State of Nevada

Division of Health Care Financing and Policy

State Fiscal Year 2014–2015 External Quality Review Technical Report

October 2015

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ACKNOWLEDGMENTS AND COPYRIGHTS

Overview of the SFY 2014–2015 External Quality Review

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

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

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

The SFY 2014–2015 EQR Technical Report includes a review of recipients' access to care and the quality of services received by recipients of Title XIX, Medicaid, and Title XXI, CHIP. In addition, the report focuses on the three federally mandated EQR activities. As described in 42 CFR 438.358, these activities are:

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

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

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

- Provided an analysis of the results of CAHPS activities conducted by the MCOs, which is presented in Section 7.
- Provided technical assistance to the DHCFP with activities related to the Nevada Comprehensive Care Waiver (NCCW) program, which is called the Health Care Guidance Program (HCGP). Those activities included:
  - Implementing the NCCW Quality Strategy, which was developed in response to the requirements included in the 1115 Research and Demonstration Waiver special terms and conditions.
  - Performing a compliance review to verify the HCGP program vendor complied with its contract six months after operations commenced, which is presented in Section 8.
- Conducted an evaluation of Nevada's Medicaid provider network. The purpose of the analysis was to estimate the provider network capacity, geographic distribution, and appointment availability of the MCOs' and fee for service networks.

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

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

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

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

Overall, both **Amerigroup** and **HPN** have demonstrated strengths and opportunities for improvement related to access, timeliness, and quality of care provided to Nevada Medicaid and Nevada Check Up populations. HSAG encourages the continued use of collaborative meetings between the DHCFP and the MCOs to continually assess MCO performance and the Medicaid and Nevada Check Up programs' achievement of the goals and objectives identified in the State's Quality Strategy.

Internal Quality Assurance Program Review of Compliance

The purpose of the SFY 2014–2015 Internal Quality Assurance Program (IQAP) on-site Review of Compliance was to determine the MCOs' compliance with federal and State managed care standards. For the SFY 2014–2015 IQAP on-site Review of Compliance, HSAG reviewed each MCO's managed care and quality program activities during SFY 2013–2014 and its compliance with the following:

- State and federal managed care requirements, which were categorized into 14 contract standards, referred to as ***IQAP Standards.***
- Outreach and educational materials associated with member rights and responsibilities, the member handbook, medical record standards, and the provider manual, referred to as ***Checklists.***
- Operational compliance for credentialing, recredentialing, service denial, grievances and appeal processing, and case management activities, referred to as ***File Reviews.***

Table 1-1 summarizes the MCOs' results for these IQAP Standards, Checklists, and File Reviews for the SFY 2014–2015 IQAP Compliance Review. In addition, the table presents the overall composite score for each MCO for all areas reviewed. The overall composite score for **Amerigroup** was 97.3 percent. The overall composite score for **HPN** was 98.6 percent.

Table 1-1—IQAP Compliance Results for Nevada MCOs

IQAP Compliance Activity	Amerigroup	HPN
IQAP Standards Score	98.7%	97.3%
File Review Score	96.5%	99.1%
Checklists Score	100%	98.7%
Overall Score	**97.3%**	**98.6%**

Amerigroup and **HPN** had a similar IQAP standards score—98.7 percent and 97.3 percent, respectively. These scores represent improvement over the IQAP standards scores received in SFY 2011–2012. The scores demonstrate the MCOs' strong application of the requirements of the MCO contract in many of the same areas.

For the file reviews, **Amerigroup** received a score of 96.5 percent and **HPN** received a score of 99.1 percent. **HPN** received 100 percent compliance in *Credentialing*, *Recredentialing*, and *Denials*. **Amerigroup** received 100 percent compliance with *Denials*. File reviews related to *Grievances* and *Appeals* proved to be a challenge for both MCOs. **Amerigroup** received scores of 90.5 percent and 92.9 percent for *Grievances* and *Appeals*, respectively. **HPN** received scores of 96.7 percent and 89.7 percent for *Grievances* and *Appeals*, respectively. **Amerigroup** had one noncompliant element for the *Credentialing* review. For the *Recredentialing* file review, which is a state-specific standard, **Amerigroup** did not reverify providers' hospital privileges during the recredentialing period. Missing this element for all 10 files reviewed resulted in the *Recredentialing* score of 95.2 percent for **Amerigroup**. Lastly, **Amerigroup** received a score of 96.4 percent for the *Case Management* file review and **HPN** received a score of 99.4 percent.

For the Checklists reviews, **Amerigroup** received 100 percent compliance for all Checklists, *Member Rights and Responsibilities*, *Member Handbook*, *Medical Record Standards*, and *Provider Manual*. **HPN** received a *Not Met* for one element in the *Member Handbook* review and received 100 percent compliance for the remaining three Checklists reviews.

Conclusions and Recommendations

Based on the results of the SFY 2014–2015 IQAP Review of Compliance, HSAG recommended the following:

- Both MCOs should provide evidence of monitoring pregnancy prevention and family planning services.
- **Amerigroup** should reverify providers' hospital privileges during the recredentialing process.
- Both MCOs should ensure that members have access to primary care providers (PCPs) within 25 miles of a member's residence.
- Both MCOs should ensure that service authorization extension notices contain the provision that members have the right to file a grievance if the MCO extends the time frame to make a decision about a service authorization and the member disagrees with that decision.
- Both MCOs should acknowledge receipt of grievances and appeals within the required time frames.
- Both MCOs should maintain the policy that the State may access medical records within 10 days of request and that the MCOs will make the records available at each MCO's expense.
- **Amerigroup** should ensure that members receiving case management services are provided with condition-specific education materials and that distribution of these materials is documented in the case management file.
- Both MCOs should ensure that all case management assessments are completed within 90 days of enrollment.
- **HPN** should develop written policies regarding the treatment of minors, as required by the MCO's contract with the DHCFP.
- **HPN** should acknowledge appeals within the time frames specified by its policy. For expedited appeals, **HPN** must ensure that a notice of extension is sent to members when the MCO requires more time to resolve the expedited appeal, and that the expedited appeal is resolved within the required time frames specified by **HPN**'s policy.
- **HPN** should ensure that policies maintain the provision that punitive action will not be taken against a provider who supports an expedited appeal.
- **HPN** should verify that prospective subcontractors have the ability to perform delegated activities before **HPN** enters an agreement with the subcontractor.
- **HPN** should require that all staff members at all levels receive ongoing education and training on culturally and linguistically appropriate service delivery to members.
- **HPN** should maintain the policy that members who are automatically enrolled after a break in eligibility of less than two months may not be allowed to disenroll without cause until the next open enrollment period.

Validation of Performance Measures—NCQA HEDIS Compliance Audits

HSAG conducted a NCQA HEDIS Compliance Audit to assess **HPN** and **Amerigroup** performance with respect to the HEDIS 2015 Technical Specifications and to review the MCOs' performance on the HEDIS measures. In HEDIS 2015, the MCOs were required to report 13 measures with a total of 48 rates for the Medicaid population and 10 measures with a total of 35 rates for the Nevada Check Up population. HSAG validated all measures reported by the MCOs. Measures with a denominator less than 30 are shown as NA in Table 1-2 and Table 1-3.

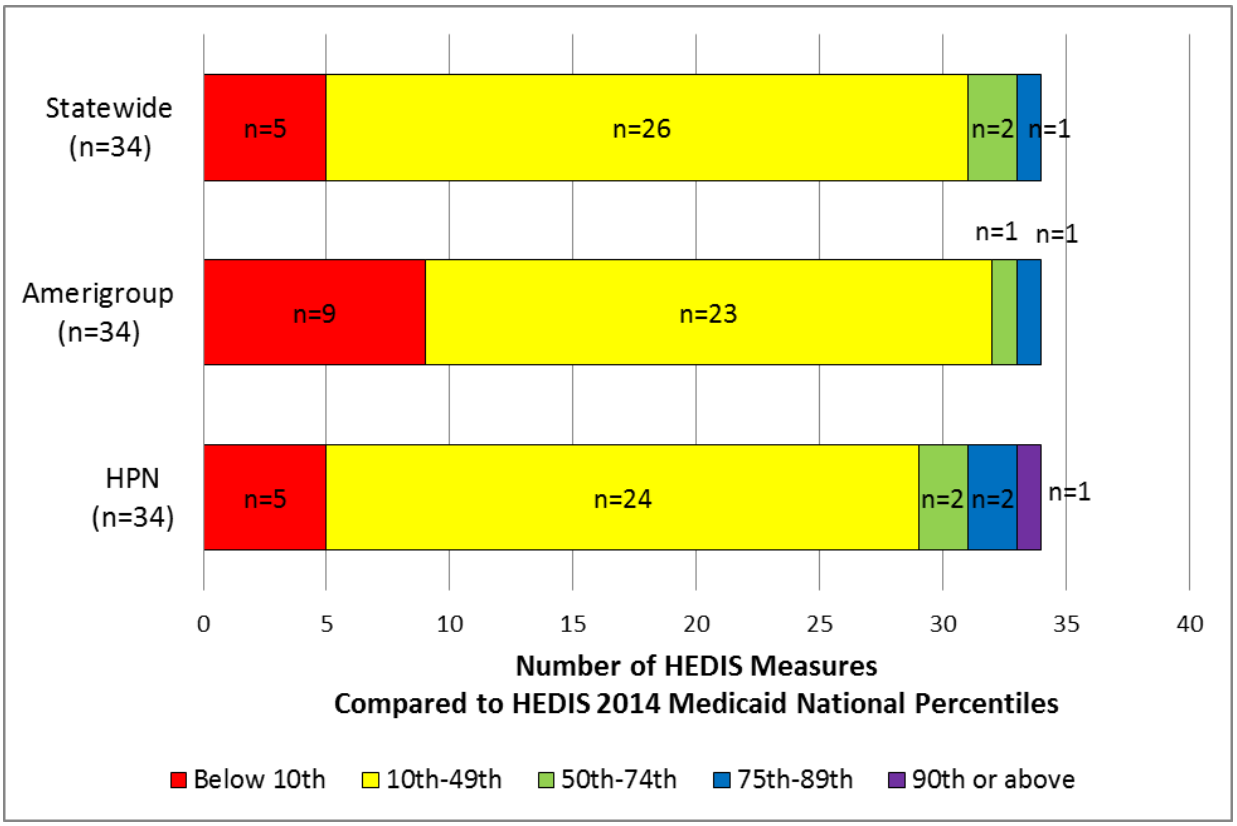
Medicaid Findings

The NCQA HEDIS Compliance Audit demonstrated that both MCOs had strong policies and procedures in place to collect, process, and report HEDIS data, and both MCOs were in full compliance with the HEDIS 2015 Technical Specifications. The claims and encounter data systems employed by the MCOs used sophisticated scanning processes and advanced software to ensure accurate data processing. Both MCOs used software, the source code of which had been certified by NCQA, to generate HEDIS measures. This ensured accurate measure calculation.

In terms of quality, access, and timeliness, both MCOs demonstrated mixed performance. Overall, the Nevada Medicaid rates have continued to improve but opportunities for additional improvement remain.

Figure 1-1 shows the MCOs' performance on the Medicaid measures compared to the national HEDIS percentiles. The graph shows the performance for **Amerigroup** and **HPN**, as well as the statewide (**Amerigroup** and **HPN** combined) performance on the measures. Since *Mental Health Utilization* is designed to capture the frequency of mental health services provided by the MCOs and higher or lower rates do not indicate better or worse performance, the percentile ranking for each rate is informational only and is not included in the figure.

Figure 1-1—Comparison of Nevada MCO Medicaid Performance Measures to HEDIS Medicaid National Percentiles



None of the Nevada statewide Medicaid rates ranked above the 2014 HEDIS 90th percentile. Three Nevada Medicaid rates ranked above the 50th percentile. Five rates were below the 10th percentile, three of which were child-related access measures.

Table 1-2 shows each MCO's rates for each Medicaid measure and the corresponding percentile ranking for each MCO's rates.

Table 1-2—Nevada MCO Medicaid Performance Measure Rates and HEDIS 2014 Percentile Ranking

HEDIS Measure	HPN Rate	HEDIS Ranking*	AGP Rate	HEDIS Ranking*
Childhood Immunization Status—Combination 2	70.56%	10th to 25th percentile	66.20%	10th to 25th percentile
Childhood Immunization Status—Combination 3	65.94%	10th to 25th percentile	60.88%	10th to 25th percentile
Childhood Immunization Status—Combination 4	64.72%	25th to 50th percentile	58.80%	10th to 25th percentile
Childhood Immunization Status—Combination 5	55.47%	25th to 50th percentile	50.23%	10th to 25th percentile
Childhood Immunization Status—Combination 6	38.44%	25th to 50th percentile	33.33%	25th to 50th percentile
Childhood Immunization Status—Combination 7	54.50%	25th to 50th percentile	48.38%	25th to 50th percentile
Childhood Immunization Status—Combination 8	37.71%	25th to 50th percentile	33.10%	25th to 50th percentile
Childhood Immunization Status—Combination 9	33.82%	25th to 50th percentile	28.24%	25th to 50th percentile
Childhood Immunization Status—Combination 10	33.09%	25th to 50th percentile	28.01%	25th to 50th percentile
Lead Screening in Children	40.88%	10th to 25th percentile	35.88%	<10th percentile
Well-Child Visits in the First 15 Months of Life (6 or More Visits)	51.58%	10th to 25th percentile	50.58%	10th to 25th percentile
Well-Child Visits 3–6 Years of Life	58.15%	<10th percentile	65.05%	10th to 25th percentile
Adolescent Well-Care Visits	42.34%	25th to 50th percentile	40.51%	10th to 25th percentile
Children's Access to Primary Care Practitioners (12–24 Months)	91.42%	<10th percentile	91.14%	<10th percentile
Children's Access to Primary Care Practitioners (25 Months–6 Years)	79.21%	<10th percentile	81.29%	<10th percentile
Children's Access to Primary Care Practitioners (7–11 Years)	83.88%	10th to 25th percentile	85.47%	10th to 25th percentile
Children's Access to Primary Care Practitioners (12–19 Years)	81.05%	<10th percentile	81.76%	10th to 25th percentile
Annual Dental Visit—Combined Rate	51.30%	25th to 50th percentile	45.81%	25th to 50th percentile
Use of Appropriate Medications for People With Asthma (5–11 Years)	89.22%	25th to 50th percentile	82.49%	<10th percentile
Use of Appropriate Medications for People With Asthma (12–18 Years)	89.54%	75th to 90th percentile	71.95%	<10th percentile
Use of Appropriate Medications for People With Asthma (19–50 Years)	70.32%	25th to 50th percentile	56.18%	<10th percentile
Use of Appropriate Medications for People With Asthma (51–64 Years)	NA	--	NA	--
Use of Appropriate Medications for People With Asthma (Combined)	86.82%	50th to 75th percentile	76.42%	<10th percentile
Comprehensive Diabetes Care—HbA1c Testing	77.13%	<10th percentile	69.84%	<10th percentile
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0)**	50.36%	25th to 50th percentile	58.70%	10th to 25th percentile
Comprehensive Diabetes Care—HbA1c Good Control (<8.0)	38.44%	25th to 50th percentile	34.34%	10th to 25th percentile
Comprehensive Diabetes Care—Eye Exam	52.55%	25th to 50th percentile	45.24%	10th to 25th percentile

Table 1-2—Nevada MCO Medicaid Performance Measure Rates and HEDIS 2014 Percentile Ranking				
HEDIS Measure	**HPN Rate**	**HEDIS Ranking***	**AGP Rate**	**HEDIS Ranking***
Comprehensive Diabetes Care—Attention for Medical Nephropathy	73.24%	10th to 25th percentile	67.52%	<10th percentile
Comprehensive Diabetes Care—Blood Pressure <140/90	64.96%	50th to 75th percentile	61.25%	25th to 50th percentile
Frequency of Ongoing Prenatal Care (<21% of Visits)**	11.68%	25th to 50th percentile	16.47%	10th to 25th percentile
Frequency of Ongoing Prenatal Care (81–100% Visits)	56.93%	25th to 50th percentile	54.76%	25th to 50th percentile
Timeliness of Prenatal Care	74.94%	10th to 25th percentile	74.48%	10th to 25th percentile
Postpartum Care	51.58%	10th to 25th percentile	50.12%	10th to 25th percentile
Follow-up After Hospitalization for Mental Illness—7 Days	63.85%	>90th percentile	57.19%	75th to 90th percentile
Follow-up After Hospitalization for Mental Illness—30 Days	77.93%	75th to 90th percentile	67.28%	50th to 75th percentile

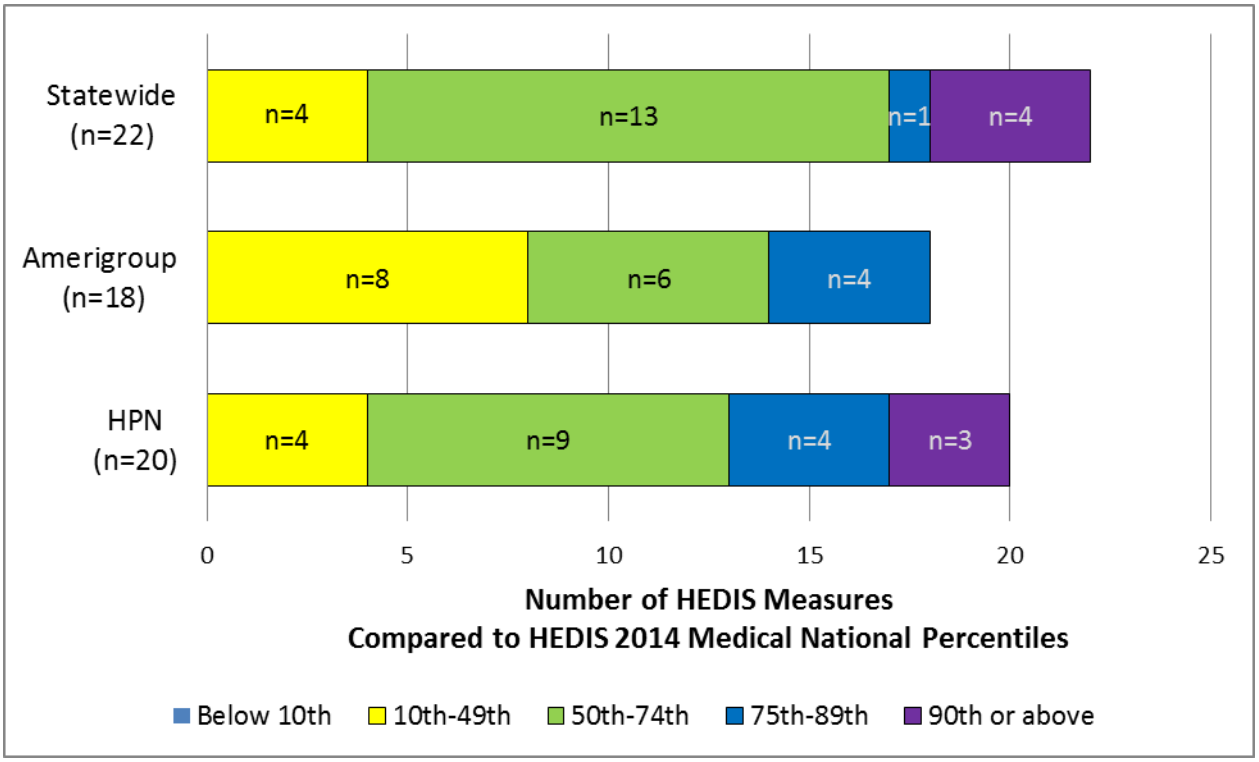
* National Medicaid HEDIS 2014 Percentile Ranking.
** Lower rates are better for this measure. The national Medicaid HEDIS 2014 percentiles were reversed to have the same performance level alignment as the other measures (i.e., the value associated with the 90th percentile suggested better performance).
NA denotes denominators less than 30. Since there is no valid rate reported for this measure, HEDIS ranking result is not available.

Overall, **HPN** performed better than **Amerigroup** for HEDIS 2015. Without counting the four *Mental Health Utilization* rates, **HPN**'s performance exceeded **Amerigroup**'s performance on 30 rates, 18 of which were at least 5 percentage points better than those of **Amerigroup**. **HPN** performed better than **Amerigroup** in all measures except *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* and *Children's Access to Primary Care Practitioners.* For *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*, **Amerigroup**'s rate was at least 5 percentage points higher than **HPN**'s. Compared to the national benchmarks, **HPN** had more rates than **Amerigroup** ranking above the 50th percentile (five versus two) and fewer rates than **Amerigroup** below the 10th percentile (five versus nine).

Nevada Check Up Findings

Figure 1-2 shows the MCOs' performance on the Nevada Check Up measures compared to the national HEDIS percentiles. The graph shows the performance for **Amerigroup** and **HPN**, as well as the statewide (**Amerigroup** and **HPN** combined) performance on the measures. National HEDIS percentiles are not available for CHIP (Nevada Check Up) populations; therefore, caution should be used when comparing Nevada Check Up rates to Medicaid HEDIS percentiles.

Figure 1-2—Comparison of MCO Nevada Check Up Performance Measures to HEDIS Medicaid National Percentiles



In general, Nevada Check Up continues to report better rates than Medicaid. Four of the statewide Nevada Check Up rates were above the HEDIS 2014 90th percentile, and an additional 14 rates were above the 50th percentile. None of the rates fell below the 10th percentile.

Table 1-3 shows MCO rates for each Nevada Check Up measure and the corresponding percentile ranking for each MCO's rates.

Table 1-3—MCO Nevada Check Up Performance Measure Rates and HEDIS 2014 Percentile Ranking

HEDIS Measure	HPN Rate	HEDIS Ranking*	AGP Rate	HEDIS Ranking*
Childhood Immunization Status—Combination 2	83.46%	>90th percentile	74.55%	25th to 50th percentile
Childhood Immunization Status—Combination 3	77.17%	50th to 75th percentile	73.64%	50th to 75th percentile
Childhood Immunization Status—Combination 4	76.38%	75th to 90th percentile	73.64%	75th to 90th percentile
Childhood Immunization Status—Combination 5	66.14%	75th to 90th percentile	54.55%	25th to 50th percentile
Childhood Immunization Status—Combination 6	48.03%	50th to 75th percentile	45.45%	50th to 75th percentile
Childhood Immunization Status—Combination 7	65.35%	75th to 90th percentile	54.55%	25th to 50th percentile
Childhood Immunization Status—Combination 8	47.24%	50th to 75th percentile	45.45%	50th to 75th percentile
Childhood Immunization Status—Combination 9	42.52%	50th to 75th percentile	32.73%	25th to 50th percentile
Childhood Immunization Status—Combination 10	41.73%	50th to 75th percentile	32.73%	25th to 50th percentile
Lead Screening in Children	42.75%	10th to 25th percentile	50.91%	10th to 25th percentile
Well-Child Visits in the First 15 Months of Life (6 or More Visits)	60.00%	25th to 50th percentile	70.37%	75th to 90th percentile

Table 1-3—MCO Nevada Check Up Performance Measure Rates and HEDIS 2014 Percentile Ranking				
HEDIS Measure	HPN Rate	HEDIS Ranking*	AGP Rate	HEDIS Ranking*
Well-Child Visits 3–6 Years of Life	71.95%	50th to 75th percentile	71.30%	25th to 50th percentile
Adolescent Well-Care Visits	55.47%	50th to 75th percentile	56.48%	50th to 75th percentile
Children's Access to Primary Care Practitioners (12–24 Months)	94.70%	10th to 25th percentile	95.83%	10th to 25th percentile
Children's Access to Primary Care Practitioners (25 Months–6 Years)	87.20%	25th to 50th percentile	90.48%	50th to 75th percentile
Children's Access to Primary Care Practitioners (7–11 Years)	93.83%	75th to 90th percentile	92.62%	50th to 75th percentile
Children's Access to Primary Care Practitioners (12–19 Years)	90.79%	50th to 75th percentile	92.18%	75th to 90th percentile
Annual Dental Visit—Combined Rate	69.50%	>90th percentile	64.48%	75th to 90th percentile
Use of Appropriate Medications for People With Asthma (5–11 Years)	95.69%	>90th percentile	NA	--
Use of Appropriate Medications for People With Asthma (12–18 Years)	88.31%	50th to 75th percentile	NA	--
Follow-up After Hospitalization for Mental Illness—7 Days	NA	--	NA	--
Follow-up After Hospitalization for Mental Illness—30 Days	NA	--	NA	--

* National Medicaid HEDIS 2014 Percentile Ranking.
NA denotes denominators less than 30. Since there is no valid rate reported for this measure, the HEDIS ranking result is not available.

HPN's performance was better than **Amerigroup**'s for the Nevada Check Up population. Without counting the *Mental Health Utilization* measure, **HPN**'s performance exceeded that of **Amerigroup** on 12 rates, six of which were at least 5 percentage points better than those of **Amerigroup**. **HPN** performed generally better than **Amerigroup** in *Childhood Immunization Status* and *Annual Dental Visits—Combined Rate.* **Amerigroup**'s performance exceeded HPN's on six rates, two of which were at least 5 percentage points higher than **HPN**'s. **Amerigroup** performed generally better than **Amerigroup** in *Lead Screening in Children*, access measures and well-child visits-related measures. Compared to the national benchmarks, **HPN** had more rates ranking above the 50th percentile than **Amerigroup** (16 versus 10). None of the MCOs had rates below the 10th percentile.

Conclusions and Recommendations

Both MCOs' performance trends for the *Children's and Adolescents' Access to PCPs* measures were either stagnant or showed declines. For both the Medicaid and Nevada Check Up populations, performance for the youngest age group (12 to 24 months) was below the national 25th percentile. Access to care issue for this age group becomes more noticeable for the Medicaid population when taking both MCOs' *Childhood Immunization Status* rates into account. Both MCOs should conduct an analysis to determine if these results are due to member noncompliance, issues with network adequacy, or other potential barriers preventing members from accessing timely care.

Both MCOs had relatively low rates for the *Comprehensive Diabetes Care* measure indicators in prior years and recommendations were provided to the MCOs. For this year, **HPN** showed improvement in these indicators while **Amerigroup** had a decline in performance. Members with these chronic conditions tend to be associated with higher levels of care and the associated costs. While it appears **HPN** may be addressing these concerns, HSAG recommends that **Amerigroup**

target its diabetic population to ensure members receive appropriate services that may help reduce the MCO's cost and improve the health of the member.

Since 2011, HSAG has made recommendations to the MCOs to improve the rates for *Follow-up After Hospitalization for Mental Illness*, and the MCOs responded with improved rates, where **Amerigroup** showed an improvement in rates in 2014 for both indicators and **HPN** showed an improvement in 2013 for both indicators. The HEDIS 2015 rates for both MCOs, however, had declined from the previous year. In both indicators, **HPN**'s rates were at least 5 percentage points higher than **Amerigroup**'s. Since performance improvement was demonstrated by both MCOs in previous years, HSAG recommends that they revisit this measure. Specifically, the MCOs should continue to identify additional areas that impede follow-up and apply interventions that can overcome barriers and improve performance for the measure.

In addition to recommendations made to both MCOs, HSAG has the following recommendations specific to each MCO:

- For **HPN,** *Lead Screening in Children* has shown some improvement in the Medicaid rate. Nonetheless, the Nevada Check Up rate for the same measure showed a notable decline (8.05 percentage points from HEDIS 2012 and 12.49 percentage points from HEDIS 2014). HSAG recommends that **HPN** conduct a root cause analysis and develop targeted interventions to improve this measure. Providers should be reminded that lead screening should be completed as part of a well-child visit or when immunizations are given.
- For **Amerigroup**, the maternity-related measures and the asthma measure have declined notably from the previous year. The HEDIS 2015 rates for the maternity-related measures dropped at least 10 percentage points for the two *Prenatal and Postpartum Care* rates and the *Frequency of Ongoing Prenatal Care 81-100% Visits* rate. When compared to the national benchmark, **Amerigroup**'s performance was below the 50th percentile for these measures. Data completeness analysis showed that at least 40 percent of these rates were derived from medical record data. **Amerigroup** should explore the potential barriers for timely prenatal care and postpartum care. For the *Use of Appropriate Medications for People With Asthma* measure, **Amerigroup**'s HEDIS 2015 rates continued to showed decline from the prior year and since 2012. With these declines, the rates ranked below the national 10th percentile for all age groups with valid rates. HSAG made recommendation to **Amerigroup** in the prior year to conduct a root cause analysis to determine the reason for the low rates, such as potentially including individuals in the denominator who do not have asthma due to provider coding practices.

Validation of Performance Improvement Projects (PIPs)

Amerigroup and **HPN** each conducted the required PIPs and submitted documentation to HSAG for validation. For **Amerigroup**, HSAG reviewed two PIPs SFY 2014–2015—*Diabetes Management* and *Reducing Avoidable Emergency Room Visits*. For **HPN**, HSAG reviewed two PIPs for the period of SFY 2014–2015—*Children and Adolescents' Access to Primary Care Practitioners* and *Reducing Avoidable Emergency Room Visits*.

Amerigroup PIP Findings

For the *Diabetes Management* PIP, **Amerigroup** progressed to reporting Remeasurement 5 data. When compared to baseline, only Study Indicator 3, Nephropathy Screening, demonstrated nonstatistically significant improvement; and the HbA1c Testing rate (Study Indicator 1) fell below the baseline. Study Indicator 2 was retired due to NCQA changes to the *Comprehensive Diabetes Care* performance measure.

The *Reducing Avoidable Emergency Room Visits* PIP progressed to reporting Remeasurement 3 data. The study indicators for the *Reducing Avoidable Emergency Room Visits* PIP are inverse indicators; therefore, a decline in the rate represents an improvement in outcomes. Study Indicator 1 demonstrated consistent improvement over the baseline rate, and at Remeasurement 3 this improvement was statistically significant. An additional measurement period is required to assess for sustained improvement for Study Indicator 1. Study Indicator 2 achieved statistically significant improvement over baseline at Remeasurement 1 and has sustained the improvement over comparable measurement periods.

Table 1-4—Performance Improvement Project Outcomes for Amerigroup

PIP #1—*Diabetes Management*

PIP Study Indicators	Baseline CY 2009	R1 CY 2010	R2 CY 2011	R3 CY 2013	R4 CY 2013	R5 CY 2014	Sustained Improvement
1. The percentage of Medicaid-eligible members 18–75 years of age with a diagnosis of diabetes who had an HbA1C test performed during the measurement year.	70.1%	73.6%	71.6%	68.8%	73.9%	69.8%	NA
2. The percentage of Medicaid-eligible members 18–75 years of age with a diagnosis of diabetes who had an LDL-C screening performed during the measurement year.	64.2%	67.5%	64.4%	65.2%	68.1%		NA
3. The percentage of Medicaid-eligible members 18–75 years of age with a diagnosis of diabetes who had a nephropathy screening test performed during the measurement year.	60.6%	66.5%	69.1%	64.0%	67.3%	67.5%	NA

PIP #2—*Reducing Avoidable Emergency Room Visits*

PIP Study Indicators	Baseline CY 2011	R1 CY 2012	R2 CY 2013	R3 CY 2014	Sustained Improvement
1. The percentage of avoidable ER visits for the Nevada Check Up (CHIP) population. ¤	39.7%	39.1%	37.5%	34.8%↓*	NA
2. The percentage of avoidable ER visits for the Medicaid population. ¤	42.6%	41.4%↓*	39.1%	33.7%	Yes

¤ The study indicators are inverse indicators; therefore, a decline in the rate represents an improvement in the outcomes.
↓* Designates statistically significant improvement over the baseline (p value < 0.05).
NA Sustained improvement cannot be determined until statistically significant improvement has been achieved across **all** study indicators followed by a subsequent measurement period.
CY Calendar year
R Remeasurement

Due to the lack of statistically significant improvement for both indicators, the overall validation status for the **Amerigroup** *Diabetes Management* PIP was *Not Met*. The *Reducing Avoidable Emergency Room Visits* PIP achieved a *Met* validation status because it demonstrated statistically significant improvement for both indicators and sustained that improvement for one indicator.

HPN PIP Findings

For the *Children and Adolescents' Access to Primary Care Practitioners* PIP, **HPN** reported Remeasurement 1 data for all study indicators. Three of the four indicators achieved improvement; however, only the improvements of Study Indicator 2 and Study Indicator 3 were statistically significant over the baseline. The decline in performance for Study Indicator 4 was not statistically significant. The MCO exceeded its goal (83.4 percent) for Study Indicator 2 only.

For the *Reducing Avoidable Emergency Room Visits* PIP, the study indicators are inverse indicators; therefore, a decline in the rate represents improved outcomes. The MCO achieved statistically significant and sustained improvement for both indicators.

Table 1-5—Performance Improvement Project Outcomes for HPN

PIP #1—*Children and Adolescents' Access to Primary Care Practitioners*

PIP Study Indicators	Baseline CY 2013	Remeasurement 1 CY 2014
1. The percentage of children 25 months to six years of age who had one or more visits with a PCP during the measurement year.	78.6%	79.2%
2. The percentage of children seven to 11 years of age who had one or more visits with a PCP during the measurement year.	82.4%	83.9%↑*
3. The percentage of children 12 to 19 years of age who had one or more visits with a PCP during the measurement year.	78.3%	81.1%↑*
4. The percentage of children 12 to 24 months of age (Nevada Check Up) who had one or more visits with a PCP during the measurement year.	95.1%	94%

PIP #2—*Reducing Avoidable Emergency Room Visits*

PIP Study Indicators	Baseline CY 2011	Remeasurement 1 CY 2012	Remeasurement 2 CY 2013	Remeasurement 3 CY 2014	Sustained Improvement^
1. The percentage of avoidable ER visits for the Nevada Check Up population.	39.0%	35.7%↓*	41.7%	24.9%	Yes
2. The percentage of avoidable ER visits for the Medicaid population.	42.0%	37.8%↓*	42.9%	27.9%	Yes

¤ The study indicators are inverse indicators; therefore, a decline in the rate represents an improvement in the outcomes.
↓* Designates statistically significant improvement over the baseline (p value < 0.05).
↑* Designates statistically significant improvement over the baseline (p value < 0.05).
CY Calendar year

Due to the lack of statistically significant improvement for two of the four indicators for **HPN**'s *Children and Adolescents' Access to Primary Care Practitioners* PIP, the overall validation status was *Not Met*. The *Reducing Avoidable Emergency Room Visits* PIP achieved a *Met* validation status.

Recommendations

Overall, HSAG recommends that the MCOs:

- Consider completing a process map and a failure modes and effects analysis to identify specific areas with greatest opportunities for improvement. HSAG can provide technical assistance on how to use these quality improvement tools.
- Conduct further drill-down analyses to identify the reason(s) for a decline in performance and why statistically significant improvement has not been achieved.
- Design small-scale tests coupled with analyses of results to determine the success of the intervention. If, after reviewing the results of the test data, it is determined that the intervention has not been successful, the MCO should determine (1) if the true root cause was identified, and if not, the MCO should conduct another causal/barrier analysis to isolate the true root cause or issue preventing improvement; and (2) if the intervention needs to be revised because a new root cause was identified or because the intervention was unsuccessful. In evaluating the results of intervention testing, the MCO may find that the test results provide more information that directs the MCO to modify an existing intervention to yield a greater result. If the existing intervention is modified and the current test has become obsolete, the MCO should develop another test to evaluate the modified intervention's effectiveness. HSAG can provide technical assistance on how to effectively test interventions using the Plan-Do-Study-Act cycle.
- Identify the national resources available to the health plan and consider implementing interventions successful in sister health plans across the country.

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

The populations surveyed for **HPN** and **Amerigroup** were adult Medicaid, child Medicaid, and Nevada Check Up. DSS Research, an NCQA-certified vendor, administered the 2015 CAHPS surveys for both **HPN** and **Amerigroup**.

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

Amerigroup Findings

In 2015, a total of 2,430 members were surveyed and 473 completed a survey. After ineligible members were excluded, the response rate was 19.9 percent. In 2014, the average NCQA response rate for the adult Medicaid population was higher than **Amerigroup**'s response rate.[1-1] **Amerigroup**'s rates decreased between 2014 and 2015 for four of the eight comparable measures:

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

Getting Care Quickly, *How Well Doctors Communicate*, *Customer Service*, and *Rating of Specialist Seen Most Often*. **Amerigroup**'s rates increased between 2014 and 2015 for four measures: *Getting Needed Care*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*. Further, one measure, *Rating of Personal Doctor*, showed a substantial increase of more than 5 percentage points.

In 2015, a total of 4,043 general child members were surveyed and 636 completed a survey.[1-2] After ineligible members were excluded, the response rate was 17.2 percent. In 2014, the average NCQA response rate for the child Medicaid population was higher than **Amerigroup**'s response rate.[1-3] **Amerigroup**'s rates increased between 2014 and 2015 for four measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Rating of All Health Care*. **Amerigroup**'s rates decreased between 2014 and 2015 for three measures: *Customer Service*, *Rating of Personal Doctor*, and *Rating of Health Plan*. Of these, *Rating of Health Plan* showed a substantial decrease of more than 5 percentage points.

In 2015, a total of 1,600 Nevada Check Up members were surveyed and 401 completed a survey. After ineligible members were excluded, the response rate was 28.5 percent. **Amerigroup**'s rate decreased between 2014 and 2015 for three measures: *Getting Needed Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*. Of these, *Rating of Personal Doctor* and *Rating of Health Plan* showed a substantial decrease of more than 5 percentage points. Four measures increased between 2014 and 2015: *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, and *Rating of All Health Care*. Furthermore, *Customer Service* showed a substantial increase of more than 5 percentage points.

HPN Findings

In 2015, a total of 1,890 adult members were surveyed and 310 completed a survey. After ineligible members were excluded, the response rate was 16.8 percent. In 2014, the average NCQA response rate for the adult Medicaid population was higher than **HPN**'s response rate.[1-4] **HPN**'s rates increased between 2014 and 2015 for four measures: *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, and *Rating of Health Plan*. Of these, two measures showed a substantial increase of more than 5 percentage points: *Rating of All Health Care* and *Rating of Health Plan*. **HPN**'s rates decreased between 2014 and 2015 for two measures: *Getting Needed Care* and *Rating of Personal Doctor*. However, these decreases were not substantial.

In 2015, a total of 2,310 general child members were surveyed and 435 completed a survey.[1-5] After ineligible members were excluded, the response rate for the general child population was 19.8 percent. In 2014, the average NCQA response rate for the child Medicaid population was higher

[1-2] The total number of members surveyed and completed surveys are based on **Amerigroup**'s general child CAHPS sample only (i.e., does not include the children with chronic conditions (CCC) supplemental sample of members that were surveyed).

[1-3] 2015 NCQA national response rate information for the CAHPS 5.0 Child Medicaid with CCC Survey was not available at the time this report was produced.

[1-4] 2015 NCQA national response rate information for the CAHPS 5.0 Adult Medicaid Survey was not available at the time this report was produced.

[1-5] The total number of members surveyed and completed surveys are based on **HPN**'s general child CAHPS sample (i.e., does not include the CCC supplemental sample of members that were surveyed).

than **HPN**'s 2015 response rate.[1-6] **HPN**'s rates decreased between 2014 and 2015 for four of the six reportable measures: *Getting Needed Care*, *Getting Care Quickly*, *Rating of All Health Care*, and *Rating of Personal Doctor*. Further, one measure showed a substantial decrease of more than 5 percentage points: *Getting Needed Care*. **HPN**'s rates increased between 2014 and 2015 for two measures: *How Well Doctors Communicate* and *Rating of Health Plan*.

In 2015, a total of 2,310 general child members were surveyed and 650 completed a survey for the Nevada Check Up population.[1-7] After ineligible members were excluded, the response rate was 32.4 percent. **HPN**'s rates increased between 2014 and 2015 for one measure: *Rating of All Health Care*. Between 2014 and 2015, **HPN**'s rates decreased for the remaining six measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, *Rating of Personal Doctor*, and *Rating of Health Plan.* Further, two measures showed a substantial decrease of more than 5 percentage points between 2014 and 2015: *Getting Care Quickly* and *Rating of Personal Doctor*.

Recommendations

Overall, HSAG recommends the following:

- Each MCO should continue to work with its CAHPS vendor to obtain a sufficient number of completed surveys that will enable reporting of all CAHPS measures. NCQA recommends targeting 411 completed surveys per survey administration. **Amerigroup** did not meet this target for the Nevada Check Up population, and **HPN** did not meet this target for the adult Medicaid population. Without sufficient responses, MCOs lack information that can be critical to designing and implementing targeted interventions that can improve both the access to and the quality and timeliness of care.
- For the adult population, **Amerigroup** should focus quality improvement initiatives on enhancing members' experiences with *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, and *Rating of Specialist Seen Most Often*, since these rates were lower than the 2014 adult CAHPS results and fell below NCQA's 2014 CAHPS adult Medicaid national averages. For the child Medicaid population, **Amerigroup** should focus its efforts on improving *Customer Service*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*, since these rates were lower than the 2014 child CAHPS results and fell below NCQA's 2014 CAHPS child Medicaid national averages. For the Nevada Check Up population, HSAG recommends that quality improvement efforts focus on improving *Getting Needed Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*, since the 2015 rates for these measures were lower than the 2014 rates. Furthermore, two of these measures' rates (*Rating of Personal Doctor* and *Rating of Health Plan*) were substantially lower than the 2014 rates.
- **HPN** should focus quality improvement initiatives on enhancing members' experiences with *Getting Needed Care* and *Rating of Personal Doctor* for the adult Medicaid population, since these rates were lower than the 2014 adult CAHPS results and fell below NCQA's 2014 CAHPS adult Medicaid national averages. For the child Medicaid population, **HPN** should focus its

[1-6] 2015 NCQA national response rate information for the CAHPS 5.0 Child Medicaid with CCC Survey was not available at the time this report was produced.

[1-7] The total number of members surveyed and completed surveys are based on **HPN**'s general child CAHPS sample only (i.e., does not include the CCC supplemental sample of members that were surveyed).

efforts on improving *Getting Needed Care*, *Getting Care Quickly*, *Rating of All Health Care*, and *Rating of Personal Doctor*, since these rates were lower than the 2014 child CAHPS results and fell below NCQA's 2014 CAHPS child Medicaid national averages. For the Nevada Check Up population, quality improvement efforts should be focused on *Getting Care Quickly* and *Rating of Personal Doctor*, since these measures showed a substantial decrease from 2014 to 2015.

Health Care Guidance Program (HCGP) Compliance Review

The DHCFP requested that HSAG conduct an interim assessment of **McKesson**'s compliance with its contract six months after **McKesson**'s HCGP operations began in June 2014. The purpose of the SFY 2014–2015 compliance review was to verify that **McKesson** had operationalized key elements of the program once services commenced. HSAG conducted an on-site compliance review of **McKesson**'s HCGP on December 10–11, 2014. On June 2, 2015, **Comvest Partners** purchased **McKesson Technologies, Inc.**'s care management business, which is now doing business as **AxisPoint Health**. Although **AxisPoint Health** is the current name of the company operating the HCGP, **McKesson Technologies, Inc**. was the name of the HCGP vendor at the time of the HCGP compliance review.

McKesson submitted the required documents to HSAG prior to the on-site review. **McKesson**'s completed questionnaire showed that 39,543 persons were enrolled in the program as of October 31, 2014. The care management file submitted by **McKesson** showed that of the 39,543 persons enrolled in the program, **McKesson** completed an assessment and a care management plan for 1,828 persons, or 4.6 percent of the enrolled population. On average, there were 72 days between the date of enrollment and the date of assessment by **McKesson** care managers.

In the case of pregnant enrollees, since the pregnancy is time-limited the window available to provide effective care management interventions during the gestation period is limited. In some cases, more than 110 days passed between the date the pregnant woman was enrolled in the program and the date her needs were assessed. In one of the 20 files reviewed, HSAG reviewers found that the woman was assessed 154 days after being identified and enrolled in the program and that she had already given birth by the date of her assessment.

The length of time between enrollment and assessing enrollees' needs may be impacted by the number of staff members designated for the program. Based on the anticipated staffing need for the HCGP (63.11 FTEs) and the number of staff members designated by **McKesson** for the HCGP (24.1 FTEs), the anticipated shortfall in staffing was 39.01 FTEs.

The on-site compliance review included a review of 12 standards, which were based on the requirements of **McKesson**'s contract with the DHCFP. The composite score for the standards reviewed was 84.6 percent. **McKesson** met all of the elements for the following five standards: Care Management Teams, Mental Health Care Management Services, Health Education Materials, Emergency Department Redirection, and Stakeholder Outreach and Education. **McKesson** received a *Partially Met* for one or more elements contained in the remaining seven of the 12 standards reviewed. Table 1-6 shows the summary results of **McKesson**'s compliance with standards.

Table 1-6—Summary of Results of Compliance with Standards							
Standard Number	Standard Name	Total Elements	Applicable Elements	Met	Partially Met	Not Met	N/A
I	Stratification of Enrollees	3	3	2	1	0	0
II	Care Management Teams	2	2	2	0	0	0
III	Care Planning	2	2	1	1	0	0
IV	Mental Health Care Management Services	2	2	2	0	0	0
V	Health Education Materials	1	1	1	0	0	0
VI	Nurse Triage and Call Services	4	4	2	2	0	0
VII	Emergency Department Redirection	3	3	3	0	0	0
VIII	Stakeholder Outreach and Education	2	2	2	0	0	0
IX	Feedback to Primary Care Providers (PCPs)	2	2	1	1	0	0
X	Provider Services	3	2	1	1	0	1
XI	Care Transitions	1	1	0	1	0	0
XII	Operational Structure and Reporting	2	2	1	1	0	0
Total Elements		**27**	**26**	**18**	**8**	**0**	**1**
Composite Score		**22/26 84.6%**					

HSAG used the care management enrollment file to select 20 cases to be included in the care management file review. The file review included four categories. Table 1-7 shows the results of the care management file review by category.

Table 1-7—Results of Care Management File Review				
Elements	Section II: Enrollee Assessment	Section III: Care Plan Development	Section IV: Ongoing Care Management	Section V: Care Monitoring and Reassessment
Percent of Elements Contained in File	**420/426 98.69%**	**171/196 87.2%**	**114/144 79.2%**	**10/10 100%**

HSAG used the grievance file submitted by **McKesson** to select 10 cases to be included in the grievance file review. There were four elements, per the **McKesson** contract, that were reviewed as part of the review. Table 1-8 shows the results of the grievance file review by review element.

Table 1-8—Results of Grievance File Review				
Grievance Elements	Provider Obtained Permission to File on Enrollee Behalf	Grievance Acknowledged	Resolved within 30 Days	Appropriate Level of Expertise
Percent of Compliant Elements	**N/A**	**10/10 100%**	**4/10 40%**	**10/10 100%**

Recommendations

HSAG offered the following recommendations to **McKesson**:

- Prioritize improvement efforts to address deficiencies in the following standards: Stratification of Enrollees, Care Planning, Nurse Triage and Call Services, Feedback to PCPs, Provider Services, Care Transitions, and Operational Structure and Reporting.
- Establish a reasonable standard (number of days between enrollment and assessment) to ensure pregnant enrollees' needs are assessed more quickly. **McKesson** should obtain the DHCFP's approval of the standard. Further, **McKesson** should monitor the standard on an ongoing basis.
- Evaluate the quantity of staff members designated for the Nevada HCGP program and ensure that the staffing ratios proposed for the program are consistent with the number of FTEs designated for the HCGP program, given the number of persons enrolled.
- Review the remediation plan **McKesson** submitted on April 10, 2014, to become familiar with the strategies **McKesson** identified to correct the issues identified during the readiness review. Further, **McKesson** should develop the required reports and submit them to the DHCFP for approval to ensure that **McKesson**'s proposed format for the reports meets the needs of the DHCFP staff for reporting to the Centers for Medicare & Medicaid Services.
- Communicate with each enrollee's identified PCP, document all communication with the PCP in the care management file, and notify the PCP when the enrollee cannot be reached or is not complying with care management goals and objectives.
- Record all notes in the grievance files and notify enrollees when the grievance is resolved. **McKesson** should also record the date the grievance was resolved and closed in the respective grievance file.

2. Overview of Nevada Managed Care Program

History of Nevada State Managed Care Program

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

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

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

The Nevada managed care program requires the enrollment of recipients found eligible for Medicaid coverage under the following Medicaid eligibility categories when there are two or more MCOs in the geographic service area:

- Childless adults (CA), including those with seriously mentally ill determinations
- Family Medical Category (FMC)/Temporary Assistance for Needy Families (TANF)
- FMC/Two-parent TANF
- FMC/TANF—Related medical only
- FMC/TANF—Post-medical (pursuant to Section 1925 of the Social Security Act)
- FMC/TANF—Transitional medical (under Section 1925 of the Act)
- FMC/TANF-Related (Sneede vs. Kizer)
- FMC/Child Health Assurance Program (CHAP)
- Children's Health Insurance Program (CHIP)

- Aged-out foster care (young adults in foster care who no longer qualify due to their age).

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

- Native Americans who are members of federally recognized tribes except when the MCO is the Indian Health Service, an Indian health program, or an urban Indian program operated by a tribe or tribal organization under a contract, grant, cooperative agreement, or compact with the Indian Health Service.
- Children younger than 19 years of age who are receiving services through a family-centered, community-based, coordinated care system that receives grant funds under Section 501(a)(1)(D) of Title V and is defined by the State in terms of either program participation or special health care needs (also known as children with special health care needs—CSHCN).
- TANF and CHAP adults diagnosed as seriously mentally ill (SMI).
- TANF and CHAP children diagnosed as severely emotionally disturbed (SED).

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

Demographics of Nevada State Managed Care Program

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

Table 2-1 presents the gender and age bands of Nevada Medicaid- and CHIP-enrolled recipients as of June 2015. The majority of members for both Medicaid and CHIP were children between 3 and 14 years of age.

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

Gender/Age Band	June 2015 Members
Males and Females <1 Year of Age	16,476
Males and Females 1–2 Years of Age	25,083
Males and Females 3–14 Years of Age	127,678
Females 15–18 Years of Age	13,842
Males 15–18 Years of Age	13,346
Females 19–34 Years of Age	56,490
Males 19–34 Years of Age	32,644
Females 35+ Years of Age	54,794
Males 35+ Years of Age	44,279
Gender Not Yet Recorded	351
Total Medicaid	**384,983**
Males and Females <1 Year of Age	212
Males and Females 1–2 Years of Age	1,126
Males and Females 3–14 Years of Age	12,958
Females 15–18 Years of Age	1,878
Males 15–18 Years of Age	1,899
Total CHIP	**18,073**
Total Medicaid and CHIP	**403,056**

Table 2-2 presents enrollment of Medicaid recipients by MCO and county for June 2015.

Table 2-2—June 2015 Nevada MCO Medicaid Recipients		
MCO	Total Eligible Clark County	Total Eligible Washoe County
HPN	184,767	33,209
Amerigroup	143,882	23,125
Total	**328,649**	**56,334**

Table 2-3 presents enrollment of CHIP recipients in the Nevada Check Up program by MCO and by county for June 2015.

Table 2-3—June 2015 Nevada MCO CHIP (Nevada Check Up) Recipients		
MCO	Total Eligible Clark County	Total Eligible Washoe County
HPN	8,763	2,215
Amerigroup	5,787	1,308
Total	**14,550**	**3,523**

Table 2-4 presents the ethnic composition of Nevada MCO Medicaid recipients in June 2015.

Table 2-4—June 2015 Nevada MCO Medicaid Ethnic Composition		
Ethnicity	Total Eligible Clark County	Total Eligible Washoe County
Asian or Pacific Islander Non-Hispanic	12,751	1,598
Black Non-Hispanic	75,706	2,828
Hispanic	64	15
Am Indian/Alaskan Non-Hispanic	1,216	598
Am Indian/Alaskan and White	380	142
Asian and White	1,149	203
Black African Am and White	3,103	458
Am Indian/Alaskan and Black	1,031	114
Other Non-Hispanic	24,361	2,901
Asian/Pacific Islander Hispanic	774	208
Black Hispanic	976	76
Am Indian/Alaskan Hispanic	191	39
White Hispanic	115,321	18,776
White Non-Hispanic	91,626	28,378
Total	**328,649**	**56,334**

Table 2-5 presents the ethnic composition of CHIP recipients in the Nevada Check Up program for June 2015.

Table 2-5—June 2015 Nevada MCO CHIP (Nevada Check Up) Ethnic Composition		
Ethnicity	Total Enrolled Clark County	Total Enrolled Washoe County
Asian or Pacific Islander Non-Hispanic	797	112
Black Non-Hispanic	1,346	47
Hispanic	0	0
Am Indian/Alaskan Non-Hispanic	53	47
Am Indian/Alaskan and White	6	1
Asian and White	72	18
Black African Am and White	108	28
Am Indian/Alaskan and Black	49	3
Other Non-Hispanic	1,124	183
Asian/Pacific Islander Hispanic	39	22
Black Hispanic	36	5
Am Indian/Alaskan Hispanic	8	6
White Hispanic	7,962	2,039
White Non-Hispanic	2,950	1,012
Total	**14,550**	**3,523**

Network Capacity Analysis

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

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

The network analysis was based on comparative evaluations of both Nevada Medicaid recipients and the providers who serve them. Additionally, comparison groups, or populations, of Nevada residents and providers were defined to evaluate network performance relative to the general population in Nevada. The study represented one of many ongoing attempts to capture, report, monitor, and explore the experience of Medicaid recipients' access to health care services. The DHCFP and its contracted MCOs will continue to monitor the accessibility and availability of the respective provider networks to Medicaid recipients; however, the scope and methodology for future studies may differ from the methodology and scope defined for the SFY 2014–2015 review.

Year Two Impact of Medicaid Expansion

By the end of SFY 2014–2015, the MCOs saw significant enrollment increases in their managed care programs. By August 2015 MCOs experienced expected and unexpected challenges in managing the care of a population whose health care previously went unchecked. Some of the initial and ongoing experiences reported by the MCOs are presented below.

HPN

HPN reported an increase in the number of persons who presented with significant chronic medical diseases, such as diabetes, osteomyelitis, renal failure, non-healing wounds, mental illness, and substance abuse. **HPN** also has experienced an increase in physician services and inpatient and outpatient services. Emergency room utilization has risen exponentially despite efforts to curb utilization for nonemergent medical issues. Dental service predetermination requests have increased sharply, as well as acute readmissions to inpatient facilities. **HPN** also has seen a significant increase in monthly member pharmacy-related costs. Although the health plan has seen an increase in service requests and utilization, **HPN** reports that significant challenges also exist with homeless members who need a skilled level of care for ongoing wound care. Currently, **HPN** is using transitional housing for some of these members to complete their medical care in a home environment with home health. Others still remain in acute hospitals at a skilled level of care due to the lack of available skilled nursing beds.

Amerigroup

Amerigroup reported an increase in the number of persons with multiple chronic medical and behavioral health conditions, and that inpatient census has doubled since the addition of the Medicaid expansion population. **Amerigroup** also reported that many newly eligible persons have advanced conditions of illnesses such as heart disease, lung disease, kidney disease, and diabetes, and that many have chronic wounds and advanced cancer. According to **Amerigroup** staff members, outpatient behavioral health services, therapy requests, pain management and spinal injections, and prescription medications have sharply increased. **Amerigroup** reported that persons with mental health and substance abuse needs have nearly tripled since 2013 although the membership has only doubled. **Amerigroup** also reported that additional concurrent review nurses and case managers have been added to the health plan's staff, and the need for additional social workers has increased due to the homeless populations.

Nevada State Quality Strategy

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

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

An evaluation of the DHCFP's progress in meeting the goals and objectives detailed in the Quality Strategy for SFY 2014–2015 is provided later in this report.

Quality Strategy Goals and Objectives

The DHCFP's mission is to purchase and ensure the provision of quality health care services, including Medicaid services, to low-income Nevadans in the most efficient manner. Furthermore, the DHCFP seeks to promote equal access to health care at an affordable cost to Nevada taxpayers, to restrain the growth of health care costs, and to review Medicaid and other State health care programs to determine the potential to maximize federal revenue opportunities. Further, the DHHS director has identified three priority focus areas for Nevada Medicaid: prevention, early intervention, and quality treatment. Consistent with the State's mission and DHHS priority areas, the purpose of the DHCFP's 2014–2015 Quality Strategy was to:

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

- Identify opportunities for improvement in the health status of the enrolled population and improve health and wellness through preventive care services, chronic disease and special needs management, and health promotion.
- Identify opportunities to improve quality of care and quality of service, and implement improvement strategies to ensure Nevada Medicaid and Nevada Check Up recipients have access to high-quality and culturally appropriate care.
- Improve recipient satisfaction with care and services.

Consistent with the proposed goals identified in Healthy People 2020 and the National Quality Strategy, the DHCFP established the following quality goals for the 2014–2015 Quality Strategy to improve the health and wellness of Nevada Medicaid and Nevada Check Up members and ensure they have access to high-quality and culturally appropriate care:

Goal 1: Improve the health and wellness of Nevada's Medicaid and Nevada Check Up

Objective 1.1: Increase children's and adolescents' access to PCPs by 10 percent.[2-1]

Objective 1.2: Increase well-child visits (0–15 months) by 10 percent.

Objective 1.3: Increase well-child visits (3–6 years) by 10 percent.

Objective 1.4: Increase the prevalence of blood lead testing for children 1–2 years of age by 10 percent.

Objective 1.5: Decrease avoidable emergency room visits by 10 percent.

Objective 2.1: Increase rate of HbA1c testing for members with diabetes by 10 percent.

Objective 2.2: Increase rate of monitoring nephropathy for members with diabetes by 10 percent.

Objective 3.1: Ensure that health plans develop, submit for review, and annually revise cultural competency plans that detail the health plans' goals, objectives, and processes to reduce and/or eliminate racial or ethnic disparities that negatively impact the quality and timeliness of, and access to, health care.

Objective 3.2: Stratify data for performance measures and avoidable emergency room utilization by race and ethnicity to determine where disparities exist. Continually identify,

[2-1] 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.

organize, and target interventions to reduce disparities and improve access to appropriate services for the Medicaid and Nevada Check Up population.

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

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

Objective 4.1: Increase the rate of postpartum visits by 10 percent.

To view the State's most recent version of the Quality Strategy, please see go to the Quality Strategy link located at: http://dhcfp.nv.gov/Members/BLU/MCOMain/. Stakeholders may provide input into the Quality Strategy at this location.

Annual Quality Strategy Evaluation

To continually track the progress of achieving the goals and objectives outlined in the Quality Strategy, the DHCFP developed the Quality Strategy Tracking Table. The Quality Strategy Tracking Table lists each of the four goals and the objectives used to measure achievement of the goals. The DHCFP and HSAG update the tracking table annually. In addition to sharing the revised table with the MCOs, the Medicaid and Nevada Check Up administration, and other stakeholders, HSAG has included the table in Appendix B. Table 2-7 lists the Quality Strategy goals, objectives, and indicators used to measure achievement, as well as the SFY 2014–2015 status of the evaluation. The DHCFP modifies the performance targets for each of the objectives every two years, thereby raising the performance bar for the MCOs. For the SFY 2014–2015 Quality Strategy revision, the DHCFP increased the QISMC goal for each of the objectives based on the prior year's performance. The new QISMC performance targets remained the same through SFY 2014–2015. During SFY 2015–2016, the DHCFP will consider adopting new QISMC performance targets for the MCOs.

Table 2-6 shows the MCOs' achievement of goals and objectives in SFY 2014–2015.

Table 2-6—SFY 2014–2015 Quality Strategy Goals and Objectives Summary of Achievement by MCO*

Metric	HPN	Amerigroup
Number of Comparable Rates (Year 1 to Year 2)	19	19
Number of Rates That Improved	9/19 (47%)	9/19 (47%)
Number of Rates That Stayed the Same	0	0
Number of Rates That Achieved QISMC Goal	5/19 (26%)	3/19 (16%)
Number of Rates That Declined	10/19 (53%)	10/19 (53%)

**Note: This table denotes changes in rates from SFY 2013–2014 to SFY 2014–2015 only and does not indicate that changes are statistically significant.*

Table 2-7—SFY 2014–2015 Quality Strategy Goals and Objectives			
Goal	**Objective**	**Indicators Used to Measure Performance (For Medicaid and Nevada Check Up)**	**SFY 2013–2014 Evaluation**
Goal 1: Improve the health and wellness of Nevada's Medicaid and Nevada Check Up population by increasing the use of preventive services, thereby modifying health care use patterns for the population.	**1.1** Increase children's and adolescents' access to PCPs by 10 percent.	*Children's and Adolescents' Access to PCPs* (12–24 months; 25 months–6 years; 7–11 years; 12–19 years).	For Medicaid, neither **Amerigroup** nor **HPN** achieved the QISMC goal for the following measures: 12–24 months; 25 months–6 years; 7–11. **HPN** achieved the QISMC goal for 12–19 years for Medicaid; however, **Amerigroup** did not. For Nevada Check Up, neither MCO achieved the QISMC goal for the measures.
	1.2 Increase well-child visits (0–15 months) by 10 percent.	*Well-Child Visits* in the *First 15 Months of Life*.	Neither **Amerigroup** nor **HPN** achieved the QISMC goal for this measure for Medicaid. For Nevada Check Up, **HPN** did not achieve the QISMC goal, but **Amerigroup** did.
	1.3 Increase well-child visits (3–6 years) by 10 percent.	*Well-Child Visits* in the *Third, Fourth, Fifth, and Sixth Years of Life.*	For both Medicaid and Nevada Check Up, neither **Amerigroup** nor **HPN** achieved the QISMC goal for these measures.
	1.4 Increase the prevalence of blood lead testing for children 1–2 years of age by 10 percent.	*Lead Screening in Children.*	For Medicaid, **HPN** achieved the QISMC goal for this measure; however, **Amerigroup** did not. For Nevada Check Up, neither **Amerigroup** nor **HPN** achieved the QISMC goal for this measure.
	1.5 Decrease avoidable emergency room visits by 10 percent.	*Avoidable Emergency Room Visit* PIP.	For both Medicaid and Nevada Check Up, both **HPN** and **Amerigroup** achieved the QISMC goal for this measure.

Table 2-7—SFY 2014–2015 Quality Strategy Goals and Objectives			
Goal	**Objective**	**Indicators Used to Measure Performance (For Medicaid and Nevada Check Up)**	**SFY 2013–2014 Evaluation**
Goal 2: Increase use of evidence-based preventive and treatment practices for members with chronic conditions.	**2.1** Increase rate of HbA1c testing for members with diabetes by 10 percent.	*Comprehensive Diabetes Care—HbA1c Testing*	This is a Medicaid-only measure. **HPN** achieved the QISMC goal for this measure; however, **Amerigroup** did not achieve the QISMC goal.
	2.2 Increase rate of monitoring for nephropathy for members with diabetes by 10 percent.	*Comprehensive Diabetes Care—Medical Attention for Nephropathy*	This is a Medicaid-only measure. Neither **Amerigroup** nor **HPN** achieved the QISMC goal for these measures.
Goal 3: Reduce and/or eliminate health care disparities for Medicaid and Nevada Check Up recipients.	**3.1** Ensure that the MCOs develop, submit for review, and annually revise cultural competency plans that detail the health plans' goals, objectives, and processes for reducing and/or eliminating racial or ethnic disparities that negatively impact the quality and timeliness of, and access to, health care.	Cultural Competency Plan (CCP) submission.	Both MCOs submitted the annual CCP and CCP evaluation to the DHCFP for review.
	3.2 Stratify data for performance measures and avoidable emergency room utilization by race and ethnicity to determine where disparities exist. Continually identify, organize, and target interventions to reduce disparities and improve access to appropriate services for the Medicaid and Nevada Check Up populations.	Submission of avoidable emergency room utilization data stratified by race and ethnicity, by the MCOs.	Both MCOs stratified data for performance measures and for avoidable emergency room utilization by race and ethnicity, and they submitted the stratification to the DHCFP and HSAG.
	3.3 Ensure that the MCOs submit an annual evaluation of their cultural competency program to the DHCFP. The MCOs must receive a *Met* compliance score for all of the criteria listed in the MCO contract for cultural competency program development, maintenance, and evaluation.	MCO CCP annual evaluation submission.	Both MCOs submitted their CCP annual evaluation to the DHCFP. Both MCOs received *Met* compliance scores for all requirements of the CCP evaluation.

Table 2-7—SFY 2014–2015 Quality Strategy Goals and Objectives			
Goal	**Objective**	**Indicators Used to Measure Performance (For Medicaid and Nevada Check Up)**	**SFY 2013–2014 Evaluation**
Goal 4: Improve the health and wellness of new mothers and infants and increase new-mother education about family planning and newborn health and wellness.	**4.1** Increase the rate of postpartum visits by 10 percent.	*Postpartum Care*	Neither **Amerigroup** nor **HPN** achieved the QISMC goal for these measures.

Quality Initiatives and Emerging Practices

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

Another method used by the DHCFP to promote best and emerging practices among the MCOs is to ensure that the State's contractual requirements for the MCOs are at least as stringent as those described in Subpart D of the BBA regulations for access to care, structure and operations, and quality measurement and improvement (42 CFR 438.204[g]). The DHCFP actively promotes the use of nationally recognized protocols, standards of care, and benchmarks by which health plan performance is measured.

MCO-Specific Quality Initiatives

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

Health Plan of Nevada (HPN)

Highlighted below are some of the strategic quality initiatives **HPN** identified for SFY 2014–2015.

- **Citibank cards** were issued to incentivize children to receive well-care visits and seek medical attention at the pediatrician's office.
- **Network Core Reports** were issued for providers to identify the member-specific outcomes and whether preventive screenings had occurred for empaneled members.
- **Cribs for Kids** was implemented to deploy cribs, or other equipment needed by new moms, to moms that completed the required number of prenatal and postpartum care visits within the required time frames.
- **HPV Postcards** were administered to members who started the HPV series of shots but had not completed the series. The outreach initiative showed an increase of 5 percentage points in less than one year.
- **Quality Provider Awards** were issued to providers who were recognized as high performers among their peers. The performance measures used as metrics for the program included A1c levels, pediatric immunization compliance, and lowest rate of cesarean section births.

- **Pay for Performance** program was conceptualized and contracts were issued. The program will incentivize high-volume primary care providers' (PCPs') offices to increase HEDIS rates for members empaneled with the PCP.
- **Now Clinic** was approved, which will provide telemedicine services to initiate engagement within the Medicaid population and encourage PCP visits for routine care.
- **Asthma Protocol** was identified, which would allow for the disease management nurse to start a member on corticosteroid on behalf of the provider for better asthma control.
- **Teddy Bear Ticket** program is planned to connect children, who are waiting in urgent care waiting rooms, to pediatricians who have offices in the same building. When a child and family are sitting in the urgent care waiting room, the nurse from the pediatric office greets and walks the family to the pediatric office exam room, where the child is immediately seen by a pediatrician. The effort is meant to connect children to more appropriate care with physicians who specialize in pediatrics.

Amerigroup

Highlighted below are some of the strategic quality initiatives **Amerigroup** identified for SFY 2014–2015.

- **Obstetrician (OB) Provider Profiles** were continued, wherein the medical director or a nurse from **Amerigroup** meets with OB providers to discuss cesarean section rates and prenatal and postpartum care visit rates.
- **Postpartum Visit Encounter Submission Incentive Plan** to increase submission of prenatal and postpartum visit encounters to the MCO. **Amerigroup** reported a 4 percentage point increase in postpartum visits.
- **My Advocate Program** continued from the prior year and provided text and verbal messaging to provide proactive and culturally appropriate communication and coaching to pregnant women during their pregnancies.
- **Taking Care of Baby and Me** program provided monetary incentives for first trimester and ongoing prenatal care visits, in addition to automated outreach calls.
- **Member Meet and Greet** was expanded to include weekly mini meets at CVS pharmacies in addition to the meetings held at locations with the top 10 ZIP codes as well as with the highest missed opportunities for health screenings and preventive care. The events were also held at Nevada Health Centers and Walnut community centers.
- **Transition Care** program was implemented as part of a population management program to reduce emergency department use and hospital readmissions within 30 days. For approximately 30 days after a member is discharged from the hospital, the team of nonclinical coordinators serve as surrogate family members to individuals who were hospitalized and assist the member with obtaining medications, setting appointments for follow-up care, coordinating transportation, and coordinating housing to promote stabilization for the member after discharge from the hospital.
- **Provider Group 1:1** with **Amerigroup** medical director to talk about missed opportunities and ways to increase performance measure rates.
- **Dedicated Data Analyst** who is dedicated to the quality management department and is responsible for quality-related reporting.

Collaborative Quality Initiatives—DHCFP and MCOs

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

Reducing Avoidable Emergency Room (ER) Visits Work Group

Over the last four years, the DHCFP and MCOs have worked to examine avoidable ER usage and the frequency at which some members accessed ERs. Upon analyzing data to determine where health care spending could reasonably be reduced and use of preventive services could be increased, the DHCFP discovered that nearly 25 percent of all ER visits in managed care had been nonemergent, using the New York University (NYU) algorithm for classifying ER claims into categories based on primary diagnosis. As part of the collaborative PIP activities, HSAG facilitated work group discussions aimed at analyzing data and identifying the reasons Medicaid recipients frequented the ER inappropriately. At the direction of HSAG and the DHCFP, the MCOs examined ER use patterns and discovered that a number of members inappropriately used the ER for primary care instead of establishing a relationship and "medical home" with a PCP. An analysis of diagnoses showed that many of the ER visits were nonemergent or emergent but treatable by a PCP. The Reducing Avoidable ER Visits Work Group was formed and continued to meet regularly to develop interventions to reduce inappropriate and/or avoidable ER utilization. To identify the individuals who would likely benefit from targeted care manager interventions (or re-education on establishing a relationship with a PCP), the DHCFP tasked the MCOs with identifying the number of individuals who visited the ER at least three or more times in a three-month period during the last calendar quarter of 2010. The MCOs were required to stratify these data by gender, age, race/ethnicity, time of day, county, and diagnostic category to determine which populations could benefit from more targeted interventions.

After stratifying individuals who frequented the ER, the MCOs hosted focus groups with members who were frequent users. During the focus groups, the MCOs learned that members were not aware of the difference between urgent and emergent care and many did not know that the MCOs offered 24-hour nurse triage telephone lines that could answer members' health-related questions after 5 p.m. The MCO's staff also made telephone inquiries to members who returned to the ER within seven to 10 days of an initial visit. Many members reported that the ER staff informed members to return to the ER for follow-up care, such as removing sutures, obtaining medications, or removing casts.

The MCOs conducted further risk-stratification analyses on frequent ER users to determine needs for complex care management or disease management. Members who fit the criteria for complex care or disease management were enrolled in disease or care management programs. The MCOs also initiated educational campaigns to new and existing members. New and existing members received educational telephone calls from the MCO's staff, who explained the appropriate uses of the ER and when to contact the 24-hour nurse advice line.

FY 2015 was the third remeasurement year for the *Avoidable Emergency Room Visit* PIP. **HPN** reported significant improvements in avoidable ER visits for both the Medicaid and Nevada Check Up populations compared to the baseline measurement. **Amerigroup** also reported significant improvements. Additional detail about the results for both MCOs' *Avoidable Emergency Room Visit* PIPs may be found in Section 6 of this report.

Lead Screening in Children Collaborative (Lead Screening)

Since SFY 2009–2010, the MCOs have stratified lead screening rates by race and ethnicity to identify any potential disparities in rates of screening among populations. Additionally, the DHCFP has invited other stakeholders, such as staff members from the Nevada Division of Public and Behavioral Health, to the collaborative group sessions to (1) learn about the interventions put in place by the MCOs to increase lead screening rates, and (2) provide additional education to the MCOs' leaders on the prevalence of lead and its harmful effects in Nevada communities. Starting in SFY 2012–2013 and through SFY 2014–2015, both MCOs encouraged more provider offices to use filter papers to collect blood samples from children. This service enabled children to be screened for lead poisoning in provider offices, rather than having parents go to a laboratory to have a child tested. Additionally, MCOs implemented interventions that targeted children under age 2 to obtain lead screenings. Both MCOs showed improved rates for lead screening in SFY 2014–2015 for the Medicaid population. **Amerigroup** also showed improved rates for lead screening for the Nevada Check Up population. The MCOs continue to stratify and evaluate lead screening rates by race and ethnicity to develop effective interventions to continue improvement in overall lead screening rates.

Medicaid Expansion Quality Tracking

In January 2014, the DHCFP expanded Medicaid coverage to persons with incomes up to 138 percent of the federal poverty level, which was allowed under the Affordable Care Act. The number of persons who enrolled in Medicaid as a result of the expansion greatly exceeded the DHCFP's original expectations. The majority of newly eligible persons reside in the managed care catchment areas; therefore, both MCOs have experienced significant increases in enrollment since January 2014. The MCOs report that many of the newly eligible persons who have chronic conditions, such as kidney disease, heart failure, and diabetes, have not properly managed their illness. To obtain a more accurate representation of the HEDIS rates for the Medicaid expansion population and its impact on HEDIS rates, the DHCFP has asked the MCOs to report 2015 Medicaid HEDIS rates for the following populations: (1) With Medicaid Expansion Population Included, and (2) Without Medicaid Expansion Included. This has enabled the MCOs to produce rates that are comparable to the previous year (i.e., without Medicaid expansion) and also to establish a baseline from which future comparisons can be made for the With Medicaid Expansion Population Included group.

Encounter Data Validation (EDV) Study

High-quality encounter data from Nevada MCOs are necessary to evaluate and improve quality of care, assess utilization, develop appropriate capitation rates, and establish acceptable rates of performance. To identify the opportunities for improvement that exist with MCO encounter data, the DHCFP contracted with Meyers and Stauffer to conduct an EDV study of MCO encounter data. The purpose of the study is to determine the accuracy and completeness of MCO encounter data compared to the data included in the DHCFP's data warehouse. The period under review is calendar

year 2013. The results from the EDV study will enable the DHCFP and the MCOs to identify inconsistencies between the two sets of data—individual MCO data and the DHCFP's data—and determine what system improvements must be made to improve encounter data quality.

Nationwide CAHPS Survey

In the summer of 2014, the DHCFP began working with its subcontractor and CMS in support of the nationwide survey of access to care and experiences of care among adult Medicaid enrollees. The survey was conducted in the fall of 2014. Once they are released, the DHCFP will use the results from the CMS nationwide survey to determine the types of quality improvement activities that should be incorporated into its next Quality Strategy revision to improve adult Medicaid members' experiences with health care.

MCO Annual Quality Improvement Evaluation

The MCOs are required to submit an annual evaluation of the quality improvement program and activities employed by the MCO for the previous year. The MCOs' annual evaluations include trends and statistical information that describe and depict the performance for each quality activity and associated indicators developed by the MCO. Annual evaluations also include an analysis and evaluation of clinical and related service areas requiring improvement for each of the quality measures that pertain to the population. The DHCFP requires the MCOs to provide an evaluation of each of the Nevada Medicaid and Nevada Check Up quality measures, which are detailed in the DHCFP Quality Strategy. As part of this effort, the MCOs are required to stratify performance measure rates by race and ethnicity. After stratifying the data, the MCOs are required to identify any health care disparities among the groups and develop a plan targeting interventions to reduce and/or eliminate disparities for members and increase performance measure rates overall. During the SFY 2014–2015 compliance review, HSAG verified that both MCOs stratified data according to the parameters set by the DHCFP and have deployed interventions to further reduce or eliminate health disparities while improving rates for each of the performance measures.

Disparities in Health Care

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

The MCOs, in cooperation with the DHCFP, are required to develop and implement cultural CCPs that encourage delivery of services in a culturally competent way to all recipients, including those with limited English proficiency and diverse cultural and ethnic backgrounds. The MCOs are also required to ensure that appropriate foreign language versions of all member materials are developed and available to members, and to provide interpreter services for members whose primary language is not English. The DHCFP reviews and approves all member materials as part of a readiness review for all new MCOs entering the Nevada Medicaid managed care program. During SFY 2014–2015 HSAG conducted a comprehensive review of each MCO's cultural competency program. Both MCOs provided evidence that each met the cultural competency objectives identified in the DHCFP Quality Strategy and developed a plan for the following year's cultural competency activities.

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

As part of the collaborative effort by the DHCFP and MCOs to reduce disparities in health care and improve access to care for Native Americans, the DHCFP hosted a meeting at the beginning of SFY 2014–2015, wherein a member of the Reno Sparks Tribal Health Center presented information about the barriers that exist for Native Americans in accessing services coordinated by the MCOs. The DHCFP, MCOs, and the tribal health center committed to having ongoing discussions about how to build awareness and reduce barriers to care for Native Americans and improve collaboration between Nevada Medicaid and tribal health care services.

Nevada Medicaid Collaborative Quality Initiatives

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

State Innovations Model

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

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

Balancing Incentive Payments Program

CMS approved the Nevada application for the Balancing Incentive Payment Program (BIPP). The BIPP offers a targeted increase in the federal medical assistance percentage (FMAP) to states that undertake structural reforms to increase access to noninstitutional long term services and supports

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

Money Follows the Person (MFP)

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

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

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

Nevada has already accomplished the following:

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

Medicaid Incentives for Prevention of Chronic Diseases (MIPCD)

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

1. Nesting incentives in the diabetes disease management programs conducted by Nevada's Medicaid MCOs. MCO enrollees with diabetes will be incentivized to receive evidence-based preventive health services known to be effective in improved management of diabetes and covered under the Nevada Medicaid state plan.

2. Linking approximately 600 adults diagnosed with diabetes and 540 adults at risk of developing type 2 diabetes enrolled in fee for service Medicaid with evidence-based programs through the Lied Clinic Outpatient Facility at University Medical Center of Southern Nevada, the Southern Nevada Health District, or the YMCA of Southern Nevada.

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

The MIPCD participants have gone through the programs, achieved goals, earned points, and redeemed incentives. The Grants Management Unit at DHCFP is in the process of drafting closeout procedures for the grant and summarizing the results of the grant activities, which will be included in the SFY 2015–2016 EQR Technical Report.

Health Information Technology

The Nevada Provider Incentive Program (NPIP) for electronic health records (EHRs) is an incentive program for Nevada health care providers to receive payments for becoming meaningful users of certified EHR technology. The goal of NPIP is to give providers access to enhanced Medicaid funds to offset the cost of implementing certified EHR technology. This funding is designed to promote the adoption of certified EHR technology and ultimately provide improved quality of care for Medicaid beneficiaries and increased cost efficiencies within the Medicaid enterprise. As of July 2015, a total of 455 providers and 30 hospitals have received over $41,796,479 in payments from NPIP.

Mandatory Activities

In accordance with 42 CFR 438.356, the DHCFP contracted with HSAG as the EQRO for the State of Nevada to conduct the mandatory EQR activities as set forth in 42 CFR 438.358. In SFY 2014–2015, HSAG conducted the following mandatory EQR activities for the Nevada Medicaid and Nevada Check Up programs:

- **Compliance monitoring evaluation:** HSAG performed a comprehensive review of compliance with State and federal standards for both MCOs, Amerigroup and HPN, during SFY 2014–2015. This review initiated a new three-year review cycle of Internal Quality Assurance Program (IQAP) Review of Compliance. In addition, HSAG reviewed each of the corrective action plans that resulted from the compliance review activities.
- **Validation of performance measures:** HSAG validated each of the performance measures identified by the State to evaluate their accuracy as reported by, or on behalf of, the MCOs.
- **Validation of PIPs:** HSAG validated the MCOs' PIPs to determine if they were designed to achieve, through ongoing measurement and intervention, significant and sustained improvement in clinical and nonclinical care. HSAG also evaluated if the PIPs would have a favorable effect on health outcomes and enrollee satisfaction.

Optional Activities

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

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

- Participating in quarterly meetings with the HCGP vendor to ensure that quality-related activities remain on track. HSAG also developed a set of quality modules that the HCGP vendor must use to guide its quality-related presentations during the quarterly meetings.
- Revising the NCCW 1115 Demonstration Evaluation Design Plan.
- Performing a compliance review of the HCGP vendor to verify that the HCGP vendor complied with its contract six months after operations commenced.
- Performing source code review of the programming code used to calculate pay for performance measures used for the NCCW program, which will be calculated by the DHCFP's actuary.

- Conducted an evaluation of Nevada's Medicaid provider network. The purpose of the analysis was to estimate the provider network capacity, geographic distribution, and appointment availability of the MCOs' and fee for service networks. The analysis evaluated three dimensions of access and availability:
  - **Capacity—**provider-to-recipient ratios for Nevada's provider networks.
  - **Geographic Network Distribution—**time/distance analysis for applicable provider specialties and average distance (miles) to the closest provider.
  - **Appointment Availability—**average length of time (number of days) to see a provider for MCOs and fee for service.

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

4. Internal Quality Assurance Program (IQAP) Review—SFY 2014–2015

Overview

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

Objectives

The purpose of the SFY 2014–2015 IQAP Review of Compliance was to determine the health plans' compliance with various access, structure and operations, and measurement and improvement standards. To accomplish this objective, HSAG:

- Reviewed quality program activities that occurred during SFY 2013–2014.
- Determined each plan's performance in complying with 14 standards and their associated elements.
- Conducted a review of individual files for the areas of credentialing, recredentialing, grievances, appeals, denials, and case management to evaluate implementation of the standards.
- Validated that the plan informed members, through the member handbook, of their rights and responsibilities and other required information.
- Confirmed that the MCOs apprised providers of the medical records standards and additional required information in the provider manual.

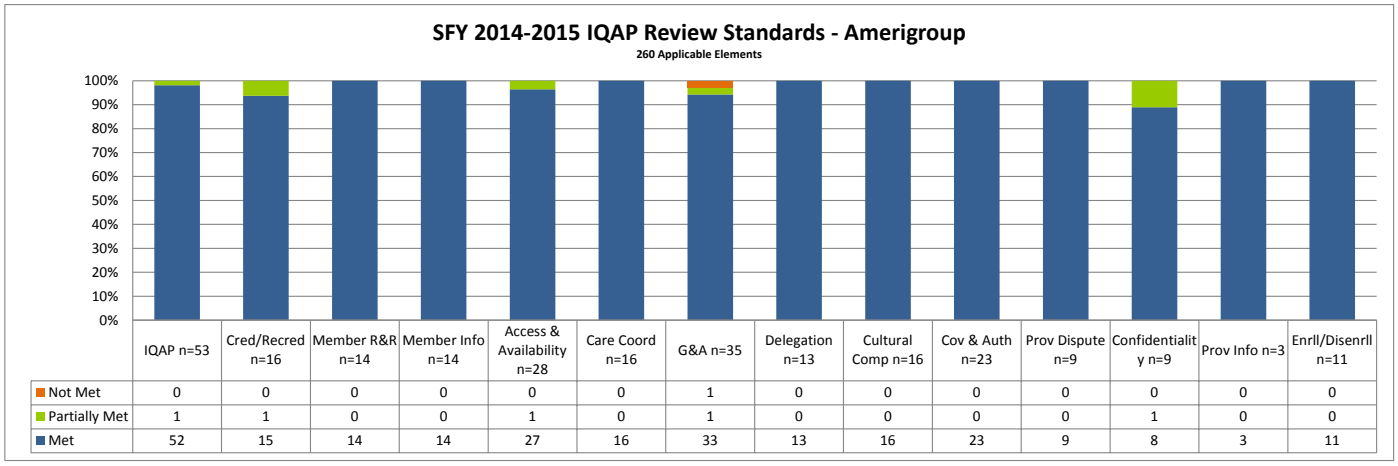
The IQAP standards were derived from the requirements as set forth in the Department of Human Services, Division of Health Care Financing and Policy Request for Proposal No. 1988 for Managed Care, and all attachments and amendments in effect during SFY 2013–2014. HSAG followed the guidelines set forth in CMS' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012[4-1] to create the process, tools, and interview questions used for the SFY 2014–2015 compliance review.

[4-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

Plan-Specific Findings—Amerigroup

A review of the IQAP standards shows how well an MCO has interpreted the required elements of the managed care contract and developed the necessary policies, procedures, and plans to carry out the required MCO functions. Figure 4-1 presents the **Amerigroup** results for the 14 IQAP standards evaluated for SFY 2014–2015. A total of 260 elements were reviewed. Each element was scored as *Met*, *Partially Met*, or *Not Met* based on evidence found in MCO documents, policies, procedures, reports, meeting minutes, and interviews with MCO staff members. Detailed findings can be found in the report, *FY 2014–2015 IQAP On-Site Review of Compliance for Amerigroup Nevada, Inc.*

Figure 4-1—SFY 2014–2015 IQAP Review Standards Results for Amerigroup



	IQAP n=53	Cred/Recred n=16	Member R&R n=14	Member Info n=14	Access & Availability n=28	Care Coord n=16	G&A n=35	Delegation n=13	Cultural Comp n=16	Cov & Auth n=23	Prov Dispute n=9	Confidentiality n=9	Prov Info n=3	Enrll/Disenrll n=11
Not Met	0	0	0	0	0	0	1	0	0	0	0	0	0	0
Partially Met	1	1	0	0	1	0	1	0	0	0	0	1	0	0
Met	52	15	14	14	27	16	33	13	16	23	9	8	3	11

Note: *Complete standard descriptions from left to right are as follows: Internal Quality Assurance Program, Credentialing and Recredentialing, Member Rights and Responsibilities, Member Information, Accessibility and Availability of Services, Continuity and Coordination of Care, Grievance and Appeals, Subcontracts and Delegation, Cultural Competency Program, Coverage and Authorization of Services, Provider Dispute Resolution, Confidentiality and Record Keeping, Provider Information, and Enrollment and Disenrollment.*

Of the 260 applicable elements, **Amerigroup** received a *Met* score for 254 elements, a *Partially Met* for five elements, and a *Not Met* for one element. This represented an IQAP standards review score of 98.7 percent for all elements reviewed.

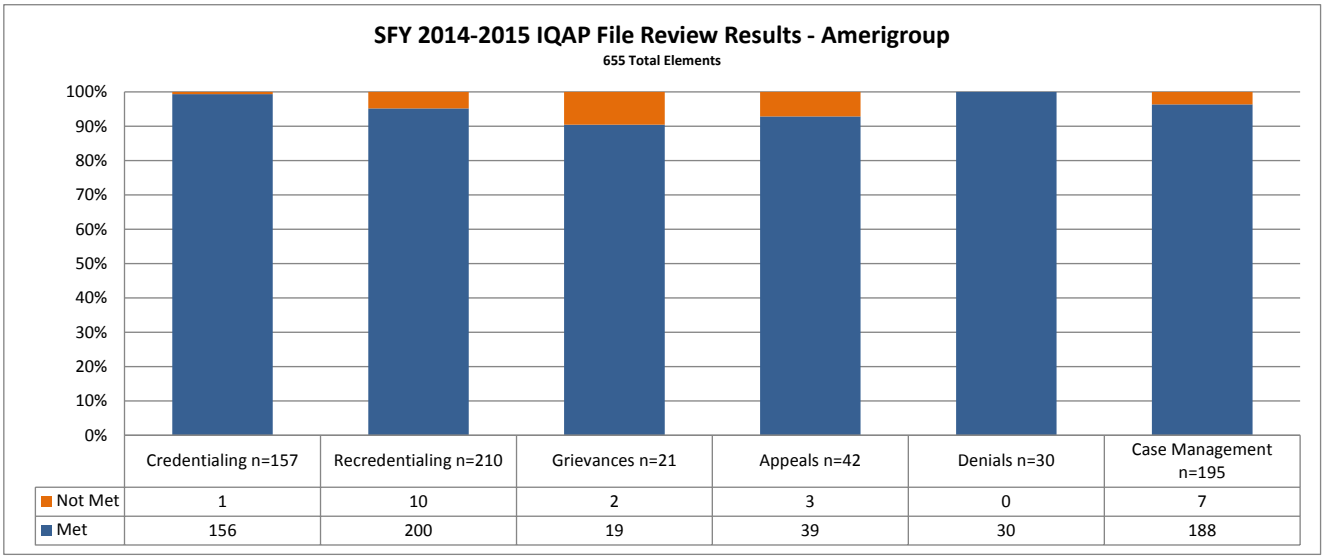
Of the 14 standard areas reviewed, **Amerigroup** achieved 100 percent compliance in nine standards, demonstrating performance strengths and adherence to all requirements measured in the areas of *Member Rights and Responsibilities*, *Member Information*, *Care Coordination*, *Subcontracts and Delegation*, *Cultural Competency*, *Coverage and Authorization*, *Provider Dispute Resolution*, *Provider Information*, and *Enrollment and Disenrollment*. The findings for these standards suggest that **Amerigroup** developed the necessary policies, procedures, and plans to operationalize the required elements of its contract and demonstrate its compliance with the contract. Further, interviews with **Amerigroup**'s staff showed that staff members were knowledgeable about the requirements of the contract and the policies and procedures the MCO employed to meet its contractual requirements.

For the remaining five standards reviewed, **Amerigroup** achieved scores of at least 94 percent or higher for the elements contained in the following standards: *IQAP*, *Credentialing and Recredentialing*, *Accessibility and Availability*, *Grievances and Appeals*, and *Confidentiality and*

Record Keeping. The element that was found *Not Met* related to *Grievances and Appeals*, where one of **Amerigroup**'s policies did not contain the required information that members be notified of their right to file a grievance if the MCO extended the time frame to make a decision about a service authorization and the member disagreed with that decision, which is required by 42 CFR §438.404(c)(4)(i).

File reviews are important to the overall findings of the IQAP review because the results show how well an MCO operationalized and followed the policies it developed for the required elements of the contract. Figure 4-2 presents the **Amerigroup** scores for the files review for credentialing, recredentialing, grievance, appeals, denials, and case management.

Figure 4-2—SFY 2014–2015 IQAP File Review Results for Amerigroup

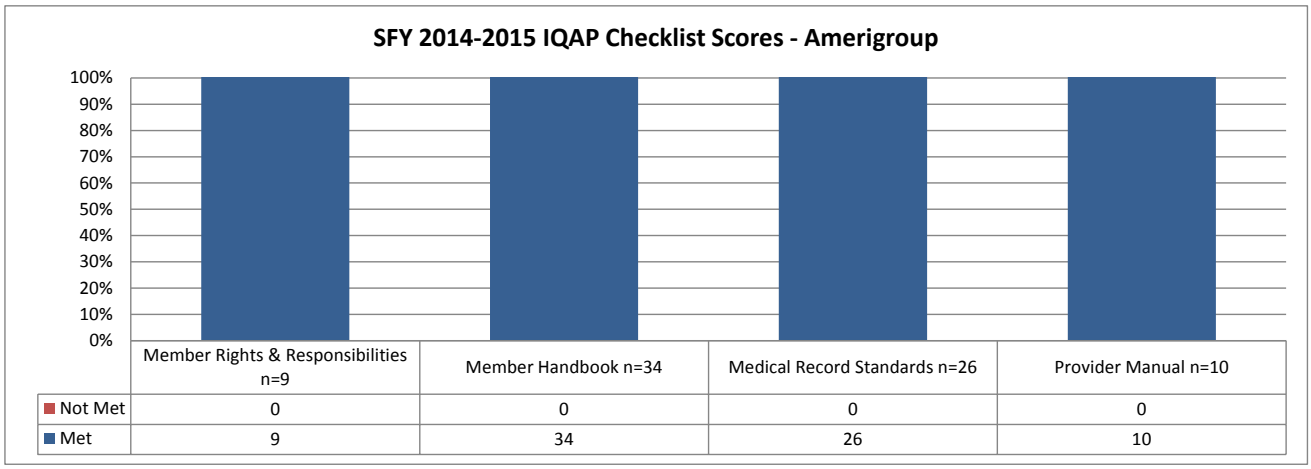


Of the 655 total elements reviewed for the file reviews, **Amerigroup** received a score of *Met* for 632 of them. All of the areas reviewed scored higher than 90 percent and four of the six areas reviewed scored higher than 95 percent. These results suggest that **Amerigroup** followed the policies it developed to operationalize the required elements of its contract.

The area with the greatest opportunity for improvement for file review was related to the *Recredentialing* standard, where **Amerigroup** did not revalidate providers' hospital privileges during recredentialing. For *Appeals* and *Grievances*, the file review results showed that some appeals and grievances were not acknowledged by the corporate office within the required time frames. Lastly, six of the 10 *Case Management* files revealed that case managers did not send disease-specific health outreach materials to members in case management or the activity was not documented in the members' case management files.

The results generated by the checklists serve as another indicator of the MCO's ability to develop the required outreach information and ensure that the information contains all contractually required elements. Figure 4-3 presents the **Amerigroup** scores for the checklists that were used to review all requirements related to *Member Rights and Responsibilities*, *Member Handbook*, *Provider Manual*, and *Medical Record* standards.

Figure 4-3—SFY 2014–2015 IQAP Checklist Results for Amerigroup

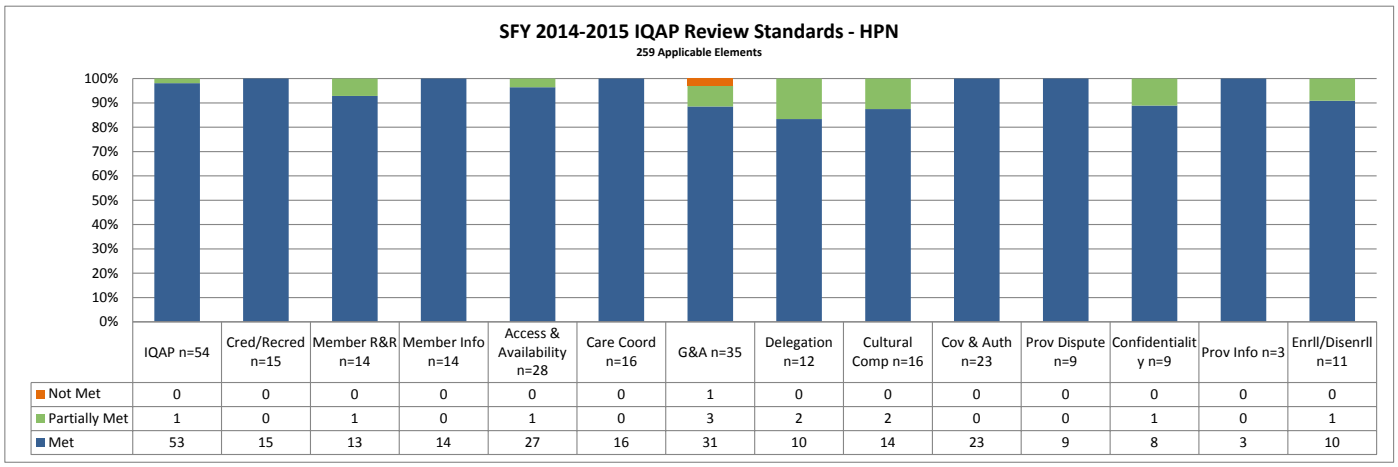


Of the 79 elements reviewed for the checklists, **Amerigroup** received a score of *Met* for all 79 elements. The findings suggest that **Amerigroup** had strong compliance with each of the areas evaluated by the checklists and **Amerigroup** developed the necessary manuals, handbooks, and policies according to contract requirements.

Plan-Specific Findings—HPN

Results from the review of IQAP standards show how well an MCO has interpreted the required elements of the managed care contract and developed the necessary policies, procedures, and plans to carry out the required functions of the MCO. Figure 4-4 presents the **HPN** results for the 14 IQAP standards evaluated for SFY 2014–2015. A total of 260 elements were reviewed for the 14 standards. Each element was scored as *Met*, *Partially Met*, or *Not Met* based on evidence found in MCO documents, policies, procedures, reports, meeting minutes, and interviews with MCO staff members. Detailed findings can be found in the report *FY 2014–2015 IQAP On-site Review of Compliance for Health Plan of Nevada, Inc.*

Figure 4-4—SFY 2014–2015 IQAP Review Standards Results for HPN



	IQAP n=54	Cred/Recred n=15	Member R&R n=14	Member Info n=14	Access & Availability n=28	Care Coord n=16	G&A n=35	Delegation n=12	Cultural Comp n=16	Cov & Auth n=23	Prov Dispute n=9	Confidentialit y n=9	Prov Info n=3	Enrll/Disenrll n=11
Not Met	0	0	0	0	0	0	1	0	0	0	0	0	0	0
Partially Met	1	0	1	0	1	0	3	2	2	0	0	1	0	1
Met	53	15	13	14	27	16	31	10	14	23	9	8	3	10

Note: Complete standard descriptions from left to right are as follows: Internal Quality Assurance Program, Credentialing and Recredentialing, Member Rights and Responsibilities, Member Information, Accessibility and Availability of Services, Continuity and Coordination of Care, Grievance and Appeals, Subcontracts and Delegation, Cultural Competency Program, Coverage and Authorization of Services, Provider Dispute Resolution, Confidentiality and Record Keeping, Provider Information, and Enrollment and Disenrollment.

Of the 259 applicable elements, **HPN** received a *Met* score for 246 of them, a *Partially Met* for 12, and a *Not Met* for one. This represented an IQAP standards review score of 97.3 percent for all elements reviewed.

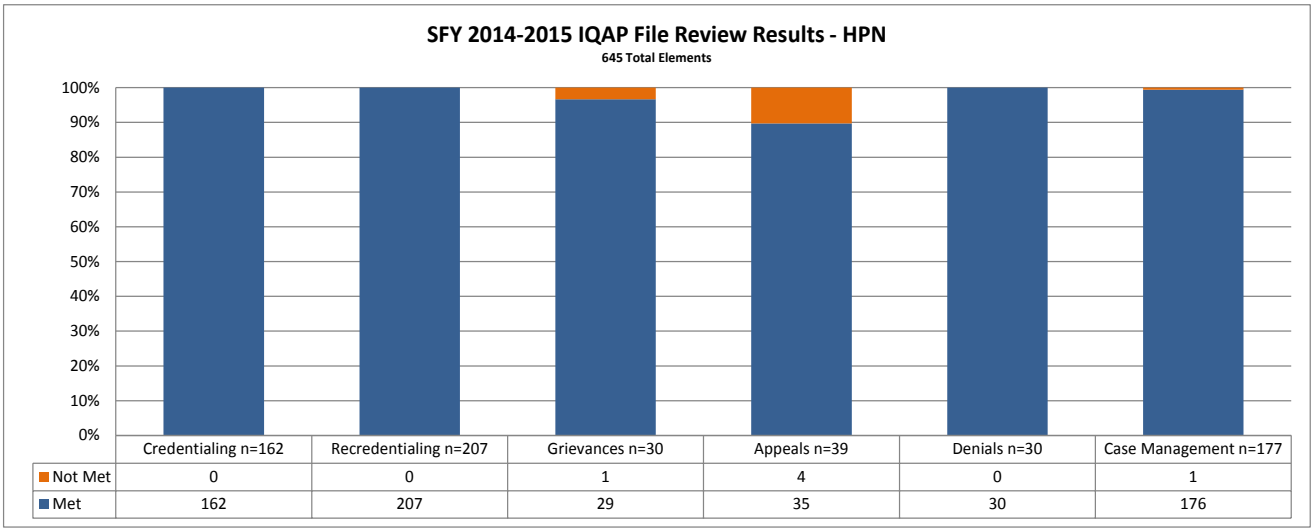
Of the 14 standard areas reviewed, **HPN** achieved 100 percent compliance on six standards: *Credentialing and Recredentialing, Member Information, Care Coordination, Coverage and Authorization, Provider Dispute Resolution,* and *Provider Information*. The findings suggest that, with a few exceptions, **HPN** developed the necessary policies, procedures, and plans to operationalize the required elements of its contract and demonstrate its compliance with the contract. Further, interviews with **HPN** staff members showed they were knowledgeable about contract requirements and the procedures the MCO employed to meet its contractual requirements.

For the remaining eight standards, **HPN** achieved scores of at least 91 percent or higher for all elements contained in these standards: *IQAP, Member Rights and Responsibilities, Availability and Accessibility of Services, Grievances and Appeals, Subcontracts and Delegation, Cultural Competency Program, Confidentiality and Record Keeping,* and *Enrollment/Disenrollment.* The element that was found *Not Met* related to *Grievances and Appeals*, where one of **HPN**'s policies

did not contain the required information that members be notified of their right to file a grievance if the MCO extended the time frame to make a decision about a service authorization and the member disagreed with that decision, which is required by 42 CFR §438.404(c)(4)(i).

File reviews are important to the overall findings of the IQAP review because the results show how well an MCO operationalized and followed the policies it developed for the required elements of the contract. Figure 4-5 presents the **HPN** scores for the files review for *Credentialing*, *Recredentialing*, *Grievances*, *Appeals*, *Denials*, and *Case Management*.

Figure 4-5—SFY 2014–2015 IQAP File Review Results for HPN

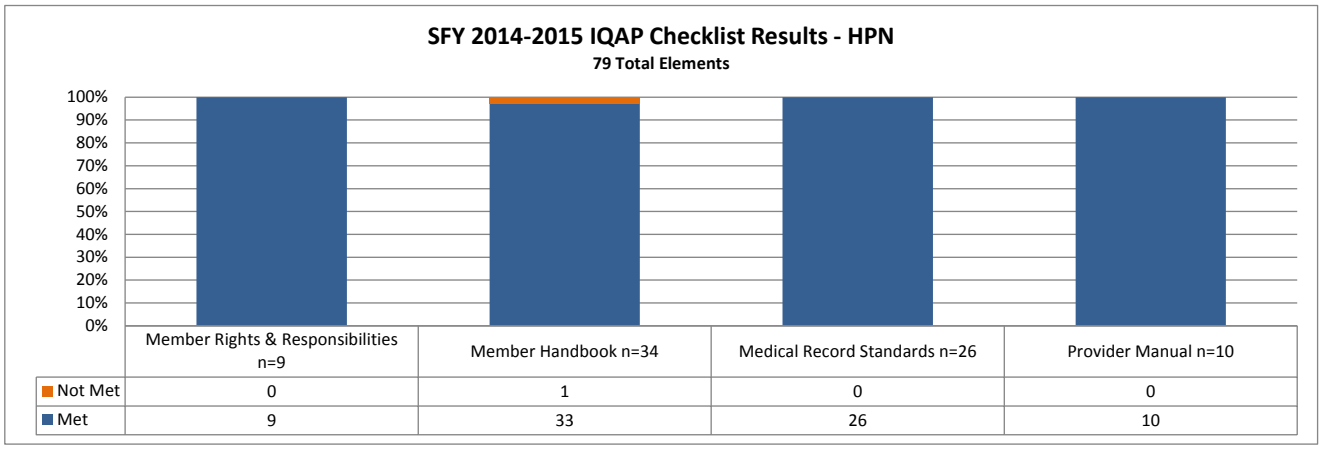


Of the 645 applicable elements reviewed for the file reviews, **HPN** received a score of *Met* for 639 of the elements, for a total score of 99.1 percent. **HPN** scored 100 percent compliant for three of the areas reviewed: *Initial Credentialing*, *Recredentialing*, and *Denials*. **HPN** scored 99.4 percent for *Case Management* and 96.7 percent for the *Grievances* record reviews. These results suggest that **HPN** followed the policies it developed to operationalize the required elements of its contract.

The greatest opportunity for improvement was with the *Appeals* record review, wherein **HPN** scored 89.7 percent. The *Appeals* record review showed that eight of 10 appeals were acknowledged within the required time frame; six of six standard appeals were resolved within the required time frame; three of four expedited appeals were resolved with the proper notice sent; and one expedited appeal was not resolved within the required time frame and no extension notice was sent to the member.

The results generated by the checklists serve as another indicator of the MCO's development of outreach information and ensures that the information contains all contractually required elements. Figure 4-6 presents the **HPN** scores for the checklists that were used to review all requirements related to *Member Rights and Responsibilities*, *Member Handbook*, *Provider Manual*, and *Medical Records* standards.

Figure 4-6—SFY 2014–2015 IQAP Checklist Results for HPN



Of the 79 elements reviewed for the checklists, **HPN** received a score of *Met* for 78 of them. **HPN**'s member handbook did not contain the provision that if a member loses Medicaid or Nevada Check Up eligibility, the member will be auto-assigned once eligibility is restored. With the exception of the one *Not Met* finding for the member handbook, the findings suggest that **HPN** had strong compliance with each of the areas evaluated by the checklists and it had developed the necessary manuals, standards, and policies according to contract requirements.

Plan Comparison

Amerigroup and **HPN** had a similar overall score for the IQAP standards—98.7 percent and 97.3 percent, respectively. These scores represent improvement over the previous IQAP compliance review that was performed in SFY 2011–2012. The scores demonstrate the MCOs' strong application of the requirements of the MCO contract in many of the same areas. Both MCOs achieved 100 percent compliance in the areas of *Member Information, Care Coordination, Coverage and Authorization of Services, Provider Dispute Resolution,* and *Provider Information*. Additionally, **Amerigroup** achieved 100 percent compliance for *Member Rights and Responsibilities, Subcontracts and Delegation, Cultural Competency, and Enrollment and Disenrollment*. **HPN** achieved 100 percent compliance for *Credentialing and Recredentialing*.

Similarities continued for those standards where a *Partially Met* score was given for at least one element for the following standards: *IQAP, Access and Availability, Grievance and Appeals,* and *Confidentiality*. For *IQAP,* neither plan demonstrated pregnancy prevention and family planning service monitoring in its quality improvement program. For *Access and Availability,* both health plans had a handful of members residing in locations that were more than 25 miles from the nearest primary care provider (PCP). For *Grievance and Appeals,* neither MCO's notice documents included the provision that members had the right to file a grievance if the MCO extended the time frame to make a decision about a service authorization and the member disagreed with the decision to extend the time frame. DHCFP staff members recognized, however, that this provision was unclear as stated in the contract and recommended a change to the contract language to make it clearer. For *Confidentiality*, neither MCO maintained the policy that the DHCFP can access medical records within 10 days of requesting the records and that the MCO will make the copies at the MCO's expense.

For the file reviews, **HPN** received 100 percent compliance in *Credentialing, Recredentialing,* and *Denials*. **Amerigroup** received 100 percent compliance with *Denials*. File reviews related to *Grievances* and *Appeals* proved to be a challenge for both MCOs. **Amerigroup** received a score of 90.5 percent and 92.9 percent for *Grievances* and *Appeals*, respectively. **HPN** received a score of 96.7 percent and 89.7 percent for *Grievances* and *Appeals*, respectively. **Amerigroup** had one noncompliant element for the *Credentialing* review. For the *Recredentialing* file review, **Amerigroup** did not reverify providers' hospital privileges during the recredentialing period, which is a State-specific standard. Missing this element for all 10 files reviewed resulted in the *Recredentialing* score of 95.2 percent for **Amerigroup**. Lastly, **Amerigroup** received a score of 96.4 percent for the *Case Management* file review and **HPN** received a score of 99.4 percent.

For the checklist reviews, **Amerigroup** received 100 percent compliance for all checklists, *Member Rights and Responsibilities, Member Handbook, Medical Record Standards,* and *Provider Manual*. **HPN** received a *Not Met* for one element in the *Member Handbook* review and received 100 percent compliance for the remaining three checklist reviews.

Overall Recommendations

For **Amerigroup**, HSAG recommended the following:

- Provide evidence of monitoring pregnancy prevention and family planning services.
- Reverify providers' hospital privileges during the recredentialing process.
- Ensure that members have access to PCPs within 25 miles of the member's residence.
- Ensure that service authorization extension notices contain the provision that members have the right to file a grievance if the MCO extends the time frame to make a decision about a service authorization and the member disagrees with that decision.
- Acknowledge receipt of grievances and appeals within the required time frames.
- Maintain the policy that the State may access medical records within 10 days of request and that the MCO will make the records available at the MCO's expense.
- Ensure that members receiving case management services are provided with condition-specific education materials and that the distribution of the materials is documented in the case management file. Also, ensure that all assessments are completed within 90 days of enrollment.

In response to the SFY 2014–2015 IQAP compliance review, **Amerigroup** submitted a corrective action plan to the DHCFP, which the DHCFP approved in June 2015.

For **HPN**, HSAG recommended the following:

- Provide evidence of monitoring pregnancy prevention and family planning services.
- Develop written policies regarding the treatment of minors.
- Ensure that members have access to PCPs within 25 miles of the member's residence.
- Acknowledge appeals within the time frames specified by the MCO's policy. For expedited appeals, the MCO must ensure that a notice of extension is sent to members when it requires more time to resolve the expedited appeal and that the expedited appeal is resolved within the required time frames specified by the MCO's policy.
- Ensure that policies maintain the provision that punitive action will not be taken against a provider who supports an expedited appeal.
- Verify that prospective subcontractors have the ability to perform delegated activities prior to entering an agreement with the subcontractor.
- Require that all staff members at all levels receive ongoing education and training in culturally and linguistically appropriate service delivery to members.
- Maintain the policy that the State may access medical records within 10 days of request and that the MCO will make the records available at the MCO's expense.
- Maintain the policy that members who are automatically enrolled after a break in eligibility of less than two months may not be allowed to disenroll without cause until the next open enrollment period.
- Ensure that grievances are acknowledged within the time frames specified by the MCO's policy.
- Complete comprehensive assessments of members within 90 days of enrollment.

In response to the SFY 2014–2015 IQAP compliance review, **HPN** submitted a corrective action plan to the DHCFP, which was the DHCFP approved in June 2015.

5. Validation of Performance Measures—NCQA HEDIS Compliance Audit—SFY 2014–2015

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

The following section provides summary information from the HEDIS compliance audits conducted by HSAG for **HPN** and **Amerigroup**. Further details regarding the results from the 2015 HEDIS compliance audits may be found in the July 2015 HEDIS Compliance Audit Final Report of Findings.

In January 2014, the DHCFP expanded Medicaid coverage to persons with incomes up to 138 percent of the federal poverty level, which was allowed under the Affordable Care Act. The majority of newly eligible persons reside in the managed care catchment areas; therefore, both MCOs experienced significant increases in enrollment since January 2014. To obtain a more accurate representation of the HEDIS rates for the Medicaid expansion population and its impact on HEDIS rates, the DHCFP has asked the MCOs to report 2015 Medicaid HEDIS rates for the following populations: (1) With Medicaid Expansion Population Included, and (2) Without Medicaid Expansion Included. This has enabled the MCOs to produce rates that are comparable to the previous years' (i.e., Without Medicaid expansion) and also to establish a baseline from which future comparisons can be made for the With Medicaid Expansion Population Included group. The results presented in this section include the rates for the Without Medicaid Expansion Population Included group so that rates could be compared to prior years' performance. The rates for the With Medicaid Expansion Population Included group are shown in Appendix A of this report.

Objectives

The objectives of the HEDIS compliance audit were to assess the performance of the MCOs with respect to the HEDIS 2015 Technical Specifications and to review their performance on the HEDIS measures. The audits incorporated two main components:

- A detailed assessment of the MCO's information system (IS) capabilities for collecting, analyzing, and reporting HEDIS information.
- A review of the specific reporting methods used for HEDIS measures, including databases and files used to store HEDIS information; medical record abstraction tools and abstraction procedures used; review of certified measure status; and any manual processes employed in HEDIS 2015 data production and reporting. The audit included any data collection and

reporting processes supplied by vendors, contractors, or third parties, as well as the MCO's oversight of these outsourced functions.

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

In HEDIS 2015, the MCOs were required to report 13 measures with a total of 39 rates for the Medicaid population. These measures include 12 performance measures and one utilization measure (Mental Health Utilization). For the Nevada Check Up population, the MCOs were required to report nine performance measures and the Mental Health Utilization measure, totaling up to 26 rates. Table 5-1 lists the required HEDIS 2015 measures for these two populations.

Table 5-1—Required HEDIS 2015 Measures

Measures	Medicaid Population	Nevada Check Up Population
Children-Related Measures		
Childhood Immunization Status (Combo 2—Combo 10)	√	√
Lead Screening in Children	√	√
Children's and Adolescents' Access to PCPs	√	√
Well-Child Visits First 15 Months of Life (Six or More Visits)	√	√
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	√	√
Adolescent Well-Care Visits	√	√
Annual Dental Visits—Combined Rate	√	√
Maternity-Related Measures		
Prenatal and Postpartum Care (Timeliness of Prenatal Care and *Postpartum Care)*	√	
Frequency of Ongoing Prenatal Care (<21% Visits and *81–100% Visits)*	√	
Condition-Specific Measures		
Comprehensive Diabetes Care	√	
Use of Appropriate Medications for People With Asthma	√	√*
Follow-up After Hospitalization for Mental Illness	√	√
Utilization Measure		
Mental Health Utilization	√	√

*The MCOs were required to report Nevada Check Up HEDIS 2015 rates for the 5–11 and 12–18 age groups only.

Plan-Specific Findings—Amerigroup

A detailed review of the 2015 performance reports submitted by **Amerigroup** determined that the reports were prepared according to the HEDIS 2015 Technical Specifications for all of the audited measures. Audits of IS capabilities for accurate HEDIS reporting found that **Amerigroup** was compliant with the standards assessed, as follows:

- **Amerigroup** was fully compliant with the IS Standard 1.0 reporting requirements for claims and encounter data processing. **Amerigroup** continued to use Facets for its claims processing system. Claims were received Monday through Friday from a variety of sources. The document management group received paper claims and scanned them into the tracking system. The scanned images were then submitted to the vendor, Smart Data Solutions, for optical character recognition or keying. There were multiple reconciliation processes in place to ensure the volume of claims sent to the vendor was received back by **Amerigroup**. Claims were returned to **Amerigroup** in an 837 Health Insurance Portability and Accountability Act (HIPAA) compliant format. Electronic claims were received daily from four clearing houses: Emdeon, Capario, Availity, and Smart Data Solutions. Electronic claims were also received via the web, where providers were able to key in the claims directly. Claims were received daily in the morning and downloaded each day. A compliance check was performed initially with multiple validation checks then loaded into a central repository, where the claims received additional edit checks, including member and provider validation as well as other State-specific checks. As claims passed the validation checks, a 999 acknowledgement file was sent back to the clearinghouse and the claims were loaded into Facets. The average monthly volume of claims received increased consistently with increases in membership. All claims were issued a document control number for tracking purposes and there were a number of audits in place to ensure accuracy. There were weekly audits during which a statistically valid random sample was selected using a 95 percent confidence limit and a 3 percent margin for error. The sample was selected weekly from the data warehouse in a post-disbursement status. All results exceeded standards for the measurement year. **Amerigroup** received vision claims from Eye Quest, pharmacy data from Caremark, and dental data from Scion. There were no issues with any ancillary claims vendors during the measurement year.
- **Amerigroup** was fully compliant with the IS Standard 2.0 reporting requirements for enrollment data processing. **Amerigroup** received enrollment files from the State on a monthly basis. An 834 compliance check was performed and then loaded into a relational database, which became the source data file. There was an enrollment load application that took the data from Edinet and applied business rules that created an input file to be loaded into Facets. The business rules looked for data that could not be manipulated or data elements that were missing. State-specific business rules were applied and a keyword file was created and processed through **Amerigroup**'s membership management system. Reconciliation counts were performed to ensure the data received were successfully loaded. The Membership Enrollment and Editing Tool was used to identify mistakes such as termination date errors for members already in the system, as well as date changes. Daily files were received with changes or edits. There were no issues in receiving data from the State during the measurement year and no backlogs in processing enrollment data.

- Enrollment files were sent to the vendors on a daily or weekly basis. All vendors were subjected to a predelegation audit and were held to claims processing and customer service standards. The vendors were monitored throughout the year via weekly, monthly, and quarterly reporting. The **Amerigroup** Vendor Selection Oversight Committee met monthly to discuss vendor issues, the delegation of new vendors, and audit results. If vendors were deficient in any area of their annual audit, corrective action plans were issued and monitored by the oversight committee. Additionally, the vendors were required to meet quarterly with the health plan during a joint quarterly operations meeting to discuss any issues or concerns regarding delegations or activities.
- **Amerigroup** was fully compliant with the IS Standard 3.0 reporting requirements for provider data processing. Provider data were stored in Facets and credentialing data were stored in Cactus. Provider applications were received and reviewed by the Provider Data Management (PDM) Team. The applications were scanned into Macess and a PDM analyst keyed the applications into Facets. The applications were then forwarded to credentialing. Once the provider applications passed credentialing, they were returned to the PDM and the provider became effective. For every provider who keyed into Facets, there was a monthly manual audit of 25 percent of all records. There was also a systematic audit that ran daily and that would catch relational data errors. Data were also compared to an outside source, Enclarity, to ensure accuracy.
- **Amerigroup** was fully compliant with the IS Standard 4.0 reporting requirements for the medical record review process. **Amerigroup** sampled according to the HEDIS sampling guidelines and assigned an appropriate measure-specific oversample. Medical record pursuit and data collection were conducted by the medical record vendor, Inovalon. HSAG reviewed and approved Inovalon's hybrid tools and corresponding abstraction instructions. Provider chase logic was reviewed and determined appropriate across the hybrid measures. Inovalon's reviewer qualifications, training, and oversight were appropriate. **Amerigroup** conducted adequate oversight of Inovalon's abstraction accuracy. Due to abstraction errors found during the 2014 validation, a convenience sample was required and subsequently passed for the *Adolescent Well-Care Visits* and the *Well-Child Visits in the First 15 Months of Life* measures. **Amerigroup** passed the MRRV process for the following measure groups:
  - Group A: *Postpartum Care*
  - Group B: *Well-Child Visits in the First 15 Months of Life (6+ Visits)*
  - Group C: *Comprehensive Diabetes Care—Medical Attention for Nephropathy*
  - Group D: *Childhood Immunization Status—Combo 5*
  - Group F: Exclusions
- **Amerigroup** was fully compliant with the IS Standard 5.0 reporting requirements for supplemental data**. Amerigroup** used the following standard and nonstandard databases for HEDIS 2015 reporting:
  - Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Data Mart (Standard)
  - Lab results from OP_RU, BioRef, LabCorp, Quest and XX_CPL (Standard)
  - Prior year's audited hybrid results (Standard)
  - Medical Records Database (Non-standard)

All of the sources included standard industry codes and did not require any mapping. Procedures were well documented for receipt and tracking of the data sources. Electronic data sources were well-tracked and trended throughout the measurement year. All supplemental data sources were approved for HEDIS 2015 reporting.

- IS 6.0 was not applicable to the scope of the audit since **Amerigroup** was not required to report the call center measures for Nevada Medicaid and Nevada Check Up.
- **Amerigroup** was fully compliant with the IS Standard 7.0 reporting requirements for data integration. **Amerigroup** continued to use Inovalon's Quality Spectrum Insight for HEDIS 2015 measure production. Data were transferred from Facets, vendor tables, and pharmacy tables into the operational data warehouse and then into the HEDIS warehouse. EPSDT data were transferred directly to the HEDIS data warehouse. There was a comprehensive quality control program in place to ensure complete and accurate data transfer from the sources to the warehouse. Data sources were logged monthly to track and trend each data load and to help identify any possible transmission errors. Due to its proprietary nature, a sample trending report was viewed on-site during the data integration session. Internal spreadsheets were maintained from year to year for benchmarking purposes. The benchmarks were very comprehensive and included comparisons with the eligible population, rates, numerators, and denominators, and they looked at any changes in the measure specifications. This should be considered a best practice and will definitely contribute positively to HEDIS measure production. There was no loss of data during the measurement year and no data had to be restored. During the final reconciliation process, the previously submitted medical record summary worksheets did not reconcile with the IDSS. Upon further discussion with **Amerigroup**, it was determined there were data entry errors in the summary sheets and sufficient evidence to conclude MRR in fact was completed by the May 15 deadline.

Medicaid Results

The Medicaid HEDIS 2015 rates for **Amerigroup** are presented in Table 5-2. Trended results are also provided, comparing the HEDIS 2015 rates with the earliest HEDIS results available. For the two measures with lower rates suggesting better performance (i.e., *Frequency of Ongoing Prenatal Care <21% Visits* and *Comprehensive Diabetes Care—Poor HbA1c Control*), their trended results signs were reversed to align with other measures. Since *Mental Health Utilization* is designed to capture the frequency of mental health services provided by the MCOs, the percentile ranking for each rate is for informational purposes only. Higher or lower rates do not indicate better or worse performance.

Table 5-2—Medicaid HEDIS Results for Amerigroup

HEDIS Measure	Medicaid HEDIS Results for Amerigroup[1]				Trended Results
	2012	2013	2014	2015	
Childhood Immunization Status—Combo 2	69.0	70.60	61.34	66.20	-2.8
Childhood Immunization Status—Combo 3	64.1	66.20	55.32	60.88	-3.22
Childhood Immunization Status—Combo 4	41.4	64.58	54.63	58.80	17.4
Childhood Immunization Status—Combo 5	45.4	50.93	45.37	50.23	4.83
Childhood Immunization Status—Combo 6	29.4	37.04	29.86	33.33	3.93

Table 5-2—Medicaid HEDIS Results for Amerigroup					
HEDIS Measure	Medicaid HEDIS Results for Amerigroup[1]				Trended Results
	2012	2013	2014	2015	
Childhood Immunization Status—Combo 7	31.7	50.23	44.91	48.38	16.68
Childhood Immunization Status—Combo 8	21.8	36.81	29.63	33.10	11.3
Childhood Immunization Status—Combo 9	20.6	29.40	25.93	28.24	7.64
Childhood Immunization Status—Combo 10	16.7	29.40	25.69	28.01	11.31
Lead Screening in Children	33.3	34.49	34.26	35.88	2.58
Children's and Adolescents' Access to PCPs (12–24 Months)	95.0	94.84	93.58	91.14	-3.86
Children's and Adolescents' Access to PCPs (25 Months–6 Years)	85.4	84.62	83.40	81.29	-4.11
Children's and Adolescents' Access to PCPs (7–11 Years)	84.7	84.65	84.96	85.47	0.77
Children's and Adolescents' Access to PCPs (12–19 Years)	80.5	81.41	80.97	81.76	1.26
Well-Child Visits First 15 Months (Six or More Visits)	57.6	55.79	53.47	50.58	-7.02
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	66.1	65.38	63.08	65.05	-1.05
Adolescent Well-Care Visits	35.7	37.27	37.96	40.51	4.81
Annual Dental Visit—Combined Rate	53.2	51.02	44.99	45.81	-7.39
Timeliness of Prenatal Care	82.3	88.84	83.98	74.48	-7.82
Postpartum Care	58.8	61.76	59.22	50.12	-8.68
Frequency of Ongoing Prenatal Care (<21% Visits)*	11.3	4.51	9.47	16.47	-5.17
Frequency of Ongoing Prenatal Care (81–100% Visits)	66.0	75.30	63.83	54.76	-11.24
Comprehensive Diabetes Care—HbA1c Testing	71.6	68.75	73.99	69.84	-1.76
Comprehensive Diabetes Care—Poor HbA1c Control*	54.3	52.98	54.16	58.70	-4.4
Comprehensive Diabetes Care—Good HbA1c Control (<8%)	38.6	41.37	38.34	34.34	-4.26
Comprehensive Diabetes Care—Eye Exams	42.8	53.57	53.62	45.24	2.44
Comprehensive Diabetes Care—Blood Pressure <140/90	62.4	61.61	58.45	61.25	-1.15
Comprehensive Diabetes Care—Monitoring for Nephropathy	69.0	63.99	67.29	67.52	-1.48
Use of Appropriate Medications for People With Asthma (5–11 Years)	87.2	86.43	84.16	82.49	-4.71
Use of Appropriate Medications for People With Asthma (12–18 Years)	88.0	82.73	77.86	71.95	-16.05
Use of Appropriate Medications for People With Asthma (19–50 Years)	74.6	73.08	60.23	56.18	-18.42
Use of Appropriate Medications for People With Asthma (51–64 Years)**	NA	NA	NA	NA	--
Use of Appropriate Medications for People With Asthma (Combined)	85.5	83.48	78.82	76.42	-9.08
Follow-up After Hospitalization for Mental Illness—7 Days	59.2	54.49	62.13	57.19	-2.01
Follow-up After Hospitalization for Mental Illness—30 Days	68.4	67.31	68.64	67.28	-1.12

* Lower rates are better for this measure.
NA is shown when the health plan followed HEDIS specifications but the denominator was too small (n<30) to report a valid rate.
[1] Rates are displayed to two decimal places to be consistently compared against the Medicaid HEDIS 2014 percentiles. For consistency purposes, the HEDIS 2012 rates are displayed to one decimal place, as in previous technical reports.

All of **Amerigroup**'s measures were reportable for HEDIS 2015, although *Use of Appropriate Medications for People with Asthma (51–64 years)* had fewer than 30 eligible cases and is displayed as NA. Reported as a new measure for HEDIS 2015, the *Mental Health Utilization* measure

indicated that less than 5 percent of **Amerigroup** members received any mental health services in 2014.

Compared to 2014, 15 child-related measure rates showed a performance improvement; one (*Childhood Immunization Status—Combination 3*) improved more than 5 percentage points. None of the four maternity-related measures showed a performance improvement from 2014. More specifically, all the measures reported a decline of more than 5 percentage points. This finding suggested potential concerns in timeliness and access to maternity services and care.

Regarding the condition-specific measures, two indicators under *Comprehensive Diabetes Care* had a slight performance improvement from 2014 but none improved for more than 5 percentage points. The four remaining *Comprehensive Diabetes Care* indicators showed a decline in performance, with the *Eye Exams* rate dropping for more than 5 percentage points. The *Use of Appropriate Medications for People with Asthma* and *Follow-up After Hospitalization for Mental Illness* also showed a performance decline. In particular, the *Use of Appropriate Medications for People with Asthma—12–18 Years* rate declined for more than 5 percentage points.

In terms of quality and access, **Amerigroup** appeared to provide appropriate services to its members. Twelve of the 33 measures (excluding *Mental Health Utilization*) with baseline rates in 2012 showed performance improvement over time, ranging from 0.77 percentage points to 17.4 percentage points. Five rates demonstrated an improvement of at least 5 percentage points, all from *Childhood Immunization Status*. Conversely, 22 measures showed a performance decline, ranging from 1.05 percentage points to 18.42 percentage points. Nine rates declined more than 5 percentage points. These rates included all four maternity-related measures, in addition to the following: *Well-Child Visits in the First 15 Months of Life—Six or More Visits*, *Annual Dental Visits—Combined Rate*, and three indicators under *Use of Appropriate Medications for People with Asthma*.

Nevada Check Up Results

The Nevada Check Up HEDIS 2015 rates for **Amerigroup** are presented in Table 5-3 along with the trended results from 2012. Similar to the Medicaid population, **Amerigroup** also reported *Mental Health Utilization* for Nevada Check Up as a new measure for HEDIS 2015. Since *Mental Health Utilization* is designed to capture the frequency of mental health services provided by the MCOs, the percentile ranking for each rate is for informational purposes only. Higher or lower rates do not indicate better or worse performance.

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

HEDIS Measure	Nevada Check Up HEDIS Results for Amerigroup[1]				Trended Results
	2012	2013	2014	2015	
Childhood Immunization Status—Combo 2	84.2	84.47	76.99	74.55	-9.65
Childhood Immunization Status—Combo 3	81.6	76.70	76.11	73.64	-7.96
Childhood Immunization Status—Combo 4	59.7	76.70	74.34	73.64	13.94
Childhood Immunization Status—Combo 5	70.2	66.99	68.14	54.55	-15.65
Childhood Immunization Status—Combo 6	42.1	53.40	51.33	45.45	3.35
Childhood Immunization Status—Combo 7	52.6	66.99	67.26	54.55	1.95
Childhood Immunization Status—Combo 8	33.3	53.40	49.56	45.45	12.15

Table 5-3—Nevada Check Up HEDIS Results for Amerigroup					
HEDIS Measure	Nevada Check Up HEDIS Results for Amerigroup[1]				Trended Results
	2012	2013	2014	2015	
Childhood Immunization Status—Combo 9	40.4	48.54	46.90	32.73	-7.67
Childhood Immunization Status—Combo 10	31.6	48.54	46.02	32.73	1.13
Lead Screening in Children	44.7	49.51	50.44	50.91	6.21
Annual Dental Visit—Combined Rate	72.4	74.31	67.67	64.48	-7.92
Children's and Adolescents' Access to PCPs (12–24 Months)	99.0	100	98.85	95.83	-3.17
Children's and Adolescents' Access to PCPs (25 Months–6 Years)	95.5	95.07	94.11	90.48	-5.02
Children's and Adolescents' Access to PCPs (7–11 Years)	95.1	97.06	97.25	92.62	-2.48
Children's and Adolescents' Access to PCPs (12–19 Years)	91.0	93.30	93.69	92.18	1.18
Well-Child Visits First 15 Months (Six or More Visits)	51.5	51.28	54.05	70.37	18.87
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	76.4	78.82	78.74	71.30	-5.1
Adolescent Well-Care Visits	54.4	56.71	58.22	56.48	2.08
Use of Appropriate Medications for People With Asthma (5–11 Years)	96.0	90.74	92.50	NA	--
Use of Appropriate Medications for People With Asthma (12–18 Years)	NA	73.08	NA	NA	--
Follow-up After Hospitalization for Mental Illness—7 Days	NA	NA	NA	NA	--
Follow-up After Hospitalization for Mental Illness—30 Days	NA	NA	NA	NA	--

NA is shown when the health plan followed HEDIS specifications but the denominator was too small (<30) to report a valid rate.
[1] Rates are displayed to two decimal places to be consistently compared against the Medicaid HEDIS 2014 percentiles. For consistency purposes, the HEDIS 2012 rates are displayed to one decimal place as in previous technical reports.

All of **Amerigroup's** rates were reportable for HEDIS 2015, although *Use of Appropriate Medications for People With Asthma* and *Follow-up After Hospitalization for Mental Illness* had fewer than 30 eligible cases and are displayed as NA. Similar to the Medicaid population, **Amerigroup** had less than 5 percent of its Nevada Check Up members receiving any mental health services in 2014.

Compared to HEDIS 2014, only one rate (*Well-Child Visits in the First 15 Months of Life—Six or More Visits*) improved its performance more than 10 percentage points. Sixteen rates declined from HEDIS 2014 and six rates declined by more than 5 percentage points. Most of these notable declines were found in *Childhood Immunization Status* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*.

In terms of quality and access, **Amerigroup** continued to provide appropriate services and improved the delivery of services to members. Nine rates improved over time from 2012, ranging from 1.13 percentage points to 18.87 percentage points. Four of these improved by at least 5 percentage points. Two of them were from *Childhood Immunization Status* and the other two were *Lead Screening in Children* and *Well-Child Visits in the First 15 Months of Life—Six or More Visits*. Nine rates declined from 2012, ranging from 2.48 percentage points to 15.65 percentage points. Seven declined for more than 5 percentage points. Four of these rates were from *Childhood Immunization Status* and the other three were *Annual Dental Visits—Combined Rate, Children's*

and Adolescents' Access to PCPs (25 Months–6 Years), and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*.

Summary of Amerigroup Strengths

Multiple vaccination combinations of the Medicaid performance measure, *Childhood Immunization Status*, were identified as strengths for **Amerigroup** based on rate improvements greater than 5 percentage points over time.

- *Childhood Immunization Status—Combinations 4, 7, 8, 9, and 10*

All Nevada Check Up rates were higher than the corresponding Medicaid reported rates. The following Nevada Check Up performance measures were identified as strengths for **Amerigroup** based on rate improvements greater than 5 percentage points over time.

- *Childhood Immunization Status—Combinations 4 and 8*
- *Lead Screening in Children*
- *Well-Child Visits in the First 15 Months of Life—Six or More Visits*

Summary of Amerigroup Opportunities for Improvement

The following Medicaid performance measures were identified as opportunities for improvement for **Amerigroup** based on a decline in performance of greater than 5 percentage points over time.

- *Well-Child Visits in the First 15 Months of Life—Six or More Visits*
- *Annual Dental Visits—Combined Rate*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care and Postpartum Care*
- *Frequency of Ongoing Prenatal Care—<20% Visits and ≥81% Visits*
- *Use of Appropriate Medications for People With Asthma—12–18 Years, 19–50 Years, and Combined*

The following Nevada Check Up performance measures were identified as opportunities for improvement for **Amerigroup** based on a decline in performance of greater than 5 percentage points over time.

- *Childhood Immunization Status—Combinations 2, 3, 5, and 9*
- *Annual Dental Visits—Combined Rate*
- *Children's and Adolescents' Access to PCPs (25 Months–6 Years)*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

Data Completeness

Table 5-4 provides an estimate of data completeness for **Amerigroup**'s hybrid performance measures for both Medicaid and Nevada Check Up. These hybrid measures use administrative data (i.e., claims

and encounter data) and supplement the results with medical record data. The table shows the HEDIS 2015 final rate and the percentage determined solely through administrative data for both populations, respectively. For example, a rate of 100 percent in the last two columns indicates that administrative data were complete for that HEDIS measure (i.e., no additional numerator compliance was determined via medical record review).

Table 5-4—Estimated Data Completeness for Amerigroup Hybrid Measures

HEDIS Hybrid Measures	2015 HEDIS Rate		Percent From Administrative Data	
	Medicaid	Nevada Check Up	Medicaid	Nevada Check Up
Childhood Immunization Status—Combo 2	66.20	74.55	53.50	26.83
Childhood Immunization Status—Combo 3	60.88	73.64	47.91	20.99
Lead Screening in Children	35.88	50.91	98.06	100.00
Well-Child Visits—First 15 Months (Six or More Visits)	50.58	70.37	89.45	86.84
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	65.05	71.30	95.73	99.03
Adolescent Well-Care Visits	40.51	56.48	90.29	97.13
Medicaid-Only HEDIS Measures				
Timeliness of Prenatal Care	74.48		62.62	
Postpartum Care	50.12		54.17	
Frequency of Ongoing Prenatal Care (81–100% Visits)	54.76		23.73	
Comprehensive Diabetes Care—HbA1c Testing	69.84		98.34	
Comprehensive Diabetes Care—Good HbA1c Control (<8%)	34.34		88.51	
Comprehensive Diabetes Care—Eye Exams	45.24		87.69	
Comprehensive Diabetes Care—Monitoring for Nephropathy	67.52		93.81	

Rates in **green** indicate that more than 90 percent of the final rate was derived from administrative data.
Rates in **red** indicate that 50 percent or less of the final rate was derived from administrative data.
The data completeness for *Childhood Immunization Status Combos 4–10* must be the same or lower as the Combo 3 data completeness rate.

Table 5-4 shows that for both of its populations, **Amerigroup** had over 90 percent of the final rate derived from administrative data (highlighted in green) for *Lead Screening in Children; Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life;* and *Adolescent Well-Care Visits*. However, at least 45 percent of the *Childhood Immunization Status—Combo 2* and *Combo 3* rates still relied on medical record data for both Medicaid and Nevada Check Up populations. The findings suggest **Amerigroup** continued to have difficulty in obtaining complete encounter data for childhood immunizations for both the Medicaid and Nevada Check Up populations. The difficulty of administrative data collection for childhood immunization may be attributed to immunizations often being provided at locations other than a provider's office (e.g., health fairs and schools). In these cases, **Amerigroup** may not receive a claim for the immunization.

Two additional Medicaid-only rates (*Comprehensive Diabetes Care—HbA1c Testing* and *Monitoring for Nephropathy*) derived at least 90 percent of their final rates from administrative data. Since these indicators are related to laboratory data, this result indicates that **Amerigroup** has

fairly complete administrative laboratory data. Only one rate (*Frequency of Ongoing Prenatal Care—81–100% Visits*) derived less than 50 percent of its rate from administrative data. In general, these results suggest that **Amerigroup** demonstrated good data completeness.

For maternity care, **Amerigroup** continued to reimburse providers using global billing, which can result in capturing fewer visits than required for the HEDIS measures, since the provider is not required to include all prenatal care visits on the claim or global billing form. However, providers should still submit encounter data for maternity care. **Amerigroup** is encouraged to focus on this area for the next audit year. Since medical record abstraction was performed for these measures, final rates were not impacted.

Plan-Specific Findings—HPN

A detailed review of the 2015 performance reports submitted by **HPN** determined that the reports were prepared according to the HEDIS 2015 Technical Specifications for all of the audited measures, which are listed in Appendix A. Audits of information system (IS) capabilities for accurate HEDIS reporting found that **HPN** was compliant with the standards assessed, as follows:

- **HPN** was fully compliant with the IS Standard 1.0 reporting requirements for data capture, transfer, and entry related to claims and encounter data processing. There was a significant increase in membership and, therefore, a corresponding increase in claims and encounter data submission. **HPN** continued to use the Facets system for claims processing. Data entry processes were effective and efficient and assured timely, accurate entry into the system. Only standard codes were accepted and the system enforced ICD-9 coding specificity, as required. **HPN** had appropriate procedures to receive and monitor electronic submission. The **HPN** staff routinely monitors and trends volume. **HPN** had appropriate processes in place to oversee vendors, which included review of submitted data and monitoring contractual standards.
- **HPN** was fully compliant with the IS Standard 2.0 reporting requirements for enrollment data processing**.** This process remained the same as in previous years; however, **HPN** had a significant increase in membership due to the Medicaid expansion, increasing from 111,000 to 229,000 members in 2014. Membership data were received by **HPN** from the State's vendor and were fully reconciled. **HPN** had processes in place to assure timely and accurate loading of membership data. **HPN** tracked members using the system-issued number. This allowed linkage of data if a member lost and regained eligibility. **HPN** also had the ability to link members who switched product lines. For newborns, the State assigned a temporary ID for the baby; the baby was identified by the mother's ID until the newborn received his or her own Medicaid ID. There appeared to be no issues with linking the appropriate claims back to the newborn's record using the system ID. Overall, there were no issues identified with the enrollment data.
- **HPN** was fully compliant with the IS Standard 3.0 reporting requirements for provider data processing. Due to the Medicaid expansion, **HPN** added an additional 125 providers during 2014 and is continuing to try to increase the provider network. This has been a concern for **HPN** as membership has increased and recruiting providers remains a challenge. All required provider-related data elements for the HEDIS measures reported were captured and verified within the systems. **HPN** was able to distinguish provider types and specialties as required for HEDIS reporting. Since the Board Certification measures were not reported by the health plan, credentialing and recredentialing were not included in the scope of the audit.
- **HPN** was fully compliant with the IS Standard 4.0 reporting requirements for medical record review process. **HPN** sampled according to the HEDIS sampling guidelines and assigned an appropriate measure-specific oversample. Provider chase logic was reviewed and determined appropriate across the hybrid measures. Medical record pursuit and data collection were conducted by **HPN**'s staff using Verisk hybrid tools. HSAG reviewed and approved the Verisk hybrid tools and corresponding abstraction instructions.
- Reviewer qualifications, training, and oversight were appropriate. Since there were no changes to **HPN**'s medical record review (MRR) process for 2015 (measures or process), and the plan was audited by HSAG in 2014 and passed the medical record review validation (MRRV), a

convenience sample was not required. **HPN** passed the MRR process for the following measure groups:

- Group A: *Timeliness of Prenatal Care*
- Group B: *Adolescent Well-Care Visits*
- Group B: *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- Group C: *Comprehensive Diabetes Care—HbA1c Control (<8.0%)*
- Group D: *Childhood Immunization Status—Combo 5*
- Group F: No exclusions

Upon validation of the Adolescent Well-Care Visits measure, one abstraction error was found. According to the National Committee for Quality Assurance (NCQA) MRRV protocol, a validation of a second sample was required. The second sample was validated and subsequently passed. Due to the error type, the findings were extrapolated to the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life.* Upon validation by HSAG, the sample subsequently passed validation.

- **HPN** was fully compliant with the IS Standard 5.0 reporting requirements for supplemental data. **HPN** received laboratory data from Quest and immunization registry data from the State. Both of these databases were considered external, standard data. **HPN** had processes for data receipt, processing, and loading into the HEDIS vendor's software. **HPN** provided all the required supporting documentation for both standard databases. **HPN** originally identified a nonstandard database, Touchworks, to use for reporting, but it was not using these data for Medicaid reporting. There were no issues identified with any of the supplemental data and all of these data were approved for HEDIS 2015 reporting.
- IS 6.0 was not applicable to the scope of the audit since **HPN** was not required to report the call center measures for Nevada Medicaid and Nevada Check Up.
- **HPN** was fully compliant with the IS Standard 7.0 reporting requirements for data integration. The data integration process followed the same method as the prior year. **HPN** used Verisk for the calculation of its HEDIS rates. Data were loaded from Facets and CRD directly into Krammer, the data warehouse repository. These data were then loaded into Verisk's software. Reports were generated during each load process to ensure accurate and complete data were captured. Additional reports were conducted monthly to compare data in Krammer versus data in Verisk, as well as data in Krammer versus data in Facets and CRD. This high-level reporting system helped to ensure the appropriateness of the data and the accuracy of the data transfers; however, it was observed for the *Prenatal and Postpartum Care* measure that the vendor accepted delivery dates from multiple sources, not just inpatient deliveries. This caused a number of delivery dates to be misidentified. Several cases during on-site primary source verification were unable to be validated and required further research. HSAG recommended that **HPN** correct the delivery dates and ensure the vendor used the final, corrected delivery date. **HPN** was able to make the corrections for HEDIS reporting. Primary source verification was conducted on-site for several additional measures and no issues were identified.

Medicaid Results

The Medicaid HEDIS rates for 2012 through 2015 for **HPN** are presented in Table 5-5. Trended results are also provided, comparing the HEDIS 2015 rates with the earliest HEDIS results available in the table. For the two measures with lower rates suggesting better performance (i.e., *Frequency of Ongoing Prenatal Care <21% Visits* and *Comprehensive Diabetes Care—Poor HbA1c Control*), their trended results signs were reversed to align with other measures. Since *Mental Health Utilization* is designed to capture the frequency of mental health services provided by the MCOs, the percentile ranking for each rate is for informational purposes only. Higher or lower rates do not indicate better or worse performance.

Table 5-5—Medicaid HEDIS Results for HPN

HEDIS Measure	Medicaid HEDIS Results for HPN[1]				Trended Results
	2012	2013	2014	2015	
Childhood Immunization Status—Combo 2	73.5	70.32	72.99	70.56	-2.94
Childhood Immunization Status—Combo 3	67.6	66.42	67.88	65.94	-1.66
Childhood Immunization Status—Combo 4	40.6	66.18	66.42	64.72	24.12
Childhood Immunization Status—Combo 5	50.6	51.34	57.42	55.47	4.87
Childhood Immunization Status—Combo 6	28.5	36.74	40.15	38.44	9.94
Childhood Immunization Status—Combo 7	32.6	51.09	56.69	54.50	21.9
Childhood Immunization Status—Combo 8	19.5	36.74	39.90	37.71	18.21
Childhood Immunization Status—Combo 9	23.8	30.41	36.50	33.82	10.02
Childhood Immunization Status—Combo 10	16.3	30.41	36.25	33.09	16.79
Lead Screening in Children	29.4	32.36	37.23	40.88	11.48
Children's and Adolescents' Access to PCPs (12–24 Months)	92.7	93.00	91.73	91.42	-1.28
Children's and Adolescents' Access to PCPs (25 Months–6 Years)	82.4	80.49	78.58	79.21	-3.19
Children's and Adolescents' Access to PCPs (7–11 Years)	84.1	82.99	82.35	83.88	-0.22
Children's and Adolescents' Access to PCPs (12–19 Years)	82.2	78.82	78.37	81.05	-1.15
Well-Child Visits First 15 Months (Six or More Visits)	49.4	51.34	54.50	51.58	2.18
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	63.0	57.42	54.74	58.15	-4.85
Adolescent Well-Care Visits	37.0	33.09	42.09	42.34	5.34
Annual Dental Visit—Combined Rate	59.4	54.71	53.32	51.30	-8.1
Timeliness of Prenatal Care	81.3	85.89	74.94	74.94	-6.36
Postpartum Care	67.2	64.96	57.66	51.58	-15.62
Frequency of Ongoing Prenatal Care (< 21% Visits)*	3.9	8.03	18.00	11.68	-7.78
Frequency of Ongoing Prenatal Care (81–100% Visits)	73.0	68.13	59.37	56.93	-16.07
Comprehensive Diabetes Care—HbA1c Testing	72.8	69.98	69.59	77.13	4.33
Comprehensive Diabetes Care—Poor HbA1c Control*	52.8	55.07	54.50	50.36	2.44
Comprehensive Diabetes Care—Good HbA1c Control (< 8%)	38.2	36.14	37.47	38.44	0.24
Comprehensive Diabetes Care—Eye Exams	49.6	44.55	44.04	52.55	2.95
Comprehensive Diabetes Care—Blood Pressure <140/90	60.8	65.39	69.10	64.96	4.16
Comprehensive Diabetes Care—Monitoring for Nephropathy	67.4	72.47	72.75	73.24	5.84
Use of Appropriate Medications for People With Asthma (5–11 Years)	92.7	89.38	90.45	89.22	-3.48
Use of Appropriate Medications for People With Asthma (12–18 Years)	84.0	83.15	86.82	89.54	5.54

Table 5-5—Medicaid HEDIS Results for HPN					
HEDIS Measure	Medicaid HEDIS Results for HPN[1]				Trended Results
	2012	2013	2014	2015	
Use of Appropriate Medications for People With Asthma (19–50 Years)	58.3	60.91	58.57	70.32	12.02
Use of Appropriate Medications for People With Asthma (51–64 Years)	NA	NA	NA	NA	--
Use of Appropriate Medications for People With Asthma (Combined)	85.6	84.42	84.54	86.82	1.22
Follow-up After Hospitalization for Mental Illness—7 Days	59.6	77.08	68.83	63.85	4.25
Follow-up After Hospitalization for Mental Illness—30 Days	70.2	86.46	81.82	77.93	7.73

* Lower rates are better for this measure, so the 2014 National Medicaid HEDIS 10th percentile is used for percentile comparison. Additionally, positive values shown in the Trended Results column for this measure should be interpreted as declines in performance.
NA is shown when the health plan followed HEDIS specifications but the denominator was too small (n<30) to report a valid rate.
[1] Rates are displayed to two decimal places to be consistently compared against the Medicaid HEDIS 2014 percentiles. For consistency, the HEDIS 2012 rates are displayed to one decimal place as in previous technical reports.

All of **HPN**'s measures were reportable for HEDIS 2015, although *Use of Appropriate Medications for People with Asthma (51–64 years)* had fewer than 30 eligible cases and is displayed as NA. Reported as a new measure for HEDIS 2015, *Mental Health Utilization* indicated that less than 5 percent of **HPN** members received any mental health services in 2014.

Compared to 2014, six child-related measure rates showed a performance improvement, although the rate increase was no more than 5 percentage points. Of the four maternity-related measures, only one (*Frequency of Ongoing Prenatal Care <21% Visits*—an inverse measure) showed a rate decline and hence an improvement from 2014. The *Postpartum Care* rate declined for more than 5 percentage points. These maternity-related measures tend to be related to both timeliness and access.

Regarding the condition-specific measures, improvement from 2014 was noted in most of the *Comprehensive Diabetes Care* and *Use of Appropriate Medications for People With Asthma* indicators. Three of these rates (*Comprehensive Diabetes Care—HbA1c Testing, Eye Exam Performed*, and *Use of Appropriate medications for People With Asthma—19 Years to 50 Years*) improved more than 5 percentage points. Both indicators under *Follow-up After Hospitalization for Mental Illness* declined, although the decline was less than 5 percentage points.

In terms of quality and access, **HPN** appeared to provide appropriate services to its members. Twenty-one of the 34 valid rates in 2012 showed performance improvement over time, ranging from 0.24 percentage points to 24.12 percentage points. Thirteen rates demonstrated an improvement of at least 5 percentage points. Seven of these notable improvements were from *Childhood Immunization Status* and two were from *Use of Appropriate Medications for People with Asthma*. Conversely, 13 measures showed a performance decline, ranging from 0.22 percentage points to 16.07 percentage points. Rates with declines greater than 5 percentage points were mostly maternity-related measures.

Nevada Check Up Results

The Nevada Check Up HEDIS rates for 2012 through 2015 for **HPN** are presented in Table 5-6, along with the trended results. Since *Mental Health Utilization* is designed to capture the frequency of mental health services provided by the MCOs, the percentile ranking for each rate is for informational purposes only. Higher or lower rates do not indicate better or worse performance.

Table 5-6—Nevada Check Up Results for HPN

HEDIS Measure	Nevada Check Up HEDIS Results for HPN[1]				Trended Results
	2012	2013	2014	2015	
Childhood Immunization Status—Combo 2	86.4	90.96	85.21	83.46	-2.94
Childhood Immunization Status—Combo 3	82.2	85.64	83.10	77.17	-5.03
Childhood Immunization Status—Combo 4	57.1	84.57	83.10	76.38	19.28
Childhood Immunization Status—Combo 5	67.5	72.34	72.54	66.14	-1.36
Childhood Immunization Status—Combo 6	36.1	47.87	48.59	48.03	11.93
Childhood Immunization Status—Combo 7	48.2	71.81	72.54	65.35	17.15
Childhood Immunization Status—Combo 8	29.8	47.87	48.59	47.24	17.44
Childhood Immunization Status—Combo 9	31.4	43.62	42.96	42.52	11.12
Childhood Immunization Status—Combo 10	25.7	43.62	42.96	41.73	16.03
Lead Screening in Children	50.8	50.53	55.24	42.75	-8.05
Annual Dental Visit—Combined Rate	78.1	76.09	77.21	69.50	-8.6
Children's and Adolescents' Access to PCPs (12–24 Months)	97.6	96.95	95.08	94.70	-2.9
Children's and Adolescents' Access to PCPs (25 Months–6 Years)	93.1	92.85	91.39	87.20	-5.9
Children's and Adolescents' Access to PCPs (7–11 Years)	94.2	94.95	94.88	93.83	-0.37
Children's and Adolescents' Access to PCPs (12–19 Years)	93.0	90.91	91.49	90.79	-2.21
Well-Child Visits First 15 Months (Six or More Visits)	56.6	65.00	63.01	60.00	3.4
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	74.2	69.34	73.72	71.95	-2.25
Adolescent Well-Care Visits	50.9	49.64	54.26	55.47	4.57
Use of Appropriate Medications for People With Asthma (5–11 Years)	98.4	93.51	97.00	95.69	-2.71
Use of Appropriate Medications for People With Asthma (12–18 Years)	95.8	86.89	91.94	88.31	-7.49
Follow-up After Hospitalization for Mental Illness—7 Days	57.5	NA	NA	NA	--
Follow-up After Hospitalization for Mental Illness—30 Days	67.5	NA	NA	NA	--

NA is shown when the health plan followed HEDIS specifications but the denominator was too small (<30) to report a valid rate.
[1] Rates are displayed to two decimal places to be consistently compared against the Medicaid HEDIS 2014 percentiles. For consistency, the HEDIS 2012 rates are displayed to one decimal place as in previous technical reports.

All of **HPN**'s rates were reportable for HEDIS 2015, although *Follow-up After Hospitalization for Mental Illness* had fewer than 30 eligible cases and are displayed as NA. Similar to the Medicaid population, the *Mental Health Utilization* rates indicated that less than 5 percent of HPN Check-Up members received any mental health services in 2014.

Compared to HEDIS 2014, only one rate (*Adolescent Well Care Visits*) improved its performance, although the rate increase was slightly over 1 percentage point. Of the 19 rates that declined from HEDIS 2014, six were by more than 5 percentage points. These notable declines were found in *Childhood Immunization Status, Lead Screening in Children,* and *Annual Dental Visits (Combined Rate).*

In terms of quality and access, **HPN** continued to provide appropriate services and improved the delivery of services to members. Eight rates improved over time from 2012, ranging from 3.4 percentage points to 19.28 percentage points. Six of these rates, all from *Childhood Immunization Status,* improved at least 10 percentage points. Of the 12 rates that declined from 2012, five declined by more than 5 percentage points. These included *Childhood Immunization Status—Combination 3, Lead Screening in Children, Annual Dental Visits—Combined Rate, Children's and Adolescents' Access to PCPs (25 Months–6 Years),* and *Use of Appropriate Medication for People With Asthma (12–18 Years).*

Summary of HPN Strengths

The following Medicaid performance measures were identified as strengths for **HPN** based on rate improvements of greater than 5 percentage points over time.

- *Childhood Immunization Status—Combinations 4, 6, 7, 8, 9, and 10*
- *Lead Screening in Children*
- *Adolescent Well-Child Visits*
- *Comprehensive Diabetes Care—Monitoring for Nephropathy*
- *Use of Appropriate Medications for People With Asthma—12–18 Years and 19–50 Years*
- *Follow-up After Hospitalization for Mental Illness—30 Days*

All comparable Nevada Check Up rates but one (*Use of Appropriate Medications for People With Asthma—12–18 Years*) were higher than the corresponding Medicaid reported rates. Multiple vaccination combinations of the Nevada Check Up performance measure, *Childhood Immunization Status,* were identified as strengths for **HPN** based on rate improvements greater than 5 percentage points over time.

- *Childhood Immunization Status–Combinations 4, 6, 7, 8, 9, and 10*

Summary of HPN Opportunities for Improvement

The following Medicaid performance measures were identified as opportunities for improvement for **HPN** based on rate declines of at least 5 percentage points in performance over time.

- *Annual Dental Visits—Combined Rate*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care and Postpartum Care*
- *Frequency of Ongoing Prenatal Care—<20% Visits and ≥81% Visits*

The following Nevada Check Up performance measures were identified as an opportunity for improvement for **HPN** based on a decline in performance of greater than 5 percentage points over time.

- *Childhood Immunization Status—Combo 3*
- *Lead Screening in Children*
- *Annual Dental Visits—Combined Rate*
- *Children's and Adolescents' Access to PCPs (25 Months—6 Years)*
- *Use of Appropriate Medications for People With Asthma (12–18 Years)*

Data Completeness

Table 5-7 provides an estimate of data completeness for the hybrid performance measures for both Medicaid and Nevada Check Up for **HPN**. These measures use administrative data (i.e., claims and encounter data) and supplement the results with medical record data. The table shows the HEDIS 2015 final rate and the percentage determined solely through administrative data for both populations, respectively. For example, a rate of 100 percent in the last two columns indicates that administrative data were complete for that HEDIS measure (i.e., no additional numerator compliance was determined via medical record review).

Table 5-7—Estimated Data Completeness for HPN Hybrid Measures

HEDIS Hybrid Measures	2015 HEDIS Rate		Percent From Administrative Data	
	Medicaid	Nevada Check Up	Medicaid	Nevada Check Up
Childhood Immunization Status—Combo 2	70.56	83.46	75.52	73.58
Childhood Immunization Status—Combo 3	65.94	77.17	43.91	29.59
Lead Screening in Children	40.88	42.75	94.64	98.21
Well-Child Visits—First 15 Months (Six or More Visits)	51.58	60.00	91.51	80.00
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	58.15	71.95	95.40	95.34
Adolescent Well-Care Visits	42.34	55.47	95.40	94.74
Medicaid-Only HEDIS Measures				
Timeliness of Prenatal Care	74.94		55.52	
Postpartum Care	51.58		41.98	
Frequency of Ongoing Prenatal Care (81–100% Visits)	56.93		28.63	
Comprehensive Diabetes Care—HbA1c Testing	77.13		93.38	
Comprehensive Diabetes Care—Good HbA1c Control (<8%)	38.44		89.87	
Comprehensive Diabetes Care—Eye Exams	52.55		80.09	
Comprehensive Diabetes Care—Monitoring for Nephropathy	73.24		98.67	

Rates in **green** indicate that more than 90 percent of the final rate was derived from administrative data.
Rates in **red** indicate that 50 percent or less of the final rate was derived from administrative data.
The data completeness for *Childhood Immunization Status Combos 4–10* must be the same or lower as the Combo 3 data completeness rate.

Table 5-7 shows that for both Medicaid and Nevada Check Up populations, **HPN** had over 90 percent of the final rate derived from administrative data (highlighted in green) for the measures *Lead Screening in Children*; *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*;

and *Adolescent Well-Care Visits*. **HPN** also derived over 90 percent of the final Medicaid *Well-Child Visits in the First 15 Months of Life—Six or More Visits* rate from administrative data. These rates indicate that the administrative data are mostly complete. *Childhood Immunization Status—Combo 3* is the only measure for which less than half of the final rate was derived from administrative data for both populations, indicating that **HPN** relied heavily on medical record data for the childhood immunization measure.

For Medicaid-only measures, two rates from the *Comprehensive Diabetes Care* measure (*HbA1c Testing* and *Monitoring for Nephropathy*) had over 90 percent of the final rate deriving from administrative data. Two of the three maternity-related measures had less than 50 percent of the final rate derived from administrative data.

As in prior years, these findings suggest **HPN** continued to have difficulty in obtaining complete encounter data for childhood immunizations for both the Medicaid and Nevada Check Up populations, as well as for maternity care (for Medicaid reporting only). The difficulty of administrative data collection for childhood immunization may be attributed to immunizations often being provided at locations other than a provider's office (e.g., health fairs and schools). In these cases, **HPN** may not receive a claim for the immunization. The maternity-related administrative data completeness issue appears to be associated with global billing. However, providers should still submit encounter data for maternity care. In keeping with past recommendations, **HPN** should focus on this area for the next audit year. Since medical record abstraction was performed for these measures, final rates were not impacted.

Plan Comparison

The HEDIS 2015 Nevada Medicaid and Nevada Check Up rates for the MCOs are shown in Table 5-8 and Table 5-10, respectively. These rates are calculated by adding the numerators and denominators for both MCOs. Rates at or above the 2014 HEDIS 50th percentile are highlighted in yellow, those at or above the 90th percentile are highlighted in green, and rates at or below the 10th percentile are highlighted in red.

Medicaid Results

Table 5-8 presents the MCO-specific rates and the Nevada Medicaid rates along with their performance levels color-coded based on comparison to the national Medicaid HEDIS 2014 percentiles. HEDIS 2015 rates shaded in yellow are at or above the 50th percentile, rates shaded in green are at or above the 90th percentile, and rates shaded in red are at or below the 10th percentile. For *Frequency of Ongoing Prenatal Care (<21 Percent of Visits)* and *Comprehensive Diabetes Care—Poor HbA1c Control*, lower rates indicated better performance; therefore, the benchmark values used for comparison were reversed so that the presentation of the performance levels were consistent with the other measures. Since *Mental Health Utilization* is designed to capture the frequency of mental health services provided by the MCOs, the percentile ranking for each rate is for informational purposes only. Higher or lower rates do not indicate better or worse performance.

Table 5-8—HEDIS 2015 Results for Medicaid

HEDIS Measure	HPN	AGP	NV Medicaid
Childhood Immunization Status—Combo 2	70.56	66.20	68.33
Childhood Immunization Status—Combo 3	65.94	60.88	63.35
Childhood Immunization Status—Combo 4	64.72	58.80	61.68
Childhood Immunization Status—Combo 5	55.47	50.23	52.79
Childhood Immunization Status—Combo 6	38.44	33.33	35.82
Childhood Immunization Status—Combo 7	54.50	48.38	51.36
Childhood Immunization Status—Combo 8	37.71	33.10	35.35
Childhood Immunization Status—Combo 9	33.82	28.24	30.96
Childhood Immunization Status—Combo 10	33.09	28.01	30.49
Lead Screening in Children	40.88	35.88	38.32
Children's and Adolescents' Access to PCPs (12–24 Months)	91.42	91.14	91.27
Children's and Adolescents' Access to PCPs (25 Months–6 Years)	79.21	81.29	80.21
Children's and Adolescents' Access to PCPs (7–11 Years)	83.88	85.47	84.50
Children's and Adolescents' Access to PCPs (12–19 Years)	81.05	81.76	81.32
Well-Child Visits First 15 Months (Six or More Visits)	51.58	50.58	51.07
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	58.15	65.05	61.68
Adolescent Well-Care Visits	42.34	40.51	41.40
Annual Dental Visit—Combined Rate	51.30	45.81	48.92
Timeliness of Prenatal Care	74.94	74.48	74.70

Table 5-8—HEDIS 2015 Results for Medicaid			
HEDIS Measure	HPN	AGP	NV Medicaid
Postpartum Care	51.58	50.12	50.83
Frequency of Ongoing Prenatal Care (<21% Visits)*	11.68	16.47	14.13
Frequency of Ongoing Prenatal Care (81–100% Visits)	56.93	54.76	55.82
Comprehensive Diabetes Care—HbA1c Testing	77.13	69.84	73.40
Comprehensive Diabetes Care—Poor HbA1c Control*	50.36	58.70	54.63
Comprehensive Diabetes Care—Good HbA1c Control (<8%)	38.44	34.34	36.34
Comprehensive Diabetes Care—Eye Exams	52.55	45.24	48.81
Comprehensive Diabetes Care—Blood Pressure <140/90	64.96	61.25	63.06
Comprehensive Diabetes Care—Monitoring for Nephropathy	73.24	67.52	70.31
Use of Appropriate Medications for People With Asthma (5–11 Years)	89.22	82.49	86.87
Use of Appropriate Medications for People With Asthma (12–18 Years)	89.54	71.95	84.52
Use of Appropriate Medications for People With Asthma (19–50 Years)	70.32	56.18	65.16
Use of Appropriate Medications for People With Asthma (51–64 Years)	NA	NA	NA
Use of Appropriate Medications for People With Asthma (Combined)	86.82	76.42	83.35
Follow-up After Hospitalization for Mental Illness—7 Days	63.85	57.19	59.81
Follow-up After Hospitalization for Mental Illness—30 Days	77.93	67.28	71.48

* Lower rates are better for this measure, so this measure uses the 2014 National Medicaid HEDIS 10th percentile for comparison.
HEDIS 2015 rates shaded in yellow are at or above the 50th percentile, rates shaded in green are at or above the 90th percentile, and rates shaded in red are at or below the 10th percentile.
NA is shown when the health plan followed HEDIS specifications but the denominator was too small (<30) to report a valid rate.

Although none of the Nevada Medicaid rates ranked above the 2014 HEDIS 90th percentile, three ranked above the 50th percentile. These rates included *Comprehensive Diabetes Care—Blood Pressure <140/90 mm Hg* and the two indicators under *Follow-up After Hospitalization for Mental Illness*. Five rates were below the 10th percentile, three of which were *Children's and Adolescents' Access to PCPs* indicators and two were *Comprehensive Diabetes Care* indicators.

Overall, **HPN** performed better than **Amerigroup** for HEDIS 2015. Thirty of **HPN**'s rates exceeded **Amerigroup**'s rates. Five of **HPN's** rates were above the 50th percentile, of which one was above the 90th percentile. Five rates were below the 10th percentile. **HPN** performed better than **Amerigroup** in all measures except *Children's and Adolescents' Access to PCPs*. More specifically, **HPN**'s performance was at least 5 percentage points better than **Amerigroup**'s in more than one indicator for *Childhood Immunization Status, Comprehensive Diabetes Care, Use of Appropriate Medications for People With Asthma,* and *Follow-Up After Hospitalization for Mental Illness*.

Amerigroup rates exceeded **HPN** rates for four measures: *Children's and Adolescents' Access to PCPs (25 Months–6 Years); Children's and Adolescents' Access to PCPs (7–11 Years); Children's and Adolescents' Access to PCPs (12–19 Years);* and *Well-Child Visits in the Third, Fourth, Fifth,*

and Sixth Years of Life. **Amerigroup** had only two rates above the 50th percentile (both under *Follow-Up After Hospitalization for Mental Illness*) and none above the 90th percentile. **Amerigroup** had nine rates ranked below the 10th percentile. **Amerigroup** performed better than **HPN** in three of the four indicators for *Children's and Adolescents' Access to PCPs.*

Data Completeness

Table 5-9 provides an estimate of data completeness for the hybrid performance measures. These measures use administrative data (i.e., claims and encounter data) and supplement the results with medical record data. Measures using only administrative data are not included. The table shows the HEDIS 2015 final rate and the percentage that was determined solely through administrative data for both populations, respectively. For example, a rate of 100 percent in the last two columns indicates that administrative data were complete for that HEDIS measure. Rates in red had a 50 percent or less data completion factor.

Table 5-9—Estimated Data Completeness for Medicaid Hybrid Measures

Performance Measures	Final HEDIS Rate		Percent From Administrative Data	
	HPN	AGP	HPN	AGP
Childhood Immunization Status—Combo 2	70.56	66.20	75.52	53.50
Childhood Immunization Status—Combo 3	65.94	60.88	43.91	47.91
Lead Screening in Children	40.88	35.88	94.64	98.06
Well-Child Visits First 15 Months (Six or More Visits)	51.58	50.58	91.51	89.45
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	58.15	65.05	95.40	97.53
Adolescent Well-Care Visits	42.34	40.51	95.40	90.29
Timeliness of Prenatal Care	74.94	74.48	55.52	62.62
Postpartum Care	51.58	50.12	41.98	54.17
Frequency of Ongoing Prenatal Care (81–100% Visits)	56.93	54.76	28.63	23.73
Comprehensive Diabetes Care—HbA1c Testing	77.13	69.84	93.38	98.34
Comprehensive Diabetes Care—Good HbA1c Control	38.44	34.34	89.87	88.51
Comprehensive Diabetes Care—Eye Exams	52.55	45.24	80.09	87.69
Comprehensive Diabetes Care—Monitoring for Nephropathy	73.24	67.52	98.67	93.81

Rates in green indicate that more than 90 percent of the final rate was derived from administrative data.
Rates in red indicate that 50 percent or less of the final rate was derived from administrative data.
The data completeness for *Childhood Immunization Status Combos 4–10* must be the same or lower as the Combo 3 data completeness rate.

Although **Amerigroup** had one more measures (seven instead of six from **HPN**) with higher administrative data completeness than **HPN**, **HPN** had one more measure that derived at least 90 percent of its final rates from administrative data than **Amerigroup** (six measures versus five measures).

Both MCOs demonstrate high administrative data completeness in all measures except *Childhood Immunization Status* and *Prenatal and Postpartum Care* measures. As noted in previous years, the MCOs should continue to research methods to capture administrative data for these measures.

Nevada Check Up Results

Table 5-10 presents the MCO-specific rates and the Nevada Check Up rates along with the national Medicaid HEDIS 2013 percentiles. Since HEDIS percentiles are not available for the CHIP population, the Nevada Check Up rates are compared to the HEDIS Medicaid percentiles; therefore, caution should be exercised when comparing the rates. Additionally, since *Mental Health Utilization* is designed to capture the frequency of mental health services provided by the MCOs, the percentile ranking for each rate is for informational purposes only. Higher or lower rates do not indicate better or worse performance.

Table 5-10—HEDIS 2014 Results for Nevada Check Up

HEDIS Measure	HPN	AGP	NV Check UP
Childhood Immunization Status—Combo 2	83.46	74.55	79.32
Childhood Immunization Status—Combo 3	77.17	73.64	75.53
Childhood Immunization Status—Combo 4	76.38	73.64	75.11
Childhood Immunization Status—Combo 5	66.14	54.55	60.76
Childhood Immunization Status—Combo 6	48.03	45.45	46.84
Childhood Immunization Status—Combo 7	65.35	54.55	60.34
Childhood Immunization Status—Combo 8	47.24	45.45	46.41
Childhood Immunization Status—Combo 9	42.52	32.73	37.97
Childhood Immunization Status—Combo 10	41.73	32.73	37.55
Lead Screening in Children	42.75	50.91	46.47
Annual Dental Visit— Combined Rate	69.50	64.48	67.62
Children's and Adolescents' Access to PCPs (12–24 Months)	94.70	95.83	95.20
Children's and Adolescents' Access to PCPs (25 Months–6 Years)	87.20	90.48	88.71
Children's and Adolescents' Access to PCPs (7–11 Years)	93.83	92.62	93.47
Children's and Adolescents' Access to PCPs (12–19 Years)	90.79	92.18	91.18
Well-Child Visits First 15 Months (Six or More Visits)	60.00	70.37	64.34
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	71.95	71.30	71.58
Adolescent Well-Care Visits	55.47	56.48	55.99
Use of Appropriate Medications for People With Asthma (5–11 Years)	95.69	NA	95.77
Use of Appropriate Medications for People With Asthma (12–18 Years)	88.31	NA	87.63
Follow-up After Hospitalization for Mental Illness—7 Days	NA	NA	73.33
Follow-up After Hospitalization for Mental Illness—30 Days	NA	NA	84.44

HEDIS 2014 rates shaded in yellow are at or above the 50th percentile, rates shaded in green are at or above the 90th percentile.
*Because national HEDIS 2013 Medicaid percentiles are not available for the Children's Health Insurance Program (CHIP) population, comparison of Nevada's Check Up to HEDIS 2013 Medicaid percentiles should be interpreted with caution.
NA is shown when the health plan followed HEDIS specifications but the denominator was too small (<30) to report a valid rate.

In general, Nevada Check Up continues to report better rates than Medicaid. Four of the Nevada Check Up rates were above the HEDIS 2014 90th percentile and another 14 rates were above the 50th percentile. None of the rates fell below the 10th percentile.

HPN's Nevada Check Up performance was better than **Amerigroup**'s in almost all measures except *Children's and Adolescents' Access to PCPs*. Three of its Nevada Check Up rates were above the 90th percentile and 13 rates were above the 50th percentile. **Amerigroup** did not have any rates above the 90th percentile but had 10 rates above the 50th percentile. **HPN** had 13 rates that exceeded **Amerigroup**'s rates. Four of these (*Childhood Immunization Status—Combinations 2, 5,* and *7* and *Annual Dental Visits—Combined Rate*) were at least 5 percentage points higher than **Amerigroup**'s.

Data Completeness

Table 5-11 provides an estimate of data completeness for the hybrid performance measures. These measures use administrative data (i.e., claims and encounter data) and supplement the results with medical record data. Measures using only administrative data are not included. The table shows the HEDIS 2015 final rate and the percentage determined solely through administrative data for both populations, respectively. For example, a rate of 100 percent in the last two columns indicates that administrative data were complete for that HEDIS measure. Rates in red had a 50 percent or less data completion factor.

Table 5-11—Estimated Data Completeness for Nevada Check Up Hybrid Measures

Performance Measures	Final HEDIS Rate		Percent From Administrative Data	
	HPN	AGP	HPN	AGP
Childhood Immunization Status—Combo 2	83.46	74.55	73.58	26.83
Childhood Immunization Status—Combo 3	77.17	73.64	29.59	20.99
Lead Screening in Children	42.75	50.91	98.21	100.00
Well-Child Visits First 15 months (Six or More Visits)	60.00	70.37	80.00	86.84
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	71.95	71.30	95.34	99.03
Adolescent Well-Care Visits	55.47	56.48	94.74	97.13

Rates in **green** indicate that more than 90 percent of the final rate was derived from administrative data.
Rates in **red** indicate that 50 percent or less of the final rate was derived from administrative data.
The data completeness for *Childhood Immunization Status Combos 4–10* must be the same or lower as the Combo 3 data completeness rate.

Table 5-11 shows that both MCOs demonstrated exceptionally complete encounter data for *Lead Screening in Children*, *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*, and *Adolescent Well-Care Visits*. However, both plans continued to experience difficulty in obtaining complete encounter data for the *Childhood Immunization Status* measure.

Conclusions

The HEDIS audit demonstrated that both MCOs had adequate policies and procedures in place to collect, prepare, process, and report HEDIS data and were in full compliance with each of the seven NCQA-specified IS standards. Both MCOs continued to use FACETS to process their claims. Data entry processes were efficient, with the assurance of timely and accurate entry into the system. Only

standard codes were accepted and the standard HIPAA 837 file format was used. Both MCOs applied several validation checks to ensure accurate information processing.

Nevada Check Up rates continued to outperform the Nevada Medicaid rates for every measure. Three of the 35 Medicaid performance measure rates were above the 50th percentile, with no rate reaching the 90th percentile and five rates falling below the 10th percentile. Conversely, 14 of the 22 Nevada Check Up rates ranked above the 50th percentile and an additional four exceeded the 90th percentile. None of the Nevada Check Up measures had rates below the 10th percentile.

Both MCOs continued to demonstrate mixed performance among the Medicaid and Nevada Check Up populations. For the Medicaid population, **HPN** reported three more measures ranking above the national 50th percentile than **Amerigroup**; 30 **HPN** rates exceeded **Amerigroup** rates, and four **Amerigroup** rates exceeded **HPN** rates. For the Nevada Check Up population, **HPN**'s performance was better than **Amerigroup**'s on 14 indicators, two of which **Amerigroup**'s eligible population was too small to report a valid rate.

In terms of administrative data completeness, both MCOs had fairly complete encounter data for most of the Medicaid and Nevada Check Up measures. Nonetheless, each MCO continued to have its own unique challenges in obtaining complete administrative data for childhood immunizations and maternity-related care. Since the MCOs supplemented their administrative data for these measures with medical record review, no bias was observed in any of these rates.

Recommendations

The following recommendations are based on the audit findings and final reported rates:

Both MCOs' performance trend for the *Children's and Adolescents' Access to PCPs* measures were either stagnant or showed a decline. For both the Medicaid and Nevada Check Up populations, performance for the youngest age group (12–24 months) was below the national 25th percentile. The access to care issue for this age group becomes more acute for the Medicaid population when taking both MCOs' *Childhood Immunization Status* rates into account. Both MCOs should conduct an analysis to determine if these results are due to member noncompliance, issues with network adequacy, or other potential barriers preventing members from accessing timely care.

In past technical reports, both MCOs had relatively low rates for the *Comprehensive Diabetes Care* measure indicators. For this year, **HPN** showed improvement in these indicators, while **Amerigroup** actually had a decline in performance. Members with these chronic conditions tend to be associated with higher levels of care and associated costs. It appears **HPN** may be addressing these concerns. However, HSAG recommends **Amerigroup** targets its diabetic population to ensure members receive appropriate services that may help reduce the MCO's cost and improve the health of the member.

Since 2011, HSAG has made recommendations to the MCOs to improve the rates for *Follow-up After Hospitalization for Mental Illness*, and the MCOs responded with improved rates, where **Amerigroup** showed an improvement in rates in 2014 for both indicators and **HPN** showed an improvement in 2013 for both indicators. The HEDIS 2015 rates for both MCOs, however, had

declined from the previous year. For both indicators, **HPN**'s rates were at least 5 percentage points higher than **Amerigroup**'s. Since performance improvement was demonstrated by both MCOs in previous years, HSAG recommends that the MCOs revisit this measure. More specifically, the MCOs should continue to identify additional areas that impede follow-up and apply interventions that can overcome barriers and improve performance for the measure.

In addition to recommendations made to both MCOs, HSAG has the following recommendations specific to each MCO:

- For **HPN,** *Lead Screening in Children* has shown some improvement in the Medicaid rate. Nonetheless, the Nevada Check Up rate for the same measure showed a notable decline (8.05 percentage points from HEDIS 2012 and 12.49 percentage points from HEDIS 2014). HSAG recommends that **HPN** conduct a root cause analysis and develop targeted intervention to improve this measure. Providers should be reminded that lead screening should be completed as part of a well-child visit or when immunizations are given.
- For **Amerigroup**, the maternity-related measures and the asthma measure have declined notably from last year. The HEDIS 2015 rates for the maternity-related measures dropped at least 10 percentage points for the two *Prenatal and Postpartum Care* rates and the *Frequency of Ongoing Prenatal Care 81-100% Visits* rate. When compared to the national benchmark, **Amerigroup**'s performance was below the 50th percentile for these measures. Data completeness analysis showed that at least 40 percent of these rates were derived from medical record data. **Amerigroup** should explore the potential barriers for timely prenatal care and postpartum care. For the *Use of Appropriate Medications for People With Asthma* measure, **Amerigroup**'s HEDIS 2015 rates continued to showed decline from the prior year and since 2012. With these declines, the rates ranked below the national 10th percentile for all age groups with valid rates. HSAG has made the recommendation to **Amerigroup** in prior years to conduct a root cause analysis to determine the reason for the low rates for this measure.

6. Validation of Performance Improvement Projects—SFY 2014–2015

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

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

Objectives

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

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

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

Further, HSAG's PIP validation process includes heightened scrutiny on:

- Barrier analyses performed by the MCO.
- Interventions planned by the MCOs as a result of barrier analyses.
- Mechanisms put in place by the MCO to track interventions and evaluate the effectiveness of the interventions to improve rates.

HSAG critically evaluated each of these areas. The findings from the outcome-focused evaluation are reflected in the validation scoring for the Study Implementation and Study Outcomes stages of each PIP. Once a PIP has achieved statistically significant improvement over baseline, it is necessary for the PIP to sustain that improvement in the following year to receive a *Met* validation status. Refer to Appendix A for the technical methods of data collection and analysis for PIPs.

Plan-Specific Findings—Amerigroup

HSAG reviewed two PIPs for the period of July 1, 2014, through June 30, 2015: *Diabetes Management* and *Reducing Avoidable Emergency Room Visits*. HSAG PIP reviewers validated each PIP twice—once when the PIP was originally submitted and then again when the PIP was resubmitted. The *Diabetes Management* PIP addressed adult preventive health and screening. For diabetics, timely screening and treatment can reduce complications related to diabetes. The second clinical PIP topic, *Reducing Avoidable Emergency Room Visits*, aims to decrease avoidable emergency room (ER) visits and promote the use of a medical home, or a primary care practitioner (PCP), to foster continuity of care and the appropriate use of health care resources.

Of the two originally submitted **Amerigroup** PIPs, one received a *Met* overall validation status and one received a *Not Met* overall validation status. HSAG provided technical assistance to **Amerigroup**'s staff to address all noted deficiencies in the initial validation of the *Diabetes Management* PIP. After receiving technical assistance, **Amerigroup** had the opportunity to incorporate HSAG's recommendations into the PIP and resubmit for a final validation. The percentage score of evaluation elements *Met* and critical elements *Met* improved; however, due to the lack of statistically significant improvement for both indicators, the overall validation status remained *Not Met*. The *Reducing Avoidable Emergency Room Visits* PIP achieved a *Met* validation status upon initial validation and did not require a resubmission.

Table 6-1—Performance Improvement Project Validation Activity for Amerigroup Nevada, Inc. July 1, 2014, through June 30, 2015

Name of Project/Study	Type of Annual Review[1]	Percentage Score of Evaluation Elements *Met* [2]	Percentage Score of Critical Elements *Met* [3]	Overall Validation Status [4]
Diabetes Management	Submission	72%	70%	*Not Met*
	Resubmission	94%	93%	*Not Met*
Reducing Avoidable Emergency Room Visits	Submission	100%	100%	*Met*
	Resubmission	N/A	NA	N/A

[1] **Type of Annual Review**—Designates the PIP reviewed as an annual submission or resubmission. A resubmission means the MCO had the opportunity to resubmit the PIP with updated documentation because it did not meet 100 percent of the validation elements.
[2] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total applicable elements of all categories (*Met*, *Partially Met*, and *Not Met*).
[3] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the applicable critical elements *Met*, *Partially Met*, and *Not Met*.
[4] **Overall Validation Status**—The overall validity and reliability of the PIP, which is based on the PIP Validation Tool results.
NA—Not Applicable. A resubmission was not required for this PIP.

Table 6-2 shows the validation results for **Amerigroup**'s *Diabetes Management* PIP, evaluated during SFY 2014–2015. This table illustrates the MCO's overall application of the PIP process and achieved success in implementing the studies. Each activity is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 6-2 show the percentage of applicable evaluation elements that received each score by activity. Additionally, HSAG calculated a score for each stage and an overall score across all activities.

Table 6-2—Performance Improvement Project Validation Results for Amerigroup Nevada, Inc.'s *Diabetes Management* PIP (N=1 PIP)				
Stage	**Activity**	**Percentage of Applicable Elements**		
		Met	***Partially Met***	***Not Met***
Design	Appropriate Study Topic	100% (6/6)	0% (0/6)	0% (0/6)
	Clearly Defined, Answerable Study Question(s)	100% (2/2)	0% (0/2)	0% (0/2)
	Clearly Defined Study Indicator(s)	100% (6/6)	0% (0/6)	0% (0/6)
	Correctly Identified Study Population	100% (3/3)	0% (0/3)	0% (0/3)
	Valid Sampling Techniques (if sampling was used)	100% (6/6)	0% (0/6)	0% (0/6)
	Accurate/Complete Data Collection	100% (11/11)	0% (0/11)	0% (0/11)
Design Total		**100% (34/34)**	**0% (0/34)**	**0% (0/34)**
Implementation	Accurate Data Analysis and Interpretation of Results	100% (9/9)	0% (0/9)	0% (0/9)
	Appropriate Improvement Strategies	100% (3/3)	0% (0/3)	0% (0/3)
Implementation Total		**100% (12/12)**	**0% (0/12)**	**0% (0/12)**
Outcomes	Real Improvement Achieved	25% (1/4)	25% (1/4)	50% (2/4)
	Sustained Improvement Achieved‡	*Not Assessed*		
Outcomes Total		**25% (1/4)**	**25% (1/4)**	**50% (2/4)**
Percentage Score of Applicable Evaluation Elements *Met*		**94% (47/50)**		

‡ The PIP was not assessed for sustained improvement. Sustained improvement can be assessed once all study indicator(s) have demonstrated statistically significant improvement over the baseline and have reported a subsequent measurement period.

Overall, 94 percent of the evaluation elements across the **Amerigroup** *Diabetes Management* PIP received a score of *Met*. While **Amerigroup**'s strong performance in the Design and Implementation stages indicated that the PIP was designed appropriately to measure outcomes and improvement, the MCO was less successful in achieving the desired outcomes. The following subsections highlight HSAG's validation findings associated with each PIP stage.

Table 6-3, on the following page, shows the combined validation results for the **Amerigroup** PIPs evaluated during SFY 2014–2015. This table illustrates the MCO's overall application of the PIP process and achieved success in implementing the studies. Each activity is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 6-3 show the percentage of applicable evaluation elements that received each

score by activity. Additionally, HSAG calculated a score for each stage and an overall score across all activities. Percentage totals may not equal 100 due to rounding.

Table 6-3—Performance Improvement Project Validation Results for Amerigroup Nevada, Inc.'s *Diabetes Management* and *Reducing Avoidable Emergency Room Visits* PIPs (N=2 PIPs)

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	Appropriate Study Topic	100% (8/8)	0% (0/8)	0% (0/8)
	Clearly Defined, Answerable Study Question(s)	100% (3/3)	0% (0/3)	0% (0/3)
	Clearly Defined Study Indicator(s)	100% (8/8)	0% (0/8)	0% (0/8)
	Correctly Identified Study Population	100% (4/4)	0% (0/4)	0% (0/4)
	Valid Sampling Techniques (if sampling was used)	100% (6/6)	0% (0/6)	0% (0/6)
	Accurate/Complete Data Collection	100% (15/15)	0% (0/15)	0% (0/15)
Design Total		**100% (44/44)**	**0% (0/44)**	**0% (0/44)**
Implementation	Accurate Data Analysis and Interpretation of Results	100% (17/17)	0% (0/17)	0% (0/17)
	Appropriate Improvement strategies	100% (6/6)	0% (0/6)	0% (0/6)
Implementation Total		**100% (23/23)**	**0% (0/23)**	**0% (0/23)**
Outcomes	Real Improvement Achieved	63% (5/8)	13% (1/8)	25% (2/8)
	Sustained Improvement Achieved‡	100% (1/1)	0% (0/1)	0% (0/1)
Outcomes Total		**67% (6/9)**	**11% (1/9)**	**22% (2/9)**
Percentage Score of Applicable Evaluation Elements *Met*		**96% (73/76)**		

Overall, 96 percent of the evaluation elements across the two **Amerigroup** PIPs received scores of *Met*. **Amerigroup**'s strong performance in the Design and Implementation stages indicated that each PIP was designed in a methodologically sound manner and that appropriate interventions were implemented; however, the MCO was less successful in achieving real improvement across all study indicators for both PIPs. The *Reducing Avoidable Emergency Room Visits* was the only PIP that could be assessed for sustained improvement for one of its study indicators. Study Indicator 2 achieved statistically significant improvement over baseline at Remeasurement 1 and has sustained the improvement over comparable time periods. An additional data point is required to determine if Study Indicator 1 can sustain the statistically significant improvement achieved at Remeasurement 3.

PIP-Specific Results

The purpose of a PIP is to achieve significant improvement sustained over time in clinical and nonclinical areas through ongoing measurements and interventions. Therefore, in addition to the validation results, the study indicator results are compared to the baseline to determine if real and sustained improvement were attained.

Table 6-4—Performance Improvement Project Outcomes for Amerigroup Nevada, Inc.

PIP #1—Diabetes Management							
PIP Study Indicators	**Baseline CY 2009**	**R1 CY 2010**	**R2 CY 2011**	**R3 CY 2012**	**R4 CY 2013**	**R5 CY 2014**	**Sustained Improvement**
1. The percentage of Medicaid-eligible members 18–75 years of age with a diagnosis of diabetes who had an HbA1C test performed during the measurement year.	70.1%	73.6%	71.6%	68.8%	73.9%	69.8%	NA
2. The percentage of Medicaid-eligible members 18–75 years of age with a diagnosis of diabetes who had an LDL-C screening performed during the measurement year.	64.2%	67.5%	64.4%	65.2%	68.1%		NA
3. The percentage of Medicaid-eligible members 18–75 years of age with a diagnosis of diabetes who had a nephropathy screening test performed during the measurement year.	60.6%	66.5%	69.1%	64.0%	67.3%	67.5%	NA

PIP #2—Reducing Avoidable Emergency Room Visits					
PIP Study Indicators	**Baseline CY 2011**	**R1 CY 2012**	**R2 CY 2013**	**R3 CY 2014**	**Sustained Improvement**
1. The percentage of avoidable ER visits for the Nevada Check Up (CHIP) population. ¤	39.7%	39.1%	37.5%	34.8%↓*	NA
2. The percentage of avoidable ER visits for the Medicaid population. ¤	42.6%	41.4%↓*	39.1%	33.7%	Yes

¤ The study indicators are inverse indicators; therefore, a decline in the rate represents an improvement in the outcomes.
↓* Designates statistically significant improvement over the baseline (p value < 0.05).
NA Sustained improvement cannot be determined until statistically significant improvement has been achieved across **all** study indicators followed by a subsequent measurement period.
CY Calendar year
R Remeasurement

For the *Diabetes Management* PIP, **Amerigroup** progressed to reporting Remeasurement 5 data. When compared to baseline, only Study Indicator 3, nephropathy screening, demonstrated nonstatistically significant improvement; and the HbA1c testing rate (Study Indicator 1) fell below the baseline. Study Indicator 2 was retired due to NCQA changes to the *Comprehensive Diabetes Care* performance measure.

The *Reducing Avoidable Emergency Room Visits* PIP progressed to reporting Remeasurement 3 data. The study indicators for the *Reducing Avoidable Emergency Room Visits* PIP are inverse indicators; therefore, a decline in the rate represents an improvement in outcomes. Study Indicator 1

has demonstrated consistent improvement over the baseline rate, and at Remeasurement 3 this improvement was statistically significant. An additional measurement period is required to assess for sustained improvement for Study Indicator 1. Study Indicator 2 achieved statistically significant improvement over baseline at Remeasurement 1 and has sustained the improvement over comparable measurement periods.

Barriers/Interventions

The identification of barriers through barrier analysis and the subsequent selection of appropriate interventions to address these barriers are necessary steps to improve outcomes. The MCO's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the overall success in improving PIP rates.

For the *Diabetes Management* PIP, **Amerigroup** continued with its "whole health plan" approach to improving HEDIS outcomes. Senior management led each cross-functional team in biweekly meetings to brainstorm and identify barriers, develop interventions, and discuss action plans. The MCO identified and prioritized recipient-focused, provider-focused, and system-focused barriers. These barriers were the MCO's inadequate data sources; recipients' lack of knowledge related to disease self-management; providers' inadequate follow-up and nonadherence to clinical practice guidelines; and lack of knowledge regarding performance scores. To address these barriers, **Amerigroup** hired a full-time data analyst to support the analysis and reporting of data, continued with its face-to-face provider education on the need for compliance with diabetes quality measures and clinical practice guidelines, continued with the missed opportunities provider reports, and provided educational materials to providers. **Amerigroup** also continues to work with DHCFP on the provider and recipient education, staff education, monitoring process, and incentive distribution. The health plan's quality team continues recipient outreach calls to recipients on the diabetes missed opportunity list. The intent of these calls is to remind diabetic members to obtain the necessary diabetes testing and to assist members with scheduling and transportation to appointments. The health fairs were discontinued in the second quarter of 2014 because of poor attendance. **Amerigroup**'s home health visit pilot intervention slated to start in 2013 was delayed until 2014 and only assisted two recipients. The health plan was unable to provide licensed personnel and discontinued this intervention. The following are **Amerigroup**'s additional interventions for this PIP:

- Added two full-time recipient liaisons to support provider and recipient outreach and education.
- Implemented a process to capture correct phone numbers or addresses that were not available from the State to enhance future communications by the health plan or provider.
- Corrected the internal computer process for LabCorp. This allowed for more complete lab data collection.
- Implemented CareCompass Member 360 (care coordination tool). The Member 360 is an enhancement for CareCompass. It allows care managers to track more detailed information for each recipient, including HEDIS care alerts, authorizations, prescriptions, lab results, claims, office visits, and emergency room visits. All information is organized into a timeline, highlighting interventions and creating an easily analyzed list of goals for the care manager and care coordinator.

- Recipient "meet and greet" hosted. Qualified health plan personnel host meet and greets in high recipient populated ZIP codes. Education on the importance of annual exams (including those for diabetics) is provided. All materials provided at these events are State-approved. Fifty-eight new recipients have been assisted with provider appointments at seven different meet and greet venues.

Regardless of the interventions put in place to improve diabetic testing and screening rates, they did not achieve the desired result as evidenced by statistically flat performance.

For the *Reducing Avoidable Emergency Room Visits* PIP, **Amerigroup**'s multidisciplinary quality committee conducted a causal/barrier analysis using a fishbone diagram and determined that there were no major changes to the previously identified barriers. The health plan prioritized barriers and found that interventions targeting education to recipients and providers were most likely to have the desired effect on outcomes. **Amerigroup**'s interventions for this PIP were as follows:

- Use of quarterly administrative reports to identify recipients using the emergency room for services that could be provided at a PCP's office and/or a medical home.
- Annual recipient newsletter article regarding **Amerigroup**'s 24-hour nurse help line.
- Automated screening phone calls to recipients identified as at-risk for future use of emergency room (more than three visits and/or increased risk per predictive model).
- Real-time emergency room reports, which allowed **Amerigroup** and providers to see which recipients frequented the emergency room and from what facility.
- Provider orientation that included emphasis on directing recipients to use urgent care and **Amerigroup**'s 24-hour nurse help line.
- Monthly provider reports that showed the recipients visiting the emergency room, the number of visits, and diagnoses.
- Quality management outreach, in which a registered nurse called the top 10 PCPs of recipients with avoidable emergency room visits.
- Recipient outreach, in which a recipient advocate contacted recipients who had an avoidable emergency room visit, provided assistance with scheduling PCP visits, and addressed other concerns and barriers identified during the call.
- Right Care, Right Place brochure was modified by the MCO. The revised brochure contained a listing of urgent care centers. The brochure, included in new recipient welcome packets, was also sent to recipients who had had three or more avoidable emergency room visits.
- Provider relations follow-up (performing one-to-one education and fax blasting contractual standards for access and availability) with providers who did not meet the after-hours care standards.
- Daily emergency room utilization reports continued, along with sending the recipients' telephone numbers to University Medical Center in Clark County. Using the information sent by the health plan, a recipient advocate contacted the recipient to determine why he or she went to the emergency room, assisted with arranging an appointment with a PCP, and provided help with any other identified needs. The advocate outreach call was also conducted for recipients 10 years of age and younger.
- Medical practice consultant hired.

- Dedicated quality management analyst hired to develop real-time reporting and analyze intervention effectiveness.

Given the improvement that has been achieved for Medicaid, it is likely that the improvement is due to the interventions **Amerigroup** implemented to reduce avoidable emergency room visits. It is likely that the interventions had the desired effect for the Nevada Check Up population; however, subsequent measurements would need to demonstrate sustained improvement to confirm this.

Plan-Specific Findings—HPN

HSAG reviewed two PIPs for the period of July 1, 2014, through June 30, 2015. HSAG PIP reviewers validated each PIP twice—once when the PIP was originally submitted and then again when the PIP was resubmitted. Of the two originally submitted PIPs, one received a *Partially Met* overall validation status and one received a *Met* overall status. HSAG provided technical assistance to **HPN**'s staff to address all noted deficiencies in the initial validation of the Children and Adolescents' Access to Primary Care Practitioners PIP. After technical assistance was provided, **HPN** had the opportunity to incorporate HSAG's recommendations and resubmit the PIP for a final validation. The percentage score of evaluation elements *Met* improved; however, due to the lack of statistically significant improvement across all four study indicators, the overall validation status remained *Partially Met*. The *Reducing Avoidable Emergency Room Visits* PIP achieved a *Met* validation status upon initial validation and did not require a resubmission.

Table 6-5—Performance Improvement Project Validation Activity for Health Plan of Nevada, Inc. July 1, 2014, through June 30, 2015

Name of Project/Study	Type of Annual Review [1]	Percentage Score of Evaluation Elements *Met* [2]	Percentage Score of Critical Elements *Met* [3]	Overall Validation Status [4]
Children and Adolescents' Access to Primary Care Practitioners	Submission	85%	82%	*Partially Met*
	Resubmission	90%	82%	*Partially Met*
Reducing Avoidable Emergency Room Visits	Submission	100%	100%	*Met*
	Resubmission	NA	NA	*NA*

[1] **Type of Annual Review**—Designates the PIP reviewed as an annual submission, or resubmission. A resubmission means the MCO had the opportunity to resubmit the PIP with updated documentation because it did not meet 100 percent of the validation elements.
[2] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total applicable elements of all categories (*Met*, *Partially Met*, and *Not Met*).
[3] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the applicable critical elements *Met*, *Partially Met*, and *Not Met*.
[4] **Overall Validation Status**—The overall validity and reliability of the PIP, which is based on the PIP Validation Tool results.
NA—Not Applicable. No resubmission was required for this PIP.

Table 6-6 shows the validation results for **HPN**'s *Children and Adolescents' Access to Primary Care Practitioners* and *Reducing Avoidable Emergency Room Visits* PIPs, evaluated during SFY 2014–2015. This table illustrates the MCO's overall application of the PIP process and achieved success with implementing the projects. Each activity is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements that received a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 6-6 show the percentage of applicable evaluation elements that received each score by

activity. Additionally, HSAG calculated a score for each stage and an overall score across all activities.

Table 6-6—Performance Improvement Project Validation Results for Health Plan of Nevada, Inc.'s *Children and Adolescents' Access to Primary Care Practitioners* and *Reducing Avoidable Emergency Room Visits* PIPs (N=2 PIPs)

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	Appropriate Study Topic	100% (4/4)	0% (0/4)	0% (0/4)
	Clearly Defined, Answerable Study Question(s)	100% (2/2)	0% (0/2)	0% (0/2)
	Clearly Defined Study Indicator(s)	100% (3/3)	0% (0/3)	0% (0/3)
	Correctly Identified Study Population	100% (2/2)	0% (0/2)	0% (0/2)
	Valid Sampling Techniques (if sampling was used)	*Not Applicable*		
	Accurate/Complete Data Collection	100% (7/7)	0% (0/7)	0% (0/7)
Design Total		**100% (18/18)**	**0% (0/18)**	**0% (0/18)**
Implementation	Accurate Data Analysis and Interpretation of Results	100% (11/11)	0% (0/11)	0% (0/11)
	Appropriate Improvement Strategies	100% (9/9)	0% (0/9)	0% (0/9)
Implementation Total		**100% (20/20)**	**0% (0/20)**	**0% (0/20)**
Outcomes	Real Improvement Achieved	71% (5/7)	29% (2/7)	0% (0/7)
	Sustained Improvement Achieved	100% (1/1)	0% (0/1)	0% (0/1)
Outcomes Total		**75% (6/8)**	**25% (2/8)**	**0% (0/8)**
Percentage Score of Applicable Evaluation Elements *Met*		**96% (44/46)**		

Overall, 96 percent of the applicable evaluation elements across the *Children and Adolescents' Access to Primary Care Practitioners* and *Reducing Avoidable Emergency Room Visits* PIPs received a score of *Met*. **HPN**'s strong performance in the Design and Implementation stages indicated that each PIP was designed in a methodologically sound manner and that appropriate interventions were implemented; however, the MCO was less successful in real improvement across all study indicators for both PIPs. The *Reducing Avoidable Emergency Room Visits* was the only PIP that achieved statistically significant improvement over baseline across all study indicators and sustained the improvement over comparable time periods.

Table 6-7 shows the validation results for **HPN**'s *Children and Adolescents' Access to Primary Care Practitioners* PIP. This table illustrates the MCO's overall application of the PIP process and success in implementing the studies. Each activity is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 6-7 show the percentage of applicable evaluation elements that received each score by activity. Additionally, HSAG calculated a score for each study stage and an overall score across all activities.

Table 6-7—Performance Improvement Project Validation Results for Health Plan of Nevada, Inc.'s *Children and Adolescents' Access to Primary Care Practitioners* PIP (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	Clearly Defined Study Indicator(s)	100% (1/1)	0% (0/1)	0% (0/1)
	Valid Sampling Techniques (if sampling was used)	*Not Applicable*		
	Accurate/Complete Data Collection	100% (3/3)	0% (0/3)	0% (0/3)
Design Total		**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Implementation	Accurate Data Analysis and Interpretation of Results	100% (3/3)	0% (0/3)	0% (0/3)
	Appropriate Improvement Strategies	100% (6/6)	0% (0/6)	0% (0/6)
Implementation Total		**100% (9/9)**	**0% (0/9)**	**0% (0/9)**
Outcomes	Real Improvement Achieved	33% (1/3)	67% (2/3)	0% (0/3)
	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total		**33% (1/3)**	**67% (2/3)**	**0% (0/3)**
Percentage Score of Applicable Evaluation Elements *Met*		**90% (18/20)**		

Overall, 90 percent of the evaluation elements across **HPN**'s *Children and Adolescents' Access to Primary Care Practitioners* PIP received a score of *Met*. While **HPN**'s strong performance in the Design and Implementation stages indicated that the PIP was designed appropriately to measure outcomes and improvement, the MCO was less successful in achieving the desired outcomes. The following subsections highlight HSAG's validation findings associated with each PIP stage.

PIP-Specific Results

The purpose of a PIP is to achieve significant improvement sustained over time in clinical and nonclinical areas through ongoing measurements and interventions. Therefore, in addition to the validation results, the study indicator results for each MCO are compared to the results from the prior measurement period to determine whether improvement and/or sustained improvement were attained.

Table 6-8 shows outcome data for **HPN**'s two PIPs. The MCO submitted Remeasurement 1 data for the *Children and Adolescents' Access to Primary Care Practitioners* PIP and Remeasurement 3 data for the *Reducing Avoidable Emergency Room Visits* PIP. Statistically significant improvement is the standard for assessing real improvement and supports the conclusion that the noted improvement is not due to chance.

Table 6-8—Performance Improvement Project Outcomes for Health Plan of Nevada, Inc.

PIP #1—*Children and Adolescents' Access to Primary Care Practitioners*

PIP Study Indicators	Baseline CY 2013	Remeasurement 1 CY 2014
1. The percentage of children 25 months to six years of age who had one or more visits with a PCP during the measurement year.	78.6%	79.2%
2. The percentage of children seven to 11 years of age who had one or more visits with a PCP during the measurement year.	82.4%	83.9%↑*
3. The percentage of children 12 to 19 years of age who had one or more visits with a PCP during the measurement year.	78.3%	81.1%↑*
4. The percentage of children 12 to 24 months of age (Nevada Check Up) who had one or more visits with a PCP during the measurement year.	95.1%	94%

PIP #2—*Reducing Avoidable Emergency Room Visits*

PIP Study Indicators	Baseline CY 2011	Remeasurement 1 CY 2012	Remeasurement 2 CY 2013	Remeasurement 3 CY 2014	Sustained Improvement^
1. The percentage of avoidable ER visits for the Nevada Check Up population.	39.0%	35.7%↓*	41.7%	24.9%	Yes
2. The percentage of avoidable ER visits for the Medicaid population.	42.0%	37.8%↓*	42.9%	27.9%	Yes

¤ The study indicators are inverse indicators; therefore, a decline in the rate represents an improvement in the outcomes.
↓* Designates statistically significant improvement over the baseline (p value < 0.05).
↑* Designates statistically significant improvement over the baseline (p value < 0.05).
CY Calendar year

For the *Children and Adolescents' Access to Primary Care Practitioners* PIP, **HPN** reported Remeasurement 1 data for all study indicators. Three of the four indicators achieved improvement; however, only the improvements of Study Indicator 2 and Study Indicator 3 were statistically significant over the baseline. The decline in performance for Study Indicator 4 was not statistically significant. **HPN** exceeded its goal (83.4 percent) for Study Indicator 2 only.

For the *Reducing Avoidable Emergency Room Visits* PIP, the study indicators are inverse indicators; therefore, a decline in the rate represents improved outcomes. Despite the increases in Medicaid population and number of visits to the emergency room, **HPN** was able to achieve statistically significant and sustained improvement and exceed the goals set for both indicators (42 percent for Medicaid and 38.9 percent for Nevada Check Up).

Barriers/Interventions

The identification of barriers through barrier analysis and the subsequent selection of appropriate interventions to address these barriers are necessary steps to improve outcomes. The MCO's choice of interventions, the combination of intervention types, and the sequence of implementing interventions are essential to the PIP's overall success.

For the *Children and Adolescents' Access to Primary Care* PIP, **HPN** documented that its team performed brainstorming activities and completed an affinity diagram. This process allowed the team to generate ideas, categorize ideas and issues, complete an in-depth relevant barrier analysis, and prioritize the identified barriers. The barriers outlined in the PIP for targeted interventions were lack of provider engagement, population increase, and demographic lack of clinic access in areas with the highest Medicaid concentration. To address these barriers, the MCO continued the following interventions:

- HEDIS office visit template—Information about using the HEDIS office visit template, which aligns with HEDIS measures, was given to the providers. **HPN**'s documentation noted that addressing multiple measures during an office visit would decrease number of visits needed by a recipient, allowing improved access for other recipients.
- Provider education—A nurse presented in-office education to providers and/or office staff members about appropriate coding and proper medical record documentation for sports physicals and minor ambulatory or preventive care visits.
- Blinded study report—This report included comparing a provider group's HEDIS measure performance to its peers' performance.
- Gaps in care report—This report lists the provider's empaneled recipients' outstanding tests and exams based on medical history. The report is distributed and reviewed with provider and/or staffs during the initial HEDIS nurse visit.
- Call outreach—Medicaid recipients were contacted by the Call Outreach Team to assist with scheduling annual appointments. In 2015, the call outreach was also initiated by the health plan's sister organization, Southwest Medical Associates (SMA). SMA is the largest provider of care for the health plan's membership.
- Citibank card incentive—Recipients received a gift card when a well-child visit was completed.

To address access for Medicaid recipients, SMA opened two new clinics that included pediatric services in ZIP codes determined to have the highest Medicaid membership and low care access compliance. **HPN** implemented a new recipient-focused intervention in 2015. The health plan reached out to recipients via text messaging in hopes of reaching the recipients not answering phone calls to remind them of upcoming or needed appointments. The health plan and SMA also hosted a

variety of health fairs where attendees were educated on the importance of having a PCP and well-child visits as well as other child health-related issues.

For the *Reducing Avoidable Emergency Room Visits* PIP, **HPN**'s HEDIS validation team conducted a detailed barrier analysis on the avoidable emergency room rate using a variety of quality improvement tools. The following continue as existing barriers: urgent care facility closed, follow-up appointments with PCPs not completed timely, lack of recipient education about urgent care services and locations, poor location of urgent care facilities, recipients preferring to use the emergency room, recipients not having an assigned PCP, and invalid recipient contact information. To address these barriers, **HPN** has these continuing interventions:

- Call outreach—A member of the quality improvement team calls recipients who accessed the emergency room and were discharged with an avoidable ER visit code. Once the recipient is reached, the date of the visit is confirmed and education is provided about use of urgent care centers and the 24-hour nurse help line as well as assistance with selecting a PCP or scheduling an appointment, if applicable.
- Urgent care education mailers, including the, "Care When You Need It" window-clings—These are mailed to all recipients who accessed the emergency room for what were deemed as nonemergencies. The letter and the window-cling are in both English and Spanish.
- Provider newsletter—This is distributed to providers urging them to educate recipients about using urgent care centers for avoidable emergency room diagnoses.
- SMA convenience care clinics—SMA opened convenience care clinics in Walmart stores. These clinics allow MCO recipients to access care for minor illnesses.
- Website update—In 2013, **HPN**'s website underwent major changes. The PIP documentation noted that the website is more user-friendly. Using the website, recipients may update contact information, access information on when to seek emergency versus urgent care services, obtain 24-hour nurse advice line information, and use the Symptom Checker 24/7 (in both English and Spanish).

HPN developed a Comprehensive Case Management Pilot Program aimed at a subgroup of recipients who had had multiple emergency room encounters. The pilot was designed to contact these recipients; assist them with selecting a PCP and/or scheduling the appointment; and provide assistance with all other needs, whether psychosocial or clinical. The premise was that with the higher skill set of registered nurses involved would assist with recipients in ways that the long-standing outreach program could not. Although some success was achieved, it was determined that this pilot program did not show an acceptable return on investment and did not have significant positive impact; therefore, it was discontinued as an intervention.

HPN has processes in place to evaluate interventions and has discontinued or revised interventions based on the outcomes of the evaluation analysis.

Plan Comparison

Both MCOs received a *Met* validation score for 100 percent of the elements in the Design and Implementation stages. The strong performance suggests both a thorough application of designing

methodologically sound study designs and linking interventions to barriers. Opportunities for improvement exist in the Outcomes Stage; however, for **Amerigroup**'s *Diabetes Management* PIP and **HPN**'s *Children and Adolescents' Access to Primary Care Practitioners* PIP, **Amerigroup** received a *Not Met* and **HPN** received a *Partially Met* validation status, respectively. Both **Amerigroup** and **HPN** received a *Met* validation status for their *Reducing Avoidable Emergency Room Visits*.

Table 6-9—Performance Improvement Project Validation Status for Nevada Managed Care Organizations July 1, 2014, through June 30, 2015

Health Plan	Name of Project/Study	Percentage Score of Evaluation Elements *Met* [1]	Percentage Score of Critical Elements *Met* [2]	Overall Validation Status [3]
Amerigroup	*Diabetes Management*	94%	93%	*Not Met*
Amerigroup	*Reducing Avoidable Emergency Room Visits*	100%	100%	*Met*
HPN		100%	100%	*Met*
HPN	*Children and Adolescents' Access to Primary Care Practitioners*	90%	82%	*Partially Met*

[1] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total applicable elements of all categories (*Met*, *Partially Met*, and *Not Met*).

[2] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the applicable critical elements *Met*, *Partially Met*, and *Not Met*.

[3] **Overall Validation Status**—The overall validity and reliability of the PIP, which is based on the PIP Validation Tool results.

For **HPN**'s *Children and Adolescents' Access to Primary Care Practitioners* PIP, the PIP did not demonstrate statistically significant improvement for all indicators; therefore, the PIP received a *Partially Met* validation status.

For the *Diabetes Management* PIP, **Amerigroup** was less successful in the Outcomes Stage, as evidenced by 25 percent of applicable evaluation elements receiving a *Met* score. NCQA retired the *LDL-C Screening* from the *Comprehensive Diabetes Care* performance measure; therefore, Study Indicator 2 was removed from the PIP for this validation year. While Study Indicator 3, *Nephropathy Screening*, demonstrated nonstatistically significant improvement, neither study indicator has achieved statistically significant improvement over baseline after five annual remeasurements.

Overall Recommendations

Overall, HSAG recommends that the MCOs:

- Consider completing a process map and a failure modes and effects analysis to identify specific areas with greatest opportunities for improvement. HSAG can provide technical assistance on how to use these quality improvement tools.
- Conduct further drill-down analyses to identify the reason(s) for a decline in performance and why statistically significant improvement has not been achieved.

- Design small-scale tests coupled with analyses of results to determine the success of the intervention. If, after reviewing the results of the test data, it is determined that the intervention has not been successful, the MCO should determine (1) if the true root cause was identified and, if not, the MCO should conduct another causal/barrier analysis to isolate the true root cause or issue preventing improvement; and (2) if the intervention needs to be revised because a new root cause was identified or because the intervention was unsuccessful. In evaluating the results of intervention testing, the MCO may find that the test results provide more information that directs the MCO to modify an existing intervention to yield a greater result. If the existing intervention is modified and the current test has become obsolete, the MCO should develop another test to evaluate the modified intervention's effectiveness. HSAG can provide technical assistance on how to effectively test interventions using the Plan-Do-Study-Act cycle.
- Identify the national resources available to the health plan and consider implementing interventions successful in sister health plans across the country.

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

Objectives

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

Technical Methods of Data Collection and Analysis

Three populations were surveyed for **HPN** and **Amerigroup**: adult Medicaid, child Medicaid, and Nevada Check Up. DSS Research, an NCQA-certified vendor, administered the 2015 CAHPS surveys for both **HPN** and **Amerigroup**.

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

The survey questions were categorized into nine measures of satisfaction. These measures included four global ratings and five composite scores.[7-1] The global ratings reflected patients' overall satisfaction with their personal doctor, specialist, health plan, and all health care. The composite scores were derived from sets of questions to address different aspects of care (e.g., getting needed care and how well doctors communicate). When a minimum of 100 responses for a measure was not achieved, the result was denoted as Not Applicable (NA).

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

For each of the five composite scores, the percentage of respondents who chose a positive response was calculated. CAHPS composite question response choices fell into one of two categories: (1) Never, Sometimes, Usually, or Always; or (2) No or Yes. A positive or top-box response for the

[7-1] For purposes of this report, the 2015 CAHPS results presented for **HPN**'s and **Amerigroup**'s child Medicaid and Nevada Check Up populations are based on the CAHPS survey results of the general child population only (i.e., results for children selected as part of the general child CAHPS sample). Therefore, results for the CAHPS survey measures evaluated through the CCC measurement set of questions (i.e., five CCC composite scores and items) and CCC population are not presented in this report.

composites was defined as a response of Usually/Always or Yes. The percentage of top-box responses is referred to as a global proportion for the composite scores. A substantial increase or decrease is denoted by a change of 5 percentage points or more.

It is important to note that with the release of the 2015 CAHPS 5.0H Medicaid Health Plan Surveys, changes were made to the survey question language and response options for the *Shared Decision Making* composite measure. As a result of these changes, comparisons to the 2014 results and/or 2014 NCQA CAHPS national averages could not be performed for this composite measure for 2015. This was denoted with a dash (—).

Effective January 1, 2014, Nevada expanded its Medicaid program to allow persons with incomes up to 138 percent of the federal poverty level to enroll in the Medicaid program. Since the majority of persons in the newly eligible population reside in managed care catchment areas, most have enrolled in one of the two MCOs offered in the Nevada Medicaid managed care program, and thus are eligible for inclusion in the 2015 CAHPS Survey for the first time. Since the new population was not included in the prior year's CAHPS survey, caution should be exercised when interpreting the comparisons of the 2015 CAHPS results to the 2014 CAHPS results.

Plan-Specific Findings—Amerigroup

Table 7-1 shows **Amerigroup**'s 2014 and 2015 adult Medicaid CAHPS top-box rates along with NCQA's 2014 CAHPS adult Medicaid national averages.[7-2] In 2015, a total of 2,430 members were surveyed and 473 completed a survey. After ineligible members were excluded, the response rate was 19.9 percent. In 2014, the average NCQA response rate for the adult Medicaid population was higher than **Amerigroup**'s response rate.[7-3]

Table 7-1—Amerigroup Adult Medicaid CAHPS Results

	2014 Top-Box Rates	2015 Top-Box Rates	2014 NCQA CAHPS Adult Medicaid National Averages
Composite Measures			
Getting Needed Care	74.7%	78.0%	***
Getting Care Quickly	74.0%	73.6%	***
How Well Doctors Communicate	87.2%	87.0%	***
Customer Service	89.3%	86.0%	***
Shared Decision Making	—	79.9%	—
Global Ratings			
Rating of All Health Care	45.3%	45.9%	***
Rating of Personal Doctor	56.0%	63.3%	***
Rating of Specialist Seen Most Often	57.7%	55.2%	***
Rating of Health Plan	46.4%	47.9%	***

1. A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as Not Applicable (NA). Measures for which comparisons to the previous year's results or NCQA national averages could not be performed are denoted with a dash (—).
2. As previously noted, given the potential differences in the population of members included in the 2014 and 2015 CAHPS Survey, caution should be exercised when interpreting the comparisons of 2014 to 2015 CAHPS results.

*** The NCQA CAHPS Medicaid national averages are the proprietary intellectual property of NCQA. The NCQA CAHPS Medicaid national averages are to be used for internal analysis only and cannot be displayed publicly.

Amerigroup's rates decreased between 2014 and 2015 for four of the eight comparable measures: *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, and *Rating of Specialist Seen Most Often*. **Amerigroup**'s rates increased between 2014 and 2015 for four measures: *Getting Needed Care*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*. Further, one measure, *Rating of Personal Doctor*, showed a substantial increase of more than 5 percentage points.

[7-2] As previously noted, due to changes to the *Shared Decision Making* composite measure, comparisons of the 2015 top-box rate to the 2014 top-box rate and 2014 NCQA national averages could not be performed for this CAHPS measure.

[7-3] 2015 NCQA national response rate information for the CAHPS 5.0 Adult Medicaid Survey was not available at the time this report was produced.

Amerigroup's 2015 top-box rates for the adult Medicaid population were lower than the 2014 NCQA adult Medicaid national averages for all eight comparable measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*.

Table 7-2 shows **Amerigroup**'s 2014 and 2015 child Medicaid CAHPS top-box rates along with NCQA's 2014 CAHPS child Medicaid national averages for the general child population.[7-4,7-5] In 2015, a total of 4,043 general child members were surveyed and 636 completed a survey.[7-6] After ineligible members were excluded, the response rate was 17.2 percent. In 2014, the average NCQA response rate for the child Medicaid population was higher than **Amerigroup**'s response rate.[7-7]

Table 7-2—Amerigroup Child Medicaid CAHPS Results

	2014 General Child Top-Box Rates	2015 General Child Top-Box Rates	2014 NCQA CAHPS Child Medicaid National Averages
Composite Measures			
Getting Needed Care	78.2%	83.1%	***
Getting Care Quickly	83.4%	83.9%	***
How Well Doctors Communicate	88.2%	91.6%	***
Customer Service	84.7%	82.1%	***
Shared Decision Making	—	79.8%	—
Global Ratings			
Rating of All Health Care	60.8%	62.2%	***
Rating of Personal Doctor	73.7%	69.1%	***
Rating of Specialist Seen Most Often	72.2%	NA	***
Rating of Health Plan	70.0%	63.5%	***

1. A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as Not Applicable (NA). Measures for which comparisons to the previous year's results or NCQA national averages could not be performed are denoted with a dash (—).
2. As previously noted, given the potential differences in the population of members included in the 2014 and 2015 CAHPS Survey, caution should be exercised when interpreting the comparisons of 2014 to 2015 CAHPS results.

*** The NCQA CAHPS Medicaid national averages are the proprietary intellectual property of NCQA. The NCQA CAHPS Medicaid national averages are to be used for internal analysis only and cannot be displayed publicly.

Amerigroup's rates increased between 2014 and 2015 for four measures: *Getting Needed Care*, *Getting Care* Quickly, *How Well Doctors Communicate*, and *Rating of All Health Care*. **Amerigroup**'s rates decreased between 2014 and 2015 for three measures: *Customer Service*,

7-4 As previously noted, the child Medicaid CAHPS results presented in Table 7-2 for **Amerigroup** are based on the results of the general child population only.

7-5 Due to changes to the *Shared Decision Making* composite measure, comparisons of the 2015 top-box rate to the 2014 top-box rate and 2014 NCQA national averages could not be performed for this CAHPS measure.

7-6 The total number of members surveyed and who completed surveys is based on **Amerigroup**'s general child CAHPS sample only (i.e., does not include the CCC supplemental sample of members who were surveyed).

7-7 2015 NCQA national response rate information for the CAHPS 5.0 Child Medicaid with CCC Survey was not available at the time this report was produced.

Rating of Personal Doctor, and *Rating of Health Plan*. Of these, *Rating of Health Plan* showed a substantial decrease of more than 5 percentage points.

Amerigroup's 2015 top-box rates for the general child Medicaid population were lower than the 2014 NCQA child Medicaid national average for seven measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*.

Table 7-3 shows **Amerigroup**'s 2014 and 2015 Nevada Check Up CAHPS top-box rates for the general child population.[7-8] Since NCQA does not publish separate rates for the CHIP program, national comparisons could not be made. In 2015, a total of 1,600 members were surveyed and 401 completed a survey. After ineligible members were excluded, the response rate was 28.5 percent.

Table 7-3—Amerigroup Nevada Check Up CAHPS Results

	2014 General Child Top-Box Rates	2015 General Child Top-Box Rates
Composite Measures		
Getting Needed Care	79.3%	77.5%
Getting Care Quickly	81.8%	82.6%
How Well Doctors Communicate	89.2%	89.9%
Customer Service	80.9%	86.7%
Shared Decision Making	—	NA
Global Ratings		
Rating of All Health Care	61.8%	63.7%
Rating of Personal Doctor	75.5%	66.3%
Rating of Specialist Seen Most Often	65.6%	NA
Rating of Health Plan	76.5%	65.7%

1. A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as Not Applicable (NA). Measures for which comparisons to the previous year's results or NCQA national averages could not be performed are denoted with a dash (—).
2. As previously noted, given the potential differences in the population of members included in the 2014 and 2015 CAHPS Survey, caution should be exercised when interpreting the comparisons of 2014 to 2015 CAHPS results.

Amerigroup's rate decreased between 2014 and 2015 for three measures: *Getting Needed Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*. Of these, *Rating of Personal Doctor* and *Rating of Health Plan* showed a substantial decrease of more than 5 percentage points. Four measures increased between 2014 and 2015: *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, and *Rating of All Health Care*. Furthermore, *Customer Service* showed a substantial increase of more than 5 percentage points.

[7-8] The Nevada Check Up CAHPS results presented in Table 7-3 for **Amerigroup** are based on the results of the general child population only.

Plan-Specific Findings—HPN

Table 7-4 shows **HPN**'s 2014 and 2015 adult Medicaid CAHPS top-box rates along with NCQA's 2014 CAHPS adult Medicaid national averages. In 2015, a total of 1,890 members were surveyed and 310 completed a survey. After ineligible members were excluded, the response rate was 16.8 percent. In 2014, the average NCQA response rate for the adult Medicaid population was higher than **HPN**'s response rate.[7-9]

Table 7-4—HPN Adult Medicaid CAHPS Results

	2014 Top-Box Rates	2015 Top-Box Rates	2014 NCQA CAHPS Adult Medicaid National Averages
Composite Measures			
Getting Needed Care	75.8%	73.5%	***
Getting Care Quickly	76.7%	78.0%	***
How Well Doctors Communicate	87.4%	88.9%	***
Customer Service	NA	87.8%	***
Shared Decision Making	NA	NA	—
Global Ratings			
Rating of All Health Care	46.0%	51.4%	***
Rating of Personal Doctor	62.4%	61.3%	***
Rating of Specialist Seen Most Often	NA	65.1%	***
Rating of Health Plan	45.0%	56.3%	***

1. A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as Not Applicable (NA). Measures for which comparisons to the previous year's results or NCQA national averages could not be performed are denoted with a dash (—).
2. As previously noted, given the potential differences in the population of members included in the 2014 and 2015 CAHPS Survey, caution should be exercised when interpreting the comparisons of 2014 to 2015 CAHPS results.

*** The NCQA CAHPS Medicaid national averages are the proprietary intellectual property of NCQA. The NCQA CAHPS Medicaid national averages are to be used for internal analysis only and cannot be displayed publicly.

HPN's rates increased between 2014 and 2015 for four measures: *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, and *Rating of Health Plan*. Of these, two measures showed a substantial increase of more than 5 percentage points: *Rating of All Health Care* and *Rating of Health Plan*. **HPN**'s rates decreased between 2014 and 2015 for two measures: *Getting Needed Care* and *Rating of Personal Doctor*. However, these decreases were not substantial.

HPN's 2015 top-box rates for the adult Medicaid population were lower than the 2014 NCQA adult Medicaid national averages for five of the eight comparable measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of Personal Doctor*, and *Rating of Health Plan*. **HPN**'s 2015 top-box rates for the adult Medicaid population were higher than or equal

[7-9] 2015 NCQA national response rate information for the CAHPS 5.0 Adult Medicaid Survey was not available at the time this report was produced.

to the 2014 NCQA adult Medicaid national average for the following three comparable measures: *Customer Service*, *Rating of All Health Care*, and *Rating of Specialist Seen Most Often*.

Table 7-5 shows **HPN**'s 2014 and 2015 child Medicaid CAHPS top-box rates along with NCQA's 2014 CAHPS child Medicaid national averages for the general child population.[7-10] In 2015, a total of 2,310 general child members were surveyed and 435 completed a survey.[7-11] After ineligible members were excluded, the response rate for the general child population was 19.8 percent. In 2014, the average NCQA response rate for the child Medicaid population was higher than **HPN**'s 2015 response rate.[7-12]

Table 7-5—HPN Child Medicaid CAHPS Results

	2014 General Child Top-Box Rates	2015 General Child Top-Box Rates	2014 NCQA CAHPS Child Medicaid National Averages
Composite Measures			
Getting Needed Care	84.3%	79.2%	***
Getting Care Quickly	86.5%	83.7%	***
How Well Doctors Communicate	91.0%	92.3%	***
Customer Service	87.5%	NA	***
Shared Decision Making	NA	NA	—
Global Ratings			
Rating of All Health Care	63.6%	59.7%	***
Rating of Personal Doctor	73.7%	70.0%	***
Rating of Specialist Seen Most Often	NA	NA	***
Rating of Health Plan	71.4%	71.5%	***

1. A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as Not Applicable (NA). Measures for which comparisons to the previous year's results or NCQA national averages could not be performed are denoted with a dash (—).
2. As previously noted, given the potential differences in the population of members included in the 2014 and 2015 CAHPS Survey, caution should be exercised when interpreting the comparisons of 2014 to 2015 CAHPS results.

*** The NCQA CAHPS Medicaid national averages are the proprietary intellectual property of NCQA. The NCQA CAHPS Medicaid national averages are to be used for internal analysis only and cannot be displayed publicly.

HPN's rates decreased between 2014 and 2015 for four of the six reportable measures: *Getting Needed Care*, *Getting Care Quickly*, *Rating of All Health Care*, and *Rating of Personal Doctor*. Further, one measure showed a substantial decrease of more than 5 percentage points: *Getting Needed Care*. **HPN**'s rates increased between 2014 and 2015 for two measures: *How Well Doctors Communicate* and *Rating of Health Plan*.

[7-10] As previously noted, the child Medicaid CAHPS results presented in Table 7-5 for **HPN** are based on the results of the general child population only.
[7-11] The total number of members surveyed and who completed surveys is based on **HPN**'s general child CAHPS sample (i.e., does not include the CCC supplemental sample of members that were surveyed).
[7-12] 2015 NCQA national response rate information for the CAHPS 5.0 Child Medicaid with CCC Survey was not available at the time this report was produced.

HPN's 2015 top-box rates for the general child Medicaid population were lower than the 2014 NCQA general child Medicaid national averages for five measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, and *Rating of Personal Doctor*. One of **HPN**'s 2015 top-box rates for the general child Medicaid population was higher than the 2014 NCQA general child Medicaid national average: *Rating of Health Plan*.

Table 7-6 shows **HPN**'s 2014 and 2015 Nevada Check UP CAHPS top-box rates for the general child population.[7-13,7-14] Since NCQA does not publish separate rates for the CHIP program, national comparisons could not be made. In 2015, a total of 2,310 general child members were surveyed and 650 completed a survey.[7-15] After ineligible members were excluded, the response rate was 32.4 percent.

Table 7-6—HPN Nevada Check Up CAHPS Results

	2014 General Child Top-Box Rates	2015 General Child Top-Box Rates
Composite Measures		
Getting Needed Care	81.9%	80.8%
Getting Care Quickly	85.8%	80.3%
How Well Doctors Communicate	91.7%	90.5%
Customer Service	89.2%	88.4%
Shared Decision Making	—	79.1%
Global Ratings		
Rating of All Health Care	62.3%	66.3%
Rating of Personal Doctor	74.6%	68.3%
Rating of Specialist Seen Most Often	73.1%	NA
Rating of Health Plan	76.6%	72.4%

1. A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as Not Applicable (NA). Measures for which comparisons to the previous year's results or NCQA national averages could not be performed are denoted with a dash (—).
2. As previously noted, given the potential differences in the population of members included in the 2014 and 2015 CAHPS Survey, caution should be exercised when interpreting the comparisons of 2014 to 2015 CAHPS results.

HPN's rates increased between 2014 and 2015 for one measure: *Rating of All Health Care*. For the remaining six measures, **HPN**'s rates decreased between 2014 and 2015: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, *Rating of Personal Doctor*, and *Rating of Health Plan.* Further, two measures showed a substantial decrease of more than 5 percentage points between 2014 and 2015: *Getting Care Quickly* and *Rating of Personal Doctor*.

[7-13] The Nevada Check Up CAHPS results presented in Table 7-6 for **HPN** are based on the results of the general child population only.

[7-14] Due to changes to the *Shared Decision Making* composite measure, comparisons of the 2015 to 2014 top-box rate could not be performed for this CAHPS measure.

[7-15] The total number of members surveyed and who completed surveys is based on **HPN**'s general child CAHPS sample only (i.e., does not include the CCC supplemental sample of members that were surveyed).

Plan Comparison

HPN's adult Medicaid CAHPS scores were below the adult Medicaid national averages for five of seven reportable composite and global measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of Personal Doctor*, and *Rating of Health Plan*. **HPN**'s response rate for the adult Medicaid population was lower than the 2014 NCQA adult Medicaid average response rate. **Amerigroup**'s adult Medicaid CAHPS scores were below the adult Medicaid national averages for all eight comparable composite and global measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*. **Amerigroup**'s response rate for the adult Medicaid population was lower than the 2014 NCQA adult Medicaid average response rate.

HPN's child Medicaid CAHPS scores were below the child Medicaid national averages for three reportable composite measures (*Getting Needed Care*, *Getting Care Quickly*, and *How Well Doctors Communicate*) and for two reportable global ratings (*Rating of All Health Care* and *Rating of Personal Doctor*). **HPN**'s response rate for the child Medicaid population was lower than the 2014 NCQA child Medicaid with CCC average response rate. **Amerigroup**'s child Medicaid CAHPS scores were below the child Medicaid national averages for all seven comparable composite and global measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*. **Amerigroup**'s response rate for the child Medicaid population was lower than the 2014 NCQA child Medicaid with CCC average response rate.

HPN's 2015 Nevada Check Up CAHPS score was above the 2014 Nevada Check Up CAHPS score for one measure: *Rating of All Health Care*. **Amerigroup**'s 2015 Nevada Check Up CAHPS scores were above the 2014 Nevada Check Up CAHPS scores for four measures: *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, and *Rating of All Health Care*. Since NCQA does not publish separate rates for the CHIP program, national comparisons could not be made.

Overall Recommendations

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

HSAG recommends that **HPN** focus quality improvement initiatives on enhancing members' experiences with *Getting Needed Care* and *Rating of Personal Doctor* for the adult Medicaid population, since these rates were lower than the 2014 adult CAHPS results and fell below NCQA's 2014 CAHPS adult Medicaid national averages. For the child Medicaid population, **HPN** should focus on improving *Getting Needed Care*, *Getting Care Quickly*, *Rating of All Health Care*, and

Rating of Personal Doctor, since these rates were lower than the 2014 child CAHPS results and fell below NCQA's 2014 CAHPS child Medicaid national averages. For the Nevada Check Up population, quality improvement efforts should be focused on *Getting Care Quickly* and *Rating of Personal Doctor*, since these measures showed a substantial decrease from 2014 to 2015.

For the adult population, HSAG recommends that **Amerigroup** focus quality improvement initiatives on enhancing members' experiences with *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, and *Rating of Specialist Seen Most Often*, since these rates were lower than the 2014 adult CAHPS results and fell below NCQA's 2014 CAHPS adult Medicaid national averages. For the child Medicaid population, **Amerigroup** should focus its efforts on improving *Customer Service*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*, since these rates were lower than the 2014 child CAHPS results and fell below NCQA's 2014 CAHPS child Medicaid national averages. For the Nevada Check Up population, HSAG recommends that quality improvement efforts focus on improving *Getting Needed Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*, since the 2015 rates for these measures were lower than the 2014 rates. Furthermore, the rates for two of these measures were substantially lower than the 2014 rates: *Rating of Personal Doctor* and *Rating of Health Plan*.

8. Health Care Guidance Program (HCGP) Compliance Review

Background

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

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

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

HSAG performed the compliance review in two phases. Phase I focused on the operational structure of key areas of the program and consisted of a desk review of documentation. Phase II consisted of a two-day on-site review, which occurred December 10–11, 2014, in the **McKesson** Carson City, Nevada, office.

Two months prior to the on-site review, HSAG submitted a data request to **McKesson** to provide HSAG with program information and data files used for the desk review and on-site review. HSAG reviewed all documentation submitted by **McKesson** prior to the on-site review. This included:

- **Questionnaire—**Used to collect additional information about **McKesson**'s operational structure, number and type of staff members designated to the Nevada HCGP, and enrollment counts by risk category, as well as the number and types of care management interventions that occurred during the review period (June 1–October 31, 2014).
- **Completed compliance review standards tool—**Wherein **McKesson** listed all of the documents and information it offered as evidence of compliance with each element for each of the 12 standards reviewed.
- **Care management data file—**Using the file layout specified by HSAG, **McKesson** listed the demographic information, dates of enrollment, dates of assessment, date the treatment plans

were developed, and primary and secondary diagnoses of each individual who had been enrolled and assessed for care management services as of October 31, 2014.

- **Grievance data file—**Using the file layout specified by HSAG, **McKesson** listed all of the grievances filed by enrollees as of October 31, 2014.

Findings

For the purposes of this report, HSAG uses the following definitions:

- **Enrolled person—**A person who meets the eligibility criteria for the program and has been identified through **McKesson**'s risk stratification process as someone who would benefit from the HCGP.
- **Served person—**A person who meets the eligibility criteria, is enrolled in the HCGP, and has completed a health risk assessment and care management plan with a **McKesson** care manager.

McKesson's completed questionnaire showed that 39,543 persons were enrolled in the program as of October 31, 2014. The care management file submitted by **McKesson** showed that of the 39,543 enrolled persons, **McKesson** completed an assessment and a care management plan for 1,828 of them, or 4.6 percent of the enrolled population. Of the 1,828 persons served, **McKesson** stratified enrollees into the following care management categories: 83 persons in complex care (4.5 percent), 451 in the high category (24.7 percent), 738 in the moderate category (40.4 percent), and 556 in the low category (30.4 percent).

The on-site compliance review included a review of 12 standards, which were based on the requirements of **McKesson**'s contract with the DHCFP. Some of the elements contained in each standard were part of the readiness review; however, most the elements contained in the standards could not be assessed prior to the program start date, which is why they were included in the compliance review. Table 8-1 lists each of the standards reviewed and the scores for each standard.

Table 8-1—Summary of Results of Compliance with Standards

Standard Number	Standard Name	Total Elements	Applicable Elements	Met	Partially Met	Not Met	N/A
I	Stratification of Enrollees	3	3	2	1	0	0
II	Care Management Teams	2	2	2	0	0	0
III	Care Planning	2	2	1	1	0	0
IV	Mental Health Care Management Services	2	2	2	0	0	0
V	Health Education Materials	1	1	1	0	0	0
VI	Nurse Triage and Call Services	4	4	2	2	0	0
VII	Emergency Department Redirection	3	3	3	0	0	0
VIII	Stakeholder Outreach and Education	2	2	2	0	0	0
IX	Feedback to Primary Care Providers (PCPs)	2	2	1	1	0	0
X	Provider Services	3	2	1	1	0	1
XI	Care Transitions	1	1	0	1	0	0
XII	Operational Structure and Reporting	2	2	1	1	0	0
	Total Elements	**27**	**26**	**18**	**8**	**0**	**1**
	Composite Score	**22/26 84.6%**					

Overall, **McKesson** received a composite score of 84.6 percent. Of the 12 standards reviewed, **McKesson** met all of the elements for the following five standards: *Care Management Teams*, *Mental Health Care Management Services*, *Health Education Materials*, *Emergency Department Redirection,* and *Stakeholder Outreach and Education*. **McKesson** received a *Partially Met* for one or more elements contained in 7 of the 12 standards reviewed, which included: *Stratification of Enrollees*, *Care Planning*, *Nurse Triage and Call Services*, *Feedback to Primary Care Providers (PCPs)*, *Provider Services*, *Care Transitions,* and *Operational Structure and Reporting*.

Since care management activities have the potential to positively impact the quality of services as well as health outcomes, enrollees benefit from early identification, enrollment, assessment, and receipt of care management services. HSAG used the care management data file submitted by **McKesson** to calculate the average length of time between the date of enrollment in the program and the date an assessment was performed. Table 8-2 shows the persons enrolled and served in the program.

Table 8-2—Persons Enrolled and Served in the HCGP

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

*The total number of persons enrolled in the program was 39,543. The percent of the total enrolled who were served in the program is calculated as follows: number of persons served divided by the total enrolled in the program (39,543). For example, 83 persons served is 0.2 percent of the total enrolled population of 39,543.

Of the 39,543 people identified and enrolled in the HCGP by October 31, 2014, and where an assessment and care management plan was developed 4.6 percent were served. On average, there were 72 days between the date of enrollment and the date of assessment by **McKesson** care managers.

In the case of pregnant enrollees, the pregnancy is time-limited so the window available to provide effective care management interventions during the gestation period is limited. In some cases, more than 110 days passed between the date the pregnant woman was enrolled in the program and the date her needs were assessed. In one of the 20 files reviewed, HSAG reviewers found that the woman was assessed 154 days after being identified and enrolled in the program and she had already given birth by the date of her assessment.

During both the readiness review and the compliance review, HSAG found the quality of staff proposed for the program to be consistent with contractual requirements. Further, HSAG found that **McKesson** maintained appropriate written descriptions for developing and operating multidisciplinary care management teams. The quantity of staff members designated to the program, however, was inconsistent with care manager-to-enrollee ratios proposed by **McKesson**, given the 39,543 persons enrolled in the program. Table 8-3 shows the number of care managers required to maintain the staffing ratios proposed by **McKesson**.

Table 8-3—Number of Care Managers to Maintain Ratios					
Case Management (CM) Risk Level	Percentage of Population	Max. Number of Enrollees Served by CM Risk Level	Ratio 1 CM to: XX Enrollees	Number of Care Managers to Maintain CM Ratio	Surplus/Deficit of FTEs to Fulfill Ratios
Complex (4)	3%	1,186	75	15.82	**39.01 FTEs**
High Risk (3)	7%	2,768	186	14.88	
Moderate Risk (2)	20%	7,909	244	32.41	
Low Risk (1)	70%	27,680	Low risk enrollees may interact with any available care manager	Unknown	
Total	**100%**	**39,543**		**63.11**	

*Note: 63.11 care managers (CMs) represents the minimum number of CMs needed to serve 39,543 enrollees based on McKesson's proposed risk stratification and care manager-to-enrollee ratios.

Based on the anticipated staffing need for HCGP noted in Table 8-3 (63.11 FTEs) and the number of staff members designated by **McKesson** for HCGP (24.1 FTEs), the anticipated shortfall in staffing was 39.01 FTEs.

HSAG used the care management enrollment file to select 20 cases to be included in the care management file review. The results of the care management file review are noted in Table 8-4.

Table 8-4—Results of Care Management File Review				
Elements	Section II: Enrollee Assessment	Section III: Care Plan Development	Section IV: Ongoing Care Management	Section V: Care Monitoring and Reassessment
Total Number of Elements	440	240	320	60
Total Number of Elements N/A	14	44	176	50
Total Number of Applicable Elements	**426**	**196**	**144**	**10**
Total Elements Contained in File (Yes)	420	171	114	10
Total Elements Not Contained in File (No)	6	25	30	0
Percent of Elements Contained in File	**420/426 98.6%**	**171/196 87.2%**	**114/144 79.2%**	**10/10 100%**

When reviewing care management files, HSAG reviewers noted that **McKesson** documented most of the elements required by its contract with the DHCFP. After **McKesson** completed the initial assessment and care management plan, **McKesson**'s electronic care management system, VITAL, generated a copy of the care management plan and faxed it to the PCP, in most cases. The elements related to ongoing care management required **McKesson** to document evidence of ongoing communication with the enrollee and his/her PCP. **McKesson** documented its communication with the enrollee. Although **McKesson** documented an enrollee's noncompliance with the care management plan and **McKesson**'s inability to reach the enrollee after an assessment was performed, the documentation, in many instances, did not show that either concern was communicated to the enrollee's PCP.

HSAG used the grievance file submitted by **McKesson** to select 10 cases for inclusion in the grievance file review. The results of the grievance file review showed that **McKesson**'s staff

verbally acknowledged receipt of the grievance during the initial call from the enrollee, and staff members with appropriate expertise handled the grievances. HSAG reviewers found that all notes concerning the investigation and resolution of the grievances were not documented in the grievance files, and many times the grievance file did not contain the date the grievance was resolved. The results of the grievance file review are shown in Table 8-5.

Table 8-5—Results of Grievance File Review

Grievance Elements	Provider Obtained Permission to File on Enrollee Behalf	Grievance Acknowledged	Resolved within 30 Days	Appropriate Level of Expertise
Total Number of Elements	10	10	10	10
Number of Applicable Elements	0	10	10	10
Number of Compliant Elements	N/A	10	4	10
Percent Compliant	**N/A**	**10/10 100%**	**4/10 40%**	**10/10 100%**

To remedy any deficiencies, **McKesson** was required to submit a corrective action plan (CAP) to the DHCFP. **McKesson** submitted several CAPs to the DHCFP in response to the report. Several of the responses submitted by **McKesson** were not acceptable to the DHCFP, which issued a closeout letter to McKesson in July 2015 citing the items that were not acceptable to the DHCFP.

To access the full **McKesson** Compliance Review Report, please see: http://dhcfp.nv.gov/Pgms/BLU/HCGP/.

Appendix A. Technical Methods of Data Collection and Analysis

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

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

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

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

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

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

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

organization compliance review. The objectives for each of these activities are described in the respective sections of this report.

Internal Quality Assurance Program (IQAP) Compliance Review

The purpose of the state fiscal year (SFY) 2014–2015 Internal Quality Assurance Program (IQAP) On-Site Review of Compliance was to determine each MCO's compliance with federal and State managed care standards. For the SFY 2014–2015 IQAP On-Site Review of Compliance, HSAG reviewed each MCO's managed care and quality program activities that occurred during SFY 2013–2014. Specifically, HSAG reviewed each MCO's compliance with the following:

- State and federal managed care requirements, which were categorized into 14 contract standards, referred to as ***IQAP Standards.***
- Outreach and educational materials associated with member rights and responsibilities, member handbook, medical record standards, and the provider manual, referred to as ***Checklists.***
- Operational compliance for credentialing, recredentialing, service denial, grievances, and appeal processing activities, referred to as ***File Reviews.***

The IQAP standards were derived from the requirements as set forth in the Department of Health and Human Services, Division of Health Care Financing and Policy Request for Proposal No. 1988 for Managed Care, and all attachments and amendments in effect during SFY 2013–2014. HSAG followed the guidelines set forth in CMS' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012[A-4] to create the process, tools, and interview questions used for the SFY 2014–2015 compliance review.

Methods for Data Collection

HSAG developed data collection tools to document the IQAP review. The requirements in the tools were selected based on applicable federal and State regulations and laws, and on the requirements set forth in the contract between the DHCFP and the MCOs, as they related to the scope of the review. HSAG conducted pre-on-site, on-site, and post-on-site review activities.

Pre-on-site review activities included:

- Developing the compliance review tools.
- Preparing and forwarding to each MCO a customized desk review form, instructions for completing the form, and instructions for submitting the requested documentation to HSAG.
- Scheduling the on-site reviews.
- Developing the agenda for the two-day on-site review.

[A-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

- Providing the detailed agenda and the data collection (compliance review) tool to each MCO to facilitate its preparation for HSAG's review.
- Conducting a pre-on-site desk review of documents. HSAG conducted a desk review of key documents and other information obtained from the DHCFP, and of documents each MCO submitted to HSAG. The desk review enabled HSAG reviewers to increase their knowledge and understanding of each MCO's operations, identify areas needing clarification, and begin compiling information and interview questions before the on-site review.
- Generating a list of 10 sample cases plus an oversample of five cases for each of the following file reviews: grievances, appeals, denials, credentialing, recredentialing, and case management.

On-site review activities included:

- An opening conference, with introductions and a review of the agenda and logistics for HSAG's on-site review activities.
- A review of the documents HSAG requested that each MCO have available on-site.
- A review of the file cases HSAG requested from each MCO.
- A review of the data systems each MCO used in its operations, which included but was not limited to care management, grievance and appeal tracking, quality improvement tracking, and quality measure reporting.
- Interviews with each MCO's key administrative and program staff members.
- A closing conference during which HSAG reviewers summarized their general findings.

HSAG documented its findings in the data collection (compliance review) tool, which served as the comprehensive record of HSAG's findings, performance scores assigned to each requirement, and the actions required to bring the MCOs' performance into compliance for those requirements that HSAG assessed as less than fully compliant.

Post-on-site review activities: HSAG reviewers aggregated findings to produce a comprehensive compliance review report for each MCO. In addition, HSAG created a corrective action plan (CAP) template for each MCO to use, which contained the findings and recommendations for each element scored *Partially Met* or *Not Met*.

Description of Data Obtained

To assess the MCOs' compliance with federal regulations, State rules, and contract requirements, HSAG obtained information from a wide range of written documents produced by the MCOs, including:

- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.
- The provider manual and other MCO communication to providers/subcontractors.
- The member handbook and other written informational materials.
- Narrative and/or data reports across a broad range of performance and content areas.
- Written plans that guide specific operational areas, which included, but were not limited to: utilization management, quality management, care management and coordination, health

management and service authorization, credentialing, cultural competency, delegation and contracting, and member education.

- MCO-maintained files for member grievances and appeals, denials of services, case management, and practitioner credentialing and recredentialing.
- MCO questionnaire.

HSAG obtained additional information for the compliance review through interaction, discussions, and interviews with the MCOs' key staff members during the on-site review.

IQAP Standards, Checklists, and Files Reviewed

Table A-1 lists the standards reviewed and associated checklists or files reviewed as evidence of compliance with internal policies.

Table A-1—IQAP Standards, Checklists, and File Reviews

IQAP Standard Number	IQAP Standard Name	Number of Elements
I	Internal Quality Assurance Program	54
II	Credentialing and Recredentialing	16
III	Member Rights and Responsibilities	14
IV	Member Information	14
V	Availability and Accessibility of Services	28
VI	Continuity and Coordination of Care	16
VII	Grievances and Appeals	35
VIII	Subcontracts and Delegation	13
IX	Cultural Competency Program	16
X	Coverage and Authorization of Services	23
XI	Provider Dispute and Complaint Resolution	9
XII	Confidentiality and Record Keeping	9
XIII	Provider Information	3
XIV	Enrollment/Disenrollment	11
	Total Number of IQAP Elements	**261**
Associated IQAP Standard #	**Checklist Name**	**Number of Elements**
III	Member Rights and Responsibilities	9
IV	Member Handbook	34
XII	Medical Record Standards	26
XIII	Provider Manual	10
	Total Number of Checklist Elements	**79**
Associated IQAP Standard #	**File Review Name**	**Number of Elements**
II	Initial Credentialing	157
II	Recredentialing	210
VII	Grievances	21
VII	Appeals	42
VII	Denials	30
VI	Case Management	195
	Total Number of File Review Elements	**655**

Data Aggregation and Analysis

IQAP Standards

HSAG used scores of *Met*, *Partially Met*, and *Not Met* to indicate the degree to which each MCO's performance complied with the requirements. A designation of *NA* was used when a requirement was *Not Applicable* to an MCO during the period covered by HSAG's review. This scoring methodology is consistent with CMS' final protocol, *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. The protocol describes the scoring as follows:

- ***Met*** indicates full compliance defined as *both* of the following:
  - All documentation listed under a regulatory provision, or component thereof, was present.
  - Staff members were able to provide responses to reviewers that were consistent with each other and with the documentation.
- ***Partially Met*** indicates partial compliance defined as *either* of the following:
  - There was compliance with all documentation requirements, but staff members were unable to consistently articulate processes during interviews.
  - Staff members were able to describe and verify the existence of processes during the interview, but documentation was incomplete or inconsistent with practice.
- ***Not Met*** indicates noncompliance defined as *either* of the following:
  - No documentation was present and staff members had little or no knowledge of processes or issues addressed by the regulatory provisions.
  - For those provisions with multiple components, key components of the provision could be identified and any findings of *Not Met* or *Partially Met* would result in an overall finding of noncompliance, regardless of the findings noted for the remaining components.

From the scores it assigned for each of the requirements, HSAG calculated a total percentage-of-compliance score for each of the 14 IQAP standards and an overall percentage-of-compliance score across the 14 IQAP standards. HSAG calculated the total score for each of the standards by adding the weighted score for each requirement in the standard receiving a score of *Met* (value: 1 point), *Partially Met* (value: 0.50 point), and *Not Met* (0 points) and dividing the summed weighted scores by the total number of applicable requirements for that standard.

HSAG determined the overall percentage-of-compliance score across the areas of review by following the same method used to calculate the scores for each standard (i.e., by summing the weighted values of the scores and dividing the result by the total number of applicable requirements).

Checklists

For the checklists reviewed, HSAG surveyors scored each applicable element within the checklists as either *Yes*, the element was contained within the associated document; or *No*, the element was not contained within the document. Elements that were not applicable to the MCO were scored as *Not Applicable* and were not included in the denominator of the total score. To obtain a percentage

score, HSAG added the total number of elements that received a *Yes* score and divided it by the total number of applicable elements.

File Reviews

HSAG conducted file reviews of the MCO's records for credentialing, recredentialing, grievances, appeals, denials, and case management to verify that the MCO had put into practice what the MCO documented in its policy. HSAG randomly selected 10 files of each type of record from the full universe of records provided by the MCO. The file reviews were not intended to be a statistically significant representation of all of the MCO's files. Rather, the file review highlighted when practices described in policy were not followed by the MCO staff's. Based on the results of the file reviews, the MCO must determine if any areas found to be out of compliance are the result of an anomaly or if a more serious breach in policy occurred.

For the file reviews, HSAG surveyors scored each applicable element within the file review tool as either *Yes*, the element was contained within the file, or *No*, the element was not contained in the file. Elements that were not applicable to the MCO were scored as *Not Applicable* and were not included in the denominator of the total score. To obtain a percentage score, HSAG added the total number of elements that received a *Yes* score and divided it by the total number of applicable elements.

Aggregating the Scores

To draw conclusions about the quality and timeliness of, and access to, care and services the MCOs provided to members, HSAG aggregated and analyzed the data resulting from its desk and on-site review activities. The data that HSAG aggregated and analyzed included:

- Documented findings describing the MCOs' performance in complying with each of the IQAP standard requirements.
- Scores assigned to the MCOs' performance for each requirement.
- The total percentage-of-compliance score calculated for each of the 14 IQAP standards.
- The overall percentage-of-compliance score calculated across the 14 IQAP standards.
- The overall percentage-of-compliance score calculated for each of the file reviews.
- The overall percentage-of-compliance score calculated for each of the checklists.
- Documentation of the actions required to bring performance into compliance with the requirements for which HSAG assigned a score of *Partially Met* or *Not Met*.

Based on the results of the data aggregation and analysis, HSAG prepared and forwarded draft reports to the DHCFP staff for their review and comment prior to issuing final reports. Each MCO submitted CAPs in response to the final report. The DHCFP reviewed and approved the CAPs in June 2015.

Validation of Performance Improvement Projects (PIPs)

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

- *Improving Children and Adolescents' Access to Primary Care Practitioners* (**HPN** only).
- *Improving Diabetes Management* (**Amerigroup** only).
- *Reducing Avoidable Emergency Room Visits* (both MCOs).

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

Validation Overview

The primary objective of PIP validation was to determine each MCO's compliance with the requirements of 42 CFR 438.240(b)(1), including:

- Measurement of performance using objective quality indicators.
- Implementation of systematic interventions to achieve improvement in quality.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

HSAG obtained the data needed to conduct the PIP validation from the MCO's PIP summary forms. These forms provided detailed information about the MCO's PIPs related to the activities the MCO completed for SFY 2014–2015. Using the information detailed in the PIP summary forms and referencing additional information provided by the MCO, HSAG evaluated the PIP submissions for the SFY 2014–2015 validation cycle.

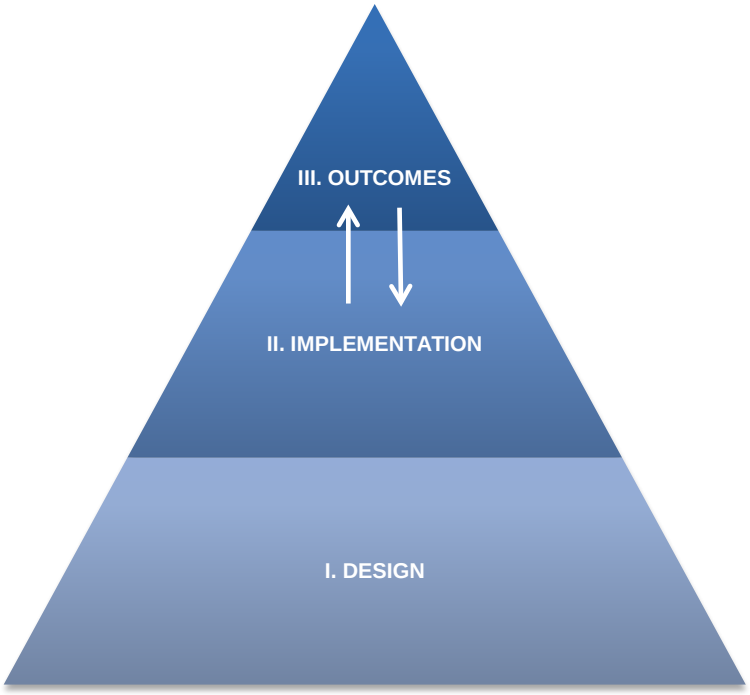
HSAG used the CMS publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012, in evaluating and validating the PIPs.[A-5]

Stages of a PIP

Figure A–1 illustrates the three stages of the PIP process—i.e., Study Design, Study Implementation, and Study Outcomes. Each sequential stage provides the foundation for the next stage. The Design Stage establishes the methodological foundation for the PIP. The activities in this section include development of the study topic, question, indicators, and population. To implement successful improvement strategies, a strong study design is necessary.

[A-5] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: February 19, 2013.

Figure A–1—PIP Stages



Once an MCO establishes its study design, the PIP process moves into the Implementation Stage. This stage includes data analysis and interventions. During this stage, the MCO analyzes data, identifies barriers to performance, and develops interventions targeted to overcome barriers and improve outcomes. Implementing effective improvement strategies is necessary to improve PIP outcomes.

The final stage is the Outcomes Stage, which involves the evaluation of real and sustained improvement based on reported results and statistical testing. Sustained improvement is achieved when outcomes exhibit statistical improvement over time and multiple measurements. This stage is the culmination of the previous two stages. The MCO should regularly evaluate interventions to ensure they are having the desired effect. A concurrent review of the data is encouraged. If the MCO's evaluation of the interventions, and/or review of the data, indicate that the interventions are not having the desired effect, the MCO should revisit its causal/barrier analysis process; verify that the proper barriers are being addressed; and discontinue, revise, or implement new interventions as needed. This cyclical process should be used throughout the duration of the PIP and revisited as often as needed.

The purpose of a PIP is to achieve significant improvement sustained over time in clinical and nonclinical areas through ongoing measurements and interventions. Therefore, in addition to the validation results, the study indicator results for each MCO are compared to the results from the prior measurement period in terms of whether improvement and/or sustained improvement were attained.

HSAG PIP Validation Scoring

Each required activity was evaluated on one or more elements that form a valid PIP. The HSAG PIP Review Team scored each evaluation element within a given activity as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed*. HSAG designated some of the evaluation elements that are pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all of the critical elements had to be *Met*. Given the importance of critical elements to the scoring methodology, any critical element that received a *Not Met* score resulted in an overall validation rating for the PIP of *Not Met*. An MCO would be given a *Partially Met* score if 60 to 79 percent of all evaluation elements were *Met* or one or more critical elements were *Partially Met*. HSAG provided a *Point of Clarification* when enhanced documentation would have demonstrated a stronger application of the PIP activities and evaluation elements.

In addition to the validation status (e.g., *Met*) HSAG gave each PIP an overall percentage score for all evaluation elements (including critical elements). HSAG calculated the overall percentage score by dividing the total number of elements scored as *Met* by the total number of elements scored as *Met*, *Partially Met*, and *Not Met*. HSAG also calculated a critical element percentage score by dividing the total number of critical elements scored as *Met* by the sum of the critical elements scored as *Met*, *Partially Met*, and *Not Met*.

Performance Measure Validation

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

- Teleconferences with the MCOs' personnel and vendor representatives, as necessary.
- Detailed review of the MCOs' completed responses to the NCQA Roadmap.
- On-site meetings, including the following:
  - Staff interviews.
  - Live system and procedure demonstration.
  - Documentation review and requests for additional information.
  - Primary HEDIS data source verification.
  - Programming logic review and inspection of dated job logs.
  - Computer database and file structure review.
  - Discussion and feedback sessions.
- Detailed evaluation of computer programming used to access administrative data sets, manipulate medical record review data, and calculate HEDIS measures.
- Detailed evaluation of encounter data completeness.
- Re-abstraction of sample medical records selected by the auditors, with a comparison of results to each MCO's review determinations for the same records, if the hybrid method was used.
- Requests for corrective actions and modifications related to HEDIS data collection and reporting processes and data samples, as necessary, and verification that actions were taken.
- Accuracy checks of the final HEDIS rates completed by the MCOs.
- Interviews with a variety of individuals whose department or responsibilities played a role in the production of HEDIS data. Representatives of vendors who provided or processed HEDIS 2014 (and earlier historical) data may also have been interviewed and asked to provide documentation of their work.

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

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

To validate the medical record review portion of the audit, NCQA policies and procedures require auditors to perform two steps: First, an audit team review of the medical record review processes

employed by the MCOs, including a review of staff qualifications, training, data collection instruments and tools, interrater reliability (IRR) testing, and the method used to combine medical record review data with administrative data; and second, a reabstraction of selected medical records and a comparison of the audit team's results to abstraction results for medical records used in the hybrid data source measures.

The analysis of the validation of performance measures involved tracking and reporting rates for the measures required for reporting by the DHCFP for Medicaid and Nevada Check Up. The audited measures (and the programs to which they apply) are presented in Table A-2.

Table A-2—Audited 2014 HEDIS Measures

Required HEDIS Measures	Medicaid	Check-Up
*Ambulatory Care (Emergency Department Visits)**		
Childhood Immunization Status—Combos 2–10	X	X
Lead Screening in Children	X	X
Children's and Adolescents' Access to Primary Care Practitioners	X	X
Well-Child Visits in the First 15 Months of Life	X	X
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	X	X
Adolescent Well-Care Visits	X	X
Annual Dental Visit	X	X
Use of Appropriate Medications for People With Asthma	X	X
Follow-Up After Hospitalization for Mental Illness	X	X
Comprehensive Diabetes Care	X	
Weeks of Pregnancy at the Time of Enrollment	X	
Timeliness of Prenatal Care	X	
Postpartum Care	X	
Frequency of Ongoing Prenatal Care	X	

*Performance Improvement Project (PIP) measure

Since the Medicaid expansion started January 2014, both plans also reported a separate set of HEDIS 2015 rates with the expansion population included in the calculation (see Table A-3). These rates were validated as part of each plan's HEDIS 2015 compliance audits and will be used as baseline data for trending with HEDIS 2016 results.

Table A-3—Audited 2015 HEDIS Measures (with Expansion Population Included)

HEDIS Measure	HPN	AGP
Childhood Immunization Status—Combo 2	70.80%	66.20%
Childhood Immunization Status—Combo 3	66.18%	60.88%
Childhood Immunization Status—Combo 4	66.18%	58.80%
Childhood Immunization Status—Combo 5	53.04%	50.23%
Childhood Immunization Status—Combo 6	39.42%	33.33%
Childhood Immunization Status—Combo 7	53.04%	48.38%
Childhood Immunization Status—Combo 8	39.42%	33.10%
Childhood Immunization Status—Combo 9	32.36%	28.24%

Table A-3—Audited 2015 HEDIS Measures (with Expansion Population Included)		
HEDIS Measure	**HPN**	**AGP**
Childhood Immunization Status—Combo 10	32.36%	28.01%
Lead Screening in Children	40.88%	35.88%
Children's and Adolescents' Access to PCPs (12–24 Months)	91.42%	91.14%
Children's and Adolescents' Access to PCPs (25 Months–6 Years)	79.24%	81.30%
Children's and Adolescents' Access to PCPs (7–11 Years)	83.93%	85.60%
Children's and Adolescents' Access to PCPs (12–19 Years)	80.80%	81.53%
Well-Child Visits First 15 Months (Six or More Visits)	51.58%	50.58%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	60.83%	65.66%
Adolescent Well-Care Visits	37.47%	42.13%
Annual Dental Visit—Combined Rate	51.12%	45.62%
Timeliness of Prenatal Care	77.62%	69.77%
Postpartum Care	58.88%	46.74%
Frequency of Ongoing Prenatal Care (<21% Visits)*	17.03%	15.81%
Frequency of Ongoing Prenatal Care (81–100% Visits)	51.34%	52.33%
Comprehensive Diabetes Care—HbA1c Testing	84.18%	81.90%
Comprehensive Diabetes Care—Poor HbA1c Control*	44.53%	46.40%
Comprehensive Diabetes Care—Good HbA1c Control (<8%)	43.80%	43.16%
Comprehensive Diabetes Care—Eye Exams	55.96%	55.45%
Comprehensive Diabetes Care—Blood Pressure <140/90	70.32%	62.18%
Comprehensive Diabetes Care—Monitoring for Nephropathy	82.73%	75.17%
Use of Appropriate Medications for People With Asthma (5–11 Years)	89.01%	82.96%
Use of Appropriate Medications for People With Asthma (12–18 Years)	89.60%	73.26%
Use of Appropriate Medications for People With Asthma (19–50 Years)	70.74%	60.16%
Use of Appropriate Medications for People With Asthma (51–64 Years)	NA	NA
Use of Appropriate Medications for People With Asthma (Combined)	85.98%	76.69%
Follow-up After Hospitalization for Mental Illness—7 Days	48.49%	53.02%
Follow-up After Hospitalization for Mental Illness—30 Days	66.89%	63.14%

* Lower rates are better for this measure.
NA is shown when the health plan followed HEDIS specifications but the denominator was too small (<30) to report a valid rate.

CAHPS Surveys

Three populations were surveyed for **HPN** and **Amerigroup**: adult Medicaid, child Medicaid, and Nevada Check Up. DSS Research, an NCQA-certified vendor, administered the 2015 CAHPS surveys for **HPN** and **Amerigroup**.

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

The survey questions were categorized into nine measures of satisfaction. These measures included four global ratings and five composite scores.[A-6] The global ratings reflected patients' overall satisfaction with their personal doctor, specialist, health plan, and all health care. The composite scores were derived from sets of questions to address different aspects of care (e.g., getting needed care and how well doctors communicate). When a minimum of 100 responses for a measure was not achieved, the result of the measure was denoted as Not Applicable (NA).

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

For each of the five composite scores, the percentage of respondents who chose a positive response was calculated. CAHPS composite question response choices fell into one of two categories: (1) Never, Sometimes, Usually, or Always; or (2) No or Yes. A positive or top-box response for the composites was defined as a response of Usually/Always or Yes. The percentage of top-box responses is referred to as a global proportion for the composite scores. A substantial increase or decrease is denoted by a change of 5 percentage points or more.

It is important to note that with the release of the 2015 CAHPS 5.0H Medicaid Health Plan Surveys, changes were made to the survey question language and response options for the Shared Decision Making composite measure. As a result of these changes, comparisons to the previous year's 2014 results and/or 2014 NCQA CAHPS national averages could not be performed for this composite measure for 2015. This was denoted with a dash (—).

[A-6] For purposes of this report, the 2015 CAHPS results presented for **HPN**'s and **Amerigroup**'s child Medicaid and Nevada Check Up populations are based on the CAHPS survey results of the general child population only (i.e., results for children selected as part of the general child CAHPS sample). Therefore, results for the CAHPS survey measures evaluated through the CCC measurement set of questions (i.e., five CCC composite scores and items) and CCC population are not presented in this report.

Health Care Guidance Program (HCGP) Compliance Review

At the request of the DHCFP, HSAG conducted a readiness review of **McKesson Health Solutions**, which later changed its name to **McKesson Technologies, Inc.** (**McKesson**), in March 2014. After completing the readiness review, HSAG provided feedback to the DHCFP and **McKesson** regarding the types of corrections to be made in order to satisfy all requirements of the readiness review. **McKesson** was required to work with the DHCFP staff to remediate any areas of concern discovered during the readiness review. At the time of the SFY 2014–2015 compliance review, there were several items that remained outstanding from the SFY 2013–2014 readiness review that had not been remedied by **McKesson.**

DHCFP requested that HSAG conduct an interim assessment of **McKesson**'s compliance with its contract within six months of **McKesson**'s program start date in June 2014. HSAG conducted a compliance review of **McKesson**'s HCGP December 10–11, 2014. The purpose of the SFY 2014–2015 compliance review was to verify that **McKesson** had operationalized key elements of the program once services commenced on June 1, 2014. The SFY 2014–2015 compliance review enabled HSAG to review elements that could not be reviewed during the March 2014 readiness review because the program had not yet begun. The period of time under review (review period) was June 1, 2014, through October 31, 2014.

Methodology for Collecting Data and Conducting the Compliance Review

HSAG performed the SFY 2014–2015 compliance review in two phases. Phase I focused on the operational structure of key areas of the program and consisted of a desk review of documentation and information supplied by **McKesson**. Phase II consisted of a two-day on-site review, which occurred December 10–11, 2014, in **McKesson**'s Carson City, Nevada, office.

On October 8, 2014, HSAG submitted a data request to **McKesson** to provide HSAG with program information and data files so HSAG could prepare for the review. HSAG reviewed all documentation submitted by **McKesson** prior to the on-site review. **McKesson** uploaded the following information to HSAG's secure file transfer protocol site by November 7, 2014, which was the required due date:

- **Questionnaire—**Used to collect additional information about **McKesson**'s operational structure, number and type of staff members designated to the Nevada HCGP, and counts of persons enrolled in the program by risk category, as well as the number and types of care management interventions that occurred during the review period (June 1–October 31, 2014).
- **Completed compliance review standards tool—**wherein **McKesson** listed all of the documents it offered as evidence of compliance with each element for each standard.
- **Care management data file—**Using the file layout specified by HSAG, **McKesson** listed the demographic information, dates of enrollment, dates of assessment, date the treatment plan was developed, and primary and secondary diagnoses of each individual who had been enrolled and assessed for care management services as of October 31, 2014.
- **Grievance data file—**Using the file layout specified by HSAG, **McKesson** listed all of the grievances filed by enrollees as of October 31, 2014.

Phase I Review Tools and Activities

Phase I consisted of a desk-review of **McKesson**'s completed questionnaire, policies and procedures, reports, guidelines, and other documentation that demonstrated compliance with contractual elements within the Compliance Review Standards tool. The completed questionnaire allowed HSAG to obtain additional information about **McKesson** and its operational structure. The questionnaire was not scored.

Review of Compliance with Standards

The Compliance Review Standards tool included 12 standards, which were based on the requirements of **McKesson**'s contract with the DHCFP. Table A-4 lists each of the standards contained in the tool.

Table A-4—Compliance Review Standards

Standard	Standard Name
I	Stratification of Enrollees
II	Care Management Teams
III	Care Planning
IV	Mental Health Care Management Services
V	Health Education Materials
VI	Nurse Triage and Call Services
VII	Emergency Department Redirection
VIII	Stakeholder Outreach and Education
IX	Feedback to PCPs
X	Provider Services
XI	Care Transitions
XII	Operational Structure and Reporting

HSAG used the Compliance Review Standards tool to record the findings from the review of **McKesson** documentation and interviews with key staff members during the on-site review. Within the review tool, **McKesson** completed the column labeled *Information Submitted as Evidence by McKesson*, to include all of the documents listed as evidence of compliance for each element. **McKesson** was encouraged to list and submit to HSAG any policies, procedures, reports, monitoring tools, screen prints, copies of emails, or other documentation that provided evidence of **McKesson**'s compliance with the contractually mandated elements. On November 7, 2014, **McKesson** uploaded the completed tool and associated documentation to HSAG's secure FTP site and organized the documents in subfolders labeled according to the corresponding standard.

From the documentation submitted by **McKesson** and interviews conducted with key staff members during the on-site review, HSAG scored each element within the Compliance Review Standards tool as either, *Met*, *Partially Met*, or *Not Met*. Any element that was not applicable to **McKesson** at the time of the review was scored as *N/A*, or *Not Applicable*. A composite score was calculated by summing the total possible points and dividing it by the total items scored as *Met* (1 point), *Partially Met* (0.5 point), or *Not Met* (0 points).

Care Management Enrollment Statistics

HSAG reviewed care management enrollment statistics from a care management file submitted by **McKesson**. From the file, HSAG calculated the total number of days between the date of enrollment into care management and the date the assessment and care management plan were completed for each enrollee. HSAG then averaged the total number of days between the enrollment date and assessment date for all enrollees. HSAG also calculated the average number of days from the enrollment date to the assessment date for enrollees who were pregnant at the time of enrollment.

Care Management Staffing

Within its questionnaire, **McKesson** submitted an organizational chart and a list of the number and type of full-time equivalent (FTE) staff members dedicated to the Nevada HCGP. HSAG reviewed number and type of care management staff members dedicated to the Nevada HCGP and who also had direct contact with enrollees during the review period. HSAG calculated the total number of **McKesson** and ValueOptions FTE staff members who had direct contact with enrollees. ValueOptions served as a subcontractor to **McKesson** and provided mental health case management services to HCGP enrollees under the direction of **McKesson**.

Checklists

HSAG reviewers also scored each element within checklists that corresponded to two standards within the Compliance Review Standards tool. The corresponding checklists were:

- **Checklist 1: Transitioning Recipients into Care Management.** The information collected using this checklist was recorded in Element 1 of Standard XI: Care Transitions, in the Compliance Review Standards tool.
- **Checklist 2: Required Reports.** The information collected using this checklist was recorded in Element 2 of Standard XII: Operational Structure and Reporting, in the Compliance Review Standards tool.

HSAG surveyors used the checklist to document findings of key elements in the contract related to transitions of care and required reports. HSAG's surveyors scored each applicable element within the tool as either *Yes*, the element was contained within the file, or *No*, the element was not contained in the file. Elements that were not applicable to the HCGP were scored as *N/A* and were not included in the denominator of the total score. To obtain a percentage score, HSAG added the total number of elements receiving a *Yes* score and divided it by the total number of applicable elements.

Phase II Review Tools and Activities

Phase II of the review consisted of a two-day on-site review at **McKesson**'s Carson City, Nevada, office. During the on-site review, HSAG interviewed key staff members to inquire about several items that were incomplete from the desk review of documentation. **McKesson** staff members were given the opportunity to provide additional documentation until the end of the second day of the on-

site review to provide evidence of **McKesson**'s compliance with a given element. HSAG surveyors assessed the additional information provided by **McKesson**'s staff and documented the findings in the Compliance Review Standards tool.

While on-site, HSAG reviewers assessed **McKesson**'s application of contractually required care management activities—identification, risk stratification, comprehensive assessments, care plan development, ongoing care management services, hospital discharge and care transitions, and care monitoring and reassessment—through a review of 20 enrollee care management records. The on-site review also consisted of a review of 10 enrollee grievances and **McKesson**'s processing of each grievance filed.

Care Management File Review

To obtain the list of enrollee records to be included in the review, **McKesson** provided a list of all enrollees in the HCGP who were currently receiving or had received care management services during the review period (June 1, 2014, through October 31, 2014). **McKesson** uploaded the complete list to HSAG on November 7, 2014, using the data file layout specified by HSAG. From the uploaded file, HSAG generated a list of 20 sample cases, plus an oversample of seven cases, and posted them to the HSAG secure FTP site for **McKesson** to retrieve five business days prior to the on-site review. While on-site, HSAG reviewed all 20 sample cases.

The care management file review tool was organized into five sections. The evaluation elements within each section were required by **McKesson**'s contract with the DHCFP. The five sections were:

- Section I: Enrollee Identification and Risk Stratification
- Section II: Enrollee Assessment
  - Primary care provider (PCP) selection
  - Linking enrollees to community resources
- Section III: Care Plan Development
- Section IV: Ongoing Care Management
  - Care transitions
  - Hospital discharge planning
- Section V: Care Monitoring and Reassessment

Using the Care Management File Review Tool, HSAG scored each element as either *Yes*, the element was contained within the file, or *No*, the element was not contained in the file. Elements that were not applicable to the enrollee were scored as *N/A* and were not included in the denominator of the total score. Elements in Section I were used to collect information about the enrollee and were not scored. For Sections II, III, IV, and V, HSAG surveyors added the number of elements receiving a *Yes* score for the respective section and divided it by the total number of applicable elements for the same section.

Grievance File Review

HSAG surveyors also reviewed grievance records during the on-site review. On November 7, 2014, **McKesson** staff members uploaded a grievance data file to HSAG's secure FTP site using a data file layout specified by HSAG. HSAG surveyors used the Grievance File Review Tool to document findings from a review of **McKesson**'s grievance records. From data provided by **McKesson**, HSAG selected 10 grievance records to review. HSAG's surveyors scored each applicable element within the tool as either *Yes*, the element was contained within the file, or *No*, the element was not contained in the file. Elements that were not applicable to the enrollee were scored as *N/A* and were not included in the denominator of the total score. For each component reviewed, HSAG added the number of elements receiving a *Yes* score for the respective component and divided it by the total number of applicable elements for the same component.

Appendix B. Quality Strategy Goals and Objectives Table

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

State of Nevada

Division of Health Care Financing and Policy

Quality Assessment and Performance Improvement Strategy (Quality Strategy)

Goals and Objectives Results for SFY 2014-2015

Goal 1:	**Improve the health and wellness of Nevada children by increasing the use of preventive services, thereby modifying health care use patterns for the population.**					
Objective 1.1:	Increase children's and adolescents' access to PCPs by 10 percent.					
	HPN 2014	QISMC Goal	**HPN 2015**	AGP 2014	QISMC Goal	**AGP 2015**
Medicaid:						
Children's Access to PCP (12-24 months)	91.73%	93.70%	**91.42%**	93.58%	95.36%	**91.14%**
Children's Access to PCP (25 months - 6 years)	78.58%	82.44%	**79.21%**	83.40%	86.16%	**81.29%**
Children's Access to PCP (7-11 years)	82.35%	84.69%	**83.88%**	84.96%	86.19%	**85.47%**
Adolescents' Access to PCP (12-19 years)	78.37%	80.94%	**81.05%**	80.97%	83.27%	**81.76%**
Nevada Check Up:						
Children's Access to PCP (12-24 months)	95.08%	97.26%	**94.70%**	98.85%	99.99%	**95.83%**
Children's Access to PCP (25 months - 6 years)	91.39%	93.57%	**87.20%**	94.11%	95.56%	**90.48%**
Children's Access to PCP (7-11 years)	94.88%	95.46%	**93.83%**	97.25%	97.35%	**92.62%**
Adolescents' Access to PCP (12-19 years)	91.49%	91.82%	**90.79%**	93.69%	93.97%	**92.18%**
Objective 1.2:	Increase well-child visits (0 - 15 Months) by 10 percent.					
	HPN 2014	QISMC Goal	**HPN 2015**	AGP 2014	QISMC Goal	**AGP 2015**
Medicaid:						
Well-Child Visits 0 - 15 Months of Life	54.50%	56.21%	**51.58%**	53.47%	60.21%	**50.58%**
Nevada Check Up:						
Well-Child Visits 0 - 15 Months of Life	63.01%	68.50%	**60.00%**	54.05%	56.15%	**70.37%**
Objective 1.3:	Increase well-child visits (3 - 6 Years) by 10 percent.					
	HPN 2014	QISMC Goal	**HPN 2015**	AGP 2014	QISMC Goal	**AGP 2015**
Medicaid:						
Well-Child Visits 3 - 6 Years of Life	54.74%	61.68%	**58.15%**	63.08%	68.84%	**65.05%**
Nevada Check Up:						
Well-Child Visits 3 - 6 Years of Life	73.72%	72.41%	**71.95%**	78.74%	80.94%	**71.30%**
Objective 1.4:	Increase the prevalence of blood lead testing for children 1-2 years of age by 10 percent.					
	HPN 2014	QISMC Goal	**HPN 2015**	AGP 2014	QISMC Goal	**AGP 2015**
Medicaid:						
Lead Screening in Children	37.23%	39.12%	**40.88%**	34.26%	41.04%	**35.88%**
Nevada Check Up:						
Lead Screening in Children	55.24%	55.48%	**42.75%**	50.44%	54.56%	**50.91%**
Objective 1.5:	Decrease avoidable emergency room visits by 10 percent.*					
	HPN 2014	QISMC Goal	**HPN 2015**	AGP 2014	QISMC Goal	**AGP 2015**
Medicaid:						
Avoidable Emergency Room Visit Rate*	42.90%	34.02%	**27.91%**	39.10%	37.26%	**33.75%**
Nevada Check Up:						
Avoidable Emergency Room Visit Rate*	41.70%	32.13%	**24.92%**	37.50%	35.19%	**34.84%**
*Lower rates are indicative of better performance for this measure.						

State of Nevada

Division of Health Care Financing and Policy

Quality Assessment and Performance Improvement Strategy (Quality Strategy)

Goals and Objectives Results for SFY 2014-2015

Goal 2:	**Increase use of evidence-based preventive treatment practices for Medicaid members with chronic conditions.**					
Objective 2.1:	Increase rate of HbA1c testing for members with diabetes by 10 percent.					
	HPN 2014	QISMC Goal	**HPN 2015**	AGP 2014	QISMC Goal	**AGP 2015**
Diabetes Care - HbA1c Testing	69.59%	72.98%	**77.13%**	73.99%	71.88%	**69.84%**
Objective 2.2:	Increase rate of monitoring for nephropathy for members with diabetes by 10 percent.					
	HPN 2014	QISMC Goal	**HPN 2015**	AGP 2014	QISMC Goal	**AGP 2015**
Diabetes Care - Nephropathy	72.75%	75.22%	**73.24%**	67.29%	67.59%	**67.52%**

Goal 3:	**Reduce and/or eliminate health care disparities for Medicaid and Nevada Check Up recipients.**			
Objective 3.1:	Ensure that health plans develop a cultural competency plan, which details the health plans' goals, objectives and processes for reducing and/or eliminating racial or ethnic disparities that negatively impact health care.			
	HPN 2014	**HPN 2015**	**AGP 2014**	**AGP 2015**
Plan Developed?	Yes	Yes	Yes	Yes
Objective 3.2:	Stratify data for performance measures and avoidable emergency room utilization by race and ethnicity to determine where disparities exist.			
	HPN 2014	**HPN 2015**	**AGP 2014**	**AGP 2015**
Medicaid: Stratified by Race and Ethnicity				
Performance Measures	Yes	Yes	Yes	Yes
Avoidable Emergency Room Visits	Yes	Yes	Yes	Yes
Nevada Check Up: Stratified by Race & Ethnicity				
Performance Measures	Yes	Yes	Yes	Yes
Avoidable Emergency Room Visits	Yes	Yes	Yes	Yes
Objective 3.3:	Ensure that health plans submit an annual evaluation of the cultural competency program (CCP) to DHCFP. Health plans must receive 100 percent *Met* compliance score for all of the criteria listed in the MCO contract for CCP development, maintenance, and evaluation.			
	HPN 2014	**HPN 2015**	**AGP 2014**	**AGP 2015**
CCP Evaluation Submitted?	Yes	Yes	Yes	Yes
MCO Fully Compliant with all CCP Provisions?	Yes	Yes	Yes	Yes

Goal 4:	**Improve the health and wellness of new mothers and infants and increase new-mother education about family planning and newborn health and wellness.**					
Objective 4.1:	Increase the rate of postpartum visits by 10 percent.					
	HPN 2014	QISMC Goal	**HPN 2015**	AGP 2014	QISMC Goal	**AGP 2015**
Medicaid:						
Postpartum Care	57.66%	68.50%	**51.58%**	59.22%	65.62%	**50.12%**

HPN - Health Plan of Nevada

AGP - Amerigroup Nevada, Inc.

Rates in **green** have met or exceeded the QISMC goal. QISMC goals were set based on 2013 rates.