State of Nevada
Department of Health and Human Services

Division of Health Care Financing and Policy

Quality Assessment and Performance Improvement Strategy (Quality Strategy)

2014–2015

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The Nevada Division of Health Care Policy and Financing (DHCFP) developed this Medicaid Quality Assessment and Performance Improvement Strategy (Quality Strategy) in accordance with the Code of Federal Regulations (CFR), at 42 CFR 438.200 et. seq. The DHCFP developed the Quality Strategy to continually improve the delivery of quality health care to all Medicaid and Nevada Check Up (the Children's Health Insurance Program [CHIP]) recipients served by the Nevada Medicaid managed care and fee-for-service (FFS) programs. The DHCFP's Quality Strategy provides the framework to accomplish the DHCFP's overarching goal of designing and implementing a coordinated and comprehensive system to proactively drive quality throughout the Nevada Medicaid and Check Up system. The Quality Strategy promotes the identification of creative initiatives to continually monitor, assess, and improve access to care and quality and timeliness of services for Nevada Medicaid and Check Up recipients.

The Quality Strategy's purpose, goals and objectives, scope, assessment of performance, interventions, and annual evaluation are detailed in this Quality Strategy. Documents referenced in the Quality Strategy include:

- The Annual External Quality Review Technical Report
    - http://dhcfp.state.nv.us/pdf%20forms/ManagedCare/Nevada's%202012-2013%20External%20Quality%20Review%20Technical%20Report.pdf
- The DHCFP Medicaid and Check Up Fact Book
    - http://dhcfp.state.nv.us/pdf%20forms/Info/2013%20Medicaid%20Fact%20Book%201-14-13.pdf
- The Medicaid State Plan
    - http://dhcfp.state.nv.us/MSPTableofContents.htm
- Medicaid Managed Care Organization (MCO) Contracts and Amendments
    - http://dhcfp.state.nv.us/ManagedCare/MCO.htm

The DHCFP maintains ultimate authority and responsibility for the maintenance and annual evaluation of the Quality Strategy. The DHCFP updates the Quality Strategy as needed based on MCO performance; stakeholder input and feedback; achievement of goals; changes resulting from legislative, State, federal, or other regulatory authority; and/or significant changes to the programmatic structure of the Nevada Medicaid program.

To demonstrate compliance with the Centers for Medicare & Medicaid Services (CMS) Quality Strategy Toolkit for States, the DHCFP created a crosswalk (Attachment D) that lists each of the required and recommended elements of state quality strategies, and the corresponding section of the DHCFP Quality Strategy and/or DHCFP/MCO Contract that addresses the required or recommended elements. The CMS Quality Strategy Toolkit for States may be accessed at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Quality-Strategy-Toolkit-for-States.pdf.

Overview

History of Program

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

In April 1992, Medicaid initiated a limited-enrollment primary care case management (PCCM) program, the first managed care program in Nevada. The PCCM program was implemented on a voluntary basis. Nevada contracted with **University Medical Center** (**UMC**), **Nevada Health Solutions**, and **Community Health Center** in both Clark County (Las Vegas) and Washoe County (Reno) for managed care services. The PCCM contract with **UMC** was terminated in the first quarter of 1997, and the remaining PCCM contracts were phased out per legislation in July 1999. In April 1997, voluntary managed care became effective again with several vendors. The State of Nevada, Department of Health and Human Resources, Division of Health Care Financing and Policy (DHCFP), contracted with **Health Plan of Nevada** (**HPN**) and **Amil International** (**Amil**) to provide services in Clark County, and with **Hometown Health Plan** to provide services in Washoe County. In addition, the DHCFP contracted with **Nevada Health Solutions**, offered by **NevadaCare**, **United Health Care**, and **HPN**, to provide services in both Clark and Washoe counties. Nevada discontinued voluntary managed care for most recipients in December 1998; however, these health plans continued to provide services to Nevada recipients when the Nevada Legislature passed Senate Bill 559, requiring that Medicaid develop a mandatory managed care program to curtail rising costs of health care. These mandatory Medicaid managed care contracts stayed in effect, with several renewals, through 2001.

In 2002, the DHCFP procured contracts again with **Nevada Health Solutions** and **HPN** in both Clark and Washoe counties. **Anthem** and **HPN** won the contract when Medicaid procured the contracts in November 2006. **Anthem** left the Nevada market in January 2009 and was replaced by **Amerigroup**. In 2013, the DHCFP reprocured contracts with **Amerigroup** and **HPN** in both Clark and Washoe counties. **Amerigroup** and **HPN** are the current the MCOs in Clark and Washoe counties.

In accordance with 42 CFR 438.350 and 438.356, each State that contracts with managed care organizations (MCOs) must ensure that a qualified external quality review organization (EQRO) performs an annual external quality review (EQR) for each contracting MCO. In accordance with these rules, the DHCFP contracted with Health Services Advisory Group (HSAG) as the EQRO for the State of Nevada to conduct the mandatory EQR activities as set forth in 42 CFR 438.358. HSAG has served as the State's EQRO since 1999 and will remain as the State's EQRO through FY 2014–2015.

Program Eligibility

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

- Family Medical Category (FMC)/Temporary Assistance for Needy Families (TANF)
- FMC/Two-parent TANF
- FMC/TANF—Related medical only
- FMC/TANF—Post-medical (pursuant to Section 1925 of the Social Security Act)
- FMC/TANF—Transitional medical (under Section 1925 of the Act)
- FMC/TANF-Related (Sneede vs. Kizer)
- FMC/Child Health Assurance Program (CHAP)
- Children's Health Insurance Program (CHIP)
- Aged-out (AO) foster care (young adults in foster care who no longer qualify due to their age)

The managed care program allows voluntary enrollment for the following recipients (these categories of 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 or 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).
- TANF and CHAP adults diagnosed as seriously mentally ill (SMI).
- TANF and CHAP children diagnosed as severely emotionally disturbed (SED).

DWSS carries out the eligibility and aid code determination functions for Medicaid and Nevada Check Up.

Program Demographics

Table 1-1 presents the gender and age bands of Nevada Medicaid- and CHIP-enrolled recipients in fiscal year (FY) 2013. The majority of members for both Medicaid and CHIP were children between 3 and 14 years of age. The enrollment figures included in Table 1-1 include retro-enrolled recipients. Table 1-2 through Table 1-5 do not include retro-enrolled recipients.

Table 1-1—Nevada Medicaid and CHIP Managed Care Demographics
July 1, 2012–June 30, 2013

Gender/Age Band	June 2013 Members
Medicaid	
Males and Females <1 Year of Age	13,566
Males and Females 1−2 Years of Age	19,511
Males and Females 3−14 Years of Age	90,232
Females 15−18 Years of Age	8,948
Males 15−18 Years of Age	8,277
Females 19−34 Years of Age	18,584
Males 19−34 Years of Age	4,489
Females 35+ Years of Age	7,928
Males 35+ Years of Age	3,407
Total Medicaid	**174,932**
CHIP	
Males and Females <1 Year of Age	227
Males and Females 1−2 Years of Age	1,534
Males and Females 3−14 Years of Age	13,827
Females 15−18 Years of Age	1,423
Males 15−18 Years of Age	1,512
Females 19–34 Years of Age	0
Males 19–34 Years of Age	0
Total CHIP	**18,523**
Total Medicaid and CHIP	**193,455**

Table 1-2 presents enrollment of Medicaid recipients by MCO and county for June 2013.

Table 1-2—June 2013 Nevada MCO Medicaid Recipients

the MCO	Total Eligible Clark County	Total Eligible Washoe County
Health Plan of Nevada	77,521	17,574
Amerigroup	70,905	8,932
Total	**148,426**	**26,506**

Table 1-3 presents enrollment of CHIP recipients in the Nevada Check Up program by MCO and county for June 2013.

Table 1-3—June 2013 Nevada MCO CHIP (Nevada Check Up) Recipients

the MCO	Total Eligible Clark County	Total Eligible Washoe County
Health Plan of Nevada	9,146	2,613
Amerigroup	5,933	831
Total	**15,079**	**3,444**

Table 1-4 presents the ethnic composition of Nevada MCO Medicaid recipients in June 2013.

Table 1-4—June 2013 Nevada MCO Medicaid Ethnic Composition

Ethnicity	Total Eligible Clark County	Total Eligible Washoe County
Asian or Pacific Islander Non-Hispanic	4,150	516
Black Non-Hispanic	34,441	1,235
Hispanic	24	10
Am Indian/Alaskan Non-Hispanic	413	248
Am Indian/Alaskan and White	189	76
Asian and White	597	122
Black African Am and White	1,759	295
Am Indian/Alaskan and Black	563	42
Other Non-Hispanic	7,744	970
Asian/Pacific Islander Hispanic	445	93
Black Hispanic	468	16
Am Indian/Alaskan Hispanic	52	21
White Hispanic	64.953	11,032
White Non-Hispanic	32,723	11,735
Total	**148,521**	**26,411**

Table 1-5 presents the ethnic composition of CHIP recipients in the Nevada Check Up program for June 2013.

Table 1-5—June 2013 Nevada MCO CHIP (Nevada Check Up) Ethnic Composition

Ethnicity	Total Enrolled Clark County	Total Enrolled Washoe County
Asian or Pacific Islander Non-Hispanic	488	46
Black Non-Hispanic	724	38
Hispanic	11,053	2,713
Am Indian/Alaskan Non-Hispanic	19	20
Other Non-Hispanic	1,042	148
White Non-Hispanic	1,751	481
Total	**15,077**	**3,446**

Table 1-6—Nevada Division of Health Care Finance and Policy
Based on Data with Service Dates July 1, 2011–June 30, 2012 (1)
TANF/CHAP/Check-up Members; Males and Females; All Age Bands
All Services—Excluding Prescription Drugs and Dental
Diagnosis Groupings Based on Primary ICD-9 Codes

Group Code	Rank	Highest Cost Diagnosis Codes	Diagnosis Group / Highest Cost Diagnosis Description (2)	Portion of Diagnosis Group Costs (3)	Patients (4)	Paid Amount (5)	Paid Amount Per Patient
O01	1		Live Newborn and Routine Infant Check	100.00%	89,885	$28,276,951	$315
		V20.2	Routine infant or child health check	46.57%	88,788	$13,169,420	$148
		V30.01	Born in hospital; delivered by cesarean delivery	24.02%	2,635	$6,792,863	$2,578
K07	2		Normal Delivery and Related Care	100.00%	10,503	$25,300,472	$2,409
		650	Normal delivery	23.37%	2432	$5,911,912	$2,431
		654.21	Previous cesarean delivery; delivered, with or without mention of antepartum condition	18.30%	1009	$4,628,836	$4,588
I04	3		Other GI disorders	100.00%	14,468	$11,275,492	$779
		521.00	Dental caries, unspecified	38.42%	4232	$4,332,180	$1,024
		521.03	Dental caries extending into pulp	7.56%	417	$851,995	$2,043
K06	4		Complications Mainly Related to Pregnancy	100.00%	6,967	$10,660,208	$1,530
		645.11	Post term pregnancy; delivered, with or without mention of antepartum condition	12.08%	360	$1,288,253	$3,578
		644.21	Early onset of delivery; delivered, with or without mention of antepartum condition	10.54%	264	$1,123,610	$4,256
H01	5		Diseases of the upper respiratory tract	100.00%	59,864	$10,482,266	$175
		465.9	Unspecified site	22.09%	26,443	$2,315,956	$88
		466.19	Acute bronchiolitis due to other infectious organisms	10.57%	4283	$1,107,567	$259
K08	6		Complications occurring Mainly in the Course of Labor and Delivery	100.00%	2,325	$7,092,668	$3,051
		664.01	First-degree perineal laceration; delivered, with or without mention of antepartum condition	16.51%	377	$1,171,251	$3,107
		664.11	Second-degree perineal laceration; delivered, with or without mention of antepartum condition	12.48%	280	$885,170	$3,161
F06	7		Disorders of the eyes	100.00%	42,861	$6,232,280	$145
		367.1	Myopia	19.83%	14,724	$1,236,001	$84
		367.9	Unspecified disorder of refraction and accommodation	15.64%	9,133	$974,550	$107
K11	8		Perinatal problems - Certain conditions originating in the perinatal period (includes fetal alcohol syndrome and others)	100.00%	3,049	$6,153,861	$2,018
		770.89	Other respiratory problems after birth	11.77%	403	$724,130	$1,797
		769	Respiratory distress syndrome	9.85%	214	$606,147	$2,832
M03	9		Diseases of the spine - Dorsopathies (neck, back, disc disease, etc.)	100.00%	8,025	$4,377,894	$546
		724.2	Lumbago	26.08%	4273	$1,141,593	$267
		723.1	Cervicalgia	11.08%	1485	$485,015	$327
F05	10		Diseases of the peripheral nervous system and sense organs except eyes	100.00%	23,881	$3,638,206	$152
		382.9	Unspecified otitis media	38.60%	13529	$1,404,325	$104
		382.00	Acute suppurative otitis media without spontaneous rupture of ear drum	8.10%	3,232	$294,605	$91
			All Other Diagnosis Groups	100.00%	163,511	$123,975,408	$758
Total					**201,262**	**$237,465,706**	**$1,180**
Total Member Months							

(1) Includes claims paid through June 2012 for HPN & Amerigroup.

(2) This column lists descriptions of the most costly diagnosis groups as well as descriptions of the two most costly diagnoses within that group.

(3) This column identifies the percentage of the total cost for that diagnosis group which is attributable to the given diagnosis code.

(4) This field identifies the number of unique members who were assigned primary diagnosis codes in that line item. Members can be in multiple line items.

(5) Paid amount includes all services, excluding prescription drug and dental.

DHCFP Mission

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

Process for Quality Strategy Development, Review, and Revision

The DHCFP fosters a multidisciplinary approach to developing, reviewing, and revising the Quality Strategy. The approach involves the public, provider stakeholders, recipient advocates, and outside partners who have a direct concern for—and impact on—access, quality of care, and quality of service. All stakeholders have the opportunity to comment on the development of quality goals and objectives highlighted in the Quality Strategy.

Quality Strategy Development

With input provided by Nevada Medicaid MCOs, the DHCFP developed performance measures used to measure health plan performance in achieving the goals and objectives identified in the Quality Strategy. The epidemiological data, detailed in Table 1-6, served as the basis for selecting performance measures to improve the health and wellness of Nevada's Medicaid and Check Up population. The DHCFP uses the Healthcare Effectiveness Data and Information Set (HEDIS®[1-1]) to develop, collect, and report data for most performance measures.

Ongoing Review of the Quality Strategy

The DHCFP's EQRO is contractually required to validate the MCOs' HEDIS information. The DHCFP tracks the MCOs' performance for each of the required performance measures and reports the information annually in the external quality review (EQR) technical report. Additionally, the MCOs are required to track their own performance and report achievements and opportunities for improvement in an MCO quality evaluation, which is submitted annually to the DHCFP by each MCO.

For areas that require a specialized focus and targeted performance improvement interventions, the DHCFP requires the MCOs to conduct ongoing performance improvement projects (PIPs). The purpose of PIPs is to achieve significant, sustained improvement in both clinical and nonclinical areas through ongoing measurements and intervention. PIPs provide a structured method of assessing and improving processes, and thereby outcomes, of care for the population that an MCO serves. The DHCFP's EQRO validates the MCOs' PIPs annually and submits to the DHCFP validation findings, conclusions, and recommendations to improve PIP interventions and outcomes for the following year's PIP review cycle. Throughout the year, the MCOs are required to conduct and report on interim measurements to determine if PIP interventions are successful. The MCOs report on their intervention

[1-1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

evaluation efforts during monthly and/or quarterly meetings with the DHCFP and the EQRO. The ongoing evaluation and exchange of information regarding PIP interventions and barriers enable the MCOs to target performance improvement efforts in specified areas. The DHCFP uses the results of the PIP validation findings to assess each MCO's achievement of goals and to make modifications to the Quality Strategy based on the MCOs' performance, if necessary.

The DHCFP monitors each MCO's compliance with its contract, and with the goals and objectives identified in the Quality Strategy, via an internal quality assurance program (IQAP) on-site review of compliance with various quality assessment/improvement standards. The DHCFP's EQRO conducts IQAP reviews at least once every three years. The purpose of the reviews is to determine an MCO's understanding and application of Balanced Budget Act of 1997 (BBA) and contractually required standards from a review of documents, observations, and interviews with key health plan staff, as well as file reviews conducted during the on-site evaluation. The IQAP review includes an assessment of each MCO's quality improvement structure. This structure is necessary in facilitating quality improvement of performance measures and PIPs, which measure each MCO's performance in achieving quality goals and objectives identified in the Quality Strategy. The IQAP report enables the MCOs to implement improvement interventions to correct any areas of deficiency. The report also helps the DHCFP determine each MCO's compliance with the contract and identify areas of the contract that need to be modified or strengthened to ensure that an MCO complies with the standards and can achieve the goals and objectives identified in the Quality Strategy.

Annually, the DHCFP assesses each MCO's Quality Strategy evaluation to ensure that the MCO continually monitors and evaluates its own achievement of goals and objectives to improve the accessibility, timeliness, and quality of services provided to Medicaid and Check Up recipients. The DHCFP provides feedback to the MCOs regarding programmatic strengths identified from the review of the MCO's Quality Strategy and opportunities to improve the structure and direction of the MCO's quality program.

Quality Strategy Evaluation and Revision

The DHCFP and its EQRO evaluate the effectiveness of the Quality Strategy and report on the evaluations in the annual EQR technical report. The DHCFP updates the Quality Strategy, as necessary, based on each MCO's performance; stakeholder input and feedback; achievement of goals; changes resulting from legislative, State, federal, or other regulatory authority; and/or significant changes to the programmatic structure of the Nevada Medicaid program. The DHCFP invites public comment and feedback by providing a direct link online for stakeholders and beneficiaries to provide input to and ask questions about the strategy. The DHCFP Quality Strategy is located at: https://dhcfp.nv.gov/ManagedCare/EQRO.htm.

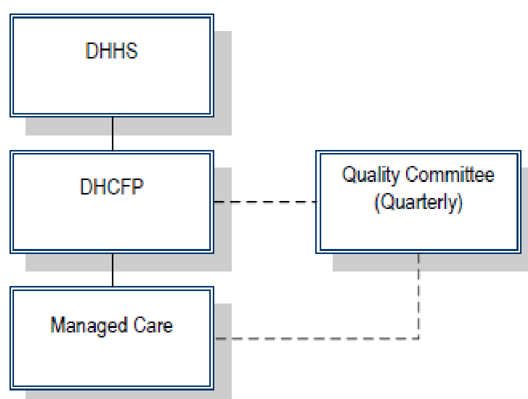
The DHCFP revises the Quality Strategy to reflect changes in scope and identified needs. The DHCFP defines significant changes to the Quality Strategy that require input from recipients and stakeholders as:

- Any change to the Quality Strategy resulting from legislative, State, federal, or other regulatory authority.
- Any change in membership demographics of 50 percent or greater within one year.
- Any change in the provider network of 50 percent or greater within one year.

Oversight and Governance of the Quality Strategy

As depicted in Figure 1-1, under the advisement of the Department of Health and Human Services, the DHCFP maintains ultimate authority and responsibility for the maintenance and annual evaluation of the Quality Strategy. The DHCFP maintains a Quality Committee, which meets during the quarterly face-to-face MCO meeting. During these meetings, the DHCFP and MCO staffs review and discuss performance measure results, PIP results, and Quality Strategy goals and objectives. Further, the MCOs are required to present information on quality improvement results, barrier analyses, and planned quality improvement activities to be implemented to overcome barriers that impede performance.

Figure 1-1—Nevada DHCFP
Quality Improvement Organizational Structure



Quality Strategy Purpose, Scope, and Goals

Purpose of the Quality Strategy

Consistent with its mission, the purpose of the DHCFP's Quality Strategy is to:

- Establish a comprehensive quality improvement system that is 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 Check Up system. The Quality Strategy promotes the identification of creative initiatives to continuously monitor, assess, and improve access to care, clinical quality of care, and health outcomes of the population served.
- Identify opportunities for improvement in the health status of the 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 Check Up recipients have access to high quality and culturally appropriate care.
- Improve recipient satisfaction with care and services.

Scope of Quality Strategy

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

- All Medicaid and Check Up managed care recipients in all demographic groups and in all service areas for which the MCOs are approved to provide Medicaid and Check Up managed care services.
- All aspects of care—including accessibility, availability, level of care, continuity, appropriateness, timeliness, and clinical effectiveness of care and services covered by Nevada Medicaid managed care and the Check Up program.
- All aspects of the MCOs' performance related to access to care, quality of care, and quality of service, including networking, contracting, and credentialing; medical record-keeping practices; environmental safety and health; health and disease management; and health promotion.
- All services covered—including preventive care services, primary care, specialty care, ancillary care, emergency services, chronic disease and special needs care, dental services, mental health services, diagnostic services, pharmaceutical services, skilled nursing care, home health care, and prescription drugs.
- All professional and institutional care in all settings, including inpatient, outpatient, and home settings.

- All providers and any other delegated or subcontracted provider type.
- All aspects of the MCOs' internal administrative processes related to service and quality of care—including customer services, enrollment services, provider relations, confidential handling of medical records and information, case management services, utilization review activities, preventive health services, health education, information services, and quality improvement.
- All Medicaid members who are enrolled in the State's care management organization (CMO) program and receive care management services via the CMO vendor. Additional detail about the Nevada Comprehensive Care Waiver (NCCS) program is provided in Attachment C of this report.

Quality Strategy Goals and Objectives

Based on a review of national goals detailed in Healthy People 2020 and the National Quality Strategy and a review of Nevada Medicaid epidemiological and prevalence data displayed in Table 1-6, the DHCFP established the following quality goals to improve the health and wellness of Nevada Medicaid and Check Up members and ensure that members have access to high quality and culturally appropriate care. The goals and objectives established for the NCCW program are described in Attachment C of this report.

Goal 1:	**Improve the health and wellness of Nevada's Medicaid and Check Up population by increasing the use of preventive services, thereby modifying health care use patterns for the population.**

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

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

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

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

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

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

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

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

Objective 2.3: Increase LDL-C screening for members with diabetes by 10 percent.

[1-2] The goal for all measures to increase performance by 10 percent refers to the hybrid QISMC methodology for reducing the gap between the performance measure rate and 100 percent by 10 percent.

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, which detail the health plans' goals, objectives, and processes for reducing and/or eliminating racial or ethnic disparities that negatively impact the quality and timeliness of, and access to, health care.
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 Check Up population.
Objective 3.3:	Ensure that the MCOs submit an annual evaluation of their cultural competency program to the DHCFP. The MCOs must receive a 100 percent *Met* compliance score for all of the criteria listed in the MCO contract for cultural competency program development, maintenance, and evaluation.
Goal 4:	**Improve the health and wellness of new mothers and infants and increase new-mother education about family planning and newborn health and wellness.**
Objective 4.1:	Increase the rate of postpartum visits by 10 percent.

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

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

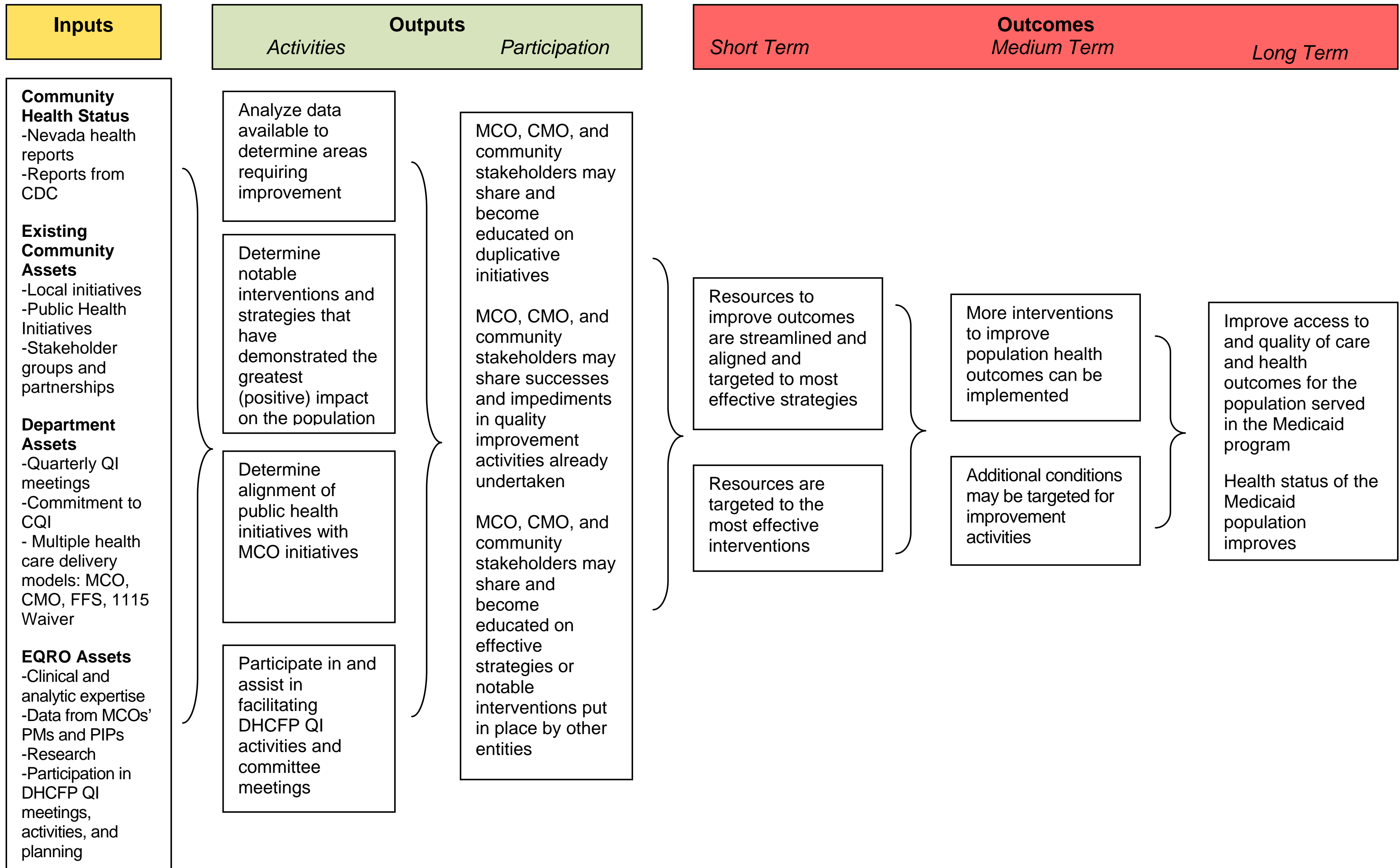
Strategy for Meeting Goals and Objectives

The methods employed by the DHCFP to achieve these goals include:

- Developing and maintaining collaborative strategies among State agencies and external partners to improve health education and health outcomes, manage vulnerable and at-risk members, and improve access to services for all Nevada Medicaid and Check Up recipients.
- Using additional performance measures, performance improvement projects, contract compliance monitoring, and emerging practice activities to drive improvement in member health care outcomes.
- Strengthening evidence-based prevention, wellness, and health management initiatives to improve members' health status and achievement of personal health goals.
- Enhancing member services and member satisfaction with services.
- Improving health information technology to ensure that information retrieval and reporting are timely, accurate, and complete.
- Working collaboratively with other Department of Health divisions and community resources to improve access to and quality of care and health outcomes of the populations served by Medicaid.

The logic model on the following page depicts the DHCFP's strategy for improving health outcomes.

DHCFP's Logic Model for Improving Health Outcomes



Medicaid Contract Provisions (42 CFR 438.204[a])

To assess the quality and appropriateness of care/services for members with routine and special health care needs, the DHCFP regularly reviews the MCOs' reports and deliverables as required by the contract. As described in Section II, Assessment of Performance, the DHCFP also contracts with its EQRO to conduct comprehensive IQAP on-site reviews of compliance.

The DHCFP reviews the MCOs' deliverables throughout the year to evaluate their compliance with the contract in the following areas:

- Operational and structural policies and procedures
- Member outreach information and materials
- Provider information, materials, and contracting
- Grievance and appeals procedures and reporting
- IQAP program
- Cultural competency

The DHCFP reviews all deliverables submitted by the MCOs and, as applicable, requires revisions until the DHCFP approves the deliverables as complete and fully compliant with the contract.

Use of National Performance Measures

NCQA Benchmarking

The DHCFP uses HEDIS data whenever possible to measure the MCOs' performance with specific indices of quality, timeliness, and access to care. In 2009, the National Committee for Quality Assurance (NCQA), under contract with CMS, invited Nevada to participate in its Medicaid Modernization: Quality Measurement Analysis project. The purpose of this project was to create a robust set of benchmarks and analyze quality measures to support efforts in establishing quality improvement goals using standardized, audited, and comparable performance information. The DHCFP will continue to work with NCQA and CMS on other data analysis and benchmarking projects to advance its health information technology (HIT) initiatives to improve quality of care for Medicaid beneficiaries and provide evidence of improving data validity for performance measures and PIP reporting.

Children's Health Insurance Program Reauthorization Act

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) reauthorized CHIP under Title XXI of the Social Security Act. Section 2108(a) of the Social Security Act (the Act) provides that states must assess the operation of the state child health plan in each federal fiscal year (FFY), and report to the Secretary, by January 1 following the end of the FFY, on the results of the assessment. The DHCFP submits Nevada Check Up

(i.e., CHIP) performance measure rates and other data to CMS as part of its annual CHIPRA reporting activities.

Use of Corrective Action Plans (42 CFR 438.204[e])

The DHCFP requests corrective action plans from the MCOs in cases for which compliance monitoring and/or deliverable reviews do not demonstrate adequate performance. The corrective action plans clearly state objectives, the individual and/or department responsible, and time frames to remedy subpar performance. The corrective action plans may include:

- Education by oral or written contact or through required training.
- Recertification for procedures or services that require certification.
- Required submission of a corrective action plan, with subsequent monitoring or re-auditing to confirm compliance with the action plan.
- A prospective or retrospective analysis of patterns or trends.
- In-service training or education.
- Modification, suspension, restriction, or termination.
- Intensified review.
- Changes to administrative policies and procedures, as appropriate.

The DHCFP shall impose intermediate sanctions if performance or noncompliance with the provision of covered, medically necessary benefits and services becomes an impediment to meeting the health care needs of recipients and/or the ability of providers to adequately attend to those health care needs. Such sanctions will disallow further Medicaid and Nevada Check Up enrollment and may also include adjusting auto-assignment formulas used for recipient enrollment.

Quality and Appropriateness of Care (42 CFR 438.204[b][1])

Procedures for Race, Ethnicity, and Primary Language Data Collection and Communication (42 CFR 438.204[b][2])

To comply with the regulatory requirement for state procedures for race, ethnicity, and primary language spoken (CFR 438.206-438.210), the DHCFP requires the MCOs to participate in Nevada's efforts to promote the delivery of service in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds. Since 2007, the State and the MCOs have participated in the Racial and Ethnicity Disparities Work Group to address disparities in health care utilization and outcomes. The DHCFP continually monitors how race, ethnicity, and the primary language of enrollees are collected, coded, and entered into the system to ensure that this information is compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and with CMS requirements to improve the delivery of services in a culturally competent manner. The DHCFP provides information on race, ethnicity, and primary language spoken to the health plans as part of the member eligibility file. Health plans are required to use the data in their efforts to identify and overcome racial and ethnic disparities in health care.

The MCOs, in cooperation with the DHCFP, are required to develop and implement a cultural competency plan that encourages delivery of services in a culturally competent manner to all recipients, including those with limited English proficiency and diverse cultural and ethnic backgrounds. The written cultural competency plan may be a component of the MCO's written Quality Strategy or a separate document incorporated by reference. Both of MCOs that participate in the Nevada Medicaid managed care program maintain separate Culturally Competency Plans that are submitted to DHCFP for review and approval on an annual basis. The MCOs are required to ensure that appropriate foreign language versions of all member materials are developed and available to members, and to provide interpreter services for members whose primary language is a non-English language. The DHCFP reviews and approves all member materials as part of a readiness review for all new MCOs entering the Nevada Medicaid managed care program. In addition, the EQRO monitors compliance with requirements during the comprehensive compliance review.

As part of their cultural competency initiatives, the MCOs examine disparities through analysis of their PIPs. The MCOs also examine performance measures used as indicators for assessing achievement of the State's Quality Strategy goals and objectives, which are detailed in Section 1. The MCOs are required to stratify PIP and performance measure data by race/ethnicity to identify disparities and opportunities to overcome barriers that impede improvement. Based on their findings, the MCOs incorporate specific interventions for race and ethnicity to improve indicator rates, such as *Lead Screening in Children*, *Access to*

Primary Care Practitioners, *Avoidable Emergency Department Utilization*, and *Well-Child Visits*. Further, the MCOs are required to document stratification findings and planned interventions to reduce health care disparities in their annual cultural competency plan evaluation and Quality Strategy evaluation. Both of these documents are submitted to the DHCFP annually for review and approval.

Identification of Members With Special Health Care Needs (42 CFR 438.204[b][1])

The DHCFP monitors quality and appropriateness of services for children with special health care needs through compliance monitoring activities and regular review of the MCOs' deliverables. The DHCFP monitors quarterly reports and tracks and trends results to determine patterns of utilization, and monitors performance of the health plan. The State Health Division and the DHCFP host a monthly teleconference call with their early intervention community providers to facilitate stakeholder involvement and collaboration. The DHCFP also monitors services provided to children with special health care needs to identify the need for continued services throughout treatment to ensure that all services are medically necessary according to federal Medicaid regulations at CFR 440.110.

Nevada Early Intervention Services (NEIS) provides services to children from birth through 2 years of age who have developmental delays and/or diagnosed conditions based on federal regulations of the Individuals with Disabilities Education Improvement Act of 2004 (IDEA). Children are eligible in Nevada if they have a 50 percent delay in one area of development, a 25 percent delay in two areas of development, or have a diagnosed condition that has a high probability of leading to a developmental delay (e.g., Down's syndrome).

A multidisciplinary team from two different disciplines—i.e., physical therapy and social work—determines eligibility and includes information from the parent using an assessment protocol, observation of the child, review of relevant health and medical history, and an informed clinical opinion.

Once a child is eligible, an Individualized Family Service Plan (IFSP) must be developed within 45 days of the referral to determine the child's program and service needs. The IDEA specifies that services must be available to a child based on his or her individual needs. NEIS provides these services in accordance with the IFSP, which determines the frequency and intensity needed (e.g., one service per week for 60 minutes). This plan is reviewed and updated at least every 6 months. NEIS ensures that all services are provided by appropriately licensed personnel. Per the IDEA, services must be provided in a "natural environment," which includes home, child care, and community settings.

At least six months prior to the child's third birthday, the case manager assists in developing a plan to transition the child to the next service delivery system. For most children this would be the school district, and services would then be provided for the child through an Individual Education Plan (IEP).

Current School-Based Services

All eligible Medicaid and Nevada Check Up children can receive school-based services in both fee-for-service and managed care. School districts may serve as the medical provider by signing an inter-local agreement with the DHCFP, which makes payments directly to the school districts for services provided.

Eligibility

- Students must be eligible for Medicaid on the date of service
- Students must be 3 to 20 years of age
- Students must be eligible for IDEA special education, with treatment services written in the IEP
- All treatment services must relate to a medical diagnosis and be medically necessary

Services are rendered by certified speech language pathologists, audiologists, RN/LPNs, occupational and physical therapists, psychologists (with a clinical license only), physicians, physician's assistants, or advanced nurse practitioners. All services billed to Medicaid must be included in the current IEP. The IEP must contain the diagnosis (disability), desired outcome (goals), nature of treatment (type of therapy), frequency of treatment (minutes/number per week), and duration (length of time).

The MCOs coordinate health care services for Medicaid and Nevada Check Up recipients who are identified as CSHCN and who remain voluntarily enrolled in the plan. The health plans' policies reflect the following:

- Recipients identified by a health plan as children with special health care needs are assigned to a pediatric case manager.
- For recipients who access school-based children's health services (SBCHS), the IEP is used by the pediatric case manager as the basis to complete an assessment. If a recipient has health care needs beyond the capacity of SBCHS, the case manager develops a treatment plan to coordinate and facilitate the provision of such health care services.
- For recipients who access early childhood intervention services through NEIS and the Division of Child and Family Services (DCFS), the Individualized Family Services Plan (IFSP) is used by the pediatric case manager to complete an assessment. If a recipient has health care needs beyond the capacity of NEIS and DCFS, the case manager will develop a treatment plan to coordinate such health care services.
- If a recipient's needs are met by NEIS, DCFS, or SBCHS, the case will continue to be tracked. The health plan's care coordination staff will contact the parents/guardians at three-month intervals to determine any new health care issues that NEIS, DCFS, or SBCHS cannot address. If issues are found, the case will be referred to a pediatric case manager. If no needs are identified, the case should remain in a tracking status for subsequent three-month follow-up telephone calls.
- For other CSHCN recipients, an assessment and treatment plan should be developed in conjunction with the recipient's primary care provider (PCP), with the recipient's

participation and in consultation with specialists. The treatment plan will specify the services the recipient needs to improve function.

- For a recipient who requires ongoing specialist care, the pediatric case manager will work with the medical director and the specialist to develop a referral/prior authorization for an estimated number of specialist visits required to meet the recipient's needs.
- The care coordination staff or designated health plan staff completes a contract-required quarterly report and forwards it to the DHCFP within 45 days after the close of the quarter.

Arrangement for External Quality Review (42 CFR 438.204[d])

In accordance with 42 CFR 438.356, the DHCFP contracts with an EQRO to conduct the mandatory and optional EQR activities as set forth in 42 CFR 438.358. To evaluate the quality and timeliness of, and access to, the services covered under the MCO contract, the DHCFP's EQRO conducts the following mandatory EQR activities for the Nevada Medicaid and Check Up program:

- **Compliance monitoring evaluation.** The DHCFP's EQRO conducts comprehensive, internal IQAP on-site reviews of compliance of the MCOs at least once in a three-year period. The DHCFP's EQRO reviews MCO compliance with standards established by the State for access to care, structure and operations, and quality measurement and improvement. In accordance with 42 CFR 438.204(g), these standards are as stringent as the federal Medicaid managed care standards described in 42 CFR 438, which address requirements related to access, structure and operations, and measurement and improvement. Compliance is also determined through review of individual files to evaluate implementation of standards.
- **Validation of performance measures.** In accordance with 42 CFR 438.240(b)(2), the DHCFP requires MCOs to submit performance measurement data as part of their quality assessment and performance improvement (QAPI) programs. To comply with 42 CFR 438.358(b)(2), the DHCFP's EQRO validates the performance measures through HEDIS compliance audits. The HEDIS compliance audits focus on the ability of the MCOs to accurately process claims and encounter data, pharmacy data, laboratory data, enrollment (or membership) data, and provider data. The DHCFP's EQRO validates each of the performance measures identified by the State to evaluate their accuracy as reported by, or on behalf of, the MCO. As part of the HEDIS compliance audits, the DHCFP's EQRO also explores the issue of completeness of claims and encounter data to improve rates for the performance measures.
- **Validation of PIPs.** As described in 42 CFR 438.240(b)(1), the DHCFP requires MCOs to conduct 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 enrollee satisfaction. In accordance with 42 CFR 438.358(b)(1), the DHCFP's EQRO validates PIPs required by the State to comply with the requirements of 42 CFR 438.240(b)(1). The DHCFP's EQRO validation determines if

PIPs were designed to achieve improvement in clinical and nonclinical care, and if the PIPs would have a favorable effect on health outcomes and enrollee satisfaction.

The 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' MCOs. The DHCFP's EQRO produces the EQR technical report, which presents all mandatory and optional EQR activities performed, although the EQRO is not currently contracted to perform the optional activities that are specifically detailed in 42 CFR 438.204(d).

The 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, Nevada Check Up. In accordance with 42 CFR 438.364, the report includes the following information for each mandatory activity conducted:

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

The report also includes an assessment of MCO strengths and weaknesses, as well as recommendations for improvements. The DHCFP uses the information obtained from each of the mandatory EQR activities, as well as the information presented in the EQR technical report, to make programmatic changes and modifications to the DHCFP Quality Strategy. The EQR technical report also contains a chapter that describes the EQRO's evaluation of the State's QAPI program. The chapter includes the Quality Strategy Goals and Objectives Tracking Table, which lists the goals and objectives described in Section 1 of the Quality Strategy and the MCO's achievement of each objective.

State Monitoring and Evaluation of MCO Requirements (42 CFR 438.204[b][3])

Performance Measures Used to Assess Members' Timely Access to Appropriate Health Care (42 CFR 438.204[c])

The DHCFP uses HEDIS to develop, collect, and report data for most performance measures. The DHCFP's EQRO is contractually required to validate MCOs' HEDIS information. The DHCFP tracks MCO performance for each of the required performance measures using the Performance Tracking Tool, as described later in this section. In collaboration with the MCOs, the DHCFP identified the following indicators to measure MCOs' success in improving access to care and quality and timeliness of services provided to Nevada Medicaid and Check Up recipients. An asterisk (*) indicates measures that have

been identified as special MCO initiatives that specifically support the goals identified in Section 1 of the Quality Strategy.

The DHCFP also supports CMS' collection of consistent performance measure data from states. The DHCFP voluntarily collects and reports on a selection of CMS core performance measures for adults and children, as noted in Table 2-1 below.

Table 2-1—Performance Measures for Nevada Medicaid and Check Up

Performance Measure (HEDIS)	Medicaid	Check Up	CMS Adult or Child Core Set**
Childhood Immunization Status			Child
**Children's and Adolescents' Access to Primary Care Practitioners*			Child
**Lead Screening in Children*			-
Well-Child Visits in the First 15 Months of Life			Child
**Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*			Child
Adolescent Well-Care Visits			Child
**Annual Dental Visit*			-
Follow-Up After Hospitalization for Mental Illness			Adult/Child
Use of Appropriate Medications for People With Asthma			-
Mental Health Utilization—Percentage of Members Receiving Inpatient, Day/Night Care, and Ambulatory Services			-
**Ambulatory Care (ED Visits only)*			Child
**Comprehensive Diabetes Care*			Adult
Timeliness of Prenatal Care			Adult/Child
**Postpartum Care*			Adult
Frequency of Ongoing Prenatal Care			Child
Weeks of Pregnancy at the Time of Enrollment			-

* Indicates measures that specifically support the goals identified in the Quality Strategy.
**CMS-designated core set Health Care Quality Measures for Medicaid-Eligible Adults and Medicaid-Eligible Children. In addition to these measures, CMS also includes Consumer Assessment of Healthcare Providers and Systems (CAHPS®[2-1]) health plan surveys for both Adults and Children in the core set measures listing. The DHCFP requires the MCOs to collect and report data on both Medicaid Adult and Child CAHPS®.

Standards for Access to Care

The contracts between the DHCFP and the MCOs detail Nevada Medicaid standards for access to care, as outlined in Subpart D of the Medicaid Managed Care Rules and Regulations. The DHCFP's standards are at least as stringent as those specified in 42 CFR 438.200–438.242. The MCOs are required to implement the following standards for access to care:

[2-1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

- Availability of services (42 CFR 438.206)
- Assurances of adequate capacity and services (42 CFR 438.207)
- Coordination and continuity of care (42 CFR 438.208)
- Coverage and authorization of services (42 CFR 438.210)

Please see Attachment A for the DHCFP's timeline for monitoring MCOs. Attachment B, Quality Strategy Goals and Objectives Tracking Grid, serves as the State's profile for monitoring MCOs' performance against the goals and objectives outlined in this Quality Strategy.

The DHCFP's contract with its Medicaid managed care organizations and all applicable amendments may be accessed at https://dhcfp.nv.gov/ManagedCare/MCO.htm**.**

Standards for Structure and Operations

The contracts between the DHCFP and the MCOs detail Nevada Medicaid standards for structure and operations, as outlined in Subpart D of the Medicaid Managed Care Rules and Regulations. The DHCFP's standards are at least as stringent as those specified in 42 CFR 438.200–438.230. The MCOs are required to implement the following standards for structure and operations:

- Provider selection and credentialing (42 CFR 438.214)
- Enrollee information (42 CFR 438.218)
- Confidentiality (42 CFR 438.224)
- Enrollment and disenrollment (42 CFR 438.226)
- Grievance systems (42 CFR 438.228)
- Subcontractual relationships and delegation (42 CFR 438.230)

Please see Attachment A for the DHCFP's timeline for monitoring MCOs.

The DHCFP's contract with its Medicaid managed care organizations and all applicable amendments may be accessed at https://dhcfp.nv.gov/ManagedCare/MCO.htm.

Measurement and Improvement Standards

The contracts between the DHCFP and the MCOs detail Nevada Medicaid standards for measurement and improvement, as outlined in Subpart D of the Medicaid Managed Care Rules and Regulations. The DHCFP's standards are at least as stringent as those specified in 42 CFR 438.236–242. The MCOs are required to implement the following standards for measurement and improvement:

- Practice Guidelines (42 CFR 438.236)
- Quality assessment and performance improvement program (42 CFR 438.240)
- Health information systems (42 CFR 438.242)

The DHCFP's contract with its Medicaid managed care organizations and all applicable amendments may be accessed at https://dhcfp.nv.gov/ManagedCare/MCO.htm.

Performance Improvement Projects (PIPs)

As described in 42 CFR 438.240(b)(1), the DHCFP requires MCOs to conduct PIPs annually, 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 enrollee satisfaction. In accordance with 42 CFR 438.358(b)(1), the DHCFP's EQRO validates PIPs required by the State to comply with the requirements of 42 CFR 438.240(b)(1).

PIPs provide a structured method of assessing and improving 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. The MCOs conduct PIPs to assess and improve the quality of clinical and nonclinical health care and services received by recipients.

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

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

Table 2-2 lists the Nevada Medicaid and Check Up PIPs under way for FY 2013–2014.

Table 2-2—Nevada Medicaid and Check Up Performance PIPs

Performance Improvement Project	Health Plan of Nevada	Amerigroup	Medicaid	Check Up
Children's and Adolescents' Access to Primary Care Practitioners	X		X	X
Improving Diabetes Screening and Control		X	X	
Decreasing Avoidable Emergency Room Visits	X	X	X	X

The DHCFP's EQRO validates the MCOs' PIPs annually and submits to the DHCFP validation findings, conclusions, and recommendations to improve PIP performance for the following year's PIP review cycle. Although the MCOs use the information provided in the annual PIP reports to target improvement interventions in specified areas, the MCOs are encouraged to use rapid cycle improvement techniques to continually monitor, via interim measurements, and make necessary changes to their interventions to improve PIP outcomes.

The DHCFP uses PIP results to assess each MCO's achievement of goals and make modifications to the Quality Strategy based on each MCO's performance, if necessary.

Measurement of Recipient Satisfaction

Annually, the MCOs administer a CAHPS® survey. The primary objective of the CAHPS® survey is to obtain information effectively and efficiently on the level of satisfaction patients have with their health care experiences. CAHPS® surveys ask recipients to report on and evaluate their experiences with health care. These surveys cover topics important to recipients, such as the communication skills of providers and the accessibility of services.

The Nevada MCOs survey three populations: adult Medicaid, child Medicaid, and Nevada Check Up. The DHCFP uses CAHPS® survey information to measure MCO and provider performance, recipient satisfaction with services provided and program characteristics, recipient access to care, and recipient expectations. The DHCFP's EQRO summarizes the findings of each CAHPS® survey completed by the MCOs and incorporates the summary in the annual EQR technical report.

State Monitoring and Evaluation of MCOs' Contractual Compliance (42 CFR 438.204[3])

Compliance Review (42 CFR 438.204[g])

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 standards established by the state for access to care, structure and operations, and quality measurement and improvement. In accordance with 42 CFR 438.204(g), these standards must be as stringent as the federal Medicaid managed care standards described in 42 CFR 438, which address requirements related to access, structure and operations, and measurement and improvement. To meet this requirement, the DHCFP contracts with its EQRO to perform a comprehensive on-site review of compliance of the MCOs.

The purpose of the compliance review is to determine each MCO's compliance with various quality assessment/improvement standards in 13 areas of compliance. The 13 compliance standards are derived from requirements in the *Department of Human Resources Division of Health Care Financing and Policy Request for Proposal No. 1988 for Medicaid Managed Care Organization Services* and all attachments effective July 1, 2013; as well as the BBA, with revisions effective June 14, 2002. The 13 compliance standards are listed below:

- Internal Quality Assurance Program (IQAP)
- Credentialing and Recredentialing
- Recipient Rights and Responsibilities
- Member Information

- Availability and Accessibility of Services
- Continuity and Coordination of Care
- Grievance and Appeals
- Subcontracts and Delegation
- Cultural Competency
- Coverage and Authorization of Services
- Provider Participation and Program Integrity
- Confidentiality and Record Keeping
- Provider Information

In addition, the EQRO conducts a review of individual files for the areas of delegation, credentialing/recredentialing, grievances, appeals, denials, and continuity of care/case management to evaluate implementation of the standards. On-site evaluations adhere to guidelines detailed in *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[2-2]

Results from compliance reviews assist the DHCFP in determining the MCOs' compliance with the contract. The compliance review results also assist the DHCFP in identifying any areas of the contract that need modification or strengthening to ensure that the MCOs have the ability to achieve the goals and objectives identified in the Quality Strategy. The DHCFP's EQRO also assists the DHCFP with a review of corrective action plans submitted by the MCOs to correct areas found to be deficient in the compliance review.

Health Information Systems (42 CFR 438.204[f])

Health Information Technology (42 CFR 438.204[f])

On February 17, 2009, the American Recovery and Reinvestment Act of 2009 (ARRA) was signed into law. This statute includes the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH Act), which establishes a plan for advancing the meaningful use of health information technology (HIT) to improve quality of care through the adoption of certified electronic health records (EHRs) and the facilitation of health information exchange (HIE).

The primary objective of the Nevada Office of Health Information Technology (OHIT) is to administer the State's ARRA HIE Cooperative Agreement, facilitate the core infrastructure and build capacity to enable the statewide HIE, and coordinate related HIT initiatives in

[2-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: February 19, 2013.

Nevada. The infrastructure built as a result of OHIT initiatives facilitates better exchange of health information that can be collected and used to analyze data for continuous quality improvement. Nevada will incorporate both private sector health information technology businesses and additional trained work force personnel to implement, service, and maintain the hardware and software for the EHR and HIE systems. For example, during the 2012–2013 contract year, the DHCFP established data-sharing agreements with the University of Nevada, Reno's (UNR's) Public Health Program to provide early periodic screening, diagnosis, and treatment (EPSDT); smoking cessation; and dental data to assist UNR with the reporting of Healthy People 2020 goals and objectives. Further, the DHCFP established a data-sharing agreement with the Office of Public Health Informatics and Epidemiology to create an interface between Medicaid's warehouse and the DHHS Division of Health's database to facilitate real-time sharing of vital statistics, immunizations, and other health data.

Additionally, the DHCFP implemented the Nevada Incentive Payment Program for Electronic Records. This program is part of CMS' Electronic Health Records Incentive Program. The program provides incentive payments to eligible professionals (EPs), eligible hospitals (EHs), and critical access hospitals (CAHs) as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology.

Goals and Objectives Tracking Table (42 CFR 438.204[f])

To continually track the progress of achieving the goals and objectives outlined in the Quality Strategy, the DHCFP developed the Quality Strategy Goals and Objectives Tracking Table (Quality Strategy Tracking Table). The Quality Strategy Tracking Table lists each of the goals and objectives and corresponding performance measures used to measure achievement of the goals and objectives. The DHCFP and its EQRO update the Quality Strategy Tracking Table annually. In addition to sharing the revised table with the MCOs, the Medicaid and Check Up administration, and other stakeholders, the DHCFP's EQRO incorporates the Quality Strategy Tracking Table as Appendix B of the Annual External Quality Review Technical Report. Table 2-3 shows the achievement of goals and objectives by the MCOs in FY 2012–2013.

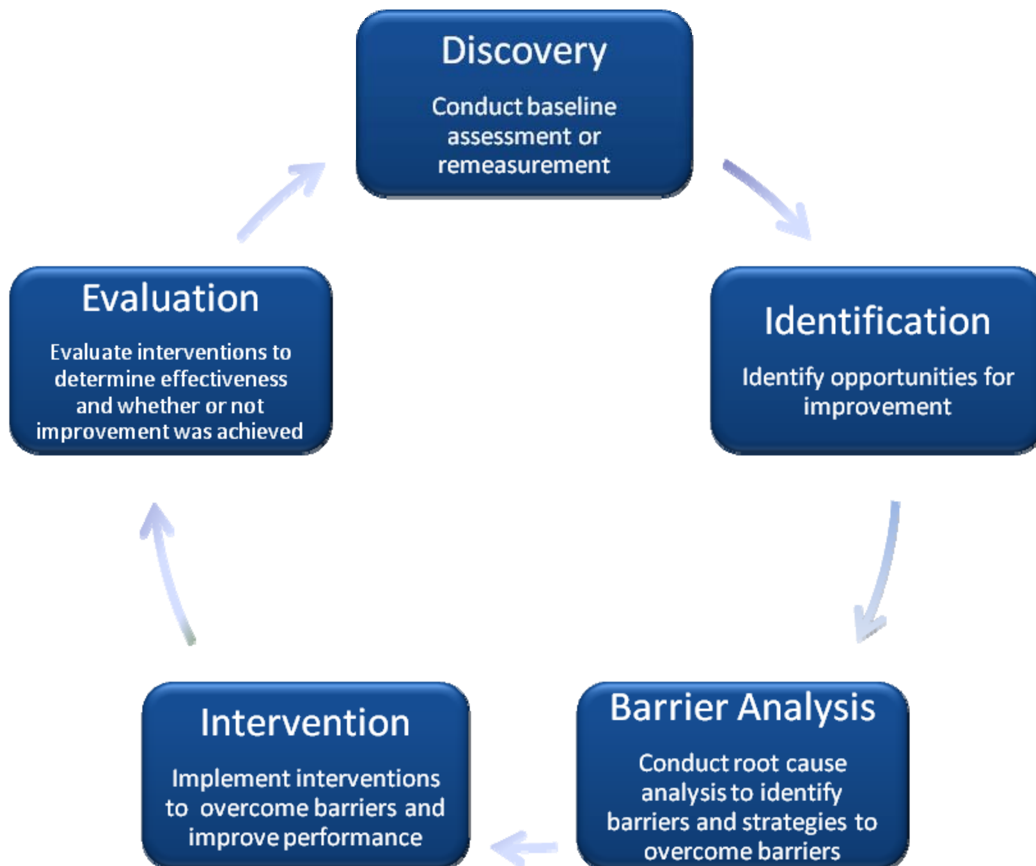
Table 2-3—2012–2013 Quality Strategy Goals and Objectives Summary of Achievement by MCOs

MCO	HPN	Amerigroup
Number of Comparable Rates (Year 1 to Year 2)	19	19
Number of Rates That Improved	7/19 (36.9%)	13/19 (68.4%)
Number of Rates That Stayed the Same	0/19 (0%)	1/19 (5.3%)
Number of Rates That Achieved QISMC Goal	11/19 (57.9%)	12/19 (63.2%)
Number of Rates That Declined	12/19 (63.2%)	5/19 (26.3%)

Annually, the DHCFP uses the information in the Quality Strategy Tracking Table and each MCO's performance measure results to determine what additional quality improvement efforts MCOs should make to improve quality of care and health outcomes of the population. PIP performance is also taken into consideration when determining the focus of the following year's quality improvement activities.

The DHCFP quality improvement program embodies a continuous quality improvement (CQI) process and problem-solving approach that is applied to specific and measurable performance indicators and operational activities. The CQI process is used to: (1) monitor access to care, timeliness and quality of care, and operational performance; (2) identify opportunities for improvement that exist throughout the Nevada Medicaid program; (3) implement intervention strategies to improve outcomes and performance; (4) evaluate interventions to determine if they were successful; and (5) reassess performance through remeasurement to identify new opportunities for improvement. The process employed to review findings from discovery activities, establish priorities, conduct barrier analyses, develop strategies for intervention and improvement, and evaluate performance is depicted in Figure 3-1 below.

Figure 3-1—DHCFP Performance Improvement Process Flow



The DHCFP uses several key interventions to drive quality improvement in the Nevada Medicaid program, which include:

- Maintaining a robust quality improvement framework that encompasses a continuous quality improvement approach, as described above.
- Using HEDIS and other performance measures, as described in Section II, to continually assess each MCO's achievement of the goals and objectives described in Section I.
- Implementing PIPs, which measure and assess targeted performance improvement interventions on specific topics.
- Monitoring CAHPS® results and other satisfaction data to determine if Nevada Medicaid recipients are satisfied with care and services.
- Monitoring the MCOs' quality improvement activities and compliance with contractual requirements to verify if the MCOs are appropriately implementing federal and State contractual standards.
- Facilitating cross-agency collaborative meetings to identify opportunities to improve care and service delivery in the Nevada Medicaid program and achieve stakeholder buy-in to implement interventions to improve care and service delivery.
- Benchmarking performance measure results to ensure that the MCOs' performance is comparable or better than the national norm.
- Implementing other initiatives, as needed, to adhere to changes in federal policy.
- Studying the health care disparities among racial and ethnic groups to implement targeted and culturally competent interventions to ensure that all Medicaid and Check Up recipients have access to high-quality care.
- Studying the health care disparities among children with special health care needs to implement targeted interventions to ensure that all Medicaid and Check Up recipients have access to high-quality care.

4. Evaluation of Effectiveness

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

Annual Evaluation of the Quality Strategy (42 CFR 438.204[d])

The annual evaluation includes an assessment of:

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

Quality Tools Used to Evaluate Quality Strategy

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

- The annual EQRO technical report
- Validated performance measure results
- Validated PIP results
- MCO compliance review results
- Ongoing review of contractually required MCO deliverables
- Fee-for-service utilization reporting
- Recipient complaint and grievance information
- Stakeholder feedback emailed to the DHCFP via the DHCFP website

To continually track the progress toward achieving the goals and objectives outlined in Section I, the DHCFP developed the Quality Strategy Goals and Objectives Tracking Table. As shown in Appendix B, the table lists each of the goals and related objectives to measure achievement of those goals. On an annual basis, the DHCFP and its EQRO update the Quality Strategy Goals and Objectives Tracking Table. In addition to sharing the revised table with the MCOs, the Medicaid and Check Up administration, and other stakeholders, the EQRO includes the table as part of the annual Quality Strategy evaluation, which is included as a chapter in the annual EQR technical report.

Quality Strategy Revision

The DHCFP updates the Quality Strategy at least biennially to incorporate new goals and objectives for the following biennium. The DHCFP updates the Quality Strategy more often, as needed, to reflect changes in State or federal policy that impact the Medicaid or Check Up programs. Prior to each update, the DHCFP solicits stakeholder input on the goals and objectives of the Quality Strategy. Once input is received and consensus is reached by all stakeholders, the Quality Strategy is finalized, shared with all pertinent stakeholders, and posted on the DHCFP Web site for public view. The DHCFP invites public comment and feedback by e-mailing the DHCFP at techhelp@dhcfp.nv.gov or by following the link provided on the DHCFP's Web site: http://dhcfp.state.nv.us/managed.htm.

5. SUMMARY OF PRIOR YEAR'S PERFORMANCE

In the second quarter of each fiscal year (FY), the DHCFP and its EQRO highlight the MCOs' performance with the mandatory EQR activities. The summary of EQR activities includes a profile of the MCO performance measure rates, PIP results, and compliance with standard or corrective action plan results from the previous fiscal year. The summary of FY 2012–2013 MCO strengths and opportunities for improvement are highlighted below. For additional detail, please see the FY 2012–2013 EQR Technical Report at: http://dhcfp.state.nv.us/ManagedCare/EQRO.htm.

Summary of Amerigroup Strengths

The following Medicaid performance measures have been identified as strengths for **Amerigroup** based on improvement in rates over time.

- *Childhood Immunization Status—Combinations 4, 6, 7, 8, 9, and 10*
- *Timeliness of Prenatal Care*
- *Frequency of Ongoing Prenatal Care (<21% Visits)*
- *Frequency of Ongoing Prenatal Care (81–100% Visits)*
- *Comprehensive Diabetes Care—Eye Exams*
- *Follow-up After Hospitalization for Mental Illness—7 Days*
- Reduction in *Avoidable Emergency Room Utilization* (based on PIP performance)

The following Nevada Check Up performance measures have been identified as strengths for **Amerigroup** based on improvement in rates over time.

- *Childhood Immunization Status—Combinations 4, 7, 8, and 10*
- *Annual Dental Visit—Combined Rate*

Summary of Amerigroup Opportunities for Improvement

The following Medicaid performance measures have been identified as opportunities for improvement for **Amerigroup** based on declines in performance over time.

- *Comprehensive Diabetes Care—HbA1c Testing*
- *Comprehensive Diabetes Care—Blood Pressure <140/80*
- *Use of Appropriate Medications for People With Asthma (5–11 Years)*
- *Use of Appropriate Medications for People With Asthma (12–18 Years)*

- *Use of Appropriate Medications for People With Asthma (Combined)*

The following Nevada Check Up performance measures have been identified as opportunities for improvement for **Amerigroup** based on declines in performance over time.

- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- *Use of Appropriate Medications for People With Asthma (5–11 Years)*
- *Use of Appropriate Medications for People with Asthma (Combined)*

Summary of HPN Strengths

The following Medicaid performance measures have been identified as strengths for HPN based on improvement in rates over time.

- *Childhood Immunization Status—Combinations 4, 6, 7, 8, 9, and 10*
- *Follow-up After Hospitalization for Mental Illness, 7–Day*
- *Follow-up After Hospitalization for Mental Illness, 30–Day*
- Reduction in *Avoidable Emergency Room Utilization* (based on PIP performance)

The following Nevada Check Up performance measures have been identified as strengths for HPN based on improvement in rates over time.

- *Childhood Immunization Status—Combinations 4, 6, 7, 8, 9, and 10*
- *Annual Dental Visit—2–3 Years of Age*
- *Follow-up After Hospitalization for Mental Illness, 30-Day*
- Reduction in *Avoidable Emergency Room Utilization* (based on PIP performance)

Summary of HPN Opportunities for Improvement

The following Medicaid performance measures have been identified as opportunities for improvement for HPN based on declines in performance over time.

- *Children's Access to Primary Care Practitioners (25 Months–6 Years)*
- *Children's Access to Primary Care Practitioners (7–11 Years)*
- *Children's Access to Primary Care Practitioners (12–19 Years)*
- *Frequency of Ongoing Prenatal Care, <21% of Visits*
- *Comprehensive Diabetes Care—Good HbA1c Control (<8%)*
- *Comprehensive Diabetes Care—HbA1c Testing*

The following Nevada Check Up performance measures have been identified as opportunities for improvement for HPN based on declines in performance over time.

- *Children's Access to Primary Care Practitioners, 12–19 Years*
- *Well Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- *Use of Appropriate Medications for People with Asthma (5–11 Years)*
- *Use of Appropriate Medications for People with Asthma (Combined)*

MCO Causal Barrier Presentation

In the quarter following the presentation of EQR results, each MCO is required to present to the DHCFP and the EQRO its quality improvement activities underway in the organization to capitalize on strengths and address opportunities for improvement that were identified through an evaluation of the prior year's performance measure rates. Each MCO is required to describe and present on the following:

- Types of interventions or quality improvement (QI) initiatives that were used to positively impact measures that yielded the greatest improvement.
- QI tools (e.g., root cause analysis, Ishikawa diagram) and techniques that have been used to evaluate measures that have declined.
- Identified causes for the declines.
- Classification of new or existing causes or issues—for reoccurring issues, the MCO must pinpoint and describe the new interventions the MCO will implement to overcome the barriers and improve rates.
- Evaluation plan the MCO has put in place to evaluate the effectiveness of the planned interventions. Without an evaluation plan, the DHCFP believes the MCO cannot determine whether to modify or discontinue existing interventions, or implement new strategies, thereby reducing the likelihood of achieving the desired goals and improving performance.

6. Emerging Practices and Collaboration

In November 2009, the DHCFP submitted its 2010–2011 Quality Strategy to CMS for review and implemented the Quality Strategy in December 2009. Since that time, the DHCFP, its EQRO, and the MCOs have continually monitored the goals and objectives of the Quality Strategy during teleconference and quarterly face-to-face MCO meetings. The DHCFP, the EQRO, and the MCOs use these collaborative forums to share information on quality initiatives and emerging practices and present performance measure and utilization data to continually track the progress toward meeting the State's goals and objectives. Since the last revision of this Quality Strategy, the DHCFP has highlighted the following quality improvement initiatives and emerging practices.

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. Only through continuous measurement and analyses to determine the efficacy of an intervention can an emerging practice be identified. Therefore, the DHCPF encourages the MCOs to continually track and monitor the efficacy of quality improvement initiatives and interventions to determine if the benefit of the intervention outweighs the effort and cost.

As part of its ongoing quality improvement efforts, the DHCFP operationalized data sharing agreements with other divisions to aid in the collection of information that can be shared with health plans to assist them in achieving the Quality Strategy goals and objectives. In the spring of 2013, the DHCFP established a data-sharing agreement with the University of Nevada, Reno's Public Health Program to provide Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), smoking cessation, and dental data for reporting of the Healthy People 2020 goals. Further, the DHCFP established a data-sharing agreement with the Office of Public Health Informatics and Epidemiology to create an interface between Medicaid's warehouse and the DHHS Division of Health's database to facilitate real-time sharing of vital statistics, immunizations, and other health data.

Another method used by the DHCFP to promote best and emerging practices among the MCOs is to ensure that the State's contractual requirements for the MCOs are at least as stringent as those described in Subpart D of the BBA regulations for access to care, structure and operations, and quality measurement and improvement (42 CFR 438.204[g]). The DHCFP actively promotes the use of nationally recognized protocols, standards of care, and benchmarks by which health plan performance is measured. Recently, the DHCFP included a new requirement in the MCO contract, which requires the MCOs to implement a shared savings model that focuses on reducing behavioral and mental health lengths of stay, re-

admissions, and emergency room utilization in general hospitals. In response to this contract requirement, **Amerigroup** contracted with a behavioral health provider to provide Rapid Response Service in emergency department settings. The Rapid Response Service staff members assist in triaging and assessing the mental health care needs of members who present in the emergency room with mental health concerns. The Rapid Response Service team coordinates outpatient care for the member if inpatient care is not medically indicated. **HPN** developed a behavioral health cost containment and quality improvement initiative in 2011 which meets this contract requirement. An example of one of the services developed by **HPN** was the creation of Rapid Response Service teams composed of behavioral health professionals. The initiative is supported by hospital emergency room staff members, who contact the Rapid Response Service team when a member presents with a mental health concern. The Rapid Response Service team is responsible for evaluating members with mental health diagnoses in the emergency room within four hours of receiving the call from the emergency room staff. Since the implementation of this program, inpatient psychiatric admissions have been reduced by 50 percent.

MCO-Specific Quality Initiatives

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

Health Plan of Nevada

HPN implemented the following quality improvement initiatives.

- Sending primary care physician quarterly profiles for members with asthma, chronic obstructive pulmonary disease, diabetes, and heart failure to indicate if members had received treatment in a hospital, emergency room, urgent care, or outpatient setting in the past year to encourage providers to ensure that the members received routine and preventive care.
- Distributing quarterly profiles of members who were non-compliant with diabetes tests and exams to primary care physicians.
- Enhancing member education for members with chronic conditions to inform them about health checks, tests, exams, immunizations, and health topics to discuss with their physicians.
- Flexing the working hours of care managers to be able to discuss health management issues in the evening with members who could not be reached during the day.
- Developing a pediatric instruction sheet for asthma patients who are discharged from urgent care or the emergency room.

- Furnishing chart advisories to selected primary care groups to inform physicians of treatment plans developed by behavioral health providers and medications prescribed by behavioral health providers after receiving consent from the member.
- Dedicating a staff member to monitor and track the number of postpartum depression screenings given to women after delivery of a newborn and ensure proper and timely follow-up with the member.
- Notifying the primary care physician and the behavioral health provider when a woman received a prescription for postpartum depression.
- Emphasizing the importance of lead screenings by including reminders about lead testing in birthday cards sent to members and including articles about lead testing in the member newsletter.
- Furnishing non-financial incentives to children who complete lead testing, well-child visits, or immunizations required by age two.
- Providing education to health plan members concerning the availability of urgent care services and the 24-hour telephone advice nurse line to decrease the number of emergency room admissions.
- Developing cling sheets that members could stick on various surfaces to remind them of what needs to be done in urgent or emergent situations.
- Using automated telephone call outreach intervention to remind members about necessary tests and exams.
- Continuing to encourage behavioral health providers to perform domestic violence screenings in suspected cases and expanding the screenings to other network providers.
- Educating members about the appropriate use of antibiotics.
- Offering on-site strep A testing in network clinics.
- Establishing a program to allow walk-in appointments for women to complete mammogram screenings.
- Encouraging providers with electronic medical record systems to use the templates for topics to discuss with members concerning preventive care, body mass index values and percentiles, immunizations, and detailed demographics.
- Participating in the State Medicaid Agency task force to improve culturally and linguistically appropriate services.

Amerigroup

Amerigroup implemented the following quality improvement initiatives.

- Providing primary care physicians with monthly reminders of overdue services for EPSDT services.
- Assigning a member of senior management, a quality or clinical expert, and every associate in the Nevada plan to one of five cross-functional teams focusing on improving specific HEDIS measures.

- Scheduling automated telephone calls to all women who delivered a baby to remind the members of the importance of the postpartum visits, well-child visits, and immunizations for babies and children.
- Partnering with the State to implement a two-year study to educate and incentivize members to obtain screenings for chronic diseases.
- Partnering with an eye vendor to develop outreach initiatives to diabetic members and their providers to improve rates for the annual eye screenings.
- Increasing the number of permanent and temporary staff members to make outreach calls concerning preventive care services to Spanish-speaking members.
- Providing a non-financial incentive for children completing the required immunizations.
- Using predictive modeling to determine members at risk for overutilization of emergency room services and contacting the members to provide education about urgent care services and the 24-hour nurse line.
- Rewarding physicians for achieving quality goals.
- Establishing a daily inpatient census report to send to primary care physicians to encourage better management of discharge planning and care coordination.
- Establishing a monthly potential missed care opportunities report to identify gaps in care for the primary care providers.
- Amending provider contracts to compensate them for after-hours visits by members.
- Focusing on the management of mental health rehabilitation and psychosocial services.
- Training staff in concepts of motivational interviewing to foster an environment of encouragement and support for members in disease management.
- Expanding strategies for increased member engagement through the development and use of direct transfers from the automated messaging systems.
- Adopting new predictive models for emergency room usage and hospital readmissions.
- Creating collaborative relationships with the member, providing proactive communication concerning available resources to address health care needs, member education, and reinforcement of the 24-hour nurse line to assist in managing urgent conditions to reduce emergency room visits for members actively enrolled in disease management.
- Using predictive modeling, providing a comprehensive clinical intake process to identify immediate needs, establishing collaborative care plans, and mitigating or removing barriers to care to decrease hospital admissions for members actively enrolled in disease management.
- Performing medical record review and reviewing missed opportunity reports to identify coding errors and opportunities to improve documentation, and increase provider awareness of individual provider HEDIS measure rates as compared to a peer group.
- Developing primary care practice integrated teams with behavioral health coaches to identify, screen, assess, treat, educate, monitor, and coordinate care for members with depression.

- Instituting a follow-up procedure for members who have been prescribed antidepressants or medications for attention deficit hyperactivity disorder (ADHD) to encourage the continued use of the medications.

Collaborative Quality Initiatives

The DHCFP established a collaborative environment that promotes sharing of information and emerging practices among the MCOs and external stakeholders through the quarterly on-site MCO meeting. The collaborative sharing among the DHCFP and the MCOs promotes continual quality improvement of the Nevada Medicaid and Nevada Check Up programs and has enabled the DHCFP to track progress toward meeting the goals and objectives identified in the DHCFP's Quality Strategy. Some of the activities promoted by the DHCFP and employed by the MCOs during FY 2012–2013 are described below.

- ***Lead Screening in Children* collaborative PIP (Lead Screening PIP)**—Since FY 2009–2010, the MCOs have stratified lead screening rates by race and ethnicity to identify any potential disparities in rates of screening among populations. Additionally, the DHCFP has invited other stakeholders, such as staff members from the Nevada Health Division, to the collaborative group sessions to (1) learn about the interventions put in place by the MCOs to increase lead screening rates, and (2) provide additional education to MCO leaders on the prevalence of lead and its harmful effects in Nevada communities. During FY 2012, both MCOs initiated the use of filter papers to collect blood samples of children in provider offices. The results of the filter paper collection efforts that continued in FY 2013 could be seen in the increase in lead screening rates for HEDIS 2013, wherein both MCOs demonstrated in improvement in rates for both Medicaid and Check Up populations. The MCOs continue to stratify and evaluate the lead screening rates by race and ethnicity to develop effective interventions to continue to improve the overall lead screening rates.
- **Reducing Avoidable Emergency Room (ER) Visits Work Group**—Over the last two years, the DHCFP and the MCOs have worked to examine avoidable emergency room (ER) usage and the frequency at which some members accessed ERs. Upon analyzing data to determine where health care spending could reasonably be reduced and use of preventive services could be increased, the DHCFP discovered that nearly 25 percent of all ER visits in managed care were non-emergent, using the New York University (NYU) algorithm for classifying emergency department claims into categories based on primary diagnosis. As part of the collaborative performance improvement project (PIP) activities, the DHCFP's EQRO facilitated monthly work group discussions aimed at analyzing data and identifying the reasons Medicaid recipients frequented the ER inappropriately. At the direction of the DHCFP and the EQRO, the MCOs examined ER usage patterns and discovered that a number of members inappropriately used the ER for primary care instead of establishing a relationship and "medical home" with a primary care physician (PCP). An analysis of diagnoses showed that many of the ER visits were non-emergent or emergent but treatable by a PCP. The "Reducing Avoidable Emergency Room (ER) Visits Work Group" was formed and continued to meet regularly to develop interventions to reduce inappropriate and/or avoidable ER utilization. To identify the

individuals who would likely benefit from targeted care manager interventions (or re-education on establishing a relationship with a PCP), the DHCFP tasked the MCOs with identifying the number of individuals who visited the ER at least three or more times in a three-month period during the last calendar quarter of 2010. The MCOs were required to stratify these data by gender, age, race/ethnicity, time of day, county, and diagnostic category to determine which populations could benefit from more targeted interventions.

After stratifying individuals that frequented the ER, the MCOs hosted focus groups with members that were frequent users. During the focus groups, the MCOs learned that members were not aware of the difference between urgent and emergent care and many did not know that the MCOs offered 24-hour nurse triage telephone lines that could answer members' health-related questions after 5:00 pm. The MCO staffs also made telephone inquiries to members who returned to the ER within 7 to 10 days of an initial visit. Many members reported that ER staff informed members to return to the ER for follow-up care, such as removing sutures, obtaining medications, or removing casts. The MCOs conducted further risk stratification analyses on frequent ER users to determine needs for complex care management or disease management. Members that fit the criteria for complex care or disease management were enrolled in disease or care management programs. The MCOs also initiated educational campaigns to new and existing members. New and existing members received educational telephone calls from MCOs' staff who explained the appropriate uses of the ER and when to contact the 24-hour nurse advice line.

FY 2013 was the first remeasurement year for the *Avoidable Emergency Room Visit* PIP. Lower rates are indicative of better performance for this measure; thus, a decrease in rates indicates improvement was achieved. **HPN** reported statistically significant decreases in avoidable ER visits for both the Medicaid and Nevada Check Up populations compared to the baseline measurement. **Amerigroup** reported a statistically significant decrease in avoidable ER visits for the Medicaid population and a non-statistically significant decrease for the Nevada Check Up population.

- **Cultural Competency Program (CCP)**—The MCOs are required to maintain a CCP that encourages delivery of services in a culturally competent way to all recipients, including those with limited English proficiency and diverse cultural and ethnic backgrounds. The MCOs are also required to ensure that appropriate foreign language versions of all member materials are developed and available to members and to provide interpreter services for members whose primary language is a foreign language. The DHCFP has determined that the most prevalent non-English language is Spanish; therefore, both MCOs are required to provide member education materials in Spanish and have Spanish-speaking nurses available to speak with member who call the MCO nurse help line. Additionally, both MCOs are required to contract with Spanish-speaking providers to provide medical services to members. Each MCO submits to the DHCFP its CCP evaluation annually, which includes an evaluation of the cultural competency objectives identified in the DHCFP Quality Strategy and a plan for the following year's cultural competency activities. The DHCFP reviews the CCP evaluations from each MCO and provides them with feedback to incorporate any required changes for the

following fiscal year. For FY 2012–2013, both MCOs successfully met all of the requirements of the cultural competency program and annual evaluation.

- **MCO Annual Quality Improvement Evaluation**—The MCOs are required to submit an annual evaluation of the quality improvement program and activities employed by the MCO for the previous year. The MCOs' annual evaluations include trends and statistical information that describe and depict the performance for each quality activity and associated indicators developed by the MCO. Annual evaluations also include an analysis and evaluation of clinical and related service areas requiring improvement for each of the quality measures that pertain to the population. The DHCFP requires the MCOs to provide an evaluation of each of the Nevada Medicaid and Check Up quality measures, which are detailed in the DHCFP Quality Strategy. As part of this effort, the MCOs are required to stratify performance measure rates by race and ethnicity. After stratifying the data, the MCOs are required to identify any health care disparities among the groups and develop a plan to target interventions to reduce and/or eliminate disparities for members and increase performance measure rates overall. For FY 2012–2013, both MCOs stratified data according to the parameters set by the DHCFP and have deployed interventions to further reduce or eliminate health disparities while improving rates for each of the performance measures.

7. Ongoing Challenges and Opportunities to Improve

Challenges in Data Collection and Opportunities to Overcome Challenges

The DHCFP has identified several key challenges associated with data collection as well as opportunities to overcome those challenges. Those challenges and opportunities include:

- Ensuring the data warehouse is fully operational (estimated to be complete in fall 2013). Initial challenges with the warehouse include limited reporting functionality until encounters and all claims are fully housed in the warehouse. The ability to compare MCO and FFS utilization data is not currently available.
  - **Opportunity**: Once the data warehouse is operational, encounters will be loaded into the warehouse in spring 2014.
  - **Opportunity**: Use of the data warehouse will reduce dependence on the State's decision support system (DSS) subsystem, which is outdated and lacks modernized reporting functionality. Paired with the capabilities of the new Medicaid Management Information System (MMIS) to be implemented in FY 2016, the data warehouse will support the capabilities of the MMIS.
- Ensuring accurate and complete encounter data are recorded in the State's MMIS. Nevada's MMIS is the second oldest MMIS in the nation, making it an antiquated system that leaves little flexibility for robust reporting and enhancements. Due to multiple challenges with file formats and coding between the fiscal intermediary and the MCOs, the DHCFP has been unable to validate the volume of encounters reported by the MCOs.
  - **Opportunity**: The DHCFP is working to remedy the issue of encounter data collection through the procurement of a new MMIS in FY 2016 and the use of contracted consultants who will work with the State to implement the new system.
  - **Opportunity**: Once the MMIS is fully operational, the DHCFP anticipates that the new MMIS and data warehouse will work jointly as an enterprise system that enables the collection, repository, and reporting of data from multiple systems, which are currently housed in separate sister-agency systems. Paired with the data warehouse, the MMIS will enable real-time sharing of information such as, eligibility, enrollment, registries, case management, etc., and allow for more robust reporting of information.
  - **Opportunity**: The Nevada Legislature funded a Medicaid Information Technology Architecture (MITA 3.0) intended to foster integrated business and information technology (IT) transformation. This process will conclude in January and will help the DHCFP with future system direction.

Challenges in Improving Care and Opportunities to Overcome Challenges

There are multiple challenges and barriers in improving the quality of care and access to services for the members served in the Medicaid and Check Up programs. Below are some

of the ongoing challenges and opportunities to overcome those challenges for improving care within the Nevada Medicaid program.

- The MCOs report many challenges related to lack of member understanding of appropriate care and appropriate settings for care and lack of provider understanding of proper methods for documenting services and coding of claims for HEDIS reporting as well as inappropriate referrals of services. As previously mentioned, both MCOs have outreached to members to inquire why some members seek primary care services in emergency departments rather than urgent care or primary care provider offices. In a focus group discussion, members reported that they did not realize there was a difference between emergency room and urgent care centers except that emergency departments are open and accessible 24 hours per day, 7 days per week. Further, members reported that after seeking care at an emergency room for a bone fracture or sutures, members were counseled by emergency room staff to return to the emergency room for cast or suture removal.
  - **Opportunity**: The MCOs will continue to engage in educational campaigns for both members and providers. The MCOs will continue to meet with providers in their offices to discuss proper charting and coding of services and outreach to members so that members are advised to seek services in primary care provider (PCP) offices or urgent care centers.
- Additional challenges faced by the State of Nevada also result from some of the highest State revenue-generating entities—casinos. Nevada's casino industry encourages unhealthy behavior by advertising free alcohol and cigarettes while gambling in certain casinos. While the advertising campaigns encourage unhealthy behavior, the MCOs and the DHCFP are not able to discourage the use of these advertising campaigns.
  - **Opportunity**: The expansion of Medicaid eligibility to cover more persons provides Nevada with a unique opportunity to provide Medicaid coverage to persons who do not have health care coverage and thus do not have the same access to preventive services and health education materials and tools that members of the Medicaid program have. Because the majority of newly eligible members will be enrolled in managed care (urban counties only), they will have access to health care educational materials that teach and promote healthy behaviors, including seeking preventive care services. Further, those members with complex health care needs who are newly eligible for Medicaid and enroll in a MCO will have access to care managers to assist with navigating the complex health care system and provide information and tools to live a healthier lifestyle.
- Nevada continues to face challenges with improving birth outcomes. Even though Nevada's infant mortality rates are decreasing, racial and ethnic disparities remain. In 2010, preterm birth rates were significantly higher among ethnic minorities in Nevada with Non-Hispanic Blacks at 18.3 percent, followed by Hispanics at 14.2 percent and Non-Hispanic Whites at 12.5 percent. Economic factors and a large number of uninsured are likely two key drivers of disparities in infant mortality and prematurity rates in Nevada. In 2012, Nevada's unemployment rates were 1.9 percentage points higher than the national average of 7.6 percent. According to the

U.S. Census Bureau, 12.9 percent of Nevadans were living below the poverty line from 2007–2011.

- **Opportunity**: In FY 2014, the DHCFP implemented an *Expedited Enrollment for Pregnant Women* initiative to accelerate the process of enrolling pregnant women into Medicaid. The new process allows the Medicaid eligible recipient to choose an MCO at the time of application to Medicaid. New members will be allowed the opportunity to select an MCO of their choice with their PCP in network. Returning Medicaid beneficiaries will be assigned to their former MCO. The MCO will work to ensure that the prior provider-beneficiary relationship is preserved if the provider is still in that MCO's network.
- **Opportunity**: In fall 2013, Nevada was notified by the National Governors Association (NGA) that it was one of five states selected to participate in the final round of a Learning Network on Improving Birth Outcomes. The goal of the learning network is to assist states in developing, aligning, and implementing their key policies and initiatives related to the improvement of birth outcomes, as measured by the incidence of preterm births and infant mortality. NGA will convene in-state sessions with the selected states to facilitate this process as well as convene a networking conference for those states to share lessons learned and improve their planning processes.

Nevada is a frontier state, which means that access to physicians is limited in rural areas. According to the Federal Register, 42 CFR Parts 412 and 413, section 412.64, entitled "Frontier States," Nevada is one of five frontier states. The definition of a frontier state is a state that has at least 50 percent of counties that have less than six people per square mile. The low density of the populations within Nevada counties makes it difficult to locate providers who are in close proximity to members and encourage members to travel a distance for medical care. Further, Nevada is experiencing a shortage of health professionals. According to the 2013 Elders Count Nevada,[7-1] the following shortages remain:

- Although from 2000 to 2010 the number of new students enrolled in Nevada medical schools grew by 273.7 percent (nationally, enrollment grew by 22.9 percent), Nevada ranks 45th in the nation for the number of active physicians per 100,000 in population.
- Nevada is last in the nation in the number of registered nurses (RNs), with 605 nurses per 100,000 in population as compared to 874 per 100,000 nationally. Nevada also moved to last in the nation in the number of nurse practitioners, 44th in the nation for dentists, and 39th in the nation for physician assistants.
  - **Opportunity**: Opportunities to overcome provider shortages are limited. The Nevada DHCFP is seeking new and innovative ways to combat provider shortages and is working with its contracted MCOs to overcome the shortage issues in the managed care program.

[7-1] Broadus, A.D., Sacks, T.M., & Fadali, E.R. (2013). Elders Count Nevada. University of Nevada, Reno: Sanford Center for Aging. Available at: http://www.medicine.nevada.edu/healthsciences/EldersCount2013.pdf. Accessed on: November 27, 2013.

Attachment A. 2014–2015 Activities Timeline

DHCFP Quality Monitoring Activity	DHCFP Monitoring Schedule
Enrollee and Provider Grievance and Appeals Reporting (DHCFP)	
MCO/Subcontractor Grievance Reporting Form	Quarterly
Notice of Action (NOA) Reporting Form	Quarterly
MCO Appeals Reporting Form	Quarterly
Subcontractor's Appeals Reporting Form	Quarterly
MCO Provider Dispute Reporting Form	Quarterly
Subcontractor's Provider Dispute Reporting Form	Quarterly
Quality Assurance Reporting (DHCFP)	
Maternal and Birth Data Report (Medicaid)	Quarterly
Maternal and Birth Data Report (Check Up)	Quarterly
Dental Report, Provider	Monthly
Dental Report, Patient	Monthly
Dental Report, Service Count and Cost	Monthly
CMS 416 Report	Quarterly/Annually
Member High-Cost Report	Quarterly
Hospital Adequacy Report	Quarterly
Network Adequacy Report	Quarterly
Dental Network Adequacy Report	Quarterly
Death Report (Medicaid)	Quarterly
Death Report (Check Up)	Quarterly
SED/SMI Consent, Determination, and Disenrollment (DHCFP)	
SED/SMI Consent Form	Per Contract Guidelines
SED/SMI Determination Form	Per Contract Guidelines
Request for Managed Care Disenrollment	Per Contract Guidelines
Voluntary Population Report—CSHCN	Quarterly
Annual Evaluation of Cultural Competency Program (CCP) (MCOs)	
Submit Annual Evaluation of CCP to DHCFP	Annually
DHCFP Evaluation of MCO CCPs	Annually
Annual Evaluation of QAPIS (DHCFP)	
DHCFP Evaluation of QAPIS	At Least Annually
DHCFP QAPIS Revision	As Needed

EQRO Quality Monitoring Activity	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
HEDIS								
Annual HEDIS Schedule, Site Visit, Audit, and Reports			←	—	—	—	—	→
Final Audit Report to MCO and NCQA								↔
PIP Validation								
Annual PIP Schedule, Validation, and Reports				←	—	—	—	→
Final PIP Reports Due								↔
Monitoring and Evaluation of MCO Contractual Compliance								
EQR Monitoring of MCO Contract Compliance	Triennially							

Attachment B. QUALITY STRATEGY GOALS AND OBJECTIVES TABLE

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

State of Nevada

Division of Health Care Financing and Policy

Quality Assessment and Performance Improvement Strategy (QAPIS)

Goals and Objectives FY 2014-2015

Goal 1:	Improve the health and wellness of Nevada children by increasing the use of preventive services, thereby modifying health care use patterns for the population.							
Objective 1.1:	Increase children's and adolescents' access to PCPs by 10 percent.							
	HPN 2013	QISMC Goal	**HPN 2014**	**HPN 2015**	AGP 2013	QISMC Goal	**AMG 2014**	**AMG 2015**
Medicaid:								
Children's Access to PCP (12-24 months)	93.0%	93.7%			94.8%	95.4%		
Children's Access to PCP (25 months - 6 years)	80.5%	82.4%			84.6%	86.2%		
Children's Access to PCP (7-11 years)	83.0%	84.7%			84.7%	86.2%		
Adolescent's Access to PCP (12-19 years)	78.8%	80.9%			81.4%	83.3%		
Nevada Check-Up:								
Children's Access to PCP (12-24 months)	97.0%	97.3%			100.0%	100.0%		
Children's Access to PCP (25 months - 6 years)	92.9%	93.6%			95.1%	95.6%		
Children's Access to PCP (7-11 years)	95.0%	95.5%			97.1%	97.4%		
Adolescent's Access to PCP (12-19 years)	90.9%	91.8%			93.3%	94.0%		

Objective 1.2:	Increase well-child visits (0 - 15 Months) by 10 percent.							
	HPN 2013	QISMC Goal	**HPN 2014**	**HPN 2015**	AGP 2013	QISMC Goal	**AMG 2014**	**AMG 2015**
Medicaid:								
Well -Child Visits 0 - 15 Months of Life	57.4%	61.7%			65.4%	68.8%		
Nevada Check-Up:								
Well -Child Visits 0 - 15 Months of Life	69.3%	72.4%			78.8%	80.9%		

Objective 1.3:	Increase well-child visits (3-6 Years) by 10 percent.							
	HPN 2013	QISMC Goal	**HPN 2014**	**HPN 2015**	AGP 2013	QISMC Goal	**AMG 2014**	**AMG 2015**
Medicaid:								
Well -Child Visits 3 - 6 Years of Life	57.4%	61.7%			65.4%	68.8%		
Nevada Check-Up:								
Well -Child Visits 3 - 6 Years of Life	69.3%	72.4%			78.8%	80.9%		

Objective 1.4:	Increase the prevalence of blood lead testing for children 1-2 years of age by 10 percent.							
	HPN 2013	QISMC Goal	**HPN 2014**	**HPN 2015**	AGP 2013	QISMC Goal	**AMG 2014**	**AMG 2015**
Medicaid:								
Lead Screening in Children	32.4%	39.1%			34.5%	41.0%		
Nevada Check-Up:								
Lead Screening in Children	50.5%	55.5%			49.5%	54.6%		

Objective 1.5:	Decrease avoidable emergency room visits by 10 percent.*							
	HPN 2013	QISMC Goal	**HPN 2014**	**HPN 2015**	AGP 2013	QISMC Goal	**AMG 2014**	**AMG 2015**
Medicaid:								
Avoidable Emergency Room Visit Rate	37.8%	34.0%			41.4%	37.3%		
Nevada Check-Up:								
Avoidable Emergency Room Visit Rate	35.7%	32.1%			39.1%	35.2%		

*Lower rates are indicative of better performance for this measure.

State of Nevada
Division of Health Care Financing and Policy

Quality Assessment and Performance Improvement Strategy (QAPIS)
Goals and Objectives FY 2014-2015

Goal 2:	**Increase use of evidence-based preventive treatment practices for Medicaid members with chronic conditions.**								
Objective 2.1:	Incrase rate of HbA1c testing for members with diabetes by 10 percent.								
		HPN 2013	QISMC Goal	**HPN 2014**	**HPN 2015**	AGP 2013	QISMC Goal	**AMG 2014**	**AMG 2015**
Diabetes Care - HbA1c Testing		70.0%	73.0%			68.8%	71.9%		
Objective 2.2:	Increase rate of monitoring for nephropathy for members with diabetes by 10 percent.								
		HPN 2013	QISMC Goal	**HPN 2014**	**HPN 2015**	AGP 2013	QISMC Goal	**AMG 2014**	**AMG 2015**
Diabetes Care - Nephropathy		72.5%	75.2%			64.0%	67.6%		
Objective 2.3:	Increase LDL-C screening for members with diabetes by 10 percent.								
		HPN 2013	QISMC Goal	**HPN 2014**	**HPN 2015**	AGP 2013	QISMC Goal	**AMG 2014**	**AMG 2015**
Diabetes Care - LDL-C Screening		67.9%	71.1%			65.2%	68.7%		

Goal 3:	**Reduce and/or eliminate health care disparities for Medicaid and Nevada Check Up recipients.**						
Objective 3.1:	Ensure that health plans develop a cultural competency plan, which details the health plans' goals, objectives and processes for reducing and/or eliminating racial or ethnic disparities that negatively impact health care.						
		HPN 2013	**HPN 2014**	**HPN 2015**	**AMG 2013**	**AMG 2014**	**AMG 2015**
Plan Developed?		Yes			Yes		
Objective 3.2:	Stratify data for performance measures and avoidable emergency room utilization by race and ethnicity to determine where disparities exist.						
		HPN 2013	**HPN 2014**	**HPN 2015**	**AMG 2013**	**AMG 2014**	**AMG 2015**
Medicaid: Stratified by Race and Ethnicity							
Performance Measures		Yes			Yes		
Avoidable Emergency Room Visits		Yes			Yes		
Nevada Check-Up: Stratified by Race & Ethnicity							
Performance Measures		Yes			Yes		
Avoidable Emergency Room Visits		Yes			Yes		
Objective 3.3:	Ensure that health plans submit an annual evaluation of the cultural competency program (CCP) to DHCFP. Health plans must receive 100 percent *Met* compliance score for all of the criteria listed in the MCO contract for CCP development, maintenance, and evaluation.						
		HPN 2013	**HPN 2014**	**HPN 2015**	**AMG 2013**	**AMG 2014**	**AMG 2015**
CCP Evaluation Submitted?		Yes			Yes		
MCO Fully Compliant with all CCP Provisions?		Yes			Yes		

Goal 4:	**Improve the health and wellness of new mothers and infants and increase new-mother education about family planning and newborn health and wellness.**								
Objective 4.1:	Increase the rate of postpartum visits by 10 percent.								
		HPN 2013	QISMC Goal	**HPN 2014**	**HPN 2015**	AMG 2013	QISMC Goal	**AMG 2014**	**AMG 2015**
Medicaid:									
Postpartum Care		65.0%	68.5%			61.8%	65.6%		

HPN - Health Plan of Nevada
AMG - Amerigroup Community Care

For more information on the Nevada Comprehensive Care Waiver Quality Strategy, see the following Web site: https://dhcfp.nv.gov/caremgmt.htm.

Nevada DHCFP Quality Strategy
Crosswalk to CMS Toolkit

The following table lists the required and recommended elements for State Quality Strategies, per 42 C.F.R. § 438.202(a), and the corresponding sections in the DHCFP Quality Strategy and the DHCFP/MCO contract which addresses each required and recommended element.

SECTION I: INTRODUCTION

Regulatory Reference	Description	Corresponding Document Page Reference or Comment
	Include a brief history of the state's Medicaid and CHIP managed care programs.	NV Quality Strategy – pgs. 1-1, 1-2
	Include an overview of the quality management structure that is in place at the state level. For example, how is the leadership team structured, are there any quality task forces, an MCO collaborative, etc.?	NV Quality Strategy – pg. 1-8
	Include general information about the state's decision to contract with MCOs/PIHPs (e.g., to address issues of cost, quality, and/or access). Include the reasons why the state believes the use of a managed care system will positively impact the quality of care delivered in Medicaid and CHIP.	NV Quality Strategy – pg. 1-1
	Include a description of the goals and objectives of the state's managed care program. This description should include priorities, strategic partnerships, and quantifiable performance driven objectives. These objectives should reflect the state's priorities and areas of concern for the population covered by the MCO/PIHP contracts. For example, "the state will demonstrate a 10 percent improvement in childhood immunization rates over the next three years" or "through expansion of the primary care network, as evidenced by geographical reporting, the state will demonstrate a 5 percent improvement in enrollee access to primary care".	NV Quality Strategy pgs. 1-10, 1-11, B-2, B-3

Regulatory Reference	Description	Corresponding Document Page Reference or Comment
	Include a description of the formal process used to develop the quality strategy.	NV Quality Strategy pgs. 1-6, 1-7, 1-8
§438.202(b)	Include a description of how the state obtained the input of beneficiaries and other stakeholders in the development of the quality strategy.	NV Quality Strategy pg. 1-7, 4-2; Contract Section 1.4.9
§438.202(b)	Include a description of how the state made (or plans to make) the quality strategy available for public comment before adopting it in final.	NV Quality Strategy pg.1-7; 1-8, 4-2; Contract Section
§438.202(d)	Include a timeline for assessing the effectiveness of the quality strategy (e.g., monthly, quarterly, annually).	NV Quality Strategy pgs.1-7, 4-1, 4-2, 5-2, A-1
§438.202(d)	Include a timeline for modifying or updating the quality strategy. If this is based on an assessment of "significant changes", include the state's definition of "significant changes".	NV Quality Strategy pgs.1-7, 1-8, 4-1, 4-2, 5-2, A-1

SECTION II: ASSESSMENT

Quality and Appropriateness of Care

Regulatory Reference	Description	Corresponding Document Page Reference or Comment
§438.204(b)(1)	Address procedures that assess the quality and appropriateness of care and services furnished to all Medicaid enrollees under the MCO and PIHP contracts, and to individuals with special health care needs.	NV Quality Strategy pgs.1-9, 1-10, 1-11, 1-12, 2-2, 2-3; Contract Sections 4.8.6,
§438.204(b)(1)	Include the state's definition of special health care needs.	NV Quality Strategy pg. 2-2; Contract pg. 17
§438.204(b)(2)	Detail the methods or procedures the state uses to identify the race, ethnicity, and primary language spoken of each Medicaid enrollee. States must provide this information to the MCO and PIHP for each Medicaid enrollee at the time of	NV Quality Strategy pgs. 1-11, 2-1, 2-2; Contract Sections 4.2.1.16, 4.8.6.5.D, 4.8.18.5, 4.9.2.2
	Document any efforts or initiatives that the state or MCO/PIHP has engaged in to reduce disparities in health care.	NV Quality Strategy pgs.1-11, 2-1, 2-2, 3-2, 5-1, 5-2, 6-6; Contract Sections 4.8.6.5.D, 4.8.18.5, 4.9.2.2

National Performance Measures

Regulatory Reference	Description	Corresponding Document Page Reference or Comment
§438.204(c)	Include a description of any required national performance measures and levels identified and developed by CMS.	NV Quality Strategy pgs. 2-6
	Indicate whether the state plans to voluntarily collect any of the CMS core performance measures for children and adults in Medicaid/CHIP. If so, identify state targets/goals for any of the core measures selected by the state for voluntary reporting.	NV Quality Strategy pgs. 2-5, 2-6

Monitoring and Compliance

Regulatory Reference	Description	Corresponding Document Page Reference or Comment
§438.204(b)(3)	Detail procedures that account for the regular monitoring and evaluation of MCO and PIHP compliance with the standards of subpart D (access, structure and operations, and measurement and improvement standards). Some examples of mechanisms that may be used for monitoring include, but are not limited to: ◆ Member or provider surveys; ◆ HEDIS® results; ◆ Report Cards or profiles; ◆ Required MCO/PIHP reporting of performance measures; ◆ Required MCO/PIHP reporting on performance improvement projects; ◆ Grievance/Appeal logs, etc.	NV Quality Strategy pgs.2-4 thru 2-10; Contract Section 4.5.5, 4.8, 4.8.1, 4.8.6, 4.8.21, 4.9.2.3,

External Quality Review (EQR)

Regulatory Reference	Description	Corresponding Document Page Reference or Comment
§438.204(d)	Include a description of the state's arrangements for an annual, external independent quality review of the quality, access, and timeliness of the services covered under each MCO and PIHP contract. Identify what entity will perform the EQR and for what period of time.	NV Quality Strategy pgs.1-1, 1-2, 1-6, 2-4, 2-5, 2-9, 2-10; Contract Section 4.16.1
	Identify what, if any, optional EQR activities the state has contracted with its External Quality Review Organization (EQRO) to perform. The five optional activities include: 1. Validation of encounter data reported by an MCO or PIHP; 2. Administration or validation of consumer or provider surveys of quality of care; 3. Calculation of performance measures in addition to those reported by an MCO or PIHP and validated by an EQRO; 4. Conduct of performance improvement projects (PIPs) in addition to those conducted by an MCO or PIHP and validated by an EQRO; and 5. Conduct of studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time.	NV Quality Strategy pgs.1-1, 1-2 2,5
§438.360(b)(4)	Identify the standards for which the EQR will use information from Medicare or private accreditation reviews. This must include an explanation of the rationale for why the standards are duplicative.	N/A: NV does not use results from Medicare or private accreditation reviews to determine EQR compliance

SECTION III: STATE STANDARDS
Access Standards

Regulatory Reference	Description	Corresponding Document Page Reference or Comment
§438.206	Availability of Services	
§438.206(b)(1)	Maintains and monitors a network of appropriate providers	NV Quality Strategy pg.2-6; Contract Sections 4.2.1.7, 4.14.8
§438.206(b)(2)	Female enrollee direct access to a women's health specialist	NV Quality Strategy pg.2-6; Contract Section 4.2.1.9
§438.206(b)(3)	Provides for a second opinion from a qualified health care professional	NV Quality Strategy pg.2-6; Contract Section 4.2.1.11 and 4.2.1.12
§438.206(b)(4)	Adequately and timely coverage of services not available in network	NV Quality Strategy pg.2-6; Contract Section 4.2.1.10.A
§438.206(b)(5)	Out-of-network providers coordinate with the MCO or PIHP with respect to payment	NV Quality Strategy pg.2-6; Contract Sections 4.2.1.10, 4.2.1.12, 4.2.10.12.1
§438.206(b)(6)	Credential all providers as required by §438.214	NV Quality Strategy pg. 2-6; 2-7 Contract Sections 4.5.10, 4.8.13
§438.206(c)(1)(i)	Providers meet state standards for timely access to care and services	NV Quality Strategy pgs.2-5, 2-6; Contract Sections 4.2.1.14, 4.2.1.15, 4.5.2.3
§438.206(c)(1)(ii)	Network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service	NV Quality Strategy pg.2-6; Contract Sections 4.2.1.14, 4.5.2.4
§438.206(c)(1)(iii)	Services included in the contract available 24 hours a day, 7 days a week	NV Quality Strategy pg.2-6; Contract Sections 4.2.1.14, 4.2.1.15, 4.4.2.6, 4.5.2.5

Regulatory Reference	Description	Corresponding Document Page Reference or Comment
§438.206(c)(1)(iv)-(vi)	Mechanisms to ensure compliance by providers	NV Quality Strategy pg.2-6; Contract Sections 4.2.1.14, 4.5.2.6, 4.5.5.2, 4.5.5.8
§438.206(c)(2)	Culturally competent services to all enrollees	NV Quality Strategy pgs.1-8, 1-9, 1-11, 2-1, 2-6, 2-9, 3-2, 5-1; A-1, B-3; Contract Sections 4.2.1.16, 4.5.2.9, 4.9.2.2
§ 438.207	Assurances of Adequate Capacity and Services	
§438.207(a)	Assurances and documentation of capacity to serve expected enrollment	NV Quality Strategy pg.2-6; Contract Sections 4.2.1.7, 4.5
§438.207(b)(1)	Offer an appropriate range of preventive, primary care, and specialty services	NV Quality Strategy pg.2-6; Contract Sections 4.2.1.7, 4.5
§438.207(b)(2)	Maintain network sufficient in number, mix, and geographic distribution	NV Quality Strategy pgs.2-6, A-1; Contract Sections 4.2.1.7, 4.5
§ 438.208	Coordination and Continuity of Care	
§438.208(b)(1)	Each enrollee has an ongoing source of primary care appropriate to his or her needs	NV Quality Strategy pgs.2-6, 5-2; Contract Section 4.4.3.1
§438.208(b)(2)	All services that the enrollee receives are coordinated with the services the enrollee receives from any other MCO/PIHP	NV Quality Strategy pgs.2-3, 2-6, 5-2; Contract Section 4.2.12
§438.208(b)(3)	Share with other MCOs, PIHPs, and PAHPs serving the enrollee with special health care needs the results of its identification and assessment to prevent duplication of services	NV Quality Strategy pg.2-6; Contract Section 4.2.8, 4.2.12
§438.208(b)(4)	Protect enrollee privacy when coordinating care	NV Quality Strategy pg.2-6; Contract Section 4.2.12
§438.208(c)(1)	State mechanisms to identify persons with special health care needs	NV Quality Strategy pgs.2-2, 2-3, 2-6

Regulatory Reference	Description	Corresponding Document Page Reference or Comment
§438.208(c)(2)	Mechanisms to assess enrollees with special health care needs by appropriate health care professionals	NV Quality Strategy pgs.2-2, 2-3, 2-6; Contract Section 4.2.8
§438.208(c)(3)	If applicable, treatment plans developed by the enrollee's primary care provider with enrollee participation, and in consultation with any specialists caring for the enrollee; approved in a timely manner; and in accord with state standards	NV Quality Strategy pgs.2-3, 2-6; Contract Sections 4.2.8, 4.2.8.1, 4.2.8.2, 4.2.8.3
§438.208(c)(4)	Direct access to specialists for enrollees with special health care needs	NV Quality Strategy pgs.2-3, 2-6; Contract Section 4.2.8.3
§ 438.210	Coverage and Authorization of Services	
§438.210(a)(1)	Identify, define, and specify the amount, duration, and scope of each service	NV Quality Strategy pgs. 2-3, 2-6; Contract Section 4.4.1.1.J
§438.210(a)(2)	Services are furnished in an amount, duration, and scope that is no less than the those furnished to beneficiaries under fee-for-service Medicaid	NV Quality Strategy pg.2-6; Contract Section 4.2.1
§438.210(a)(3)(i)	Services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished	NV Quality Strategy pg.2-6; Contract Section 4.2.1.1
§438.210(a)(3)(ii)	No arbitrary denial or reduction in service solely because of diagnosis, type of illness, or condition	NV Quality Strategy pg.2-6; Contract Section 4.2.1.2
§438.210(a)(3)(iii)	Each MCO/PIHP may place appropriate limits on a service, such as medical necessity	NV Quality Strategy pg.2-6; Contract Section 4.2.1.3
§438.210(a)(4)	Specify what constitutes "medically necessary services"	NV Quality Strategy pg.2-6 Contract Section 4.2.1.4
§438.210(b)(1)	Each MCO/PIHP and its subcontractors must have written policies and procedures for authorization of services	NV Quality Strategy pgs.2-6, 2-9; Contract Section 4.5.8.1.J; 4.8.17.3.D,
§438.210(b)(2)	Each MCO/PIHP must have mechanisms to ensure consistent application of review criteria for authorization decisions	NV Quality Strategy pg.2-6; Contract Section 4.2.1.6, 4.5.2.2
§438.210(b)(3)	Any decision to deny or reduce services is made by an appropriate health care professional	NV Quality Strategy pg.2-6; Contract Section 4.2.1.6

Regulatory Reference	Description	Corresponding Document Page Reference or Comment
§438.210(c)	Each MCO/PIHP must notify the requesting provider, and give the enrollee written notice of any decision to deny or reduce a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested	NV Quality Strategy pg.2-6; Contract Sections 4.11.3
§438.210(d)	Provide for the authorization decisions and notices as set forth in §438.210(d)	NV Quality Strategy pg.2-6; Contract Section 4.11.2,
§438.210(e)	Compensation does not provide incentives to deny, limit, or discontinue medically necessary services	NV Quality Strategy pg.2-6; Contract Section 4.5.4.7

Structure and Operations Standards

Regulatory Reference	Description	Corresponding Document Page Reference or Comment
§438.206	Provider Selection	
§438.214(a)	Written policies and procedures for selection and retention of providers	NV Quality Strategy pg.2-7; Contract Sections 4.5.10, 4.8.13
§438.214(b)(1)	Uniform credentialing and recredentialing policy that each MCO/PIHP must follow	NV Quality Strategy pgs.2-7, 2-9; Contract Sections 4.5.10, 4.8.13
§438.214(b)(2)	Documented processes for credentialing and recredentialing that each MCO/PIHP must follow	NV Quality Strategy pgs.2-7, 2-9; Contract Sections 4.5.10, 4.8.13
§438.214(c)	Provider selection policies and procedures do not discriminate against providers serving high-risk populations or specialize in conditions that require costly treatment	Contract Section 4.5.2.9
§438.214(d)	MCOs/PIHPs may not employ or contract with providers excluded from Federal health care programs	NV Quality Strategy pg.2-7; Contract Section 4.5.10
§438.214(e)	Comply with any additional requirements established by the state	Contract Section 4.5
§438.218	Enrollee Information	
§438.218	Incorporate requirements of §438.10	
§438.224	Confidentiality	

Regulatory Reference	Description	Corresponding Document Page Reference or Comment
§438.224	Individually identifiable health information is disclosed in accordance with Federal privacy requirements	NV Quality Strategy pg.2-7; Contract Sections 4.2.12, 4.3.10.3, 4.12.2, 4.15.4, 4.15.5
§438.226	Enrollment and Disenrollment	
§438.226	Each MCO/PIHP contract complies with the enrollment and disenrollment requirements and limitations set forth in §438.56	NV Quality Strategy pgs.2-7, 2-7, A-1; Contract Sections 4.3, 4.3.5, 4.3.5.1, 4.3.5.2, 4.3.5.3, 4.3.5.4, 4.3.6
§438.228	Grievance Systems	
§438.228(a)	Grievance systems meet the requirements of Part 438, subpart F	NV Quality Strategy pgs.1-10, 2-6, 2-7, 2-9, 4-1, A-1; Contract Section 4.8.14.5
§438.228(b)	If applicable, random state reviews of notice of action delegation to ensure notification of enrollees in a timely manner	N/A
§438.228	Subcontractual Relationships and Delegation	
§438.228(a)	Each MCO/PIHP must oversee and be accountable for any delegated functions and responsibilities	NV Quality Strategy pgs.2-7, 2-7; Contract Section
§438.228(b)(1)	Before any delegation, each MCO/PIHP must evaluate prospective subcontractor's ability to perform	NV Quality Strategy pg.2-7; Contract Section 4.13.3.2
§438.228(b)(2)	Written agreement that specifies the activities and report responsibilities delegated to the subcontractor; and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.	NV Quality Strategy pg.2-7; Contract Section 4.13.3.7
§438.228(b)(3)	Monitoring of subcontractor performance on an ongoing basis	NV Quality Strategy pg.2-7; Contract Section 4.13.3.8
§438.228(b)(4)	Corrective action for identified deficiencies or areas for improvement	NV Quality Strategy pg.2-7; Contract Section 4.13.3.8

Measurement and Improvement Standards

Regulatory Reference	Description	Corresponding Document Page Reference or Comment
§ 438.236	Practice Guidelines	
§438.236(b)	Practice guidelines are: 1) based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field; 2) consider the needs of enrollees; 3) are adopted in consultation with contracting health care professionals; and 4) are reviewed and updated	NV Quality Strategy pg.2-7; Contract Sections 4.5.1, 4.5.1.1, 4.5.1.2, 4.5.1.3,
§438.236(c)	Dissemination of practice guidelines to all providers, and upon request, to enrollees	NV Quality Strategy pg.2-7; Contract Sections 4.5.2.1
§ 438.240	Quality Assessment and Performance Improvement Program	
§438.240(a)	Each MCO and PIHP must have an ongoing quality assessment and performance improvement program	NV Quality Strategy pgs. 1-7, 2-4, 2-6, 2-7, 2-8; Contract
§438.240(b)(1)	Each MCO and PIHP must conduct PIPs List out PIPs in the quality strategy	NV Quality Strategy pgs. 2-4, 2-6, 2-7, 2-8, 5-1; Contract Sections 4.8.1, 4.8.6.2.C
§438.240(b)(2)	Each MCO and PIHP must submit performance measurement data as specified by the state	NV Quality Strategy pgs.2-5, 2-6, 2-7, A-1; Contract Section 4.8.21
	List out performance measures in the quality strategy	
§438.240(b)(3)	Each MCO and PIHP must have mechanisms to detect both underutilization and overutilization of services	NV Quality Strategy pg.2-6; Contract Section 4.8.6.3.D
§438.240(b)(4)	Each MCO and PIHP must have mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs	NV Quality Strategy pgs. 2-2, 2-3, 2-7; Contract Section
§438.240(e)	Annual review by the state of each quality assessment and performance improvement program. If the state requires that an MCO or PIHP have in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program, indicate this in the quality strategy.	NV Quality Strategy pgs.2-7, 5-2, A-1; Contract Section 4.8
§ 438.242	Health Information Systems	
§438.242(a)	Each MCO and PIHP must maintain a health information system that can collect, analyze, integrate, and report data	NV Quality Strategy pg.2-7; Contract Section 4.8.4

Regulatory Reference	Description	Corresponding Document Page Reference or Comment
§438.242(b)(1)	Each MCO and PIHP must collect data on enrollee and provider characteristics and on services furnished to enrollees	NV Quality Strategy pgs. 2-1, 2-7; Contract Section 4.8.4.1
§438.242(b)(2)	Each MCO and PIHP must ensure data received is accurate and complete	NV Quality Strategy pgs. 1-10, 2-7; Contract Section 4.8.4.2

SECTION IV: IMPROVEMENT and INTERVENTIONS

Regulatory Reference	Description	Corresponding Document Page Reference or Comment
	Describe, based on the results of assessment activities, how the state will attempt to improve the quality of care delivered by MCOs and PIHPs through interventions such as, but not limited to: ◆ Cross-state agency collaborative; ◆ Pay-for-performance or value-Based purchasing initiatives; ◆ Accreditation requirements; ◆ Grants; ◆ Disease management programs; ◆ Changes in benefits for enrollees; ◆ Provider network expansion, etc.	NV Quality Strategy pgs.3-2, 2-2, 2-3, 2-6; Sections 5 and 6; Contract Section 4.8.6.2.C.4 (PIPs); and 2.2.3.4, 4.8.18.5 (Disease/Case Management);
	Describe how the state's planned interventions tie to each specific goal and objective of the quality strategy.	NV Quality Strategy Sections 2, 3, 4, 6, 7

Intermediate Sanctions

Regulatory Reference	Description	Corresponding Document Page Reference or Comment
§438.204(e)	For MCOs, detail how the state will appropriately use intermediate sanctions that meet the requirements of 42 C.F.R. Part 438, subpart I.	NV Quality Strategy pgs. 1-11, 1-12; Contract Section 4.9.2.7
	Specify the state's methodology for using intermediate sanctions as a vehicle for addressing identified quality of care problems.	NV Quality Strategy pgs.1-11, 1-12; Contract Section

Health Information Technology

Regulatory Reference	Description	Corresponding Document Page Reference or Comment
438.204(f)	Detail how the state's information system supports initial and ongoing operation and review of the state's quality strategy.	NV Quality Strategy pg.2-10; Contract Section 4.9.2.6
	Include any health information technology (HIT) initiatives that will support the objectives of the state's quality strategy.	NV Quality Strategy pg.2-10, Section 7

SECTION V: DELIVERY SYSTEM REFORMS

Regulatory Reference	Description	Corresponding Document Page Reference or Comment
	Describe the reasons for incorporating this population/service into managed care. Include a definition of this population and methods of identifying enrollees in this population.	N/A Managed care population includes acute care only.
	List any performance measures applicable to this population/service, as well as the reasons for collecting these performance measures.	N/A

Regulatory Reference	Description	Corresponding Document Page Reference or Comment
	List any performance improvement projects that are tailored to this population/service. This should include a description of the interventions associated with the performance improvement projects.	N/A
	Address any assurances required in the state's Special Terms and Conditions (STCs), if applicable.	N/A

SECTION VI: CONCLUSIONS and OPPORTUNITIES

Regulatory Reference	Description	Corresponding Document Page Reference or Comment
	Identify any successes that the state considers to be best or promising practices.	NV Quality Strategy, Section 6,
	Include a discussion of the ongoing challenges the state faces in improving the quality of care for beneficiaries.	NV Quality Strategy, Section 7
	Include a discussion of challenges or opportunities with data collection systems, such as registries, claims or enrollment reporting systems, pay-for-performance tracking or profiling systems, electronic health record (EHR) information exchange, regional health information technology collaborative, telemedicine initiatives, grants that support state HIT/EHR development or enhancement, etc.	NV Quality Strategy, Section 7
	Include recommendations that the state has for ongoing Medicaid and CHIP quality improvement activities in the state. Highlight any grants received that support improvement of the quality of care received by managed care enrollees, if applicable.	NV Quality Strategy, Section 5, and Annual EQR Technical Report