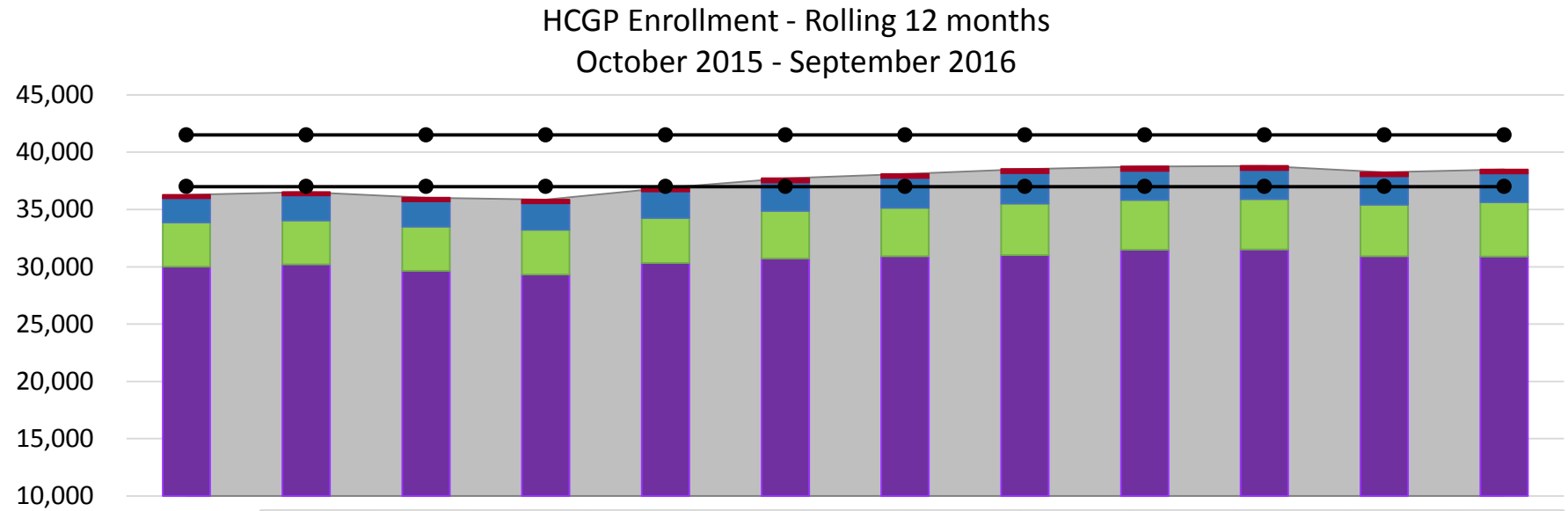
HCGP Program Performance Dashboard

- **Enrollment**
- **Staffing Update**
- **Member Contacts**
  - Care Management Staff
  - Focused IVR Contacts
  - GuidePoint
- **Real-Time-Referrals and Serious Occurrences**
- **Complaints and Compliments**
- **Member and Provider Satisfaction**



HCGP Program Performance Dashboard

Enrollment



	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Total Enrollment	36,280	36,522	36,028	35,864	36,890	37,721	38,102	38,527	38,752	38,802	38,252	38,497
CM Risk Level 4	287	290	303	332	324	350	348	364	380	363	348	346
DM Risk Level 3	2,115	2,194	2,222	2,289	2,299	2,503	2,594	2,645	2,536	2,530	2,474	2,511
DM Risk Level 2	3,865	3,834	3,864	3,906	3,927	4,140	4,227	4,499	4,344	4,404	4,503	4,747
DM Risk Level 1	30,013	30,204	29,639	29,337	30,340	30,728	30,933	31,019	31,492	31,505	30,927	30,893
Minimum	37,000	37,000	37,000	37,000	37,000	37,000	37,000	37,000	37,000	37,000	37,000	37,000
Maximum	41,500	41,500	41,500	41,500	41,500	41,500	41,500	41,500	41,500	41,500	41,500	41,500

Notes/Observations:

- Since Feb 2016, enrollment remains above waiver minimum
- HCGP receives a monthly average of 1,000 newly eligible Members.

HCGP Program Performance Dashboard

Staffing

HCGP Enrollee-to-Active Care Manager Ratio					
Risk Level	# of Enrollees	# Active Care Managers	Contract Ratio	Actual Ratio	Note:
Complex (Risk Level 4)	346	5	1:75	1:69	There are currently a total of 27 Care Managers approved. Of those 27 approved, 23 are active. Status of the four open positions: x2 DM RN requisitions open/being recruited. x2 DM RN's positions offered and accepted. They will begin training November 28th.
High (Risk Level 3)	2,511	18	1:215 (Blended)	1:403	
Moderate (Risk Level 2)	4,747				
Low (Risk Level 1)	30,893	A Case Manager is assigned when a member is escalated to a higher risk level			

HCGP Program Performance Dashboard

Staffing

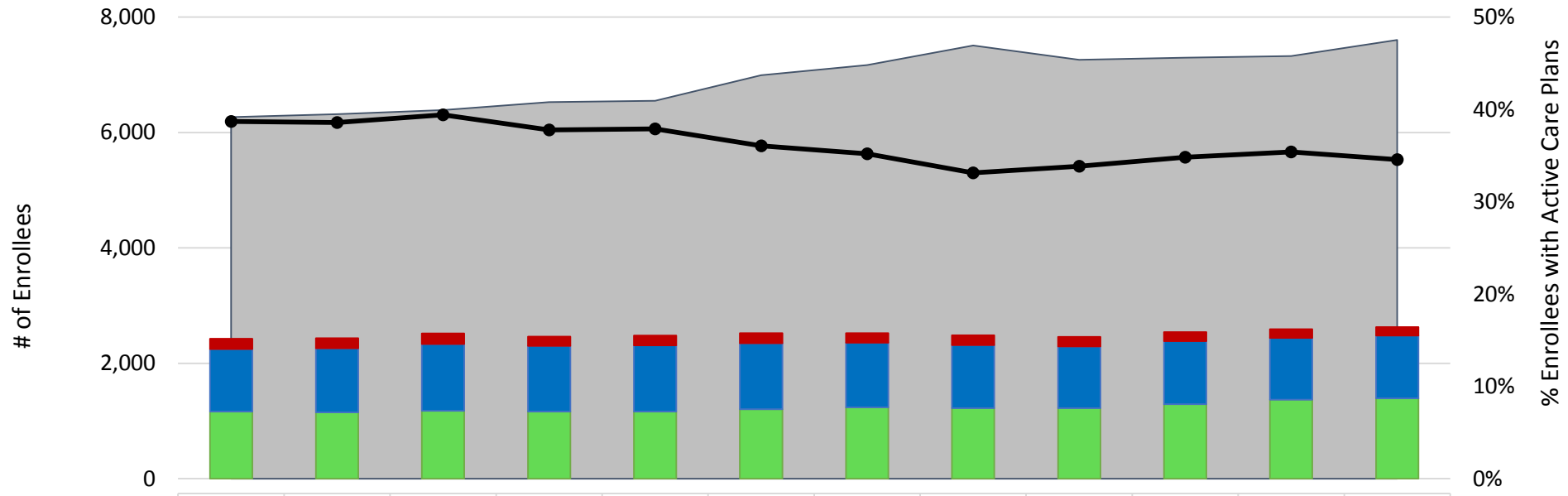
HCGP Enrollee-to-Active Care Staff Ratio					
Risk Level	# of Enrollees	# Active Care Staff	Standard Ratio	Revised Ratio	Note:
Complex (Risk Level 4)	346	7	1:75	1:49	There are currently a total of 48.5 Direct Care Staff approved. Of those 48.5 approved, 42.5 are active. Status of the six open positions: x4 RN requisitions, x2 CHW requisitions and There are x2 RN's positions offered who will begin training November 28th.
High (Risk Level 3)	2,511	35.5	1:215 (Blended)	1:204	
Moderate (Risk Level 2)	4,747				
Low (Risk Level 1)	30,893	A Case Manager is assigned when a member is escalated to a higher risk level			

*Notes/Observations:

1. This table includes ratio calculations which represent an alternative staffing approach, i.e. other than the current contractual standard.

HCGP Program Performance Dashboard

Staffing



	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Total Enrollment at RL2-4	6,267	6,318	6,389	6,527	6,550	6,993	7,169	7,508	7,260	7,297	7,325	7,604
CM Risk Level 4	178	177	184	162	171	171	167	171	162	156	154	148
DM Risk Level 3	1087	1110	1160	1140	1147	1145	1120	1095	1073	1093	1070	1086
DM Risk Level 2	1161	1150	1175	1163	1165	1205	1237	1221	1222	1293	1369	1394
% of 2-4 Enrollment Actively Managed	39%	39%	39%	38%	38%	36%	35%	33%	34%	35%	35%	35%

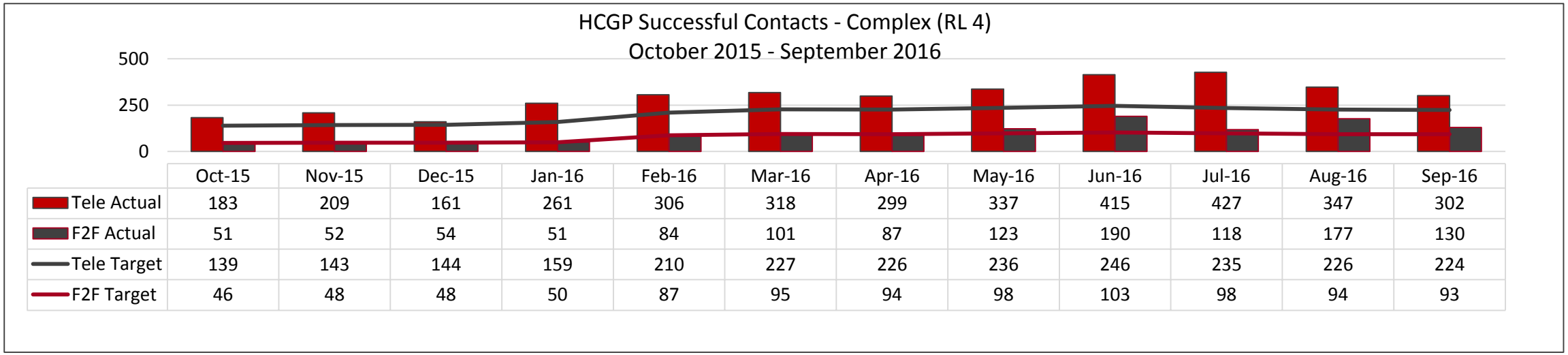
Notes/Observations:

% of enrollment with Active Care Plan
September 2016:
RL4 Complex = 43%
RL3 High = 43%
RL2 Moderate = 29%

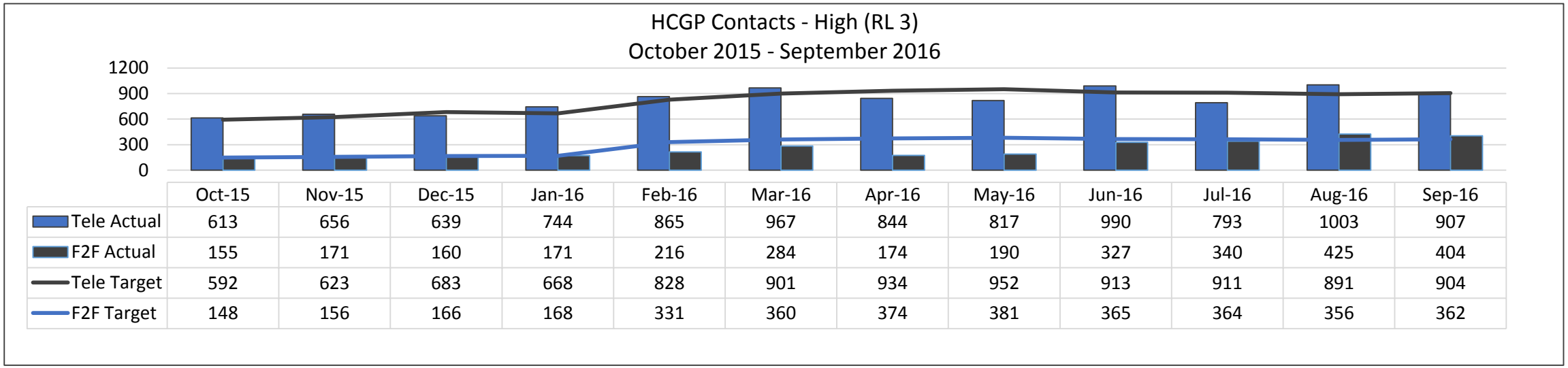
October MTD:
RL4 Complex = 45%
RL3 High = 43%
RL2 = 30%

HCGP Program Performance Dashboard

Member Contacts



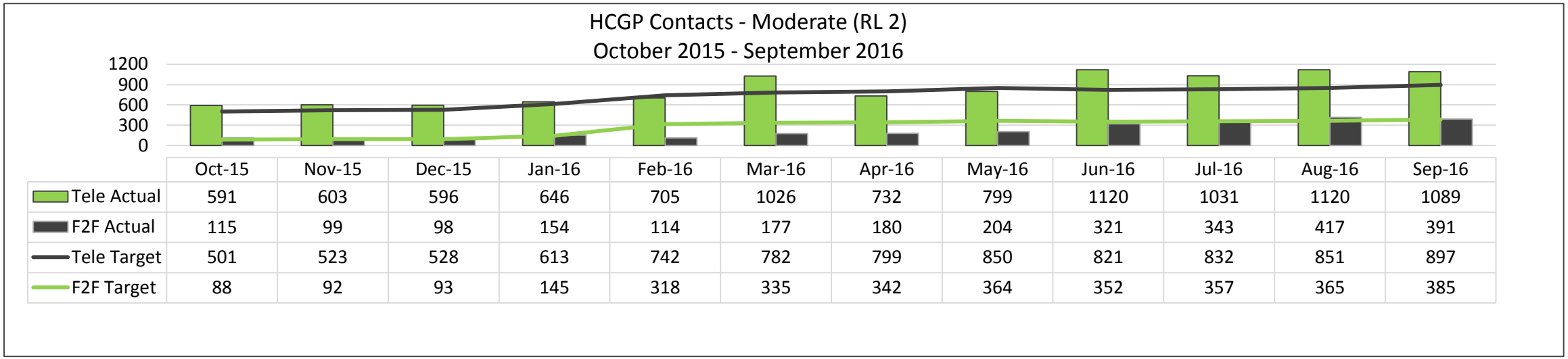
	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Tele Actual	183	209	161	261	306	318	299	337	415	427	347	302
F2F Actual	51	52	54	51	84	101	87	123	190	118	177	130
Tele Target	139	143	144	159	210	227	226	236	246	235	226	224
F2F Target	46	48	48	50	87	95	94	98	103	98	94	93



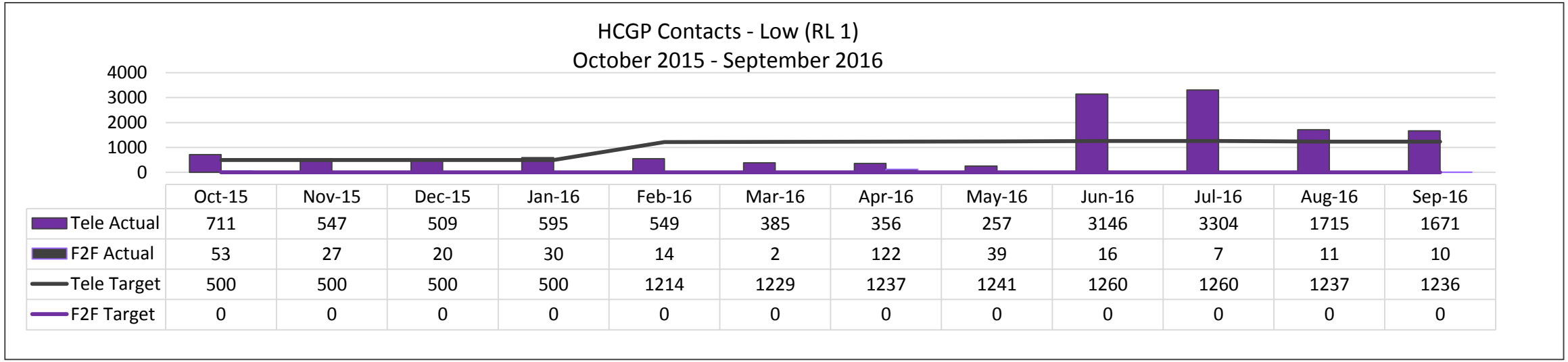
	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Tele Actual	613	656	639	744	865	967	844	817	990	793	1003	907
F2F Actual	155	171	160	171	216	284	174	190	327	340	425	404
Tele Target	592	623	683	668	828	901	934	952	913	911	891	904
F2F Target	148	156	166	168	331	360	374	381	365	364	356	362

HCGP Program Performance Dashboard

Member Contacts



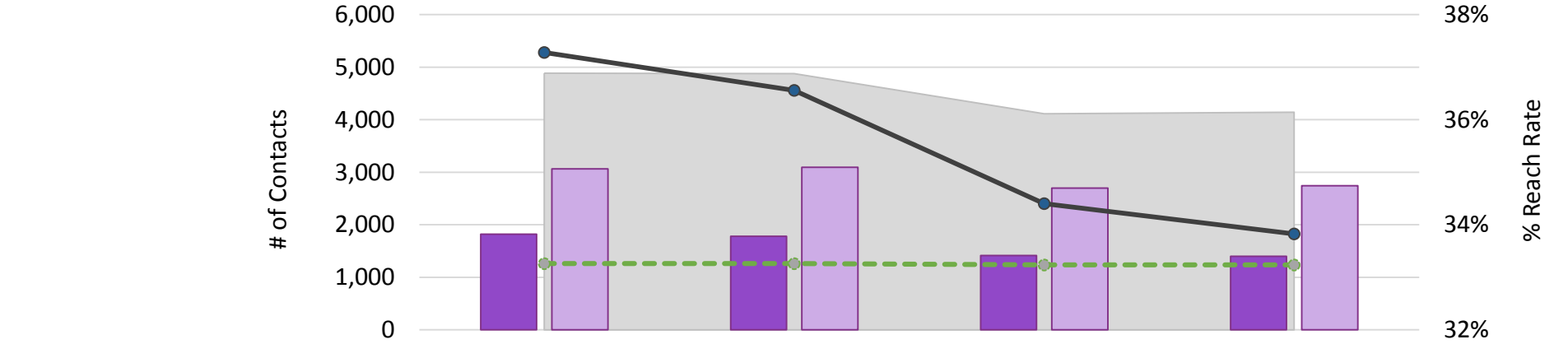
	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Tele Actual	591	603	596	646	705	1026	732	799	1120	1031	1120	1089
F2F Actual	115	99	98	154	114	177	180	204	321	343	417	391
Tele Target	501	523	528	613	742	782	799	850	821	832	851	897
F2F Target	88	92	93	145	318	335	342	364	352	357	365	385



	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Tele Actual	711	547	509	595	549	385	356	257	3146	3304	1715	1671
F2F Actual	53	27	20	30	14	2	122	39	16	7	11	10
Tele Target	500	500	500	500	1214	1229	1237	1241	1260	1260	1237	1236
F2F Target	0	0	0	0	0	0	0	0	0	0	0	0

HCGP Program Performance Dashboard

Member Contacts - Focused IVR Contacts



	Jun-16	Jul-16	Aug-16	Sep-16
Total Member Outreach	4,885	4,877	4,113	4,142
Successful RL 1 (Low)	1,821	1,783	1,415	1,401
Unsuccessful RL1 (Low) Contact	3,064	3,094	2,698	2741
RL 1(Low) Target	1,260	1,260	1,237	1,236
% Reach Rate	37%	37%	34%	34%

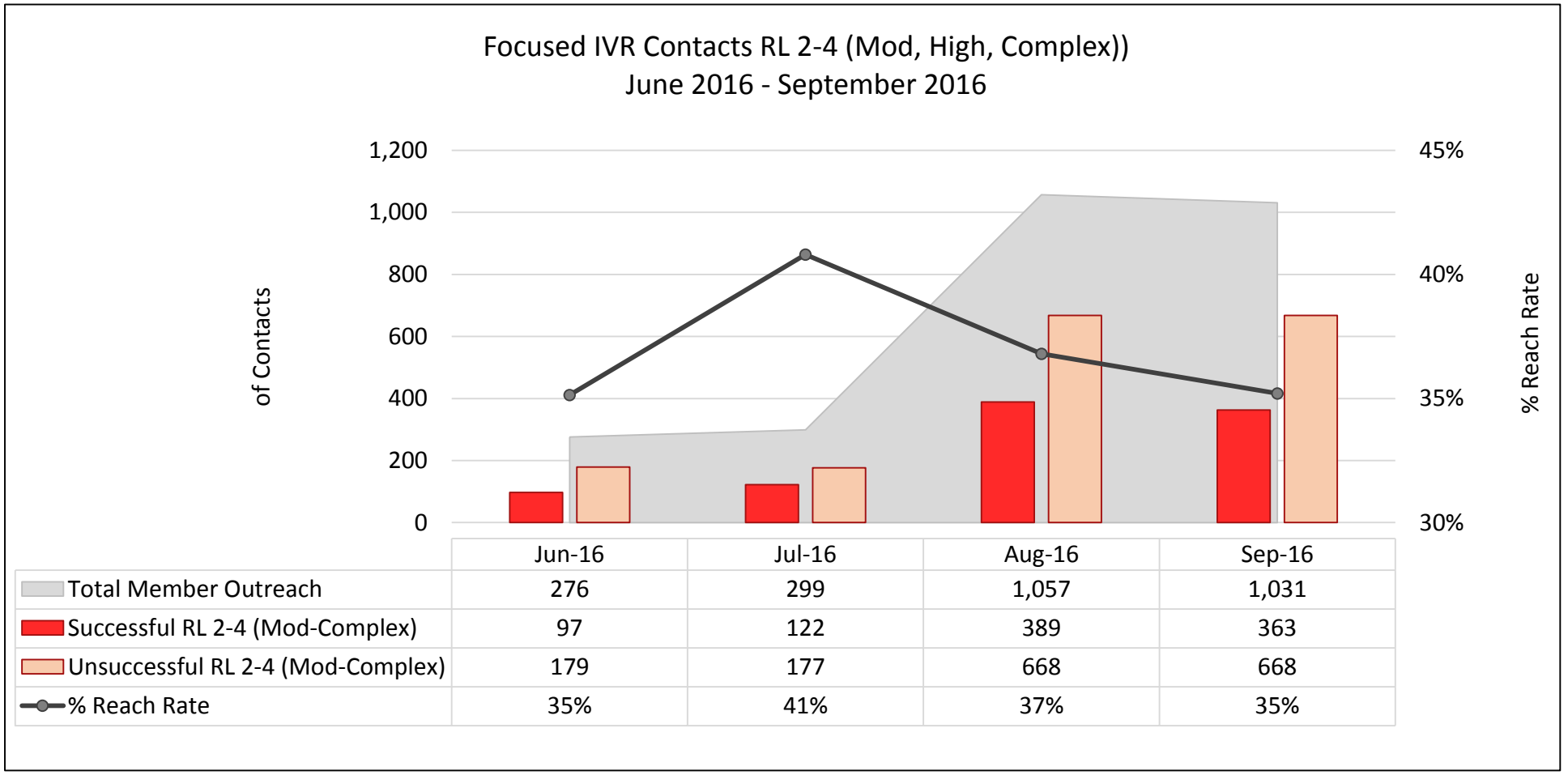
Notes/Observations:

- The primary purpose of Focused IVR Contacts is to ensure optimal outreach with our RL1 members. Target objective: one contact with 25% of our RL1 member every 6 months.

- Focused IVR Contacts introduces the HCGP and GuidePoint services.
The member has the option to request a transfer to a Care Manager at any point during the call.

HCGP Program Performance Dashboard

Member Contacts - Focused IVR Contacts



	Jun-16	Jul-16	Aug-16	Sep-16
Total Member Outreach	276	299	1,057	1,031
Successful RL 2-4 (Mod-Complex)	97	122	389	363
Unsuccessful RL 2-4 (Mod-Complex)	179	177	668	668
% Reach Rate	35%	41%	37%	35%

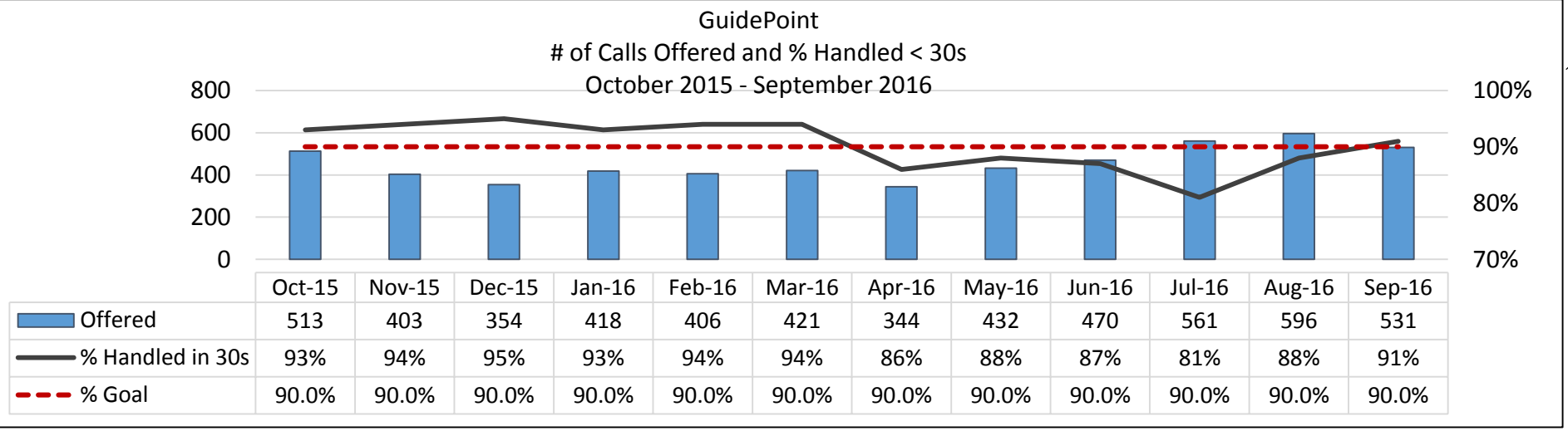
Notes/Observations:

- The secondary objective of Focused IVR Contacts is to expedite outreach efforts to newly eligible RL2-4 members each month.

- Focused IVR introduces the HCGP and GuidePoint services.
The member has the option to request a transfer to a Care Manager at any point during the call.

HCGP Program Performance Dashboard

GuidePoint

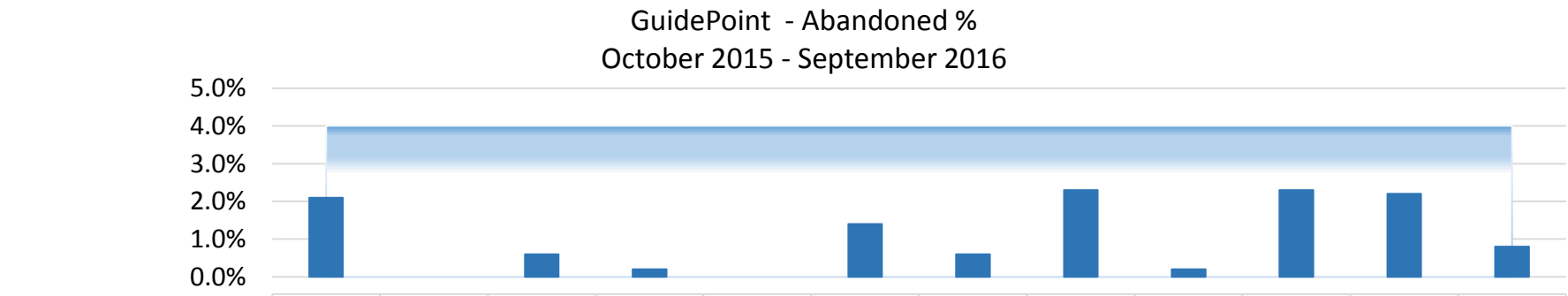


	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Offered	513	403	354	418	406	421	344	432	470	561	596	531
% Handled in 30s	93%	94%	95%	93%	94%	94%	86%	88%	87%	81%	88%	91%
% Goal	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%

Notes/Observations:

- Goal is 90% or greater within 30s

- Improvement over Aug and Sept-16 and continuing through Oct-16 MTD.



	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Abandonded % Threshold	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%
Abandonded %	2.1%	0.0%	0.6%	0.2%	0.0%	1.4%	0.6%	2.3%	0.2%	2.3%	2.2%	0.8%

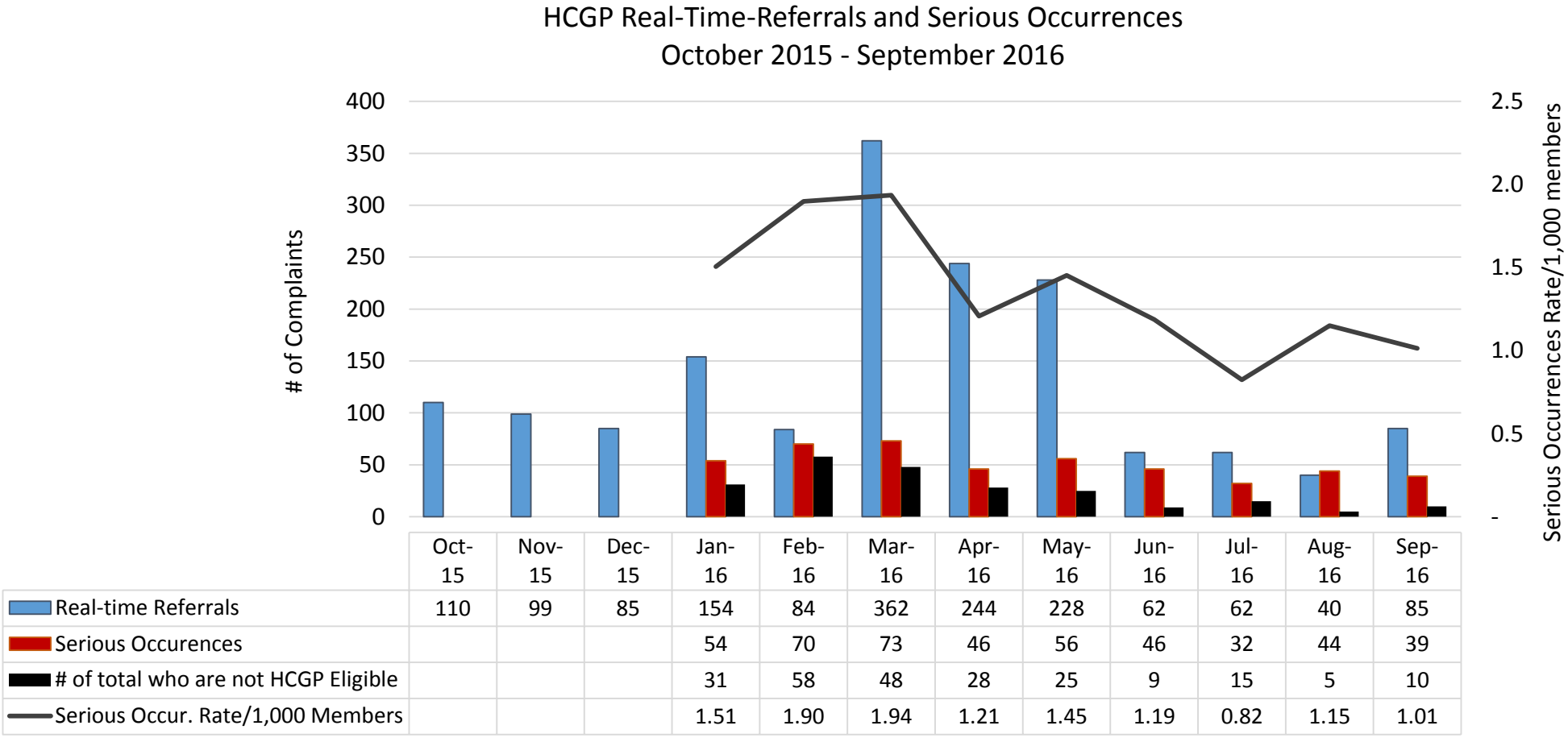
Notes/Observations

- Goal is not to exceed or < 4% unanswered in 30s

- URAQ Standard is <5% in 30s

- Improvement over Sept-16 with a rate of 0.0% Oct-16 MTD.

HCGP Program Performance Dashboard
Real-time-Referrals and Serious Occurrences



	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Real-time Referrals	110	99	85	154	84	362	244	228	62	62	40	85
Serious Occurences				54	70	73	46	56	46	32	44	39
# of total who are not HCGP Eligible				31	58	48	28	25	9	15	5	10
Serious Occur. Rate/1,000 Members				1.51	1.90	1.94	1.21	1.45	1.19	0.82	1.15	1.01

Notes/Observations

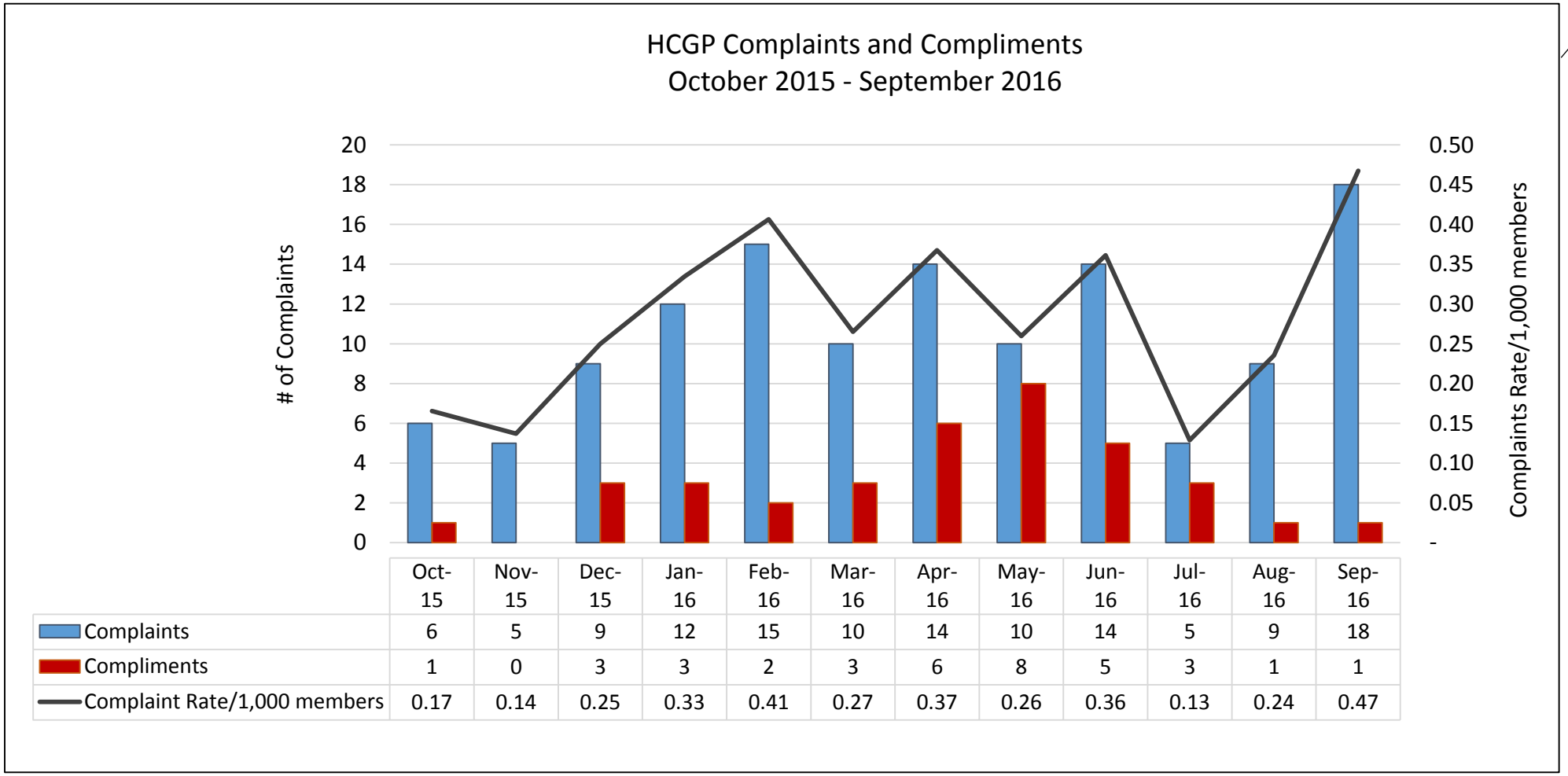
- The significant decrease in RTR's starting Jun-16 was attributed to the loss of data from Renown and Carson Tahoe.

- Serious Occurrences include; home healthcare-related hospitalizations, any deaths, accidents, falls, allegations of, assault, arrest, auto accident, pedestrian accident, etc.

- HCGP was not tracking Serious Occurrences or # of Ineligibles of RTR and SOR until Jan-16.

HCGP Program Performance Dashboard

Complaints and Compliments



	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Complaints	6	5	9	12	15	10	14	10	14	5	9	18
Compliments	1	0	3	3	2	3	6	8	5	3	1	1
Complaint Rate/1,000 members	0.17	0.14	0.25	0.33	0.41	0.27	0.37	0.26	0.36	0.13	0.24	0.47

Observations:

- Increase in member complaints tied to 'wrong number' outreach through IVR. Members are requesting that they be removed from the call list due to "wrong number'. *NOTE: September's 9 'wrong number' complaints represent people who are not program members and 9 of 5,173 total contacts or 0.173% of those contacted.*

- Top 3 Complaint Categories:
Erroneous demographics
Providers
Transportation vendor

HCGP Program Performance Dashboard

PY2 Satisfaction Surveys

Annual Satisfaction Surveys

Member Satisfaction - Annual PY2	2014	2015	2016
Survey Candidates	33,866	34,857	38,554
Survey Completions	3,031	3,205	2,153
Response Rate	9.0%	9.2%	5.6%
Rate HCGP Good or Best Care Possible	0.0%	0.0%	69.5%

Provider Satisfaction – Annual PY2	2015	2016
Survey Recipients	1,185	1,588
Participants	60	46
Response Rate	5.1%	2.9%

Quarterly Satisfaction Surveys

DM Member Satisfaction (Quarterly-Q2)	Q1 2016	Q2 2016
Survey Recipients	1,024	1,458
Participants	236	320
Response Rate	23.0%	22.0%
Satisfaction Rate	90.0%	90.0%

CM Member Satisfaction (Quarterly-Q2)	Q1 2016	Q2 2016
Survey Recipients	695	377
Participants	95	108
Response Rate	13.7%	28.6%
Satisfaction Rate	98.9%	94.4%

Quality Module #4

Goal #4: Member and Provider Satisfaction Surveys

- Program Year 2 Satisfaction Survey Results
  - Annual Member Satisfaction Survey
  - Quarterly DM/CM Member Satisfaction Survey
  - Annual Provider Satisfaction Survey

Objective 4.1: NCCW Enrollee Satisfaction Survey

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.

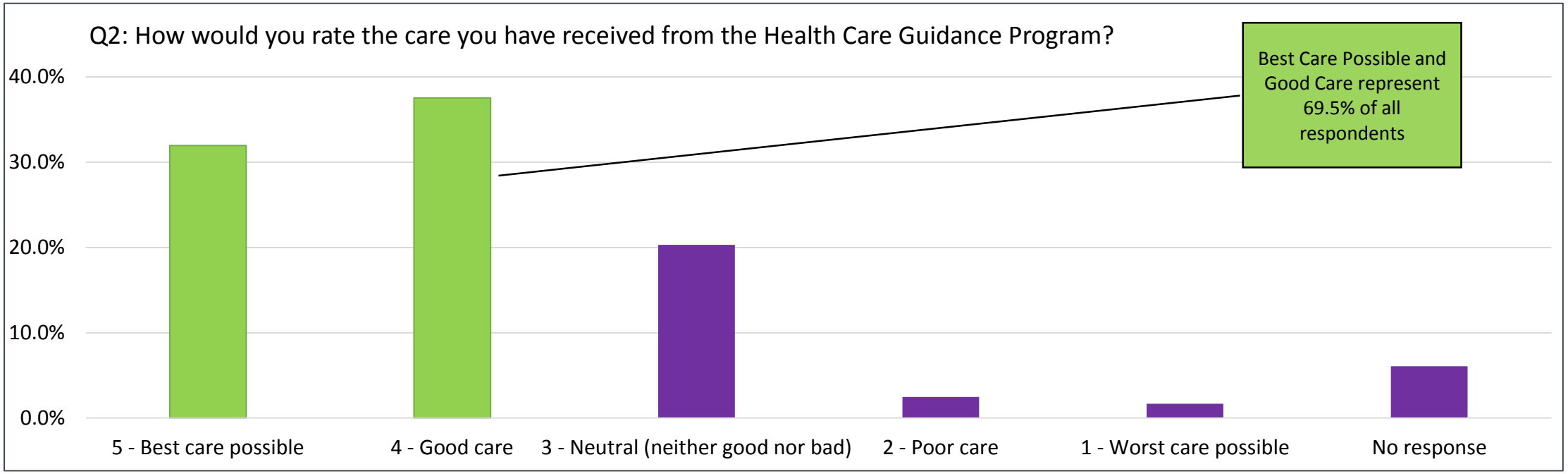
Program Year	2014	2015	2016
Survey Candidates	33,866	34,857	38,554
Survey Completions	3,031	3,205	2,153
Rate	9.00%	9.19%	5.59%

Observations:

Reduction in response rate is due to larger number of returned surveys due to erroneous demographics vs PY1

Objective 4.1: NCCW Enrollee Satisfaction Survey

Question # 2 (below) represents revised content added for this year's survey

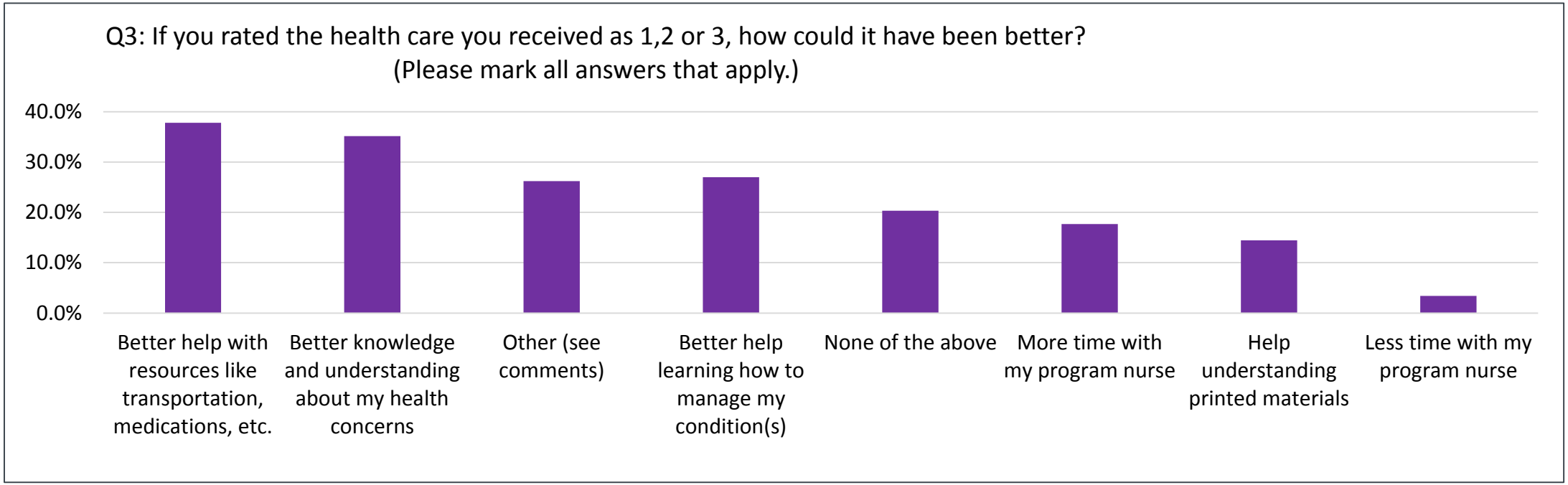


Observations:

Added in 2016 correlates to no baseline for 2016

Objective 4.1: NCCW Enrollee Satisfaction Survey

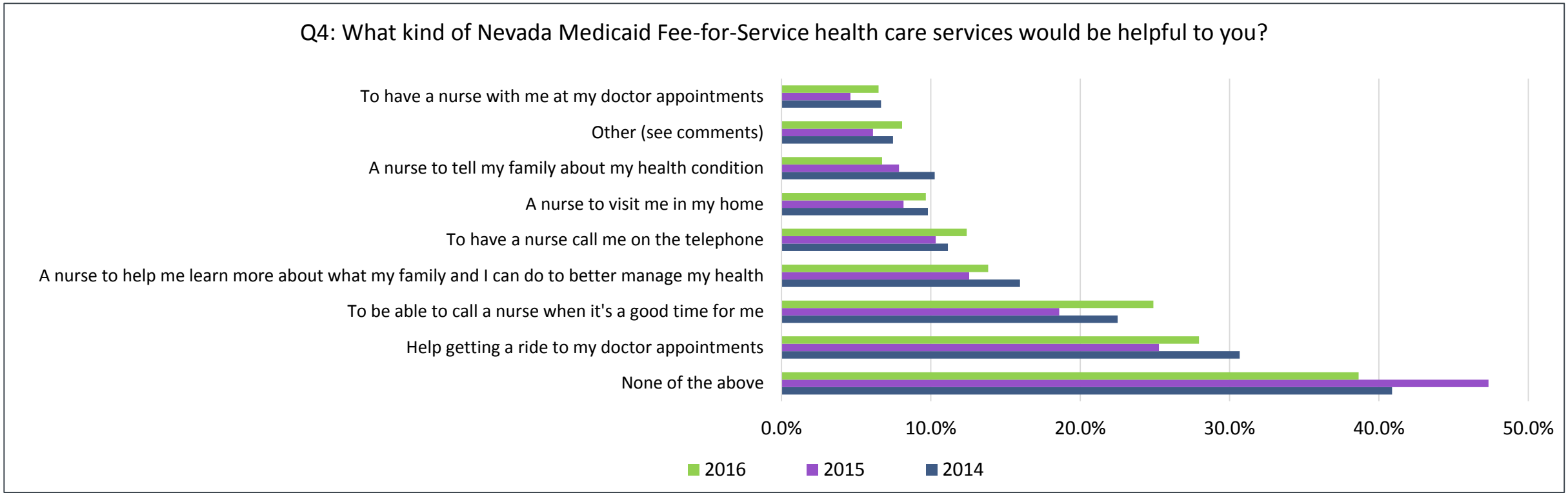
Question # 3 (below) represents revised content added for this year's survey



Observations:

Added in 2016 correlates to no baseline in 2016

Objective 4.1: NCCW Enrollee Satisfaction Survey



Observations:

- Nurse support continues to be a benefit for program members.
- Access to care, either with transportation and/or locating Medicaid physicians remains a concern.
- Member concerns regarding taking care of their health appear more consistent to Year 1 results.

Objective 4.1: NCCW Member Satisfaction Survey

Annual Member Satisfaction Survey

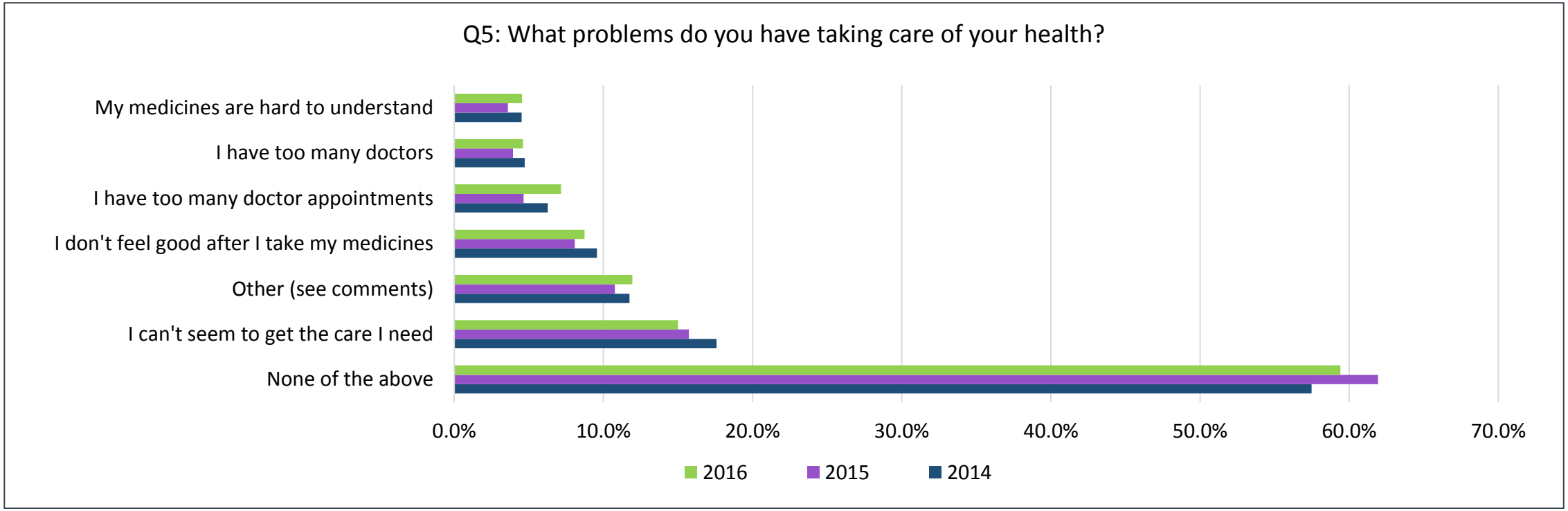
What kind of Nevada Medicaid Fee-for-Service health care services would be helpful to you? (Please mark all answers that apply.)

Measure Description	Measure Category/ Measure #	*Baseline (Baseline Period Ending May 31, 2014)*			*Program Year 1 (June 2014 – May 2015)*			*Program Year 2 (June 2015 – May 2016)*		
		Num.	Den	%	Num.	Den	%	Num.	Den	%
Medicaid Member Satisfaction Survey	None of the above	1239	3,031	41%	1517	3,205	47%	832	2,153	39%
	Help getting a ride to my doctor appointments	930	3,031	31%	810	3,205	25%	602	2,153	28%
	To be able to call a nurse when it's a good time for me	682	3,031	23%	596	3,205	19%	536	2,153	25%
	A nurse to help me learn more about what my family and I can do to better manage my health	484	3,031	16%	403	3,205	13%	298	2,153	14%
	To have a nurse call me on the telephone	338	3,031	11%	331	3,205	10%	267	2,153	12%
	A nurse to visit me in my home	297	3,031	10%	262	3,205	8%	208	2,153	10%
	A nurse to tell my family about my health condition	311	3,031	10%	252	3,205	8%	145	2,153	7%
	Other (see comments)	226	3,031	7%	196	3,205	6%	174	2,153	8%
	To have a nurse with me at my doctor appointments	202	3,031	7%	148	3,205	5%	140	2,153	7%

***Notes/Observations:**

1. Increased interest in being able to schedule coaching/assessment calls on demand and according to the members availability.
2. Increase in transportation concerns versus PY1

Objective 4.1: NCCW Enrollee Satisfaction Survey



Observations:

- Nurse support continues to be a benefit for program members.
- Access to care, either with transportation and/or locating Medicaid physicians remains a concern.
- Member concerns regarding taking care of their health appear more consistent to Year 1 results.

Objective 4.1: NCCW Member Satisfaction Survey

Annual Member Satisfaction Survey

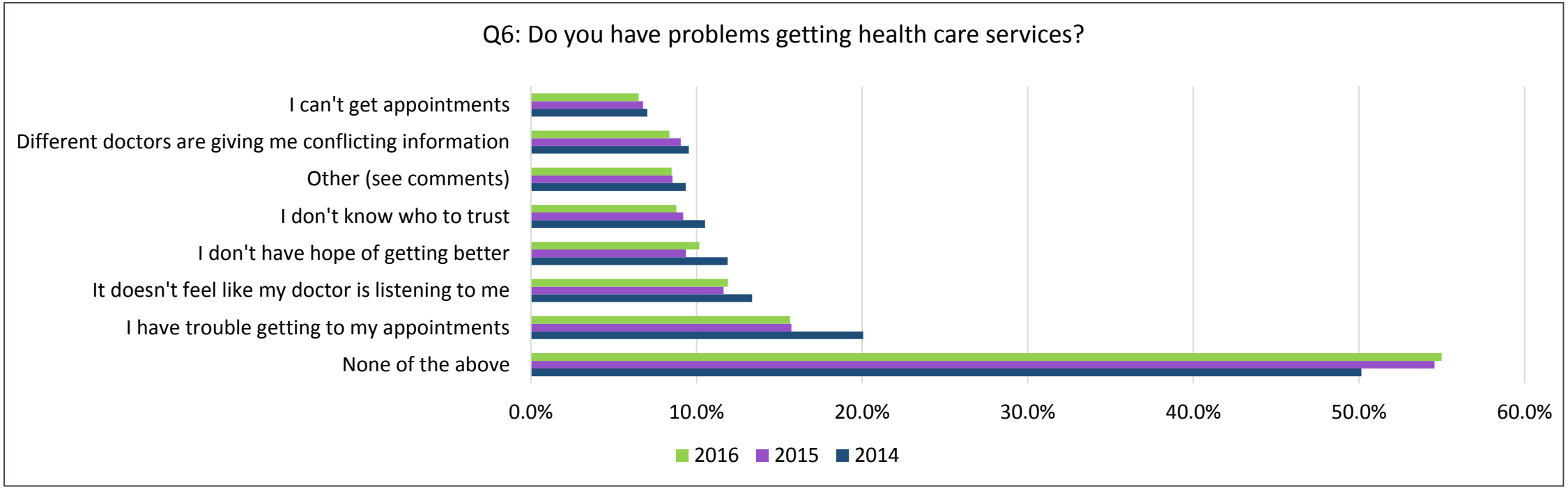
What problems do you have taking care of your health? (Please mark all answers that apply.)

Measure Description	Measure Category/ Measure #	*Baseline (Baseline Period Ending May 31, 2014)*			*Program Year 1 (June 2014 – May 2015)*			*Program Year 2 (June 2015 – May 2016)*		
		Num.	Den	%	Num.	Den	%	Num.	Den	%
Medicaid Member Satisfaction Survey	None of the above	1742	3,031	57%	1985	3,205	62%	1279	2,153	59%
	I can't seem to get the care I need	533	3,031	18%	504	3,205	16%	323	2,153	15%
	Other (see comments)	356	3,031	12%	345	3,205	11%	257	2,153	12%
	I don't feel good after I take my medicines	290	3,031	10%	259	3,205	8%	188	2,153	9%
	I have too many doctor appointments	190	3,031	6%	149	3,205	5%	154	2,153	7%
	I have too many doctors	143	3,031	5%	126	3,205	4%	99	2,153	5%
	My medicines are hard to understand	137	3,031	5%	115	3,205	4%	98	2,153	5%

***Notes/Observations:**

1. Nurse support continues to be a benefit for program members.
2. Access to care, either with transportation and/or locating Medicaid physicians remains a concern.
3. Member concerns regarding taking care of their health appear more consistent to Year 1 results.

Objective 4.1: NCCW Enrollee Satisfaction Survey



Observations:

- Concerns around getting health care services appear more consistent with Year 2 results.
- More than half of the responses are for reasons not given in the survey; can’t find doctor, can’t get dental care, cost, etc.
- Biggest health challenge is pain management and dealing with stress. Additional comments by members show depression and anxiety also being a concern.

Objective 4.1: NCCW Member Satisfaction Survey

Annual Member Satisfaction Survey

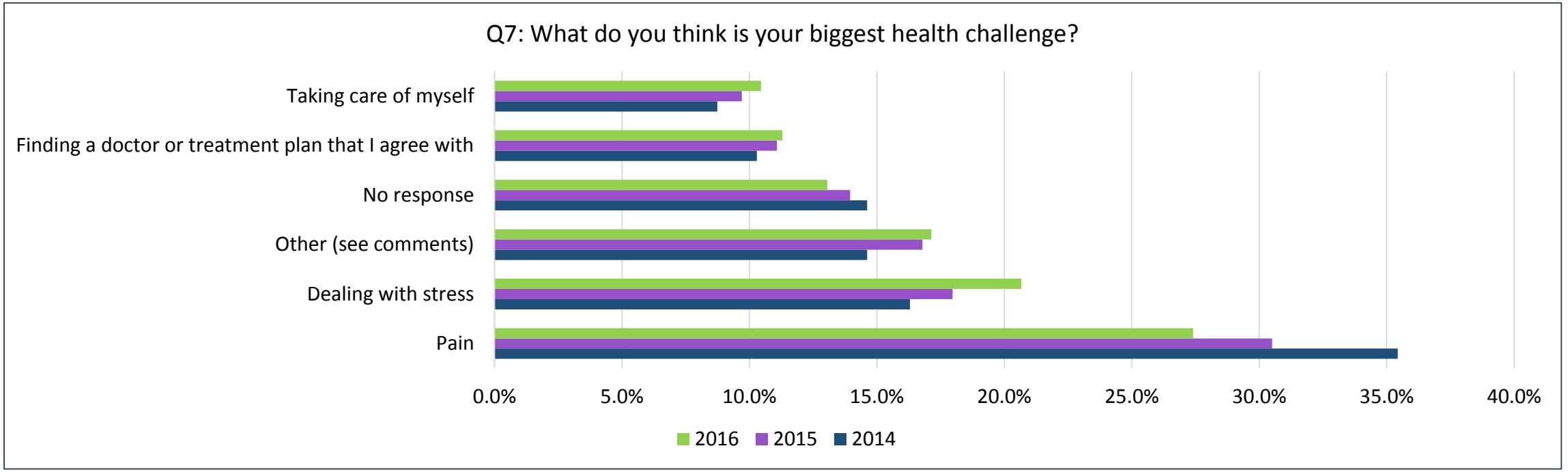
Do you have problems getting health care services? (Please mark all answers that apply.)

Measure Description	Measure Category/ Measure #	*Baseline (Baseline Period Ending May 31, 2014)*			*Program Year 1 (June 2014 – May 2015)*			*Program Year 2 (June 2015 – May 2016)*		
		Num.	Den	%	Num.	Den	%	Num.	Den	%
Medicaid Member Satisfaction Survey	None of the above	1520	3,031	50%	1749	3,205	55%	1184	2,153	55%
	I have trouble getting to my appointments	608	3,031	20%	504	3,205	16%	337	2,153	16%
	It doesn't feel like my doctor is listening to me	405	3,031	13%	373	3,205	12%	256	2,153	12%
	I don't have hope of getting better	360	3,031	12%	300	3,205	9%	219	2,153	10%
	I don't know who to trust	319	3,031	11%	295	3,205	9%	189	2,153	9%
	Other (see comments)	283	3,031	9%	274	3,205	9%	183	2,153	9%
	Different doctors are giving me conflicting information	289	3,031	10%	290	3,205	9%	180	2,153	8%

***Notes/Observations:**

1. Concerns around getting health care services appear more consistent with Year 2 results.
2. More than half of the responses are for reasons not given in the survey; can't find doctor, can't get dental care, cost, etc.
3. Biggest health challenge is pain management and dealing with stress. Additional comments by members show depression and anxiety also being a concern.

Objective 4.1: NCCW Enrollee Satisfaction Survey



Observations:

- Concerns around getting health care services appear more consistent with Year 2 results.
- More than half of the responses are for reasons not given in the survey, i.e. can't get dental care, cost, etc.
- At 27%, "Pain" as "biggest health challenge" is disproportionate with the number of members with condition 'pain management'.
- Second biggest challenge is dealing with stress linked to depression and anxiety.

Objective 4.1: NCCW Member Satisfaction Survey

Annual Member Satisfaction Survey

What do you think is your biggest health challenge? (Please mark one answer.)

Measure Description	Measure Category/ Measure #	*Baseline (Baseline Period Ending May 31, 2014)*			*Program Year 1 (June 2014 – May 2015)*			*Program Year 2 (June 2015 – May 2016)*		
		Num.	Den	%	Num.	Den	%	Num.	Den	%
Medicaid Member Satisfaction Survey	Pain	1074	3,031	35%	978	3,205	31%	590	2,153	27%
	Dealing with stress	494	3,031	16%	576	3,205	18%	445	2,153	21%
	Other (see comments)	443	3,031	15%	538	3,205	17%	369	2,153	17%
	No response	443	3,031	15%	447	3,205	14%	281	2,153	13%
	Finding a doctor or treatment plan that I agree with	312	3,031	10%	355	3,205	11%	243	2,153	11%
	Taking care of myself	265	3,031	9%	311	3,205	10%	225	2,153	10%

***Notes/Observations:**

1. Concerns around getting health care services appear more consistent with Year 2 results.
2. More than half of the responses are for reasons not given in the survey, i.e. can't get dental care, cost, etc.
3. At 27%, "Pain" as "biggest health challenge" is disproportionate with the number of members with condition 'pain management'.
4. Second biggest challenge is dealing with stress linked to depression and anxiety.

Objective 4.1: NCCW Enrollee Satisfaction Survey

Top 5 Member Comments:
Haven't used service
Insurance doesn't cover medications I need
Dental
Need transportation help
Dr.'s don't listen/have enough time

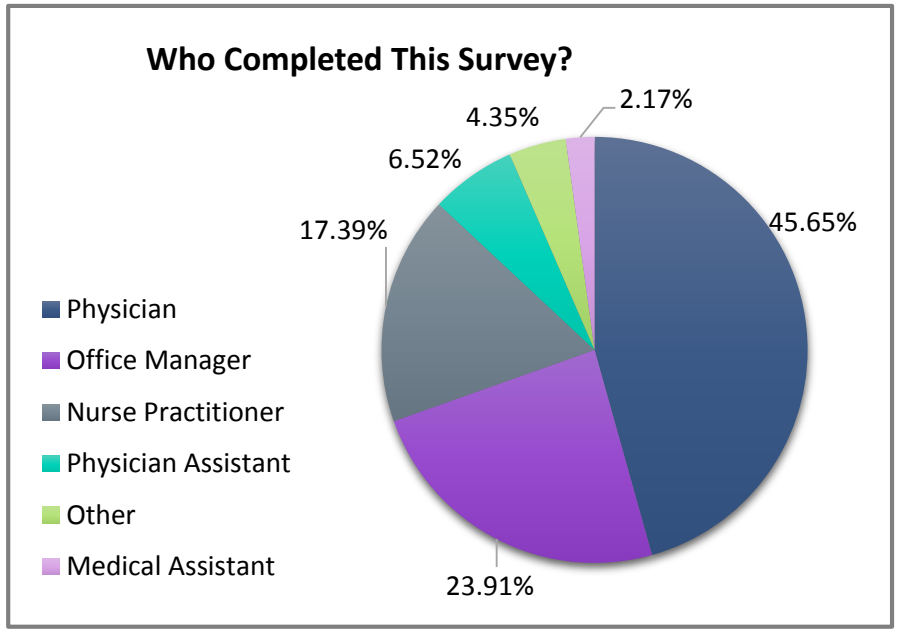
Recommendations:

- Additional Promotion
  - Program through events and member communications
  - MTM transportation through RN interaction.
- Provide resources of Medicaid physicians for members with limited access.
- Reinforcement around medication adherence; introducing 'pill box' as leave behind for members.

Objective 4.1: Medicaid Provider Satisfaction Survey

Provider Satisfaction Survey

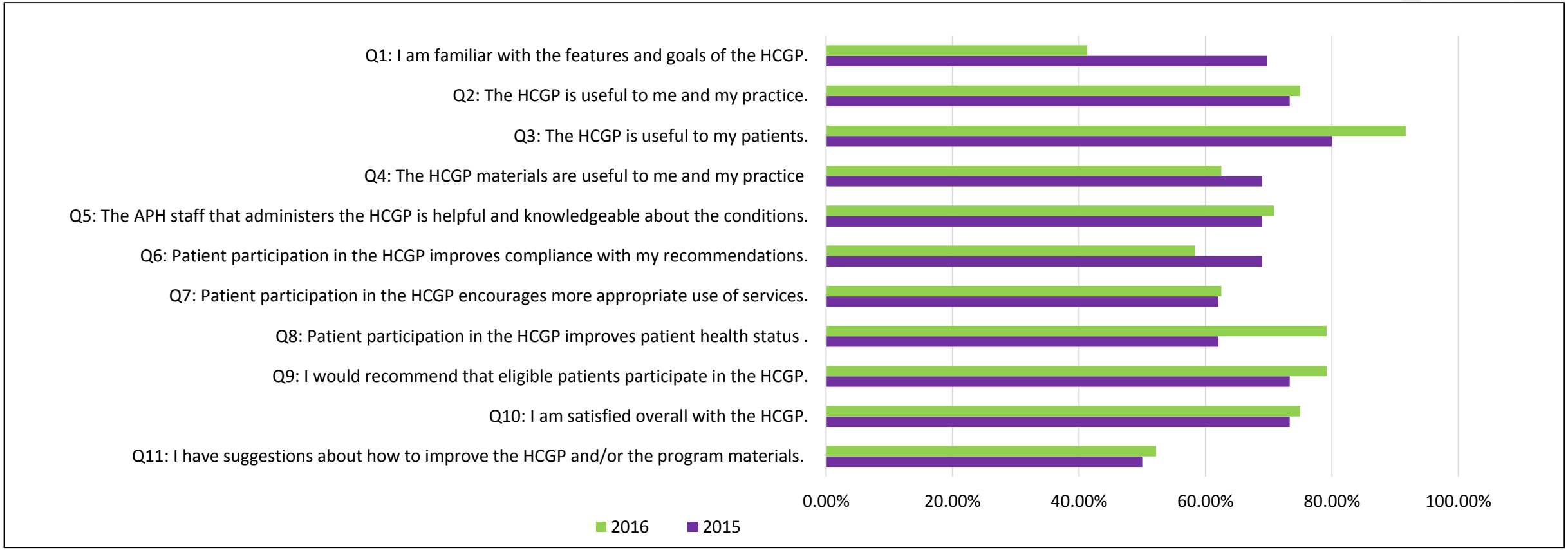
Program Year	2015	2016
Survey Candidates	1,185	1,588
Survey Completions	60	46
Response Rate	5.1%	2.9%



Overall Observations:

- 92% would recommend that eligible patients participate in the program
- 79% agree that the program is useful to enrolled patients.
- 75% of respondents are satisfied overall with the program

Objective 4.1: Medicaid Provider Satisfaction Survey



Recommendations:

- Generally speaking the respondents agree that the program is of benefit and something they would recommend to their patients.
- Continue outreach around education on program services
- Low response rates render the feedback less actionable.

Objective 4.1: Medicaid Provider Satisfaction Survey

Annual Provider Satisfaction Survey

NOTE: The results below represent feedback collected via annual provider satisfaction survey

Measure Description	Measure Category/ Measure #	Baseline (Baseline Period Ending May 31, 2014)			Program Year 1 (June 2014 – May 2015)			Program Year 2 (June 2015 – May 2016)		
		Num.	Den	%	Num.	Den	%	Num.	Den	%
Provider Satisfaction Survey	I have suggestions about how to improve the HCGP and/or the program materials	n/a	n/a	n/a	30	60	50%	24	46	52%
	I am satisfied overall with the HCGP	n/a	n/a	n/a	44	60	73%	35	46	75%
	I would recommend that eligible patients participate in the HCGP	n/a	n/a	n/a	44	60	73%	36	46	79%
	Patient participation in the HCGP improves patient health status	n/a	n/a	n/a	37	60	62%	36	46	79%
	Patient participation in the HCGP encourages more appropriate use of services	n/a	n/a	n/a	37	60	62%	29	46	63%
	Patient participation in the HCGP improves compliance with my recommendations	n/a	n/a	n/a	41	60	69%	27	46	58%
	The APH staff that administers the HCGP is helpful and knowledgeable about the conditions	n/a	n/a	n/a	41	60	69%	33	46	71%
	The HCGP materials are useful to me and my practice	n/a	n/a	n/a	41	60	69%	29	46	63%
	The HCGP is useful to my patients	n/a	n/a	n/a	48	60	80%	42	46	92%
	The HCGP is useful to me and my practice	n/a	n/a	n/a	44	60	73%	35	46	75%
	I am familiar with the features and goals of the HCGP	n/a	n/a	n/a	42	60	70%	19	46	41%

***Notes/Observations:**

1. Generally speaking the respondents agree that the program is of benefit and something they would recommend to their patients.
2. Continue outreach around education on program services
3. Low response rates render the feedback less actionable.

Objective 4.1: Medicaid Provider Satisfaction Survey

Top 5 Provider Comments
I don't have any information on this program.
I have not received any literature or/and information regarding the program.
I have no idea which patients are in this program or how the program works.
Integrate Health Care Guidance Program into the EMR.
Provide a number or name of the health care worker assigned to each patient on all communications. We need to know who has actual knowledge about the patient and their medical program.

Recommendations:

- Generic program website is being incorporated in provider and member materials as well as through provider outreach efforts - http://nevadahcgp.com/.
- Have sample materials for in-person visits to reinforce the program.
- Increased emphasis on provider care plan with the member during coaching interactions.
- Increase utilization to Provider Portal via outreach efforts.

Objective 4.1: APH Quarterly Disease Management Satisfaction

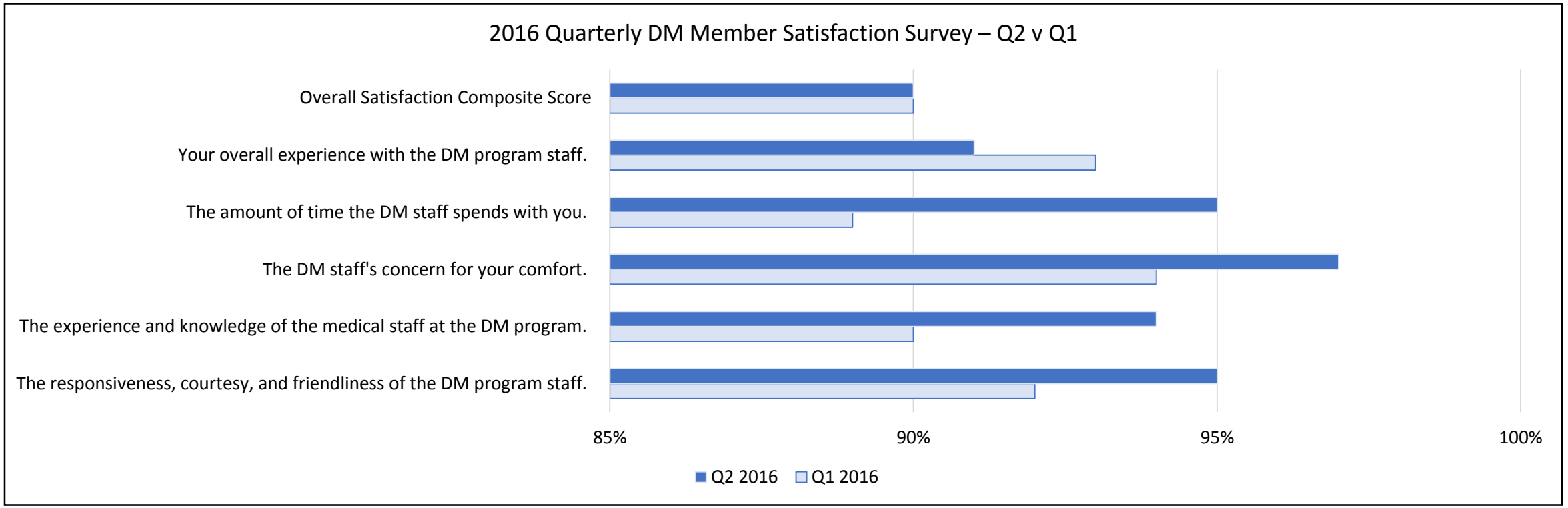
Quarterly DM Member Satisfaction Survey

DM Member Satisfaction (Quarterly-Q2)	Q1 2016	Q2 2016
Survey Recipients	1,024	1,458
Participants	236	320
Response Rate	23.0%	22.0%
Satisfaction Rate	90.0%	90.0%

Overall Notes/Observations:

- This survey is conducted weekly via phone, following case closure.
- It is consolidated and reviewed by APH Quality Assurance Review Board on a quarterly basis.
- Slightly above average response rates (20%).

Objective 4.1: APH Quarterly Disease Management Satisfaction



Observations:

- Respondents are asked; “Using a scale from 1 to 10 where 1 is Unacceptable, 5 is Average, and 10 is Outstanding, please rate the experiences you have had with...”
- Members are exceptionally satisfied with APH staff’s concern for their comfort

Quality Objective 4.1: Enrollee Satisfaction Survey

Quarterly APH Disease Management Survey

NOTE: The results below represent feedback collected using the standard Disease Management survey. It was not implemented until January of 2016 at the request of DHCFP.

Measure Description	Measure Category/ Measure #	Baseline (Period End May 31, 2014)			Program Year 1 (June 2014 – May 2015)			Program Year 2 (June 2015 – May 2016)		
		Num.	Den	%	Num.	Den	%	Num.	Den	%
APH DM Member Survey	The responsiveness, courtesy, and friendliness of the DM program staff.	n/a	n/a	n/a	217	236	92%	304	320	95%
	The experience and knowledge of the medical staff at the DM program.	n/a	n/a	n/a	212	236	90%	301	320	94%
	The DM staff's concern for your comfort.	n/a	n/a	n/a	222	236	94%	310	320	97%
	The amount of time the DM staff spends with you.	n/a	n/a	n/a	210	236	89%	304	320	95%
	Your overall experience with the DM program staff.	n/a	n/a	n/a	219	236	93%	291	320	91%
	Overall Satisfaction Composite Score	n/a	n/a	n/a	212	236	90%	288	320	90%

***Notes/Observations:**

1. Respondents are asked; “Using a scale from 1 to 10 where 1 is Unacceptable, 5 is Average, and 10 is Outstanding, please rate the experiences you have had with...”
2. Members are exceptionally satisfied with APH staff’s concern with their comfort

Objective 4.1: APH Quarterly Case Management Satisfaction

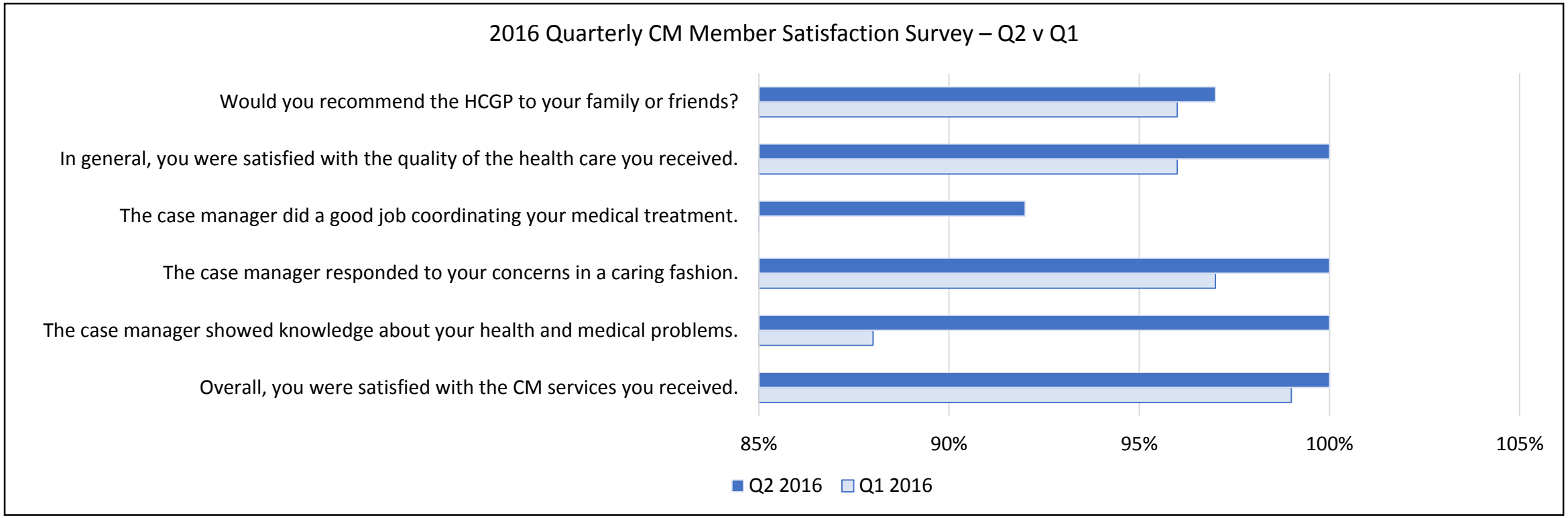
Quarterly CM Member Satisfaction Survey

CM Member Satisfaction (Quarterly-Q2)	Q1 2016	Q2 2016
Survey Recipients	567	196
Participants	68	39
Response Rate	11.8%	19.9%
Satisfaction Rate	98.9%	100.0%

Overall Notes/Observations:

- This survey is conducted weekly via phone, following case closure.
- It is consolidated and reviewed by APH Quality Assurance Review Board on a quarterly basis.
- Response rate increase versus Q1 2016, however, slightly below standard response rates of 20%

Objective 4.1: APH Quarterly Case Management Satisfaction Survey



Observations:

- Respondents are asked; “Using a scale from 1 to 10 where 1 is Unacceptable, 5 is Average, and 10 is Outstanding, please rate the experiences you have had with...”
- 100% for quality of care, responding to concerns, knowledgeable staff and overall satisfaction.

Quality Objective 4.1: Enrollee Satisfaction Survey

Quarterly APH Case Management Survey

NOTE: The results below represent feedback collected using the standard Case Management survey. It was not implemented until January of 2016 at the request of DHCFP.

Measure Description	Measure Category/ Measure #	Baseline (Period End May 31, 2014)			Program Year 1 (June 2014 – May 2015)			Program Year 2 (June 2015 – May 2016)		
		Num.	Den	%	Num.	Den	%	Num.	Den	%
APH CM Member Survey	Overall, you were satisfied with the case management services you received.	n/a	n/a	n/a	67	68	99%	39	39	100%
	The case manager showed knowledge about your health and medical problems.	n/a	n/a	n/a	60	68	88%	39	39	100%
	The case manager responded to your concerns in a caring fashion.	n/a	n/a	n/a	66	68	97%	39	39	100%
	The case manager did a good job coordinating your medical treatment.	n/a	n/a	n/a	53	68	78%	36	39	92%
	In general, you were satisfied with the quality of the health care you received.	n/a	n/a	n/a	65	68	96%	39	39	100%
	Would you recommend the HCGP to your family or friends?	n/a	n/a	n/a	65	68	96%	38	39	97%

***Notes/Observations:**

1. Respondents are asked; "Using a scale from 1 to 10 where 1 is Unacceptable, 5 is Average, and 10 is Outstanding, please rate the experiences you have had with..."
2. 100% for quality of care, responding to concerns, knowledgeable staff and overall satisfaction.

HCGP Program Year 2 Lessons Learned

- Multi-disciplinary team approach to managing members is critical to success
- 'Data is king': identifying and targeting most impactable members will yield the right results
- Care Management is quickly evolving as better data becomes available
- Updated Identification and Targeting methodologies translate into "Assertive Rapid Engagement"
  - Meeting our members where they're located
  - Consumer driven communication based upon member preferences
- Optimal grassroots member outreach ensures HCGP staff are well connected to community resources to assist in member needs
- Better Monitoring of Performance by:
  - Comparing Year-to-date results to the results at that same point the previous year. For example: if PY1 9+3 results showed $15 million in savings and PY1 12+12 results show $20 million, then if PY2 9+3 results show $10 million in savings, we forecast PY2 12+12 results to be $10 * (20/15) = $13.3 million in savings.
  - Running P4P clinical metrics comparing the most recent 12+6 rolling result to the baseline
  - Dependencies include following the quarterly data delivery schedule, no change in methodology, and Milliman and APH results to materially match

V. Provider Outreach

Hospitals – Admissions, Discharge and Transfer (ADT's)

Provider Outreach

Top 10 Hospital Name	Census data?	Admits
Sunrise Hospital & Medical Center	In process-1	1,267
Valley Hospital Med Ctr	Yes-2	1,197
Renown Regional Medical Center	In process-3	735
North Vista Hospital	No-4	679
University Medical Center	In process-5	674
Montevista Hospital	No-4	573
Mountain View Hospital	In process-1	552
Carson Tahoe Regional Medical Center	Stopped-6	535
Desert Springs Hospital	Yes-2	387
Summerlin Hospital Medical Ctr llc	Yes-2	327

1. Agreed to provide reports months ago, but negotiations ongoing about IT and a HIPAA Business Associates agreement.
2. Valley System provides daily reports
3. Had been receiving census but stopped this year, lots of turnover at Renown. Meeting this month to re-establish reporting
4. Will begin negotiations to receive reports from this facility.
5. UMC has agreed months ago to provide reports, but has not yet.
6. Carson Tahoe had been giving regular reports but stopped this year, above the level of their Case management. Will need to negotiate to get reporting

II. Focus for Next Quarter

- Execute Amendment #5 – Program Renewal
- Work with DHCFP staff to draft Amendment #6
- Continue to add staff in key regions and key positions
- Work with DHCFP leadership to produce program information to inform stakeholders of Program Year One results. Stakeholders include:
    - HHS leadership
    - Governor's office
    - Legislature
- Revisit providers – hospitals and clinics – to reinforce program goals and leverage PY1 results to emphasize quality goals.
- Work with APH quality team to incorporate PY1 and PY2 results to ensure program improvement and enhancements

Health Care Guidance Program

Coordinating with you for better care!

Health Care Guidance Program Upcoming Quarterly Meetings

January 31,2017 1:00 PM- 4:00 PM
April 25, 2016 9:00 AM- 12:00 PM
July 25,2017 1:00 PM- 4:00 PM
October 24, 2017 9:00 AM- 12:00 PM

- Meeting location: 1000 E. William St. 2nd Floor Conference Room, Carson City, NV 89706
- Call in Number: : 877-336-1829 Access Code: 8793897