



**Division of Health Care Financing and Policy
Nevada Medicaid Managed Care**

**State Fiscal Year 2016–2017 External
Quality Review Technical Report**

October 2017

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HEDIS® refers to the Healthcare Effectiveness Data and Information Set and is a registered trademark of the National Committee for Quality Assurance (NCQA).

NCQA HEDIS Compliance Audit™ is a trademark of NCQA.

1. Executive Summary

Overview of the SFY 2015–2016 External Quality Review

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

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

The Nevada Medicaid MCOs included in the state fiscal year (SFY) 2016–2017 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 expansion of enrollment was much higher than the DHCFP originally anticipated. In June 2013, enrollment in managed care was 193,455 and in June 2017, enrollment in managed care was 478,040, which is a 147 percent increase.

The SFY 2016–2017 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. The report focuses on three EQR activities, which were federally required during the time period. As described in 42 CFR §438.358, these activities are:

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

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

- Evaluated the State’s quality strategy and the managed care program’s achievement of the goals and objectives identified in the strategy. HSAG’s evaluation of the activities that occurred in support of the State’s quality strategy is presented in Section 2.
- Provided an analysis of the results of CAHPS activities conducted by the MCOs, which is presented in Section 7.
- Provided technical assistance to the DHCFP with activities related to the Nevada Comprehensive Care Waiver (NCCW) program, the fee-for-service care management program that resulted from Nevada’s section 1115(a) Medicaid research and demonstration waiver approved by CMS. The DHCFP contracted with a care management organization (CMO) to provide care management services to the enrolled population. The CMO’s care management program is called the Health Care Guidance Program (HCGP). HSAG’s technical assistance activities included:
 - Evaluating the HCGP Quality Strategy and developing a set of quality modules that the HCGP vendor must use to guide its quality-related presentations during the quarterly meetings.
 - Performing source code review of the programming code used to calculate pay for performance (P4P) measures used for the NCCW program, which will be calculated by the DHCFP’s actuary.
- Performed performance measure validation audit of non-P4P measures used to monitor the HCGP’s progress in achieving the goals and objectives of the NCCW demonstration waiver, which is presented in Section 8.

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

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

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

Lastly, consistent with 42 CFR §438.364(a)(6), HSAG has included in Section 9 of this report an assessment of the degree to which each MCO has effectively addressed recommendations for quality improvement that HSAG made in the previous year.

Internal Quality Assurance Program (IQAP)

SFY 2016–2017 was the third year of the three-year cycle of reviews for Nevada and all activities conducted in the previous two years are complete. SFY 2017–2018 initiates a new three-year cycle of reviews. HSAG will report on the SFY 2017–2018 IQAP results in the SFY 2017–2018 technical report.

Validation of Performance Measures—NCQA HEDIS Compliance Audits

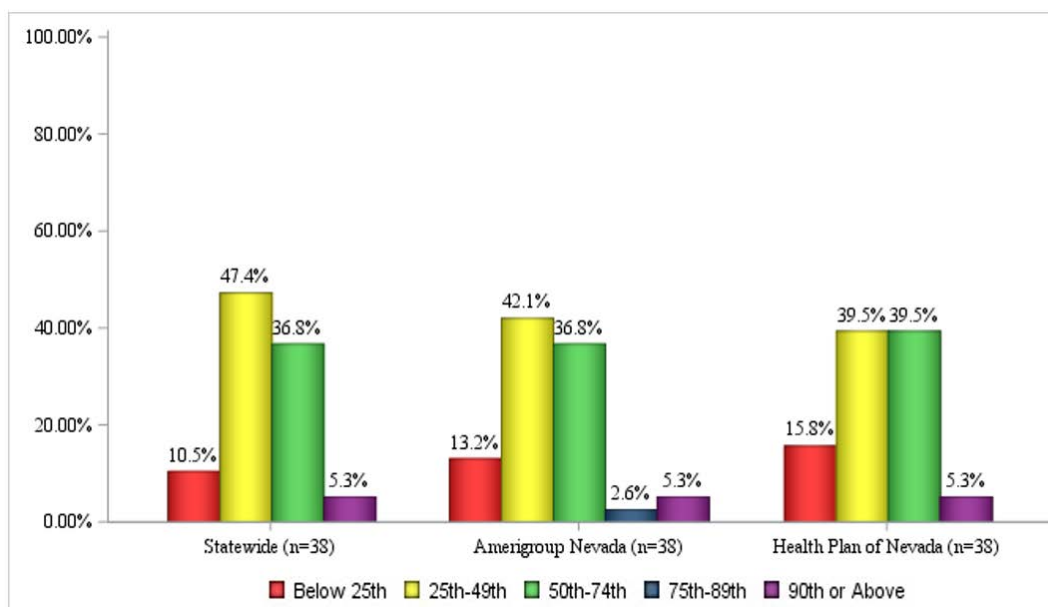
HSAG conducted an NCQA HEDIS Compliance Audit to assess **Amerigroup** and **HPN** performance with respect to the *HEDIS 2017 Technical Specifications* and to review the MCOs' performance on the HEDIS measures. For HEDIS 2017, the MCOs were required to report 17 measures yielding a total of 45 rates for the Medicaid population and 14 measures yielding a total of 35 rates for the Nevada Check Up population. HSAG validated all measures reported by the MCOs.

The audit demonstrated that both MCOs had strong policies and procedures to collect, process, and report HEDIS data for the Medicaid and Nevada Check Up populations, and both MCOs were in full compliance with the *HEDIS 2017 Technical Specifications*. The claims and encounter data systems the MCOs employed used sophisticated scanning processes and advanced software to ensure accurate data processing. Both MCOs used software, the source code of which NCQA certified, to generate HEDIS measure rates. This ensured accurate measure calculation.

Medicaid Findings

Figure 1-1 shows the percentage of Medicaid population rates for HEDIS 2017 for the statewide weighted average, **Amerigroup**, and **HPN** compared to NCQA's Quality Compass[®] national Medicaid HMO percentiles for HEDIS 2016.¹⁻¹

Figure 1-1—Percentage of HEDIS 2017 Performance Measures Rates for Medicaid Population Compared to HEDIS National Medicaid Percentiles



Note: Percentages may not total 100 percent due to rounding.

¹⁻¹ Quality Compass[®] is a registered trademark for the National Committee for Quality Assurance (NCQA).

For HEDIS 2017, approximately 55 percent of the MCOs' rates fell below the national Medicaid 50th percentile, which represented an improvement from HEDIS 2016 when approximately 85 percent of **Amerigroup**'s rates and 67 percent of **HPN**'s rates fell below the national Medicaid 50th percentile. As a result, approximately 45 percent of the MCOs' HEDIS 2017 rates ranked at or above the national Medicaid 50th percentile compared to HEDIS 2016, when only about 15 percent of **Amerigroup**'s rates and 33 percent of **HPN**'s rates ranked at or above the national Medicaid 50th percentile. However, most of the MCOs' HEDIS 2017 rates fell at or above the national Medicaid 25th percentile but below the 75th percentile, indicating continued opportunities for improvement with regard to national benchmark comparisons.

Table 1–1 presents the HEDIS 2017 MCO-specific rates and the statewide weighted average Medicaid rates along with star ratings based on rate comparisons to the Quality Compass national Medicaid percentiles for HEDIS 2016. Measure results were compared to benchmarks and rated using the following star ratings:

Table 1–1—HEDIS Star Ratings

Star Rating	Performance Level
★★★★★	At or above the national Medicaid 90th percentile
★★★★	At or above the national Medicaid 75th percentile but below the 90th percentile
★★★	At or above the national Medicaid 50th percentile but below the 75th percentile
★★	At or above the national Medicaid 25th percentile but below the 50th percentile
★	Below the national Medicaid 25th percentile

Table 1–2—HEDIS 2017 Results for Medicaid

HEDIS Measure	AGP	HPN	Medicaid
Access to Care			
<i>Children and Adolescents' Access to Primary Care Practitioners (CAP)</i>			
<i>Ages 12–24 Months</i>	93.83% ★★	95.17% ★★	94.55% ★★
<i>Ages 25 Months–6 Years</i>	82.25% ★	83.81% ★	83.08% ★
<i>Ages 7–11 Years</i>	86.59% ★	87.57% ★	87.16% ★
<i>Ages 12–19 Years</i>	82.95% ★	85.51% ★	84.54% ★
Annual Dental Visit (ADV)			
<i>Total</i>	51.63% ★★	53.85% ★★★	52.91% ★★★

HEDIS Measure	AGP	HPN	Medicaid
Children's Preventive Care			
Adolescent Well-Care Visits (AWC)			
Adolescent Well-Care Visits	47.69% ★★	44.77% ★★	45.88% ★★
Childhood Immunization Status (CIS)			
Combination 2	72.92% ★★	73.72% ★★	73.33% ★★
Combination 3	67.13% ★★	71.05% ★★	69.12% ★★
Combination 4	66.67% ★★	71.05% ★★★★	68.90% ★★★★
Combination 5	56.71% ★★	61.07% ★★★★	58.93% ★★
Combination 6	36.11% ★★	34.79% ★★	35.44% ★★
Combination 7	56.25% ★★	61.07% ★★★★	58.71% ★★★★
Combination 8	36.11% ★★	34.79% ★★	35.44% ★★
Combination 9	32.18% ★★	30.41% ★★	31.28% ★★
Combination 10	32.18% ★★	30.41% ★★	31.28% ★★
Immunizations for Adolescents (IMA)			
Combination 1 (Meningococcal, Tdap)	79.40% ★★★★	80.78% ★★★★	80.25% ★★★★
Combination 2 (Meningococcal, Tdap, HPV)	26.85% NC	27.49% NC	27.25% NC
Well-Child Visits in the First 15 Months of Life (W15)			
Six or More Well-Child Visits	62.50% ★★★★	62.77% ★★★★	62.64% ★★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)			
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	68.72% ★★	65.21% ★★	66.85% ★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)			
BMI Percentile—Total	70.14% ★★★★	71.78% ★★★★	71.10% ★★★★
Counseling for Nutrition—Total	62.73% ★★★★	62.29% ★★	62.47% ★★
Counseling for Physical Activity—Total	56.48% ★★★★	59.61% ★★★★	58.31% ★★★★

HEDIS Measure	AGP	HPN	Medicaid
Maternity Care			
<i>Prenatal and Postpartum Care (PPC)</i>			
<i>Timeliness of Prenatal Care</i>	83.33% ★★★	72.75% ★	77.85% ★★
<i>Postpartum Care</i>	62.50% ★★★	59.12% ★★	60.75% ★★
<i>Frequency of Ongoing Prenatal Care (FPC)</i>			
<i><21 Percent of Expected Visits*</i>	5.56% ★★★	11.19% ★★	8.47% ★★
<i>≥81 Percent of Expected Visits</i>	62.50% ★★★	60.83% ★★★	61.63% ★★★
Care for Chronic Conditions			
<i>Comprehensive Diabetes Care (CDC)</i>			
<i>Hemoglobin A1c (HbA1c) Testing</i>	81.02% ★	82.73% ★	82.10% ★
<i>HbA1c Poor Control (>9.0%)*</i>	46.30% ★★	42.82% ★★★	44.10% ★★
<i>HbA1c Control (<8.0%)</i>	45.60% ★★	48.42% ★★★	47.38% ★★★
<i>Eye Exam (Retinal) Performed</i>	59.49% ★★★	61.31% ★★★	60.64% ★★★
<i>Medical Attention for Nephropathy</i>	90.28% ★★	90.75% ★★★	90.58% ★★★
<i>Blood Pressure Control (<140/90 mm Hg)</i>	61.11% ★★★	50.36% ★	54.33% ★★
<i>Medication Management for People with Asthma (MMA)</i>			
<i>Medication Compliance 50%—Total¹</i>	56.19% ★★★	53.37% ★★	54.52% ★★
<i>Medication Compliance 75%—Total</i>	32.16% ★★★	32.81% ★★★	32.54% ★★★
Behavioral Health			
<i>Follow-Up After Hospitalization for Mental Illness (FUH)</i>			
<i>7-Day Follow-Up</i>	79.81% ★★★★★	79.16% ★★★★★	79.52% ★★★★★
<i>30-Day Follow-Up</i>	84.98% ★★★★★	84.20% ★★★★★	84.63% ★★★★★

HEDIS Measure	AGP	HPN	Medicaid
Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication (ADD)			
<i>Initiation Phase</i>	43.51% ★★★	43.68% ★★★	43.60% ★★★
<i>Continuation and Maintenance Phase</i>	64.91% ★★★★★	49.28% ★★	56.35% ★★★
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)^{2,*}			
<i>Total</i>	3.74% ★	2.26% ★★	2.92% ★★
Utilization and Diversity of Membership			
Mental Health Utilization (MPT)			
<i>Any Service (Total)</i>	8.63% NC	6.80% NC	7.57% NC
<i>Inpatient (Total)</i>	1.16% NC	0.78% NC	0.94% NC
<i>Intensive Outpatient or Partial Hospitalization (Total)</i>	0.24% NC	0.30% NC	0.28% NC
<i>Outpatient, ED, or Telehealth (Total)</i>	8.50% NC	6.73% NC	7.47% NC
Ambulatory Care (AMB)—Total			
<i>Outpatient Visits—Total</i>	287.09 NC	298.12 NC	293.47 NC
<i>ED Visits—Total*</i>	54.02 NC	52.60 NC	53.20 NC

* A lower rate indicates better performance for this measure.

¹ Quality Compass percentiles were not available for this measure; therefore, NCQA's HEDIS Audit Means and Percentiles was used as the comparative source for national Medicaid percentiles for this measure.

² Due to changes in NCQA's HEDIS 2017 technical specifications for this measure, exercise caution when comparing HEDIS 2017 rates for this measure to the national percentiles, since these values were derived using the HEDIS 2016 Technical Specifications.

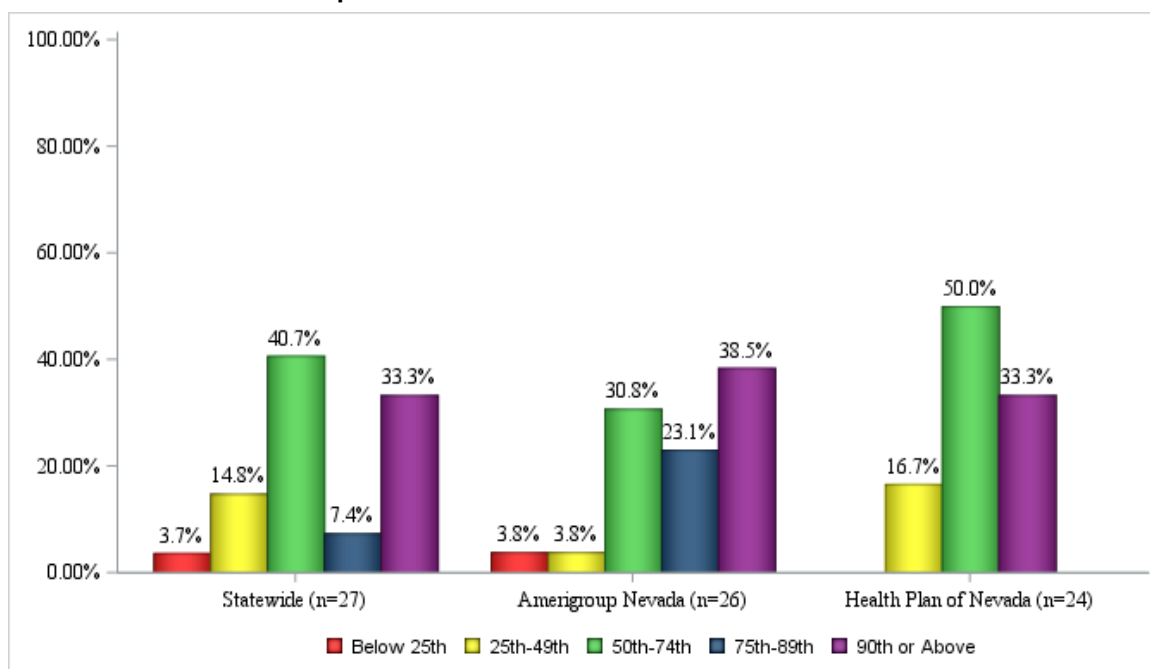
NC (i.e., Not Compared) indicates the HEDIS 2017 rate was not compared to benchmarks either because national Medicaid percentiles were not available or because the measure is presented only for information purposes and comparisons to benchmarks are not appropriate.

Amerigroup's and HPN's HEDIS 2017 rates for the Medicaid population indicate positive performance related to timely follow-up care for members hospitalized for mental illness, but there are areas for improvement related to access to care for children and adolescents, and appropriate HbA1c testing for members with diabetes. Additionally, HPN's rates present opportunities for improved prenatal care timeliness for pregnant women, blood pressure control for members with diabetes, and follow-up care for children on ADHD medication.

Nevada Check Up Findings

Figure 1-2 shows the percentage of Nevada Check Up population rates for HEDIS 2017 for the statewide weighted average, **Amerigroup**, and **HPN** as compared to NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS 2016.¹⁻²

Figure 1-2—Percentage of HEDIS 2017 Performance Measures Rates for Nevada Check Up Population Compared to HEDIS Medicaid National Percentiles



Note: Percentages may not total 100 percent due to rounding.

For HEDIS 2017, approximately 92 percent of **Amerigroup**'s rates ranked at or above the national Medicaid 50th percentile, which represented an improvement from HEDIS 2016 when approximately 73 percent of its rates reached this percentile ranking. Most notably, from HEDIS 2016 to 2017 the number of rates that ranked approximately between the national Medicaid 50th and 75th percentiles increased from about 23 percent to almost 31 percent, and the number of rates ranking at or above the national Medicaid 90th percentile increased from about 31 percent to approximately 39 percent. Further, the number of **Amerigroup**'s rates that fell below the national Medicaid 50th percentile decreased from approximately 27 percent for HEDIS 2016 to about only 8 percent for HEDIS 2017.

Percentile rankings for **HPN**'s rates shifted downward from 48 percent of its HEDIS 2016 rates ranking approximately between the national Medicaid 50th and 90th percentiles to 50 percent of its HEDIS 2017 rates ranking approximately between the national Medicaid 50th and 75th percentiles. Shifts in the

¹⁻² Because national benchmarks for HEDIS measures are not available for the CHIP population, comparisons of Nevada's Check Up population rates to the national Medicaid percentiles should be interpreted with caution.

national benchmark comparisons indicate opportunities for **HPN** to focus efforts on determining root causes linked to declines in performance.

Table 1–3 presents the HEDIS 2017 MCO-specific rates and the statewide weighted average Nevada Check Up rates along with star ratings based on comparisons of the rates to the Quality Compass national Medicaid percentiles for HEDIS 2016.

Table 1–3—HEDIS 2017 Results for Nevada Check Up

HEDIS Measure	AGP	HPN	NV Check Up
Access to Care			
<i>Children and Adolescents' Access to Primary Care Practitioners (CAP)</i>			
<i>Ages 12–24 Months</i>	98.18% ★★★★★	98.50% ★★★★★	98.36% ★★★★★
<i>Ages 25 Months–6 Years</i>	89.45% ★★★	89.61% ★★★	89.54% ★★★
<i>Ages 7–11 Years</i>	91.83% ★★★	92.98% ★★★	92.55% ★★★
<i>Ages 12–19 Years</i>	91.08% ★★★	91.29% ★★★	91.22% ★★★
<i>Annual Dental Visit (ADV)</i>			
<i>Total</i>	67.81% ★★★★★	68.88% ★★★★★	68.48% ★★★★★
Children's Preventive Care			
<i>Adolescent Well-Care Visits (AWC)</i>			
<i>Adolescent Well-Care Visits</i>	60.88% ★★★★	54.74% ★★★	56.79% ★★★
<i>Childhood Immunization Status (CIS)</i>			
<i>Combination 2</i>	91.16% ★★★★★	84.38% ★★★★★	87.39% ★★★★★
<i>Combination 3</i>	82.87% ★★★★★	82.14% ★★★★★	82.47% ★★★★★
<i>Combination 4</i>	81.22% ★★★★★	82.14% ★★★★★	81.73% ★★★★★
<i>Combination 5</i>	72.93% ★★★★★	71.88% ★★★★★	72.34% ★★★★★
<i>Combination 6</i>	47.51% ★★★★	41.52% ★★★	44.18% ★★★
<i>Combination 7</i>	72.38% ★★★★★	71.88% ★★★★★	72.10% ★★★★★
<i>Combination 8</i>	47.51% ★★★★	41.52% ★★★	44.18% ★★★

HEDIS Measure	AGP	HPN	NV Check Up
<i>Combination 9</i>	44.75% ★★★★	37.50% ★★★	40.72% ★★★
<i>Combination 10</i>	44.75% ★★★★	37.50% ★★★	40.72% ★★★
Immunizations for Adolescents (IMA)			
<i>Combination 1 (Meningococcal, Tdap)</i>	83.61% ★★★★	87.59% ★★★★★	86.28% ★★★★
<i>Combination 2 (Meningococcal, Tdap, HPV)</i>	38.46% NC	38.69% NC	38.61% NC
Well-Child Visits in the First 15 Months of Life (W15)			
<i>Six or More Well-Child Visits</i>	78.92% ★★★★★	63.49% ★★★	70.70% ★★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)			
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	76.16% ★★★	67.64% ★★	71.34% ★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)			
<i>BMI Percentile—Total</i>	71.30% ★★★	73.24% ★★★	72.52% ★★★
<i>Counseling for Nutrition—Total</i>	65.28% ★★★	61.07% ★★	62.61% ★★
<i>Counseling for Physical Activity—Total</i>	59.72% ★★★	58.39% ★★★	58.88% ★★★
Care for Chronic Conditions			
Medication Management for People with Asthma (MMA)			
<i>Medication Compliance 50%—Total¹</i>	58.43% ★★★	51.02% ★★	53.81% ★★
<i>Medication Compliance 75%—Total</i>	24.72% ★	27.89% ★★	26.69% ★★
Behavioral Health			
Follow-Up After Hospitalization for Mental Illness (FUH)			
<i>7-Day Follow-Up</i>	82.50% ★★★★★	NA	80.00% ★★★★★
<i>30-Day Follow-Up</i>	97.50% ★★★★★	NA	92.31% ★★★★★
Follow-Up Care for Children Prescribed ADHD Medication (ADD)			
<i>Initiation Phase</i>	41.67% ★★	48.89% ★★★	45.68% ★★★
<i>Continuation and Maintenance Phase</i>	NA	NA	NA

HEDIS Measure	AGP	HPN	NV Check Up
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)^{2,*}			
<i>Total</i>	NA	NA	5.71% ★
Utilization and Diversity of Membership			
Mental Health Utilization (MPT)			
<i>Any Service (Total)</i>	5.68% NC	5.19% NC	5.38% NC
<i>Inpatient (Total)</i>	0.42% NC	0.22% NC	0.29% NC
<i>Intensive Outpatient or Partial Hospitalization (Total)</i>	0.16% NC	0.77% NC	0.53% NC
<i>Outpatient, ED, or Telehealth (Total)</i>	5.64% NC	5.18% NC	5.36% NC
Ambulatory Care (AMB)—Total			
<i>Outpatient Visits—Total</i>	258.30 NC	252.28 NC	254.60 NC
<i>ED Visits—Total*</i>	26.30 NC	22.11 NC	23.73 NC

* A lower rate indicates better performance for this measure.

¹ Quality Compass percentiles were not available for this measure; therefore, NCQA's HEDIS Audit Means and Percentiles was used as the comparative source for national Medicaid percentiles for this measure.

² Due to changes in NCQA's HEDIS 2017 technical specifications for this measure, exercise caution when comparing HEDIS 2017 rates for this measure to the national percentiles, since these values were derived using the HEDIS 2016 Technical Specifications.

NC (i.e., Not Compared) indicates the HEDIS 2017 rate was not compared to benchmarks either because national Medicaid percentiles were not available or because the measure is presented only for information purposes and comparisons to benchmarks are not appropriate.

NA (i.e., Small Denominator) indicates the health plan(s) followed the specifications, but the denominator was too small (<30) to report a valid rate.

Amerigroup's and **HPN's** HEDIS 2017 rates for the Nevada Check Up population indicate positive performance related to access to primary care, dental care, and immunizations for children.

Amerigroup's rates also demonstrate timely follow-up care for members hospitalized for mental illness. Conversely, **HPN's** rates present improvement opportunities for access to well-child visits for infants. As mentioned above, comparisons between Nevada's Check Up population rates to national Medicaid benchmarks should be interpreted with caution.

Validation of Performance Improvement Projects (PIPs)

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

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

In SFY 2016–2017, the MCOs continued using the rapid-cycle PIP approach for the two DHCFP selected PIP topics: *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents*, and *Behavioral Health Hospital Readmissions*. The topics addressed CMS requirements related to quality outcomes, specifically the quality and timeliness of, and access to, care and services. Upon final validation, each PIP was given a validation score of either *High Confidence*, *Confidence*, *Low Confidence*, or *PIP Results Were Not Credible*. See Appendix A for a detailed description of PIP validation scoring.

Table 1–4—PIP Results

PIP Title	Amerigroup PIP Module Results	HPN PIP Module Results
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents</i>	Module 4: <i>Achieved</i> Module 5: <i>Partially Achieved</i> Confidence Level: <i>Low confidence</i>	Module 4: <i>Achieved</i> Module 5: <i>Achieved</i> Confidence Level: <i>Confidence</i>
<i>Behavioral Health Hospital Readmissions</i>	Module 4: <i>Achieved</i> Module 5: <i>Partially Achieved</i> Confidence Level: <i>Low confidence</i>	Module 4: <i>Achieved</i> Module 5: <i>Partially Achieved</i> Confidence Level: <i>PIP results not credible</i>

Summary of Amerigroup’s PIP Performance

Upon initial validation of Module 5 for Amerigroup’s PIP, *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents*, HSAG identified opportunities for Amerigroup to improve how it summarized the specific, measurable, attainable, relevant, and time-bound (SMART) Aim measure outcomes and findings. After receiving guidance from HSAG, Amerigroup made the necessary corrections and submitted Module 5 for final validation. After final validation of three components that comprised the PIP, Amerigroup achieved all of the Module 5

validation criteria and documentation requirements. HSAG assigned a level of *Low Confidence* to the PIP because the SMART Aim goal was only achieved for two of the three measure components. For the two components that did achieve the respective goals, **Amerigroup** is encouraged to determine the interventions that were most successful and spread those interventions to a larger population.

Upon initial validation of Module 5 for **Amerigroup**'s *Behavioral Health Hospital Readmissions* PIP, HSAG identified opportunities for **Amerigroup** to improve how it summarized the SMART Aim measure outcomes and findings. After receiving HSAG's guidance, **Amerigroup** made the necessary corrections and submitted Module 5 for final validation. After final validation, **Amerigroup** achieved all of Module 5's validation criteria and documentation requirements. HSAG assigned a level of *Low Confidence* to the PIP because the SMART Aim goal was not achieved. **Amerigroup** is encouraged to continue the PDSA cycle of improvement to test other interventions to determine if they are successful in achieving the SMART Aim goal.

Summary of HPN's PIP Performance

Upon initial validation of Module 5 for **HPN**'s PIP, *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents*, HSAG identified opportunities for improvement with the MCO's narrative summary of findings and its documentation related to how it will sustain improvement beyond the SMART Aim end date. HSAG provided **HPN** with technical assistance to discuss the initial validation feedback. **HPN** resubmitted Module 5 after making corrections; upon final validation, all of the validation criteria were met. Although the MCO exceeded the SMART Aim goal for all three measure components, this occurred before intervention testing and there was no clear link between the demonstrated improvement and all of the MCO's quality improvement activities. HSAG assigned a level of *Confidence* to the PIP.

Upon initial validation of Module 5 for **HPN**'s *Behavioral Health Hospital Readmission* PIP, HSAG identified opportunities for improvement with the MCO's narrative summary of findings and the execution of the PIP methodology. HSAG provided **HPN** with technical assistance to discuss the initial validation feedback. **HPN** resubmitted Module 5 after making corrections; however, due to **HPN** changing the top 50 super-utilizer eligible population and not executing the PIP as approved, not all validation criteria could be achieved despite the resubmission. HSAG assigned a level of *Reported PIP Results Were Not Credible* because the MCO did not execute the PIP as designed by **HPN** and approved by HSAG. **HPN** requested a rescoring of the PIP based on additional information it provided in a letter and a teleconference meeting with HSAG; however, the MCO would have been required to recreate and resubmit Modules 4 and 5 in order for HSAG to revalidate the PIP. Since the time period for resubmission had passed and SFY 2016–2017 was closed, the DHCFP advised HSAG and **HPN** to close the PIP. To initiate the new PIPs for SFY 2017–2018, HSAG's PIP team members have provided weekly technical assistance sessions to **HPN** staff members at **HPN**'s request.

Summary of the Quality and Timeliness of, and Access to, Care Furnished by MCOs

Amerigroup

Overall, **Amerigroup** demonstrated strengths related to measures and activities that related to quality of care. Performance measures like *Immunizations for Adolescents*, *Well Child Visits in the First 15 Months of Life*, *Comprehensive Diabetes Care—Blood Pressure Control*, and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*, which are also related to one of the MCO's PIPs, require the provider to perform the services that meet numerator compliance and properly document the services in the medical record. Over the last several years, **Amerigroup** staff members have reported an increase in provider outreach and education by **Amerigroup** clinical staff members to coach providers on proper documentation and coding in order to show numerator compliance with HEDIS measures and fill gaps in care noted by the MCO. Based on the MCO's performance, it is plausible that these interventions are having an impact. Quality-related performance measures like *Frequency of Prenatal Care* and *Medication Management for People with Asthma* all require effort on the part of the provider and the member to meet the required service and achieve numerator compliance. These measures demonstrated strong performance for **Amerigroup**.

Performance measures like *Timeliness of Prenatal Care*, *Postpartum Care*, *Follow-Up Care for Children Prescribed ADHD Medication*, and *Follow-Up After Hospitalization for Mental Illness* demonstrated strong performance and are indicative of MCO- and provider-level initiatives that impact access to services within a specified time period to improve the efficacy of care. The quality initiatives that have been implemented, as reported by **Amerigroup** staff members during quarterly quality meetings with the DHCFP and HSAG, have included increased outreach and care management for members with mental illness so they can coordinate outpatient services upon discharge from inpatient facilities. These initiatives also have the potential to reduce behavioral health readmissions, which was one of the MCO's PIP topics. **Amerigroup** staff members also have increased education and incentives to pregnant women so they can obtain the required prenatal and postpartum care visits and also have increased incentives to providers to submit service encounters for all prenatal and postpartum service visits.

Amerigroup demonstrates opportunities for improvement related to *Children and Adolescents' Access to Primary Care Practitioners*, which falls within the access domain, as well as for *Use of Multiple Concurrent Antipsychotics in Children and Adolescents* and *Comprehensive Diabetes Care—HbA1c Testing* for members with diabetes, all of which are quality-related measures. **Amerigroup**'s CAHPS results also show opportunities for improvement based on members' perceptions of access to care and quality of the visit with the provider. For opportunities for improvement, HSAG encourages **Amerigroup** to conduct a comprehensive causal barrier analysis and apply the PDSA cycle of performance improvement to identify and test interventions that have the potential to improve performance in these areas. The approach uses resources more efficiently and implements improvement interventions that may improve performance.

HPN

Overall, **HPN** demonstrated strengths related to measures and activities that fell within the domain of quality of care. Performance measures like *Immunizations for Adolescents*, *Well Child Visits in the First 15 Months of Life*, and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*, which are also related to one of the MCO's PIPs, require the provider to perform the services that meet numerator compliance as well as to properly document the services in the medical record. Quality-related performance measures like *Comprehensive Diabetes Care—Poor Control*, *Comprehensive Diabetes Care—HbA1c Control*, *Comprehensive Diabetes Care—Eye Exams*, *Comprehensive Diabetes Care—Medical Attention for Nephropathy*, and *Medication Management for People with Asthma* require effort from both the provider and the member to meet the required service and achieve numerator compliance. Over the last several years, **HPN** staff members have reported an increase in case management services for people with diabetes, member outreach regarding immunizations and well-child visits, and provider outreach and education by **HPN** clinical staff members to educate providers on addressing gaps in care. Based on the MCO's performance, it is plausible that these interventions are having an impact.

Performance measures like *Follow-Up Care for Children Prescribed ADHD Medication* and *Follow-Up After Hospitalization for Mental Illness* demonstrated strong performance and are indicative of MCO- and provider-level initiatives that impact access to services within a specified time period to increase the efficacy of care. **HPN** staff members' presentations during quarterly quality meetings with the DHCFP and HSAG staff members showed that behavioral health care manager outreach to persons prior to discharge from an inpatient mental health facility was very effective in securing timely follow-up appointments after members were discharged from mental health services. These interventions have the potential to reduce behavioral health readmissions, which was one of the MCO's PIP topics.

Performance measures like *Timeliness of Prenatal Care*, *Postpartum Care*, and *Children and Adolescents' Access to Primary Care Providers*, which demonstrated opportunities for improvement, are access-related measures. According to **HPN**'s 2016 Quality Improvement Program Evaluation, initiatives like expanding the physician network to increase availability and access to care and connecting members with primary care physicians were planned for 2017. These access-related initiatives have the potential to improve accessibility to these services.

HPN demonstrates opportunities for improvement related to HbA1c testing and blood pressure control for members with diabetes, which are quality-related measures. The **HPN** 2016 Quality Improvement Program Evaluation showed an evaluation and analysis (e.g., by race and ethnicity) of comprehensive diabetes care indicators; however, HbA1c testing was not included as one of the evaluated indicators. HSAG recommends that **HPN** analyze data related to HbA1c testing as it does for other diabetes-related indicators to identify opportunities for improvement and potential disparities among the data. This will enable **HPN** to identify interventions that may be targeted to the subpopulations that have the least numerator compliance for the measure. **HPN**'s CAHPS results also showed opportunities for improvement based on members' perceptions of the quality of the visit with the provider. For all opportunities for improvement, HSAG encourages **HPN** to conduct a comprehensive causal barrier analysis and apply the PDSA cycle of performance improvement to identify and test interventions that

have the potential to improve performance in these areas. The approach uses resources more efficiently and implements improvement interventions that have the potential to improve performance.

Pay-For-Performance Opportunities for Both MCOs

For the managed care contract that started on July 1, 2017, each MCO may receive P4P bonus awards for up to six performance indicators based on each MCO's performance on each indicator. Given the financial incentive, the MCOs likely will see a positive return on investment for interventions implemented to improve the rates for the following P4P measures:

- *Children and Adolescents Access to Primary Care Practitioners—12 Months–24 Months*
- *Children and Adolescents Access to Primary Care Practitioners—25 Months–6 Years*
- *Children and Adolescents Access to Primary Care Practitioners—12 Years–19 Years*
- *Childhood Immunization Status—Combination 10*
- *Comprehensive Diabetes Care—HbA1c Testing*
- *Frequency of Ongoing Prenatal Care—Greater than 81 Percent of Visits*

HCGP Performance Measure Validation (PMV)

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

The DHCFP sought to verify that, on an annual basis, **AxisPoint Health (APH)** collected and reported complete and accurate performance measure data for contractually required performance measures. To verify the accuracy of **APH**'s reported rates, the DHCFP contracted with HSAG to validate the performance measure rates that **APH** calculated and reported. To ensure that the PMV activity was performed in accordance with industry standards of practice, HSAG validated **APH**'s performance measures using the EQR Protocol 2¹⁻³ developed by CMS as its guide. HSAG's PMV activity focused on the following objectives:

1. Assess the accuracy of the required performance measures reported by **APH**.

¹⁻³ Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 1, 2012. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html>. Accessed on: Jul 18, 2017.

2. Determine the extent to which the measures that **APH** calculated followed the DHCFP's specifications and reporting requirements.

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

Performance Measure Validation Findings

This audit reviewed 22 performance measures. All of the measures were determined to be reportable by **APH** for the reporting period under review; however, there were several issues identified during the on-site audit.

It was determined during the audit for the first program period (June 1, 2014, through May 30, 2015), that all of the indicators (numerators) for the *Childhood Immunization Status* measure were under-reported and based solely on administrative data. Without immunization data from the State registry or medical record review, this measure's rates were too low to derive effective conclusions. The State provided the immunization registry data to **APH** for both program periods during the second program period (June 1, 2015, through May 30, 2016). **APH** calculated the current program period immunization rates and recalculated them for the first program period. The rates for both program periods were approved.

For the *Stroke and Stroke Rehabilitations—Discharged on Antithrombotic Therapy (NEUR)* measure, the denominator remained low for the second program period. Members in the denominator must have been in the HCGP program the entire program period. The numerator only included members who were discharged on antithrombotic therapy.

The *Adult Kidney Disease—Laboratory Testing (CKD)* measure evaluated whether a member with kidney disease had a fasting lipid profile completed during the program year. The rate provided by **APH** was 0.00 percent. A line-by-line evaluation of the source code identified that the code aligned with the technical specifications. However, the auditor determined that the technical specifications did not include the most common CPT code (80061) used for the fasting lipid profile. During the on-site visit, **APH** recalculated the measure to determine the impact of the missing code 80061. The results of the recalculation increased the rate to more than 77 percent.

During the first program year, for the *Cognitive Assessment for Dementia (DEM)* measure **APH** was not able to fully identify the denominator. **APH** applied the State-allowed changes to the denominator code, which improved the identification of dementia. However, the numerator for this measure continued to be problematic for **APH**. Its providers were not submitting claims that incorporated the CPT code for the assessment. Since the members with dementia were identified, it is likely the majority of those members had an assessment completed.

The weight assessment body mass index (BMI) component of the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children Adolescents (OBS)* measure for both age groups (3–11 and 12–18 years of age) had no administrative data and was reported as 0.0 percent. The source code appeared to use the adult BMI code set instead of the child BMI code set. During the on-site visit, **APH** corrected its source code and the new rates were considered reportable. It was also noted by the auditor that the rates produced by Milliman were low.

As identified during the first program year's audit, the rates for *Timeliness of Prenatal Care*, *Postpartum Care*, and *Frequency of Ongoing Prenatal Care* were very low compared to national percentiles. Global billing practices may have impacted these rates. Global billing is the submission of a single claim for a fixed fee that covers all care related to a certain condition over a particular period of time, such as billing for prenatal and postpartum care visits in conjunction with the delivery. Since generally only global billing is submitted for the duration of the woman's pregnancy, performance measures could be under-reported without medical record abstraction to augment records found to be numerator-compliant. *Timeliness of Prenatal Care*, *Postpartum Care*, and *Frequency of Ongoing Prenatal Care* rates were considered reportable since the calculation of the measures met the technical specifications, and a true under-reported bias could not be ascertained during the audit.

Overall, **APH** would benefit from conducting a rigorous evaluation of its performance as it relates to the performance measures adopted for the HCGP. It was not clear from the PMV audit or from quarterly quality meetings with **APH** whether the contractor conducts regular subgroup analyses of its quality measures to examine what might be impacting numerator noncompliance. Although DHCFP staff members have pressed the importance and educated **APH** on the need for continually evaluating data and applying quality improvement strategies to improve performance on the population overall, **APH** remains fixated on evaluating the performance on the less than 3,000 enrollees (of 39,000 enrolled) who are served through active case management. HSAG recommends that **APH** follow the expectations outlined to **APH** in the 2017 Quality Strategy Modules, which state:

DHCFP expects that **APH** will monitor these performance measures on an ongoing basis and calculate the rates regularly to determine if any of the interventions used by **APH** to improve rates are having the desired effect. Further, DHCFP expects that **APH** will apply a continuous quality improvement approach and conduct barrier analyses on performance measure rates that appear to be stagnant or have declined over time.

2. Overview of Nevada Managed Care Program

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 an SPA, a state ensures that individuals will have a choice of at least two managed care organizations (MCOs) in each geographic area. When fewer than two MCOs are available, the managed care program must be voluntary. In Nevada, there are two geographic areas, the urban areas of Clark and Washoe counties, covered by mandatory managed care.

In April 1997, Nevada implemented voluntary managed care with several vendors. It contracted with **Health Plan of Nevada (HPN)** and **Amil International (Amil)** to provide services in Clark County, and with **Hometown Health Plan** for services in Washoe County 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 July 1, 2013. Both **HPN** and **Amerigroup** were selected to serve as the MCOs in Clark and Washoe counties through June 30, 2017. This report displays the results from the external quality review (EQR) activities performed during SFY 2016–2017.

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

- AM—Parents and Caretakers
- AM1—Expanded Parent and Caretakers
- CH—Poverty Level Children and Pregnant Women
- CH1—Expanded Children’s Group Ages 6–18 Years
- CH5—Omnibus Budget Reconciliation Act (OBRA)
- CA—Childless Adults, Without Dependents, Ages 19–64 Years
- TR—Transitional Medicaid
- PM—Post Medical
- NC—Nevada Check Up—State CHIP Program for Children Under 19 Years

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

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

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. For example, in June 2013, enrollment in managed care was 193,455 and in June 2017, enrollment in managed care was 478,040, which is a 147 percent increase.

Table 2-1 presents the gender and age bands of Nevada Medicaid- and CHIP-enrolled recipients as of June 2017. 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 2017 Members
Males and Females <1 Year of Age	18,740
Males and Females 1–2 Years of Age	29,909
Males and Females 3–14 Years of Age	144,901
Females 15–18 Years of Age	16,477
Males 15–18 Years of Age	16,242
Females 19–34 Years of Age	69,538
Males 19–34 Years of Age	40,964
Females 35+ Years of Age	65,222
Males 35+ Years of Age	53,087
Total Medicaid	455,080

Gender/Age Band	June 2017 Members
Males and Females <1 Year of Age	155
Males and Females 1–2 Years of Age	1,456
Males and Females 3–14 Years of Age	16,541
Females 15–18 Years of Age	2,388
Males 15–18 Years of Age	2,420
Total CHIP	22,960
Total Medicaid and CHIP	478,040

Table 2-2 presents enrollment of Medicaid recipients by MCO and county for June 2017.

Table 2-2—June 2017 Nevada MCO Medicaid Recipients

MCO	Total Eligible Clark County	Total Eligible Washoe County
HPN	232,673	34,223
Amerigroup	164,771	23,413
Total	397,444	57,636

Table 2-3 presents enrollment of CHIP recipients in the Nevada Check Up program by MCO and by county for June 2017.

Table 2-3—June 2017 Nevada MCO CHIP (Nevada Check Up) Recipients

MCO	Total Eligible Clark County	Total Eligible Washoe County
HPN	11,397	2,698
Amerigroup	7,402	1,463
Total	18,799	4,161

Table 2-4 presents the ethnic composition of Nevada MCO Medicaid recipients in June 2017.

Table 2-4—June 2017 Nevada MCO Medicaid Ethnic Composition

Ethnicity	Total Eligible Clark County	Total Eligible Washoe County
Asian or Pacific Islander Non-Hispanic	14,852	1,518
Black Non-Hispanic	98,002	3,284
Hispanic	36	20

Ethnicity	Total Eligible Clark County	Total Eligible Washoe County
Am Indian/Alaskan Non-Hispanic	1,348	661
Am Indian/Alaskan and White	414	121
Asian and White	1,183	222
Black African Am and White	3,284	428
Am Indian/Alaskan and Black	969	106
Other Non-Hispanic	34,013	3,392
Asian/Pacific Islander Hispanic	937	167
Black Hispanic	1,788	125
Am Indian/Alaskan Hispanic	215	44
White Hispanic	132,576	19,038
White Non-Hispanic	107,729	28,608
Total	397,346	57,734

Table 2-5 presents the ethnic composition of CHIP recipients in the Nevada Check Up program for June 2017.

Table 2-5—June 2017 Nevada MCO CHIP (Nevada Check Up) Ethnic Composition

Ethnicity	Total Enrolled Clark County	Total Enrolled Washoe County
Asian or Pacific Islander Non-Hispanic	769	82
Black Non-Hispanic	1,897	63
Hispanic	2	1
Am Indian/Alaskan Non-Hispanic	35	51
Am Indian/Alaskan and White	17	6
Asian and White	82	19
Black African Am and White	113	16
Am Indian/Alaskan and Black	63	6
Other Non-Hispanic	1,759	272
Asian/Pacific Islander Hispanic	55	18
Black Hispanic	75	3
Am Indian/Alaskan Hispanic	17	7
White Hispanic	10,387	2,546
White Non-Hispanic	3,568	1,031
Total	18,839	4,121

Network Capacity Analysis

With the May 2016 release of revised federal regulations for managed care, CMS required states to set standards to ensure ongoing state assessment and certification of MCO, prepaid inpatient health plan, and prepaid ambulatory health plan networks; set threshold standards to establish network adequacy measures for a specified set of providers; establish criteria to develop network adequacy standards for managed long-term services and supports programs; and ensure the transparency of network adequacy standards. The requirement stipulates that states must establish time and distance standards for the following network provider types: primary care (adult and pediatric); obstetricians/gynecologists; behavioral health; specialist (adult and pediatric); hospital; pharmacy; pediatric dental; and additional provider types when they promote the objectives of the Medicaid program for the provider type to be subject to such time and distance standards. The DHCFP is working with the Nevada Department of Insurance to develop these standards. Once the standards are finalized, the DHCFP will use them as part of its network capacity monitoring of the managed care program.

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 §438.340 require Medicaid state agencies that operate Medicaid managed care programs to develop and implement a written quality strategy to assess and improve the quality of health care services offered to Medicaid members. The written strategy must describe the standards that a state and its contracted MCOs and prepaid inpatient health plans must meet. This section outlines the goals and objectives of the DHCFP 2016–2017 Quality Strategy as well as the annual evaluation of the strategy for SFY 2016–2017.

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. The Nevada Department of Health and Human Services (DHHS) director has identified three priority focus areas for Nevada Medicaid: prevention, early intervention, and quality treatment. Consistent with the State's mission and DHHS priority areas, the purpose of the DHCFP's 2016–2017 Quality Strategy is to:

- Establish a comprehensive quality improvement system that was consistent with the Triple Aim adopted by CMS to achieve better care for patients, better health for communities, and lower costs through improvement in the health care system.
- Provide a framework for the DHCFP to design and implement a coordinated and comprehensive system to proactively drive quality throughout the Nevada Medicaid and Nevada Check Up system.

The Quality Strategy promotes the identification of creative initiatives to continually monitor, assess, and improve access to care, clinical quality of care, and health outcomes of the population served.

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

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

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

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

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

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

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

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

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

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

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

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

Objective 1.5: Increase immunizations for adolescents.

Objective 1.6: Increase annual dental visits for children.

Objective 1.7: Increase human papillomavirus vaccine for female adolescents.²⁻¹

Objective 1.8: Increase adolescent well-care visits.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Objective 4.1: Increase the rate of postpartum visits.

²⁻¹ NCQA retired this measure in 2016; therefore, no rates.

Objective 4.2: Increase timeliness of prenatal care.

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

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

Goal 5: Increase use of evidence-based practices for members with behavioral health conditions.

Objective 5.1a: Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication—initiation phase.

Objective 5.1b: Increase follow-up care for children prescribed ADHD medication—continuation and maintenance phase.

Objective 5.2: Reduce use of multiple concurrent antipsychotics in children and adolescents.**

Objective 5.3: Reduce behavioral health-related hospital readmissions within 30 days of discharge (improvement based on MCO PIP goals.)

Objective 5.4: Increase follow-up after hospitalization for mental illness—7 days.

Objective 5.5: Increase follow-up after hospitalization for mental illness—30 days.

Goal 6: Increase reporting of CMS quality measures.

Objective 6.1: Increase the number of CMS adult core measures reported to the Medicaid and CHIP Program (MACPro) System.

Objective 6.2: Increase the number of CMS child core measures reported to MACPro.

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

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

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

Annual Quality Strategy Evaluation

To continually track the progress of achieving the goals and objectives outlined in the Quality Strategy, the HSAG developed the Quality Strategy Tracking Table as shown in Appendix B. The Quality Strategy Tracking Table lists each of the six goals and the objectives used to measure achievement of

the goals. SFY 2014–2015 marked the baseline year of measurement for the 2016–2017 Quality Strategy goals and objectives and also established the QISMC goal for each of the objectives.

Table 2-6 shows the MCOs’ achievement of goals and objectives in SFY 2016–2017. HSAG updates the tracking table annually and produce the results in each year’s annual EQR technical report. For additional detail, please see Appendix B of this report.

Table 2-6—2016–2017 Quality Strategy Goals and Objectives Summary of Achievement by MCO*

Metric	Amerigroup Medicaid	Amerigroup Check Up	HPN Medicaid	HPN Check Up
Number of Comparable Rates (Year 1 to Year 2)	41	28	41	27
Number of Rates That Improved	28/41 (68%)	20/28 (71%)	24/41 (59%)	10/27 (37%)
Number of Rates That Stayed the Same	3/41 (7%)	3/28 (11%)	3/41 (7%)	3/27 (11%)
Number of Rates That Achieved QISMC Goal	25/41 (61%)	20/28 (71%)	25/41 (61%)	10/27 (37%)
Number of Rates That Declined	10/41 (24%)	5/28 (18%)	14/41 (34%)	14/27 (52%)

* Note: This table denotes changes in rates from SFY 2015–2016 to SFY 2016–2017 only and does not indicate that changes are statistically significant.

The DHCFP modifies the performance targets for each of the objectives every two years, thereby raising the performance bar for the MCOs. Most QISMC goals were set based on SFY 2014–2015 results. In SFY 2015–2016, the DHCFP added performance measures to the list of performance measures that MCOs were required to report. For those newly added measures, SFY 2014–2015 rates were not available; therefore, HSAG used SFY 2015–2016 rates to set the QISMC goals for these measures and noted whether the SFY 2016–2017 performance measure rates met the QISMC goal. Overall, the MCOs achieved proportionately more Medicaid QISMC goals than in the prior year.

Annual Health Care Guidance Program (HCGP) Quality Strategy Evaluation

The DHCFP requested that HSAG complete performance measure validation of program Year 2 non-P4P rates, which will be final after this report is due. HSAG will provide the results of the HCGP Quality Strategy evaluation in the SFY 2017–2018 EQR Technical Report.

Quality Initiatives and Emerging Practices

Emerging practices can be achieved by incorporating evidence-based guidelines into operational structures, policies, and procedures. Emerging practices are born out of continuous 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 and to improve health outcomes. Only through continual measurement and analyses to determine the efficacy of an intervention can an emerging practice be identified. Therefore, the DHCFP encourages the MCOs to continually track and monitor the effectiveness of quality improvement initiatives and interventions, using a PDSA cycle, to determine if the benefit of the intervention outweighs the effort and cost.



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

MCO-Specific Quality Initiatives

Listed below is a sampling of the strategic quality initiatives the health plans employ to improve performance health outcomes.

HPN

HPN highlighted the following strategic quality initiatives as priorities for calendar year 2016:

- **Citibank Initiative:** Incentivizes members to complete visit(s) and screenings within appropriate time frame to receive Citibank gift card.
- **Teddy Bear Transfer Program:** Encourages the use of the Southwest Medical Associates (SMA) pediatric clinics for acute and routine care vs. urgent or convenient cares. SMA staff members assist families with obtaining care from the nearest pediatric clinic instead of an urgent care facility for non-urgent care needs. This allows the patient and family to establish a relationship with a primary care physician so that the patient and family may obtain primary care appropriately. Every attempt is made to get a child to a pediatrician; however, if one is not available, urgent care may be accessed to complete the visit.
- **Urgent Care Visits with SMA:** Includes urgent care visits for SMA members. A member's primary care physician may access the medical records by being a participant in the medical home.
- **Extended Pediatric Clinic Hours:** Includes extended hours to 6:45 p.m. at three SMA clinics on Tuesdays, Wednesdays, and Thursdays.

- **HEDIS Nurses Conducted Clinic Visits:** Includes site visits to pediatric clinics for Medicaid members. Nurses discussed necessary documentation elements, provided tools for the providers, and assisted with template development.
- **Provider Education:** Provides education to providers on how to turn a sick visit into a well-child visit.
- **Covered Sports Physicals:** Educate providers on using sports physicals to provide well-child services as well.
- **Distributes Provider Resource Sheets** that included the timeline, documentation elements, and tasks that would be considered a missed opportunity for pediatric and adult HEDIS measures so that providers have a better opportunity to ensure the documentation is correct and receive full credit for the visit.
- **Care For Me Program (CFMP)** provides high-touch case management services and care coordination with a single point of contact for hospital discharges and outpatient members in all clinics. The case manager works in collaboration with members, providers, and key stakeholders in coordinating healthcare services and referrals.
- **Provides Gaps in Care Reports** to provider groups on a monthly basis to show where gaps in care exist.

Amerigroup

Amerigroup highlighted the following strategic quality initiatives as priorities for calendar year 2016:

- **Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Annual Birthday Reminders:** Member receives a birthday mailer during his or her birth month to seek the relevant services according to the member's age and gender. Adults are sent an annual wellness visit reminder.
- **EPSDT Monthly Reminder of Overdue Services:** Members who are 90 days past-due for specific EPSDT services receive a reminder mailer to complete relevant services.
- **EPSDT Physician Monthly Reminder Overdue Services:** PCP receives a report of assigned members who are overdue for EPSDT services.
- **Member Reminder Program through VOXIVA:** Members receive interactive automated voice response calls from VOXIVA, a health and wellness company, to remind members of important health information and required screenings.
- **My Wellness Guide:** Members have access to a smart phone-based member engagement solution managed by Medicaid Digital Solutions, which tracks fitness activities for members.
- **Incentives:** Member and provider incentive programs continue.
- **Pursuant Health:** Members use kiosks at Walmart, Safeway, and other retail venues to complete health risk assessments or obtain flu shots. Members receive incentives by scanning the receipt from the activity they completed at the kiosk. The incentive can be used immediately in the store. The service allows blood pressure checks, body mass index and weight management, smoking cessation, and stress management assessments, and members may stay engaged through email, text, and digital ads.

3. Description of EQR Activities

Mandatory Activities

In accordance with 42 CFR §438.356, the DHCFP contracted with HSAG as the EQRO for the State of Nevada to conduct the mandatory EQR activities as set forth in 42 CFR §438.358. In SFY 2016–2017, HSAG conducted the following mandatory EQR activities for the Nevada Medicaid and Nevada Check Up programs:

- **Compliance monitoring evaluation:** SFY 2014–2015 initiated a new three-year review cycle of Internal Quality Assurance Program review of compliance. SFY 2015–2016 was the second year of the cycle. In SFY 2015–2016, HSAG reviewed each of the corrective action plans that resulted from the compliance review activities and assisted the DHCFP staff with clarifying program requirements for the MCOs. SFY 2016–2017 was the third year of the three-year cycle during which HSAG worked with the DHCFP to plan the next cycle of reviews that will begin in SFY 2017–2018.
- **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:

- Evaluating the HCGP 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.
- Performing source code review of the programming code used to calculate pay for performance (P4P) measures used for the NCCW program, which are calculated by the DHCFP's actuary.
- Performing a performance measure validation audit of non-P4P measures used to monitor the HCGP's progress in achieving the goals and objectives of the NCCW demonstration waiver, which is presented in Section 8.

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 2016–2017

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. 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.

SFY 2016–2017 was the third year of the three-year cycle of reviews for Nevada; all activities conducted in the previous two years are complete. SFY 2017–2018 initiates a new three-year cycle of reviews. HSAG will report on the SFY 2017–2018 IQAP results in the SFY 2017–2018 EQR technical report.

5. Validation of Performance Measures—NCQA HEDIS Compliance Audit— SFY 2016–2017

The DHCFP requires the MCOs to submit performance measurement data as part of their quality assessment and performance improvement programs for the Medicaid and Nevada Check Up populations. Validating the MCOs' performance measures is one of the federally required external quality review (EQR) activities described in 42 CFR §438.358(b)(2). To comply with this requirement, the DHCFP contracted with HSAG to validate the performance measures through NCQA HEDIS Compliance Audits. These audits focused on the ability of the MCOs to process claims and encounter data, pharmacy data, laboratory data, enrollment (or membership) data, and provider data accurately. As part of the 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 NCQA HEDIS Compliance Audits conducted by HSAG for **HPN** and **Amerigroup**. Further details regarding the results from the 2017 audits may be found in the July 2017 NCQA HEDIS Compliance Audit Final Report of Findings.

Of note, the DHCFP expanded Medicaid coverage in January 2014 to persons with incomes up to 138 percent of the federal poverty level, which was allowed under the Affordable Care Act. The majority of newly eligible persons resided in the managed care catchment areas; therefore, both MCOs experienced significant increases in enrollment since January 2014.

Objectives

The objectives of the NCQA HEDIS Compliance Audit were to assess the performance of the MCOs with respect to the *HEDIS 2017 Technical Specifications* and to review their performance on the HEDIS measures. The audits incorporated two main components:

- A detailed assessment of the MCO's information system (IS) capabilities for collecting, analyzing, and reporting HEDIS information.
- A review of the specific reporting methods used for HEDIS measures, including databases and files used to store HEDIS information; medical record abstraction tools and abstraction procedures used; certified measure status; and any manual processes employed in HEDIS 2017 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.

Table 5–1 lists the required HEDIS 2017 measures for the Medicaid and Nevada Check Up populations.

Table 5–1—Required HEDIS 2017 Measures

HEDIS Measure	Medicaid Population	Nevada Check-Up Population
Access to Care		
<i>Children and Adolescents’ Access to Primary Care Practitioners (CAP)—Ages 12–24 Months, Ages 25 Months–6 Years, Ages 7–11 Years, and Ages 12–19 Years</i>	√	√
<i>Annual Dental Visit (ADV)—Total</i>	√	√
Children’s Preventive Care		
<i>Adolescent Well-Care Visits (AWC)—Adolescent Well-Care Visits</i>	√	√
<i>Childhood Immunization Status (CIS)—Combinations 2–10</i>	√	√
<i>Immunizations for Adolescents (IMA)—Combination 1 (Meningococcal, Tdap) and Combination 2 (Meningococcal, Tdap, HPV)</i>	√	√
<i>Well-Child Visits in the First 15 Months of Life (W15)—Six or More Well-Child Visits</i>	√	√
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)</i>	√	√
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—BMI Percentile—Total, Counseling for Nutrition—Total, and Counseling for Physical Activity—Total</i>	√	√
Maternity Care		
<i>Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care and Postpartum Care</i>	√	
<i>Frequency of Ongoing Prenatal Care (FPC)—<21 Percent of Expected Visits and ≥81 Percent of Expected Visits</i>	√	
Care for Chronic Conditions		
<i>Comprehensive Diabetes Care (CDC)—Hemoglobin A1c (HbA1c) Testing, HbA1c Poor Control (>9.0%), HbA1c Control (<8.0%), Eye Exam (Retinal) Performed, Medical Attention for Nephropathy, and Blood Pressure Control (<140/90 mm Hg)</i>	√	
<i>Medication Management for People with Asthma (MMA)—Medication Compliance 50%—Total and Medication Compliance 75%—Total</i>	√	√
Behavioral Health		
<i>Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up and 30-Day Follow-Up</i>	√	√
<i>Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Initiation Phase and Continuation and Maintenance Phase</i>	√	√
<i>Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)—Total</i>	√	√

HEDIS Measure	Medicaid Population	Nevada Check-Up Population
Utilization and Diversity of Membership		
<i>Mental Health Utilization (MPT)—Any Service (Total), Inpatient (Total), Intensive Outpatient or Partial Hospitalization (Total), and Outpatient or Emergency Department (ED) (Total)</i>	√	√
<i>Ambulatory Care (AMB)—Outpatient Visits—Total and ED Visits—Total</i>	√	√

Plan-Specific Findings—Amerigroup

A detailed review of the 2017 performance reports submitted by **Amerigroup** determined that the rates were prepared according to the *HEDIS 2017 Technical Specifications* for all of the audited measures. Audits of IS capabilities for accurate HEDIS reporting found that **Amerigroup** was compliant with the standards assessed, as follows:

- Amerigroup** was fully compliant with IS standard 1.0 and continued to receive paper and electronic claims daily. **Amerigroup**'s document management group received paper claims, entered them into the system, and sent them to Smart Data Solutions for scanning or keying. Electronic claims were received from Change Health Care, Availity, and Smart Data Solutions. Providers also had the ability to submit directly to **Amerigroup**. Excellent reconciliation processes continued in place to ensure that all transmission processes were accurate and complete. Front-end business edits were in place within **Amerigroup**'s claims processing system, Facets, to ensure accuracy of submitted claims. Accepted claims were loaded into Facets for adjudication. Facets captured all medical codes required for HEDIS reporting. There were no nonstandard codes or forms accepted during the measurement year. **Amerigroup** performed an on-site demonstration of Facets and identified the necessary edits to ensure accuracy. Accuracy results for the measurement year exceeded **Amerigroup**'s established standards and there was no backlog of processing claims during the measurement year. Financial and procedural audits were in place and reached 99 percent for the measurement year. All providers were fee-for-service, so data completeness was not a concern. Pharmacy data were received from the State's vendor, Express Scripts, during the measurement year and there were no issues with receipt of these data. Vision data were received from DentaQuest and dental data from Scion Dental. Data were tracked and trended throughout the measurement year.
- Amerigroup** was fully compliant with IS standard 2.0. It experienced an increase in enrollment for its Medicaid and Nevada Check Up product lines. Despite the increase, there was no backlog in processing enrollment data. Files were received daily in an 834 format that included edits and updates. Error reports were reviewed and resolved within 24 hours. Accuracy results met established standards. All enrollment segments were captured and while retroactivity exists, it does not contribute to the extent where it would be considered for continuous enrollment

determination. A system demonstration was performed on-site and all fields required for HEDIS reporting were present.

- **Amerigroup** was fully compliant with IS standard 3.0. Cactus was the system that continued to be used to maintain credentialing data. Applications were received by the plan where primary source verification was conducted. **Amerigroup** maintains a Common Practitioner ID for internal tracking and uses National Provider Identifier (NPI) for claims processing. Facets was used to adjudicate claims and an automated process reconciled data between Cactus and Facets. This is an organizationally developed procedure and **Amerigroup** should consider it a best practice. There was a percentage of delegated credentialing and **Amerigroup** conducted the appropriate oversight for these providers. On-site, the Facets and Cactus systems were examined and all fields required for HEDIS reporting were present.
- **Amerigroup** was fully compliant with IS standard 4.0. HSAG reviewed **Amerigroup**'s IS 4 Roadmap pertaining to the policies and procedures for standard 4.0. The review found these policies and procedures to be consistent with the 4.0 requirements. **Amerigroup** sampled according to the HEDIS sampling guidelines and assigned measure-specific oversamples. A review of provider chase logic determined it was appropriate across the hybrid measures. For HEDIS 2017, **Amerigroup** contracted with Ciox Health, LLC, (formerly known as Enterprise Consulting Solutions, Inc.) to retrieve medical records. **Amerigroup** continued to contract with Inovolan for use of its Quality Spectrum Hybrid Reporter (QSHR) abstraction tool for HEDIS 2017. HSAG participated in a live vendor demonstration of the QSHR tool and instructions. All fields, edits, and drop-down boxes were reviewed for accuracy against NCQA's *HEDIS 2017, Volume 2, Technical Specifications for Health Plans*. HSAG reviewed and approved QSHR's hybrid tool and instructions on January 20, 2017. **Amerigroup** used internal staff members to conduct medical record reviews and quality assurance. Staff members were sufficiently qualified and trained in the current year's HEDIS Technical Specifications and the use of QSHR's abstraction tools to conduct the reviews accurately. **Amerigroup** maintained appropriate quality assurance of reviews, including over-reads of all abstractions resulting in a numerator positive or exclusion as well as a random sample of numerator negatives. HSAG reviewed and approved **Amerigroup**'s abstraction training manual on February 8, 2017.
- Due to significant changes in the measure specifications for IMA, a convenience sample was requested for *Immunizations for Adolescents—Combination 2*. The *Immunizations for Adolescents—Combination 2* records passed HSAG's review.
- **Amerigroup** passed the medical record review validation (MRRV) process for the following measure groups:
 - Group A: *Biometrics (BMI, BP) and Maternity—Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
 - Group B: *Anticipatory Guidance and Counseling—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity*
 - Group C: *Laboratory—Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*
 - Group D: *Immunizations and Other Screenings—Immunizations for Adolescents—Combination 2*

- **Amerigroup** was fully compliant with IS standard 5.0. **Amerigroup** presented four standard supplemental databases—EPSDT Immunization Registry, CPL, LabCorp, and Quest—which were approved to use for HEDIS 2017 reporting. Roadmap Section 5 for each database was provided and reviewed; there were no concerns with any of the data sources. On-site, data sources were examined and all required fields for HEDIS reporting were present. Supplemental data impact reports were received in accordance with final rate production. **Amerigroup** did not submit any nonstandard supplemental databases for HEDIS 2017 reporting.
- **Amerigroup** was fully compliant with IS standard 7.0. **Amerigroup** continued to use Inovolan’s Quality Spectrum Insight software for HEDIS measure reporting. The software was maintained with **Amerigroup** and upgrades and patches were applied appropriately. The warehouse was examined on-site and the file structure fully supported HEDIS reporting. File transfer logs were used to monitor data integration from various sources and reconciled appropriately. There were no variances in the file transfer logs examined on-site. Primary source verification (Query 3) was conducted on-site for the *Follow-Up After Hospitalization for Mental Illness (FUH)* measure and no issues were identified. All Tier 2 and Tier 4 warnings were resolved, where applicable, before rates were finalized. All measures under the scope of the audit received a *Reportable* designation.

Medicaid Results

The Medicaid HEDIS 2015, 2016, and 2017 rates for **Amerigroup** are presented in Table 5–2, along with HEDIS 2015 to HEDIS 2017 rate comparisons. For measures for which lower rates suggest better performance (i.e., *Frequency of Ongoing Prenatal Care—<21 Percent of Expected Visits*; *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*; *Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total*; and *Ambulatory Care—Total—Emergency Department [ED] Visits—Total*), a decrease in the rate from 2015 to 2017 represents performance improvement and an increase in the rate from 2015 to 2017 represents performance decline. Since measures in the Utilization and Diversity of Membership measure domain are designed to capture the frequency of services provided by the MCOs and characteristics of the population served by the MCO, higher or lower rates in this domain do not necessarily indicate better or worse performance. These rates are provided for information purposes only.

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

HEDIS Measure	HEDIS 2015 Rate	HEDIS 2016 Rate	HEDIS 2017 Rate	2015–2017 Rate Comparison
Access to Care				
<i>Children and Adolescents’ Access to Primary Care Practitioners (CAP)</i>				
<i>Ages 12–24 Months</i>	91.14%	94.15%	93.83%	2.69
<i>Ages 25 Months–6 Years</i>	81.30%	83.55%	82.25%	0.95
<i>Ages 7–11 Years</i>	85.60%	87.12%	86.59%	0.99
<i>Ages 12–19 Years</i>	81.53%	83.76%	82.95%	1.42
<i>Annual Dental Visit (ADV)</i>				
<i>Total</i>	45.62%	53.21%	51.63%	6.01
Children’s Preventive Care				
<i>Adolescent Well-Care Visits (AWC)</i>				
<i>Adolescent Well-Care Visits</i>	42.13%	38.43%	47.69%	5.56
<i>Childhood Immunization Status (CIS)</i>				
<i>Combination 2</i>	66.20%	73.15%	72.92%	6.72
<i>Combination 3</i>	60.88%	66.67%	67.13%	6.25
<i>Combination 4</i>	58.80%	65.28%	66.67%	7.87
<i>Combination 5</i>	50.23%	57.18%	56.71%	6.48
<i>Combination 6</i>	33.33%	32.41%	36.11%	2.78
<i>Combination 7</i>	48.38%	56.48%	56.25%	7.87
<i>Combination 8</i>	33.10%	32.41%	36.11%	3.01
<i>Combination 9</i>	28.24%	29.63%	32.18%	3.94
<i>Combination 10</i>	28.01%	29.63%	32.18%	4.17
<i>Immunizations for Adolescents (IMA)</i>				
<i>Combination 1 (Meningococcal, Tdap)</i>	—	71.93%	79.40%	NC
<i>Combination 2 (Meningococcal, Tdap, HPV)</i>	—	—	26.85%	NC
<i>Well-Child Visits in the First 15 Months of Life (W15)</i>				
<i>Six or More Well-Child Visits</i>	50.58%	52.78%	62.50%	11.92

HEDIS Measure	HEDIS 2015 Rate	HEDIS 2016 Rate	HEDIS 2017 Rate	2015–2017 Rate Comparison
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)				
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	65.66%	66.33%	68.72%	3.06
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
<i>BMI Percentile—Total</i>	—	64.12%	70.14%	NC
<i>Counseling for Nutrition—Total</i>	—	54.40%	62.73%	NC
<i>Counseling for Physical Activity—Total¹</i>	—	43.75%	56.48%	NC
Maternity Care				
Prenatal and Postpartum Care (PPC)				
<i>Timeliness of Prenatal Care</i>	69.77%	75.41%	83.33%	13.56
<i>Postpartum Care</i>	46.74%	53.16%	62.50%	15.76
Frequency of Ongoing Prenatal Care (FPC)				
<i><21 Percent of Expected Visits*</i>	15.81%	17.80%	5.56%	-10.25
<i>≥81 Percent of Expected Visits</i>	52.33%	56.44%	62.50%	10.17
Care for Chronic Conditions				
Comprehensive Diabetes Care (CDC)¹				
<i>Hemoglobin A1c (HbA1c) Testing</i>	81.90%	79.63%	81.02%	-0.88
<i>HbA1c Poor Control (>9.0%)*</i>	46.40%	46.76%	46.30%	-0.10
<i>HbA1c Control (<8.0%)</i>	43.16%	46.30%	45.60%	2.44
<i>Eye Exam (Retinal) Performed</i>	55.45%	55.09%	59.49%	4.04
<i>Medical Attention for Nephropathy</i>	75.17%	89.58%	90.28%	15.11
<i>Blood Pressure Control (<140/90 mm Hg)</i>	62.18%	55.32%	61.11%	-1.07
Medication Management for People with Asthma (MMA)				
<i>Medication Compliance 50%—Total</i>	—	50.22%	56.19%	NC
<i>Medication Compliance 75%—Total</i>	—	26.84%	32.16%	NC
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness (FUH)				
<i>7-Day Follow-Up</i>	53.02%	52.99%	79.81%	26.79
<i>30-Day Follow-Up</i>	63.14%	64.55%	84.98%	21.84

HEDIS Measure	HEDIS 2015 Rate	HEDIS 2016 Rate	HEDIS 2017 Rate	2015–2017 Rate Comparison
<i>Follow-Up Care for Children Prescribed ADHD Medication (ADD)</i>				
<i>Initiation Phase</i>	—	36.68%	43.51%	NC
<i>Continuation and Maintenance Phase</i>	—	40.91%	64.91%	NC
<i>Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)^{2,*}</i>				
<i>Total</i>	—	0.00%	3.74%	NC
Utilization and Diversity of Membership				
<i>Mental Health Utilization (MPT)</i>				
<i>Any Service (Total)</i>	5.79%	7.21%	8.63%	2.84
<i>Inpatient (Total)</i>	0.42%	1.18%	1.16%	0.74
<i>Intensive Outpatient or Partial Hospitalization (Total)</i>	0.13%	0.28%	0.24%	0.11
<i>Outpatient, ED, or Telehealth (Total)</i>	5.67%	7.01%	8.50%	2.83
<i>Ambulatory Care (AMB)—Total</i>				
<i>Outpatient Visits—Total</i>	286.25	294.01	287.09	0.84
<i>ED Visits—Total*</i>	53.27	55.08	54.02	0.75

¹ Due to changes in NCQA's HEDIS 2016 technical specifications for this measure, exercise caution when comparing HEDIS 2015 to HEDIS 2016 and 2017 rates.

² Due to changes in NCQA's HEDIS 2017 technical specifications for this measure, exercise caution when comparing HEDIS 2017 to prior years' rates.

* A lower rate indicates better performance for this measure.

— Indicates the rate is not presented in the table above because reporting the measure was not required for the respective reporting year.

NC (i.e., Not Compared) indicates the HEDIS 2015 and HEDIS 2017 rates were not available for comparison.

Amerigroup's performance improved from HEDIS 2015 to HEDIS 2017 in several areas, including dental care and immunizations for children, well-child visits for infants, well-care visits for adolescents, prenatal and postpartum care, and timely follow-up care for members hospitalized for mental illness. The most notable increase was in *Follow-Up After Hospitalization for Mental Illness*, where the seven-day follow-up had a 26.79 percentage point increase and the 30-day follow-up had a 21.84 percentage point increase. Based on comparisons from HEDIS 2015 to HEDIS 2017, none of **Amerigroup's** Medicaid rates demonstrated a notable decline in performance (i.e., a decline of greater than 5 percentage points between the HEDIS 2015 and 2017 rates).

Nevada Check Up Results

The Nevada Check Up HEDIS 2015, 2016, and 2017 rates for **Amerigroup** are presented in Table 5–3, along with HEDIS 2015 to HEDIS 2017 rate comparisons. For measures for which lower rates suggest better performance (i.e., *Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total* and *Ambulatory Care—Total—Emergency Department [ED] Visits—Total*), a decrease in the rate from 2015 to 2017 represents performance improvement and an increase in the rate from 2015 to 2017 represents performance decline. Since measures in the Utilization and Diversity of Membership measure domain are designed to capture the frequency of services provided by the MCOs and characteristics of the population served by the MCO, higher or lower rates in this domain do not necessarily indicate better or worse performance. These rates are provided for information purposes only.

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

HEDIS Measure	HEDIS 2015 Rate	HEDIS 2016 Rate	HEDIS 2017 Rate	2015–2017 Rate Comparison
Access to Care				
<i>Children and Adolescents’ Access to Primary Care Practitioners (CAP)</i>				
<i>Ages 12–24 Months</i>	95.83%	98.73%	98.18%	2.35
<i>Ages 25 Months–6 Years</i>	90.48%	89.53%	89.45%	-1.03
<i>Ages 7–11 Years</i>	92.62%	92.91%	91.83%	-0.79
<i>Ages 12–19 Years</i>	92.18%	88.95%	91.08%	-1.10
<i>Annual Dental Visit (ADV)</i>				
<i>Total</i>	64.48%	67.05%	67.81%	3.33
Children’s Preventive Care				
<i>Adolescent Well-Care Visits (AWC)</i>				
<i>Adolescent Well-Care Visits</i>	56.48%	56.34%	60.88%	4.40
<i>Childhood Immunization Status (CIS)</i>				
<i>Combination 2</i>	74.55%	85.90%	91.16%	16.61
<i>Combination 3</i>	73.64%	78.21%	82.87%	9.23
<i>Combination 4</i>	73.64%	77.56%	81.22%	7.58
<i>Combination 5</i>	54.55%	68.59%	72.93%	18.38
<i>Combination 6</i>	45.45%	46.79%	47.51%	2.06
<i>Combination 7</i>	54.55%	67.95%	72.38%	17.83
<i>Combination 8</i>	45.45%	46.79%	47.51%	2.06

HEDIS Measure	HEDIS 2015 Rate	HEDIS 2016 Rate	HEDIS 2017 Rate	2015–2017 Rate Comparison
<i>Combination 9</i>	32.73%	42.95%	44.75%	12.02
<i>Combination 10</i>	32.73%	42.95%	44.75%	12.02
<i>Immunizations for Adolescents (IMA)</i>				
<i>Combination 1 (Meningococcal, Tdap)</i>	—	81.61%	83.61%	NC
<i>Combination 2 (Meningococcal, Tdap, HPV)</i>	—	—	38.46%	NC
<i>Well-Child Visits in the First 15 Months of Life (W15)</i>				
<i>Six or More Well-Child Visits</i>	70.37%	78.05%	78.92%	8.55
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)</i>				
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	71.30%	70.28%	76.16%	4.86
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)</i>				
<i>BMI Percentile—Total</i>	—	62.04%	71.30%	NC
<i>Counseling for Nutrition—Total</i>	—	55.56%	65.28%	NC
<i>Counseling for Physical Activity—Total¹</i>	—	47.69%	59.72%	NC
Care for Chronic Conditions				
<i>Medication Management for People with Asthma (MMA)</i>				
<i>Medication Compliance 50%—Total</i>	—	47.76%	58.43%	NC
<i>Medication Compliance 75%—Total</i>	—	26.87%	24.72%	NC
Behavioral Health				
<i>Follow-Up After Hospitalization for Mental Illness (FUH)</i>				
<i>7-Day Follow-Up</i>	NA	84.85%	82.50%	NC
<i>30-Day Follow-Up</i>	NA	93.94%	97.50%	NC
<i>Follow-Up Care for Children Prescribed ADHD Medication (ADD)</i>				
<i>Initiation Phase</i>	—	NA	41.67%	NC
<i>Continuation and Maintenance Phase</i>	—	NA	NA	NC
<i>Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)^{2,*}</i>				
<i>Total</i>	—	NA	NA	NC

HEDIS Measure	HEDIS 2015 Rate	HEDIS 2016 Rate	HEDIS 2017 Rate	2015–2017 Rate Comparison
Utilization and Diversity of Membership				
<i>Mental Health Utilization (MPT)</i>				
<i>Any Service (Total)</i>	4.31%	5.76%	5.68%	1.37
<i>Inpatient (Total)</i>	0.33%	0.46%	0.42%	0.09
<i>Intensive Outpatient or Partial Hospitalization (Total)</i>	0.18%	0.32%	0.16%	-0.02
<i>Outpatient, ED, or Telehealth (Total)</i>	4.23%	5.69%	5.64%	1.41
<i>Ambulatory Care (AMB)—Total</i>				
<i>Outpatient Visits—Total</i>	268.54	263.50	258.30	-10.24
<i>ED Visits—Total*</i>	23.94	26.14	26.30	2.36

¹ Due to changes in NCQA’s HEDIS 2016 technical specifications for this measure, exercise caution when comparing HEDIS 2015 to HEDIS 2016 and 2017 rates.

² Due to changes in NCQA’s HEDIS 2017 technical specifications for this measure, exercise caution when comparing HEDIS 2017 to prior years’ rates.

* A lower rate indicates better performance for this measure.

— Indicates the rate is not presented in the table above because reporting the measure was not required for the respective reporting year.

NC (i.e., Not Compared) indicates the HEDIS 2015 and HEDIS 2017 rates were not available for comparison.

NA (i.e., Not Applicable due to a small denominator) indicates the health plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

Amerigroup’s performance improved from HEDIS 2015 to HEDIS 2017 in the areas of immunizations for children and well-child visits for infants. Based on comparisons from HEDIS 2015 to HEDIS 2017, none of **Amerigroup**’s Nevada Check Up rates demonstrated a notable decline in performance (i.e., a decline of greater than 5 percentage points between the HEDIS 2015 and 2017 rates).

Summary of Amerigroup Strengths

The following Medicaid performance measure indicators were identified as emerging improvement for **Amerigroup** based on rate improvements greater than 5 percentage points from HEDIS 2015 to HEDIS 2017:

- *Annual Dental Visit—Total*
- *Adolescent Well-Care Visits*
- *Childhood Immunization Status—Combinations 2, 3, 4, 5, and 7*
- *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care and Postpartum Care*

- *Frequency of Ongoing Prenatal Care—<21 Percent of Expected Visits and ≥81 Percent of Expected Visits*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy⁵⁻¹*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up and 30-Day Follow-Up*

The following Nevada Check Up performance measure indicators were identified as emerging improvement for **Amerigroup** based on rate improvements greater than 5 percentage points from HEDIS 2015 to HEDIS 2017:

- *Childhood Immunization Status—Combinations 2, 3, 4, 5, 7, 9, and 10*
- *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*

Summary of Amerigroup Opportunities for Improvement

None of the Medicaid or Nevada Check Up performance measure rates for **Amerigroup** demonstrated a decline in performance of greater than 5 percentage points from HEDIS 2015 to HEDIS 2017.

Plan-Specific Findings—HPN

A detailed review of the 2017 performance reports submitted by **HPN** determined that the reports were prepared according to the *HEDIS 2017 Technical Specifications* for all of the audited measures, which are listed in Appendix A. Audits of IS capabilities for accurate HEDIS reporting found that **HPN** was compliant with the standards assessed, as follows:

- **HPN** was fully compliant with IS standard 1.0 for medical services data. **HPN** continued to use the Facets system for claims and encounter data processing. Only standard codes and standard forms were accepted, and data entry processes were effective and efficient and they assured timely, accurate entry into the system. **HPN** continued to increase auto-adjudication, and approximately 79 percent of the claims and encounters were auto-adjudicated. The Facets system captured the rendering provider even for claims submitted by federally qualified health centers. Most claims that **HPN** received were electronic claims (electronic data interchange [EDI]). **HPN** had appropriate procedures to receive and monitor the EDI submissions. The **HPN** staff monitored and trended volume routinely to ensure data completeness. In addition to monitoring data completeness, **HPN** had appropriate validation processes to ensure accurate claims and encounter data submission. Pharmacy data were obtained from Optum Rx, while lab data came from Quest. **HPN** also had appropriate processes in place to oversee these vendors, including review of submitted data and monitoring of contract standards. There were no issues identified with the medical services data.

⁵⁻¹ Due to changes in NCQA's HEDIS 2016 technical specifications for this measure, exercise caution when comparing HEDIS 2015 to HEDIS 2016 and 2017 rates.

- **HPN** was fully compliant with IS standard 2.0 for enrollment data. The enrollment data processes have been consistent for many years and there were no changes in them during 2016. **HPN** received membership data from the State’s vendor and these data were fully reconciled each month. **HPN** had processes 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 initially provided a file with the mother and an unborn baby identified for enrollment. Once the baby’s birth was reported, the new enrollment file was updated to include the baby’s new ID. There appeared to be no issues with linking the appropriate claims back to the newborn’s record using the system ID. Several years ago the State encountered a technical issue with the enrollment files that has continued to cause some members to drop off the files each month. As a result, **HPN** had to manually correct approximately 200 member enrollments each month in 2016. Since **HPN** continued to work these adjustments manually each month, there was no impact to the HEDIS eligible populations.
- **HPN** was fully compliant with IS standard 3.0 for practitioner data. **HPN** had an increase of nearly 400 providers during 2016. It continued to use the Cactus software for provider credentialing and to determine provider types and specialties. All provider-related data elements required for the Medicaid HEDIS measures under the scope of the audit were captured and verified within the systems. The credentialing data were directly entered into Facets using the add-change-track (ACT) form, and then verified against the source data (Cactus). There were no issues identified and **HPN** was able to distinguish provider types and specialties as required for HEDIS reporting. Since the *Board Certification* measure was not included in the scope of the audit, credentialing and recredentialing were not reviewed.
- **HPN** was fully compliant with IS standard 4.0. HSAG reviewed **HPN**’s IS 4 Roadmap pertaining to the policies and procedures for IS 4.0. The roadmap review found these policies and procedures to be consistent with the IS 4.0 requirements. **HPN** sampled according to the HEDIS sampling guidelines and assigned measure-specific oversamples. A review determined that provider chase logic was appropriate across the hybrid measures. **HPN** staff members procured and abstracted medical records using the Verscend Technologies, Inc. (Verscend’s) hybrid medical record abstraction tools. HSAG participated in a live demonstration of the Verscend tools and instructions. All fields, edits, and drop-down boxes were reviewed for accuracy against NCQA’s *HEDIS 2017, Volume 2, Technical Specifications for Health Plans*. HSAG reviewed and approved the Verscend tools and instructions on January 6, 2017. **HPN** used internal staff members to conduct medical record reviews and quality assurance. Staff members were sufficiently qualified and trained in the current year’s HEDIS Technical Specifications and the use of **HPN**’s abstraction tools to conduct medical record reviews accurately. **HPN** maintained appropriate quality assurance of reviews, including over-reads of all abstractions resulting in numerator positives or exclusions, and a random sample of numerator negatives.
- **HPN** passed the MRRV in 2016 and did not make any significant changes to its staff, systems, or processes used for medical record review in 2017; therefore, a convenience sample was not required.

- **HPN** passed the MRRV process for the following measures and corresponding measure groups:
 - Group A: *Biometrics (BMI, BP) and Maternity—Prenatal and Postpartum Care—Postpartum Care*
 - Group B: *Anticipatory Guidance and Counseling—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition (12–17 Years)*
 - Group C: *Laboratory—Comprehensive Diabetes Care—HbA1c Control <8.0%*
 - Group C: *Laboratory—Comprehensive Diabetes Care—HbA1c Testing*
 - Group C: *Laboratory—Comprehensive Diabetes Care—HbA1c Poor Control >9.0%*
 - Group C: *Laboratory—Comprehensive Diabetes Care—Medical Attention for Nephropathy*
 - Group D: *Immunizations and Other Screenings—Immunizations for Adolescents—Combination 2*
 - Group F: *Exclusions—All medical record exclusions*
- **HPN** was fully compliant with IS standard 5.0 for supplemental data. **HPN** received laboratory data from Allscripts and Quest, and immunization registry data from the State. All 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 the standard databases and identified a nonstandard database, Touchworks, to use for reporting. This database contained one member for the *Comprehensive Diabetes Care—Eye Exam* measure. The one case was reviewed and passed the data validation process. There were no issues identified with any of the supplemental data and all standard and nonstandard databases were approved for HEDIS 2017 reporting.
- **HPN** was fully compliant with IS standard 7.0 for data integration. **HPN** used Verscend (formerly Verisk) to calculate its HEDIS rates. The data integration process has been consistent for many years. Data were loaded from Facets and the Corporate Reporting Database (CRD) directly into Kramer, the data warehouse repository. These data were then loaded into the Verscend software. Reports were generated during each load process to ensure accurate and complete data were captured. Additional reports were generated monthly to compare data in Kramer versus data in Verscend, as well as data in Kramer 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.

Query 3, primary source verification, was conducted on-site for 25 cases across several measures and no issues were identified. In addition, preliminary rates were reviewed prior to and during the on-site audit. *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* rates appeared low; **HPN** acknowledged it was having difficulties improving the rates for this measure. Other rates that appeared low did not yet have medical record data incorporated. In general, Nevada Check Up rates were higher than the corresponding rates for Nevada Medicaid. A formal preliminary rate review was conducted after the on-site audit and rates appeared reasonable. The final rate review did not identify any issues and the patient level detail file matched the reported rates. Overall, there were no issues identified with the data integration process. Therefore, all of the rates were approved for reporting.

Medicaid Results

The Medicaid HEDIS 2015, 2016, and 2017 rates for **HPN** are presented in Table 5–4, along with HEDIS 2015 to HEDIS 2017 rate comparisons. For measures for which lower rates suggest better performance (i.e., *Frequency of Ongoing Prenatal Care—<21 Percent of Expected Visits*; *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*; *Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total*; and *Ambulatory Care—Total—Emergency Department [ED] Visits—Total*), a decrease in the rate from 2015 to 2017 represents performance improvement and an increase in the rate from 2015 to 2017 represents performance decline. Since measures in the Utilization and Diversity of Membership measure domain are designed to capture the frequency of services provided by the MCOs as well as characteristics of the population served by the MCO, higher or lower rates in this domain do not necessarily indicate better or worse performance. These rates are provided for information purposes only.

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

HEDIS Measure	HEDIS 2015 Rate	HEDIS 2016 Rate	HEDIS 2017 Rate	2015–2017 Rate Comparison
Access to Care				
<i>Children and Adolescents’ Access to Primary Care Practitioners (CAP)</i>				
<i>Ages 12–24 Months</i>	91.42%	94.80%	95.17%	3.75
<i>Ages 25 Months–6 Years</i>	79.24%	84.29%	83.81%	4.57
<i>Ages 7–11 Years</i>	83.93%	87.36%	87.57%	3.64
<i>Ages 12–19 Years</i>	80.80%	85.21%	85.51%	4.71
<i>Annual Dental Visit (ADV)</i>				
<i>Total</i>	51.12%	55.03%	53.85%	2.73
Children’s Preventive Care				
<i>Adolescent Well-Care Visits (AWC)</i>				
<i>Adolescent Well-Care Visits</i>	37.47%	44.04%	44.77%	7.30
<i>Childhood Immunization Status (CIS)</i>				
<i>Combination 2</i>	70.80%	74.94%	73.72%	2.92
<i>Combination 3</i>	66.18%	70.32%	71.05%	4.87
<i>Combination 4</i>	66.18%	70.07%	71.05%	4.87
<i>Combination 5</i>	53.04%	55.72%	61.07%	8.03
<i>Combination 6</i>	39.42%	38.44%	34.79%	–4.63
<i>Combination 7</i>	53.04%	55.72%	61.07%	8.03

HEDIS Measure	HEDIS 2015 Rate	HEDIS 2016 Rate	HEDIS 2017 Rate	2015–2017 Rate Comparison
<i>Combination 8</i>	39.42%	38.44%	34.79%	-4.63
<i>Combination 9</i>	32.36%	31.14%	30.41%	-1.95
<i>Combination 10</i>	32.36%	31.14%	30.41%	-1.95
<i>Immunizations for Adolescents (IMA)</i>				
<i>Combination 1 (Meningococcal, Tdap)</i>	—	79.81%	80.78%	NC
<i>Combination 2 (Meningococcal, Tdap, HPV)</i>	—	—	27.49%	NC
<i>Well-Child Visits in the First 15 Months of Life (W15)</i>				
<i>Six or More Well-Child Visits</i>	51.58%	53.77%	62.77%	11.19
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)</i>				
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	60.83%	64.48%	65.21%	4.38
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)</i>				
<i>BMI Percentile—Total</i>	—	70.32%	71.78%	NC
<i>Counseling for Nutrition—Total</i>	—	57.91%	62.29%	NC
<i>Counseling for Physical Activity—Total¹</i>	—	52.07%	59.61%	NC
Maternity Care				
<i>Prenatal and Postpartum Care (PPC)</i>				
<i>Timeliness of Prenatal Care</i>	77.62%	73.97%	72.75%	-4.87
<i>Postpartum Care</i>	58.88%	57.18%	59.12%	0.24
<i>Frequency of Ongoing Prenatal Care (FPC)</i>				
<i><21 Percent of Expected Visits*</i>	17.03%	14.60%	11.19%	-5.84
<i>≥81 Percent of Expected Visits</i>	51.34%	52.07%	60.83%	9.49
Care for Chronic Conditions				
<i>Comprehensive Diabetes Care (CDC)¹</i>				
<i>Hemoglobin A1c (HbA1c) Testing</i>	84.18%	85.64%	82.73%	-1.45
<i>HbA1c Poor Control (>9.0%)*</i>	44.53%	45.74%	42.82%	-1.71
<i>HbA1c Control (<8.0%)</i>	43.80%	46.47%	48.42%	4.62
<i>Eye Exam (Retinal) Performed</i>	55.96%	56.93%	61.31%	5.35

HEDIS Measure	HEDIS 2015 Rate	HEDIS 2016 Rate	HEDIS 2017 Rate	2015–2017 Rate Comparison
<i>Medical Attention for Nephropathy</i>	82.73%	92.21%	90.75%	8.02
<i>Blood Pressure Control (<140/90 mm Hg)</i>	70.32%	60.83%	50.36%	-19.96
Medication Management for People with Asthma (MMA)				
<i>Medication Compliance 50%—Total</i>	—	46.96%	53.37%	NC
<i>Medication Compliance 75%—Total</i>	—	24.14%	32.81%	NC
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness (FUH)				
<i>7-Day Follow-Up</i>	48.49%	56.51%	79.16%	30.67
<i>30-Day Follow-Up</i>	66.89%	69.41%	84.20%	17.31
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
<i>Initiation Phase</i>	—	46.65%	43.68%	NC
<i>Continuation and Maintenance Phase</i>	—	58.02%	49.28%	NC
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)^{2,*}				
<i>Total</i>	—	1.80%	2.26%	NC
Utilization and Diversity of Membership				
Mental Health Utilization (MPT)				
<i>Any Service (Total)</i>	4.66%	5.90%	6.80%	2.14
<i>Inpatient (Total)</i>	0.27%	0.77%	0.78%	0.51
<i>Intensive Outpatient or Partial Hospitalization (Total)</i>	0.16%	0.23%	0.30%	0.14
<i>Outpatient, ED, or Telehealth (Total)</i>	4.57%	5.67%	6.73%	2.16
Ambulatory Care (AMB)—Total				
<i>Outpatient Visits—Total</i>	275.76	292.44	298.12	22.36
<i>ED Visits—Total*</i>	45.67	49.39	52.60	6.93

¹ Due to changes in NCQA's HEDIS 2016 technical specifications for this measure, exercise caution when comparing HEDIS 2015 to HEDIS 2016 and 2017 rates.

² Due to changes in NCQA's HEDIS 2017 technical specifications for this measure, exercise caution when comparing HEDIS 2017 to prior years' rates.

* A lower rate indicates better performance for this measure.

— Indicates the rate is not presented in the table above because reporting the measure was not required for the respective reporting year.

NC (i.e., Not Compared) indicates the HEDIS 2015 and HEDIS 2017 rates were not available for comparison.

HPN’s performance improved from HEDIS 2015 to HEDIS 2017 in several areas, including access to primary care and some immunizations for children, well-child visits for infants, well-care visits for adolescents and, most notably, timely follow-up care for members hospitalized for mental illness. HPN’s rates indicated improvement in the frequency of prenatal care from HEDIS 2015 to HEDIS 2017, but rates for the measure assessing timely prenatal care indicated a performance decline year over year, suggesting opportunities for improvement.

Nevada Check Up Results

The Nevada Check Up HEDIS 2015, 2016, and 2017 rates for HPN are presented in Table 5–5, along with HEDIS 2015 to HEDIS 2017 rate comparisons. For measures for which lower rates suggest better performance (i.e., *Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total* and *Ambulatory Care—Total—Emergency Department [ED] Visits—Total*), a decrease in the rate from 2015 to 2017 represents performance improvement and an increase in the rate from 2015 to 2017 represents performance decline. Since measures in the Utilization and Diversity of Membership measure domain are designed to capture the frequency of services provided by the MCOs and characteristics of the population served by the MCO, higher or lower rates in this domain do not necessarily indicate better or worse performance. These rates are provided for information purposes only.

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

HEDIS Measure	HEDIS 2015 Rate	HEDIS 2016 Rate	HEDIS 2017 Rate	2015–2017 Rate Comparison
Access to Care				
<i>Children and Adolescents’ Access to Primary Care Practitioners (CAP)</i>				
<i>Ages 12–24 Months</i>	94.70%	99.48%	98.50%	3.80
<i>Ages 25 Months–6 Years</i>	87.20%	89.55%	89.61%	2.41
<i>Ages 7–11 Years</i>	93.83%	93.54%	92.98%	-0.85
<i>Ages 12–19 Years</i>	90.79%	90.78%	91.29%	0.50
<i>Annual Dental Visit (ADV)</i>				
<i>Total</i>	69.50%	70.11%	68.88%	-0.62
Children’s Preventive Care				
<i>Adolescent Well-Care Visits (AWC)</i>				
<i>Adolescent Well-Care Visits</i>	55.47%	52.83%	54.74%	-0.73
<i>Childhood Immunization Status (CIS)</i>				
<i>Combination 2</i>	83.46%	87.93%	84.38%	0.92
<i>Combination 3</i>	77.17%	84.48%	82.14%	4.97

HEDIS Measure	HEDIS 2015 Rate	HEDIS 2016 Rate	HEDIS 2017 Rate	2015–2017 Rate Comparison
<i>Combination 4</i>	76.38%	83.91%	82.14%	5.76
<i>Combination 5</i>	66.14%	79.89%	71.88%	5.74
<i>Combination 6</i>	48.03%	52.30%	41.52%	-6.51
<i>Combination 7</i>	65.35%	79.31%	71.88%	6.53
<i>Combination 8</i>	47.24%	51.72%	41.52%	-5.72
<i>Combination 9</i>	42.52%	50.00%	37.50%	-5.02
<i>Combination 10</i>	41.73%	49.43%	37.50%	-4.23
<i>Immunizations for Adolescents (IMA)</i>				
<i>Combination 1 (Meningococcal, Tdap)</i>	—	87.35%	87.59%	NC
<i>Combination 2 (Meningococcal, Tdap, HPV)</i>	—	—	38.69%	NC
<i>Well-Child Visits in the First 15 Months of Life (W15)</i>				
<i>Six or More Well-Child Visits</i>	60.00%	68.00%	63.49%	3.49
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)</i>				
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	71.95%	70.13%	67.64%	-4.31
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)</i>				
<i>BMI Percentile—Total</i>	—	72.02%	73.24%	NC
<i>Counseling for Nutrition—Total</i>	—	60.34%	61.07%	NC
<i>Counseling for Physical Activity—Total¹</i>	—	57.18%	58.39%	NC
Care for Chronic Conditions				
<i>Medication Management for People with Asthma (MMA)</i>				
<i>Medication Compliance 50%—Total</i>	—	47.62%	51.02%	NC
<i>Medication Compliance 75%—Total</i>	—	26.98%	27.89%	NC
Behavioral Health				
<i>Follow-Up After Hospitalization for Mental Illness (FUH)</i>				
<i>7-Day Follow-Up</i>	NA	NA	NA	NC
<i>30-Day Follow-Up</i>	NA	NA	NA	NC
<i>Follow-Up Care for Children Prescribed ADHD Medication (ADD)</i>				
<i>Initiation Phase</i>	—	39.53%	48.89%	NC

HEDIS Measure	HEDIS 2015 Rate	HEDIS 2016 Rate	HEDIS 2017 Rate	2015–2017 Rate Comparison
<i>Continuation and Maintenance Phase</i>	—	NA	NA	NC
<i>Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)^{2,*}</i>				
<i>Total</i>	—	NA	NA	NC
Utilization and Diversity of Membership				
<i>Mental Health Utilization (MPT)</i>				
<i>Any Service (Total)</i>	3.87%	4.71%	5.19%	1.32
<i>Inpatient (Total)</i>	0.19%	0.14%	0.22%	0.03
<i>Intensive Outpatient or Partial Hospitalization (Total)</i>	0.50%	0.55%	0.77%	0.27
<i>Outpatient, ED, or Telehealth (Total)</i>	3.83%	4.67%	5.18%	1.35
<i>Ambulatory Care (AMB)—Total</i>				
<i>Outpatient Visits—Total</i>	259.27	259.29	252.28	-6.99
<i>ED Visits—Total*</i>	18.83	21.00	22.11	3.28

¹ Due to changes in NCQA's HEDIS 2016 technical specifications for this measure, exercise caution when comparing HEDIS 2015 to HEDIS 2016 and 2017 rates.

² Due to changes in NCQA's HEDIS 2017 technical specifications for this measure, exercise caution when comparing HEDIS 2017 to prior years' rates.

* A lower rate indicates better performance for this measure.

— Indicates the rate is not presented in the table above because reporting the measure was not required for the respective reporting year.

NC (i.e., Not Compared) indicates the HEDIS 2015 and HEDIS 2017 rates were not available for comparison.

NA (i.e., Small Denominator) indicates the health plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

HPN's rates demonstrated mixed performance in the area of immunizations for children from HEDIS 2015 to HEDIS 2017. Vaccination rates for combinations 4, 5, and 7 increased by greater than 5 percentage points and vaccination rates for combinations 6, 8, and 9 decreased by greater than 5 percentage points. These changes present opportunities for **HPN** to focus efforts on determining root causes linked to improvements and declines in performance.

Summary of HPN Strengths

The following Medicaid performance measure indicators were identified as emerging improvement for **HPN** based on rate improvements greater than 5 percentage points from HEDIS 2015 to HEDIS 2017:

- *Adolescent Well-Care Visits*
- *Childhood Immunization Status—Combination 5 and 7*
- *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*
- *Frequency of Ongoing Prenatal Care—<21 Percent of Expected Visits and ≥81 Percent of Expected Visits*
- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed and Medical Attention for Nephropathy⁵⁻²*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up and 30-Day Follow-Up*

The following Nevada Check Up performance measure indicators were identified as emerging improvement for **HPN** based on rate improvements greater than 5 percentage points from HEDIS 2015 to HEDIS 2017:

- *Childhood Immunization Status—Combinations 4, 5, and 7*

Summary of HPN Opportunities for Improvement

The following Medicaid performance measure indicators were identified as opportunities for improvement for **HPN** based on a decline in performance of greater than 5 percentage points from HEDIS 2015 to HEDIS 2017:

- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)⁵⁻³*

The following Nevada Check Up performance measure indicators were identified as opportunities for improvement for **HPN** based on a decline in performance of greater than 5 percentage points from HEDIS 2015 to HEDIS 2017:

- *Childhood Immunization Status—Combinations 6, 8, and 9*

⁵⁻² Due to changes in NCQA's HEDIS 2016 technical specifications for this measure, exercise caution when comparing HEDIS 2015 to HEDIS 2016 and 2017 rates.

⁵⁻³ Ibid.

Plan Comparison

The HEDIS 2017 measure rates for **HPN**, **Amerigroup**, and the statewide weighted average results for the Medicaid and Nevada Check Up populations relative to the Quality Compass national Medicaid percentiles for HEDIS 2016 are shown in Table 5–7 and Table 5–9. Measure results were compared to benchmarks and rated using the following star ratings:

Table 5–6—HEDIS Star Ratings

Star Rating	Performance Level
★★★★★	At or above the national Medicaid 90th percentile
★★★★	At or above the national Medicaid 75th percentile but below the 90th percentile
★★★	At or above the national Medicaid 50th percentile but below the 75th percentile
★★	At or above the national Medicaid 25th percentile but below the 50th percentile
★	Below the national Medicaid 25th percentile

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

Medicaid Results

Table 5–7 presents the HEDIS 2017 MCO-specific rates and the statewide weighted average Medicaid rates along with star ratings based on comparisons of the rates to the Quality Compass national Medicaid percentiles for HEDIS 2016.

Table 5–7—HEDIS 2017 Results for Medicaid

HEDIS Measure	AGP	HPN	Medicaid
Access to Care			
<i>Children and Adolescents’ Access to Primary Care Practitioners (CAP)</i>			
<i>Ages 12–24 Months</i>	93.83% ★★	95.17% ★★	94.55% ★★
<i>Ages 25 Months–6 Years</i>	82.25% ★	83.81% ★	83.08% ★
<i>Ages 7–11 Years</i>	86.59% ★	87.57% ★	87.16% ★

HEDIS Measure	AGP	HPN	Medicaid
<i>Ages 12–19 Years</i>	82.95% ★	85.51% ★	84.54% ★
Annual Dental Visit (ADV)			
<i>Total</i>	51.63% ★★	53.85% ★★★★	52.91% ★★★★
Children's Preventive Care			
Adolescent Well-Care Visits (AWC)			
<i>Adolescent Well-Care Visits</i>	47.69% ★★	44.77% ★★	45.88% ★★
Childhood Immunization Status (CIS)			
<i>Combination 2</i>	72.92% ★★	73.72% ★★	73.33% ★★
<i>Combination 3</i>	67.13% ★★	71.05% ★★	69.12% ★★
<i>Combination 4</i>	66.67% ★★	71.05% ★★★★	68.90% ★★★★
<i>Combination 5</i>	56.71% ★★	61.07% ★★★★	58.93% ★★
<i>Combination 6</i>	36.11% ★★	34.79% ★★	35.44% ★★
<i>Combination 7</i>	56.25% ★★	61.07% ★★★★	58.71% ★★★★
<i>Combination 8</i>	36.11% ★★	34.79% ★★	35.44% ★★
<i>Combination 9</i>	32.18% ★★	30.41% ★★	31.28% ★★
<i>Combination 10</i>	32.18% ★★	30.41% ★★	31.28% ★★
Immunizations for Adolescents (IMA)			
<i>Combination 1 (Meningococcal, Tdap)</i>	79.40% ★★★★	80.78% ★★★★	80.25% ★★★★
<i>Combination 2 (Meningococcal, Tdap, HPV)</i>	26.85% NC	27.49% NC	27.25% NC
Well-Child Visits in the First 15 Months of Life (W15)			
<i>Six or More Well-Child Visits</i>	62.50% ★★★★	62.77% ★★★★	62.64% ★★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)			
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	68.72% ★★	65.21% ★★	66.85% ★★

HEDIS Measure	AGP	HPN	Medicaid
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)			
<i>BMI Percentile—Total</i>	70.14% ★★★	71.78% ★★★	71.10% ★★★
<i>Counseling for Nutrition—Total</i>	62.73% ★★★	62.29% ★★	62.47% ★★
<i>Counseling for Physical Activity—Total</i>	56.48% ★★★	59.61% ★★★	58.31% ★★★
Maternity Care			
Prenatal and Postpartum Care (PPC)			
<i>Timeliness of Prenatal Care</i>	83.33% ★★★	72.75% ★	77.85% ★★
<i>Postpartum Care</i>	62.50% ★★★	59.12% ★★	60.75% ★★
Frequency of Ongoing Prenatal Care (FPC)			
<i><21 Percent of Expected Visits*</i>	5.56% ★★★	11.19% ★★	8.47% ★★
<i>≥81 Percent of Expected Visits</i>	62.50% ★★★	60.83% ★★★	61.63% ★★★
Care for Chronic Conditions			
Comprehensive Diabetes Care (CDC)			
<i>Hemoglobin A1c (HbA1c) Testing</i>	81.02% ★	82.73% ★	82.10% ★
<i>HbA1c Poor Control (>9.0%)*</i>	46.30% ★★	42.82% ★★★	44.10% ★★
<i>HbA1c Control (<8.0%)</i>	45.60% ★★	48.42% ★★★	47.38% ★★★
<i>Eye Exam (Retinal) Performed</i>	59.49% ★★★	61.31% ★★★	60.64% ★★★
<i>Medical Attention for Nephropathy</i>	90.28% ★★	90.75% ★★★	90.58% ★★★
<i>Blood Pressure Control (<140/90 mm Hg)</i>	61.11% ★★★	50.36% ★	54.33% ★★
Medication Management for People with Asthma (MMA)			
<i>Medication Compliance 50%—Total¹</i>	56.19% ★★★	53.37% ★★	54.52% ★★
<i>Medication Compliance 75%—Total</i>	32.16% ★★★	32.81% ★★★	32.54% ★★★

HEDIS Measure	AGP	HPN	Medicaid
Behavioral Health			
<i>Follow-Up After Hospitalization for Mental Illness (FUH)</i>			
7-Day Follow-Up	79.81% ★★★★★	79.16% ★★★★★	79.52% ★★★★★
30-Day Follow-Up	84.98% ★★★★★	84.20% ★★★★★	84.63% ★★★★★
<i>Follow-Up Care for Children Prescribed ADHD Medication (ADD)</i>			
Initiation Phase	43.51% ★★★	43.68% ★★★	43.60% ★★★
Continuation and Maintenance Phase	64.91% ★★★★	49.28% ★★	56.35% ★★★
<i>Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)^{2,*}</i>			
Total	3.74% ★	2.26% ★★	2.92% ★★
Utilization and Diversity of Membership			
<i>Mental Health Utilization (MPT)</i>			
Any Service (Total)	8.63% NC	6.80% NC	7.57% NC
Inpatient (Total)	1.16% NC	0.78% NC	0.94% NC
Intensive Outpatient or Partial Hospitalization (Total)	0.24% NC	0.30% NC	0.28% NC
Outpatient, ED, or Telehealth (Total)	8.50% NC	6.73% NC	7.47% NC
<i>Ambulatory Care (AMB)—Total</i>			
Outpatient Visits—Total	287.09 NC	298.12 NC	293.47 NC
ED Visits—Total*	54.02 NC	52.60 NC	53.20 NC

* A lower rate indicates better performance for this measure.

¹ Quality Compass percentiles were not available for this measure; therefore, NCQA's HEDIS Audit Means and Percentiles was used as the comparative source for national Medicaid percentiles for this measure.

² Due to changes in NCQA's HEDIS 2017 technical specifications for this measure, exercise caution when comparing HEDIS 2017 rates for this measure to the national percentiles because these values were derived using the HEDIS 2016 technical specifications.

NC (i.e., Not Compared) indicates the HEDIS 2017 rate was not compared to benchmarks either because national Medicaid percentiles were not available or because the measure is presented only for information purposes and comparisons to benchmarks are not appropriate.

Amerigroup's and **HPN's** rates for *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* ranked at or above the national Medicaid 90th percentile for HEDIS 2017, indicating timely follow-up care for members hospitalized for mental illness.

However, both MCOs' rates for *Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years, Ages 7–11 Years, and Ages 12–19 Years*, as well as *Comprehensive Diabetes Care—HbA1c Testing* fell below the national Medicaid 25th percentile, indicating areas for improvement related to access to care for children and adolescents, and appropriate HbA1c testing for members with diabetes.

HPN's rates for *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* fell below the national Medicaid 25th percentile, while **Amerigroup's** rates were more than 10 percentage points higher than **HPN's** rates and ranked at or above the national 50th percentile, which suggests that timely prenatal care for pregnant women and blood pressure control for members with diabetes are opportunities for improvement for **HPN**. Additionally, **HPN's** rate for *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* fell below the national Medicaid 50th percentile, while **Amerigroup's** rate for this measure indicator was almost 16 percentage points above **HPN's** rate and ranked at or above the national 75th percentile. **HPN's** rate did improve 9.36 percentage points over the previous year; however, there is still opportunity to improve the rate for follow-up care for children on ADHD medication further.

Data Completeness

Table 5–8 provides an estimate of data completeness for the hybrid performance measures. These measures used administrative data (i.e., claims and encounter data) and supplemented the results with medical record review data. Measures that used only administrative data were not included. The table shows the HEDIS 2017 rates and the percentage of each reported rate that was determined solely through administrative data for both MCOs. Rates shaded green with one caret (^) indicate that more than 90 percent of the final rate was derived using administrative data. Rates shaded red with two carets (^) indicate that less than 50 percent of the final rate was derived using administrative data.

Table 5–8—Estimated Encounter Data Completeness for Medicaid Hybrid Measures

HEDIS Measure	AGP HEDIS 2017 Rate	AGP Percent from Administrative Data	HPN HEDIS 2017 Rate	HPN Percent from Administrative Data
Children's Preventive Care				
<i>Adolescent Well-Care Visits (AWC)</i>				
<i>Adolescent Well-Care Visits</i>	47.69%	85.92%	44.77%	98.37% ^
<i>Childhood Immunization Status (CIS)</i>				
<i>Combination 2</i>	72.92%	97.78% ^	73.72%	84.49%
<i>Combination 3</i>	67.13%	96.90% ^	71.05%	82.53%
<i>Combination 4</i>	66.67%	96.88% ^	71.05%	82.53%

HEDIS Measure	AGP HEDIS 2017 Rate	AGP Percent from Administrative Data	HPN HEDIS 2017 Rate	HPN Percent from Administrative Data
<i>Combination 5</i>	56.71%	96.73% ^	61.07%	82.07%
<i>Combination 6</i>	36.11%	96.15% ^	34.79%	81.12%
<i>Combination 7</i>	56.25%	96.71% ^	61.07%	82.07%
<i>Combination 8</i>	36.11%	96.15% ^	34.79%	81.12%
<i>Combination 9</i>	32.18%	96.40% ^	30.41%	79.20%
<i>Combination 10</i>	32.18%	96.40% ^	30.41%	79.20%
Immunizations for Adolescents (IMA)				
<i>Combination 1 (Meningococcal, Tdap)</i>	79.40%	97.08% ^	80.78%	93.98% ^
<i>Combination 2 (Meningococcal, Tdap, HPV)</i>	26.85%	93.10% ^	27.49%	89.38%
Well-Child Visits in the First 15 Months of Life (W15)				
<i>Six or More Well-Child Visits</i>	62.50%	79.26%	62.77%	89.53%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)				
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	68.72%	93.66% ^	65.21%	97.39% ^
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
<i>BMI Percentile—Total</i>	70.14%	33.66% ^^	71.78%	34.92% ^^
<i>Counseling for Nutrition—Total</i>	62.73%	29.15% ^^	62.29%	32.42% ^^
<i>Counseling for Physical Activity—Total</i>	56.48%	11.48% ^^	59.61%	15.51% ^^
Maternity Care				
Prenatal and Postpartum Care (PPC)				
<i>Timeliness of Prenatal Care</i>	83.33%	64.44%	72.75%	71.91%
<i>Postpartum Care</i>	62.50%	60.00%	59.12%	63.79%
Frequency of Ongoing Prenatal Care (FPC)				
<i><21 Percent of Expected Visits</i>	5.56%	83.33%	11.19%	97.83% ^
<i>≥81 Percent of Expected Visits</i>	62.50%	22.22% ^^	60.83%	25.60% ^^
Care for Chronic Conditions				
Comprehensive Diabetes Care (CDC)				
<i>Hemoglobin A1c (HbA1c) Testing</i>	81.02%	97.14% ^	82.73%	99.12% ^

HEDIS Measure	AGP HEDIS 2017 Rate	AGP Percent from Administrative Data	HPN HEDIS 2017 Rate	HPN Percent from Administrative Data
<i>HbA1c Poor Control (>9.0%)</i>	46.30%	71.50%	42.82%	98.86% ^
<i>HbA1c Control (<8.0%)</i>	45.60%	58.88%	48.42%	96.48% ^
<i>Eye Exam (Retinal) Performed</i>	59.49%	89.88%	61.31%	87.70%
<i>Medical Attention for Nephropathy</i>	90.28%	99.23% ^	90.75%	99.46% ^
<i>Blood Pressure Control (<140/90 mm Hg)</i>	61.11%	0.00% ^^	50.36%	0.00% ^^

Green Shading^ indicates that more than 90 percent of the final rate was derived from administrative data.

Red Shading^^ indicates that 50 percent or less of the final rate was derived from administrative data.

The MCOs reported a total of 27 rates for the Medicaid population using the hybrid methodology. Fourteen rates reported by **Amerigroup** (i.e., more than half of **Amerigroup**'s hybrid rates) were derived using more than 90 percent administrative data, indicating high levels of encounter data completeness. Eight rates reported by **HPN** (less than one-third of **HPN**'s rates) were derived using more than 90 percent administrative data. For both MCOs, five rates were derived using 50 percent or less administrative data, including rates for all three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* indicators, *Frequency of Ongoing Prenatal Care—≥81 Percent of Expected Visits*, and *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*. However, for these measures the numerator-positive hits are often detected primarily through medical record review, not administrative data.

Nevada Check Up Results

Table 5–9 presents the HEDIS 2016 MCO-specific rates and the statewide weighted average Nevada Check Up rates along with star ratings on comparisons of the rates to the Quality Compass national Medicaid percentiles for HEDIS 2016.⁵⁻⁴

Table 5–9—HEDIS 2017 Results for Nevada Check Up

HEDIS Measure	AGP	HPN	NV Check Up
Access to Care			
<i>Children and Adolescents’ Access to Primary Care Practitioners (CAP)</i>			
<i>Ages 12–24 Months</i>	98.18% ★★★★★	98.50% ★★★★★	98.36% ★★★★★
<i>Ages 25 Months–6 Years</i>	89.45% ★★★	89.61% ★★★	89.54% ★★★
<i>Ages 7–11 Years</i>	91.83% ★★★	92.98% ★★★	92.55% ★★★
<i>Ages 12–19 Years</i>	91.08% ★★★	91.29% ★★★	91.22% ★★★
<i>Annual Dental Visit (ADV)</i>			
<i>Total</i>	67.81% ★★★★★	68.88% ★★★★★	68.48% ★★★★★
Children’s Preventive Care			
<i>Adolescent Well-Care Visits (AWC)</i>			
<i>Adolescent Well-Care Visits</i>	60.88% ★★★★★	54.74% ★★★	56.79% ★★★
<i>Childhood Immunization Status (CIS)</i>			
<i>Combination 2</i>	91.16% ★★★★★	84.38% ★★★★★	87.39% ★★★★★
<i>Combination 3</i>	82.87% ★★★★★	82.14% ★★★★★	82.47% ★★★★★
<i>Combination 4</i>	81.22% ★★★★★	82.14% ★★★★★	81.73% ★★★★★
<i>Combination 5</i>	72.93% ★★★★★	71.88% ★★★★★	72.34% ★★★★★
<i>Combination 6</i>	47.51% ★★★★★	41.52% ★★★	44.18% ★★★

⁵⁻⁴ Because national benchmarks for HEDIS measures are not available for the Children’s Health Insurance Program (CHIP) population, comparisons of Nevada’s Check Up population rates to the national Medicaid percentiles should be interpreted with caution.

HEDIS Measure	AGP	HPN	NV Check Up
<i>Combination 7</i>	72.38% ★★★★★	71.88% ★★★★★	72.10% ★★★★★
<i>Combination 8</i>	47.51% ★★★★★	41.52% ★★★	44.18% ★★★
<i>Combination 9</i>	44.75% ★★★★★	37.50% ★★★	40.72% ★★★
<i>Combination 10</i>	44.75% ★★★★★	37.50% ★★★	40.72% ★★★
Immunizations for Adolescents (IMA)			
<i>Combination 1 (Meningococcal, Tdap)</i>	83.61% ★★★★★	87.59% ★★★★★	86.28% ★★★★★
<i>Combination 2 (Meningococcal, Tdap, HPV)</i>	38.46% NC	38.69% NC	38.61% NC
Well-Child Visits in the First 15 Months of Life (W15)			
<i>Six or More Well-Child Visits</i>	78.92% ★★★★★	63.49% ★★★	70.70% ★★★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)			
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	76.16% ★★★	67.64% ★★	71.34% ★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)			
<i>BMI Percentile—Total</i>	71.30% ★★★	73.24% ★★★	72.52% ★★★
<i>Counseling for Nutrition—Total</i>	65.28% ★★★	61.07% ★★	62.61% ★★
<i>Counseling for Physical Activity—Total</i>	59.72% ★★★	58.39% ★★★	58.88% ★★★
Care for Chronic Conditions			
Medication Management for People with Asthma (MMA)			
<i>Medication Compliance 50%—Total¹</i>	58.43% ★★★	51.02% ★★	53.81% ★★
<i>Medication Compliance 75%—Total</i>	24.72% ★	27.89% ★★	26.69% ★★
Behavioral Health			
Follow-Up After Hospitalization for Mental Illness (FUH)			
<i>7-Day Follow-Up</i>	82.50% ★★★★★	NA	80.00% ★★★★★
<i>30-Day Follow-Up</i>	97.50% ★★★★★	NA	92.31% ★★★★★

HEDIS Measure	AGP	HPN	NV Check Up
<i>Follow-Up Care for Children Prescribed ADHD Medication (ADD)</i>			
<i>Initiation Phase</i>	41.67% ★★	48.89% ★★★	45.68% ★★★
<i>Continuation and Maintenance Phase</i>	NA	NA	NA
<i>Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)^{2,*}</i>			
<i>Total</i>	NA	NA	5.71% ★
Utilization and Diversity of Membership			
<i>Mental Health Utilization (MPT)</i>			
<i>Any Service (Total)</i>	5.68% NC	5.19% NC	5.38% NC
<i>Inpatient (Total)</i>	0.42% NC	0.22% NC	0.29% NC
<i>Intensive Outpatient or Partial Hospitalization (Total)</i>	0.16% NC	0.77% NC	0.53% NC
<i>Outpatient, ED, or Telehealth (Total)</i>	5.64% NC	5.18% NC	5.36% NC
<i>Ambulatory Care (AMB)—Total</i>			
<i>Outpatient Visits—Total</i>	258.30 NC	252.28 NC	254.60 NC
<i>ED Visits—Total*</i>	26.30 NC	22.11 NC	23.73 NC

* A lower rate indicates better performance for this measure.

¹ Quality Compass percentiles were not available for this measure; therefore, NCQA's HEDIS Audit Means and Percentiles was used as the comparative source for national Medicaid percentiles for this measure.

² Due to changes in NCQA's HEDIS 2017 technical specifications for this measure, exercise caution when comparing HEDIS 2017 rates to national benchmarks that were derived using NCQA's HEDIS 2016 specifications.

NC (i.e., Not Compared) indicates the HEDIS 2017 rate was not compared to benchmarks either because national Medicaid percentiles were not available or because the measure is presented only for information purposes and comparisons to benchmarks are not appropriate.

NA (i.e., Small Denominator) indicates the health plan(s) followed the specifications, but the denominator was too small (<30) to report a valid rate.

Amerigroup's and **HPN's** HEDIS 2017 rates for the Nevada Check Up population indicate positive performance related to access to primary care, dental care, and immunizations for children. Specifically, the MCOs' rates for *Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months, Annual Dental Visit—Total*, and *Childhood Immunization Status—Combinations 2–5*, ranked at or above the national Medicaid 90th percentile.

Amerigroup's rates for *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* ranked at or above the national Medicaid 90th percentile, demonstrating timely follow-up care for members hospitalized for mental illness.

Conversely, **HPN**'s rate for *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* was below the national Medicaid 75th percentile, but **Amerigroup**'s rate for this measure was above the national Medicaid 90th percentile and more than 15 percentage points above **HPN**'s rate, indicating there were opportunities for improvement for access to well-child visits for infants for **HPN**.

As mentioned previously, comparisons between Nevada's Check Up population rates to national Medicaid benchmarks should be interpreted with caution.

Data Completeness

Table 5–10 provides an estimate of data completeness for the hybrid performance measures. These measures used administrative data (i.e., claims and encounter data) and supplemented the results with medical record review data. Measures that used only administrative data were not included. The table shows the HEDIS 2017 rates and the percentage of each reported rate that was determined solely through administrative data for both MCOs. Rates shaded green with one caret (^) indicate that more than 90 percent of the final rate was derived using administrative data. Rates shaded red with two carets (^^) indicate that less than 50 percent of the final rate was derived using administrative data.

Table 5–10—Estimated Encounter Data Completeness for Nevada Check Up Hybrid Measures

HEDIS Measure	AGP HEDIS 2017 Rate	AGP Percent from Administrative Data	HPN HEDIS 2017 Rate	HPN Percent from Administrative Data
Children's Preventive Care				
<i>Adolescent Well-Care Visits (AWC)</i>				
<i>Adolescent Well-Care Visits</i>	60.88%	87.45%	54.74%	98.67% ^
<i>Childhood Immunization Status (CIS)</i>				
<i>Combination 2</i>	91.16%	97.58% ^	84.38%	88.36%
<i>Combination 3</i>	82.87%	96.67% ^	82.14%	86.96%
<i>Combination 4</i>	81.22%	96.60% ^	82.14%	86.96%
<i>Combination 5</i>	72.93%	97.73% ^	71.88%	86.34%
<i>Combination 6</i>	47.51%	97.67% ^	41.52%	80.65%
<i>Combination 7</i>	72.38%	97.71% ^	71.88%	86.34%
<i>Combination 8</i>	47.51%	97.67% ^	41.52%	80.65%
<i>Combination 9</i>	44.75%	98.77% ^	37.50%	79.76%
<i>Combination 10</i>	44.75%	98.77% ^	37.50%	79.76%

HEDIS Measure	AGP HEDIS 2017 Rate	AGP Percent from Administrative Data	HPN HEDIS 2017 Rate	HPN Percent from Administrative Data
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	83.61%	97.60%^	87.59%	91.67%^
Combination 2 (Meningococcal, Tdap, HPV)	38.46%	95.65%^	38.69%	83.02%
Well-Child Visits in the First 15 Months of Life (W15)				
Six or More Well-Child Visits	78.92%	80.92%	63.49%	85.00%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	76.16%	93.62%^	67.64%	96.76%^
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile—Total	71.30%	28.90%^	73.24%	33.22%^
Counseling for Nutrition—Total	65.28%	26.60%^	61.07%	34.66%^
Counseling for Physical Activity—Total	59.72%	15.89%^	58.39%	19.17%^

Green Shading^ indicates that more than 90 percent of the final rate was derived from administrative data.

Red Shading^^ indicates that 50 percent or less of the final rate was derived from administrative data.

The MCOs reported a total of 17 rates for the Nevada Check Up population using the hybrid methodology. Twelve rates reported by **Amerigroup** (i.e., more than half of **Amerigroup**'s hybrid rates) were derived using more than 90 percent administrative data, as were three rates reported by **HPN**. Rates for all three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure indicators for both MCOs were derived using 50 percent or less administrative data. However, for these measures, numerator-positive hits are often detected primarily through medical record review, not administrative data.

Amerigroup Conclusions and Recommendations

Conclusions

The NCQA HEDIS compliance audits demonstrated that **Amerigroup** had adequate policies and procedures to collect, prepare, process, and report HEDIS data and the MCO was in full compliance with each of the six NCQA-specified IS standards. **Amerigroup** continued to use Facets to process its 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. **Amerigroup** applied several validation checks to ensure accurate information processing.

For the Medicaid population performance measure evaluation, **Amerigroup**'s HEDIS 2017 rates as compared to the national Medicaid percentiles indicated strong performance related to timely follow-up care for members hospitalized for mental illness. **Amerigroup**'s rates for this measure demonstrated notable improvements from HEDIS 2015 to HEDIS 2017. **Amerigroup**'s performance improved from HEDIS 2015 to HEDIS 2017 with regard to well-child visits for infants and well-care visits for adolescents. Additionally, **Amerigroup**'s rates for immunizations for children, dental care for children, and prenatal/postpartum care for pregnant women demonstrated improvements from HEDIS 2015 to HEDIS 2017. Although there was no rate for weight assessment and counseling for nutrition and physical activity for children in HEDIS 2015, the comparison from HEDIS 2016 to HEDIS 2017 showed that each of the three indicators improved by 6 percentage points or more and all indicators were above the 50th national Medicaid percentile. **Amerigroup** also demonstrated strong improvement from HEDIS 2016 to HEDIS 2017 for medication management for people with asthma and follow-up care for children prescribed ADHD medication.

Amerigroup's HEDIS 2017 rates as compared to the national Medicaid percentiles indicated areas for improvement related to access to care for children/adolescents and appropriate HbA1c testing for members with diabetes.

For the Nevada Check Up population performance measure evaluation, **Amerigroup**'s HEDIS 2017 rates indicated positive performance related to access to primary care and dental care for children as compared to the national Medicaid percentiles. **Amerigroup**'s rates also demonstrated timely follow-up care for members hospitalized for mental illness for the 30-day follow up visit. **Amerigroup**'s performance improved from HEDIS 2015 to HEDIS 2017 in the areas of immunizations for children and well-child visits for infants.

Recommendations

Amerigroup's HEDIS 2017 Medicaid population rates indicated areas for improvement related to access to care for children/adolescents. While all four children/adolescent access to care indicators have shown slight improvement from HEDIS 2015 to HEDIS 2017, the rates demonstrate opportunities for improvement when compared to the national Medicaid percentiles. In conducting a causal barrier analysis to determine causes that impact CAHPS rates (see Section 9 of this report for more information), **Amerigroup** staff members reported that the expansion of Medicaid eligibility in 2014 may have strained the provider network and, as a result, negatively impacted the availability of appointments. For HEDIS 2017, the denominators in each of the children's access to primary care indicators increased, which was expected with Medicaid expansion. In 2016, **Amerigroup** hired additional provider relations consultants to review the network and contract with additional providers to fill network gaps. It is possible that the timing of these efforts may not have been early enough to positively impact the availability of appointments to such a degree that it would improve children's and adolescents access to care. Since *Children and Adolescents' Access to Primary Care Practitioners* is an access-related measure, HSAG recommends that **Amerigroup** continue to evaluate the adequacy of its provider network for children's services, including capacity and geographic locations, to determine if a sufficient number of providers have been added to improve capacity and accessibility. Further, **Amerigroup** should evaluate the provider appointment availability for children and adolescents as part

of its secret shopper survey activities, which is one of the new contract requirements for the MCOs operating in the Nevada managed care program.

Amerigroup's HEDIS 2017 Medicaid population rates also indicated areas for improvement related to HbA1c testing for diabetic members. In its 2016 Annual Quality Evaluation, **Amerigroup** reported an increase in enrollment in the disease management program for diabetics. Of the 3,673 members enrolled in disease management for diabetes, 96.8 percent received "passive management," which according to the **Amerigroup** quality evaluation meant that members were "considered lower risk and received non-interactive interventions, including condition-specific educational mailings." According to **Amerigroup**'s quality evaluation, members enrolled in active management had "complex, comorbid conditions and worked collaboratively with a nurse case manager by phone to establish holistic goals, develop a plan of care, and track progress toward meeting goals." HSAG recommends that **Amerigroup** evaluate the effectiveness of active disease management compared to passive disease management to determine if active disease management with a care manager, or components of it, are more effective in meeting numerator compliance for the *Comprehensive Diabetes Care* indicators. By evaluating the effectiveness of its interventions, **Amerigroup** will be able to discern the most effective interventions and spread those across the population.

HPN Conclusions and Recommendations

Conclusions

The NCQA HEDIS compliance audits demonstrated that **HPN** had adequate policies and procedures to collect, prepare, process, and report HEDIS data and was in full compliance with each of the six NCQA-specified IS standards. **HPN** continued to use Facets to process its 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. **HPN** applied several validation checks to ensure accurate information processing.

For the Medicaid population performance measure evaluation, **HPN**'s HEDIS 2017 rates as compared to the national Medicaid percentiles indicated positive performance related to timely follow-up care for members hospitalized for mental illness. **HPN**'s rates for this measure also demonstrated notable improvements from HEDIS 2015 to HEDIS 2017. **HPN**'s performance improved from HEDIS 2015 to HEDIS 2017 with regard to well-child visits for infants and well-care visits for adolescents. Some of the measures were not required for HEDIS 2015; however, **HPN** did show improvement from HEDIS 2016 to HEDIS 2017 for the following measures: *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*, and *Medication Management for People With Asthma*.

HPN's Medicaid rates indicated improvement in the frequency of prenatal care from HEDIS 2015 to HEDIS 2017, but rates for the measure assessing timely prenatal care showed a decline in performance year over year, indicating opportunities for improvement. Comparisons of **HPN**'s timely prenatal care rates as compared to the national Medicaid percentiles also suggested opportunities for improvement in this area. **HPN**'s HEDIS 2017 rates compared to the national Medicaid percentiles indicated areas for improvement related to access to care for children/adolescents and appropriate HbA1c testing for

members with diabetes. Further, **HPN**'s rates as compared to the national Medicaid percentiles presented opportunities for improvement for blood pressure control for members with diabetes and follow-up care for children on ADHD medication.

For the Nevada Check Up population performance measure evaluation, **HPN**'s HEDIS 2017 rates indicated positive performance related to access to primary care and dental care for children as compared to the national Medicaid percentiles. **HPN**'s rates demonstrated mixed performance in the area of immunizations for children from HEDIS 2015 to HEDIS 2017, with vaccination rates for combinations 4, 5, and 7 increasing by greater than 5 percentage points and vaccination rates for combinations 6, 8, and 9 decreasing by greater than 5 percentage points. These changes present opportunities for **HPN** to focus efforts on determining root causes linked to improvements and declines in performance. Additionally, **HPN**'s rates present opportunities for improvement for access to well-child visits for infants as compared to the national Medicaid percentiles.

Recommendations

HPN's HEDIS 2017 Medicaid population rates indicated areas for improvement for access to care for children/adolescents when compared to national Medicaid percentiles, even though all of the indicators have shown improvement based on performance from HEDIS 2015 to HEDIS 2017. The **HPN** 2016 Quality Improvement Program Evaluation contained a subgroup analysis performed at **HPN** for the access to care for children/adolescent indicators, which included an analysis by race/ethnicity for all four indicators. The annual evaluation did not show, however, an analysis of numerator compliance by geographic location. Since access to primary care for children and adolescents is an access-related measure, HSAG recommends that **HPN** evaluate the numerator compliance by geographic location to determine if disparities exist. Further, **HPN** should continue to evaluate the adequacy of its provider network by geographic location to determine if the network has a sufficient number of available pediatric providers to serve the population. When completing its contractually required secret shopper survey to determine appointment availability, **HPN** should ensure that pediatricians are included in the sample to determine if network pediatricians are accepting new patients and if appointments are available.

HPN's rates indicated improvement in the frequency of prenatal care from HEDIS 2015 to HEDIS 2017. This suggests that once pregnant women are identified in **HPN**'s population, the MCO's strategies to increase the number of prenatal care visits for women have been successful. The decline in performance for **HPN**'s rate for timeliness of prenatal care, however, suggests that pregnant women either haven't been identified early enough in the pregnancy or enrollment in the MCO, or once identified, pregnant women are not receiving prenatal services as quickly as they should. This could indicate an access to care issue. HSAG recommends that **HPN** evaluate the availability of prenatal care appointments within its provider network to determine if providers are accepting new patients and if earlier appointments may be established for members. The secret shopper survey the MCOs are required to complete as part of the MCO contract 3260 will be helpful in determining appointment availability for pregnant members.

HPN's HEDIS 2017 Medicaid population rates indicated areas for improvement related to HbA1c testing and blood pressure control for members with diabetes when compared to national Medicaid percentiles. The HPN 2016 Quality Improvement Program Evaluation showed an evaluation and analysis of comprehensive diabetes care indicators (e.g., race and ethnicity analysis); however, HbA1c testing was not included as one of the indicators. Further, the HPN 2017 Quality Improvement Work Plan did not include diabetes care goals for the Medicaid population. HSAG recommends that HPN conduct detailed analyses to determine the factors that are impacting performance in these areas. Further, HSAG recommends that HPN establish performance goals for HbA1c testing and blood pressure control for Medicaid members with diabetes and evaluate interventions to determine which have the greatest impact on the Medicaid population. The prioritization to study and improve HbA1c testing for Medicaid members with diabetes has the potential to earn HPN a performance award since it is one of the pay-for-performance indicators identified by the DHCFP.

HPN's rates presented opportunities for improvement for follow-up care for children on ADHD medication, where both indicators demonstrated a decline in performance from HEDIS 2016 to HEDIS 2017 and the continuation and maintenance phase indicator fell below the 50th national Medicaid percentile. HSAG noted that the HPN 2016 Quality Improvement Program Evaluation did not include an analysis of the measure *Follow-Up Care for Children Prescribed ADHD Medication*, as it did for other Medicaid performance measures. Further, the HPN 2017 Quality Improvement Work Plan did not include any goals for the performance measure. HSAG recommends that to identify interventions that may improve rates, HPN monitor performance related to care for children on ADHD medication in a manner similar to what is performed for other Medicaid performance measures.

For the Nevada Check Up population performance measure evaluation, HPN's rates demonstrated mixed performance for immunizations for children, with select vaccination rates improving from the previous year and select vaccinations rates declining. Those that declined were combinations 6, 8, 9, and 10. This same trend existed for both Medicaid and Nevada Check Up populations. These combination vaccines are the only ones that include the influenza antigen, which may have been the missing antigen that caused the decline in rates. For example, the only difference between combinations 3 and 6 is the inclusion of the influenza antigen in combination 6. All other antigens are the same between the two combinations and the combination 3 vaccine demonstrated a 4.97 percentage point increase from HEDIS 2015 to HEDIS 2017 for the Nevada Check Up population. HSAG recommends that HPN conduct a root cause analysis to determine the factors that may be impacting the immunization rates that contain the influenza antigen, such as failure of the provider offices to administer the recommended vaccines; failure to report the vaccines to WebIZ, which is Nevada's immunization registry; or failure of a provider, who is not the child's primary care provider, to report to WebIZ in the event the child received the vaccine at a flu clinic or pharmacy, for example. HPN might benefit from hosting a focused discussion with parents of children who were not numerator-compliant to determine if there are other factors that might impede immunizations that contain the influenza antigen. Since the Medicaid pay-for-performance incentive for MCOs includes the measure *Childhood Immunization Status—Combination 10*, HPN will be rewarded for improving this measure beyond the minimum performance standard for the Medicaid population.

6. Validation of Performance Improvement Projects—SFY 2016–2017

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.

Over time, HSAG and some of its contracted states identified that while MCOs have designed methodologically valid projects and received *Met* validation scores by complying with documentation requirements, few of them actually achieved real and sustained improvement. In July 2014, HSAG developed a new PIP framework based on a modified version of the Model for Improvement developed by Associates in Process Improvement and modified by the Institute for Healthcare Improvement. The redesigned PIP methodology is intended to improve processes and outcomes of healthcare by way of continuous quality improvement. The redesigned framework redirects MCOs to focus on small tests of change in order to determine what interventions have the greatest impact and can bring about real improvement. PIPs must meet CMS requirements; therefore, HSAG completed a crosswalk of this new framework against the Department of Health and Human Services, CMS publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.⁶⁻¹ HSAG presented the crosswalk and new PIP framework components to CMS to demonstrate how the new PIP framework aligned with the CMS validation protocols. CMS agreed that—with the pace of quality improvement science development and the prolific use of plan, do, study, act (PDSA) cycles in modern improvement projects within healthcare settings—a new approach was needed. After meeting with the DHCFP and HSAG staff members to discuss the topics and approach, CMS approved the DHCFP to implement this new PIP approach in the State of Nevada.

Objectives

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

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

⁶⁻¹ Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html>. Accessed on: Feb 19, 2013.

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

For the rapid-cycle PIP approach, HSAG developed five modules with an accompanying companion guide. Throughout SFY 2016–2017, HSAG continued to provide guidance, training, and oversight for the MCO’s PIPs. HSAG has been involved from the onset of the PIPs to determine methodological soundness and to ensure that MCOs had the knowledge and guidance needed to be successful, not only in documenting its approach but also in applying the rapid-cycle quality improvement methods that are central to achieving improved outcomes. For the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* PIP, HSAG received DHCFP instructions for the MCOs to include all three components in each MCO’s SMART Aim statement. HSAG’s validation requirements, which were approved by the DHCFP, stipulated that the MCOs must achieve the goal set for each component of the SMART Aim in order for the PIP to receive a rating of *Confidence* or *High Confidence*. See Appendix A, Technical Methods of Data Collection and Analysis, for more information on PIP validation scoring.

Plan-Specific Results—Amerigroup

In SFY 2016–2017, **Amerigroup** continued with the DHCFP selected PIP topics: *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)* and *Behavioral Health Hospital Readmissions* and progressed to completing Modules 4 and 5 (Plan-Do-Study-Act [PDSA]: Intervention Testing and PIP Conclusions). The topics, selected by the DHCFP, addressed CMS requirements related to quality outcomes—specifically, the quality and timeliness of and access to care and services.

For each PIP topic, **Amerigroup** defined a SMART Aim statement that identified the narrowed population and process to be evaluated, set a goal for improvement, and defined the indicator used to measure progress toward the goal. The SMART Aim statement set the framework for the PIP and identified the goal against which the PIP was evaluated for the annual validation.

Table 6–1—PIP Titles and SMART Aim Statements

PIP Title	SMART Aim Statement
<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)</i>	By March 31, 2017, the MCO aims to increase the compliance rate for body mass index (BMI) percentile, counseling for nutrition, and counseling for physical activity among children and adolescents 3 to 17 years of age residing in Clark County who are assigned to a Nevada Health Centers practitioner, from 78.24 percent to 88.24 percent, from 58.33 percent to 68.33 percent, and from 57.41 to 67.41 percent, respectively.

PIP Title	SMART Aim Statement
<i>Behavioral Health Hospital Readmissions</i>	By March 31, 2017, the MCO aims to reduce the number of inpatient behavioral health readmissions in Clark County by 10 percentage points from 29.07 percent to 19.07 percent.

HSAG organized and analyzed the PIP information and data submitted by **Amerigroup** to draw conclusions about the MCOs’ quality improvement efforts. Based on its review, HSAG determined the overall methodological validity of the PIP as well as the overall success in achieving the SMART Aim goal. HSAG also evaluated the appropriateness and validity of the SMART Aim measure as well as trends in the SMART Aim measurements, in comparison with the reported baseline rate and goal. The data displayed in the SMART Aim run chart were used to determine whether the SMART Aim goal was achieved.

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

Module 4: Plan-Do-Study-Act (PDSA) Intervention Testing

Amerigroup tested two interventions and submitted two Module 4 documents for validation.

The first intervention involved conducting training sessions that included the electronic health record documentation measure components using the Weight Assessment and Counseling for Nutrition and Physical Activity (WCC) Quick Reference Guide (QRG). The MCO selected the provider and office staff at the Nevada Health Center (NVHC) Martin Luther King (MLK) location. The purpose of this test was to determine if providing education and training to the staff on correct coding and documentation standards for the three components of the WCC measure would improve compliance. The training sessions occurred from September 14, 2016 through October 6, 2016. Prior to the training, **Amerigroup** administered a pre-test to obtain participants’ current knowledge. At the conclusion of each training session, each participant was given a post-test comprising the same questions as the pre-test to determine the knowledge gained from the training. After analysis of the pre- and post-test data, **Amerigroup** determined statistically significant improvement in the post-test scores. Because of this improvement, the MCO determined that it would continue testing on a larger scale at other NVHC locations.

The second intervention involved targeted QRG education and reeducation for the NVHC MLK location providers. Medical record reviews were conducted by the MCO’s quality management nurse during August through November. Data gathered during August and September (before training occurred) were used for comparison to assess post-training compliance rates for October and November. The MCO compared pre-training medical record review data to post-medical record review data to determine the success in increasing the WCC documentation compliance rates for the NVHC MLK providers. The intervention was abandoned because the post-training data showed that the QRG training was not successful in increasing the documentation compliance rates.

Upon initial validation of the first Module 4 submitted for the WCC PIP, opportunities for improvement were identified within the MCO’s summary of findings. Amerigroup sought technical assistance from HSAG prior to resubmitting the module. The MCO made the necessary corrections and met all of the validation criteria on the final validation. For the second Module 4 submitted, HSAG identified opportunities for improvement with the MCO’s summary of findings and intervention testing results reported. After receiving technical assistance from HSAG, Amerigroup made the necessary corrections, submitted the module for final validation, and achieved all of the validation criteria.

To sustain improvement that was achieved during the PIP process, Amerigroup’s documentation described the MCO’s intent to provide training for medical assistants and providers during scheduled training sessions and on-site visits to include proper documentation. The public relations (PR) director would monitor activities of those who conduct training and site visits, as well as recruitment of facilities. Quality managers and the HEDIS support team were required to provide support when needed. The data collected was used to secure buy-in from facilities in meetings prior to implementation. Ongoing data sharing was implemented, and data was shared with providers. The PR staff, PR director, and HEDIS team planned to communicate ongoing WCC results to providers and provide technical support.

Module 5: PIP Conclusions

SMART Aim Measure Outcomes

Table 6–2—SMART Aim Measure Results for the Weight Assessment PIP

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
The percentage of children and adolescents 3 to 17 years of age residing in Clark County who are assigned to a Nevada Health Centers practitioner and had a BMI percentile completed during an office visit.	78.2%	88.2%	88.0%	Low Confidence
The percentage of children and adolescents 3 to 17 years of age residing in Clark County who are assigned to a Nevada Health Centers practitioner and received counseling for nutrition during an office visit.	58.3%	68.3%	77.0%	
The percentage of children and adolescents 3 to 17 years of age residing in Clark County who are assigned to a Nevada Health Centers practitioner and received counseling for physical activity during an office visit.	57.4%	67.4%	77.0%	

Amerigroup established a goal of increasing the BMI percentile completion rate for Clark County members assigned to a NVHC practitioner by 10 percentage points, from 78.2 percent to 88.2 percent. The SMART Aim measure rate did not achieve the goal of 88.2 percent, with the highest rate achieved being 88.0 percent. From March 2016 to March 2017, the MCO was able to achieve improvement above the baseline rate for two months. However, the remaining 11 months' performance did not improve, and rates were below the baseline rate of 78.2 percent.

Amerigroup set a goal of increasing the counseling for nutrition completion rate for Clark County members assigned to a NVHC practitioner by 10 percentage points, from 58.3 percent to 68.3 percent. The SMART Aim measure rate exceeded the goal of 68.3 percent, with the highest rate achieved being 77.0 percent. The SMART Aim measure goal was exceeded for two of the 13 months from March 2016 to March 2017. In addition, **Amerigroup** was able to achieve improvement above the baseline rate for five consecutive months. The remaining eight months' performance did not improve, and rates were below the baseline rate of 58.3 percent.

Amerigroup set a goal of increasing the counseling for physical activity completion rate for Clark County members assigned to a NVHC practitioner by 10 percentage points, from 57.4 percent to 67.4 percent. The SMART Aim measure rate exceeded the goal of 68.3 percent, with the highest rate achieved being 77.0 percent. The SMART Aim measure goal was exceeded for two of the 13 months from March 2016 to March 2017. In addition, **Amerigroup** was able to achieve improvement above the baseline rate for five consecutive months. The remaining eight months' performance did not improve, and rates were below the baseline rate of 57.4 percent.

Upon initial validation of Module 5, HSAG identified opportunities for **Amerigroup** to improve how it summarized the SMART Aim measure outcomes and findings. After receiving guidance from HSAG, **Amerigroup** made the necessary corrections and submitted Module 5 for final validation. After final validation, **Amerigroup** achieved all of the Module 5 validation criteria and documentation requirements. HSAG assigned a level of *Low Confidence* to the PIP because the SMART Aim goal was only achieved for two of the three measure components.

Behavioral Health Hospital Readmissions PIP

Module 4: Plan-Do-Study-Act (PDSA) Intervention Testing

Amerigroup tested two interventions and submitted two Module 4 documents for validation.

The first intervention involved provider training and education of the Patient360 system. Patient360 is a longitudinal patient record that allows providers to view content such as claims, authorizations, labs, pharmacy and medication information, and clinical history. This system is a new initiative; therefore, the providers in the facility did not know how to use the system. To implement this intervention, the MCO identified Spring Mountain Medical Center as its location for testing and selected 12 participants. Training sessions occurred from September 23 through September 30, 2016. Immediately following the training course, the MCO administered a survey to measure the provider's knowledge of the Patient360 system. After analyzing the survey data, **Amerigroup** determined that all participants who received the

training were able to log into the system correctly, and all but one could access the member’s clinical information and complete the member’s treatment and discharge plan. Based on the intervention results, **Amerigroup** chose to adopt this intervention and will spread it to all providers. New providers will be trained to use Patient360 during the monthly new provider call.

The second intervention related to continued use of the Patient360 system at Spring Mountain. After the Patient360 training was completed, the next phase of the intervention involved generating reports to examine user logins and behavior, and provide targeted provider retraining, as needed. **Amerigroup** collected weekly user reports for 13 weeks and analyzed the data. **Amerigroup** adopted the intervention because the results from the intervention testing showed continued use of Patient360. In addition, readmission rates for members for whom a search was performed using Patient360 were 11.2 percent lower than readmission rates for members for whom a search was not performed using Patient360.

Upon initial validation of the first Module 4 submitted for the *Behavioral Health Hospital Readmissions* PIP, **Amerigroup** achieved all of the validation criteria, and a resubmission was not required. For the second Module 4 submitted, HSAG identified opportunities for improvement with the MCO’s summary of findings and intervention testing results displayed on the run chart. After receiving technical assistance from HSAG, **Amerigroup** made the necessary corrections, submitted the module for final validation, and achieved all of the validation criteria.

To sustain improvement that was achieved during the PIP process, **Amerigroup** will continue to work with Spring Mountain and offer regular Patient360 training for new associates, as well as refresher training for existing staff. Both interventions have been integrated into regular operating procedures. **Amerigroup** plans to continue tracking readmission rates to monitor for sustained improvement. The Utilization Management team has been trained to identify patterns in the rate that may signify the need for further improvement activities.

Module 5: PIP Conclusions

SMART Aim Measure Outcomes

Table 6–3—SMART Aim Measure Results for the Behavioral Health PIP

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Lowest Rate Achieved*	Confidence Level
The percentage of inpatient behavioral health readmissions in Clark County.	29.1%	19.1%	25.0%	<i>Low Confidence</i>

* The Lowest Rate Achieved is reported for the *Behavioral Health Hospital Readmissions* SMART Aim measure because the measure is an inverse indicator, where a lower rate is better.

Amerigroup established a goal of reducing the inpatient behavioral health readmission rate for members in Clark County by 10 percentage points, from 29.1 percent to 19.1 percent. The SMART Aim measure rate did not achieve the goal of 19.1 percent, with the lowest rate achieved being 25.0 percent. From March 2016 to March 2017, the MCO was able to achieve improvement below the baseline rate

for four months. However, the remaining nine months’ performance did not improve, and rates were above the baseline rate of 29.1 percent.

Upon initial validation of Module 5, HSAG identified opportunities for **Amerigroup** to improve how it summarized the SMART Aim measure outcomes and findings. After receiving guidance from HSAG, **Amerigroup** made the necessary corrections and submitted Module 5 for final validation. After final validation, **Amerigroup** achieved all of the Module 5 validation criteria and documentation requirements. HSAG assigned a level of *Low Confidence* to the PIP because the SMART Aim goal was not achieved.

Plan-Specific Results—HPN

In SFY 2017, **HPN** continued with the DHCFP selected PIP topics: *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)* and *Behavioral Health Hospital Readmissions* and progressed to completing Modules 4 and 5 (Intervention Testing and PIP Conclusions): The topics selected by the DHCFP addressed CMS requirements related to quality outcomes—specifically, the quality and timeliness of and access to care and services.

For each PIP topic, **HPN** defined a SMART Aim statement that identified the narrowed population and process to be evaluated, set a goal for improvement, and defined the indicator used to measure progress toward the goal. The SMART Aim statement set the framework for the PIP and identified the goal against which the PIP was evaluated for the annual validation.

Table 6–4—PIP Titles and SMART Aim Statements

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

HSAG reviewed the data and information submitted by **HPN** to draw conclusions about the MCO’s quality improvement efforts. Based on its review, HSAG determined the overall methodological validity of the PIP, as well as the overall success in achieving the SMART Aim goal. HSAG also evaluated the appropriateness and validity of the SMART Aim measure, as well as trends in the SMART Aim

measurements, in comparison with the reported baseline rate and goal. The data displayed in the SMART Aim run chart were used to determine whether the SMART Aim goal was achieved.

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

Module 4: Plan-Do-Study-Act (PDSA) Intervention Testing

HPN tested two interventions and submitted two Module 4s for validation.

The first intervention involved the creation of a standardized operating procedure (SOP) for Dr. Veeramachaneni's office. This provider was selected due to a low rate for WCC documentation compliance. **HPN** trained the physician and office staff on the new SOP, which focused on the required documentation for the WCC measure in the medical record. Testing took place between July 15 and September 15, 2016. The initial effectiveness of this intervention was demonstrated by the increase in the number of medical records that contained documentation of all three required components for the WCC measure. **HPN** determined that it would adopt the intervention.

The second intervention involved the next step of the SOP, billing for the three required WCC components (BMI, counseling for nutrition, and counseling for physical activity). **HPN** trained the physician and office staff on accurately billing for each of the required WCC components. Testing took place between November 1, 2016, and February 24, 2017. A claims review was conducted for those members with an outpatient visit with Dr. Veeramachaneni during November, December, and January to ensure BMI percentile, nutrition counseling, and physical activity counseling were appropriately included in the outpatient visit submitted claim. During intervention testing, it was determined that the HEDIS codes were not universal and could only be used if specific services were rendered. This finding was problematic because the MCO would never be fully compliant. To determine the extent of the problem, **HPN** asked the provider to continue to include the appropriate codes in the outpatient claim. Although the number of claims with BMI increased, the number of claims for nutrition counseling never exceeded 23 percent, and counseling for physical activity remained at zero percent. Despite these challenges, the SMART Aim remained at 100 percent due to the medical record review. Although the intervention was not the primary reason for the SMART Aim to remain at 100 percent, it would serve as a good secondary intervention if the documentation was not available and if HEDIS increased the number of acceptable codes for the measure. Due to the challenges encountered, **HPN** abandoned the intervention and will research other possible interventions to test in the future.

Upon initial validation for both Module 4's submitted for the **HPN** met all of the validation criteria and a resubmission was not required. However, HSAG provided several general comments in the validation tool to assist and strengthen the MCO's testing of future interventions.

To sustain improvement that was achieved during the PIP process, Dr. Veeramachaneni's practice is committed to continuing the improvement beyond the SMART Aim goal end date, as well as expanding the intervention to include other providers in the practice. The practice will conduct internal medical record reviews to ensure an overall increase in documentation compliance.

Module 5: PIP Conclusions

SMART Aim Measure Outcomes

Table 6–5—SMART Aim Measure Results for the Weight Assessment PIP

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
The percentage of children and adolescents 3 to 17 years of age who are assigned to Dr. Veeramachaneni and had a BMI percentile completed during an office visit.	2.1%	10.0%	100%	<i>Confidence</i>
The percentage of children and adolescents 3 to 17 years of age who are assigned to Dr. Veeramachaneni and received counseling for nutrition during an office visit.	4.8%	12.0%	100%	
The percentage of children and adolescents 3 to 17 years of age who are assigned to Dr. Veeramachaneni and received counseling for physical activity during an office visit.	2.7%	10.0%	100%	

HPN established a goal of increasing the BMI percentile completion rate for Dr. Veeramachaneni’s members by 7.9 percentage points, from 2.1 percent to 10 percent. The SMART Aim measure goal of 10.0 percent was achieved, with the highest rate achieved being 100 percent. From June 2016 to March 2017, the MCO was able to achieve a 100 percent compliance rate for every month.

The MCO set a goal of increasing the counseling for nutrition completion rate for Dr. Veeramachaneni’s members by 7.2 percentage points, from 4.8 percent to 12 percent. The SMART Aim measure goal of 12.0 percent was achieved, with the highest rate achieved being 100 percent. From July 2016 to March 2017, the MCO was able to achieve a 100 percent compliance rate for every month.

HPN set a goal of increasing the counseling for physical activity completion rate for Dr. Veeramachaneni’s members by 7.3 percentage points, from 2.7 percent to 10 percent. The SMART Aim measure goal of 10.0 percent was achieved, with the highest rate achieved being 100 percent. From July 2016 to March 2017, the MCO was able to achieve a 100 percent compliance rate for every month.

Upon initial validation of Module 5, HSAG identified opportunities for improvement with the MCO’s narrative summary of findings and its documentation related to how it will sustain improvement beyond the SMART Aim end date. HSAG provided technical assistance to **HPN** to discuss the initial validation feedback. **HPN** resubmitted Module 5 after making corrections; and upon final validation, all of the validation criteria were met. Although the MCO exceeded the SMART Aim goal for all three measure components, this occurred prior to intervention testing and there was not a clear link between the

demonstrated improvement and all of the MCO's quality improvement activities. HSAG assigned a level of *Confidence* to the PIP.

Behavioral Health Hospital Readmissions PIP

Module 4: Plan-Do-Study-Act (PDSA) Intervention Testing

HPN tested two interventions and submitted two Module 4s for validation.

The first intervention involved having the member and a nurse from **HPN** or Behavioral Health Options (BHO) establish the best location and method for post-discharge follow-up while the member was still inpatient. This intervention was predicted to increase the rate of the top 50 utilizers who were seen inpatient and who had consented to outpatient follow-up. The intervention was tested from July 19 through September 28, 2016. At the end of the testing period, the data were analyzed, and it was determined that only three members of the top 50 utilizers were able to be seen in the hospital by the nurse and agreed to outpatient care. Of the three members seen, one had an inpatient admission following consenting to outpatient follow-up care. **HPN** reported numerous challenges with this intervention; and although the SMART Aim run chart showed a reduction in readmissions during the testing period of this intervention, **HPN** could not attribute this reduction to the intervention. As a result, the MCO chose to abandon the intervention.

The second intervention involved enrolling the identified top 50 utilizers in the case management program. This program assists these high-need members with ongoing care and addresses the social barriers to receiving outpatient care. Educating and engaging the members and addressing the social determinants were predicted to reduce the number of hospitalizations. Testing took place from November 7, 2016, through February 24, 2017. According to the data collected, 13 of the top 50 utilizers consented to and became active in case management services. Nine members refused case management services, eight were unable to be contacted, and 20 were no longer eligible for services. When comparing the data from the run chart for the 13 members in case management from December to January, seven had no inpatient hospitalizations, three had an increase in the number of hospitalizations, and three had a decrease in the number of inpatient stays. **HPN** determined that it would adopt this intervention and expand it each month to a list of 50 members who had the most hospitalizations in the past year, were eligible for services, and were not currently enrolled in case management.

Upon initial validation of the first Module 4 for the *Behavioral Health Hospital Readmissions* PIP, HSAG identified opportunities for improvement with **HPN**'s summary of findings. The SMART Aim run chart included all of the top 50 utilizers. According to the Microsoft Excel sheet provided by the MCO, only three members accepted the intervention. Because the SMART Aim measure included members who did not receive the intervention, it would not be appropriate to use the SMART Aim measure to measure the effectiveness of the intervention. In addition, HSAG recommended that the MCO test the intervention longer to more accurately measure its success because the total number of members who received the intervention was very low. **HPN** made the necessary corrections to the module submission form and provided additional documentation. The MCO chose to abandon the

intervention due to numerous challenges. At the final validation of this module, **HPN** met all of the validation criteria.

Upon initial validation of the second Module 4 submitted for the *Behavioral Health Hospital Readmissions* PIP, **HPN** met all of the validation criteria and a resubmission was not required.

For sustainability, **HPN** determined Intervention 1 was not effective and therefore will not be pursued. For Intervention 2, **HPN** determined that active participation in BHO case management was successful in reducing hospital readmissions. The BHO was committed to continuing the intervention by expanding it to include a new monthly list of 50 non-active case management members with the most hospitalizations in the past year who are still eligible. In addition, the inpatient stays for those participating in case management will be tracked monthly to determine if there was an overall reduction.

Module 5: PIP Conclusions

SMART Aim Measure Outcomes

Table 6–6—SMART Aim Measure Results for the Behavioral Health PIP

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Lowest Rate Achieved*	Confidence Level
The percentage of inpatient substance abuse and/or mental health admissions for the identified top 50 utilizers.	13.8%	12.0%	Not Reportable	<i>Reported PIP results were not credible</i>

* The Lowest Rate Achieved is reported for the *Behavioral Health Hospital Readmissions* SMART Aim measure because the measure is an inverse indicator, where a lower rate is better.

HPN established a goal of reducing the inpatient substance abuse and/or mental health admission rate for the identified top 50 utilizers by 1.8 percentage points, from 13.8 percent to 12.0 percent. HSAG was unable to determine if **HPN** was able to achieve the SMART Aim measure goal of 12.0 percent due to several confounding factors. HSAG observed that for calendar year (CY) 2016 the SMART Aim measure denominator nearly doubled, from 3,058 to 5,642, when compared with the baseline period of CY 2015. The difference in visits was an 84.5 percent increase. This trend continued beyond CY 2016 through the SMART Aim end date of March 2017. Over the same time period that the SMART Aim measure denominator nearly doubled, **HPN** reported that 20 of the top 50 utilizers were no longer eligible for the project, decreasing the total admissions for the numerator. The substantial increase in the SMART Aim measure denominator, combined with the decrease in the SMART Aim measure numerator, resulted in a decrease (improvement) in the SMART Aim measure independent of any interventions.

In addition to the changes that occurred with the SMART Aim measure numerator and denominator, **HPN** abandoned the top 50 super utilizer eligible population in November 2016 due to 20 of the 50 members no longer being eligible. The November 2016 newly identified top 50 super utilizers were no longer aligned with the SMART Aim measure and goal. The approved Module 1 and 2 methodology

required **HPN** to follow the original top 50 super utilizers through the SMART Aim end date, March 31, 2017. These factors affected HSAG’s ability to determine if **HPN** achieved the SMART Aim goal through the tested interventions; therefore, the SMART Aim measure rate was entered as “Not Reportable.”

Upon initial validation of Module 5, HSAG identified opportunities for improvement with the MCO’s narrative summary of findings and the execution of the PIP methodology. HSAG provided technical assistance to **HPN** to discuss the initial validation feedback. **HPN** resubmitted Module 5 after making corrections; however, due to **HPN** changing the top 50 super utilizer eligible population and not executing the PIP as approved, not all validation criteria could be achieved despite the resubmission. HSAG assigned a level of *Reported PIP Results Were Not Credible* because the MCO did not execute the PIP as designed by **HPN** and approved by HSAG. **HPN** requested a rescoring of the PIP based on additional information **HPN** provided in a letter and teleconference meeting with HSAG; however, the MCO would have been required to recreate and resubmit Module 4 and Module 5 in order for HSAG to revalidate the PIP. Since the time period for resubmission had passed and SFY 2016-2017 was closed, DHCFP advised HSAG and **HPN** to close the PIP. To initiate the new PIPs for SFY 2017-2018, HSAG PIP team members have provided weekly technical assistance sessions with **HPN** staff members at **HPN**’s request.

Plan Comparison

The validation findings show that both MCOs were able to complete Module 4 successfully and attained *Achieved* scores across all evaluation elements. For Module 5, the validation findings and level of confidence assigned to the PIPs were mixed. **Amerigroup** received *Low Confidence* in the reported PIP results for both PIPs because the SMART Aim was not achieved. For **HPN**’s WCC PIP, the SMART Aim goal was achieved; however, this occurred prior to intervention testing. Therefore, there was no clear link between the demonstrated improvement and the MCO’s quality improvement activities, and the PIP was assigned a level of *Confidence*. For the behavioral health PIP, **HPN** did not execute the PIP according to the HSAG-approved SMART Aim data collection methodology (Module 2); therefore, the PIP results were deemed not credible.

Summary of Recommendations

Based on the validation and outcome findings, HSAG offers the following recommendations:

- MCOs should execute improvement projects according to the approved methodology outlined in Module 2. If changes to the methodology are necessary, the MCO must contact HSAG to discuss the changes.
- MCOs should apply to future PIPs and quality improvement activities the identified lessons learned and knowledge gained from HSAG’s feedback throughout the life of the PIP.

- MCOs should ensure that their core PIP teams include data analytical staff members who are involved in all data-related PIP processes for the life of the PIP.
- MCOs should complete an upfront analysis before testing an intervention. The MCOs should be able to gauge current performance, compare it to improved performance, and have a method of measuring the difference. By completing the upfront analysis, both of these objectives can be accomplished.
- MCOs should conduct a series of thoughtful and incremental PDSA cycles to accelerate the rate of improvement. Each PDSA cycle should be initiated with a methodologically sound evaluation plan using a clearly defined testing measure to ensure meaningful and actionable testing results.

7. CAHPS Surveys—SFY 2016–2017

Objectives

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. 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 2017 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 mixed-mode methodology for data collection (i.e., mailed surveys followed by telephone interviews of non-respondents).

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

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

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

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

Plan-Specific Findings—Amerigroup

Table 7–1 shows **Amerigroup**’s 2016 and 2017 adult Medicaid CAHPS top-box rates. In 2017, a total of 2,430 adult members were administered a survey, of which 471 completed a survey. After ineligible members were excluded, the response rate was 19.8 percent. In 2016, the average NCQA response rate for the adult Medicaid population was 24.8 percent, higher than **Amerigroup**’s response rate.⁷⁻¹

Table 7–1—Amerigroup Adult Medicaid CAHPS Results

	2016 Top-Box Rates	2017 Top-Box Rates
Composite Measures		
<i>Getting Needed Care</i>	77.6%	75.7%
<i>Getting Care Quickly</i>	76.4%	76.8%
<i>How Well Doctors Communicate</i>	87.5%	87.0%
<i>Customer Service</i>	84.7%	89.5%
<i>Shared Decision Making</i>	80.0%	75.4%
Global Ratings		
<i>Rating of All Health Care</i>	44.2%	44.8%
<i>Rating of Personal Doctor</i>	58.6%	58.3%
<i>Rating of Specialist Seen Most Often</i>	58.6%	58.2%
<i>Rating of Health Plan</i>	45.9%	48.4%
Effectiveness of Care*		
<i>Advising Smokers and Tobacco Users to Quit</i>	62.6%	64.8%
<i>Discussing Cessation Medications</i>	34.8%	36.7%
<i>Discussing Cessation Strategies</i>	32.6%	29.9%

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

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

 Indicates the 2017 rate is at least 5 percentage points less than the 2016 national average.

Amerigroup’s rates decreased between 2016 and 2017 for six of 12 measures: *Getting Needed Care*, *How Well Doctors Communicate*, *Shared Decision Making*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Discussing Cessation Strategies*. **Amerigroup**’s rates increased between 2016 and 2017 for six measures: *Getting Care Quickly*, *Customer Service*, *Rating of All Health*

⁷⁻¹ 2017 NCQA national response rate information for the CAHPS 5.0 Adult Medicaid Survey was not available at the time this report was produced.

Care, Rating of Health Plan, Advising Smokers and Tobacco Users to Quit, and Discussing Cessation Medications. None of the measure rates had a substantial increase or decrease from the 2016 rate.

Amerigroup's 2017 top-box rates for the adult Medicaid population were lower than the 2016 NCQA adult Medicaid national averages for 11 of the 12 measures: *Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Shared Decision Making, Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often, Rating of Health Plan, Advising Smokers and Tobacco Users to Quit, Discussing Cessation Medications, and Discussing Cessation Strategies.* Of these, seven measures were at least 5 percentage points less than the 2016 national averages: *Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often, Rating of Health Plan, Advising Smokers and Tobacco Users to Quit, Discussing Cessation Medications, and Discussing Cessation Strategies.*

Table 7–2 shows **Amerigroup**’s 2016 and 2017 general child Medicaid CAHPS top-box rates.⁷⁻² In 2017, a total of 4,042 general child members were administered a survey, of which 783 completed a survey.⁷⁻³ After ineligible members were excluded, the response rate was 19.6 percent. In 2016, the average NCQA response rate for the child Medicaid population was 23.0 percent, higher than **Amerigroup**’s response rate.⁷⁻⁴

Table 7–2—Amerigroup General Child Medicaid CAHPS Results

	2016 General Child Top-Box Rates	2017 General Child Top-Box Rates
Composite Measures		
<i>Getting Needed Care</i>	77.5%	77.1%
<i>Getting Care Quickly</i>	83.3%	80.7%
<i>How Well Doctors Communicate</i>	88.5%	89.9%
<i>Customer Service</i>	87.2%	87.0%
<i>Shared Decision Making</i>	77.3%	78.7%
Global Ratings		
<i>Rating of All Health Care</i>	68.6%	66.3%
<i>Rating of Personal Doctor</i>	69.2%	72.4%
<i>Rating of Specialist Seen Most Often</i>	80.0%	70.9%
<i>Rating of Health Plan</i>	64.5%	70.2%

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

 Indicates the 2017 rate is at least 5 percentage points less than the 2016 national average.

Amerigroup’s rates increased between 2016 and 2017 for four measures: *How Well Doctors Communicate*, *Shared Decision Making*, *Rating of Personal Doctor*, and *Rating of Health Plan*. None of these rates showed a substantial increase of more than 5 percentage points. **Amerigroup**’s rates decreased between 2016 and 2017 for five measures: *Getting Needed Care*, *Getting Care Quickly*, *Customer Service*, *Rating of all Health Care*, and *Rating of Specialist Seen Most Often*. Of these, *Rating of Specialist Seen Most Often* showed a substantial decrease of more than 9 percentage points.

Amerigroup’s 2017 top-box rates for the general child Medicaid population were lower than the 2016 NCQA child Medicaid national averages for seven measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, *Rating of All Health Care*, *Rating of*

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

⁷⁻³ 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).

⁷⁻⁴ 2017 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.

Personal Doctor, and *Rating of Specialist Seen Most Often*. Of these, two measures were at least 5 percentage points less than the 2016 national average: *Getting Needed Care* and *Getting Care Quickly*. Two measures were greater than the 2016 national average: *Shared Decision Making* and *Rating of Health Plan*. None of these measures, however, were at least 5 percentage points greater than the 2016 national averages.

Table 7–3 shows Amerigroup’s 2016 and 2017 CCC Medicaid CAHPS top-box rates.⁷⁻⁵ In 2017, a total of 259 child members with a chronic condition completed a survey.⁷⁻⁶

Table 7–3—Amerigroup CCC Medicaid CAHPS Results

	2016 CCC Supplemental Top- Box Rates	2017 CCC Supplemental Top- Box Rates
Composite Measures		
<i>Getting Needed Care</i>	79.4%	79.6%
<i>Getting Care Quickly</i>	81.9%	86.0%
<i>How Well Doctors Communicate</i>	89.8%	92.6%
<i>Customer Service</i>	NA	NA
<i>Shared Decision Making</i>	NA	NA
Global Ratings		
<i>Rating of All Health Care</i>	62.6%	65.0%
<i>Rating of Personal Doctor</i>	69.2%	75.1%
<i>Rating of Specialist Seen Most Often</i>	72.6%	72.1%
<i>Rating of Health Plan</i>	61.4%	65.2%
CCC Composite Measures/Items		
<i>Access to Specialized Services</i>	NA	NA
<i>Family Centered Care (FCC): Personal Doctor Who Knows Child</i>	89.7%	87.6%
<i>Coordination of Care for Children with Chronic Conditions</i>	NA	NA
<i>Access to Prescription Medicines</i>	79.2%	85.1%
<i>FCC: Getting Needed Information</i>	88.5%	90.6%

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

 Indicates the 2017 rate is at least 5 percentage points less than the 2016 national average.

⁷⁻⁵ The child Medicaid CAHPS results presented in Table 7-3 for Amerigroup are based on the results of the CCC population only.

⁷⁻⁶ The total number of members who completed surveys is based on Amerigroup’s CCC supplemental CAHPS sample only.

Amerigroup's rates increased between 2016 and 2017 for eight reportable measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Health Plan*, *Access to Prescription Medicines*, and *FCC: Getting Needed Information*. Of these, *Rating of Personal Doctor* and *Access to Prescription Medicines* showed a substantial increase of more than 5 percentage points. **Amerigroup**'s rates decreased between 2016 and 2017 for two reportable measures: *Rating of Specialist Seen Most Often* and *FCC: Personal Doctor Who Knows Child*. None of these measure rates had a substantial decrease from the 2016 rate.

Amerigroup's 2017 top-box rates for the CCC population were lower than the 2016 NCQA CCC child Medicaid national averages for eight reportable measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Health Plan*, *FCC: Personal Doctor Who Knows Child*, *Access to Prescription Medicines*, and *FCC: Getting Needed Information*. Of these, three measures were at least 5 percentage points less than the 2016 national averages: *Getting Needed Care*, *Getting Care Quickly*, and *Access to Prescription Medicines*.

Table 7–4 shows **Amerigroup**’s 2016 and 2017 Nevada Check Up CAHPS top-box rates.⁷⁻⁷ Since NCQA does not publish separate rates for the Children’s Health Insurance Program (CHIP), national comparisons could not be made. In 2017, a total of 1,377 Nevada Check Up general child members were administered a survey, of which 348 completed a survey.⁷⁻⁸ After ineligible members were excluded, the response rate was 25.9 percent.

Table 7–4—Amerigroup Nevada Check Up CAHPS Results

	2016 General Child Top-Box Rates	2017 General Child Top-Box Rates
Composite Measures		
<i>Getting Needed Care</i>	76.5%	76.6%
<i>Getting Care Quickly</i>	81.6%	82.0%
<i>How Well Doctors Communicate</i>	90.8%	93.5%
<i>Customer Service</i>	84.5%	NA
<i>Shared Decision Making</i>	78.3%	NA
Global Ratings		
<i>Rating of All Health Care</i>	60.3%	68.3%
<i>Rating of Personal Doctor</i>	72.7%	74.4%
<i>Rating of Specialist Seen Most Often</i>	NA	NA
<i>Rating of Health Plan</i>	68.6%	68.2%

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

Amerigroup’s rates decreased between 2016 and 2017 for one reportable measure, *Rating of Health Plan*. Between 2016 and 2017, the rates increased for five reportable measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, and *Rating of Personal Doctor*. None of the measure rates had a substantial increase or decrease from the 2016 rate.

Table 7-5 shows **Amerigroup**’s 2016 and 2017 Nevada Check Up CAHPS top-box rates for the CCC population.⁷⁻⁹ Since NCQA does not publish separate rates for the CHIP program, national comparisons

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

⁷⁻⁸ The total number of members surveyed and who completed surveys is based on Amerigroup’s Nevada Check Up general child CAHPS sample only.

⁷⁻⁹ The child Medicaid CAHPS results presented in Table 7-5 for Amerigroup are based on the results of the Nevada Check Up CCC population only.

could not be made. In 2017, a total of 73 Nevada Check Up child members with a chronic condition completed a survey.⁷⁻¹⁰

Table 7–5—Amerigroup CCC Nevada Check Up CAHPS Results

	2016 CCC Supplemental Top- Box Rates	2017 CCC Supplemental Top- Box Rates
Composite Measures		
<i>Getting Needed Care</i>	NA	NA
<i>Getting Care Quickly</i>	NA	NA
<i>How Well Doctors Communicate</i>	NA	NA
<i>Customer Service</i>	NA	NA
<i>Shared Decision Making</i>	NA	NA
Global Ratings		
<i>Rating of All Health Care</i>	NA	NA
<i>Rating of Personal Doctor</i>	NA	NA
<i>Rating of Specialist Seen Most Often</i>	NA	NA
<i>Rating of Health Plan</i>	NA	NA
CCC Composite Measures/Items		
<i>Access to Specialized Services</i>	NA	NA
<i>Family Centered Care (FCC): Personal Doctor Who Knows Child</i>	NA	NA
<i>Coordination of Care for Children with Chronic Conditions</i>	NA	NA
<i>Access to Prescription Medicines</i>	NA	NA
<i>FCC: Getting Needed Information</i>	NA	NA

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

Amerigroup’s 2016 and 2017 rates could not be reported for the Nevada Check Up CCC population since all measures did not meet the minimum number of responses.

⁷⁻¹⁰ The total number of members who completed surveys is based on Amerigroup’s Nevada Check Up CCC supplemental CAHPS sample only.

Plan-Specific Findings—HPN

Table 7–6 shows **HPN**’s 2016 and 2017 adult Medicaid CAHPS top-box rates. In 2017, a total of 1,890 members were administered a survey, of which 276 completed a survey. After ineligible members were excluded, the response rate was 14.8 percent. In 2016, the average NCQA response rate for the adult Medicaid population was 24.8 percent, higher than **HPN**’s response rate.⁷⁻¹¹

Table 7–6—HPN Adult Medicaid CAHPS Results

	2016 Top-Box Rates	2017 Top-Box Rates
Composite Measures		
<i>Getting Needed Care</i>	73.1%	76.1%
<i>Getting Care Quickly</i>	70.4%	75.9%
<i>How Well Doctors Communicate</i>	86.5%	85.6%
<i>Customer Service</i>	NA	NA
<i>Shared Decision Making</i>	NA	NA
Global Ratings		
<i>Rating of All Health Care</i>	44.6%	48.7%
<i>Rating of Personal Doctor</i>	54.3%	56.3%
<i>Rating of Specialist Seen Most Often</i>	NA	NA
<i>Rating of Health Plan</i>	52.5%	49.4%
Effectiveness of Care*		
<i>Advising Smokers and Tobacco Users to Quit</i>	63.1%	63.0%
<i>Discussing Cessation Medications</i>	24.8%	22.4%
<i>Discussing Cessation Strategies</i>	26.8%	19.9%

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

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

 Indicates the 2017 rate is at least 5 percentage points less than the 2016 national average.

HPN’s rates decreased between 2016 and 2017 for five of nine reportable measures: *How Well Doctors Communicate*, *Rating of Health Plan*, *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*. Of these, one measure showed a substantial decrease of more than 5 percentage points: *Discussing Cessation Strategies*. Four measures increased between 2016 and 2017: *Getting Needed Care*, *Getting Care Quickly*, *Rating of All Health*

⁷⁻¹¹ 2017 NCQA national response rate information for the CAHPS 5.0 Adult Medicaid Survey was not available at the time this report was produced.

Care, and Rating of Personal Doctor. Of these, *Getting Care Quickly* showed a substantial increase of more than 5 percentage points.

HPN’s 2017 top-box rates for the adult Medicaid population were lower than the 2016 NCQA adult Medicaid national averages for all reportable measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Health Plan*, *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*. Of these, six measures were at least 5 percentage points less than the 2016 national average: *How Well Doctors Communicate*, *Rating of Personal Doctor*, *Rating of Health Plan*, *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*.

Table 7–7 shows HPN’s 2016 and 2017 child Medicaid CAHPS top-box rates.⁷⁻¹² In 2017, a total of 2,310 general child members were administered a survey, of which 332 completed a survey.⁷⁻¹³ After ineligible members were excluded, the response rate was 14.5 percent. In 2016, the average NCQA response rate for the child Medicaid population was 23.0 percent, higher than HPN’s response rate.⁷⁻¹⁴

Table 7–7—HPN General Child Medicaid CAHPS Results

	2016 General Child Top-Box Rates	2017 General Child Top-Box Rates
Composite Measures		
<i>Getting Needed Care</i>	80.6%	84.3%
<i>Getting Care Quickly</i>	85.9%	86.1%
<i>How Well Doctors Communicate</i>	89.5%	92.4%
<i>Customer Service</i>	90.1%	NA
<i>Shared Decision Making</i>	78.4%	NA
Global Ratings		
<i>Rating of All Health Care</i>	68.5%	62.1%
<i>Rating of Personal Doctor</i>	74.4%	77.6%
<i>Rating of Specialist Seen Most Often</i>	NA	NA
<i>Rating of Health Plan</i>	74.9%	75.3%

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

 Indicates the 2017 rate is at least 5 percentage points greater than the 2016 national average.

 Indicates the 2017 rate is at least 5 percentage points less than the 2016 national average.

⁷⁻¹² The child Medicaid CAHPS results presented in Table 7-7 for HPN are based on the results of the general child population only.

⁷⁻¹³ The total number of members surveyed and who completed surveys is based on HPN’s general child CAHPS sample only (i.e., does not include the CCC supplemental sample of members who were surveyed).

⁷⁻¹⁴ 2017 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 rates decreased between 2016 and 2017 for one of the six reportable measures: *Rating of All Health Care*. The decrease was more than 5 percentage points. HPN’s rates increased between 2016 and 2017 for five reportable measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of Personal Doctor*, and *Rating of Health Plan*. Of these, no measures showed a substantial increase of more than 5 percentage points.

HPN’s 2017 top-box rates for the general child Medicaid population were lower than the 2016 NCQA general child Medicaid national averages for three measures: *Getting Care Quickly*, *How Well Doctors Communicate*, and *Rating of All Health Care*. Three of HPN’s 2017 top-box rates for the general child Medicaid population were higher than the 2016 NCQA general child Medicaid national average: *Getting Needed Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*. *Rating of Health Plan* was at least 5 percentage points greater than the 2016 national average.

Table 7–8 shows HPN’s 2016 and 2017 CCC Medicaid CAHPS top-box rates.⁷⁻¹⁵ In 2017, a total of 199 child members with a chronic condition completed a survey.⁷⁻¹⁶

Table 7–8—HPN CCC Medicaid CAHPS Results


	2016 CCC Supplemental Top- Box Rates	2017 CCC Supplemental Top- Box Rates
Composite Measures		
<i>Getting Needed Care</i>	76.5%	77.8%
<i>Getting Care Quickly</i>	85.0%	89.9%
<i>How Well Doctors Communicate</i>	91.8%	91.1%
<i>Customer Service</i>	NA	NA
<i>Shared Decision Making</i>	78.7%	NA
Global Ratings		
<i>Rating of All Health Care</i>	64.9%	59.6%
<i>Rating of Personal Doctor</i>	68.9%	74.1%
<i>Rating of Specialist Seen Most Often</i>	63.2%	NA
<i>Rating of Health Plan</i>	66.8%	68.0%
CCC Composite Measures/Items		
<i>Access to Specialized Services</i>	NA	NA
<i>Family Centered Care (FCC): Personal Doctor Who Knows Child</i>	88.6%	86.7%

⁷⁻¹⁵ The child Medicaid CAHPS results presented in Table 7-8 for HPN are based on the results of the CCC population only.

⁷⁻¹⁶ The total number of members who completed surveys is based on HPN’s CCC supplemental CAHPS sample only.

	2016 CCC Supplemental Top- Box Rates	2017 CCC Supplemental Top- Box Rates
<i>Coordination of Care for Children with Chronic Conditions</i>	NA	NA
<i>Access to Prescription Medicines</i>	89.1%	92.7%
<i>FCC: Getting Needed Information</i>	87.3%	87.7%

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

 Indicates the 2017 rate is at least 5 percentage points less than the 2016 national average.

HPN's rates increased between 2016 and 2017 for six reportable measures: *Getting Needed Care*, *Getting Care Quickly*, *Rating of Personal Doctor*, *Rating of Health Plan*, *Access to Prescription Medicines*, and *FCC: Getting Needed Information*. Of these, one measure showed a substantial increase of more than 5 percentage points: *Rating of Personal Doctor*. **HPN**'s rates decreased between 2016 and 2017 for three reportable measures: *How Well Doctors Communicate*, *Rating of All Health Care*, and *FCC: Personal Doctor Who Knows Child*. Of these, one measure showed a substantial decrease of more than 5 percentage points: *Rating of All Health Care*.

HPN's 2017 top-box rates for the CCC population were lower than the 2016 NCQA CCC national average for seven reportable measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, *FCC: Personal Doctor Who Knows Child*, and *FCC: Getting Needed Information*. Two of **HPN**'s 2017 top-box rates for the CCC child Medicaid population were higher than the 2016 NCQA CCC national average: *Rating of Health Plan* and *Access to Prescription Medicines*. However, two measures were at least 5 percentage points less than the 2016 national average: *Getting Needed Care* and *Rating of All Health Care*.

Table 7–9 shows **HPN**'s 2016 and 2017 Nevada Check Up CAHPS top-box rates for the general child population.⁷⁻¹⁷ Since NCQA does not publish separate rates for the CHIP program, national comparisons could not be made. In 2017, a total of 1,650 Nevada Check Up general child members were surveyed and 378 completed a survey.⁷⁻¹⁸ After ineligible members were excluded, the response rate was 23.1 percent.

⁷⁻¹⁷ The Nevada Check Up CAHPS results presented in Table 7-9 for HPN are based on the results of the general child population only.

⁷⁻¹⁸ The total number of members surveyed and who completed surveys is based on HPN's general child CAHPS sample only (i.e., does not include the CCC supplemental sample of members who were surveyed).

Table 7–9—HPN Nevada Check Up CAHPS Results

	2016 General Child Top-Box Rates	2017 General Child Top-Box Rates
Composite Measures		
<i>Getting Needed Care</i>	79.6%	79.1%
<i>Getting Care Quickly</i>	82.2%	86.0%
<i>How Well Doctors Communicate</i>	89.7%	93.1%
<i>Customer Service</i>	85.2%	NA
<i>Shared Decision Making</i>	73.8%	NA
Global Ratings		
<i>Rating of All Health Care</i>	66.6%	68.1%
<i>Rating of Personal Doctor</i>	73.5%	72.6%
<i>Rating of Specialist Seen Most Often</i>	68.4%	NA
<i>Rating of Health Plan</i>	73.9%	73.2%

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

HPN’s rates increased between 2016 and 2017 for three reportable measures: *Getting Care Quickly*, *How Well Doctors Communicate*, and *Rating of All Health Care*. HPN’s rates decreased between 2016 and 2017 for the remaining three reportable measures: *Getting Needed Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*. No measures showed a substantial increase or decrease of more than 5 percentage points between 2016 and 2017.

Table 7–10 shows HPN’s 2016 and 2017 Nevada Check Up CAHPS top-box rates for the CCC population.⁷⁻¹⁹ Since NCQA does not publish separate rates for the CHIP program, national comparisons could not be made. In 2017, 151 Nevada Check Up child members with a chronic condition completed a survey.⁷⁻²⁰

⁷⁻¹⁹ The child Medicaid CAHPS results presented in Table 7-10 for HPN are based on the results of the Nevada Check Up CCC population only.

⁷⁻²⁰ The total number of members who completed surveys is based on HPN’s Nevada Check Up CCC supplemental CAHPS sample only.

Table 7–10—HPN CCC Nevada Check Up CAHPS Results

	2016 CCC Supplemental Top- Box Rates	2017 CCC Supplemental Top- Box Rates
Composite Measures		
<i>Getting Needed Care</i>	80.9%	77.5%
<i>Getting Care Quickly</i>	84.2%	NA
<i>How Well Doctors Communicate</i>	90.7%	93.8%
<i>Customer Service</i>	NA	NA
<i>Shared Decision Making</i>	NA	NA
Global Ratings		
<i>Rating of All Health Care</i>	67.2%	62.5%
<i>Rating of Personal Doctor</i>	73.1%	75.0%
<i>Rating of Specialist Seen Most Often</i>	70.6%	NA
<i>Rating of Health Plan</i>	67.8%	65.8%
CCC Composite Measures/Items		
<i>Access to Specialized Services</i>	NA	NA
<i>Family Centered Care (FCC): Personal Doctor Who Knows Child</i>	86.7%	NA
<i>Coordination of Care for Children with Chronic Conditions</i>	NA	NA
<i>Access to Prescription Medicines</i>	87.7%	90.0%
<i>FCC: Getting Needed Information</i>	88.4%	91.3%

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

HPN’s rates increased between 2016 and 2017 for four reportable measures: *How Well Doctors Communicate*, *Rating of Personal Doctor*, *Access to Prescription Medicines*, and *FCC: Getting Needed Information*. HPN’s rates decreased between 2016 and 2017 for three measures: *Getting Needed Care*, *Rating of All Health Care*, and *Rating of Health Plan*. No measures showed a substantial increase or decrease of more than 5 percentage points between 2016 and 2017.

Plan Comparison

HPN's adult Medicaid CAHPS scores were below the 2016 NCQA adult Medicaid national averages for all reportable measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Health Plan*, *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*. **HPN**'s response rate for the 2017 adult Medicaid population was 10 percentage points lower than the 2016 NCQA adult Medicaid average response rate. **Amerigroup**'s adult Medicaid CAHPS scores were below the 2016 NCQA adult Medicaid national averages for 11 of the 12 measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Shared Decision Making*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Rating of Health Plan*, *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*. **Amerigroup**'s response rate for the adult Medicaid population was lower than the 2016 NCQA adult Medicaid average response rate by 5 percentage points.

HPN's general child Medicaid CAHPS scores were below the 2016 NCQA general child Medicaid national averages for two reportable composite measures: *Getting Care Quickly* and *How Well Doctors Communicate*, and for one reportable global rating: *Rating of All Health Care*. **HPN**'s response rate for the 2017 general child Medicaid population was lower than the 2016 NCQA general child Medicaid average response rate by 8.5 percentage points. **Amerigroup**'s general child Medicaid CAHPS scores were below the 2016 NCQA general child Medicaid national averages for four composite measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*. In addition, **Amerigroup**'s general child Medicaid CAHPS scores were below the 2016 NCQA general child Medicaid national averages for three global ratings: *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often*. **Amerigroup**'s response rate for the general child Medicaid population was 3.4 percentage points lower than the average 2016 NCQA response rate for the general child Medicaid population.

HPN's CCC child Medicaid CAHPS scores were below the 2016 NCQA CCC child Medicaid national averages for three reportable composite measures: *Getting Needed Care*, *Getting Care Quickly*, and *How Well Doctors Communicate*. **HPN**'s CCC child Medicaid CAHPS scores were also below the 2016 NCQA CCC child Medicaid national averages for two reportable global ratings: *Rating of All Health Care* and *Rating of Personal Doctor*. In addition, **HPN**'s CCC child Medicaid CAHPS scores were below the 2016 NCQA CCC child Medicaid national averages for two reportable CCC composite measures: *FCC: Personal Doctor Who Knows Child* and *FCC: Getting Needed Information*. **Amerigroup**'s CCC child Medicaid CAHPS scores were below the 2016 NCQA CCC child Medicaid national averages for three reportable composite measures: *Getting Needed Care*, *Getting Care Quickly*, and *How Well Doctors Communicate*. In addition, **Amerigroup**'s CCC child Medicaid CAHPS scores were also below the 2016 NCQA CCC child Medicaid national averages for two global ratings: *Rating of All Health Care* and *Rating of Health Plan*, and for three reportable CCC composite measures: *FCC: Personal Doctor Who Knows Child*, *Access to Prescription Medicines*, and *FCC: Getting Needed Information*.

HPN's 2017 Nevada Check Up CAHPS scores were below the 2016 Nevada Check Up CAHPS scores for three reportable measures for the general child population: *Getting Needed Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*. **Amerigroup**'s 2017 Nevada Check Up CAHPS scores were above the 2016 Nevada Check Up CAHPS scores for five reportable measures for the general child population: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, and *Rating of Personal Doctor*. Since NCQA does not publish separate rates for the CHIP program, national comparisons could not be made.

HPN's 2017 Nevada Check Up CCC CAHPS score was below the 2016 Nevada Check Up CCC CAHPS score for one composite measure: *Getting Needed Care*. **HPN**'s 2017 Nevada Check Up CCC CAHPS score was also below the 2016 Nevada Check Up CCC CAHPS score for two global ratings: *Rating of All Health Care* and *Rating of Health Plan*. **Amerigroup**'s 2017 Nevada Check Up CCC CAHPS survey results were lower than the minimum required 100 responses; therefore, the comparisons could not be completed. Additionally, since NCQA does not publish separate rates for the CHIP program, national comparisons could not be made.

Conclusions and Recommendations

Amerigroup

HSAG recommends that **Amerigroup** continue to work with its CAHPS vendor to ensure that a sufficient number of completed surveys is obtained to enable reporting of all CAHPS measures. NCQA recommends targeting 411 completed surveys per survey administration. **Amerigroup** had measures that did not meet the minimum 100 responses for the CCC Medicaid population, Nevada Check Up general child population, and Nevada Check Up CCC population.

For the adult population, HSAG recommends that **Amerigroup** focus quality improvement initiatives on enhancing members' experiences with *Getting Needed Care*, *How Well Doctors Communicate*, *Shared Decision Making*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Discussing Cessation Strategies*, since these rates were lower than the 2016 adult CAHPS results and fell below NCQA's 2016 CAHPS adult Medicaid national averages.

For the general child Medicaid population, **Amerigroup** should focus on improving *Rating of Specialist Seen Most Often*, since the rate for this measure was substantially lower than the 2016 general child CAHPS results and fell slightly below NCQA's 2016 CAHPS child Medicaid national averages. Interventions targeted at the provider level for this measure likely will have the greatest impact on the measure. Additionally, efforts should focus on improving *Getting Needed Care* and *Getting Care Quickly*, since these rates were substantially lower than the NCQA's 2016 CAHPS child Medicaid national averages. For the CCC Medicaid population, **Amerigroup** should focus on improving *FCC: Personal Doctor Who Knows Child*, since the rate for this reportable measure was lower than the 2016 CCC child CAHPS results and fell below NCQA's 2016 CAHPS CCC child Medicaid national average. In addition, **Amerigroup** should look to improve *Getting Needed Care*, *Getting Care Quickly*, and *Access to Prescription Medicines*, since the rates for these measures were substantially lower than the

2016 NCQA CCC child Medicaid national averages. For the Nevada Check Up population, HSAG recommends that **Amerigroup** focus quality improvement initiatives on enhancing members' experiences with *Rating of Health Plan*, since the 2017 rate for this reportable measure was lower than the 2016 rate.

CAHPS measures like *Getting Needed Care* and *Getting Care Quickly* are access-related and lower rates indicate a perception that members cannot obtain needed care with providers or that members cannot obtain services as quickly as desired. **Amerigroup**'s 2016 Annual Quality Evaluation described the efforts the MCO employed to expand the network to include additional providers and provider relations consultants (See Section 9 for more information). HSAG encourages **Amerigroup** to evaluate those interventions to determine if they are having the desired effect. For the remaining CAHPS measures that fell below the Medicaid national averages (*How Well Doctors Communicate*, *Shared Decision Making*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Discussing Cessation Strategies*), interventions targeted at the provider level and provider communication and interaction with Medicaid members most likely will have the greatest impact on the measures.

HPN

HSAG recommends that **HPN** 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. **HPN** had measures that did not meet the minimum number of responses for the adult Medicaid population, general child and CCC Medicaid populations, and the CCC Nevada Check Up population. Without sufficient responses, MCOs lack information that can be critical to designing and implementing targeted interventions that can improve access to, and the quality and timeliness of, care.

HSAG recommends that **HPN** focus quality improvement initiatives on enhancing members' experiences with *How Well Doctors Communicate*, *Rating of Health Plan*, *Rating of a Personal Doctor*, *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies* for the adult Medicaid population, since these rates were lower than the NCQA's 2016 CAHPS adult Medicaid national averages. For the general child Medicaid population, **HPN** should focus on improving *Rating of All Health Care*, since the rate was lower than the 2016 child CAHPS result and fell below NCQA's 2016 CAHPS child Medicaid national average. For the CCC child Medicaid population, **HPN** should focus on improving *Getting Needed Care* and *Rating of All Health Care*, since the rates for these measures were substantially lower than the 2016 NCQA CCC child Medicaid national averages. In addition, **HPN** should look to improve on *How Well Doctors Communicate* and *FCC: Personal Doctor Who Knows Child*, since the rates were lower than the 2016 CCC child Medicaid results and fell below the 2016 NCQA CCC child Medicaid national averages. For the Nevada Check Up population, **HPN** should focus quality improvement efforts on *Getting Needed Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*, since these measures showed a slight decrease from 2016 to 2017. For the CCC Nevada Check Up population, **HPN** should improve on *Getting Needed Care*, *Rating of All Health Care*, and *Rating of Health Plan*, since the rates for these measures decreased from 2016 to 2017.

The **HPN** 2016 Quality Improvement Evaluation described several interventions the MCO deployed to improve CAHPS rates. Those included expanding the Medicaid network and encouraging providers to use the automated referral application to reduce the turnaround time for referrals to specialists. These interventions have the greatest likelihood of impacting access-related CAHPS measures like *Getting Needed Care* and *Getting Care Quickly*. CAHPS measures like *How Well Doctors Communicate*, *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, *Discussing Cessation Strategies*, and *Rating of Personal Doctor* would be most affected by targeting interventions at the provider level. The **HPN** 2016 Quality Improvement Evaluation described **HPN**'s intervention to conduct monthly patient satisfaction surveys to identify poor performing providers who may be referred to the health plan's Credentialing Committee. HSAG encourages **HPN** to evaluate the effectiveness of the intervention and use survey data collected from monthly surveys to advise and educate providers on ways to improve interactions with Medicaid members.

8. Health Care Guidance Program (HCGP) Performance Measure Validation

Background

In February 2012, the State of Nevada Department of Health and Human Services, Division of Health Care Financing and Policy (the DHCFCP), 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 DHCFCP awarded a contract to **McKesson Health Solutions**, which later changed its name to **McKesson Technologies, Inc. (McKesson)**, to serve as the State's CMO. The contract took effect November 12, 2013, and **McKesson** implemented the Nevada Health Care Guidance Program (HCGP) with a program start date of June 1, 2014. The first day of **McKesson**'s operations, however, was Monday June 2, 2014. On June 2, 2015, **Comvest Partners** purchased **McKesson Technologies, Inc.**'s care management business, which is now doing business as **AxisPoint Health (APH)**.

The DHCFCP sought to verify that **APH** collected and reported complete and accurate performance measure data annually for contractually required performance measures. To that end, the DHCFCP contracted with Health Services Advisory Group, Inc. (HSAG), the State's external quality review organization (EQRO), to validate the performance measure rates that **APH** calculated and reported. HSAG validated **APH**'s performance measures using the CMS external quality review (EQR) Protocol 2⁹⁻¹ as its guide to ensure the performance measure validation (PMV) activity was performed in accordance with industry standards of practice. HSAG's PMV activity focused on the following objectives:

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

Performance Measure Validated

HSAG validated a set of performance measures selected by the DHCFCP for validation. The measures primarily consisted of performance measures that were contractually required by the DHCFCP, but not

⁹⁻¹ Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 1, 2012. Available at: <https://www.medicare.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html>. Accessed on: Jul 18, 2017.

part of the HCGP pay-for-performance (P4P) program. These measures are herein referred to as the non-P4P measures.

Validation Results

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

Data Retrieval

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

Data Integration

HSAG reviewed the **APH** data integration process, including a review of file consolidations or extracts, data integration documentation, source code, and linking mechanisms. Overall, HSAG determined that the data integration processes in place at **APH** were adequate.

Data Control

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

Source Code Development and Performance Measure Documentation

HSAG conducted a line-by-line source code review for all measures and reviewed related documentation, which included the completed Information Systems Capabilities Assessment Tool, computer programming code, output files, work flow diagrams, and narrative descriptions of performance measure calculations. All applicable source code was approved before the on-site visit. HSAG also determined that **APH**'s documentation of performance measure calculations was adequate.

Performance Measure-Specific Rates

On October 18, 2016, HSAG received the final performance measure results generated by **APH** based on the latest receipt of all applicable monthly operational files. All measure results were reviewed for

reasonability. Table 8-1 shows the measure-specific rates for **APH** for program period 2 (June 1, 2015, through May 30, 2016).

Table 8-1—Measure-Specific Rates and Validation Results for APH

Measure ID	Measure	Program Period 2 (June 1, 2015–May 30, 2016)			Audit Validation Results
		Num	Den	Rate	
<i>CCHU.1</i>	<i>Ambulatory Care-Sensitive Condition Hospital Admission (per 100,000 population)</i>	2713	60781	4463.57	Reportable
<i>CCHU.2</i>	<i>“Avoidable” ER Visits</i>	20332	62881	32.3%	Reportable
<i>FUP</i>	<i>Follow-Up with PCP After Hospitalization</i>	1706	5337	32.0%	Reportable
<i>MRP</i>	<i>Medication Reconciliation Post-Discharge</i>	54	5337	1.0%	Reportable
<i>DEM</i>	<i>Cognitive Assessment for Dementia</i>	8	349	2.3%	Reportable
<i>NEUR</i>	<i>Stroke and Stroke Rehabilitations—Discharged on Antithrombotic Therapy</i>	8	83	9.6%	Reportable
<i>CKD</i>	<i>Adult Kidney Disease—Laboratory Testing (Lipid Profile)</i>	0	549	0.0%	Reportable
<i>RA</i>	<i>Disease-modifying Anti-Rheumatic Drug (DMARD) Therapy for Rheumatoid Arthritis</i>	142	208	68.3%	Reportable
<i>OST</i>	<i>Osteoporosis—Pharmacologic therapy for men and women aged 50 years and older</i>	19	436	4.4%	Reportable
<i>OBS</i>	<i>Percentage of members whose BMI calculation is documented, and counseling for nutrition and physical activity is provided during the measurement year (3–11 Years) BMI total</i>	0	9927	0.0%	Reportable
<i>OBS</i>	<i>Percentage of members whose BMI calculation is documented, and counseling for nutrition and physical activity is provided during the measurement year. (12–17 Years) BMI total</i>	114	6255	1.8%	Reportable
<i>OBS</i>	<i>Percentage of members whose BMI calculation is documented, and counseling for nutrition and physical activity is provided during the measurement year (3–11 Years) Counseling for Nutrition Total</i>	237	9927	2.4%	Reportable
<i>OBS</i>	<i>Percentage of members whose BMI calculation is documented, and counseling for nutrition and physical activity is provided during the measurement year (12–17 Years) Counseling for Nutrition Total</i>	151	6255	2.4%	Reportable
<i>OBS</i>	<i>Percentage of members whose BMI calculation is documented, and counseling for nutrition and physical activity is provided during the measurement year (3–11 Years) Counseling for Physical Activity Total</i>	54	9927	0.5%	Reportable

Measure ID	Measure	Program Period 2 (June 1, 2015–May 30, 2016)			Audit Validation Results
		Num	Den	Rate	
OBS	Percentage of members whose BMI calculation is documented, and counseling for nutrition and physical activity is provided during the measurement year (12–17 Years) Counseling for Physical Activity Total	44	6255	0.7%	Reportable
CAP	Children and Adolescents' Access to Primary Care Practitioners (12–24 months)	958	1081	88.6%	Reportable
CAP	Children and Adolescents' Access to Primary Care Practitioners (25 months–6 years)	5193	6951	74.7%	Reportable
CAP	Children and Adolescents' Access to Primary Care Practitioners (7–11 years)	7051	8374	84.2%	Reportable
CAP	Children and Adolescents' Access to Primary Care Practitioners (12–19 years)	10065	12140	82.9%	Reportable
W15	Well-Child Visits in the First 15 Months of Life (0 Visits)	186	1067	17.4%	Reportable
W15	Well-Child Visits in the First 15 Months of Life (1 Visit)	112	1067	10.5%	Reportable
W15	Well-Child Visits in the First 15 Months of Life (2 Visits)	111	1067	10.4%	Reportable
W15	Well-Child Visits in the First 15 Months of Life (3 Visits)	108	1067	10.1%	Reportable
W15	Well-Child Visits in the First 15 Months of Life (4 Visits)	120	1067	11.2%	Reportable
W15	Well-Child Visits in the First 15 Months of Life (5 Visits)	119	1067	11.2%	Reportable
W15	Well-Child Visits in the First 15 Months of Life (6 or more visits)	311	1067	29.1%	Reportable
W34	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	2398	5902	40.6%	Reportable
AWC	Adolescent Well-Care Visits	3227	13868	23.3%	Reportable
CIS	Childhood Immunization Status (Dtap)	612	1139	53.7%	Reportable
CIS	Childhood Immunization Status (IPV)	832	1139	73.0%	Reportable
CIS	Childhood Immunization Status (MMR)	815	1139	71.6%	Reportable
CIS	Childhood Immunization Status (HiB)	799	1139	70.1%	Reportable
CIS	Childhood Immunization Status (HepB)	829	1139	72.8%	Reportable
CIS	Childhood Immunization Status (VZV)	807	1139	70.9%	Reportable
CIS	Childhood Immunization Status (PCV)	622	1139	54.6%	Reportable
CIS	Childhood Immunization Status (HepA)	817	1139	71.7%	Reportable
CIS	Childhood Immunization Status (Rotavirus)	771	1139	67.7%	Reportable
CIS	Childhood Immunization Status (Influenza)	333	1139	29.2%	Reportable

Measure ID	Measure	Program Period 2 (June 1, 2015–May 30, 2016)			Audit Validation Results
		Num	Den	Rate	
CIS	Childhood Immunization Status (Combination #2)	583	1139	51.2%	Reportable
CIS	Childhood Immunization Status (Combination #3)	531	1139	46.6%	Reportable
CIS	Childhood Immunization Status (Combination #4)	531	1139	46.6%	Reportable
CIS	Childhood Immunization Status (Combination #5)	477	1139	41.9%	Reportable
CIS	Childhood Immunization Status (Combination #6)	241	1139	21.2%	Reportable
CIS	Childhood Immunization Status (Combination #7)	477	1139	41.9%	Reportable
CIS	Childhood Immunization Status (Combination #8)	241	1139	21.2%	Reportable
CIS	Childhood Immunization Status (Combination #9)	211	1139	18.5%	Reportable
CIS	Childhood Immunization Status (Combination #10)	211	1139	18.5%	Reportable
PPC	Timeliness of Prenatal Care	234	856	27.3%	Reportable
PPC	Postpartum Care	116	856	13.6%	Reportable
FPC	Frequency of Ongoing Prenatal Care, <21 percent of expected visits	541	856	63.2%	Reportable
FPC	Frequency of Ongoing Prenatal Care, 21 percent–40 percent of expected visits	181	856	21.1%	Reportable
FPC	Frequency of Ongoing Prenatal Care, 41 percent–60 percent of expected visits	91	856	10.6%	Reportable
FPC	Frequency of Ongoing Prenatal Care, 61 percent–80 percent of expected visits	23	856	2.7%	Reportable
FPC	Frequency of Ongoing Prenatal Care, ≥81 percent of expected visits	20	856	2.3%	Reportable
ABA	Adult BMI Assessment	2859	23466	12.2%	Reportable
BCS	Breast Cancer Screening	3138	9980	31.4%	Reportable
CCS	Cervical Cancer Screening	5579	18409	30.3%	Reportable
COL	Colorectal Cancer Screening	2444	11765	20.8%	Reportable
WOP	Percentage of women who delivered a live birth during the measurement year by the weeks of pregnancy at the time of their enrollment in the organization. 1–12 weeks (279–196 days prior to delivery)	140	1321	10.6%	Reportable
WOP	Percentage of women who delivered a live birth during the measurement year by the weeks of pregnancy at the time of their enrollment in the organization. 13–27 weeks (195–91 days prior to delivery)	424	1321	32.1%	Reportable
WOP	Percentage of women who delivered a live birth during the measurement year by the weeks of pregnancy at the time of their enrollment in the organization. 28 or more weeks of pregnancy (<=90 days prior to delivery)	610	1321	46.2%	Reportable

Measure ID	Measure	Program Period 2 (June 1, 2015–May 30, 2016)			Audit Validation Results
		Num	Den	Rate	
WOP	Percentage of women who delivered a live birth during the measurement year by the weeks of pregnancy at the time of their enrollment in the organization. <=0 weeks (280 days or more prior to delivery)	83	1321	6.3%	Reportable
WOP	Percentage of women who delivered a live birth during the measurement year by the weeks of pregnancy at the time of their enrollment in the organization. Unknown	64	1321	4.8%	Reportable

Summary of Findings

This audit reviewed 22 performance measures. All were determined to be reportable by **APH** for the reporting period under review; however, there were several issues identified during the on-site audit.

It was determined that for the first program period (June 1, 2014, through May 30, 2015), all indicators (numerators) for the *Childhood Immunization Status* measure were underreported and based solely on administrative data. Without immunization data from the State registry or medical record review, the measure's rates were too low to derive effective conclusions. The State provided **APH** with the immunization registry data for both program periods during the second period (June 1, 2015, through May 30, 2016). **APH** calculated the current program period immunization rates and recalculated the rates for the first period. The rates for both program periods were approved.

For the *Stroke and Stroke Rehabilitations–Discharged on Antithrombotic Therapy (NEUR)* measure, the denominator remained low for the second program period. Members in the denominator must have been in the HCGP program the entire period. The numerator only included members who were discharged on antithrombotic therapy.

The *Adult Kidney Disease–Laboratory Testing (CKD)* measure evaluated whether a member with kidney disease had a fasting lipid profile completed during the program year. The rate provided by **APH** was 0.00 percent. A line-by-line evaluation of the source code identified that the code aligned with the technical specifications. However, the auditor determined the technical specifications did not include the most common CPT code (80061) used for the fasting lipid profile. During the on-site visit, **APH** recalculated the measure to determine the impact of the missing code 80061. The results of the recalculation increased the rate to more than 77 percent.

During the first program year for the *Cognitive Assessment for Dementia (DEM)* measure, **APH** was not able to fully identify the denominator. **APH** applied the State-allowed changes to the denominator code, which improved the identification of dementia. However, the numerator for this measure continued to be problematic for **APH**. The **APH** providers were not submitting claims that incorporated the CPT code

for the assessment. Since the members with dementia were identified, it is likely the majority of those members who were identified had an assessment completed.

The weight assessment body mass index (BMI) component of the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children Adolescents (OBS)* measure for both age groups (3–11 and 12–18 years) had no administrative data and was reported as 0.0 percent. The source code appeared to use the adult BMI code set instead of the child BMI code set. During the on-site visit, **APH** corrected its source code and the new rates were considered reportable. The auditor also noted the rates produced by Milliman were low.

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

Overall Recommendations and Status of Recommendations

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

- HSAG recommended that the DHCFP examine the technical specification for the *CKD* measure and consider adding the CPT code 80061. The DHCFP also should review all other codes available for this measure and add other appropriate fasting lipid profiles codes to enhance the technical specification for the measure.
- **APH** experienced challenges in capturing numerator-positive cases for the *DEM* measure due to providers not submitting claims for the assessment. HSAG recommended that **APH** consider implementing additional provider training or payment methodologies to capture completed assessments administratively.
- HSAG recommended the DHCFP ensure that **APH** correct its source code to include the child BMI code set for the weight assessment BMI component of the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children Adolescents (OBS)* measure for both 3–11 and 12–18 age groups.
 - **Update:** During the on-site visit, **APH** corrected its source code to include the child BMI code set and recalculated its rates. The newly calculated rates were considered reportable.

Based on the audit findings, HSAG recommended that the technical specifications for all measures be reviewed annually by the DHCFP, or at a minimum every other year in order to ensure that the codes were valid and complete. The review of the technical specifications should also consider prior audit findings and current medical and/or clinical practices.

9. Follow-Up on Recommendations

Introduction

This section of the EQR technical report presents an assessment of how effectively the MCOs addressed the recommendations that HSAG made based on the results of the previous year's EQR activities. Since compliance review activities were not performed in SFY 2015–2016, there were no recommendations related to compliance.

The DHCFP established a collaborative environment to promote sharing of information about emerging practices identified by the MCOs, which would take place at a quarterly on-site meeting that includes MCO, DHCFP, and HSAG staff members as well as external stakeholders. The collaborative sharing among the staffs from 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. 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 of them yield the greatest improvement.

It is at these collaborative quarterly meetings that MCOs present the results of data analyses and evaluations that address recommendations made by HSAG. MCOs also present the interventions and initiatives that have yielded success for their membership and, consequently, performance measure rates. Presented below is a summary of how the MCOs addressed the recommendations that HSAG made based on the previous year's EQR activities.

Validation of Performance Measures—NCQA HEDIS Compliance Audit

Presentation of Emerging Practices

The SFY 2015–2016 EQR technical report summarized emerging practices and opportunities for improvement for both MCOs. Emerging practices and improvement were defined as a 5 percentage point or greater improvement in rates from HEDIS 2015 to HEDIS 2016. For those performance measures, MCOs were asked to present the types of interventions and quality improvement initiatives used to positively impact the Medicaid and Nevada Check Up performance measure rates and ultimately improve access to care and quality and timeliness of care.

Amerigroup Actions Taken

In January 2017, **Amerigroup**'s staff presented its analyses of the interventions and quality initiatives that staff members implemented and that contributed to the 5 percentage-point improvement for the following Medicaid performance measures:

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

Amerigroup's staff also presented its analyses of the interventions and quality initiatives that staff members implemented and that contributed to the 5 percentage-point improvement for the following Nevada Check Up performance measures:

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

Overall, **Amerigroup** found that member and provider reminders were very successful in prompting members to receive required screenings, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, and wellness visits, which had the potential to improve quality and timeliness of care. **Amerigroup** reported the use of interactive automated voice response systems as an effective method for the reminders. **Amerigroup** also used a series of texting campaigns to communicate with members and it continued its member and provider incentive programs. Additionally, **Amerigroup** had increased its provider relations consultants in an effort to contract with more providers and expand its network, which had the potential to improve availability of providers.

HPN Actions Taken

In January 2017, **HPN**'s staff presented its analyses of the interventions and quality initiatives that staff members implemented and that contributed to the 5 percentage-point improvement for the following Medicaid performance measures:

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

HPN's staff also presented its analyses of the interventions and quality initiatives that staff members implemented and that contributed to the 5 percentage-point improvement for the following Nevada Check Up performance measures:

- *Childhood Immunization Status—Combinations 3, 4, 5, 7, 9, and 10*

- *Well-Child Visits in the First 15 Months of Life—Six or More Visits*

HPN's staff reported that by promoting the use of extended office hours for primary care physician offices and urgent care, members were more likely to seek care in more appropriate settings as well as obtain wellness checks and age-appropriate screenings. Extended office hours helped to improve access and availability of services as well as quality and timeliness of care by promoting wellness and preventive care. HPN also reported the use of member and provider incentives to promote health and wellness screenings.

Opportunities for Improvement

The SFY 2015–2016 EQR technical report summarized opportunities for improvement for both MCOs. Opportunities were defined as a 5 percentage-point or greater decline in rates from HEDIS 2015 to HEDIS 2016. For those performance measures, HSAG recommended that the MCOs conduct causal barrier analyses and identify the interventions that were planned to overcome those barriers. HSAG asked MCOs to present the analyses in the January 2017 quarterly meeting. Specifically, MCOs were asked to prepare presentations addressing the interventions that would improve performance as well as those that had been discontinued due to lack of improvement. MCOs also were asked to present the evaluation plan put in place to evaluate the effectiveness of each planned intervention.

Amerigroup Actions Taken

In January 2017, Amerigroup staff members presented the barrier analysis and planned improvement strategies for *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*, the Medicaid performance measure that declined in performance of greater than 5 percentage points from HEDIS 2015 to HEDIS 2016. There were no other performance measures that declined by 5 percentage points or more from HEDIS 2015 to HEDIS 2016 for either Medicaid or Nevada Check Up.

While the causes of the decline may have been attributed to changes in the technical specifications for the measure, Amerigroup conducted an analyses of the interventions it used for this and other measures. Amerigroup staff members reported that outreach phone calls alone were not effective; however, if the automated phone calls were paired with letter or postcard reminders, the interventions were more effective. Amerigroup also enrolled more people in the diabetes disease management program, which increased enrollment from 2,786 members in the first quarter of 2016 to 3,673 members in the fourth quarter of 2016. Members enrolled in the disease management program will have access to additional information and services that are condition-specific and improve the quality of care they receive by educating them on the importance of self-care and allowing them to effectively manage their health care needs. Amerigroup staff members reported that the interventions would be monitored through the collection of HEDIS data and member feedback.

HPN Actions Taken

In January 2017, **HPN** staff members presented the barrier analysis and planned improvement strategies for *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg.)* the Medicaid performance measure that declined in performance more than 5 percentage points from HEDIS 2015 to HEDIS 2016. There were no other performance measures that declined by 5 percentage points or more from HEDIS 2015 to HEDIS 2016 for either Medicaid or Nevada Check Up.

While the causes of the decline may have been attributed to changes in the technical specifications for the measure, **HPN** conducted an analyses of the interventions it used for this and other measures. The **HPN** 2016 Quality Improvement Program Evaluation included information about the evaluation of outreach calls to members and noted that Medicaid members were not as likely to be home during the day when the staff made the outreach calls. During the January 2017 presentation, **HPN** staff members reported that the MCO increased the number of health, education, and wellness classes offered to members with diabetes. The MCO also increased the amount of member case management education and outreach to address gaps in care and address preventive care services that had not been accessed by the member, enabling the member to be the driver in obtaining quality-related services.

Performance Improvement Projects

Since the MCOs were allowed to resubmit PIP modules and incorporate HSAG recommendations at the time of resubmission, HSAG did not have recommendations for the PIP modules that were submitted, approved, and reported on in the SFY 2015–2016 EQR Technical Report.

CAHPS Surveys

The SFY 2015–2016 EQR Technical Report offered recommendations for the MCOs as they prioritized their performance improvement initiatives. HSAG recommended that both MCOs work with the respective CAHPS vendor to obtain a sufficient number of completed surveys so that all measures could be reported. HSAG recommendations to improve rates for quality and access-related CAHPS measures are detailed below.

Amerigroup Recommendations

For **Amerigroup**'s Medicaid population, HSAG recommended that the MCO focus on improving *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Shared Decision Making*. For the CCC Medicaid population, **Amerigroup** should focus on improving *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of Personal Doctor*, *Access to Prescription Medicines*, and *FCC: Getting Needed Information*. For the Nevada Check Up population, HSAG recommended that **Amerigroup** focus quality improvement initiatives on enhancing members'

experiences with *Getting Needed Care*, *Getting Care Quickly*, *Customer Service*, and *Rating of All Health Care*.

Amerigroup Actions Taken

Amerigroup formed a cross-functional committee supported by representation from each of the quality departments. The committee reviewed results of the CAHPS scores and also reviewed the analysis the vendor provided. The committee found that some possible barriers to access were related to the physician network and characteristics of providers as well as member ethnicity, location of the provider, and membership as well as individual knowledge of health plan systems. The committee completed a barrier analysis and identified possible root causes regarding access issues. It also identified opportunities to overcome the barriers. With the Medicaid expansion population, the health plan saw a large rise in membership year over year. The committee surmised that this may have strained the existing network, resulting in a need for additional providers and for provider relations consultants to service the entire network. **Amerigroup** contracted with additional providers and hired additional provider relations consultants in early 2016. The consultants continued to review the network to determine if gaps existed in the presence of provider locations and specialties. If any gaps in the network were identified, the provider relations consultants initiated the contracting process with new providers.

HPN Recommendations

HSAG recommended that **HPN** focus quality improvement initiatives on enhancing members' experiences with *Getting Needed Care*, *Getting Care Quickly*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Health Plan*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies* for the adult Medicaid population. For the general child Medicaid population, HSAG recommended that **HPN** focus on improving *How Well Doctors Communicate*. For the CCC child Medicaid population, HSAG recommended that **HPN** focus on improving *Getting Needed Care* and *Shared Decision Making*, and for the Nevada Check Up population it recommended that quality improvement efforts should focus on *Shared Decision Making*. For the CCC Nevada Check Up population, HSAG recommended that **HPN** improve *Getting Needed Care*, *Access to Prescription Medicines*, and *FCC: Getting Needed Information*.

HPN Actions Taken

HPN evaluated the results from its CAHPS survey and identified a set of interventions and activities to improve CAHPS rates. Specifically, **HPN**:

- Encouraged providers to use the automated referral application. This process reduced the turnaround time for referrals to specialists in order to improve access to medically necessary specialized services.
- Expanded the Medicaid physician network to increase the availability and access to care.

- Conducted follow-up phone calls to members who accessed the emergency room for what appeared to be nonemergent medical conditions. **HPN** provided information on accessing urgent care and establishing a medical home with a primary care physician.
- Conducted monthly patient satisfaction surveys to identify poor-performing providers who may be referred to the health plan's credentialing committee.

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, PIHP, PAHP, or PCCM entity (described in § 438.310(c)(2)) increases the likelihood of desired health outcomes of its enrollees through its (1) structural and operational characteristics, (2) the provision of services that are consistent with current professional, evidence-based-knowledge, and (3) interventions for performance improvement.”^{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).²
- **Access**—CMS defines “access” in the final rule at 42 CFR §438.320 as follows:
“Access, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness

^{A-1} Federal Register. *Code of Federal Regulations, Title 42, Volume 4*, May 6, 2016. Available at: https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=703857ac1ca45c61298fad35c026d482&ty=HTML&h=L&mc=true&r=PART&n=pt42.4.438#se42.4.438_1320. Accessed on: October 26, 2017.

^{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.

elements defined under §438.68 (Network adequacy standards) and §438.206 (Availability of services).”^{A-3}

This appendix describes the technical methods for data collection and analysis for each of the following activities: Internal Quality Assurance Program compliance review, performance measure validation, validation of performance improvement projects, CAHPS surveys, Health Care Guidance Program (HCGP) compliance review follow up, and HCGP performance measure validation (PMV). The objectives for each of these activities are described in the respective sections of this report.

Internal Quality Assurance Program (IQAP)

SFY 2016–2017 was the third year of the three-year cycle of reviews for Nevada and all activities conducted in the previous two years are complete. SFY 2017–2018 initiates a new three-year cycle of reviews. HSAG will report on the SFY 2017–2018 IQAP results in the SFY 2017–2018 technical report.

Validation of Performance Improvement Projects (PIPs)

The DHCFP requires its MCOs to conduct PIPs annually. The topics for the SFY 2016–2017 PIP validation cycle were:

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

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

PIP Components and Process

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

^{A-3} Federal Register. *Code of Federal Regulations, Title 42, Volume 4*, May 6, 2016. Available at: https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=703857ac1ca45c61298fad35c026d482&ty=HTML&h=L&mc=true&r=PART&n=pt42.4.438#se42.4.438_1320. Accessed on: October 26, 2017.

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

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

Approach to PIP Validation

In SFY 2016–2017, HSAG obtained the data needed to conduct the PIP validation from the MCO's module submission forms. These forms provided detailed information about each of the PIPs and the activities completed in Modules 4 through 5.

The MCO submitted each module according to the approved timeline. After the initial validation of each module, the MCO received HSAG's feedback and technical assistance and resubmitted the modules for final validation.

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

PIP Validation Scoring

HSAG assigned a score of Achieved or Failed for each of the criteria in Modules 4 through 4. Any validation criteria not applicable (N/A) were not scored. Using a standardized scoring methodology,

HSAG will assign a level of confidence and report the overall validity and reliability of the findings as one of the following:

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

For the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* PIP, HSAG received DHCFP instructions for the MCOs to include all three components in each MCO's SMART Aim statement. HSAG's validation requirements, which were approved by the DHCFP, stipulated that the MCOs must achieve the goal set for each component of the SMART Aim in order for the PIP to receive a rating of *Confidence* or *High Confidence*.

Performance Measure Validation/HEDIS Audit

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

- Teleconferences with the MCOs' personnel and vendor representatives, as necessary.
- Detailed review of the MCOs' completed responses to the NCQA Roadmap.
- On-site meetings, including the following:
 - Staff interviews.
 - Live system and procedure demonstration.
 - Documentation review and requests for additional information.
 - Primary HEDIS data source verification.
 - Programming logic review and inspection of dated job logs.
 - Computer database and file structure review.
 - Discussion and feedback sessions.
- Detailed evaluation of computer programming used to access administrative data sets, manipulate medical record review data, and calculate HEDIS measures.
- Detailed evaluation of encounter data completeness.

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

In addition, activities conducted prior to on-site meetings with **HPN** and **Amerigroup** representatives 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 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 that the DHCFP requires for reporting.

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

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

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

Note that the *Weeks of Pregnancy at Time of Enrollment (WOP)* and *Human Papillomavirus Vaccine for Female Adolescents (HPV)* measures were retired for HEDIS 2017; however, HPV was added as a new indicator in the *Immunizations for Adolescents (IMA)* measure.

Table A–1—SFY 2016–2017 Performance Measures for Nevada Medicaid and Nevada Check Up

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

CAHPS Survey

Three populations were surveyed for **HPN** and **Amerigroup**: adult Medicaid, child Medicaid, and Nevada Check Up. DSS Research, an NCQA-certified vendor, administered the 2017 CAHPS surveys for **HPN** and **Amerigroup**.

The technical method of data collection was through 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 preapproved enhanced mixed-mode methodology for data collection (i.e.,

mailed surveys followed by telephone interviews of nonrespondents to the mailed surveys). Respondents were given the option of completing the survey in Spanish. The survey cover letter provided a telephone number for members to call if they wanted to complete the survey in Spanish.

The survey questions were categorized into various measures of satisfaction. These measures included four global ratings, five composite scores, and three Effectiveness of Care measures for the adult population only. Additionally, five CCC composite measures/items were used for CCC eligible population. The global ratings reflected patients' overall satisfaction with their personal doctor, specialist, health plan, and all health care. The composite scores were derived from sets of questions to address different aspects of care (e.g., getting needed care and how well doctors communicate). The CCC composite measures/items evaluated the satisfaction of families with children with chronic conditions accessing various services (e.g., specialized services, prescription medications). The Effectiveness of Care measures assessed the various aspects of providing assistance with smoking and tobacco use cessation. When a minimum of 100 responses for a measure was not achieved, the result 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 and CCC composite measures/items, the percentage of respondents who chose a positive response was calculated. CAHPS composite question response choices fell into one of two categories: (1) Never, Sometimes, Usually, or Always; or (2) No or Yes. A positive or top-box response for the composites and CCC composites/items was defined as a response of Usually/Always or Yes. The percentage of top-box responses is referred to as a global proportion for the composite scores and CCC composite measures/items. For the Effectiveness of Care measures, responses of Always/Usually/Sometimes were used to determine if the respondent qualified for inclusion in the numerator. The rates presented follow NCQA's methodology of calculating a rolling average using the current and prior years' results. A substantial increase or decrease is denoted by a change of 5 percentage points or more.

Health Care Guidance Program (HCGP) Performance Measure Validation

In the fall of 2016, HSAG conducted a performance measure validation (PMV) audit of **APH** to verify the accuracy of its reported rates. HSAG validated **APH**'s performance measures using the external quality review (EQR) Protocol 2^{A-4} developed by CMS as its guide. HSAG's **APH** activity focused on the following objectives:

^{A-4} Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 1, 2012. Available at: <https://www.medicare.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html>. Accessed on: Jul 18, 2017.

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

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

Table A–2—Performance Measures for HCGP

Measure ID	Measure Name
<i>CCHU.1</i>	<i>Ambulatory Care—Sensitive Condition Hospital Admission</i>
<i>CCHU.2</i>	<i>Avoidable Emergency Room Visits</i>
<i>FUP</i>	<i>Follow-Up With Primary Care Physician After Hospitalization</i>
<i>MRP</i>	<i>Medication Reconciliation Post-Discharge</i>
<i>DEM</i>	<i>Cognitive Assessment for Dementia</i>
<i>NEUR</i>	<i>Stroke and Stroke Rehabilitations—Discharged on Antithrombotic Therapy</i>
<i>CKD</i>	<i>Adult Kidney Disease—Laboratory Testing (Lipid Profile)</i>
<i>RA</i>	<i>Disease-modifying Anti-Rheumatic Drug (DMARD) Therapy for Rheumatoid Arthritis</i>
<i>OST</i>	<i>Osteoporosis—Pharmacologic therapy for men and women aged 50 years and older</i>
<i>OBS</i>	<i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</i>
<i>CAP</i>	<i>Children and Adolescents’ Access to Primary Care Practitioners</i>
<i>W15</i>	<i>Well-Child Visits in the First 15 Months of Life</i>
<i>W34</i>	<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>
<i>AWC</i>	<i>Adolescent Well-Care Visits</i>
<i>CIS</i>	<i>Childhood Immunization Status</i>
<i>PPC</i>	<i>Prenatal and Postpartum Care</i>
<i>WOP</i>	<i>Weeks of Pregnancy at Time of Enrollment</i>
<i>FPC</i>	<i>Frequency of Ongoing Prenatal Care</i>
<i>ABA</i>	<i>Adult BMI Assessment</i>
<i>BCS</i>	<i>Breast Cancer Screening</i>
<i>CCS</i>	<i>Cervical Cancer Screening</i>
<i>COL</i>	<i>Colorectal Cancer Screening</i>

Pre-audit Strategy

To assist **APH** with the validation process, HSAG provided technical assistance to **APH**'s staff throughout the audit process.

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

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

On-site Activities

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

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

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

Post-on-site Activities

During the on-site visit, HSAG auditors identified several items that required follow-up from **APH**, including revision of some source code for several measures. **APH** submitted the revised source code

along with revised non-P4P performance measure rates. Upon resolving all outstanding items, HSAG auditors reviewed the revised rates provided by **APH** before issuing the final report.

Appendix B. Goals and Objectives Tracking

Nevada 2016–2017 Quality Strategy Goals and Objectives for Medicaid

Unless otherwise indicated, all objectives will follow the QISMC methodology to improve rates.

Goal 1:	Improve the Health and Wellness of Nevada's Medicaid Population by Increasing the Use of Preventive Services.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 1.1a:	Increase children and adolescents' access to PCPs (12–24 months).	94.15%	92.03%	93.83%	94.80%	92.28%	95.17%
Objective 1.1b:	Increase children and adolescents' access to PCPs (25 months–6 years).	83.55%	83.17%	82.25%	84.29%	81.32%	83.81%
Objective 1.1c:	Increase children and adolescents' access to PCPs (7–11 years).	87.12%	87.04%	86.59%	87.36%	85.54%	87.57%
Objective 1.1d:	Increase children and adolescents' access to PCPs (12–19 years).	83.76%	83.38%	82.95%	85.21%	82.72%	85.51%
Objective 1.2:	Increase well-child visits (0–15 months).	52.78%	55.52%	62.50%	53.77%	56.42%	62.77%
Objective 1.3:	Increase well-child visits (3–6 years).	66.33%	69.09%	68.72%	64.48%	64.75%	65.21%
Objective 1.4a:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (BMI percentile).	64.12%	67.71% [†]	70.14%	70.32%	73.29% [†]	71.78%
Objective 1.4b:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (counseling for nutrition).	54.40%	58.96% [†]	62.73%	57.91%	62.12% [†]	62.29%
Objective 1.4c:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (counseling for physical activity).	43.75%	49.38% [†]	56.48%	52.07%	56.86% [†]	59.61%
Objective 1.5:	Increase immunizations for adolescents.	71.93%	74.74% [†]	79.40%	79.81%	81.83% [†]	80.78%
Objective 1.6:	Increase annual dental visits for children.	53.21%	51.06%	51.63%	55.03%	56.01%	53.85%
Objective 1.7:	Increase human papillomavirus vaccine for female adolescents.	24.59%	32.13% [†]	R*	29.68%	36.71% [†]	R*

Goal 1:	Improve the Health and Wellness of Nevada's Medicaid Population by Increasing the Use of Preventive Services.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 1.8:	Increase adolescent well-care visits.	38.43%	47.92%	47.69%	44.04%	43.72%	44.77%
Objective 1.9a:	Increase childhood immunization status (Combination 2).	73.15%	69.58%	72.92%	74.94%	73.72%	73.72%
Objective 1.9b:	Increase childhood immunization status (Combination 3).	66.67%	64.79%	67.13%	70.32%	69.56%	71.05%
Objective 1.9c:	Increase childhood immunization status (Combination 4).	65.28%	62.92%	66.67%	70.07%	69.56%	71.05%
Objective 1.9d:	Increase childhood immunization status (Combination 5).	57.18%	55.21%	56.71%	55.72%	57.74%	61.07%
Objective 1.9e:	Increase childhood immunization status (Combination 6).	32.41%	40.00%	36.11%	38.44%	45.48%	34.79%
Objective 1.9f:	Increase childhood immunization status (Combination 7).	56.48%	53.54%	56.25%	55.72%	57.74%	61.07%
Objective 1.9g:	Increase childhood immunization status (Combination 8).	32.41%	39.79%	36.11%	38.44%	45.48%	34.79%
Objective 1.9h:	Increase childhood immunization status (Combination 9).	29.63%	35.42%	32.18%	31.14%	39.12%	30.41%
Objective 1.9i:	Increase childhood immunization status (Combination 10).	29.63%	35.21%	32.18%	31.14%	39.12%	30.41%
Goal 2:	Increase Use of Evidence-Based Practices for Members With Chronic Conditions.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 2.1:	Increase rate of HbA1c testing for members with diabetes.	79.63%	83.71%	81.02%	85.64%	85.76%	82.73%
Objective 2.2:	Decrease rate of HbA1c poor control (>9.0%) for members with diabetes. **	46.76%	41.76%	46.30%	45.74%	40.08%	42.82%
Objective 2.3:	Increase rate of HbA1c good control (<8.0%) for members with diabetes.	46.30%	48.84%	45.60%	46.47%	49.42%	48.42%
Objective 2.4:	Increase rate of eye exams performed for members with diabetes.	55.09%	59.91%	59.49%	56.93%	60.36%	61.31%
Objective 2.5:	Increase medical attention for nephropathy for members with diabetes.	89.58%	77.65%	90.28%	92.21%	84.46%	90.75%

Goal 2:	Increase Use of Evidence-Based Practices for Members With Chronic Conditions.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 2.6:	Increase blood pressure control (<140/90 mm Hg) for members with diabetes.	55.32%	65.96%	61.11%	60.83%	73.29%	50.36%
Objective 2.7a:	Increase medication management for people with asthma—medication compliance 50 percent.	50.22%	55.20% [†]	56.19%	46.96%	52.26% [†]	53.37%
Objective 2.7b:	Increase medication management for people with asthma—medication compliance 75 percent.	26.84%	34.16% [†]	32.16%	24.14%	31.73% [†]	32.81%
Goal 3:	Reduce and/or Eliminate Health Care Disparities for Medicaid Recipients.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 3.1:	Ensure that health plans maintain, submit for review, and annually revise cultural competency plans.	Met	Met	Met	Met	Met	Met
Objective 3.2:	Stratify data for performance measures by race and ethnicity to determine where disparities exist. Continually identify, organize, and target interventions to reduce disparities and improve access to appropriate services for the Medicaid and Nevada Check Up population.	Met	Met	Met	Met	Met	Met
Objective 3.3:	Ensure that each MCO submits an annual evaluation of its cultural competency programs to the DHCFP. The MCOs must receive a 100 percent <i>Met</i> compliance score for all criteria listed in the MCO contract for cultural competency program development, maintenance, and evaluation.	Met	Met	Met	Met	Met	Met

Goal 4:	Improve the Health and Wellness of New Mothers and Infants and Increase New-Mother Education About Family Planning and Newborn Health and Wellness.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 4.1:	Increase the rate of postpartum visits.	53.16%	52.07%	62.50%	57.18%	62.99%	59.12%
Objective 4.2:	Increase timeliness of prenatal care.	75.41%	72.79%	83.33%	73.97%	79.86%	72.75%
Objective 4.3:	Increase frequency of prenatal care visits (≥ 81 percent of visits).	56.44%	57.10%	62.50%	52.07%	56.21%	60.83%
Objective 4.4:	Increase frequency of prenatal care visits (< 21 percent of visits). **	17.80%	14.23%	5.56%	14.60%	15.33%	11.19%
Goal 5:	Increase Use of Evidence-Based Practices for Members With Behavioral Health Conditions.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 5.1a:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication—initiation phase.	36.68%	43.01% [†]	43.51%	46.65%	51.99% [†]	43.68%
Objective 5.1b:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication—continuation and maintenance phase.	40.91%	46.82% [†]	64.91%	58.02%	62.22% [†]	49.28%
Objective 5.2:	Reduce use of multiple concurrent antipsychotics in children and adolescents. **	0.00%	***	3.74%	1.80%	1.62% [†]	2.26%
Objective 5.3:	Reduce behavioral health-related hospital readmissions within 30 days of discharge.	*N/A	Complete	Complete	*N/A	Complete	Complete
Objective 5.4:	Increase follow-up after hospitalization for mental illness within 7 days of discharge.	52.99%	57.72%	79.81%	56.51%	53.64%	79.16%
Objective 5.5:	Increase follow-up after hospitalization for mental illness within 30 days of discharge.	64.55%	66.83%	84.98%	69.41%	70.20%	84.20%

Goal 6:	Increase Reporting of CMS Quality Measures for Medicaid.			
		DHCFP 2015 Reporting	DHCFP 2016 Reporting	DHCFP 2017 Reporting
Objective 6.1:	Increase number of CMS adult core measures reported to MACPro (non-QISMC).	4	5	N/A**
Objective 6.2:	Increase number of CMS child core measures reported to MACPro (non-QISMC).	7	13	N/A**

Green shading indicates the QISMC goal was met.

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

*** Indicates that QISMC goal could not be established based on prior performance.

*N/A indicates that the PIP had not progressed to the measurement stage at the time of this report.

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

† indicates that the indicator was not required in 2015; therefore, the QISMC goal was set based on 2016 results.

R* Indicates that NCQA retired the indicator.

Nevada 2016–2017 Quality Strategy Goals and Objectives for Nevada Check Up

Unless otherwise indicated, all objectives will follow the QISMC methodology to improve rates.

Goal 1:	Improve the Health and Wellness of the Nevada Check Up Population by Increasing the Use of Preventive Services.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 1.1a:	Increase children and adolescents' access to PCPs (12–24 months).	98.73%	96.25%	98.18%	99.48%	95.23%	98.50%
Objective 1.1b:	Increase children and adolescents' access to PCPs (25 months–6 years).	89.53%	91.43%	89.45%	89.55%	88.48%	89.61%
Objective 1.1c:	Increase children and adolescents' access to PCPs (7–11 years).	92.91%	93.36%	91.83%	93.54%	94.45%	92.98%
Objective 1.1d:	Increase children and adolescents' access to PCPs (12–19 years).	88.95%	92.96%	91.08%	90.78%	91.71%	91.29%
Objective 1.2:	Increase well-child visits (0–15 months).	78.05%	73.33%	78.92%	68.00%	64.00%	63.49%
Objective 1.3:	Increase well-child visits (3–6 years).	70.28%	74.17%	76.16%	70.13%	74.76%	67.64%
Objective 1.4a:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (BMI percentile).	62.04%	65.84% [†]	71.30%	72.02%	74.82% [†]	73.24%
Objective 1.4b:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (counseling for nutrition).	55.56%	60.00% [†]	65.28%	60.34%	64.31% [†]	61.07%
Objective 1.4c:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (counseling for physical activity).	47.69%	52.92% [†]	59.72%	57.18%	61.46% [†]	58.39%
Objective 1.5:	Increase immunizations for adolescents.	81.61%	83.45% [†]	83.61%	87.35%	88.62% [†]	87.59%
Objective 1.6:	Increase annual dental visits for children.	67.05%	68.03%	67.81%	70.11%	72.55%	68.88%
Objective 1.7:	Increase human papillomavirus vaccine for female adolescents.	34.11%	40.70% [†]	R*	42.62%	48.36% [†]	R*
Objective 1.8:	Increase adolescent well-care visits.	56.34%	60.83%	60.88%	52.83%	59.92%	54.74%

Goal 1:	Improve the Health and Wellness of the Nevada Check Up Population by Increasing the Use of Preventive Services.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 1.9a:	Increase childhood immunization status (Combination 2).	85.90%	77.10%	91.16%	87.93%	85.11%	84.38%
Objective 1.9b:	Increase childhood immunization status (Combination 3).	78.21%	76.28%	82.87%	84.48%	79.45%	82.14%
Objective 1.9c:	Increase childhood immunization status (Combination 4).	77.56%	76.28%	81.22%	83.91%	78.74%	82.14%
Objective 1.9d:	Increase childhood immunization status (Combination 5).	68.59%	59.10%	72.93%	79.89%	69.53%	71.88%
Objective 1.9e:	Increase childhood immunization status (Combination 6).	46.79%	50.91%	47.51%	52.30%	53.23%	41.52%
Objective 1.9f:	Increase childhood immunization status (Combination 7).	67.95%	59.10%	72.38%	79.31%	68.82%	71.88%
Objective 1.9g:	Increase childhood immunization status (Combination 8).	46.79%	50.91%	47.51%	51.72%	52.52%	41.52%
Objective 1.9h:	Increase childhood immunization status (Combination 9).	42.95%	39.46%	44.75%	50.00%	48.27%	37.50%
Objective 1.9i:	Increase childhood immunization status (Combination 10).	42.95%	39.46%	44.75%	49.43%	47.56%	37.50%
Goal 2:	Increase Use of Evidence-Based Practices for Members With Chronic Conditions.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 2.1:	Increase rate of HbA1c testing for members with diabetes.	—	—	—	—	—	—
Objective 2.2:	Decrease rate of HbA1c poor control (>9.0%) for members with diabetes. **	—	—	—	—	—	—
Objective 2.3:	Increase rate of HbA1c good control (<8.0%) for members with diabetes.	—	—	—	—	—	—
Objective 2.4:	Increase rate of eye exams performed for members with diabetes.	—	—	—	—	—	—
Objective 2.5:	Increase medical attention for nephropathy for members with diabetes.	—	—	—	—	—	—
Objective 2.6:	Increase blood pressure control (<140/90 mm Hg) for members with diabetes.	—	—	—	—	—	—

Goal 2:	Increase Use of Evidence-Based Practices for Members With Chronic Conditions.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 2.7a:	Increase medication management for people with asthma—medication compliance 50 percent.	47.76%	52.98% [†]	58.43%	47.62%	52.86% [†]	51.02%
Objective 2.7b:	Increase medication management for people with asthma—medication compliance 75 percent.	26.87%	34.18% [†]	24.72%	26.98%	34.28% [†]	27.89%
Goal 3:	Reduce and/or Eliminate Health Care Disparities for Nevada Check Up Recipients.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 3.1:	Ensure that health plans maintain, submit for review, and annually revise cultural competency plans.	Met	Met	Met	Met	Met	Met
Objective 3.2:	Stratify data for performance measures by race and ethnicity to determine where disparities exist. Continually identify, organize, and target interventions to reduce disparities and improve access to appropriate services for the Medicaid and Nevada Check Up populations.	Met	Met	Met	Met	Met	Met
Objective 3.3:	Ensure that each MCO submits an annual evaluation of its cultural competency programs to the DHCFP. The MCOs must receive a 100 percent <i>Met</i> compliance score for all criteria listed in the MCO contract for cultural competency program development, maintenance, and evaluation.	Met	Met	Met	Met	Met	Met

Goal 4:	Improve the Health and Wellness of New Mothers and Infants and Increase New-Mother Education About Family Planning and Newborn Health and Wellness.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 4.1:	Increase the rate of postpartum visits.	—	—	—	—	—	—
Objective 4.2:	Increase timeliness of prenatal care.	—	—	—	—	—	—
Objective 4.3:	Increase frequency of prenatal care visits (≥ 81 percent of visits).	—	—	—	—	—	—
Objective 4.4:	Increase frequency of prenatal care visits (<21 percent of visits). **	—	—	—	—	—	—
Goal 5:	Increase Use of Evidence-Based Practices for Members with Behavioral Health Conditions.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 5.1a:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication—initiation phase.	NR	NC	41.67%	39.53%	45.58% [†]	48.89%
Objective 5.1b:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication—continuation and maintenance phase.	NR	NC	NR	NR	NC	NR
Objective 5.2:	Reduce use of multiple concurrent antipsychotics in children and adolescents. **	NR	NC	NR	NR	NC	NR
Objective 5.3:	Reduce behavioral health-related hospital readmissions within 30 days of discharge. (One of MCOs' PIPs. Improvement TBD by MCO PIP goals.)	*N/A	*N/A	Complete	*N/A	*N/A	Complete
Objective 5.4:	Increase follow-up after hospitalization for mental illness within 7 days of discharge.	84.85%	86.37% [†]	82.50%	NR	NC	NR
Objective 5.5:	Increase follow-up after hospitalization for mental illness within 30 days of discharge.	93.94%	94.55% [†]	97.50%	NR	NC	NR

Goal 6:	Increase Reporting of CMS Quality Measures.			
		DHCFP 2015 Reporting	DHCFP 2016 Reporting	DHCFP 2017 Reporting
Objective 6.1:	Increase number of CMS child core measures reported to MACPro (non-QISMC).	7	15	N/A**

Green shading indicates the QISMC goal was met.

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

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

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

“—” indicates that the measure was not required for the Nevada Check Up population; therefore, no rate is provided.

NR indicates that no rate was reported.

† indicates that the indicator was not required in 2015; therefore, the QISMC goal was set based on 2016 results.

NC indicates that a QISMC goal could not be calculated based on the prior rate.

R* Indicates that NCQA retired the indicator.