# 2014–2015

# NEVADA COMPREHENSIVE CARE WAIVER (NCCW)

# QUALITY STRATEGY

The NCCW Quality Strategy serves both as a stand-alone document and serves as Attachment C of the DHCFP Quality Assessment and Performance Improvement Strategy, also known as the "State Quality Strategy."

*The DHCFP fosters a multidisciplinary approach to developing, reviewing, and revising the NCCW Quality Strategy. The approach involves the public, provider stakeholders, enrollee advocates, and outside partners who have a direct concern for, and impact on, access, quality of care, and quality of service.*

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## Overview

On April 24, 2012, the State of Nevada Department of Health and Human Services, Division of Health Care Financing and Policy (the DHCFP) submitted a Medicaid section 1115 Research and Demonstration proposal entitled the Nevada Comprehensive Care Waiver (NCCW). Nevada contracts with managed care organizations (MCOs) in urban Clark and Washoe counties for certain populations; the remainder of the State operates Medicaid as a fee-for-service (FFS) program. Historically, this meant that many Medicaid beneficiaries did not have access to care management services which might be able to both improve quality of care and generate program savings.

Nevada's Waiver program is a comprehensive demonstration that seeks to improve the value of the Medicaid delivery system. The program is operated under the NCCW initially approved by the Centers for Medicare & Medicaid Services (CMS) on June 28, 2013. Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of the State plan requirements contained in section 1902 of the Act are granted in order to enable Nevada to implement the NCCW Medicaid section 1115 demonstration: Section 1902(a)(10)(B), Section 1902(a)(17), and Section 1902(a)(23)(A).

The NCCW maintains mandatory care management services throughout the State for a subset of high-cost, high-need beneficiaries not served by the existing MCOs. This subset of beneficiaries will receive care management services from a care management organization (CMO). This entity supports improved quality of care, which is expected to generate savings/efficiencies for the Medicaid program. Enrollment in the CMO is mandatory for demonstration-eligible, fee-for-service Medicaid beneficiaries with qualifying health conditions. Enrollment in the CMO is optional for the qualifying Native American population. Children's Health Insurance Program (Nevada Check Up) members are excluded from the CMO.

The NCCW Quality Strategy serves both as a stand-alone document and is part of the DHCFP's comprehensive Quality Assessment and Performance Improvement Strategy, also known as the "State Quality Strategy."

### *DHCFP Mission*

The DHCFP's mission is to purchase and ensure the provision of quality health care services, including Medicaid services, to low-income Nevadans in the most efficient manner. Further, the DHCFP seeks to promote equal access to health care at an affordable cost to Nevada taxpayers, to restrain the growth of health care costs, and to review Medicaid and other State health care programs to determine potential federal revenue maximization opportunities.

## Process for Obtaining Input on NCCW Program and Quality Strategy

The DHCFP fosters a multidisciplinary approach to developing, reviewing, and revising the NCCW Quality Strategy. The approach involves the public, provider stakeholders, enrollee advocates, and outside partners who have a direct concern for, and impact on, access, quality of care, and quality of service. All stakeholders have the opportunity to comment on the development of quality goals and objectives highlighted in the NCCW Quality Strategy. From the time the NCCW program was first conceptualized, the DHCFP sought to educate and obtain stakeholder input on the NCCW program and its overarching program goals and objectives from multiple stakeholders, who included:

- Public at large, via public workshops held at the Nevada Legislature.
- Inter-Tribal Council of Nevada.
- Nevada Medical Care Advisory Committee (MCAC).
- Northern Nevada Child and Adolescent Services (NNCAS).
- Nevada State Health Division, Diabetes Policy Workgroup.
- Nevada State Health Division, Chronic Disease Prevention & Health Promotion Workgroup.

The DHCFP maintains an ongoing approach to community outreach and education about the NCCW program and continually updates the schedule of outreach activities, which can be seen in Appendix A. Throughout its outreach efforts, the DHCFP will continue to solicit stakeholder input on the NCCW program and its overarching program goals and objectives from stakeholders. At any time, stakeholders may offer input into goals and objectives and quality improvement efforts by accessing the following link: https://dhcfp.nv.gov/caremgmt.htm.

## Process for NCCW Quality Strategy Development, Review, and Revision

The NCCW Quality Strategy is comprehensive and continuous. The DHCFP maintains ultimate authority and responsibility for the maintenance and annual evaluation of the NCCW Quality Strategy. Annually, the DHCFP evaluates the effectiveness of the NCCW Quality Strategy and will report the evaluation in the annual 1115 Waiver report to CMS. The DHCFP updates the NCCW Quality Strategy, as necessary, based on the CMO vendor's performance; stakeholder input and feedback; achievement of goals; changes resulting from legislative, State, federal, or other regulatory authority; and/or significant changes to the programmatic structure of the Nevada Medicaid program.

The DHCFP amends the NCCW Quality Strategy to reflect changes in scope and identified needs. The DHCFP defines significant changes to the NCCW Quality Strategy that require input from enrollees and stakeholders as:

- Any change to the NCCW Quality Strategy resulting from legislative, State, federal, or other regulatory authority.
- Any change in membership demographics of 50 percent or greater within one year.
- Any change in the Nevada Medicaid fee-for-service (FFS) provider network of 50 percent or greater within one year.

## Quality Strategy Purpose, Scope, and Goals

Consistent with its mission, the purpose of the DHCFP's NCCW 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 NCCW 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 NCCW enrollees have access to high-quality and culturally appropriate care.
- Improve NCCW enrollee satisfaction with care and services.

### *Scope of Quality Strategy*

The following are included in the scope of the NCCW Quality Strategy:

- All NCCW enrollees in all demographic groups statewide.
- All aspects of care—including accessibility, availability, level of care, continuity, appropriateness, timeliness, and clinical effectiveness of care and services coordinated by the NCCW CMO and covered by Nevada's fee-for-service program.
- All aspects of CMO performance related to access to care, quality of care, and quality of service; care management medical record-keeping practices; environmental safety and health; health and disease management; and health promotion.
- All services covered in Medicaid fee-for-service (FFS)—including preventive care services, primary care, specialty care, ancillary care, emergency services, chronic disease and special needs care, dental services, mental health services, diagnostic services, pharmaceutical services, skilled nursing care, home health care, and prescription drugs.
- All Medicaid FFS professional and institutional care in all settings, including inpatient, outpatient, and home settings.
- All Medicaid FFS providers.
- All aspects of CMO internal administrative processes related to service and quality of care—including customer services, enrollment services, provider relations, confidential handling of medical records and information, case management services, preventive health promotion services, health education, information services, quality improvement, and ensuring that care provided is culturally appropriate.

## NCCW Goals and Objectives

Based on a review of Nevada Medicaid prevalence data, the DHCFP identified the most pervasive high-cost and chronic conditions for persons served through the FFS system. Because the care enrollees received in Nevada's FFS was unmanaged, the DHCFP estimated that costs for providing care to persons with chronic illness would only escalate. To curtail the costs and provide appropriate care navigation assistance to persons with chronic illness, the State saw a distinct need for a comprehensive care management program, namely, the NCCW program. As part of its 1115 Research and Demonstration Waiver, the DHCFP's overall evaluation of the successful implementation and operation of the waiver will include an assessment of the following four hypotheses:

- Enrollment in a CMO improves the quality of care for Medicaid beneficiaries with a demonstration-qualifying condition compared to enrollment in the FFS system without the additional care coordination provided by the CMO.
- Enrollment in a CMO improves health outcomes for Medicaid beneficiaries with a demonstration-qualifying condition compared to enrollment in the FFS system without the additional care coordination provided by the CMO.
- Enrollment in a CMO reduces the total and per capita costs of providing Medicaid services to Medicaid beneficiaries with a demonstration-qualifying condition compared to enrollment in the FFS system without the additional care coordination provided by the CMO.
- Medicaid beneficiaries enrolled in a CMO are more satisfied with the quality of their health care than are beneficiaries in the FFS system without the additional care coordination provided by the CMO.

To aid in the evaluation of the program, the DHCFP established the following quality goals to improve the health and wellness of NCCW enrollees and ensure they have access to high-quality and culturally appropriate care. The overarching goals and objectives of the program are listed below:

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

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

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

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

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

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

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

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

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

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

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

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

**Objective 3.1**: Reduce hospital readmissions by 10 percent.

**Objective 3.2**: Reduce emergency department utilization by 10 percent.

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

**Objective 4.1**: NCCW enrollee satisfaction improves over baseline.

Table 3-1 and Table 3-2 list the performance measures used in evaluating performance of the CMO and the objectives to which each performance measure corresponds.

To establish minimum performance goals (i.e., benchmarks), the DHCFP uses a hybrid Quality Improvement System for Managed Care (QISMC) methodology. The hybrid QISMC methodology takes into consideration high performance levels (HPLs) and minimum performance levels (MPLs) and is used when national performance measure scores are above the established goals or fall below the national 25th percentile for the measure. If, for example, a plan had a goal of 80 percent and reached 90 percent, the QISMC method would call for an improvement of 1 percent (i.e., 10 percent of the adverse outcome rate of 10 percent), indicating an expectation of reaching 91 percent. In contrast, the QISMC hybrid method expects only that the CMO will stay above the 80 percent goal.

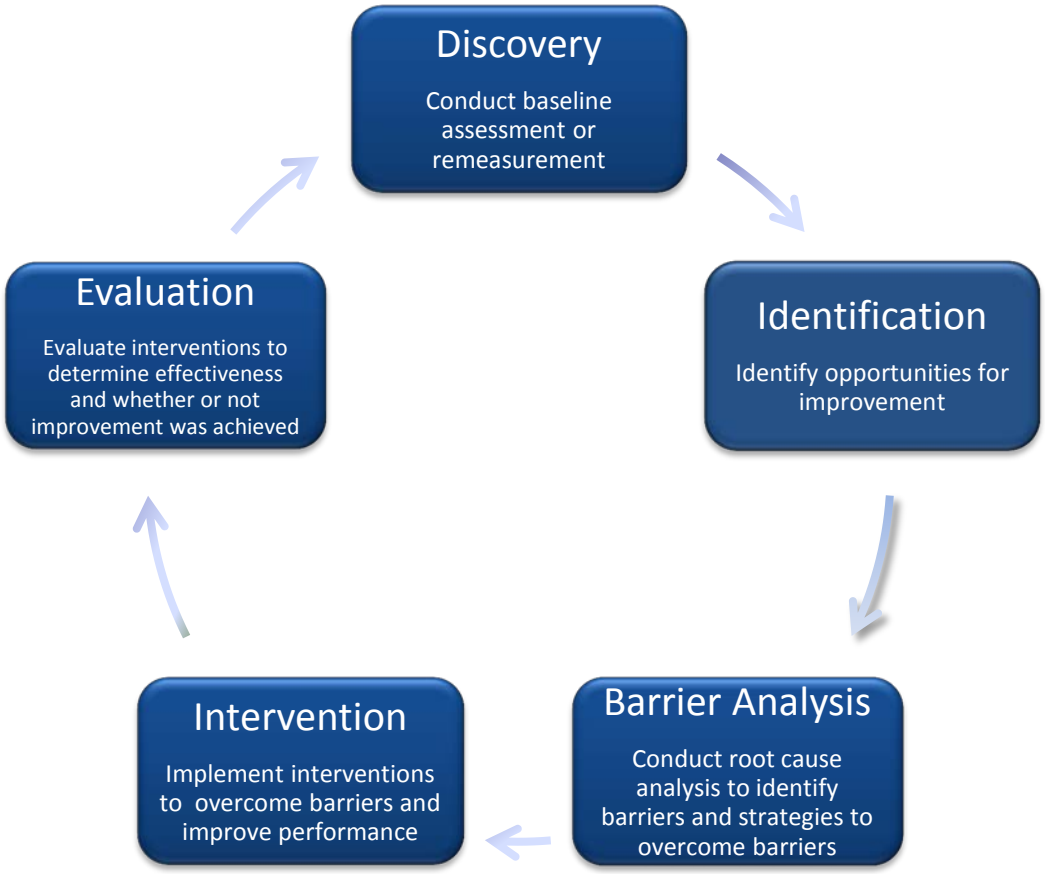
Similarly, the hybrid method allows for "bottom" goals. If, for example, the CMO is at 10 percent and the national benchmark for the 25th percentile is 23 percent, the QISMC method calls for an improvement of 9 percent (i.e., 10 percent of the adverse outcome rate of 90 percent), indicating a goal of 19 percent. In contrast, the hybrid method calls for the CMO to perform at least at the MPL of 23 percent. When the MPL is achieved, the normal QISMC calculations apply.

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

## Strategy for Meeting Goals and Objectives

The DHCFP quality improvement program embodies a continuous quality improvement (CQI) process and problem-solving approach that is applied to specific and measurable performance indicators and operational activities. The CQI process is used to (1) monitor access to care, timeliness and quality of care, and operational performance; (2) identify opportunities for improvement that exist throughout the Nevada Medicaid program; (3) implement intervention strategies to improve outcomes and performance; and (4) evaluate performance to ensure that interventions were successful. The process employed to review findings from discovery activities, establish priorities, conduct barrier analyses, develop strategies for intervention and improvement, and evaluate performance is depicted in Figure 1-1 below.

**Figure 1-1—DHCFP Performance Improvement Process Flow**




The methods employed by the DHCFP to achieve the goals and objectives of the NCCW program include:

- Developing and maintaining collaborative strategies among State agencies and external partners to improve health education and health outcomes, manage vulnerable and at-risk enrollees, and improve access to services for all NCCW enrollees.

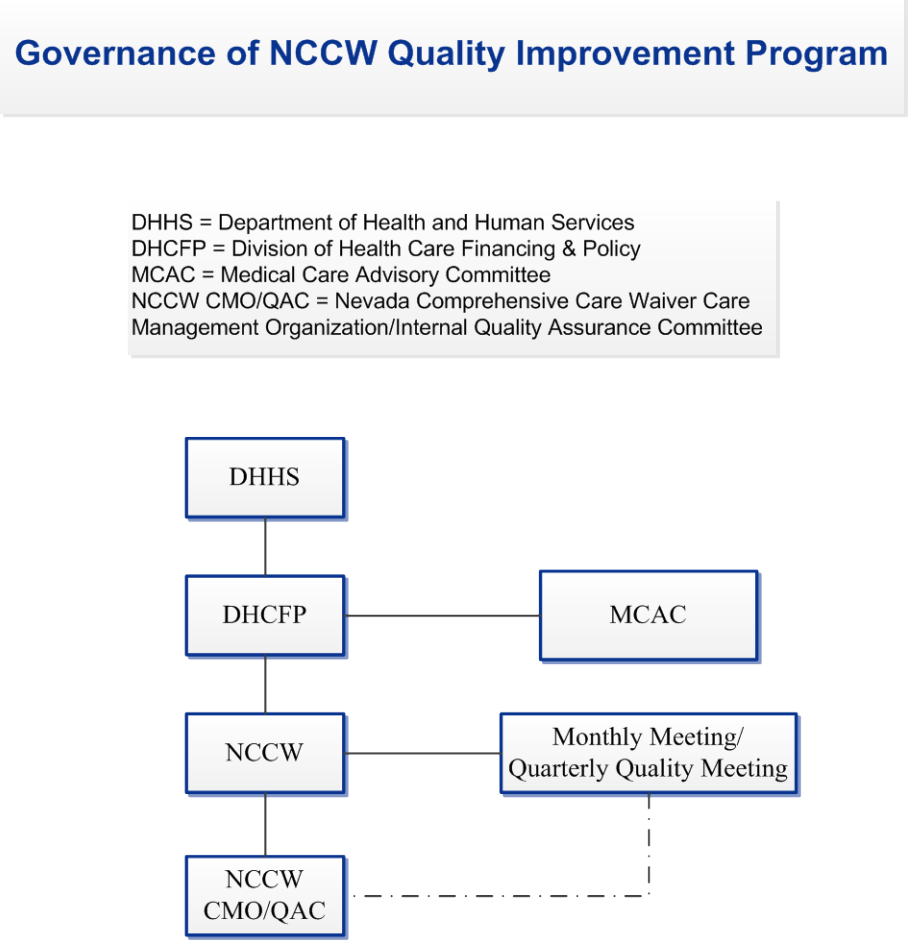
- Using additional performance measures, contract compliance monitoring, and emerging practice activities to drive improvement in enrollee health care outcomes.
- Overseeing the CMO vendor to ensure they apply evidence-based prevention, wellness, and health management initiatives to improve NCCW enrollees' health status and achievement of personal health goals.
- Enhancing NCCW enrollee services and enrollee satisfaction with services.
- Improving health information technology to ensure that information retrieval and reporting are timely, accurate, and complete.

## Organizational Structure

As depicted in Figure 2-1 below, the Nevada Department of Health and Human Services, Division of Health Care Financing and Policy (the DHCFP) maintains ultimate authority and oversight of the NCCW program, including operational oversight of the CMO vendor. The DHCFP's Medical Care Advisory Committee (MCAC) will serve as the NCCW State Advisory Committee and will be responsible for the following:

- Advising the DHCFP on the provisions of services for Medicaid recipients.
- Providing stakeholders with the opportunity for participation in policy development and program administration.
- Increasing the participation of Medicaid recipients in the development of policy and administration of programs by the DHCFP.
- Reviewing the NCCW Quality Strategy plan, outreach, and education services and serving in a consultative capacity to Medicaid.

**Figure 2-1 Governance of NCCW Quality Improvement Program**



## Roles and Responsibilities

The DHCFP and relevant stakeholders will meet monthly with the CMO and its care coordination staff. The focus of these meetings will be to evaluate the provision of health care, recipient and provider participation, and quality of care concerns. The DHCFP will guide the CMO through improvement activities to advance the quality of health care services received by the CMO's enrollees. The DHCFP will report on the quality improvement activities underway in the NCCW program to the MCAC.

Stakeholders could include interested parties, (such as DHHS sister agency staff), FFS providers, and other subject matter experts who can provide support and resources to the DHCFP and the CMO on specific program and/or quality activities. Minutes from these meetings and the NCCW Advisory Committee (via MCAC meetings) shall be maintained and will be included as an attachment to the annual report for each demonstration year.

The CMO vendor is responsible for maintaining an ongoing quality assessment and performance improvement program for the services it provides to the CMO's enrollees. Additionally, the CMO is responsible for maintaining an Internal Quality Assurance Committee (IQAC). The IQAC is responsible for reporting quality improvement activities and quality of care concerns directly to the DHCFP designee.

## Quality Indicators

With input provided by various stakeholders, including CMS, the DHCFP identified a set of quality indicators that are used to assess the achievement of the goals and objectives outlined for the NCCW program. The full suite of measures includes quality indicators that have been designated for the Pay-for-Performance (P4P) program and a subset of quality indicators that will be used to measure performance of the NCCW program overall. Table 3-1 and Table 3-2 list the performance measures used in evaluating performance of the NCCW program, a description of each measure, and the objectives to which each performance measure corresponds.

### *Pay-for-Performance Indicators*

A subset of the quality indicators is part of the P4P program. The P4P program enables the CMO to receive incentive payments for producing cost savings and achieving improvements over baseline rates for a selected set of pervasive conditions. As shown in Table 3-1 below, the cadre of P4P quality indicators selected by the DHCFP to address the chronic diseases targeted by the program is also used to assess the achievement of goals and objectives listed in Section 1 above. The last column of the table lists the objective to which each measure corresponds.

Quality indicator rates used in the P4P program will be calculated and reported by the DHCFP's actuary. The DHCFP's EQRO will conduct source code review of all P4P measures. Source code review is the process of examining original programming to verify that it is accurate and complete and that it complies with the performance measure specifications. By conducting a review of the programming code used to calculate the measures, the EQRO will be able to identify any issues with the code that are not in alignment with the specifications for the measures, prior to the measures being calculated.

**Table 3-1—Pay for Performance (P4P) Quality Measures**

| Disease Category | Measure Number | P4P Measure Description | Corresponding Objective |
|---|---|---|---|
| Asthma | ASM.1 | Percentage of members 5–64 years of age during the measurement period who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement period. | 2.4 |
| | ASM.2 | Percent of patients who have a record of influenza immunization in the past 12 months. | 2.1 |
| | ASM.3 | The percentage of members enrolled during the measurement period with at least one emergency department visit or an urgent care visit for an asthma-related event. | 3.2 |

| Table 3-1—Pay for Performance (P4P) Quality Measures | | | |
|---|---|---|---|
| **Disease Category** | **Measure Number** | **P4P Measure Description** | **Corresponding Objective** |
| | ASM.4 | The percentage of discharges for members who were hospitalized with a primary discharge diagnosis of asthma and had a follow-up ambulatory care visit within 7 days of discharge. | 2.2 |
| Coronary Artery Disease (CAD) | CAD.1 | The percentage of members identified with coronary artery disease (CAD) who were prescribed a lipid lowering medication during the measurement period. | 2.4 |
| | CAD.2 | The percentage of members identified with a coronary artery disease (CAD) who had an LDL-C screen performed during the measurement period. | 2.1 |
| | CAD.3 | The percentage of discharges for members who were hospitalized with a primary discharge diagnosis of coronary artery disease (CAD) and who had a follow-up, ambulatory care visit within 7 days of discharge. | 2.2 |
| Chronic Obstructive Pulmonary Disease (COPD) | SPR.1 | The percentage of members 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis. | 2.1 |
| | SPR.2 | Percentage of patients aged 18 years and older with a diagnosis of COPD who received influenza immunization in the past 12 months. | 2.1 |
| | SPR.3 | The percentage of discharges for members who were hospitalized with a primary discharge diagnosis of COPD and who had a follow-up, ambulatory care visit within 7 days of discharge. | 2.2 |
| Diabetes | CDC.1 | Percent of members 18–75 years of age, with diabetes, who had an HbA1c test performed in the measurement period. | 2.1 |
| | CDC.2 | Percent of members 18–75 years of age who have diabetes and have had a low-density lipoprotein cholesterol (LDL-C) screening performed in the measurement period. | 2.1 |
| | CDC.3 | Percent of members 18–75 years of age, with diabetes, who had a nephropathy screening test or evidence of nephropathy. | 2.1 |
| | CDC.4 | Percent of members 18–75 years of age, with diabetes, who had an eye screening for diabetic retinal disease in the measurement period. | 2.1 |
| | CDC.5 | Percent of members 18–75 years of age, with diabetes, who received an influenza immunization during the measurement period. | 2.1 |
| | CDC.6 | Percent of members 5–17 years of age, with diabetes, who had an HbA1c test performed in the measurement period. | 2.1 |
| Heart Failure | HF.1 | Percent of members 18 years and older who were hospitalized in the intake period with a diagnosis of acute myocardial infarction (AMI) and received persistent beta-blocker treatment for six months after being discharged alive. | 2.4 |

| Table 3-1—Pay for Performance (P4P) Quality Measures | | | |
|---|---|---|---|
| **Disease Category** | **Measure Number** | **P4P Measure Description** | **Corresponding Objective** |
| | HF.2 | Percent of members with heart failure who had at least one ED visit for acute exacerbation. | 3.2 |
| | HF.3 | Percent of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for angiotensin-converting enzyme inhibitors (ACEIs) or angiotensin II receptor blockers (ARBs) during the measurement period and at least one serum creatinine or blood urea nitrogen therapeutic monitoring test in the measurement period. | 2.4 |
| | HF.4 | The percentage of discharges for members who were hospitalized with a primary discharge diagnosis of heart failure (HF) and had a follow-up, ambulatory care visit within 7 days of discharge. | 2.2 |
| HIV/AIDS | HIV.1 | The percentage of members with a diagnosis of HIV/AIDS with at least one ambulatory care visit in the first half and second half of the measurement period, with a minimum of 60 days between each visit. | 1.5 |
| Hyper-tension | HPTN.1 | The percentage of members with hypertension who were on an anti-hypertension multi-drug therapy regimen, during the measurement period, that included a thiazide diuretic. | 2.4 |
| Mental Health | MH.1 | The percentage of members with bipolar I disorder treated with mood stabilizers at least 80% of the time during the measurement period. | 2.3 |
| | MH.2 | Percentage of members who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication treatment for at least 84 days. | 2.3 |
| | MH.3 | Percentage of members ages 6 and older with schizophrenia who remained on an antipsychotic medication during the measurement period. Two rates are reported:<br>MH.3.1—rate for 6 months of medication adherence<br>MH.3.2—rate for one year of medication adherence | 2.4 |
| | MH.4 | Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of select mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner. Two rates are reported:<br>MH.4.1—percentage of discharges for which the member received follow-up within 30 days of discharge (not used for P4P)<br>MH.4.2—the percentage of discharges for which the member received follow-up within 7 days of discharge (used for P4P). | 2.2 |

| Table 3-1—Pay for Performance (P4P) Quality Measures | | | |
|---|---|---|---|
| **Disease Category** | **Measure Number** | **P4P Measure Description** | **Corresponding Objective** |
| Substance Abuse | S.A.1 | Percentage of adolescents and adults members with a new episode of alcohol or other drug (AOD) dependence who received AOD treatment. Two rates are reported:<br>SA.5.1—The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis<br>SA.5.2—The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit. | 1.5 |

### *Other Quality Indicators*

Annually, the CMO will be required to calculate and report the rates for the quality indicators not included in the P4P program. The DHCFP's External Quality Review Organization (EQRO) will conduct an annual performance measure validation to ensure that the data used to report rates for each measure were generated appropriately and that the CMO followed the required specifications for each indicator. Table 3-2 below displays the quality measures that will be used to monitor performance of the CMO and the corresponding objectives associated with each indicator.

| Table 3-2—Quality Measures for the NCCW Program | | | |
|---|---|---|---|
| **Disease Category** | **Measure Number / Name** | **Quality Measure Description** | **Corresponding Objective** |
| 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. | 1.5 |
| | CCHU.2 | "Avoidable" emergency room (ER) visits are defined as visits with a primary diagnosis that match the diagnosis codes selected. The rate of avoidable ER visits used represents the percentage of all ER visits that match the selected "avoidable" diagnosis codes. | 3.2 |
| | CCHU.3, 4 & 5 | Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within:<br>◆ *24 hours.*<br>◆ *7 days.*<br>◆ *30 days of discharge.* | 3.1 |

| Table 3-2—Quality Measures for the NCCW Program | | | |
|---|---|---|---|
| **Disease Category** | **Measure Number / Name** | **Quality Measure Description** | **Corresponding Objective** |
| | CCHU.6 | Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care, or their caregiver(s), who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, *all* specified elements. | 3.1 |
| | CCHU.7 | Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care, or their caregiver(s), who received a reconciled medication list at the time of discharge including, at a minimum, medications in the specified categories. | 3.1 |
| 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. | 1.3 |
| Neuro-logical | 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. | 2.4 |
| Renal | CKD | Percentage of patients aged 18 years and older with a diagnosis of chronic kidney disease (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. | 2.1 |
| Cancer/ Neoplasm | CAN | Percentage of female patients aged 18 years and older with Stage IC through IIIC, estrogen receptive (ER) or progesterone receptive (PR) positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period. | 2.4 |
| Musculo-skeletal | RA | Percentage of patients aged 18 years and older who were diagnosed with rheumatoid arthritis (RA) and were dispensed or administered at least one ambulatory prescription for a disease-modifying antirheumatic drugs (DMARD). | 2.4 |
| | OST | Percentage of patients aged 50 years and older with a diagnosis of osteoporosis who were prescribed pharmacologic therapy within 12 months. | 2.4 |
| Obesity | OBS | Percentage of members 2–17 years of age whose body mass index (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. | 2.1 |

| Table 3-2—Quality Measures for the NCCW Program | | | |
|---|---|---|---|
| **Disease Category** | **Measure Number / Name** | **Quality Measure Description** | **Corresponding Objective** |
| Preventive | CAP | Percentage of members 12 months–19 years of age who had a visit with a primary care practitioner (PCP). The organization reports four separate percentages for each product line. | 2.1 |
| | W15 | Percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life:<br>◆ No well-child visits.<br>◆ One well-child visit.<br>◆ Two well-child visits.<br>◆ Three well-child visits.<br>◆ Four well-child visits.<br>◆ Five well-child visits.<br>◆ Six or more well-child visits. | 2.1 |
| | W34 | Percentage of members 3–6 years of age who had one or more well-child visits with a PCP during the measurement year. | 2.1 |
| | AWC | Percentage of enrolled members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an obstetrician/gynecologist (OB/GYN) practitioner during the measurement year. | 2.1 |
| | CIS | Percentage of children 2 years of age who had four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB), one chickenpox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and nine separate combination rates. | 2.1 |
| Pregnancy | PPC | Percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. | N/A |
| | WOP | Percentage of women who delivered a live birth during the measurement year (by the weeks of pregnancy) at the time of their enrollment in the organization. | N/A |
| | FPC | 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:<br>◆ <21 percent of expected visits.<br>◆ 21 percent–40 percent of expected visits.<br>◆ 41 percent– 0 percent of expected visits.<br>◆ 61 percent–80 percent of expected visits.<br>◆ ≥81 percent of expected visits. | 2.1 |

| Table 3-2—Quality Measures for the NCCW Program | | | |
|---|---|---|---|
| **Disease Category** | **Measure Number / Name** | **Quality Measure Description** | **Corresponding Objective** |
| Preventive | 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. | 2.1 |
| | BCS | Percentage of women 40–69 years of age who had a mammogram to screen for breast cancer. | 2.1 |
| | CCS | Percentage of women 21–64 years of age who received one or more Pap tests to screen cervical cancer. | 2.1 |
| | COL | Percentage of members 50–75 years of age who had appropriate screening for colorectal cancer. | 2.1 |

### *Approach to Monitoring Performance*

To continually track the progress toward achieving the goals and objectives, the DHCFP developed the Performance Measure Tracking Grid (PM Tracking Grid). As shown in Appendix B, the PM Tracking Grid includes all P4P performance measures and all other quality measures. Using the QISMC methodology applied to the baseline rate, the PM Tracking Grid automatically calculates a performance target that the CMO must achieve for each performance measure listed. The PM Tracking Grid is updated each year to include remeasurement rates achieved by the CMO.

### *Monitoring and Oversight of CMO Vendor*

The DHCFP monitors the CMO's compliance with its contract with the DHCFP, and with the goals and objectives identified in the NCCW Quality Strategy through several methods, which include contract compliance monitoring, deliverables monitoring and tracking, and performance measure validation. As part of the DHCFP's contract with an External Quality Review Organization (EQRO) for the managed care program, the EQRO also assists the DHCFP with certain monitoring and oversight activities for the NCCW program. Specifically, the EQRO conducts the following activities for the NCCW program:

- **Compliance monitoring evaluation.** The DHCFP's EQRO will conduct a readiness review prior to CMO implementation to ensure that the CMO has the capability to perform the requirements of the CMO contract. In addition, the EQRO will conduct a comprehensive review of compliance of the CMO after the CMO is operational. The DHCFP's EQRO will review the standards established by the State for assessment of care needs, structure and operations, care planning and coordination, and quality measurement and improvement. The compliance review will also include an assessment of the CMO's quality improvement structure and program to determine if the CMO has the capability of continually assessing and achieving the quality goals and objectives identified in the NCCW Quality Strategy. The DHCFP will oversee a corrective action

process to enable the CMO to implement improvement interventions to correct any areas of deficiency that may be found during the compliance review.

- **Evaluation of Quality Assessment and Performance Improvement Program.** The DHCFP requires the CMO to have an ongoing quality assessment and performance improvement program for the services it furnishes its Enrollees consisting of systematic activities, undertaken under the direction of the CMO's Medical Director and Internal Quality Assurance Committee, to monitor and evaluate the care delivered to Enrollees according to predetermined, objective standards, and affect improvements as needed. As part of its quality assessment and performance improvement program, the DHCFP expects the CMO to apply continuous quality improvement principles and methodologies to improve health care services for persons enrolled in the CMO, which includes the use of performance improvement projects. Further, the DHCFP expects the CMO to utilize standardized performance measures to survey the health care use patterns of the population and apply Plan Do Study Act (PDSA) principles to improve performance measure rates and health outcomes.
- **Validation of performance measures.** As part of its contract requirements, the DHCFP will require the CMO to submit performance measurement data (i.e., calculated rates for each of the measures listed in Table 3-2 above) as part of its internal quality assurance program. The DHCFP's EQRO will conduct performance measure validation (PMV) activities to ensure that the CMO accurately captured and coded claims and encounter data, pharmacy data, laboratory data, enrollment (or membership) data, and provider data to calculate rates for each of the selected performance indicators that are not part of the P4P program. The EQRO will conduct all PMV audits in accordance with CMS' Validation of Performance Measures protocol and using the Information Systems Capabilities Assessment Tool (ISCAT) to collect information from the CMO. The complete PMV audit incorporates the following:
  - **Review the data management processes of the CMO**: The EQRO will employ a variety of audit methods to determine how the data sources are combined and how the analytic file is produced for reporting the selected performance measures. Those methods will include review of backup documentation on data integration as well as interviews of CMO staff regarding software products used for data file production, sampling, and measure computation. The EQRO's PMV audit team also will review the CMOs' data control and security procedures.
  - **Evaluate algorithmic compliance (the translation of captured data into actual statistics) with specifications defined by the DHCFP**: The audit will include evaluation of the processes used to collect and calculate the performance measures, including accurate numerator and denominator identification and algorithmic compliance. The objective is to ensure that rate calculations are performed correctly, all data are combined appropriately, and numerator events are counted accurately.
  - **Verify performance measures to confirm that the reported results are based on accurate source information**: The EQRO will obtain detailed source code and programming logic used for each measure's calculation for a detailed review of each line of code to ensure strict compliance with measure

specifications, identify and estimate any potential bias, and identify any corrections that need to be made.

In addition to the performance measure validation and compliance review activities, the DHCFP will provide ongoing monitoring and oversight of the CMO vendor by requiring the CMO to submit monthly, quarterly, and annual deliverables. Ongoing review of the CMO deliverables will enable the DHCFP to provide regular feedback to the CMO on its performance with the contract and ongoing achievement of the goals and objectives identified in the NCCW Quality Strategy. Table 3-3 displays the schedule of deliverables for the NCCW program.

**Table 3-3—CMO Schedule of Deliverables**

| Deliverable | Due Date |
|---|---|
| Waiting List Protocol | Within one month of finalized contract negotiations |
| Algorithm used to identify targeted recipients | Following contract finalization (see below) |
| Sample list of enrollees using identification algorithm | 45 days prior to enrolling recipients |
| Implementation Plan | Within one month of finalized contract negotiations |
| Company Profile | Within one month of finalized contract negotiations |
| Business References | Within one month of finalized contract negotiations |
| Staff Resumes | Within one month of finalized contract negotiations |
| | |
| Provider Outreach Plan | Within 60 days of contract approval |
| | |
| Enrollee Stratification Report | Monthly (within 15 days after close of month) |
| Enrollee Contact Report | Monthly (within 15 days after close of month) |
| Call Center and Nurse Triage Report | Monthly (within 15 days after close of month) |
| Provider Engagement Report | Monthly (within 15 days after close of month) |
| | |
| Summary Enrollee Utilization Report | Annual (Within 90 business days after the DHCFP provides claims data) |
| Quality Assurance Report | Annual (Within 90 business days after the DHCFP provides claims data) |
| Satisfaction Report | Annual—must enable the DHCFP to meet CMS annual reporting requirement (due June 30) |
| Enrollee Eligibility Re-assessment Report | Annual |
| | |
| Provider Profiling Report | Quarterly |
| Grievance, Complaint, and Dispute Resolution Report | Within 45 days after close of the quarter to which they apply |
| Noncompliance Report | Monthly |
| | |
| Fraud and Abuse Report | Immediate |
| Requests for Disenrollment | Within 7 calendar days of receipt |

## 4. EVALUATION OF EFFECTIVENESS

The DHCFP works throughout the year to support, oversee, and monitor quality activities and evaluate the Nevada NCCW program's achievement of goals and objectives. Nevada's EQRO provides ongoing technical support to the DHCFP in the development of oversight monitoring strategies. The DHCFP works to ensure that the CMO stays informed about new State and federal requirements and the evolving technologies for quality measurement and reporting. Additionally, the DHCFP will conduct a formal, annual evaluation of the NCCW Quality Strategy to assess its overall effectiveness and determine whether demonstrated improvement in the quality of services provided to recipients, providers, and integrated stakeholders was accomplished. The annual evaluation will include an assessment of the following:

- The effectiveness of quality interventions and remediation strategies during the previous year (demonstrated by improvements in care and services) and trending of indicator data.
- The appropriateness of the program structure, processes, and objectives.
- The identification of program limitations.
- The evaluation of all internal activities, including quality improvement committees, task forces, recipient complaints, and provider complaints and issues.
- Feedback obtained from the DHCFP leadership, the CMO, the provider community, advocacy groups, NCCW enrollees, and other internal and external stakeholders that can impact enrollee access to high-quality and timely care and services.
- Recommendations for enhanced goals and objectives for the upcoming year.

The DHCFP will use several tools to evaluate the effectiveness and achievement of goals, including:

- Validated performance measure results.
- P4P results.
- CMO compliance review results.
- Ongoing review of contractually required CMO deliverables.
- Fee-for-service utilization reporting.
- Recipient complaint information.
- Performance Measure Tracking Grid (Appendix B).

The DHCFP will update the NCCW Quality Strategy at least biennially to incorporate new goals and objectives for the following biennium. The DHCFP will update the NCCW Quality Strategy more often, as needed, to reflect changes in State or federal policy that impact the Medicaid programs. Prior to each update, the DHCFP will solicit stakeholder input on the goals and objectives of the NCCW Quality Strategy. Once input is received and consensus is reached by all stakeholders, the Quality Strategy is finalized, shared with all pertinent stakeholders, and posted on the DHCFP Web site for public view. The DHCFP invites public comment and feedback through the following link on the DHCFP's Web site: https://dhcfp.nv.gov/caremgmt.htm.

## 5. APPENDIX A.

# Stakeholder Outreach and Education Meetings

| DATE/LOCATION | STAKEHOLDER | SUMMARY OF MEETING | FOLLOW-UP NEEDED | ATTENDED BY: |
|---|---|---|---|---|
| 4/19/2011<br>MCAC meeting<br>Nevada State Health Division<br>Technology Way<br>Carson City | MCAC members<br>The Public | Discussion on Medical Homes | | John Whaley |
| 9/8/2011 | Inter-Tribal Council of Nevada | Tribal letter sent: Notification of implementation of a health home pilot project effective 1/2012 | | Sent by DHCFP |
| 9/28/2011<br>Nevada State Legislature Building<br>9 a.m. & 1 p.m. | The Public | DHCFP & PCG presented a PowerPoint Presentation as a Public Workshop | | Betsy Aiello<br>Alexis Ulrich<br>David Rogers (PCG) |
| 10/18/2011<br>MCAC meeting<br>Legislative Counsel Bureau | MCAC members<br>The Public | Presentation of Health Homes | | Alexis Ulrich<br>John Whaley |
| 2/21/2012<br>Legislative Counsel Bureau<br>Carson City | MCAC members<br>The Public | Presentation on Care Management Organizations and Health Homes Update | | Alexis Ulrich |
| 3/15/2012<br>Nevada State Legislative Building | The Public | Public Workshop (PowerPoint Presentation) | | Alexis Ulrich<br>John Whaley |
| 3/15/2012 | Inter-Tribal Council of Nevada | Tribal letter sent to notify of upcoming implementation of 1115 Research and Demonstration Waiver | | Sent by DHCFP |
| 4/17/2012<br>Legislative Counsel Bureau<br>Carson City | MCAC members<br>The Public | Care Management Organization/Health Homes/1115 Waiver Update | | Alexis Ulrich<br>John Whaley |
| 1/13/2013<br>MCAC (Medical Care Advisory Committee) meeting | MCAC members<br>The Public | Update on the status of the 1115 Waiver and the CMO | | Jennifer White<br>John Whaley |
| 2/25/2013, Northern Nevada Child and Adolescent Services (NNCAS)<br>Reno | NNCAS | NNCAS inquired about the 115 Waiver and whether TCM (Targeted case management) was included (not at this time). They are looking for more access to SEDs through MCOs or TCM. Interested in becoming a medical home once we reach that phase of the Waiver. We updated them on Waiver status. | Stay in touch with NNCAS throughout the Waiver process, particularly when we start looking at medical homes. | Jennifer White<br>Tracy Palmer<br>Alexis Ulrich<br>Jenni Bonk |

| DATE/LOCATION | STAKEHOLDER | SUMMARY OF MEETING | FOLLOW-UP NEEDED | ATTENDED BY: |
|---|---|---|---|---|
| 2/28/2013, Nevada State Health Division (NSHD) via phone | Diabetes Policy Workgroup Meeting | Discussion over the best policy to pursue regarding diabetes workgroup priorities. The options, Electronic Health Data (EHD) and Care Coordination, were discussed. Currently, EHD is limited to what is available through Medicaid and private entities are not included. More interest in Care Coordination was expressed with numerous examples available. The next step will be to assign a consultant to assist. | In-person meeting planned for week of 4/22 or 4/29; depending on group preference. | Jenni Bonk |
| 4/16/2012 MCAC mtg. 1100 Wm. St. Carson City | MCAC members the public | Update on 1115 waiver provided. Reinforced update given on 1/2013 and work DHCFP is doing with CMS. | | Jennifer White Jenni Bonk MCAC members Meeting attendees |
| 5/10/13, Nevada State Health Division (NSHD), 4150 Tech Way, Carson City | Chronic Disease Prevention & Health Promotion | Provided an explanation of the CMO and how it will affect the chronically ill population. Discussed how we can work together with the information gained from the CMO and apply it to other programs. | Consider including this group in future stakeholder presentations with the CMO | Jenni Bonk Kimberly Fahey |
| 10/15/13, MCAC meeting: 1115 Waiver & CMO update | MCAC committee | Update on Waiver and CMO | | Jenni Bonk Hilary Jones Jennifer White |
| 10/15/13, Annual Conference (2013)--HP | Providers | Overview of Waiver and CMO | | Jenni Bonk John Whaley |
| 11/14/13, Public Hearing, Present Chapter 3800 | Public | | | Jenni Bonk Hilary Jones Jennifer White |

# 6. APPENDIX B.

The following pages contain the Performance Measure Tracking Grids for the P4P measures (Appendix B-1) as well as other quality measures (Appendix B-2).

**Nevada Comprehensive Care Waiver Program**
**Performance Measure Tracking Grid - P4P Measures**

| Condition | Measure Number | Measure Description (Use numerator description) | Age Group | Baseline Rate (Indicate Year) | | | Performance Target (Year 1) | Remeasurement 1 (Indicate Year) | | | Performance Target Met? (Y/N) | Performance Target (Year 2) | Corresponding Objective |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Numerator | Denominator | Rate (Percent) | | Numerator | Denominator | Rate (Percent) | | | |
| | Example 1 | measure example 1 | 6 years + | 183 | 345 | 53.0% | 57.7% | 196 | 300 | 65.3% | Yes | 65.3% | 0.0 |
| | Example 2 | measure example 2 | 18+ | 90 | 180 | 50.0% | 55.0% | 120 | 240 | 50.0% | No | 55.0% | 0.0 |
| | Example 3 | measure example 3 | 0-18 years | 290 | 590 | 49.2% | 54.2% | 330 | 595 | 55.5% | Yes | 55.5% | 0.0 |
| | Example 4 | measure example 4 | 18+ | 234 | 789 | 29.7% | 36.7% | 239 | 760 | 31.4% | No | 36.7% | 0.0 |
| Asthma | ASM.1 | Percentage of members 5-64 years of age during the measurement period who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement period. | 5-64 years | | | | | | | | | | 2.4 |
| | ASM.2 | Percent of patients who have a record of influenza immunization in the past 12 months. | No restrictions | | | | | | | | | | 2.1 |
| | ASM.3 | The percentage of members enrolled during the measurement period with at least one emergency department visit or an urgent care visit for an asthma related event. | No restrictions | | | | | | | | | | 3.2 |
| | ASM.4 | The percentage of discharges for members who were hospitalized with a primary discharge diagnosis of asthma and had a follow-up ambulatory care visit within 7 days of discharge. | No restrictions | | | | | | | | | | 2.2 |
| CAD | CAD.1 | The percentage of members identified with coronary artery disease (CAD) who were prescribed a lipid lowering medication during the measurement period. | No restrictions | | | | | | | | | | 2.4 |
| | CAD.2 | The percentage of members identified with a coronary artery disease (CAD) who had an LDL-C screen performed during the measurement period. | No restrictions | | | | | | | | | | 2.1 |
| | CAD.3 | The percentage of discharges for members who were hospitalized with a primary discharge diagnosis of coronary artery disease (CAD) and who had a follow-up, ambulatory care visit within 7 days of discharge. | No restrictions | | | | | | | | | | 2.2 |
| COPD | SPR.1 | The percentage of members 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis. | 42+ | | | | | | | | | | 2.1 |
| | SPR.2 | Percentage of patients aged 18 years and older with a diagnosis of COPD who received influenza immunization in the past 12 months. | 18+ | | | | | | | | | | 2.1 |
| | SPR.3 | The percentage of discharges for members who were hospitalized with a primary discharge diagnosis of COPD and who had a follow-up, ambulatory care visit within 7 days of discharge. | No restrictions | | | | | | | | | | 2.2 |
| Diabetes | CDC.1 | Percent of members 18 – 75 years of age, with diabetes, who had an HbA1c test performed in the measurement period. | 18-75 years | | | | | | | | | | 2.1 |
| | CDC.2 | Percent of members 18 – 75 years of age who with diabetes mellitus (type 1 and type 2) and have had a low-density lipoprotein cholesterol (LDL-C) screening performed in the measurement period. | 18-75 years | | | | | | | | | | 2.1 |
| | CDC.3 | Percent of members 18 – 75 years of age, with diabetes, who had a nephropathy screening test or evidence of nephropathy. | 18-75 years | | | | | | | | | | 2.1 |
| | CDC.4 | Percent of members 18 – 75 years of age, with diabetes, who had an eye screening for diabetic retinal disease in the measurement period. | 18-75 years | | | | | | | | | | 2.1 |

**Nevada Comprehensive Care Waiver Program**
**Performance Measure Tracking Grid - P4P Measures**

| Condition | Measure Number | Measure Description (Use numerator description) | Age Group | Baseline Rate (Indicate Year) | | | Performance Target (Year 1) | Remeasurement 1 (Indicate Year) | | | Performance Target Met? (Y/N) | Performance Target (Year 2) | Corresponding Objective |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Numerator | Denominator | Rate (Percent) | | Numerator | Denominator | Rate (Percent) | | | |
| | CDC.5 | Percent of members 18 – 75 years of age, with diabetes, who received an influenza immunization during the measurement period. | 18-75 years | | | | | | | | | | 2.1 |
| | CDC.6 | Percent of members 5 – 17 years of age, with diabetes, who had an HbA1c test performed in the measurement period. | 5-17 years | | | | | | | | | | 2.1 |
| Heart Failure | HF.1 | Percent of members 18 years and older who were hospitalized in the intake period with a diagnosis of acute myocardial infarction (AMI) and received persistent beta-blocker treatment for six months after being discharged alive. | 18+ | | | | | | | | | | 2.4 |
| | HF.2 | Percent of members with heart failure who had at least one ED visit for acute exacerbation. | No restrictions | | | | | | | | | | 3.2 |
| | HF.3 | Percent of members 18 years of age and older who received at least 180 treatment days of ambulatory medication therapy for ACEIs or ARBs during the measurement period and at least one serum creatinine or blood urea nitrogen therapeutic monitoring test in the measurement period. | 18+ | | | | | | | | | | 2.4 |
| | HF.4 | The percentage of discharges for members who were hospitalized with a primary discharge diagnosis of heart failure (HF) and had a follow-up, ambulatory care visit within 7 days of discharge. | No restrictions | | | | | | | | | | 2.2 |
| HIV/AIDS | HIV.1 | The percentage of members with a diagnosis of HIV/AIDS with at least one ambulatory care visit in the first half and second half of the measurement period, with a minimum of 60 days between each visit. | No restrictions | | | | | | | | | | 1.5 |
| Hypertension | HPTN.1 | The percentage of members with hypertension who were on an anti-hypertension multi-drug therapy regimen, during the measurement period, that included a thiazide diuretic. | No restrictions | | | | | | | | | | 2.4 |
| Mental Health | MH.1 | The percentage of members with bipolar I disorder treated with mood stabilizers at least 80% of the time during the measurement period. | No restrictions | | | | | | | | | | 2.3 |
| | MH.2 | Percentage of members who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication treatment for at least 84 days. | No restrictions | | | | | | | | | | 2.3 |
| | MH.3.1 | Percentage of members ages 6 and older with schizophrenia who remained on an antipsychotic medication during the measurement period. Two rates are reported:<br>MH.3.1 – rate for 6 months of medication adherence | 6+ | | | | | | | | | | 2.4 |
| | MH.3.2 | Percentage of members ages 6 and older with schizophrenia who remained on an antipsychotic medication during the measurement period. Two rates are reported:<br>MH.3.2 – rate for one year of medication adherence | 6+ | | | | | | | | | | 2.4 |
| | MH.4.2 (See other quality Measures for MH.4.1) | Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of select mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported:<br>MH.4.2 – the percentage of discharges for which the member received follow-up within 7 days of discharge (used for P4P). | 6+ | | | | | | | | | | 2.2 |

**Nevada Comprehensive Care Waiver Program**
**Performance Measure Tracking Grid - P4P Measures**

| Condition | Measure Number | Measure Description (Use numerator description) | Age Group | Baseline Rate (Indicate Year) | | | Performance Target (Year 1) | Remeasurement 1 (Indicate Year) | | | Performance Target Met? (Y/N) | Performance Target (Year 2) | Corresponding Objective |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Numerator | Denominator | Rate (Percent) | | Numerator | Denominator | Rate (Percent) | | | |
| Substance Abuse | S.A.1 | Percentage of adolescents and adults members with a new episode of alcohol or other drug (AOD) dependence who received AOD treatment. Two rates are reported:<br>MH.5.1 – The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.<br>MH.5.2 – The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit. | 13+ | | | | | | | | | | 1.5 |

**Nevada Comprehensive Care Waiver Program**
**Performance Measure Tracking Grid - Other Quality Measures**

| Condition | Measure Number | Measure Description (Use numerator description) | Age Group | Baseline Rate (Indicate Year) | | | Performance Target (Year 1) | Remeasurement 1 (Indicate Year) | | | Performance Target Met? (Y/N) | Performance Target (Year 2) | Corresponding Objective |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Numerator | Denominator | Rate (Percent) | | Numerator | Denominator | Rate (Percent) | | | |
| | Example 1 | measure example 1 | 6 years + | 183 | 345 | 53.0% | 57.7% | 196 | 300 | 65.3% | Yes | 65.3% | 0.0 |
| | Example 2 | measure example 2 | 18+ | 90 | 180 | 50.0% | 55.0% | 131 | 240 | 54.6% | No | 55.0% | 0.0 |
| | Example 3 | measure example 3 | 0-18 years | 290 | 590 | 49.2% | 54.2% | 330 | 595 | 55.5% | Yes | 55.5% | 0.0 |
| | Example 4 | measure example 4 | 18+ | 234 | 789 | 29.7% | 36.7% | 239 | 760 | 31.4% | No | 36.7% | 0.0 |
| 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. | <75 years | | | | | | | | | | 1.5 |
| | CCHU.2 | "Avoidable" ER visits are defined as visits with a primary diagnosis that match the avoidable diagnosis codes. The rate of avoidable ER visits used represents the percentage of all ER visits that match the selected "avoidable" diagnosis codes. | No restrictions | | | | | | | | | | 3.2 |
| | CCHU.3 | Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within: 24 hours of discharge | No restrictions | | | | | | | | | | 3.1 |
| | CCHU.4 | Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within: 7 days of discharge | No restrictions | | | | | | | | | | 3.1 |
| | CCHU.5 | Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within: 30 days of discharge | No restrictions | | | | | | | | | | 3.1 |
| | CCHU.6 | This measure is used to assess the percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care, or their caregiver(s), who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the specified elements. | No restrictions | | | | | | | | | | 3.1 |

**Nevada Comprehensive Care Waiver Program**
**Performance Measure Tracking Grid - Other Quality Measures**

| Condition | Measure Number | Measure Description (Use numerator description) | Age Group | Baseline Rate (Indicate Year) | | | Performance Target (Year 1) | Remeasurement 1 (Indicate Year) | | | Performance Target Met? (Y/N) | Performance Target (Year 2) | Corresponding Objective |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Numerator | Denominator | Rate (Percent) | | Numerator | Denominator | Rate (Percent) | | | |
| | CCHU.7 | Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care, or their caregiver(s), who received a reconciled medication list at the time of discharge including, at a minimum, medications in the specified categories. | No restrictions | | | | | | | | | | 3.1 |
| Dementia | DEM | The percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least within a 12 month period. | No restrictions | | | | | | | | | | 1.3 |
| 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+ | | | | | | | | | | 2.4 |
| 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+ | | | | | | | | | | 2.1 |
| Cancer/ Neoplasm | CAN | Percentage of female patients aged 18 years and older with Stage IC through IIIC, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period. | 18+ | | | | | | | | | | 2.4 |
| 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+ | | | | | | | | | | 2.4 |
| | OST | Percentage of patients aged 50 years and older with a diagnosis of osteoporosis who were prescribed pharmacologic therapy within 12 months. | 67+ | | | | | | | | | | 2.4 |
| Obesity | OBS | Percentage of members 2-17 years of age 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. | 2-17 years | | | | | | | | | | 2.1 |
| | CAP | Percentage of members 12 months-19 years of age who had a visit with a Primary Care Practitioner (PCP). The organization reports four separate percentages for each product line. | 12 mos-19 years | | | | | | | | | | 2.1 |

**Nevada Comprehensive Care Waiver Program**
**Performance Measure Tracking Grid - Other Quality Measures**

| Condition | Measure Number | Measure Description (Use numerator description) | Age Group | Baseline Rate (Indicate Year) | | | Performance Target (Year 1) | Remeasurement 1 (Indicate Year) | | | Performance Target Met? (Y/N) | Performance Target (Year 2) | Corresponding Objective |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Numerator | Denominator | Rate (Percent) | | Numerator | Denominator | Rate (Percent) | | | |
| Preventative | W15 | Percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life: No well-child visits | Turned 15 months old during the measure-ment year | | | | | | | | | | 2.1 |
| | W15 | Percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life: One well-child visit | Turned 15 months old during the measure-ment year | | | | | | | | | | 2.1 |
| | W15 | Percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life: Two well-child visits | Turned 15 months old during the measure-ment year | | | | | | | | | | 2.1 |
| | W15 | Percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life: Three well-child visits | Turned 15 months old during the measure-ment year | | | | | | | | | | 2.1 |
| | W15 | Percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life: Four well-child visits | Turned 15 months old during the measure-ment year | | | | | | | | | | 2.1 |
| | W15 | Percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life: Five well-child visits | Turned 15 months old during the measure-ment year | | | | | | | | | | 2.1 |
| | W15 | Percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life: Six well-child visits | Turned 15 months old during the measure-ment year | | | | | | | | | | 2.1 |

**Nevada Comprehensive Care Waiver Program**
**Performance Measure Tracking Grid - Other Quality Measures**

| Condition | Measure Number | Measure Description (Use numerator description) | Age Group | Baseline Rate (Indicate Year) | | | Performance Target (Year 1) | Remeasurement 1 (Indicate Year) | | | Performance Target Met? (Y/N) | Performance Target (Year 2) | Corresponding Objective |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Numerator | Denominator | Rate (Percent) | | Numerator | Denominator | Rate (Percent) | | | |
| Preventative | W34 | Percentage of members 3-6 years of age who had one or more well-child visits with a PCP during the measurement year. | 3-6 years | | | | | | | | | | 2.1 |
| | AWC | Percentage of enrolled members 12-21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year. | 12-21 years | | | | | | | | | | 2.1 |
| | CIS | Percentage of children 2 years of age who had four DTaP vaccines by their second birthday. | 2 years | | | | | | | | | | 2.1 |
| | CIS | Percentage of children 2 years of age who had three IPV vaccines by their second birthday. | 2 years | | | | | | | | | | 2.1 |
| | CIS | Percentage of children 2 years of age who had one MMR vaccine by their second birthday. | 2 years | | | | | | | | | | 2.1 |
| | CIS | Percentage of children 2 years of age who had three HiB vaccines by their second birthday. | 2 years | | | | | | | | | | 2.1 |
| | CIS | Percentage of children 2 years of age who had three HepB vaccines by their second birthday. | 2 years | | | | | | | | | | 2.1 |
| | CIS | Percentage of children 2 years of age who had one VZV (varicella) vaccine by their second birthday. | 2 years | | | | | | | | | | 2.2 |
| | CIS | Percentage of children 2 years of age who had four PCV vaccines by their second birthday. | 2 years | | | | | | | | | | 2.3 |
| | CIS | Percentage of children 2 years of age who had one HepA vaccine by their second birthday. | 2 years | | | | | | | | | | 2.4 |
| | CIS | Percentage of children 2 years of age who had two or three RV vaccines by their second birthday. | 2 years | | | | | | | | | | 2.5 |
| | CIS | Percentage of children 2 years of age who had two flu vaccines by their second birthday. | 2 years | | | | | | | | | | 2.6 |
| | PPC | Percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. | No restrictions | | | | | | | | | | N/A |
| | WOP | Percentage of women who delivered a live birth during the measurement year by the weeks of pregnancy at the time of their enrollment in the organization. | No restrictions | | | | | | | | | | N/A |
| | FPC.1 | Percentage of Medicaid deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that had the following number of expected prenatal visits:<br><21 percent of expected visits | No restrictions | | | | | | | | | | 2.1 |

**Nevada Comprehensive Care Waiver Program**
**Performance Measure Tracking Grid - Other Quality Measures**

| Condition | Measure Number | Measure Description (Use numerator description) | Age Group | Baseline Rate (Indicate Year) | | | Performance Target (Year 1) | Remeasurement 1 (Indicate Year) | | | Performance Target Met? (Y/N) | Performance Target (Year 2) | Corresponding Objective |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Numerator | Denominator | Rate (Percent) | | Numerator | Denominator | Rate (Percent) | | | |
| Pregnancy | 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:<br>21 percent - 40 percent of expected visits | No restrictions | | | | | | | | | | 2.1 |
| | FPC.3 | Percentage of Medicaid deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that had the following number of expected prenatal visits:<br>41 percent - 60 percent of expected visits | No restrictions | | | | | | | | | | 2.1 |
| | FPC.4 | Percentage of Medicaid deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that had the following number of expected prenatal visits:<br>61 percent - 80 percent of expected visits | No restrictions | | | | | | | | | | 2.1 |
| | FPC.5 | Percentage of Medicaid deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that had the following number of expected prenatal visits:<br>≥81 percent of expected visits | No restrictions | | | | | | | | | | 2.1 |
| 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 | | | | | | | | | | 2.1 |
| | BCS | Percentage of women 40-69 years of age who had a mammogram to screen for breast cancer. | 42-69 years | | | | | | | | | | 2.1 |
| | CCS | Percentage of women 21-64 years of age who received one or more Pap tests to screen cervical cancer. | 22-64 years | | | | | | | | | | 2.1 |
| | COL | The percentage of members 50-75 years of age who had appropriate screening for colorectal cancer. | 51-75 years | | | | | | | | | | 2.1 |