State of Nevada

Division of Health Care Financing and Policy

State Fiscal Year 2015–2016 External Quality Review Technical Report

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HSAG HEALTH SERVICES ADVISORY GROUP

3133 East Camelback Road, Suite 100 ◆ Phoenix, AZ 85016

Phone 602.264.6382 ◆ Fax 602.241.0757

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ACKNOWLEDGMENTS AND COPYRIGHTS

Overview of the SFY 2015–2016 External Quality Review

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

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

The Nevada Medicaid MCOs included in the state fiscal year (SFY) 2015–2016 external quality review (EQR) were **Amerigroup Nevada, Inc.** (**Amerigroup**), and **Health Plan of Nevada** (**HPN**), which operate in both Clark and Washoe counties. Effective January 1, 2014, Nevada expanded its Medicaid program to allow persons with incomes up to 138 percent of the federal poverty level to enroll in Medicaid. Since the majority of persons in the newly eligible population reside in managed care catchment areas, many persons eligible as a result of Medicaid expansion have enrolled with one of the two MCOs offered in the Nevada Medicaid managed care program.

The SFY 2015–2016 EQR Technical Report includes a review of recipients' access to care and the quality of services received by recipients of Title XIX, Medicaid, and Title XXI, CHIP. In addition, the report focuses on the three federally mandated EQR activities. As described in 42 CFR §438.358, these activities are:

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

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

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

- Provided an analysis of the results of CAHPS activities conducted by the MCOs, which is presented in Section 7.
- Provided technical assistance to the DHCFP with activities related to the Nevada Comprehensive Care Waiver (NCCW) program, the fee-for-service care management program that resulted from Nevada's section 1115(a) Medicaid research and demonstration waiver approved by CMS. The DHCFP contracted with a care management organization (CMO) to provide care management services to the enrolled population. The CMO's care management program is called the Health Care Guidance Program (HCGP). HSAG's technical assistance activities included:
  - Implementing the NCCW Quality Strategy and developing a set of quality modules that the HCGP vendor must use to guide its quality-related presentations during the quarterly meetings.
  - Tracking the NCCW 1115 Demonstration Evaluation Design Plan.
  - Reviewing the corrective action plans that resulted from the HCGP compliance review, which is presented in Section 8.
  - Performing source code review of the programming code used to calculate pay for performance (P4P) measures used for the NCCW program, which will be calculated by the DHCFP's actuary.
- Performed performance measure validation audit of non-P4P measures used to monitor the HCGP's progress in achieving the goals and objectives of the NCCW demonstration waiver, which is presented in Section 9.

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

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

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

Since SFY 2014–2015 served as the baseline collection period for the With Medicaid Expansion Included performance measure rates, no specific recommendations were made for the rates reported for this population in the SFY 2014–2015 EQR Technical Report. SFY 2015–2016 was the first year that a comparison could be performed (between HEDIS 2015 and HEDIS 2016 rates) for the With Medicaid Expansion Included population; therefore, an assessment of the degree to which each MCO has effectively addressed recommendations for quality improvement made by HSAG will be reported in the SFY 2016–2017 EQR Technical Report. Similarly, the SFY 2016–2017 EQR Technical Report will contain an assessment of the degree to which each MCO and the PCCM has effectively addressed performance improvement recommendations made by HSAG in this technical report and throughout the state fiscal year.

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

Overall, both **Amerigroup** and **HPN** have demonstrated strengths and opportunities for improvement related to access, timeliness, and quality of care provided to Nevada Medicaid and Nevada Check Up populations. HSAG encourages MCOs to incorporate rapid-cycle improvement (RCI) concepts acquired from the newly required RCI PIP framework to improve performance measure rates. The approach uses resources more efficiently and implements improvement interventions that have the can bring about real improvement. Further, HSAG recommends the continued use of collaborative meetings between the DHCFP and the MCOs to continually assess MCO performance and the Medicaid and Nevada Check Up programs' achievement of the goals and objectives identified in the State's quality strategy.

Internal Quality Assurance Program—Corrective Action Plan Review

SFY 2015–2016 was the second year of the three-year cycle of reviews for Nevada. HSAG reviewed each of the corrective action plans that resulted from the compliance review activities and assisted the DHCFP staff with clarifying program requirements for the MCOs. The DHCFP approved the MCOs' corrective action plans. No further action was required by the MCOs or HSAG.

Validation of Performance Measures—NCQA HEDIS Compliance Audits

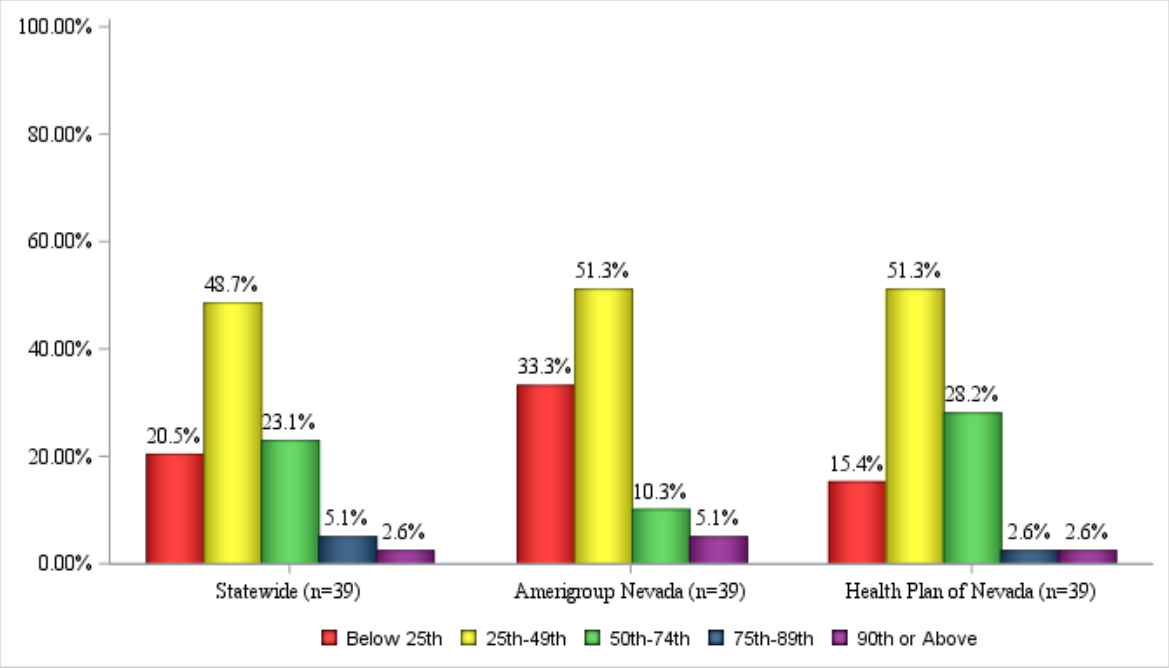
HSAG conducted an NCQA HEDIS Compliance Audit to assess **HPN** and **Amerigroup** performance with respect to the *HEDIS 2016 Technical Specifications* and to review the MCOs' performance on the HEDIS measures. For HEDIS 2016, the MCOs were required to report 19 measures with a total of 50 measure indicator rates for the Medicaid population and 15 measures with a total of 35 measure indicator rates for the Nevada Check Up population. HSAG validated all measures reported by the MCOs.

The NCQA HEDIS Compliance Audit demonstrated that both MCOs had strong policies and procedures in place to collect, process, and report HEDIS data for the Medicaid and Nevada Check Up populations, and both MCOs were in full compliance with the *HEDIS 2016 Technical Specifications*. The claims and encounter data systems employed by the MCOs used sophisticated scanning processes and advanced software to ensure accurate data processing. Both MCOs used software, the source code of which was certified by NCQA, to generate HEDIS measures. This ensured accurate measure calculation.

Medicaid Findings

Figure 1-1 shows the percentage of Medicaid population rates for HEDIS 2016 for the statewide weighted average, **Amerigroup**, and **HPN** compared to the NCQA HEDIS 2015 Audit Means and Percentiles national Medicaid benchmarks.

Figure 1-1—Percentage of HEDIS 2016 Performance Measures Rates for Medicaid Population Compared to HEDIS Medicaid National Percentiles



Thirty-nine of **Amerigroup**'s and **HPN**'s Medicaid HEDIS 2016 rates were evaluated and compared to national Medicaid benchmarks. **Amerigroup** reported two rates (approximately 5 percent) that ranked at or above the 90th percentile and 13 measure indicator rates (approximately 33 percent) that fell below the 25th percentile. **HPN** reported one rate (approximately 3 percent) that ranked at or above the 90th percentile and six measure indicator rates (approximately 15 percent) that fell below the 25th percentile.

Table 1-1 presents the HEDIS 2016 MCO-specific rates and the statewide weighted average Medicaid rates along with star ratings based on rate comparisons to the NCQA HEDIS 2015 Audit Means and Percentiles national Medicaid benchmarks. Measure results were compared to benchmarks and rated using the following star ratings:

★ = Below the national Medicaid 25th percentile

★★ = At or above the national Medicaid 25th percentile but below the 50th percentile

★★★ = At or above the national Medicaid 50th percentile but below the 75th percentile

★★★★ = At or above the national Medicaid 75th percentile but below the 90th percentile

★★★★★ = At or above the national Medicaid 90th percentile

Table 1-1—HEDIS 2016 Results for Medicaid			
HEDIS Measure	**HPN**	**AGP**	**Medicaid**
Access to Care			
Children and Adolescents' Access to Primary Care Practitioners			
Ages 12–24 Months	94.80% ★★	94.15% ★	94.48% ★★
Ages 25 Months–6 Years	84.29% ★	83.55% ★	83.93% ★
Ages 7–11 Years	87.36% ★	87.12% ★	87.26% ★
Ages 12–19 Years	85.21% ★	83.76% ★	84.67% ★
Annual Dental Visit			
Total	55.03% ★★★	53.21% ★★	54.25% ★★
Children's Preventive Care			
Adolescent Well-Care Visits			
Adolescent Well-Care Visits	44.04% ★★	38.43% ★	41.89% ★★
Childhood Immunization Status			
Combination 2	74.94% ★★	73.15% ★★	74.04% ★★
Combination 3	70.32% ★★	66.67% ★★	68.48% ★★
Combination 4	70.07% ★★★	65.28% ★★	67.65% ★★★
Combination 5	55.72% ★★	57.18% ★★	56.45% ★★
Combination 6	38.44% ★★	32.41% ★	35.40% ★
Combination 7	55.72% ★★★	56.48% ★★★	56.10% ★★★
Combination 8	38.44% ★★	32.41% ★	35.40% ★★
Combination 9	31.14% ★★	29.63% ★★	30.38% ★★
Combination 10	31.14% ★★	29.63% ★★	30.38% ★★
Immunizations for Adolescents			
Combination 1 (Meningococcal, Tdap/Td)	79.81% ★★★	71.93% ★★	76.80% ★★★
Well-Child Visits in the First 15 Months of Life			
Six or More Well-Child Visits	53.77% ★★	52.78% ★★	53.26% ★★
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life			
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	64.48% ★	66.33% ★★	65.36% ★

Table 1-1—HEDIS 2016 Results for Medicaid			
HEDIS Measure	**HPN**	**AGP**	**Medicaid**
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Percentile—Total	70.32% ★★★	64.12% ★★	67.74% ★★★
Counseling for Nutrition—Total	57.91% ★★	54.40% ★★	56.45% ★★
Counseling for Physical Activity—Total	52.07% ★★	43.75% ★	48.61% ★★
Human Papillomavirus Vaccine for Female Adolescents			
Human Papillomavirus Vaccine for Female Adolescents	29.68% ★★★★	24.59% ★★★	27.74% ★★★★
Maternity Care			
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	73.97% ★	75.41% ★	74.67% ★
Postpartum Care	57.18% ★★	53.16% ★	55.22% ★
Frequency of Ongoing Prenatal Care			
*<21 Percent of Expected Visits**	14.60% ★★	17.80% ★	16.16% ★
≥81 Percent of Expected Visits	52.07% ★★	56.44% ★★	54.20% ★★
Care for Chronic Conditions			
Comprehensive Diabetes Care			
Hemoglobin A1c (HbA1c) Testing	85.64% ★★	79.63% ★	83.34% ★★
*HbA1c Poor Control (>9.0%)**	45.74% ★★	46.76% ★★	46.13% ★★
Blood Pressure Control (<140/90 mm Hg)	60.83% ★★	55.32% ★	58.71% ★★
Eye Exam (Retinal) Performed	56.93% ★★★	55.09% ★★★	56.23% ★★★
Medical Attention for Nephropathy	92.21% ★★★★★	89.58% ★★★★★	91.20% ★★★★★
HbA1c Control (<8.0%)	46.47% ★★	46.30% ★★	46.40% ★★
Medication Management for People With Asthma			
Medication Compliance 50%—Total	46.96% ★	50.22% ★★	48.14% ★★
Medication Compliance 75%—Total	24.14% ★★	26.84% ★★	25.12% ★★
Behavioral Health			
Follow-Up After Hospitalization for Mental Illness			
7-Day Follow-Up	56.51% ★★★	52.99% ★★★	54.56% ★★★
30-Day Follow-Up	69.41% ★★★	64.55% ★★	66.72% ★★★

Table 1-1—HEDIS 2016 Results for Medicaid			
HEDIS Measure	**HPN**	**AGP**	**Medicaid**
Follow-Up Care for Children Prescribed ADHD Medication			
Initiation Phase	46.65% ★★★	36.68% ★★	42.15% ★★★
Continuation and Maintenance Phase	58.02% ★★★	40.91% ★★	52.00% ★★★
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*			
Total	1.80% ★★★	0.00% ★★★★★	1.02% ★★★★
Utilization and Diversity of Membership			
Mental Health Utilization—Total			
Any Service—Total	5.90% NC	7.21% NC	6.47% NC
Inpatient—Total	0.77% NC	1.18% NC	0.95% NC
Intensive Outpatient or Partial Hospitalization—Total	0.23% NC	0.28% NC	0.25% NC
Outpatient or Emergency Department—Total	5.67% NC	7.01% NC	6.25% NC
Ambulatory Care—Total			
*Emergency Department (ED) Visits—Total**	49.39 NC	55.08 NC	51.85 NC
Outpatient Visits—Total	292.44 NC	294.01 NC	293.12 NC
Weeks of Pregnancy at Time of Enrollment			
Prior to 0 Weeks	33.27% NC	26.39% NC	32.80% NC
1–12 Weeks	12.99% NC	12.50% NC	12.96% NC
13–27 Weeks	28.38% NC	41.44% NC	29.26% NC
28 or More Weeks of Pregnancy	21.28% NC	19.68% NC	21.17% NC
Unknown	4.09% NC	0.00% NC	3.81% NC

* A lower rate indicates better performances for this measure.

NC indicates the HEDIS 2016 rate was not compared to benchmarks either because data were not available or because a measure is informational only and comparisons to benchmarks are not appropriate.

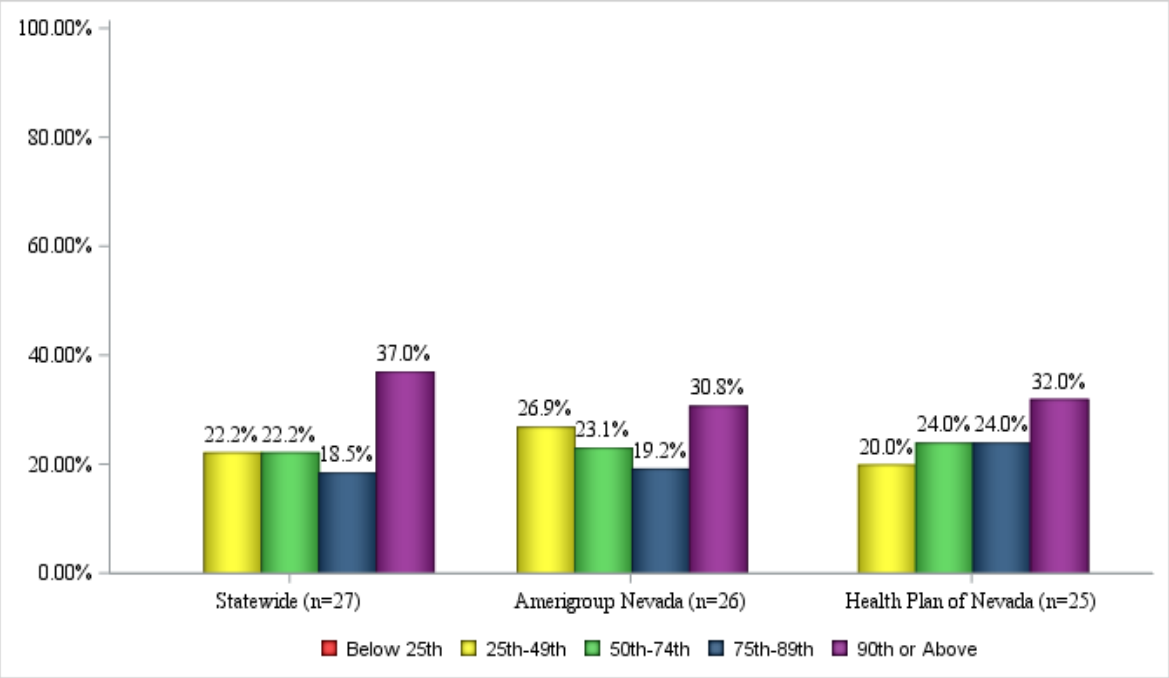
NA indicates the denominator for the measure was too small to report (less than 30).

Most of the statewide weighted average Medicaid population rates fell below the national 50th percentile. However, statewide weighted averages for *Human Papillomavirus Vaccine for Female Adolescents* and *Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total* ranked at or above the national 75th percentile but below the 90th percentile, and the rate for *Comprehensive Diabetes Care—Medical Attention for Nephropathy* ranked at or above the national 90th percentile, indicating performance strengths.

Nevada Check Up Findings

Figure 1-2 shows the percentage of Nevada Check Up population rates for HEDIS 2016 for the statewide weighted average, **Amerigroup**, and **HPN** as compared to the NCQA HEDIS 2015 Audit Means and Percentiles national Medicaid benchmarks.[1-1]

Figure 1-2—Percentage of HEDIS 2016 Performance Measures Rates for Nevada Check Up Population Compared to HEDIS Medicaid National Percentiles



Twenty-six of **Amerigroup**'s Nevada Check Up HEDIS 2016 rates were evaluated as compared to national Medicaid benchmarks, of which eight rates (approximately 31 percent) ranked at or above the 90th percentile and none of the measure indicator rates fell below the 25th percentile. Twenty-five of **HPN**'s Nevada Check Up HEDIS 2016 rates were evaluated as compared to national Medicaid benchmarks, of which eight rates (approximately 32 percent) ranked at or above the 90th percentile and none of the measure indicator rates fell below the 25th percentile.

Table 1-2 presents the HEDIS 2016 MCO-specific rates and the statewide weighted average Nevada Check Up rates along with star ratings based on comparisons of the rates to the NCQA HEDIS 2015 Audit Means and Percentiles national Medicaid benchmarks.

[1-1] Because NCQA HEDIS 2015 Audit Means and Percentiles benchmarks are not available for the Children's Health Insurance Program (CHIP) population, comparisons of Nevada's Check Up population measure indicator rates to the national Medicaid benchmarks should be interpreted with caution.

Table 1-2—HEDIS 2016 Results for Nevada Check Up			
HEDIS Measure	**HPN**	**AGP**	**Nevada Check Up**
Access to Care			
Children and Adolescents' Access to Primary Care Practitioners			
Ages 12–24 Months	99.48% ★★★★★	98.73% ★★★★★	99.15% ★★★★★
Ages 25 Months–6 Years	89.55% ★★★	89.53% ★★★	89.54% ★★★
Ages 7–11 Years	93.54% ★★★	92.91% ★★★	93.32% ★★★
Ages 12–19 Years	90.78% ★★★	88.95% ★★	90.18% ★★★
Annual Dental Visit			
Total	70.11% ★★★★★	67.05% ★★★★★	68.96% ★★★★★
Children's Preventive Care			
Adolescent Well-Care Visits			
Adolescent Well-Care Visits	52.83% ★★★	56.34% ★★★	54.04% ★★★
Childhood Immunization Status			
Combination 2	87.93% ★★★★★	85.90% ★★★★★	86.97% ★★★★★
Combination 3	84.48% ★★★★★	78.21% ★★★★	81.52% ★★★★★
Combination 4	83.91% ★★★★★	77.56% ★★★★	80.92% ★★★★★
Combination 5	79.89% ★★★★★	68.59% ★★★★	74.56% ★★★★★
Combination 6	52.30% ★★★★	46.79% ★★★	49.70% ★★★
Combination 7	79.31% ★★★★★	67.95% ★★★★★	73.96% ★★★★★
Combination 8	51.72% ★★★★	46.79% ★★★	49.40% ★★★★
Combination 9	50.00% ★★★★	42.95% ★★★	46.68% ★★★★
Combination 10	49.43% ★★★★	42.95% ★★★★	46.37% ★★★★
Immunizations for Adolescents			
Combination 1 (Meningococcal, Tdap/Td)	87.35% ★★★★	81.61% ★★★★	85.33% ★★★★
Well-Child Visits in the First 15 Months of Life			
Six or More Well-Child Visits	68.00% ★★★★	78.05% ★★★★★	72.53% ★★★★

Table 1-2—HEDIS 2016 Results for Nevada Check Up			
HEDIS Measure	**HPN**	**AGP**	**Nevada Check Up**
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life			
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	70.13% ★★	70.28% ★★	70.19% ★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Percentile—Total	72.02% ★★★	62.04% ★★	68.43% ★★★
Counseling for Nutrition—Total	60.34% ★★	55.56% ★★	58.62% ★★
Counseling for Physical Activity—Total	57.18% ★★★	47.69% ★★	53.77% ★★
Human Papillomavirus Vaccine for Female Adolescents			
Human Papillomavirus Vaccine for Female Adolescents	42.62% ★★★★★	34.11% ★★★★★	39.68% ★★★★★
Care for Chronic Conditions			
Medication Management for People With Asthma			
Medication Compliance 50%—Total	47.62% ★★	47.76% ★★	47.67% ★★
Medication Compliance 75%—Total	26.98% ★★	26.87% ★★	26.94% ★★
Behavioral Health			
Follow-Up After Hospitalization for Mental Illness			
7-Day Follow-Up	NA	84.85% ★★★★★	83.33% ★★★★★
30-Day Follow-Up	NA	93.94% ★★★★★	89.58% ★★★★★
Follow-Up Care for Children Prescribed ADHD Medication			
Initiation Phase	39.53% ★★	NA	35.21% ★★
Continuation and Maintenance Phase	NA	NA	NA
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*			
Total	NA	NA	NA
Utilization and Diversity of Membership			
Mental Health Utilization—Total			
Any Service—Total	4.71% NC	5.76% NC	5.12% NC
Inpatient—Total	0.14% NC	0.46% NC	0.26% NC
Intensive Outpatient or Partial Hospitalization—Total	0.55% NC	0.32% NC	0.46% NC
Outpatient or Emergency Department—Total	4.67% NC	5.69% NC	5.07% NC

Table 1-2—HEDIS 2016 Results for Nevada Check Up			
HEDIS Measure	**HPN**	**AGP**	**Nevada Check Up**
Ambulatory Care—Total			
*Emergency Department (ED) Visits—Total**	21.00 NC	26.14 NC	23.00 NC
Outpatient Visits—Total	259.29 NC	263.50 NC	260.93 NC

* A lower rate indicates better performances for this measure.

NC indicates the HEDIS 2016 rate was not compared to benchmarks either because data were not available or because a measure is informational only and comparisons to benchmarks are not appropriate.

NA indicates the denominator for the measure was too small to report (less than 30).

For the statewide weighted average results for Nevada Check Up, most of the rates ranked at or above the national 75th percentile. However, statewide weighted averages for the following measures fell at or above the national 25th percentile but below the 50th percentile, indicating opportunities for improvement: *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*; *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total,* and *Counseling for Physical Activity—Total*; *Medication Management for People With Asthma—Medication Compliance 50%—Total,* and *Medication Compliance 75%—Total*; and *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*. As mentioned above, comparisons of Nevada's Check Up population measure indicator rates to the national Medicaid benchmarks should be interpreted with caution.

Conclusions and Recommendations

The HEDIS audit demonstrated that both MCOs had adequate policies and procedures in place to collect, prepare, process, and report HEDIS data and were fully compliant with each of the seven NCQA-specified IS standards. Both MCOs continued to use FACETS to process their claims. Data entry processes were efficient and ensured timely and accurate entry into the system. Only standard codes were accepted and the standard HIPAA 837 file format was used. Both MCOs applied several validation checks to ensure accurate information processing, and both had appropriate processes in place for the ICD-9 to ICD-10 transition and did not experience any data concerns.

Most of the MCOs' performance measure rates from HEDIS 2015 to HEDIS 2016 remained relatively stable from year-to-year for Medicaid. As evidenced by the comparisons of the rates to national Medicaid benchmarks, HSAG suggests that the MCOs focus efforts on improving children and adolescents' access to primary care practitioners. Further, HSAG recommends that the MCOs analyze any improvement strategies that can be linked to the overall success of the measure, counseling children/adolescents for nutrition and physical activity, and improvement interventions that were implemented to improve well child visits. HSAG also recommends that the MCOs monitor performance with regard to maternity care, managing medications for asthmatic members, and appropriate testing and control of HbA1c levels and controlling blood pressure for diabetic members. The areas recommended for improvement are based on rates that mostly ranked below the national Medicaid 50th percentile. Additionally, for the Nevada Check Up population, the MCOs are urged to focus efforts on improving counseling for nutrition and physical activity provided to

children and adolescents and analyze strategies that could be linked to increased rates of well-care visits for adolescents and asthma medication compliance for asthmatic members. Although none of the Nevada Check Up population rates showed declines from 2015 to 2016, rates in these areas fell below the national Medicaid 50th percentile, indicating opportunities for improvement.

For each measure requiring improvement, HSAG recommends that each MCO conduct a thorough analysis of the root cause of poor performance for each measure and identify provider, member, and systems interventions that can be implemented to improve performance measure rates in each area. Similar to the RCI approach required by PIPs, MCOs should test changes on a small scale, using a series of plan, do, study, act (PDSA) cycles and applying rapid-cycle learning principles over the course of the improvement project to adjust intervention strategies so that improvement can occur more efficiently and lead to long-term sustainability.

Validation of Performance Improvement Projects (PIPs)

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

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

In SFY 2015–2016, the DHCFP selected two PIP topics for the MCOs: *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents*, and *Behavioral Health Hospital Readmissions*. The topics addressed CMS requirements related to quality outcomes, specifically the quality and timeliness of and access to care and services.

Table 1-3—PIP Results

PIP Title	Amerigroup PIP Module Results	HPN PIP Module Results
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	Module 1: *Achieved* Module 2: *Achieved* Module 3: *Achieved*	Module 1: *Achieved* Module 2: *Achieved* Module 3: *Achieved*
Behavioral Health Hospital Readmissions	Module 1: *Achieved* Module 2: *Achieved* Module 3: *Achieved*	Module 1: *Achieved* Module 2: *Achieved* Module 3: *Achieved*

Recommendations

Since the MCOs were allowed to resubmit PIP modules and incorporate HSAG recommendations in each resubmission, HSAG does not have recommendations for the first three PIP modules that were submitted and approved. For future module submissions, HSAG offers the following recommendations:

- As each MCO moves through the quality improvement process and conducts PDSA cycles, each MCO's PIP team should ensure that it is communicating the MCO's reasons for making changes to intervention strategies and how those changes will lead to improvement. Without a common understanding and agreement about the causes that affect improvement, the MCO's PIP team might misdirect resources and improvement activities toward changes that do not lead to improvement.
- When planning a test of change, each MCO should be proactive with the intervention (i.e., scaling/ramping up to build confidence in the change, and eventually implementing policy to sustain changes).
- When testing an intervention, each MCO should conduct a series of thoughtful and incremental PDSA cycles to accelerate the rate of improvement.
- As each MCO tests new interventions, it should ensure it is making a prediction in each step of the PDSA cycle and discussing the basis for the prediction. This will help keep the theory for improvement in the project in the forefront for everyone involved.
- When developing the intervention testing methodology, the MCOs should determine the best method for identifying the intended effect of an intervention prior to testing. The intended effect should be known up front to help determine which data need to be collected.
- When testing an intervention, the MCOs should collect detailed, process-level data to ensure they collect enough data to illustrate the effects of the intervention.
- The key driver diagram and failure modes and effects analysis (FMEA) for all PIPs should be updated as each MCO progresses through its PDSA cycles.

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

The populations surveyed for **HPN** and **Amerigroup** were adult Medicaid, child Medicaid, and Nevada Check Up. DSS Research, an NCQA-certified vendor, administered the 2016 CAHPS surveys for both **HPN** and **Amerigroup**.

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

For each of the five composite scores and children with chronic conditions (CCC) composite measures/items, the percentage of respondents who chose a positive response was calculated. CAHPS composite question response choices fell into one of two categories: (1) Never, Sometimes, Usually, or Always; or (2) No or Yes. A positive or top-box response for the composites and CCC composites/items was defined as a response of Usually/Always or Yes. The percentage of top-box responses is referred to as a global proportion for the composite scores and CCC composite

measures/items. For the Effectiveness of Care measures, responses of Always/Usually/Sometimes were used to determine if the respondent qualified for inclusion in the numerator. NCQA's methodology for calculating a rolling average using the current and prior years' results was followed. A substantial increase or decrease is denoted by a change of 5 percentage points or more.

Amerigroup Findings

In 2016, a total of 2,499 adult members were sent a survey and 469 completed a survey.[1-2] After ineligible members were excluded, the response rate was 19.3 percent. In 2015, the average NCQA response rate for the adult Medicaid population was 27.2 percent, which was higher than **Amerigroup**'s response rate.[1-3] **Amerigroup**'s rates decreased between 2015 and 2016 for five of 12 measures: *Getting Needed Care*, *Customer Service*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*. **Amerigroup**'s rates increased between 2015 and 2016 for seven measures: *Getting Care Quickly*, *How Well Doctors Communicate*, *Shared Decision Making*, *Rating of Specialist Seen Most Often*, *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*. Of these, the 2016 *Discussing Cessation Medications* measure rate was at least 5 percentage points greater than the 2015 rate.

In 2016, a total of 4,066 general child members were sent a survey and 686 completed a survey.[1-4] After ineligible members were excluded, the response rate was 17.9 percent. In 2015, the average NCQA response rate for the general child Medicaid population was 25.2 percent, which was higher than **Amerigroup**'s response rate.[1-5] **Amerigroup**'s rates increased between 2015 and 2016 for four measures: *Customer Service*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*. Of these, *Customer Service* and *Rating of All Health Care* showed a substantial increase of more than 5 percentage points. **Amerigroup**'s rates decreased between 2015 and 2016 for four measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Shared Decision Making*. Of these, *Getting Needed Care* showed a substantial decrease of more than 5 percentage points.

In 2016, a total of 236 child members with a chronic condition completed a survey.[1-6] **Amerigroup**'s rates increased between 2015 and 2016 for four reportable measures: *Getting Needed Care*, *Rating of All Health Care*, *Rating of Health Plan*, and *Family Centered Care (FCC): Personal Doctor Who Knows Child*. **Amerigroup**'s rates decreased between 2015 and 2016 for five reportable measures: *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of Personal Doctor*, *Access to Prescription Medicines*, and *FCC: Getting Needed Information*. Of these, *Getting Care Quickly* showed a substantial decrease of more than 5 percentage points.

[1-2] The total number of members surveyed and who completed surveys is based on **Amerigroup**'s adult CAHPS sample only.

[1-3] The 2016 NCQA national response rate information for the CAHPS 5.0 Adult Medicaid Survey was not available at the time this report was produced.

[1-4] The total number of members surveyed and who completed surveys is based on **Amerigroup**'s general child CAHPS sample only (i.e., does not include the CCC supplemental sample of members who were surveyed).

[1-5] The 2015 NCQA national response rate information for the CAHPS 5.0 Child Medicaid with CCC Survey was not available at the time this report was produced.

[1-6] The total number of members who completed surveys is based on **Amerigroup**'s CCC supplemental CAHPS sample only.

In 2016, a total of 1,605 Nevada Check Up general child members were sent a survey and 409 completed a survey.[1-7] After ineligible members were excluded, the response rate was 28.8 percent. **Amerigroup**'s rates decreased between 2015 and 2016 for four measures: *Getting Needed Care*, *Getting Care Quickly*, *Customer Service*, and *Rating of All Health Care*. The rates for three measures increased between 2015 and 2016: *How Well Doctors Communicate*, *Rating of Personal Doctor*, and *Rating of Health Plan*. Of these, *Rating of Personal Doctor* showed a substantial increase of more than 5 percentage points.

In 2016, a total of 80 Nevada Check Up child members with a chronic condition completed a survey.[1-8] **Amerigroup**'s 2015 and 2016 rates could not be reported for the Nevada Check Up CCC population, since all measures did not meet the minimum number of responses.

HPN Findings

In 2016, a total of 1,899 adult members were surveyed and 271 completed a survey.[1-9] After ineligible members were excluded, the response rate was 14.4 percent. In 2015, the average NCQA response rate for the adult Medicaid population was 27.2 percent, higher than **HPN**'s response rate.[1-10] **HPN**'s rates decreased between 2015 and 2016 for eight of nine reportable measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Health Plan*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*. Of these, three measures showed a substantial decrease of more than 5 percentage points: *Getting Care Quickly*, *Rating of All Health Care*, and *Rating of Personal Doctor*. One measure, *Advising Smokers and Tobacco Users to Quit*, increased between 2015 and 2016. The increase was more than 5 percentage points.

In 2016, a total of 2,372 general child members were surveyed and 466 completed a survey.[1-11] After ineligible members were excluded, the response rate for the general child population was 20.4 percent. In 2015, the average NCQA response rate for the child Medicaid population was 25.2 percent, higher than **HPN**'s 2016 response rate.[1-12] **HPN**'s rates decreased between 2015 and 2016 for one of the six reportable measures: *How Well Doctors Communicate*. **HPN**'s rates increased between 2015 and 2016 for five measures: *Getting Needed Care*, *Getting Care Quickly*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*. Further, one measure, *Rating of all Health Care*, showed a substantial increase of at least 5 percentage points.

In 2016, a total of 267 child members with a chronic condition completed a survey.[1-13] **HPN**'s rates decreased between 2015 and 2016 for two measures: *Getting Needed Care* and *Shared Decision*

[1-7] The total number of members surveyed and who completed surveys is based on **Amerigroup**'s Nevada Check Up general child CAHPS sample only.
[1-8] The total number of members who completed surveys is based on **Amerigroup**'s Nevada Check Up CCC supplemental CAHPS sample only.
[1-9] The total number of members surveyed and who completed surveys is based on **HPN**'s adult CAHPS sample only.
[1-10] The 2015 NCQA national response rate information for the CAHPS 5.0 Adult Medicaid Survey was not available at the time this report was produced.
[1-11] The total number of members surveyed and who completed surveys is based on **HPN**'s general child CAHPS sample (i.e., does not include the CCC supplemental sample of members who were surveyed).
[1-12] The 2015 NCQA national response rate information for the CAHPS 5.0 Child Medicaid with CCC Survey was not available at the time this report was produced.
[1-13] The total number of members who completed surveys is based on **HPN**'s CCC supplemental CAHPS sample only.

Making. **HPN**'s rates substantially increased between 2015 and 2016 for four measures: *Getting Care Quickly*, *Rating of All Health Care*, *FCC: Personal Doctor Who Knows Child*, and *Coordination of Care for Children with Chronic Conditions.*

In 2016, a total of 2,352 Nevada Check Up general child members were surveyed and 538 completed a survey.[1-14] For the general child population, **HPN**'s 2016 Nevada Check Up CAHPS scores were below the 2015 Nevada Check Up CAHPS scores for four composite measures: *Getting Needed Care*, *How Well Doctors Communicate*, *Customer Service*, and *Shared Decision Making*. **HPN**'s rates increased between 2015 and 2016 for the remaining four reportable measures: *Getting Care Quickly*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*.

In 2016, 244 Nevada Check Up child members with a chronic condition completed a survey.[1-15] For the CCC population, **HPN**'s 2016 Nevada Check Up CAHPS scores were below the 2015 Nevada Check Up CAHPS scores for three measures: *Getting Needed Care*, *Access to Prescription Medicines*, and *FCC: Getting Needed Information*. **HPN**'s rates increased between 2015 and 2016 for five measures: *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *FCC: Personal Doctor Who Knows Child.*

Recommendations

Overall, HSAG recommends the following:

- Each MCO should continue to work with its CAHPS vendor to ensure that a sufficient number of completed surveys is obtained to enable reporting of all CAHPS measures. NCQA recommends targeting 411 completed surveys per survey administration. **Amerigroup** had measures that did not meet the minimum number of responses (i.e., 100 responses) for the CCC Medicaid population, Nevada Check Up general child population, and Nevada Check Up CCC population. **HPN** had measures that did not meet the minimum number of responses for the adult Medicaid population, general child and CCC Medicaid populations, and the CCC Nevada Check Up population. Without sufficient responses, MCOs lack information that can be critical to designing and implementing targeted interventions that can improve access to, and the quality and timeliness of, care.
- For the adult population, HSAG recommends that **Amerigroup** focus quality improvement initiatives on enhancing members' experiences with *Getting Needed Care*, *Customer Service*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*, since these rates were lower than the 2015 adult CAHPS results and fell below NCQA's 2015 CAHPS adult Medicaid national averages. For the general child Medicaid population, **Amerigroup** should focus its efforts on improving *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Shared Decision Making*, since the rates for these measures were lower than the 2015 general child CAHPS results and fell below NCQA's 2015 CAHPS child Medicaid national averages. For the CCC Medicaid population, **Amerigroup** should focus its efforts on improving *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of Personal Doctor*,

[1-14] The total number of members surveyed and who completed surveys is based on **HPN**'s general child CAHPS sample only (i.e., does not include the CCC supplemental sample of members who were surveyed).
[1-15] The total number of members who completed surveys is based on **HPN**'s Nevada Check Up CCC supplemental CAHPS sample only.

Access to Prescription Medicines, and *FCC: Getting Needed Information*, since the rates for these reportable measures were lower than the 2015 CCC child CAHPS results and fell below NCQA's 2015 CAHPS CCC child national averages. For the Nevada Check Up population, HSAG recommends that **Amerigroup** focus quality improvement initiatives on enhancing members' experiences with *Getting Needed Care*, *Getting Care Quickly*, *Customer Service*, and *Rating of All Health Care*, since the 2016 rates for these reportable measures were lower than the 2015 rates.

- HSAG recommends that **HPN** focus quality improvement initiatives on enhancing members' experiences with *Getting Needed Care*, *Getting Care Quickly*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Health Plan*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies* for the adult Medicaid population, since these rates were lower than the 2015 adult CAHPS results and fell below NCQA's 2015 CAHPS adult Medicaid national averages. For the general child Medicaid population, **HPN** should focus on improving *How Well Doctors Communicate*, since the rate for this composite measure was lower than the 2015 child CAHPS result and fell below NCQA's 2015 CAHPS child Medicaid national average. For the CCC child Medicaid population, **HPN** should focus on improving *Getting Needed Care* and *Shared Decision Making*, since the rates for these measures fell below the 2015 CAHPS results and were substantially lower than the 2015 NCQA CCC child Medicaid national averages. For the Nevada Check Up population, quality improvement efforts should be focused on *Shared Decision Making*, since this measure showed a substantial decrease from 2015 to 2016. For the CCC Nevada Check Up population, **HPN** should improve the *Getting Needed Care*, *Access to Prescription Medicines*, and *FCC: Getting Needed Information*, since the rates for these measures decreased from 2015 to 2016.

Health Care Guidance Program (HCGP) Corrective Action Plan Review

In SFY 2014–2015, HSAG conducted an interim assessment of **McKesson Technologies, Inc**.'s (**McKesson**'s) compliance with its contract six months after **McKesson**'s HCGP operations began in June 2014. Out of 12 standards reviewed during the compliance review, seven were found to be deficient. HSAG recommended that **McKesson**, doing business as **AxisPoint Health** (**APH**), submit to DHCFP a corrective action plan to remedy all deficiencies that resulted from the compliance review. **APH** was responsible for developing the CAP, obtaining DHCFP approval of the CAP, and implementing the strategies outlined in the DHCFP-approved CAP.

CAP Review Findings

In SFY 2015–2016, HSAG worked with the DHCFP staff to review the CAPs submitted by **APH** and give DHCFP feedback regarding the feasibility that the strategies proposed by **APH** would remedy the deficiencies noted in the compliance review. Several of the responses submitted by **APH** were not acceptable to the DHCFP, which issued a closeout letter to **McKesson** in July 2015 citing the items that were not acceptable. During SFY 2015–2016, HSAG worked with the DHCFP staff to review additional strategies that **APH** proposed to remedy outstanding deficiencies. Of the seven corrective action plans initially submitted, DHCFP fully accepted only two and partly accepted one. As a result of DHCFP's initial feedback, **APH** was required to resubmit corrective action plans until DHCFP fully accepted them. DHCFP monitored the deficient standards until it

fully accepted all plans submitted by **APH**. The last one was approved by DHCFP on March 15, 2016.

Recommendations

Although, there are no additional recommendations as a result of the corrective action plan review, HSAG recommends that DHCFP require future plans be submitted and resolved more timely so that **APH** does not remain out of compliance with contractual elements longer than necessary.

HCGP Performance Measure Validation (PMV)

To verify the accuracy of **APH**'s reported rates, DHCFP contracted with HSAG, the State's EQRO, to validate the performance measure rates calculated and reported by **APH**. To ensure that the PMV activity was performed in accordance with industry standards of practice, HSAG validated **APH**'s performance measures using the external quality review (EQR) Protocol 2[1-16] developed by CMS as its guide. HSAG's PMV activity focused on the following objectives:

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

Performance Measure Validation Findings

HSAG examined 24 measures with a total of 63 indicators, or individual rates. Of the 63 indicators, 26 were Not Completed (NC). The rates for the other 37 indicators appeared to be appropriately calculated and reported by **APH**.

Recommendations

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

- **APH** should work to obtain WebIZ supplemental immunization registry data in order to calculate a rate for the *Childhood Immunization* Status measures.
  - **Update: APH** secured the necessary access to obtain WebIZ supplemental immunization registry data in the spring 2016.
- DHCFP should revisit the care transition measures, CCHU 3-7, to determine the likelihood that data can be obtained to report the measures. If data cannot be obtained, then the measures should be omitted or replaced with other measures.
  - **Update:** DHCFP and HSAG staff members worked to replace the CCHU 3-7 measures with measures that could be calculated by **APH**. The new measures are *Follow-Up with PCP After Hospitalization—7 days* and *30 days* and *Medication Reconciliation Post-Discharge*.

[1-16] *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 1, 2012.

- For the *Cognitive Assessment for Dementia* measure, DHCFP should consider modifying the specifications so the denominator can be identified by **APH**.
  - **Update:** DHCFP and HSAG staff members worked to modify the codes used to specify the denominator so it could be identified by **APH** and a rate could be generated.
- DHCFP should consider replacing or removing the measure *Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor Positive Breast Cancer (CAN)*, since CPT II codes cannot be collected.
  - **Update:** DHCFP removed the measure *Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor Positive Breast Cancer (CAN)* from the suite of non-P4P performance measures, since CPT II codes could not be collected.

2. Overview of Nevada Managed Care Program

History of Nevada State Managed Care Program

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

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

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

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

- AM—Parents and Caretakers
- AM1—Expanded Parent and Caretakers
- CH—Poverty Level Children and Pregnant Women
- CH1—Expanded Children's Group Ages 6–18 Years
- CH5—Omnibus Budget Reconciliation Act (OBRA)
- CA—Childless Adults, Without Dependents, Ages 19–64 Years
- TR—Transitional Medicaid

- PM—Post Medical
- NC—Nevada Check Up–State CHIP Program for Children Under 19 Years

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

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

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

Demographics of Nevada State Managed Care Program

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

Table 2-1 presents the gender and age bands of Nevada Medicaid- and CHIP-enrolled recipients as of June 2016. The majority of members for both Medicaid and CHIP were children between 3 and 14 years of age.

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

Gender/Age Band	June 2016 Members
Males and Females <1 Year of Age	21,695
Males and Females 1–2 Years of Age	33,869
Males and Females 3–14 Years of Age	180,668
Females 15–18 Years of Age	21,088
Males 15–18 Years of Age	21,027
Females 19–34 Years of Age	84,344
Males 19–34 Years of Age	52,270
Females 35+ Years of Age	119,233
Males 35+ Years of Age	90,608
Total Medicaid	**624,802**
Males and Females <1 Year of Age	186
Males and Females 1–2 Years of Age	1,526
Males and Females 3–14 Years of Age	17,093
Females 15–18 Years of Age	2,435
Males 15–18 Years of Age	2,515
Total CHIP	**23,755**
Total Medicaid and CHIP	**648,557**

Table 2-2 presents enrollment of Medicaid recipients by MCO and county for June 2016.

Table 2-2—June 2016 Nevada MCO Medicaid Recipients		
MCO	Total Eligible Clark County	Total Eligible Washoe County
HPN	214,243	34,643
Amerigroup	156,416	23,830
Total	**370,659**	**58,473**

Table 2-3 presents enrollment of CHIP recipients in the Nevada Check Up program by MCO and by county for June 2016.

Table 2-3—June 2016 Nevada MCO CHIP (Nevada Check Up) Recipients		
MCO	Total Eligible Clark County	Total Eligible Washoe County
HPN	10,313	2,717
Amerigroup	6,808	1,414
Total	**17,121**	**4,131**

Table 2-4 presents the ethnic composition of Nevada MCO Medicaid recipients in June 2016.

Table 2-4—June 2016 Nevada MCO Medicaid Ethnic Composition		
Ethnicity	Total Eligible Clark County	Total Eligible Washoe County
Asian or Pacific Islander Non-Hispanic	14,070	1,591
Black Non-Hispanic	86,841	2,909
Hispanic	25	17
Am Indian/Alaskan Non-Hispanic	1,290	621
Am Indian/Alaskan and White	386	152
Asian and White	1,257	203
Black African Am and White	3,062	452
Am Indian/Alaskan and Black	1,079	118
Other Non-Hispanic	28,689	3,244
Asian/Pacific Islander Hispanic	926	182
Black Hispanic	1,390	105
Am Indian/Alaskan Hispanic	188	42
White Hispanic	127,967	19,649
White Non-Hispanic	103,489	29,188
Total	**370,659**	**58,473**

Table 2-5 presents the ethnic composition of CHIP recipients in the Nevada Check Up program for June 2016.

Table 2-5—June 2015 Nevada MCO CHIP (Nevada Check Up) Ethnic Composition

Ethnicity	Total Enrolled Clark County	Total Enrolled Washoe County
Asian or Pacific Islander Non-Hispanic	747	96
Black Non-Hispanic	1,500	54
Hispanic	0	2
Am Indian/Alaskan Non-Hispanic	26	57
Am Indian/Alaskan and White	12	2
Asian and White	66	19
Black African Am and White	123	19
Am Indian/Alaskan and Black	58	6
Other Non-Hispanic	1,389	200
Asian/Pacific Islander Hispanic	42	17
Black Hispanic	58	4
Am Indian/Alaskan Hispanic	9	9
White Hispanic	9,902	2,642
White Non-Hispanic	3,189	1,004
Total	**17,121**	**4,131**

Network Capacity Analysis

In SFY 2014–2015, at the request of the DHCFP, HSAG conducted an evaluation of Nevada's Medicaid provider network. The purpose of the analysis was to review the provider network capacity, geographic distribution, and appointment availability of the MCOs' and fee for service (FFS) networks. The analysis evaluated three dimensions of access and availability:

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

The network analysis was based on comparative evaluations of both Nevada Medicaid recipients and the providers who serve them. Additionally, comparison groups, or populations, of Nevada residents and providers were defined to evaluate network performance relative to the general population in Nevada. The study represented one of many ongoing attempts to capture, report, monitor, and explore the experience of Medicaid recipients' access to health care services. The study also enabled DHCFP to establish baseline network capacity and distance results so that results

from future studies may be compared to the SFY 2014–2015 results to determine what changes, if any, have occurred to the network. This will be especially helpful with the addition of new network monitoring requirements from CMS for both the fee-for-service (FFS) and managed care provider networks. Those new requirements included:

- **Access Monitoring Review Plan**—CMS issued a final rule to allow states and CMS to make better informed, data-driven decisions when considering whether proposed changes to Medicaid fee-for-service payment rates are sufficient to ensure that Medicaid beneficiaries have access to covered Medicaid services. In order to improve the data with which states and CMS monitor access, the regulation requires states to submit access monitoring review plans. The plans must specify data sources that will support a finding of sufficient beneficiary access and will address:
  - The extent to which beneficiary needs are met.
  - The availability of care and providers.
  - Changes in beneficiary service utilization.
  - Comparisons between Medicaid rates and rates paid by other public and private payers.

  The plans must provide for state reviews a core set of five services: primary care, physician specialists, behavioral health, pre- and post-natal obstetrics (including labor and delivery), and home health services. Nevada chose to add a sixth topic, dental, to the list of services reviewed. The DHCFP will evaluate the new Department of Insurance (DOI) network standards once developed.
- **Availability of Services, Assurances of Adequate Capacity and Services, and Network Adequacy Standards**—CMS required states to set standards to ensure ongoing state assessment and certification of MCO, prepaid inpatient health plan, and prepaid ambulatory health plan networks; set threshold standards to establish network adequacy measures for a specified set of providers; establish criteria to develop network adequacy standards for managed long term services and supports programs; and ensure the transparency of network adequacy standards. The rule stipulates that states must establish time and distance standards for the following network provider types: primary care (adult and pediatric); obstetricians/gynecologists; behavioral health; specialist (adult and pediatric); hospital; pharmacy; pediatric dental; and additional provider types when they promote the objectives of the Medicaid program for the provider type to be subject to such time and distance standards.

Nevada State Quality Strategy

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

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

An evaluation of the DHCFP's progress in meeting the goals and objectives detailed in the Quality Strategy for SFY 2015–2016 is provided later in this report.

Quality Strategy Goals and Objectives

The DHCFP's mission is to purchase and ensure the provision of quality health care services, including Medicaid services, to low-income Nevadans in the most efficient manner. Furthermore, the DHCFP seeks to promote equal access to health care at an affordable cost to Nevada taxpayers, to restrain the growth of health care costs, and to review Medicaid and other State health care programs to determine the potential to maximize federal revenue opportunities. Further, the DHHS director has identified three priority focus areas for Nevada Medicaid: prevention, early intervention, and quality treatment. Consistent with the State's mission and DHHS priority areas, the purpose of the DHCFP's 2016–2017 Quality Strategy was to:

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

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

In SFY 2015–2016, HSAG worked with DHCFP staff members to revise the State's quality strategy. Consistent with the national quality strategy, the DHCFP established the following quality goals for the 2016–2017 Quality Strategy to improve the health and wellness of Nevada Medicaid and Nevada Check Up members. Unless otherwise indicated, all objectives will follow the Quality Improvement System for Managed Care (QISMC) methodology to increase rates by 10 percent.

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

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

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

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

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

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

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

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

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

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

Objective 1.5: Increase immunizations for adolescents.

Objective 1.6: Increase annual dental visits for children.

Objective 1.7: Increase human papillomavirus vaccine for female adolescents.

Objective 1.8: Increase adolescent well-care visits.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Objective 4.1: Increase the rate of postpartum visits.

Objective 4.2: Increase timeliness of prenatal care.

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

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

Goal 5:	**Increase use of evidence-based practices for members with behavioral health conditions.**
Objective 5.1a:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication—initiation phase.
Objective 5.1b:	Increase follow-up care for children prescribed ADHD medication—continuation and maintenance phase.
Objective 5.2:	Reduce use of multiple concurrent antipsychotics in children and adolescents.**
Objective 5.3:	Reduce behavioral health-related hospital readmissions within 30 days of discharge (improvement based on MCO PIP goals.)
Objective 5.4:	Increase follow-up after hospitalization for mental illness—7 days.
Objective 5.5:	Increase follow-up after hospitalization for mental illness—30 days.
Goal 6:	**Increase reporting of CMS quality measures.**
Objective 6.1:	Increase the number of CMS adult core measures reported to the Medicaid and CHIP Program (MACPro) System.
Objective 6.2:	Increase the number of CMS child core measures reported to MACPro.

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

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

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

Annual Quality Strategy Evaluation

To continually track the progress of achieving the goals and objectives outlined in the Quality Strategy, the HSAG developed the Quality Strategy Tracking Table as shown in Appendix B. The Quality Strategy Tracking Table lists each of the six goals and the objectives used to measure achievement of the goals. SFY 2014–2015 marked the baseline year of measurement for the 2016–2017 Quality Strategy goals and objectives and also establishes the QISMC goal for each of the objectives.

Table 2-6 shows the MCOs' achievement of goals and objectives in SFY 2015–2016. For additional detail, please see Appendix B of this report.

Table 2-6—2015–2016 Quality Strategy Goals and Objectives Summary of Achievement by MCO*				
Metric	**Amerigroup Medicaid**	**Amerigroup Check Up**	**HPN Medicaid**	**HPN Check Up**
Number of Comparable Rates (Year 1 to Year 2)	32	20	32	20
Number of Rates That Improved	20/32 (63%)	13/20 (65%)	21/32 (66%)	13/20 (65%)
Number of Rates That Stayed the Same	3/32 (9%)	3/20 (15%)	3/32 (9%)	3/20 (15%)
Number of Rates That Achieved QISMC Goal	16/32 (50%)	12/20 (60%)	14/32 (44%)	13/20 (65%)
Number of Rates That Declined	9/32 (28%)	4/20 (20%)	8/32 (25%)	4/20 (20%)
* Note: This table denotes changes in rates from SFY 2014–2015 to SFY 2015–2016 only and does not indicate that changes are statistically significant.				

The DHCFP modifies the performance targets for each of the objectives every two years, thereby raising the performance bar for the MCOs. HSAG will update the tracking table annually and produce the results in each year's annual EQR technical report.

Quality Initiatives and Emerging Practices

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

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

MCO-Specific Quality Initiatives

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

Health Plan of Nevada (HPN)

Following are some of the strategic quality initiatives **HPN** highlighted as priorities for calendar year 2016:

- **Implemented Now Clinic**, which is a telemedicine service where recipients may see a provider face-to-face through a mobile device.
- **Implemented Medicine on the Move**, which is a mobile medical center unit operated by Southwest Medical.
- **Provided Gaps in Care reports** to provider groups on a monthly basis to show where gaps in care exist.
- **Facilitated HEDIS nurse provider visit** with large provider groups to identify and correct inconsistencies in medical record documentation and increase opportunities for compliance.
- **Issued Citibank cards** to incentivize children to receive well-care visits and seek medical attention at the pediatrician's office.

- **Distributed provider resource sheets** that included the timeline, documentation elements, and tasks that would be considered a missed opportunity for pediatric and adult HEDIS measures so that providers have a better opportunity of ensuring the documentation is correct to receive full credit for the visit.
- **Issued Network Core Reports** to providers to help them identify the member-specific outcomes and whether preventive screenings had occurred for empaneled members.
- **Conducted Follow-up calls and visits to postpartum women** to discuss the importance of postpartum and wellness visits and selecting a pediatrician.
- **Implemented Value-based contracting** to encourage provider engagement through financial incentives and also help increase member engagement.
- **Implemented a Diaper Reward Program** for women who complete postpartum visits.
- **Assigned health care analyst** to analyze data, identify barriers, and assist in implementing solutions to overcome barriers.
- **Access Center/Telephone Advice Nurse (TAN)** is a 24-hour per day clinical access center that continues transitions of care after traditional business hours, weekends, and holidays so the member gets the best possible care and services at all times.
- **Care For Me Program (CFMP)** provides high-touch case management services and care coordination with a single point of contact for hospital discharges and outpatient members in all clinics. The case manager works in collaboration with members, providers and key stakeholders in coordinating healthcare services and referrals.
- **Willing Hands Program** is an 11-bed facility designed to support homeless members' post-discharge care. The program provides home health, a social worker, case manager, and other stakeholders needed to meet the members' needs.

Amerigroup

Following are some of the strategic quality initiatives **Amerigroup** highlighted as priorities for calendar year 2016:

- **Expand the population management programs**, such as the Innovative Healthcare Delivery program, Behavioral Health WellCare Program, and Primary Care Insight.
- **Expand use of data to guide interventions** and evaluate the effectiveness of those interventions.
- **Increase use of technology**, such as electronic data exchange (i2i), Constant Contact® emails to members, and social networking such as Facebook and Twitter.
- **Continue collaboration on quality** across all departments
- **Continue My Advocate Program** used to provide text and verbal messaging as vehicles for proactive and culturally appropriate communication and coaching to pregnant women during their pregnancies.
- **Provide well-child/EPSDT screenings** during health fairs.
- **Facilitate medical director 1:1 meetings with physicians** to talk about missed opportunities and ways to increase performance measure rates.
- **Continue member and provider incentive programs**.

- **Continue Member Meet and Greet** at CVS pharmacies in addition to the meetings held at locations with the top 10 ZIP codes as well as with the highest missed opportunities for health screenings and preventive care.
- **Continue Transition Care Program**, which was implemented as part of a population management program to reduce emergency department use and hospital readmissions within 30 days. For approximately 30 days after a member is discharged from the hospital, the team of nonclinical coordinators serves as surrogate family to individuals who were hospitalized and assists the members with obtaining medications, setting appointments for follow-up care, coordinating transportation, and coordinating housing to promote stabilization after discharge from the hospital.

Collaborative Quality Initiatives—DHCFP and MCOs

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

Improving Access to Care

In response to the results that were presented from the FY 2014–2015 Network Capacity Analysis, The MCOs developed several strategies to remediate the concerns noted in the report. Both MCOs supported the use of outreach mobile units to provide comprehensive exams in the communities they serve. Additionally, both MCOs have increased telemedicine services for urgent and primary care. The MCOs also have staffed nurse community health workers, who provide health services and work with beneficiaries who are homeless. Each health plan is increasing its provider outreach by conducting more on-site visits and providing one-on-one education to providers. Other areas of focus include assisting with non-emergency transportation service arrangements, daycare outreach solutions, and outreach to specialists in Nevada.

Nationwide CAHPS Survey

In the summer of 2014, the DHCFP began working with its subcontractor and CMS in support of the nationwide survey of access to care and experiences of care among adult Medicaid enrollees. The survey was conducted in the fall of 2014. As of the date of this report, CMS has not released the results of the survey. Once the results are released, the DHCFP will use the results from the CMS nationwide survey to determine the types of quality improvement activities that should be incorporated into its next Quality Strategy revision to improve adult Medicaid members' experiences with health care.

MCO Annual Quality Improvement Evaluation

The MCOs are required to submit an annual evaluation of the quality improvement program and activities employed by the MCO for the previous year. The MCOs' annual evaluations include

trends and statistical information that describe and depict the performance for each quality activity and associated indicators developed by the MCO. Annual evaluations also include an analysis and evaluation of clinical and related service areas requiring improvement for each of the quality measures that pertain to the population. The DHCFP requires the MCOs to provide an evaluation of each of the Nevada Medicaid and Nevada Check Up quality measures, which are detailed in the DHCFP Quality Strategy. As part of this effort, the MCOs are required to stratify performance measure rates by race and ethnicity. After stratifying the data, the MCOs are required to identify any health care disparities among the groups and develop a plan targeting interventions to reduce and/or eliminate disparities for members and increase performance measure rates overall. On an annual basis, both MCOs present performance measure data, which is stratified by race and ethnicity for a select set of HEDIS measures. At the end of the second calendar quarter of 2016, the MCOs submitted the required documents (quality description, annual quality work plan, and annual evaluation) to DHCFP for review and approval. DHCFP approved the documents submitted by both MCOs. The MCOs also presented SFY 2015–2016 data during the July 2016 quarterly MCO meeting for the new HEDIS measures adopted by DHCFP in the fall of 2015.

Disparities in Health Care

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

The MCOs, in cooperation with the DHCFP, are required to develop and implement cultural CCPs that encourage delivery of services in a culturally competent way to all recipients, including those with limited English proficiency and diverse cultural and ethnic backgrounds. The MCOs are also required to ensure that appropriate foreign language versions of all member materials are developed and available to members, and to provide interpreter services for members whose primary language is not English. The DHCFP reviews and approves all member materials as part of a readiness review for all new MCOs entering the Nevada Medicaid managed care program. During SFY 2015–2016 both MCOs provided evidence that each met the cultural competency objectives identified in the DHCFP Quality Strategy and developed a plan for the following year's cultural competency activities.

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

Nevada Medicaid Collaborative Quality Initiatives

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

State Innovations Model

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

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

Balancing Incentive Payments Program

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

Money Follows the Person (MFP)

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

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

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

Nevada has already accomplished the following:

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

Medicaid Incentives for Prevention of Chronic Diseases (MIPCD)

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

1. Nesting incentives in the diabetes disease management programs conducted by Nevada's Medicaid MCOs. MCO enrollees with diabetes will be incentivized to receive evidence-based preventive health services known to be effective in improved management of diabetes and covered under the Nevada Medicaid state plan.
2. Linking approximately 600 adults diagnosed with diabetes and 540 adults at risk of developing type 2 diabetes enrolled in fee for service Medicaid with evidence-based programs through the

Lied Clinic Outpatient Facility at University Medical Center of Southern Nevada, the Southern Nevada Health District, or the YMCA of Southern Nevada.

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

The MIPCD participants have gone through the programs, achieved goals, earned points, and redeemed incentives. The Grants Management Unit at DHCFP is in the process of drafting closeout procedures for the grant and summarizing the results of the grant activities.

Health Information Technology

The Nevada Medicaid Incentive Payment Program for electronic health records (EHRs) is an incentive program for Nevada health care providers to receive payments for becoming meaningful users of certified EHR technology. The goal of the Nevada Medicaid Incentive Payment Program is to give providers access to enhanced Medicaid funds to offset the cost of implementing certified EHR technology. This funding is designed to promote the adoption of certified EHR technology and ultimately provide improved quality of care for Medicaid beneficiaries and increased cost efficiencies within the Medicaid enterprise. As of August 5, 2016, 607 providers and 31 hospitals have received more than $49,886,938 in payments from the Nevada Medicaid EHR Incentive Payment Program.

3. Description of EQR Activities

Mandatory Activities

In accordance with 42 CFR §438.356, the DHCFP contracted with HSAG as the EQRO for the State of Nevada to conduct the mandatory EQR activities as set forth in 42 CFR §438.358. In SFY 2015–2016, HSAG conducted the following mandatory EQR activities for the Nevada Medicaid and Nevada Check Up programs:

- **Compliance monitoring evaluation:** SFY 2014–2015 initiated a new three-year review cycle of Internal Quality Assurance Program review of compliance. SFY 2015–2016 was the second year of the cycle. In SFY 2015–2016, HSAG reviewed each of the corrective action plans that resulted from the compliance review activities and assisted the DHCFP staff with clarifying program requirements for the MCOs.
- **Validation of performance measures:** HSAG validated each of the performance measures identified by the State to evaluate their accuracy as reported by, or on behalf of, the MCOs.
- **Validation of PIPs:** HSAG validated the MCOs' PIPs to determine if they were designed to achieve, through ongoing measurement and intervention, significant and sustained improvement in clinical and nonclinical care. HSAG also evaluated if the PIPs would have a favorable effect on health outcomes and enrollee satisfaction.

Optional Activities

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

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

- Participating in quarterly meetings with the HCGP vendor to ensure that quality-related activities remain on track. HSAG also developed a set of quality modules that the HCGP vendor must use to guide its quality-related presentations during the quarterly meetings.
- Tracking the NCCW 1115 Demonstration Evaluation Design Plan.
- Reviewing the corrective action plans that resulted from the HCGP compliance review, which is presented in Section 8.
- Performing source code review of the programming code used to calculate pay for performance (P4P) measures used for the NCCW program, which will be calculated by the DHCFP's actuary.
- Performing a performance measure validation audit of non-P4P measures used to monitor the HCGP's progress in achieving the goals and objectives of the NCCW demonstration waiver, which is presented in Section 9.

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

4. Internal Quality Assurance Program (IQAP) Review—SFY 2015–2016

Overview

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

Follow-Up on Corrective Actions from SFY 2014–2015 IQAP Review

SFY 2015–2016 was the second year of the three-year cycle of reviews for Nevada. HSAG reviewed each of the corrective action plans that resulted from the compliance review activities and assisted the DHCFP staff with clarifying program requirements for the MCOs. DHCFP approved the corrective action plans submitted by the MCOs. No further action was required by the MCOs or HSAG.

5. Validation of Performance Measures—NCQA HEDIS Compliance Audit—SFY 2015–2016

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

For HEDIS 2016, DHCFP required the MCOs to report rates for Medicaid and Nevada Check Up. The MCOs also were required to report seven new measures for HEDIS 2016, one of which replaced a measure retired by NCQA.

The following section provides summary information from the HEDIS compliance audits conducted by HSAG for **HPN** and **Amerigroup**. Further details regarding the results from the 2016 HEDIS compliance audits may be found in the July 2016 HEDIS Compliance Audit Final Report of Findings.

Of note, DHCFP expanded Medicaid coverage in January 2014 to persons with incomes up to 138 percent of the federal poverty level, which was allowed under the Affordable Care Act. The majority of newly eligible persons resided in the managed care catchment areas; therefore, both MCOs experienced significant increases in enrollment since January 2014. To obtain an accurate representation of the HEDIS rates for the Medicaid expansion population and its impact on HEDIS rates, the DHCFP asked the MCOs to report 2015 Medicaid HEDIS rates for the following populations: With Medicaid Expansion Population Included, and Without Medicaid Expansion Population Included. Performance measure rates for both populations were presented in the SFY 2014–2015 technical report to establish a baseline from which future comparisons could be made for the With Medicaid Expansion Population Included group and so that rates could be compared to prior years' performance (i.e., representative of the Without Medicaid Expansion Population Included group). The results presented in this section include the rates for the With Medicaid Expansion Population Included group; therefore, only HEDIS Medicaid 2015 and HEDIS Medicaid 2016 results are presented and discussed, and prior years' rates for the Without Medicaid Expansion Population Included group are not included.

Objectives

The objectives of the HEDIS compliance audit were to assess the performance of the MCOs with respect to the *HEDIS 2016 Technical Specifications* and to review their performance on the HEDIS measures. The audits incorporated two main components:

- A detailed assessment of the MCO's information system (IS) capabilities for collecting, analyzing, and reporting HEDIS information.
- A review of the specific reporting methods used for HEDIS measures, including databases and files used to store HEDIS information; medical record abstraction tools and abstraction procedures used; certified measure status; and any manual processes employed in HEDIS 2016 data production and reporting. The audit included any data collection and reporting processes supplied by vendors, contractors, or third parties, as well as the MCO's oversight of these outsourced functions.

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

For HEDIS 2016, the MCOs were required to report 19 measures with a total of 50 measure indicator rates for the Medicaid population. These measures included 16 performance measures and three utilization or diversity of membership measures (*Mental Health Utilization—Total*, *Ambulatory Care—Total*, and *Weeks of Pregnancy at Time of Enrollment*). For the Nevada Check Up population, the MCOs were required to report 13 performance measures and two utilization measures (*Mental Health Utilization—Total* and *Ambulatory Care—Total*), totaling 35 measure indicator rates. Table 5-1 lists the required HEDIS 2016 measures for these two populations.

Table 5-1—Required HEDIS 2016 Measures

Performance Measure	Medicaid Population	Nevada Check Up Population
Access to Care		
Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months, 25 Months–6 Years, 7–11 Years, and *12–19 Years*	√	√
Annual Dental Visit—Total	√	√
Children's Preventive Care		
Adolescent Well-Care Visits	√	√
Childhood Immunization Status—Combinations 2–10	√	√
Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap/Td)	√	√
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	√	√
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	√	√
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total, Counseling for Nutrition—Total, and *Counseling for Physical Activity—Total*	√	√
Human Papillomavirus Vaccine for Female Adolescents	√	√
Maternity Care		
Prenatal and Postpartum Care—Timeliness of Prenatal Care and *Postpartum Care*	√	
Frequency of Ongoing Prenatal Care—<21 Percent of Expected Visits and *≥81 Percent of Expected Visits*	√	

Table 5-1—Required HEDIS 2016 Measures		
Performance Measure	**Medicaid Population**	**Nevada Check Up Population**
Care for Chronic Conditions		
Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing, HbA1c Poor Control (>9.0%), Blood Pressure Control (<140/90 mm Hg), Eye Exam (Retinal) Performed, Medical Attention for Nephropathy, and HbA1c Control (<8.0%)	√	
Medication Management for People With Asthma—Medication Compliance 50%—Total and *Medication Compliance 75%—Total*	√	√
Behavioral Health		
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up and *30-Day Follow-Up*	√	√
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase and *Continuation and Maintenance Phase*	√	√
Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total	√	√
Utilization and Diversity of Membership		
Mental Health Utilization—Total—Any Service, Inpatient, Intensive Outpatient or Partial Hospitalization, and *Outpatient or Emergency Department*	√	√
Ambulatory Care—Emergency Department (ED) Visits—Total and Outpatient Visits—Total	√	√
Weeks of Pregnancy at Time of Enrollment—Prior to 0 Weeks, 1–12 Weeks, 13–27 Weeks, 28 or More Weeks of Pregnancy, and *Unknown*	√	

Plan-Specific Findings—Amerigroup

A detailed review of the 2016 performance reports submitted by **Amerigroup** determined that the reports were prepared according to the *HEDIS 2016 Technical Specifications* for all of the audited measures. Audits of IS capabilities for accurate HEDIS reporting found that **Amerigroup** was compliant with the standards assessed, as follows:

- **Amerigroup** was fully compliant with IS 1.0. All claims were received Monday through Friday. **Amerigroup**'s document management group received paper claims, entered them into the system, and sent them to Smart Data Solutions for scanning or keying. Electronic claims were received from four different clearinghouses daily. There were a number of reconciliation processes to monitor and track claims loaded into EDINET, and there were front-end business edits that were performed and that determined claim acceptance or claim rejection. Rejected claims went through a secondary review prior to a final rejection. Once all claims were accepted, they were loaded into Facets for adjudication. Facets captured all medical codes required for HEDIS reporting. There were no nonstandard codes or forms accepted during the measurement year. Implementation of ICD-10 was successful without any identified issues. There were multiple tests performed with Facets to ensure a smooth implementation. The system has the capacity to distinguish ICD-9 and ICD-10 codes, and after October 1, 2015, ICD-9 codes were no longer accepted. An on-site demonstration was performed and the

necessary edits were identified to ensure accuracy. Accuracy results for the measurement year exceeded **Amerigroup**'s established standards and there was no backlog of processing claims during the measurement year. All providers were fee-for-service so data completeness was not a concern. **Amerigroup** received vision data from EyeQuest, pharmacy data from CVS Caremark, and dental data from SCION. Vendor oversight was performed to ensure quality performance and there were no issues during the measurement year. Data were tracked and trended to ensure completeness.

- **Amerigroup** was fully compliant with IS 2.0. Daily enrollment files were received Monday through Friday via secure file transfer protocol from the State. **Amerigroup**'s internal operations staff downloaded the data and validated the record counts to ensure the data received were successfully loaded. A report was generated to ensure validation and a log was used to create reconciliation files. Load reports were generated to ensure complete data loads into Facets. Any identified errors were corrected. Full files were received from the State and reconciliation procedures were performed. Facets contained all of the necessary data elements relevant to enrollment data required for HEDIS reporting. Effective and termination dates were captured and there was no limit to the number of enrollment segments. **Amerigroup** might consider the use of the notification date to determine continuous enrollment. There were no backlogs in processing enrollment data during the measurement year.
- **Amerigroup** was fully compliant with IS 3.0. Provider applications were first received by the local office and reviewed against national credentialing standards. Initial applications were loaded into the MACESS system and then the primary source verification, including board certification, was performed at a corporate level. Data were then entered into Cactus and there was an interface between Cactus and Facets, which loaded the practitioner data into Facets to avoid additional data entry. Any specialty changes were sent to the credentialing department for verification. Systems were reconciled routinely to ensure accuracy. **Amerigroup** used an internal unique common practitioner identification number as well as the National Provider Identifier to identify practitioners. The number of primary care physicians remained stable from the previous measurement year.
- **Amerigroup** was fully compliant with IS standard 4.0. HSAG reviewed **Amerigroup**'s IS 4 Roadmap pertaining to the policies and procedures for IS standards 4.1, 4.2, 4.3, 4.4, and 4.5. The review found these policies and procedures to be consistent with NCQA's current HEDIS Compliance Audit Standard requirements. **Amerigroup** sampled according to the HEDIS sampling guidelines and assigned an appropriate measure-specific oversample. Provider chase logic was reviewed and determined appropriate across all hybrid measures. For HEDIS 2016, **Amerigroup** contracted with a medical record review (MRR) vendor, Health Data Vision, Inc. (HDVI), to procure and abstract medical records. HSAG participated in a live vendor demonstration of the HDVI tools and instructions. All fields, edits, and drop-down boxes were reviewed for accuracy against NCQA's current *HEDIS Volume 2, Technical Specifications for Health Plans*. HSAG reviewed HDVI's training abstraction manual and found no concerns. **Amerigroup** conducted appropriate oversight of its vendor through quality assurance of reviews, including over-reads of all abstractions resulting in a numerator positive or exclusions, and a random sample of numerator negatives. For HEDIS 2016, **Amerigroup** changed its MRR vendor from Inovalon, Inc. to HDVI with different tools, staff, and processes. Since the MRR vendor was responsible for all procurement and abstraction, a full convenience sample was required. HSAG completed the convenience sample review and did not find any issues.
- **Amerigroup** passed the MRRV process for the following measure groups:

  - Group A: *Biometrics (BMI, BP) & Maternity—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile*
  - Group B: *Anticipatory Guidance & Counseling—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition*
  - Group C: *Laboratory—Comprehensive Diabetes Care—HbA1c Control (<8.0%)*
  - Group D: *Immunization & Other Screenings—Childhood Immunization Status—Combination 3*
  - Group D: *Immunization & Other Screenings—Childhood Immunization Status—Combination 4*
  - Group D: *Immunization & Other Screenings—Childhood Immunization Status—Combination 5*
  - Group F: Exclusions
- **Amerigroup** was fully compliant with IS 5.0. **Amerigroup** used several sources of standard supplemental data for HEDIS 2016 reporting, including LabCorp; Quest; Clinical Pathology Laboratories (CPL); and Early and Periodic Screening, Diagnosis and Treatment data. Roadmap Section 5 for each supplemental data source was updated prior to finalizing rates. All data sources were tracked and trended throughout the year to ensure data completeness. Consideration should be extended for future reporting years to determine relevant supplemental data sources for measure impact while completing the roadmap. There were no nonstandard data sources used for HEDIS 2016.
- IS 6.0 was not applicable to the scope of the audit, since **Amerigroup** was not required to report the call center measures for Nevada Medicaid and Nevada Check Up.
- **Amerigroup** was fully compliant with IS 7.0. **Amerigroup** continued to use Inovolan's software, Quality Spectrum Insight (QSI), for HEDIS 2016 certified measure production. Monthly, six programmers extracted data from the data warehouse and transferred it to QSI in the required format. Benchmarking data were compiled to check rates for reasonability and ensure data integrity. A uniform format was created for each type of data to avoid data issues during the compilation process and quality controls were in place after file creation to ensure accuracy. The vision, dental, pharmacy, and laboratory results were stored in independent tables within the data warehouse. Comprehensive trending logs were used to monitor all data types and sources. Duplicated claims were identified and no data were excluded. On-site primary source verification was conducted for the CDC, W15, and CAP measures and no issues were identified. On-site queries were conducted and all on-site documentation satisfied the required queries.

Medicaid Results

The Medicaid HEDIS 2015 rates and HEDIS 2016 rates for **Amerigroup** are presented in Table 5-2, along with 2015–2016 rate comparisons. For the measures with lower rates suggesting better performance (i.e., *Frequency of Ongoing Prenatal Care—<21 Percent of Expected Visits; Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*; *Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total*; and *Ambulatory Care—Total—Emergency Department [ED] Visits—Total*), a decrease in the rate from 2015 to 2016 represents improved performance and an increase in the rate from 2015 to 2016 represents a decline in performance.

Since measures in the Utilization and Diversity of Membership measure domain are designed to capture the frequency of services provided by the MCOs and characteristics of the population served by the MCO, higher or lower rates in this domain do not necessarily indicate better or worse performance. These rates are provided for information purposes only.

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

HEDIS Measure	HEDIS 2015 Rate	HEDIS 2016 Rate	2015–2016 Rate Comparison
Access to Care			
Children and Adolescents' Access to Primary Care Practitioners			
Ages 12–24 Months	91.14%	94.15%	3.01
Ages 25 Months–6 Years	81.30%	83.55%	2.25
Ages 7–11 Years	85.60%	87.12%	1.52
Ages 12–19 Years	81.53%	83.76%	2.23
Annual Dental Visit			
Total	45.62%	53.21%	7.59
Children's Preventive Care			
Adolescent Well-Care Visits			
Adolescent Well-Care Visits	42.13%	38.43%	-3.70
Childhood Immunization Status			
Combination 2	66.20%	73.15%	6.95
Combination 3	60.88%	66.67%	5.79
Combination 4	58.80%	65.28%	6.48
Combination 5	50.23%	57.18%	6.95
Combination 6	33.33%	32.41%	-0.92
Combination 7	48.38%	56.48%	8.10
Combination 8	33.10%	32.41%	-0.69
Combination 9	28.24%	29.63%	1.39
Combination 10	28.01%	29.63%	1.62
Immunizations for Adolescents			
Combination 1 (Meningococcal, Tdap/Td)	—	71.93%	NC
Well-Child Visits in the First 15 Months of Life			
Six or More Well-Child Visits	50.58%	52.78%	2.20
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life			
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	65.66%	66.33%	0.67
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Percentile—Total	—	64.12%	NC
Counseling for Nutrition—Total	—	54.40%	NC
Counseling for Physical Activity—Total[1]	—	43.75%	NC

Table 5-2—Medicaid HEDIS Performance Measures Results for Amerigroup			
HEDIS Measure	**HEDIS 2015 Rate**	**HEDIS 2016 Rate**	**2015–2016 Rate Comparison**
Human Papillomavirus Vaccine for Female Adolescents			
Human Papillomavirus Vaccine for Female Adolescents	—	24.59%	NC
Maternity Care			
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	69.77%	75.41%	5.64
Postpartum Care	46.74%	53.16%	6.42
Frequency of Ongoing Prenatal Care			
*<21 Percent of Expected Visits**	15.81%	17.80%	1.99
≥81 Percent of Expected Visits	52.33%	56.44%	4.11
Care for Chronic Conditions			
Comprehensive Diabetes Care[1]			
Hemoglobin A1c (HbA1c) Testing	81.90%	79.63%	-2.27
*HbA1c Poor Control (>9.0%)**	46.40%	46.76%	0.36
Blood Pressure Control (<140/90 mm Hg)	62.18%	55.32%	-6.86
Eye Exam (Retinal) Performed	55.45%	55.09%	-0.36
Medical Attention for Nephropathy	75.17%	89.58%	14.41
HbA1c Control (<8.0%)	43.16%	46.30%	3.14
Medication Management for People With Asthma			
Medication Compliance 50%—Total	—	50.22%	NC
Medication Compliance 75%—Total	—	26.84%	NC
Behavioral Health			
Follow-Up After Hospitalization for Mental Illness			
7-Day Follow-Up	53.02%	52.99%	-0.03
30-Day Follow-Up	63.14%	64.55%	1.41
Follow-Up Care for Children Prescribed ADHD Medication			
Initiation Phase	—	36.68%	NC
Continuation and Maintenance Phase	—	40.91%	NC
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*			
Total	—	0.00%	NC
Utilization and Diversity of Membership			
Mental Health Utilization—Total			
Any Service—Total	—	7.21%	NC
Inpatient—Total	—	1.18%	NC
Intensive Outpatient or Partial Hospitalization—Total	—	0.28%	NC
Outpatient or Emergency Department—Total	—	7.01%	NC
Ambulatory Care—Total			
*Emergency Department (ED) Visits—Total**	—	55.08	NC
Outpatient Visits—Total	—	294.01	NC

Table 5-2—Medicaid HEDIS Performance Measures Results for Amerigroup			
HEDIS Measure	**HEDIS 2015 Rate**	**HEDIS 2016 Rate**	**2015–2016 Rate Comparison**
Weeks of Pregnancy at Time of Enrollment			
Prior to 0 Weeks	—	26.39%	NC
1–12 Weeks	—	12.50%	NC
13–27 Weeks	—	41.44%	NC
28 or More Weeks of Pregnancy	—	19.68%	NC
Unknown	—	0.00%	NC

[1] Due to changes in the technical specifications for this measure, caution should be exercised when comparing rates between 2015 and 2016.

* A lower rate indicates better performances for this measure.

— Indicates the measure was not presented in the previous year's technical report, and therefore a HEDIS 2015 measure rate is not presented in this year's report.

NC indicates the 2015–2016 rate comparison could not be calculated because data were not available for both years or because an increase or decrease in the rate did not necessarily indicate better or worse performance.

NA indicates the denominator for the measure was too small to report (less than 30).

A majority of **Amerigroup**'s measures with rates presented for HEDIS 2015 and HEDIS 2016 for the Medicaid population were stable (i.e., decreased or increased by fewer than 5 percentage points) across all measure domains and several measure rates demonstrated performance improvement. Specifically, **Amerigroup**'s *Annual Dental Visit—Total* measure rate in the Access to Care measure domain increased by more than 7 percentage points from HEDIS 2015 to HEDIS 2016. With regard to Children's Preventive Care, five of the nine *Childhood Immunization Status* measure indicator rates demonstrated improvement, with increases of more than 5 percentage points from HEDIS 2015 to HEDIS 2016. In the Maternity Care measure domain, **Amerigroup**'s *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* rates showed improvement by more than 5 percentage points. **Amerigroup**'s *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure rate increased by more than 14 percentage points from HEDIS 2015 to HEDIS 2016. However, due to changes in HEDIS technical specifications, caution should be exercised when comparing HEDIS 2015 rates to HEDIS 2016 rates for the *Comprehensive Diabetes Care* measure indicators.

Conversely, the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* rate decreased by more than 6 percentage points, indicating performance decline. As mentioned above, caution should be exercised when comparing HEDIS 2015 rates to HEDIS 2016 rates for the *Comprehensive Diabetes Care* measure indicators. Of note, within the Behavioral Health measure domain, the rate for *Use of Multiple Concurrent Antipsychotics in Children and Adolescents* indicated overall positive performance, reporting zero members ages 1–17 who were on two or more concurrent antipsychotic medications.

Nevada Check Up Results

The Nevada Check Up HEDIS 2015 rates and HEDIS 2016 rates for **Amerigroup** are presented in Table 5-3, along with 2015–2016 rate comparisons. For the measures with lower rates suggesting better performance (i.e., *Use of Multiple Concurrent Antipsychotics in Children and Adolescents—*

Total and *Ambulatory Care—Total—Emergency Department [ED] Visits—Total*), a decrease in the rate from 2015 to 2016 represents improved performance and an increase in the rate from 2015 to 2016 represents a decline in performance. Since measures in the Utilization and Diversity of Membership measure domain are designed to capture the frequency of services provided by the MCOs and characteristics of the population served by the MCO, higher or lower rates in this domain do not necessarily indicate better or worse performance. These rates are provided for information purposes only.

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

HEDIS Measure	HEDIS 2015 Rate	HEDIS 2016 Rate	2015–2016 Rate Comparison
Access to Care			
Children and Adolescents' Access to Primary Care Practitioners			
Ages 12–24 Months	95.83%	98.73%	2.90
Ages 25 Months–6 Years	90.48%	89.53%	-0.95
Ages 7–11 Years	92.62%	92.91%	0.29
Ages 12–19 Years	92.18%	88.95%	-3.23
Annual Dental Visit			
Total	64.48%	67.05%	2.57
Children's Preventive Care			
Adolescent Well-Care Visits			
Adolescent Well-Care Visits	56.48%	56.34%	-0.14
Childhood Immunization Status			
Combination 2	74.55%	85.90%	11.35
Combination 3	73.64%	78.21%	4.57
Combination 4	73.64%	77.56%	3.92
Combination 5	54.55%	68.59%	14.04
Combination 6	45.45%	46.79%	1.34
Combination 7	54.55%	67.95%	13.40
Combination 8	45.45%	46.79%	1.34
Combination 9	32.73%	42.95%	10.22
Combination 10	32.73%	42.95%	10.22
Immunizations for Adolescents			
Combination 1 (Meningococcal, Tdap/Td)	—	81.61%	NC
Well-Child Visits in the First 15 Months of Life			
Six or More Well-Child Visits	70.37%	78.05%	7.68
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life			
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	71.30%	70.28%	-1.02
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Percentile—Total	—	62.04%	NC
Counseling for Nutrition—Total	—	55.56%	NC
Counseling for Physical Activity—Total[1]	—	47.69%	NC

Table 5-3—Nevada Check Up HEDIS Performance Measures Results for Amerigroup			
HEDIS Measure	**HEDIS 2015 Rate**	**HEDIS 2016 Rate**	**2015–2016 Rate Comparison**
Human Papillomavirus Vaccine for Female Adolescents			
Human Papillomavirus Vaccine for Female Adolescents	—	34.11%	NC
Care for Chronic Conditions			
Medication Management for People With Asthma			
Medication Compliance 50%—Total	—	47.76%	NC
Medication Compliance 75%—Total	—	26.87%	NC
Behavioral Health			
Follow-Up After Hospitalization for Mental Illness			
7-Day Follow-Up	NA	84.85%	NC
30-Day Follow-Up	NA	93.94%	NC
Follow-Up Care for Children Prescribed ADHD Medication			
Initiation Phase	—	NA	NC
Continuation and Maintenance Phase	—	NA	NC
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*			
Total	—	NA	NC
Utilization and Diversity of Membership			
Mental Health Utilization—Total			
Any Service—Total	—	5.76%	NC
Inpatient—Total	—	0.46%	NC
Intensive Outpatient or Partial Hospitalization—Total	—	0.32%	NC
Outpatient or Emergency Department—Total	—	5.69%	NC
Ambulatory Care—Total			
*Emergency Department (ED) Visits—Total**	—	26.14	NC
Outpatient Visits—Total	—	263.50	NC

[1] Due to changes in the technical specifications for this measure, caution should be exercised when comparing rates between 2015 and 2016.

* A lower rate indicates better performances for this measure.

— Indicates the measure was not presented in previous year's technical report, and therefore a HEDIS 2015 measure rate is not presented in this year's report.

NC indicates the 2015–2016 rate comparison could not be calculated because data were not available for both years or because an increase or decrease in the rate did not necessarily indicate better or worse performance.

NA indicates the denominator for the measure was too small to report (less than 30).

Analogous to the Medicaid population's rates, **Amerigroup**'s rates for the Nevada Check Up population also remained stable from HEDIS 2015 to HEDIS 2016, with several Children's Preventive Care rates indicating performance improvement. Five of the nine *Childhood Immunization Status* measure indicator rates increased by more than 10 percentage points from HEDIS 2015 to HEDIS 2016, demonstrating improved reporting of immunizations for children. Further, **Amerigroup**'s rate for W*ell-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* increased from HEDIS 2015 to HEDIS 2016 by more than 7 percentage points.

None of the rates reported for the Nevada Check Up population demonstrated a decline in performance of greater than 5 percentage points from HEDIS 2015 to HEDIS 2016.

Summary of Amerigroup Emerging Improvement

The following Medicaid performance measure indicators were identified as emerging improvement for **Amerigroup** based on rate improvements greater than 5 percentage points from HEDIS 2015 to HEDIS 2016:

- *Annual Dental Visit—Total*
- *Childhood Immunization Status—Combinations 2, 3, 4, 5, 7*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*[5-1]

The following Nevada Check Up performance measure indicators were identified as emerging improvement for **Amerigroup** based on rate improvements greater than 5 percentage points from HEDIS 2015 to HEDIS 2016:

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

Summary of Amerigroup Opportunities for Improvement

The following Medicaid performance measure indicator was identified as an opportunity for improvement for **Amerigroup** based on a decline in performance of greater than 5 percentage points from HEDIS 2015 to HEDIS 2016.

- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*[5-2]

None of the Nevada Check Up performance measure indicators for **Amerigroup** had a decline in performance by greater than 5 percentage points from HEDIS 2015 to HEDIS 2016.

[5-1] Due to changes in the technical specifications for this measure, caution should be exercised when comparing rates between 2015 and 2016.
[5-2] Ibid.

Plan-Specific Findings—HPN

A detailed review of the 2016 performance reports submitted by **HPN** determined that the reports were prepared according to the *HEDIS 2016 Technical Specifications* for all of the audited measures, which are listed in Appendix A. Audits of IS capabilities for accurate HEDIS reporting found that **HPN** was compliant with the standards assessed, as follows:

- **HPN** was fully compliant with IS Standard 1.0 for medical services data and continued to use the Facets system for claims processing. Data entry processes were effective and efficient, and they assured timely, accurate entry into the system. Only standard codes were accepted, and approximately 75 percent of the claims and encounters were auto-adjudicated. The Facets system captured the rendering provider, even for claims submitted from federally qualified health centers (FQHCs), and enforced ICD-9 coding specificity, as required. As of October 1, 2015, **HPN** no longer accepted ICD-9 codes and transitioned to ICD-10 codes. This transition was well-planned and appeared to be seamless. There was no noticeable reduction in claims or diagnoses codes submitted. Most claims received by **HPN** were electronic claims (electronic data interchange [EDI]). **HPN** had appropriate procedures to receive and monitor the EDI submissions. The **HPN** staff monitored and trended volume on a routine basis to ensure data completeness. In addition to monitoring data completeness, **HPN** had appropriate validation processes to ensure accurate claims and encounter data submission. Pharmacy data were obtained from Optum Rx, while lab data came from Quest. **HPN** also had appropriate processes in place to oversee these vendors, which included review of submitted data and monitoring contract standards. There were no issues identified with the medical services data.
- **HPN** was fully compliant with IS Standard 2.0 for enrollment data. Membership data were received by **HPN** from the State's vendor and were fully reconciled each month. **HPN** had processes in place to assure timely and accurate loading of these data. **HPN** tracked members using the system-issued number. This allowed linkage of data if a member lost and regained eligibility. **HPN** also had the ability to link members who switched product lines. For newborns, the State initially provided a file with the mother and an unborn baby identified for enrollment. Once the baby's birth was reported, the new enrollment file was updated to include the baby's new ID. There appeared to be no issues with linking the appropriate claims back to the newborn's record using the system ID. The State encountered a technical issue with the enrollment files that caused some members to drop off of the enrollment files in 2015. As a result, **HPN** manually corrected approximately 800 to 1,000 member enrollments each month. The issue has not yet been corrected by the State. **HPN** continues to work these adjustments manually each month; therefore, there was no impact to the HEDIS eligible populations.
- **HPN** was fully compliant with IS Standard 3.0 for practitioner data. All of the provider-related data elements required for the Medicaid HEDIS measures under the scope of the audit were captured and verified within the systems. **HPN** continued to use the Cactus software for provider credentialing and to determine provider types and specialties. The credentialing data were directly entered into Facets and then verified against the source data (Cactus). There were no issues identified, and **HPN** was able to distinguish provider types and specialties as required for HEDIS reporting. Since the Board Certification measure was not included in the scope of the audit, credentialing and recredentialing were not reviewed.

- **HPN** was fully compliant with the IS standard 4.0 requirements. HSAG reviewed **HPN**'s IS 4 Roadmap pertaining to the policies and procedures for IS standards 4.1, 4.2, 4.3, 4.4, and 4.5. The roadmap review found these policies and procedures to be consistent with the NCQA *HEDIS 2016, Volume 5, HEDIS Compliance Audit: Standards, Policies and Procedures*. **HPN** sampled according to the HEDIS sampling guidelines and assigned an appropriate measure-specific oversample. Provider chase logic was reviewed and determined appropriate across all hybrid measures. **HPN**'s staff used Verisk hybrid medical record abstraction tools. HSAG participated in a live vendor demonstration of the Verisk tools and instructions. All fields, edits, and drop-down boxes were reviewed for accuracy against the NCQA *HEDIS 2016, Volume 2, Technical Specifications for Health Plans*. HSAG reviewed **HPN**'s training abstraction manual and found no concerns. **HPN** used internal staff members to conduct medical record reviews and quality assurance. Staff members were sufficiently qualified and trained in the HEDIS 2016 technical specifications and the use of Verisk's abstraction tools to accurately conduct medical record reviews. Verisk maintained appropriate quality assurance of reviews, including over-reads of all abstractions resulting in numerator positives or exclusions, and a random sample of numerator negatives.
- A convenience sample was required for the *Adolescent Well-Care Visits* measure due to errors found during the 2015 validation. A convenience sample was also required for the following State-required measures: *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, Immunizations for Adolescents,* and *Human Papillomavirus Vaccine for Female Adolescents*. HSAG completed the convenience sample review and did not find any issues.
- **HPN** passed the MRR process for the following measure groups:
  - *Group A: Biometrics (BMI, BP) & Maternity—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile*
  - *Group B: Anticipatory Guidance & Counseling—Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity*
  - *Group C: Laboratory—Comprehensive Diabetes Care—HbA1c Control (<8.0%)*
  - *Group C: Laboratory—Comprehensive Diabetes Care—Medical Attention for Nephropathy*
  - *Group C: Laboratory—Comprehensive Diabetes Care—HbA1c Testing*
  - *Group D: Immunization & Other Screenings—Childhood Immunization Status—Combination 3*
  - *Group F: Exclusions*
- **HPN** was fully compliant with IS Standard 5.0 for supplemental data. **HPN** received laboratory data from QUEST and immunization registry data from the State. Both databases were considered external, standard data. **HPN** also identified historical medical record review data as standard data. **HPN** had processes for data receipt, processing, and loading into the HEDIS vendor's software. **HPN** provided all the required supporting documentation for the standard databases. **HPN** also identified a nonstandard database, Touchworks, to use for reporting. This database contained nine members across three different measures. Proof of service was requested and validated for these supplemental data cases. All nine cases were reviewed and passed the data validation process. There were no issues identified with any of the supplemental data and all standard and nonstandard databases were approved for HEDIS 2016 reporting.

- IS 6.0 was not applicable to the scope of the audit since **HPN** was not required to report the call center measures for Nevada Medicaid and Nevada Check Up.
- **HPN** was fully compliant with IS Standard 7.0 for data integration. **HPN** used Verisk for the calculation of its HEDIS rates. The data integration process has been consistent for many years. Data were loaded from Facets and the Corporate Reporting Database (CRD) directly into Kramer, the data warehouse repository. These data were then loaded into Verisk's software. Reports were generated during each load process to ensure accurate and complete data were captured. Additional reports were generated monthly to compare data in Kramer versus data in Verisk, as well as data in Kramer versus data in Facets and CRD. This high-level reporting system helped ensure the appropriateness of the data and the accuracy of the data transfers. Overall, there were no issues identified with the data integration process. Record tracing verification was conducted on-site for 10 measures and no issues were identified. In addition, preliminary rates were reviewed on-site, showing some improvements with *Comprehensive Diabetes Care* (CDC) rates and well-child rates. Rates that appeared low did not yet have medical record data incorporated. In general, Nevada Check-Up rates were higher than the corresponding rates for Nevada Medicaid. A formal preliminary rate review was conducted following the on-site audit and rates appeared reasonable. The final rate review did not identify any issues and the patient level detail file matched the reported rates. Therefore, all of the rates were approved for reporting.

Medicaid Results

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

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

HEDIS Measure	HEDIS 2015 Rate	HEDIS 2016 Rate	2015–2016 Rate Comparison
Access to Care			
Children and Adolescents' Access to Primary Care Practitioners			
Ages 12–24 Months	91.42%	94.80%	3.38
Ages 25 Months–6 Years	79.24%	84.29%	5.05
Ages 7–11 Years	83.93%	87.36%	3.43
Ages 12–19 Years	80.80%	85.21%	4.41
Annual Dental Visit			
Total	51.12%	55.03%	3.91

Table 5-4—Medicaid HEDIS Performance Measures Results for HPN			
HEDIS Measure	**HEDIS 2015 Rate**	**HEDIS 2016 Rate**	**2015–2016 Rate Comparison**
Children's Preventive Care			
Adolescent Well-Care Visits			
Adolescent Well-Care Visits	37.47%	44.04%	6.57
Childhood Immunization Status			
Combination 2	70.80%	74.94%	4.14
Combination 3	66.18%	70.32%	4.14
Combination 4	66.18%	70.07%	3.89
Combination 5	53.04%	55.72%	2.68
Combination 6	39.42%	38.44%	-0.98
Combination 7	53.04%	55.72%	2.68
Combination 8	39.42%	38.44%	-0.98
Combination 9	32.36%	31.14%	-1.22
Combination 10	32.36%	31.14%	-1.22
Immunizations for Adolescents			
Combination 1 (Meningococcal, Tdap/Td)	—	79.81%	NC
Well-Child Visits in the First 15 Months of Life			
Six or More Well-Child Visits	51.58%	53.77%	2.19
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life			
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	60.83%	64.48%	3.65
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Percentile—Total	—	70.32%	NC
Counseling for Nutrition—Total	—	57.91%	NC
Counseling for Physical Activity—Total[1]	—	52.07%	NC
Human Papillomavirus Vaccine for Female Adolescents			
Human Papillomavirus Vaccine for Female Adolescents	—	29.68%	NC
Maternity Care			
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	77.62%	73.97%	-3.65
Postpartum Care	58.88%	57.18%	-1.70
Frequency of Ongoing Prenatal Care			
*<21 Percent of Expected Visits**	17.03%	14.60%	-2.43
≥81 Percent of Expected Visits	51.34%	52.07%	0.73
Care for Chronic Conditions			
Comprehensive Diabetes Care[1]			
Hemoglobin A1c (HbA1c) Testing	84.18%	85.64%	1.46
*HbA1c Poor Control (>9.0%)**	44.53%	45.74%	1.21
Blood Pressure Control (<140/90 mm Hg)	70.32%	60.83%	-9.49

Table 5-4—Medicaid HEDIS Performance Measures Results for HPN			
HEDIS Measure	**HEDIS 2015 Rate**	**HEDIS 2016 Rate**	**2015–2016 Rate Comparison**
Eye Exam (Retinal) Performed	55.96%	56.93%	0.97
Medical Attention for Nephropathy	82.73%	92.21%	9.48
HbA1c Control (<8.0%)	43.80%	46.47%	2.67
Medication Management for People With Asthma			
Medication Compliance 50%—Total	—	46.96%	NC
Medication Compliance 75%—Total	—	24.14%	NC
Behavioral Health			
Follow-Up After Hospitalization for Mental Illness			
7-Day Follow-Up	48.49%	56.51%	8.02
30-Day Follow-Up	66.89%	69.41%	2.52
Follow-Up Care for Children Prescribed ADHD Medication			
Initiation Phase	—	46.65%	NC
Continuation and Maintenance Phase	—	58.02%	NC
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*			
Total	—	1.80%	NC
Utilization and Diversity of Membership			
Mental Health Utilization—Total			
Any Service—Total	—	5.90%	NC
Inpatient—Total	—	0.77%	NC
Intensive Outpatient or Partial Hospitalization—Total	—	0.23%	NC
Outpatient or Emergency Department—Total	—	5.67%	NC
Ambulatory Care—Total			
*Emergency Department (ED) Visits—Total**	—	49.39	NC
Outpatient Visits—Total	—	292.44	NC
Weeks of Pregnancy at Time of Enrollment			
Prior to 0 Weeks	—	33.27%	NC
1–12 Weeks	—	12.99%	NC
13–27 Weeks	—	28.38%	NC
28 or More Weeks of Pregnancy	—	21.28%	NC
Unknown	—	4.09%	NC

[1] Due to changes in the technical specifications for this measure, caution should be exercised when comparing rates between 2015 and 2016.

* A lower rate indicates better performances for this measure.

— Indicates the measure was not presented in the previous year's technical report and therefore, a HEDIS 2015 measure rate is not presented in this year's report.

NC indicates the 2015–2016 rate comparison could not be calculated because data were not available for both years or because an increase or decrease in the rate does not necessarily indicate better or worse performance.

NA indicates the denominator for the measure was too small to report (less than 30).

Most of **HPN**'s measures with rates presented for HEDIS 2015 and HEDIS 2016 for the Medicaid population were relatively stable across all measure domains, with select measurement areas demonstrating performance changes. Within the Access to Care and Children's Preventive Care measure domains, rates for *Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years,* and for *Adolescent Well-Care Visits,* increased from HEDIS 2015 to HEDIS 2016 by more than 5 percentage points.

With regard to the Care for Chronic Conditions measure domain, **HPN**'s *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure rate demonstrated performance improvement in providing medical attention for nephropathy, with an increase of more than 9 percentage points from HEDIS 2015 to HEDIS 2016. Conversely, the rate for *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* declined by more than 9 percentage points. However, due to changes in the technical specifications for these measures, caution should be exercised when comparing rates between 2015 and 2016.

Within the Behavioral Health measure domain, the rate for *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* increased by more than 8 percentage points from HEDIS 2015 to HEDIS 2016.

Nevada Check Up Results

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

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

HEDIS Measure	HEDIS 2015 Rate	HEDIS 2016 Rate	2015–2016 Rate Comparison
Access to Care			
Children and Adolescents' Access to Primary Care Practitioners			
Ages 12–24 Months	94.70%	99.48%	4.78
Ages 25 Months–6 Years	87.20%	89.55%	2.35
Ages 7–11 Years	93.83%	93.54%	-0.29
Ages 12–19 Years	90.79%	90.78%	-0.01
Annual Dental Visit			
Total	69.50%	70.11%	0.61

Table 5-5—Nevada Check Up HEDIS Performance Measures Results for HPN			
HEDIS Measure	**HEDIS 2015 Rate**	**HEDIS 2016 Rate**	**2015–2016 Rate Comparison**
Children's Preventive Care			
Adolescent Well-Care Visits			
Adolescent Well-Care Visits	55.47%	52.83%	-2.64
Childhood Immunization Status			
Combination 2	83.46%	87.93%	4.47
Combination 3	77.17%	84.48%	7.31
Combination 4	76.38%	83.91%	7.53
Combination 5	66.14%	79.89%	13.75
Combination 6	48.03%	52.30%	4.27
Combination 7	65.35%	79.31%	13.96
Combination 8	47.24%	51.72%	4.48
Combination 9	42.52%	50.00%	7.48
Combination 10	41.73%	49.43%	7.70
Immunizations for Adolescents			
Combination 1 (Meningococcal, Tdap/Td)	—	87.35%	NC
Well-Child Visits in the First 15 Months of Life			
Six or More Well-Child Visits	60.00%	68.00%	8.00
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life			
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	71.95%	70.13%	-1.82
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Percentile—Total	—	72.02%	NC
Counseling for Nutrition—Total	—	60.34%	NC
Counseling for Physical Activity—Total[1]	—	57.18%	NC
Human Papillomavirus Vaccine for Female Adolescents			
Human Papillomavirus Vaccine for Female Adolescents	—	42.62%	NC
Care for Chronic Conditions			
Medication Management for People With Asthma			
Medication Compliance 50%—Total	—	47.62%	NC
Medication Compliance 75%—Total	—	26.98%	NC
Behavioral Health			
Follow-Up After Hospitalization for Mental Illness			
7-Day Follow-Up	NA	NA	NC
30-Day Follow-Up	NA	NA	NC
Follow-Up Care for Children Prescribed ADHD Medication			
Initiation Phase	—	39.53%	NC
Continuation and Maintenance Phase	—	NA	NC

Table 5-5—Nevada Check Up HEDIS Performance Measures Results for HPN			
HEDIS Measure	**HEDIS 2015 Rate**	**HEDIS 2016 Rate**	**2015–2016 Rate Comparison**
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*			
Total	—	NA	NC
Utilization and Diversity of Membership			
Mental Health Utilization—Total			
Any Service—Total	—	4.71%	NC
Inpatient—Total	—	0.14%	NC
Intensive Outpatient or Partial Hospitalization—Total	—	0.55%	NC
Outpatient or Emergency Department—Total	—	4.67%	NC
Ambulatory Care—Total			
*Emergency Department (ED) Visits—Total**	—	21.00	NC
Outpatient Visits—Total	—	259.29	NC

[1] Due to changes in the technical specifications for this measure, caution should be exercised when comparing rates between 2015 and 2016.

* A lower rate indicates better performances for this measure.

— Indicates the measure was not presented in the previous year's technical report and therefore, a HEDIS 2015 measure rate is not presented in this year's report.

NC indicates the 2015–2016 rate comparison could not be calculated because data were not available for both years or because an increase or decrease in the rate does not necessarily indicate better or worse performance.

NA indicates the denominator for the measure was too small to report (less than 30).

Performance improvement was limited to rates in the Children's Preventive Care measure domain for **HPN**'s Nevada Check Up population. Of note, six of the nine *Childhood Immunization Status* measure indicator rates demonstrated performance improvement from HEDIS 2015 to HEDIS 2016. Specifically, *Combinations 3, 4, 9,* and *10* increased more than 7 percentage points from HEDIS 2015 to HEDIS 2016, and *Combinations 5* and *7* increased by more than 13 percentage points. Additionally, the *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* rate increased by 8 percentage points from HEDIS 2015 to HEDIS 2016. None of the rates reported by **HPN** for the Nevada Check Up population demonstrated a decline in performance of greater than 5 percentage points from HEDIS 2015 to HEDIS 2016.

Summary of HPN Emerging Improvement

The following Medicaid performance measure indicators were identified as emerging improvement for **HPN** based on rate improvements greater than 5 percentage points from HEDIS 2015 to HEDIS 2016:

- *Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years*
- *Adolescent Well-Care Visits*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*[5-3]
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up*

[5-3] Due to changes in the technical specifications for this measure, caution should be exercised when comparing rates between 2015 and 2016.

The following Nevada Check Up performance measure indicators were identified as emerging improvement for **HPN** based on rate improvements greater than 5 percentage points from HEDIS 2015 to HEDIS 2016:

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

Summary of HPN Opportunities for Improvement

The following Medicaid performance measure indicators were identified as opportunities for improvement for **HPN** based on a decline in performance of greater than 5 percentage points from HEDIS 2015 to HEDIS 2016.

- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*[5-4]

None of the Nevada Check Up performance measure indicators for **HPN** had a decline in performance by greater than 5 percentage points from HEDIS 2015 to HEDIS 2016.

Plan Comparison

The HEDIS 2016 measure rates for **HPN**, **Amerigroup**, and the statewide weighted average results for the Medicaid and Nevada Check Up populations relative to the NCQA HEDIS 2015 Audit Means and Percentiles national Medicaid benchmarks are shown in Table 5-6 and Table 5-8. Measure results were compared to benchmarks and rated using the following star ratings:

★ = Below the national Medicaid 25th percentile
★★ = At or above the national Medicaid 25th percentile but below the 50th percentile
★★★ = At or above the national Medicaid 50th percentile but below the 75th percentile
★★★★ = At or above the national Medicaid 75th percentile but below the 90th percentile
★★★★★ = At or above the national Medicaid 90th percentile

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

[5-4] Due to changes in the technical specifications for this measure, caution should be exercised when comparing rates between 2015 and 2016.

Medicaid Results

Table 5-6 presents the HEDIS 2016 MCO-specific rates and the statewide weighted average Medicaid rates along with star ratings based on comparisons of the rates to the NCQA HEDIS 2015 Audit Means and Percentiles national Medicaid benchmarks.

Table 5-6—HEDIS 2016 Results for Medicaid

HEDIS Measure	HPN	AGP	Medicaid
Access to Care			
Children and Adolescents' Access to Primary Care Practitioners			
Ages 12–24 Months	94.80% ★★	94.15% ★	94.48% ★★
Ages 25 Months–6 Years	84.29% ★	83.55% ★	83.93% ★
Ages 7–11 Years	87.36% ★	87.12% ★	87.26% ★
Ages 12–19 Years	85.21% ★	83.76% ★	84.67% ★
Annual Dental Visit			
Total	55.03% ★★★	53.21% ★★	54.25% ★★
Children's Preventive Care			
Adolescent Well-Care Visits			
Adolescent Well-Care Visits	44.04% ★★	38.43% ★	41.89% ★★
Childhood Immunization Status			
Combination 2	74.94% ★★	73.15% ★★	74.04% ★★
Combination 3	70.32% ★★	66.67% ★★	68.48% ★★
Combination 4	70.07% ★★★	65.28% ★★	67.65% ★★★
Combination 5	55.72% ★★	57.18% ★★	56.45% ★★
Combination 6	38.44% ★★	32.41% ★	35.40% ★
Combination 7	55.72% ★★★	56.48% ★★★	56.10% ★★★
Combination 8	38.44% ★★	32.41% ★	35.40% ★★
Combination 9	31.14% ★★	29.63% ★★	30.38% ★★
Combination 10	31.14% ★★	29.63% ★★	30.38% ★★
Immunizations for Adolescents			
Combination 1 (Meningococcal, Tdap/Td)	79.81% ★★★	71.93% ★★	76.80% ★★★

Table 5-6—HEDIS 2016 Results for Medicaid			
HEDIS Measure	**HPN**	**AGP**	**Medicaid**
Well-Child Visits in the First 15 Months of Life			
Six or More Well-Child Visits	53.77% ★★	52.78% ★★	53.26% ★★
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life			
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	64.48% ★	66.33% ★★	65.36% ★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Percentile—Total	70.32% ★★★	64.12% ★★	67.74% ★★★
Counseling for Nutrition—Total	57.91% ★★	54.40% ★★	56.45% ★★
Counseling for Physical Activity—Total	52.07% ★★	43.75% ★	48.61% ★★
Human Papillomavirus Vaccine for Female Adolescents			
Human Papillomavirus Vaccine for Female Adolescents	29.68% ★★★★	24.59% ★★★	27.74% ★★★★
Maternity Care			
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	73.97% ★	75.41% ★	74.67% ★
Postpartum Care	57.18% ★★	53.16% ★	55.22% ★
Frequency of Ongoing Prenatal Care			
*<21 Percent of Expected Visits**	14.60% ★★	17.80% ★	16.16% ★
≥81 Percent of Expected Visits	52.07% ★★	56.44% ★★	54.20% ★★
Care for Chronic Conditions			
Comprehensive Diabetes Care			
Hemoglobin A1c (HbA1c) Testing	85.64% ★★	79.63% ★	83.34% ★★
*HbA1c Poor Control (>9.0%)**	45.74% ★★	46.76% ★★	46.13% ★★
Blood Pressure Control (<140/90 mm Hg)	60.83% ★★	55.32% ★	58.71% ★★
Eye Exam (Retinal) Performed	56.93% ★★★	55.09% ★★★	56.23% ★★★
Medical Attention for Nephropathy	92.21% ★★★★★	89.58% ★★★★★	91.20% ★★★★★
HbA1c Control (<8.0%)	46.47% ★★	46.30% ★★	46.40% ★★
Medication Management for People With Asthma			
Medication Compliance 50%—Total	46.96% ★	50.22% ★★	48.14% ★★
Medication Compliance 75%—Total	24.14% ★★	26.84% ★★	25.12% ★★

Table 5-6—HEDIS 2016 Results for Medicaid			
HEDIS Measure	**HPN**	**AGP**	**Medicaid**
Behavioral Health			
Follow-Up After Hospitalization for Mental Illness			
7-Day Follow-Up	56.51% ★★★	52.99% ★★★	54.56% ★★★
30-Day Follow-Up	69.41% ★★★	64.55% ★★	66.72% ★★★
Follow-Up Care for Children Prescribed ADHD Medication			
Initiation Phase	46.65% ★★★	36.68% ★★	42.15% ★★★
Continuation and Maintenance Phase	58.02% ★★★	40.91% ★★	52.00% ★★★
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*			
Total	1.80% ★★★	0.00% ★★★★★	1.02% ★★★★
Utilization and Diversity of Membership			
Mental Health Utilization—Total			
Any Service—Total	5.90% NC	7.21% NC	6.47% NC
Inpatient—Total	0.77% NC	1.18% NC	0.95% NC
Intensive Outpatient or Partial Hospitalization—Total	0.23% NC	0.28% NC	0.25% NC
Outpatient or Emergency Department—Total	5.67% NC	7.01% NC	6.25% NC
Ambulatory Care—Total			
*Emergency Department (ED) Visits—Total**	49.39 NC	55.08 NC	51.85 NC
Outpatient Visits—Total	292.44 NC	294.01 NC	293.12 NC
Weeks of Pregnancy at Time of Enrollment			
Prior to 0 Weeks	33.27% NC	26.39% NC	32.80% NC
1–12 Weeks	12.99% NC	12.50% NC	12.96% NC
13–27 Weeks	28.38% NC	41.44% NC	29.26% NC
28 or More Weeks of Pregnancy	21.28% NC	19.68% NC	21.17% NC
Unknown	4.09% NC	0.00% NC	3.81% NC

* A lower rate indicates better performances for this measure.

NC indicates the HEDIS 2016 rate was not compared to benchmarks either because data were not available or because a measure is informational only and comparisons to benchmarks are not appropriate.

NA indicates the denominator for the measure was too small to report (less than 30).

With regard to the statewide weighted average results for Medicaid, most of the rates fell below the national 50th percentile. However, statewide weighted averages for *Human Papillomavirus Vaccine for Female Adolescents* and *Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total* ranked at or above the national 75th percentile but below the 90th percentile, and the rate for *Comprehensive Diabetes Care—Medical Attention for Nephropathy* ranked at or above the national 90th percentile indicating performance strengths.

Overall, **HPN**'s and **Amerigroup**'s HEDIS 2016 rates for the Medicaid population ranked similarly compared to the national benchmarks. Rates across all the measure domains indicated opportunities for improvement for both MCOs. Of the 39 measure rates that were comparable to national benchmarks, 26 of **HPN**'s rates fell below the national 50th percentile (67 percent), and 33 of **Amerigroup**'s rates fell below the national 50th percentile (85 percent).

Within the Access to Care measure domain, **HPN**'s rates ranked slightly higher than **Amerigroup**'s rates only for *Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months* and *Annual Dental Visit—Total*.

For Children's Preventive Care, most of **HPN**'s rates ranked the same as or slightly higher than **Amerigroup**'s rates, with the exception of **Amerigroup**'s *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* rate, which ranked slightly higher than **HPN**'s rate.

Two of the four Maternity Care measure rates reported by **HPN** ranked slightly higher than **Amerigroup**'s rates (i.e., *Prenatal and Postpartum Care—Postpartum Care* and *Frequency of Ongoing Prenatal Care—<21 Percent of Expected Visits*).

With regard to Care for Chronic Conditions, two of the six *Comprehensive Diabetes Care* measure indicators reported by **HPN** ranked slightly higher than **Amerigroup**'s reported rates (i.e., *Hemoglobin A1c [HbA1c] Testing* and *Blood Pressure Control [<140/90 mm Hg]*). Conversely, **Amerigroup**'s *Medication Management for People With Asthma—Medication Compliance 50%—Total* rate ranked slightly higher than **HPN**'s rate. Of note, both MCOs' rates for *Comprehensive Diabetes Care—Medical Attention for Nephropathy* were at or above the national 90th percentile.

Measure indicator rates in the Behavioral Health domain ranked slightly higher for **HPN** than **Amerigroup** for the *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up* and for Follow*-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase* measure indicators. Of note, **Amerigroup**'s reported rate for *Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total* was at or above the national 90th percentile, indicating overall positive performance.

Data Completeness

Table 5-7 provides an estimate of data completeness for the hybrid performance measures. These measures used administrative data (i.e., claims and encounter data) and supplemented the results with medical record review data. Measures that used only administrative data were not included. The table shows the HEDIS 2016 measure rates and the percentage of each reported rate that was determined solely through administrative data for both MCOs. Rates shaded green with one caret (^) indicate that more than 90 percent of the final rate was derived using administrative data. Rates shaded red with two carets (^^) indicate that less than 50 percent of the final rate was derived using administrative data.

Table 5-7—Estimated Encounter Data Completeness for Medicaid Hybrid Measures				
HEDIS Measure	**HPN HEDIS 2016 Rate**	**HPN Percent from Administrative Data**	**AGP HEDIS 2016 Rate**	**AGP Percent from Administrative Data**
Children's Preventive Care				
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	44.04%	92.27%^	38.43%	79.52%
Childhood Immunization Status				
Combination 2	74.94%	85.71%	73.15%	94.94%^
Combination 3	70.32%	84.43%	66.67%	94.10%^
Combination 4	70.07%	84.38%	65.28%	94.33%^
Combination 5	55.72%	82.53%	57.18%	95.14%^
Combination 6	38.44%	78.48%	32.41%	91.43%^
Combination 7	55.72%	82.53%	56.48%	95.49%^
Combination 8	38.44%	78.48%	32.41%	91.43%^
Combination 9	31.14%	76.56%	29.63%	92.19%^
Combination 10	31.14%	76.56%	29.63%	92.19%^
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap/Td)	79.81%	92.68%^	71.93%	96.13%^
Well-Child Visits in the First 15 Months of Life				
Six or More Well-Child Visits	53.77%	88.24%	52.78%	86.84%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	64.48%	96.60%^	66.33%	95.80%^
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total	70.32%	**16.61%^^**	64.12%	**16.61%^^**
Counseling for Nutrition—Total	57.91%	**15.13%^^**	54.40%	**19.57%^^**
Counseling for Physical Activity—Total	52.07%	**8.88%^^**	43.75%	**12.70%^^**
Human Papillomavirus Vaccine for Female Adolescents				
Human Papillomavirus Vaccine for Female Adolescents	29.68%	92.62%^	24.59%	93.40%^
Maternity Care				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	73.97%	66.45%	75.41%	67.70%
Postpartum Care	57.18%	**49.79%^^**	53.16%	64.76%
Frequency of Ongoing Prenatal Care				
<21 Percent of Expected Visits	14.60%	98.33%^	17.80%	90.79%^
≥81 Percent of Expected Visits	52.07%	**33.18%^^**	56.44%	**36.10%^^**

Table 5-7—Estimated Encounter Data Completeness for Medicaid Hybrid Measures				
HEDIS Measure	**HPN HEDIS 2016 Rate**	**HPN Percent from Administrative Data**	**AGP HEDIS 2016 Rate**	**AGP Percent from Administrative Data**
Care for Chronic Conditions				
Comprehensive Diabetes Care				
Hemoglobin A1c (HbA1c) Testing	85.64%	98.58%^	79.63%	98.84%^
HbA1c Poor Control (>9.0%)	45.74%	97.87%^	46.76%	75.74%
Blood Pressure Control (<140/90 mm Hg)	60.83%	**0.40%^^**	55.32%	**0.00%^^**
Eye Exam (Retinal) Performed	56.93%	88.03%	55.09%	88.66%
Medical Attention for Nephropathy	92.21%	99.21%^	89.58%	97.67%^
HbA1c Control (<8.0%)	46.47%	95.29%^	46.30%	**34.00%^^**

Green Shading^ indicates that more than 90 percent of the final rate was derived using administrative data.
Red Shading^^ indicates that 50 percent or less of the final rate was derived using administrative data.

A total of 27 measure indicators were reported by the MCOs for the Medicaid population using the hybrid methodology. Fifteen final measure rates reported by **Amerigroup** were derived using more than 90 percent administrative data, indicating that more than half of **Amerigroup**'s hybrid measures reported demonstrated high levels of encounter data completeness. Nine final measure indicator rates reported by **HPN** were derived using more than 90 percent administrative data, indicating that one-third of **HPN**'s hybrid measure reporting demonstrated high levels of encounter data completeness. For both MCOs, rates were derived using 50 percent or less administrative data, indicating opportunities to improve data completeness, including rates for all three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure indicators, *Frequency of Ongoing Prenatal Care—≥81 Percent of Expected Visits*, and *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*.

Nevada Check Up Results

Table 5-8 presents the HEDIS 2016 MCO-specific rates and the statewide weighted average Nevada Check Up rates along with star ratings based on comparisons of the rates to the NCQA HEDIS 2015 Audit Means and Percentiles national Medicaid benchmarks.[5-5]

[5-5] Because NCQA HEDIS 2015 Audit Means and Percentiles benchmarks are not available for the Children's Health Insurance Program (CHIP) population, comparisons of Nevada's Check Up population measure indicator rates to the national Medicaid benchmarks should be interpreted with caution.

Table 5-8—HEDIS 2016 Results for Nevada Check Up			
HEDIS Measure	**HPN**	**AGP**	**Nevada Check Up**
Access to Care			
Children and Adolescents' Access to Primary Care Practitioners			
Ages 12–24 Months	99.48% ★★★★★	98.73% ★★★★★	99.15% ★★★★★
Ages 25 Months–6 Years	89.55% ★★★	89.53% ★★★	89.54% ★★★
Ages 7–11 Years	93.54% ★★★	92.91% ★★★	93.32% ★★★
Ages 12–19 Years	90.78% ★★★	88.95% ★★	90.18% ★★★
Annual Dental Visit			
Total	70.11% ★★★★★	67.05% ★★★★★	68.96% ★★★★★
Children's Preventive Care			
Adolescent Well-Care Visits			
Adolescent Well-Care Visits	52.83% ★★★	56.34% ★★★	54.04% ★★★
Childhood Immunization Status			
Combination 2	87.93% ★★★★★	85.90% ★★★★★	86.97% ★★★★★
Combination 3	84.48% ★★★★★	78.21% ★★★★	81.52% ★★★★★
Combination 4	83.91% ★★★★★	77.56% ★★★★	80.92% ★★★★★
Combination 5	79.89% ★★★★★	68.59% ★★★★	74.56% ★★★★★
Combination 6	52.30% ★★★★	46.79% ★★★	49.70% ★★★
Combination 7	79.31% ★★★★★	67.95% ★★★★★	73.96% ★★★★★
Combination 8	51.72% ★★★★	46.79% ★★★	49.40% ★★★★
Combination 9	50.00% ★★★★	42.95% ★★★	46.68% ★★★★
Combination 10	49.43% ★★★★	42.95% ★★★★	46.37% ★★★★
Immunizations for Adolescents			
Combination 1 (Meningococcal, Tdap/Td)	87.35% ★★★★	81.61% ★★★★	85.33% ★★★★
Well-Child Visits in the First 15 Months of Life			
Six or More Well-Child Visits	68.00% ★★★★	78.05% ★★★★★	72.53% ★★★★

Table 5-8—HEDIS 2016 Results for Nevada Check Up			
HEDIS Measure	**HPN**	**AGP**	**Nevada Check Up**
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life			
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	70.13% ★★	70.28% ★★	70.19% ★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Percentile—Total	72.02% ★★★	62.04% ★★	68.43% ★★★
Counseling for Nutrition—Total	60.34% ★★	55.56% ★★	58.62% ★★
Counseling for Physical Activity—Total	57.18% ★★★	47.69% ★★	53.77% ★★
Human Papillomavirus Vaccine for Female Adolescents			
Human Papillomavirus Vaccine for Female Adolescents	42.62% ★★★★★	34.11% ★★★★★	39.68% ★★★★★
Care for Chronic Conditions			
Medication Management for People With Asthma			
Medication Compliance 50%—Total	47.62% ★★	47.76% ★★	47.67% ★★
Medication Compliance 75%—Total	26.98% ★★	26.87% ★★	26.94% ★★
Behavioral Health			
Follow-Up After Hospitalization for Mental Illness			
7-Day Follow-Up	NA	84.85% ★★★★★	83.33% ★★★★★
30-Day Follow-Up	NA	93.94% ★★★★★	89.58% ★★★★★
Follow-Up Care for Children Prescribed ADHD Medication			
Initiation Phase	39.53% ★★	NA	35.21% ★★
Continuation and Maintenance Phase	NA	NA	NA
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*			
Total	NA	NA	NA
Utilization and Diversity of Membership			
Mental Health Utilization—Total			
Any Service—Total	4.71% NC	5.76% NC	5.12% NC
Inpatient—Total	0.14% NC	0.46% NC	0.26% NC
Intensive Outpatient or Partial Hospitalization—Total	0.55% NC	0.32% NC	0.46% NC
Outpatient or Emergency Department—Total	4.67% NC	5.69% NC	5.07% NC

Table 5-8—HEDIS 2016 Results for Nevada Check Up			
HEDIS Measure	**HPN**	**AGP**	**Nevada Check Up**
Ambulatory Care—Total			
*Emergency Department (ED) Visits—Total**	21.00 NC	26.14 NC	23.00 NC
Outpatient Visits—Total	259.29 NC	263.50 NC	260.93 NC

* A lower rate indicates better performances for this measure.
NC indicates the HEDIS 2016 rate was not compared to benchmarks either because data were not available or because a measure is informational only and comparisons to benchmarks are not appropriate.
NA indicates the denominator for the measure was too small to report (less than 30).

With regard to the statewide weighted average results for Nevada Check Up, most of the rates ranked at or above the national 75th percentile. However, statewide weighted averages for the following measures fell at or above the national 25th percentile but below the 50th percentile, indicating opportunities for improvement: W*ell-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*; *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total*; *Medication Management for People With Asthma—Medication Compliance 50%—Total*, and *Medication Compliance 75%—Total*; and *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*. As mentioned previously, comparisons of Nevada's Check Up population measure indicator rates to the national Medicaid benchmarks should be interpreted with caution.

Overall, **HPN**'s and **Amerigroup**'s HEDIS 2016 rates for the Nevada Check Up population ranked similarly compared to the national benchmarks. Of the 25 measure rates reported by **HPN** that were comparable to national benchmarks, eight rates ranked at or above the national 90th percentile (32 percent). Of the 26 measure rates reported by **Amerigroup** and that were comparable to national benchmarks, eight rates ranked at or above the national 90th percentile (31 percent).

HPN's and **Amerigroup**'s rates in the Access to Care measure domain ranked the same, with the exception of **HPN**'s C*hildren and Adolescents' Access to Primary Care Practitioners—Ages 12–19 Years* rate, which indicated slightly higher performance. **Amerigroup**'s rate for this measure fell at or above the national 25th percentile but below the 50th percentile, indicating opportunity for improvement.

For Children's Preventive Care, most of **HPN**'s rates ranked the same as or slightly higher than **Amerigroup**'s rates, with the exception of **Amerigroup**'s *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* rate, which ranked slightly higher than **HPN**'s rate. Of note, both MCOs' rates for *Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life* fell at or above the national 25th percentile but below the 50th percentile. Further, **Amerigroup**'s rates for all three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* indicators fell at or above the national 25th percentile but below the 50th percentile.

Rates indicated opportunities for improvement for both MCOs in the Care for Chronic Conditions measure domain, with **HPN**'s and **Amerigroup**'s rates for the two *Medication Management for People With Asthma* measure indicators falling at or above the national 25th percentile but below the 50th percentile.

In the Behavioral Health measure domain, **HPN**'s reported rate for *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* fell at or above the national 25th percentile but below the 50th percentile, demonstrating an area for improvement with regard to follow-up care for children on ADHD medications. Conversely, both of **Amerigroup**'s rates that were reportable for HEDIS 2016 in the Behavioral Health measure domain, *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up*, ranked at or above the national 90th percentile, indicating **Amerigroup**'s favorable performance in this area.

Data Completeness

Table 5-9 provides an estimate of data completeness for the hybrid performance measures. These measures used administrative data (i.e., claims and encounter data) and supplemented the results with medical record review data. Measures that used only administrative data were not included. The table shows the HEDIS 2016 measure rates and the percentage of each reported rate that was determined solely through administrative data for both MCOs. Rates shaded green with one caret (^) indicate that more than 90 percent of the final rate was derived using administrative data. Rates shaded red with two carets (^^) indicate that less than 50 percent of the final rate was derived using administrative data.

Table 5-9—Estimated Encounter Data Completeness for Nevada Check Up Hybrid Measures

HEDIS Measure	HPN HEDIS 2016 Rate	HPN Percent from Administrative Data	AGP HEDIS 2016 Rate	AGP Percent from Administrative Data
Children's Preventive Care				
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	52.83%	92.09%^	56.34%	88.33%
Childhood Immunization Status				
Combination 2	87.93%	84.97%	85.90%	94.03%^
Combination 3	84.48%	82.99%	78.21%	94.26%^
Combination 4	83.91%	82.88%	77.56%	94.21%^
Combination 5	79.89%	82.01%	68.59%	93.46%^
Combination 6	52.30%	79.12%	46.79%	91.78%^
Combination 7	79.31%	81.88%	67.95%	93.40%^
Combination 8	51.72%	78.89%	46.79%	91.78%^
Combination 9	50.00%	79.31%	42.95%	91.04%^
Combination 10	49.43%	79.07%	42.95%	91.04%^

Table 5-9—Estimated Encounter Data Completeness for Nevada Check Up Hybrid Measures				
HEDIS Measure	**HPN HEDIS 2016 Rate**	**HPN Percent from Administrative Data**	**AGP HEDIS 2016 Rate**	**AGP Percent from Administrative Data**
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap/Td)	87.35%	88.02%	81.61%	94.84%^
Well-Child Visits in the First 15 Months of Life				
Six or More Well-Child Visits	68.00%	86.76%	78.05%	87.50%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	70.13%	97.47%^	70.28%	96.05%^
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total	72.02%	**20.61%^^**	62.04%	**19.03%^^**
Counseling for Nutrition—Total	60.34%	**14.52%^^**	55.56%	**18.75%^^**
Counseling for Physical Activity—Total	57.18%	**10.21%^^**	47.69%	**10.19%^^**
Human Papillomavirus Vaccine for Female Adolescents				
Human Papillomavirus Vaccine for Female Adolescents	42.62%	91.35%^	34.11%	86.36%

Green Shading^ indicates that more than 90 percent of the final rate was derived using administrative data.
Red Shading^^ indicates that 50 percent or less of the final rate was derived using administrative data.

A total of 17 measure indicators were reported by the MCOs for the Nevada Check Up population using hybrid methodology. Only three final measure indicator rates reported by **HPN** were derived using more than 90 percent administrative data, indicating overall low levels of encounter data completeness. Conversely, 11 final measure rates reported by **Amerigroup** were derived using more than 90 percent administrative data, indicating that almost two-thirds of **Amerigroup**'s hybrid measure reporting demonstrated high levels of encounter data completeness. Rates for all three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure indicators for both MCOs were derived using 50 percent or less administrative data, indicating opportunities to improve data completeness.

Conclusions

The HEDIS audit demonstrated that both MCOs had adequate policies and procedures to collect, prepare, process, and report HEDIS data and were in full compliance with each of the seven NCQA-specified IS standards. Both MCOs continued to use Facets to process their claims. Data entry processes were efficient, with the assurance of timely and accurate entry into the system. Only standard codes were accepted and the standard HIPAA 837 file format was used. Both MCOs applied several validation checks to ensure accurate information processing. Both MCOs had appropriate processes in place for the ICD-9 to ICD-10 transition and did not experience any data concerns.

Upon evaluation of the Medicaid population rates, 29 measure indicator rates were comparable from HEDIS 2015 to HEDIS 2016 for **Amerigroup**. The reported rates showed performance improvement (i.e., improved more than 5 percentage points) on nine measure indicator rates (approximately 31 percent) from HEDIS 2015. Conversely, rates declined (i.e., decreased more than 5 percentage points) for one measure rate (approximately 3 percent) from HEDIS 2015 to HEDIS 2016. Thirty-nine of **Amerigroup**'s Medicaid HEDIS 2016 rates were evaluated compared to national Medicaid benchmarks. Two rates (approximately 5 percent) ranked at or above the 90th percentile and 13 measure indicator rates (approximately 33 percent) fell below the 25th percentile.

For **HPN**'s Medicaid population rates, 29 measures were comparable from HEDIS 2015 to HEDIS 2016, and four measure indicator rates (approximately 14 percent) showed improvement from HEDIS 2015. One rate (approximately 3 percent) declined from HEDIS 2015 to HEDIS 2016. Additionally, 39 of **HPN**'s Medicaid HEDIS 2016 rates were evaluated compared to national Medicaid benchmarks: One rate (approximately 3 percent) ranked at or above the 90th percentile and six measure indicator rates (approximately 15 percent) fell below the 25th percentile.

With regard to **Amerigroup**'s Nevada Check Up population, 17 measures were comparable from HEDIS 2015 to HEDIS 2016, and six measure indicator rates (approximately 35 percent) showed improvement from HEDIS 2015. None of the rates declined from HEDIS 2015 to HEDIS 2016. Additionally, 26 of **Amerigroup**'s Nevada Check Up HEDIS 2016 rates were evaluated compared to national Medicaid benchmarks, of which eight rates (approximately 31 percent) ranked at or above the 90th percentile and none of the measure indicator rates fell below the 25th percentile.

For **HPN**'s Nevada Check Up population, 17 measures were comparable from HEDIS 2015 to HEDIS 2016, and seven measure indicator rates (approximately 41 percent) showed improvement from HEDIS 2015. None of the rates declined from HEDIS 2015 to HEDIS 2016. Additionally, 25 of **HPN**'s Nevada Check Up HEDIS 2016 rates were evaluated compared to national Medicaid benchmarks, of which eight rates (approximately 32 percent) ranked at or above the 90th percentile and none of the measure indicator rates fell below the 25th percentile.

Recommendations

As evidenced by the comparisons of the rates to national Medicaid benchmarks, HSAG suggests that the MCOs focus efforts on improving children and adolescents' access to primary care practitioners. HSAG recommends that the MCOs analyze any improvement strategies that could be linked to the overall success of the measure, counseling children/adolescents for nutrition and physical activity, and improvement interventions implemented to improve well-child visits. Further, HSAG recommends that the MCOs monitor performance with regard to maternity care, managing medications for asthmatic members, appropriate testing and control of HbA1c levels, and controlling blood pressure for diabetic members. The areas recommended for improvement are based on rates that mostly ranked below the national Medicaid 50th percentile.

Additionally, for the Nevada Check Up population, the MCOs are urged to focus efforts on improving documentation of counseling for nutrition and physical activity provided to children and adolescents, and to analyze strategies that could be linked to increased rates of well-care visits for adolescents and asthma medication compliance for asthmatic members. Although none of the

Nevada Check Up population rates showed declines from 2015 to 2016, rates in these areas fell below the national Medicaid 50th percentile, indicating opportunities for improvement.

For each measure requiring improvement, HSAG recommends that each MCO conduct a thorough analysis of the root cause of poor performance for each measure and identify provider, member, and systems interventions that can be implemented to improve performance measure rates in each area. Similar to the rapid cycle improvement approach required by PIPs, MCOs should test changes on a small scale, using a series of PDSA cycles and applying rapid-cycle learning principles over the course of the improvement project to adjust intervention strategies so that improvement can occur more efficiently and lead to long-term sustainability.

6. Validation of Performance Improvement Projects—SFY 2015–2016

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

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

In July 2014, HSAG developed a new PIP framework based on a modified version of the Model for Improvement developed by Associates in Process Improvement and modified by the Institute for Healthcare Improvement. The redesigned PIP methodology is intended to improve processes and outcomes of healthcare by way of continuous quality improvement. The redesigned framework redirects MCOs to focus on small tests of change in order to determine which interventions have the greatest impact and can bring about real improvement. PIPs must meet CMS requirements; therefore, HSAG completed a crosswalk of this new framework against the Department of Health and Human Services, CMS publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR), Version 2.0*, September 2012.[6-1]

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

Objectives

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

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

[6-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: Feb 19, 2013.

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

For this new PIP framework, HSAG developed five modules with an accompanying companion guide. Prior to issuing each module, HSAG held technical assistance sessions with the MCOs to educate about application of the modules. The PIP modules and associated validation scoring are described in Appendix A, Technical Methods of Data Collection and Analysis.

Plan-Specific Findings—Amerigroup

In SFY 2015–2016, the DHCFP selected two PIP topics for the MCOs: *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)* and *Behavioral Health Hospital Readmissions*. The topics selected by the DHCFP addressed CMS requirements related to quality outcomes—specifically, the quality and timeliness of and access to care and services.

Table 6-1 presents each PIP topic and the SMART Aim statement as stated by the MCO. **Amerigroup** was required to specify the outcome being measured, the baseline value for the outcome measure, a quantifiable goal for the outcome measure, and the target date for attaining the goal.

Table 6-1—PIP Titles and SMART Aim Statements

PIP Title	SMART Aim Statement
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)	By March 31, 2017, the MCO aims to increase the compliance rate for BMI percentile, counseling for nutrition, and counseling for physical activity among children and adolescents 3 to 17 years of age residing in Clark County who are assigned to a Nevada Health Centers practitioner, from 78.24 percent to 88.24 percent, from 58.33 percent to 68.33 percent, and from 57.41 to 67.41 percent, respectively.
Behavioral Health Hospital Readmissions	By March 31, 2017, the MCO aims to reduce the number of inpatient behavioral health readmissions in Clark County by 10 percentage points from 29.07 percent to 19.07 percent.

Amerigroup completed and submitted Modules 1 through 3 for validation. The following section outlines the validation findings for each of these completed modules.

Module 1: PIP Initiation

The objective of Module 1 is for the MCO to ask and answer the first fundamental question, "What are we trying to accomplish?" In this phase, for both PIPs, **Amerigroup** determined its narrowed

focus, developed its PIP team, established external partnerships, determined the Global and SMART Aims, and developed the key driver diagram.

Behavioral Health Hospital Readmissions

Upon initial validation of Module 1 for the *Behavioral Health Hospital Readmissions* PIP, HSAG identified that **Amerigroup**'s Global Aim statement required revisions in order to have an overarching outcome to which the PIP was contributing and that some potential interventions listed in the key driver diagram were not actual interventions but statements. After receiving technical assistance from HSAG, **Amerigroup** made the necessary corrections and resubmitted the module for final validation. For the final validation, the MCO received *Achieved* scores across all evaluation elements for Module 1.

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

Upon initial validation of Module 1 for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)* PIP, HSAG identified that **Amerigroup** needed to include data on all three components of the WCC measure (body mass index [BMI] documentation, referral for physical activity, and referral for nutrition). After receiving technical assistance from HSAG, Amerigroup made the necessary corrections and resubmitted the module for final validation. For the final validation, the MCO received *Achieved* scores across all evaluation elements for Module 1.

Module 2: SMART Aim Data Collection

The objective of Module 2 is for the MCO to ask and answer the question, "How will we know that a change is improvement?" In this phase, for both PIPs, Amerigroup defined how and when it will be evident that improvement is being achieved.

Behavioral Health Hospital Readmissions

Amerigroup defined the SMART Aim measure as:

Numerator: The total number of monthly inpatient behavioral health readmissions within 30 days in Clark County during the measurement month.

Denominator: The total number of monthly inpatient behavioral health admissions in Clark County during the measurement month.

Amerigroup will be using an administrative data collection methodology for this PIP. The administrative and authorization data have a one-to-one relationship; therefore, all paid claims have an authorization. Authorization data is a manual process and uses real-time data. For this project, "readmission" was defined as "any eligible admission to a hospital within 30 days of discharge from a hospital." An "eligible member" was defined as "one being continuously enrolled for 30 days following an admission." Amerigroup's business information consultant will be responsible for

setting up the query to identify all behavioral health readmissions in Clark County. The results will be displayed monthly on the SMART Aim run chart.

Upon initial validation of Module 2 for the *Behavioral Health Hospital Readmissions* PIP, HSAG identified that **Amerigroup** needed to define and support how the administrative claims data would be used to determine when an admission occurred after discharge from an inpatient setting. HSAG made the recommendation that **Amerigroup** make necessary revisions to its SMART Aim measure. After receiving technical assistance from HSAG, **Amerigroup** clarified how it would use prior authorization data to determine the date of admission within 30 days of discharge from an inpatient setting. **Amerigroup** made the necessary corrections and submitted the module for final validation. For the final validation, the MCO received *Achieved* scores across all evaluation elements for Module 2.

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

Amerigroup defined the SMART Aim measure as:

Numerator:

1. All Nevada Health Centers (NVHC) WCC eligible members with a BMI percentile documented within the previous 12 months.
2. All Nevada Health Centers WCC eligible members who have had counseling for nutrition within the previous 12 months.
3. All Nevada Health Centers WCC eligible members who have had counseling for physical activity within the previous 12 months.

Denominator: All WCC eligible members residing in Clark County who are assigned to a Nevada Health Centers practitioner as of the last business day of each measurement month.

On the first business day of the month, **Amerigroup** will generate a list from its Missed Opportunities report for all WCC eligible members residing in Clark County and assigned to a Nevada Health Centers practitioner as of the last business day of the current measurement month. Using this denominator, the MCO will query those WCC eligible members who had a documented BMI percentile, counseling for nutrition, and counseling for physical activity within the previous 12 months. An Excel spreadsheet with a list of the remaining WCC eligible members without a documented BMI percentile, counseling for nutrition, and counseling for physical activity within the previous 12 months will be sent to NVHC via a secure, encrypted email. Throughout the month, an NVHC administrative coordinator will record on the Excel spreadsheet the WCC eligible members with a documented BMI percentile, counseling for nutrition, and counseling for physical activity. On the last business day of the month, NVHC's coordinator will return the list to **Amerigroup** through a secure, encrypted email. The MCO's HEDIS subject matter expert (SME) will coordinate with NVHC to retrieve medical records for the members listed on the Excel spreadsheet. **Amerigroup**'s HEDIS SME will review each medical record for compliance as per the *HEDIS 2016 Technical Specifications*. Once the information on the spreadsheet is verified, the MCO will enter the data and calculate the rate. The rates will be displayed on the SMART Aim run chart.

Upon initial validation of Module 2 for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)* PIP, HSAG identified that **Amerigroup** needed to include an anchor date for the age criteria, include all measure components in the SMART Aim measure, update the spreadsheet to include all measure components, and update the run chart with baseline data for all three measure components. After receiving technical assistance from HSAG, **Amerigroup** made the necessary corrections and submitted the module for final validation. For the final validation, the MCO received *Achieved* scores across all evaluation elements for Module 2.

Module 3: Intervention Determination

Module 3 is the intervention determination phase of the PIP. In this module, the MCO will ask and answer the question, "What changes can we make that will result in improvement?"

Behavioral Health Hospital Readmissions

Amerigroup completed a process map and an FMEA to determine the areas within its process with the greatest need for improvement and which would have the most impact on the intended outcomes. The MCO identified the following four subprocesses on which to focus efforts:

- Emergency department physician-directed medical evaluation to rule out acute medical condition.
- Member does not meet inpatient criteria and is discharged.
- Finalize discharge plan, review with member, and verify member comprehension.
- Transportation assistance.

Using a risk-priority numbering process to prioritize the identified failure modes within these subprocesses, **Amerigroup** determined that its top four failure modes for which to develop interventions and test through the use of PDSA cycles in Module 4 are:

1. Incomplete discharge planning.
2. Amerigroup is not notified of member discharged from facilities.
3. Inconsistent use of the Patient360 system to support collaboration of real-time member information.
4. Member is unable to navigate or obtain services or to access resources identified in the discharge plan.

Upon initial validation of Module 3 for the *Behavioral Health Hospital Readmissions* PIP, HSAG identified that **Amerigroup** needed to revise its process map so that the selected subprocesses in the FMEA aligned with the opportunities for improvement identified in the process map. The MCO also needed to revise its FMEA so that identified failure causes and failure effects aligned with the listed failure mode. In addition, the MCO was required to revise its documentation to ensure that all narrative documentation in the process map and FMEA were consistent. After receiving technical assistance from HSAG, **Amerigroup** made the necessary corrections and submitted the module for

final validation. For the final validation, the MCO received *Achieved* scores across all evaluation elements for Module 3.

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

For its *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)* PIP, **Amerigroup** completed a process map and an FMEA to determine the areas within its process with the greatest need for improvement and which would have the most impact on intended outcomes. The MCO identified the following five subprocesses on which to focus its efforts:

- Scheduler reviews alert screen for WCC visit in current measurement year.
- Physician reviews alert screen for WCC visit in current measurement year.
- Physician documents visit in electronic medical record.
- Medical assistant inputs vitals in electronic medical record.
- Member outreach and education.

Using a risk-priority numbering process to prioritize the identified failure modes within these sub-processes, **Amerigroup** determined that the top three failure modes for which to develop interventions and test through the use of PDSA cycles in Module 4 are:

1. Incomplete coding by physician of the well-child visit.
2. Not all well-child visits are captured.
3. Member education and outreach to schedule well-child visits are not consistent.

Upon initial validation of Module 3 for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)* PIP, HSAG identified that **Amerigroup** needed to revise its process map so that the selected subprocesses in the FMEA aligned with the opportunities for improvement identified in the process map. The MCO also needed to revise its FMEA so that the identified failure causes and failure effects aligned with the listed failure mode. After receiving technical assistance from HSAG, **Amerigroup** made the necessary corrections and submitted the module for final validation. For the final validation, the MCO received *Achieved* scores across all evaluation elements for Module 3.

At the time of this SFY 2015–2016 EQR Technical Report, **Amerigroup** had completed its PIP cycle through Module 3. HSAG will report on each PIP's Modules 4 and 5 in the SFY 2016–2017 EQR Technical Report.

Plan-Specific Findings—HPN

In SFY 2015–2016, the DHCFP selected two PIP topics for the MCOs: *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)* and *Behavioral Health Hospital Readmissions*. The topics selected by the DHCFP addressed CMS requirements

related to quality outcomes—specifically, the quality and timeliness of and access to care and services.

Table 6-2 presents each PIP topic and the SMART Aim statement as stated by the MCO. **HPN** was required to specify the outcome being measured, the baseline value for the outcome measure, a quantifiable goal for the outcome measure, and the target date for attaining the goal.

Table 6-2—PIP Titles and SMART Aim Statements

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

HPN completed and submitted Modules 1 through 3 for validation. The following section outlines the validation findings for each of these completed modules.

Module 1: PIP Initiation

The objective of Module 1 is for the MCO to ask and answer the first fundamental question, "What are we trying to accomplish?" In this phase, for both PIPs, **HPN** determined its narrowed focus, developed its PIP team, established external partnerships, determined the Global and SMART Aims, and developed the key driver diagram.

Behavioral Health Hospital Readmissions

Upon initial validation of Module 1 for the *Behavioral Health Hospital Readmissions* PIP, HSAG identified that **HPN** needed to provide both an explanation as to why the baseline data provided covered 10 months and not a full year and clarification as to the targeted focus of the PIP. The MCO also needed to identify the external partners for the PIP and revise its Global Aim and key driver diagram. After receiving technical assistance from HSAG, **HPN** made the necessary corrections and resubmitted the module for final validation. For the final validation, the MCO received *Achieved* scores across all evaluation elements for Module 1.

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

Upon initial validation of Module 1 for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)* PIP, HSAG identified that **HPN** needed to provide its comparative provider data that demonstrated that Dr. Veeramachaneni was a high-volume, low-performing provider relative to the other providers in the network. In addition, the MCO needed to simplify its SMART Aim statement and ensure that the goals set for each measure were reasonable and attainable. **HPN** also needed to revise the key driver diagram so that the documented drivers were truly drivers and not interventions. After receiving technical assistance from HSAG, **HPN** made the necessary corrections and resubmitted the module for final validation. For the final validation, the MCO received *Achieved* scores across all evaluation elements for Module 1.

Module 2: SMART Aim Data Collection

The objective of Module 2 is for the MCO to ask and answer the question, "How will we know that a change is improvement?" In this phase, for both PIPs **HPN** defined how and when it will be evident that improvement is being achieved.

Behavioral Health Hospital Readmissions

HPN defined the SMART Aim measure as:

Numerator: The total number of admissions during the measurement month for the top 50 utilizers. "Admission" is defined as "any inpatient substance abuse and/or mental health admission, regardless of time between the original admission and subsequent admissions or specific diagnosis." The top 50 super utilizers are those members with the most claims for inpatient substance abuse and/or mental health admissions from January 1, 2015, through December 31, 2015.

Denominator: The total number of inpatient substance abuse and/or mental health admissions for all members during the measurement month.

On the fifth business day of the month, the Behavioral Healthcare Options, Inc. clinical administrator will review the daily inpatient utilization spreadsheet and determine the number of admissions that the previously identified top 50 members had for the month and the total number of admissions for the month. This daily utilization spreadsheet will be sent to **HPN**'s associate director of quality and the Behavioral Health Options Medicaid Program utilization manager for review. Once the spreadsheet has been reviewed, the rate will be determined by dividing the numerator by the denominator and then plotting it on the SMART Aim run chart.

Upon initial validation of Module 2 for the *Behavioral Health Hospital Readmissions* PIP, HSAG identified that **HPN** needed to revise its quarterly measurement intervals to monthly intervals. The MCO also documented that it would use a claim query based data collection methodology. HSAG requested that **HPN** provide greater detail and supporting documentation that hospital claims queried will be complete within a 30-day period for monthly data collection. HSAG also identified that the axes for the run chart needed to be rescaled to accurately reflect the data to be collected and

that the data collection tool needed to be revised to reflect monthly data collection rather than quarterly.

After receiving technical assistance from HSAG, **HPN** clarified how it will use real-time inpatient authorization data and hospital admission claims data and that claims lag would not be a factor for this PIP. **HPN** also made all other necessary revisions and resubmitted Module 2 for final validation. For the final validation, the MCO received *Achieved* scores across all evaluation elements for Module 2.

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

HPN defined the SMART Aim measure as:

Numerator: **HPN** children 3 through 17 years of age with an outpatient visit with Dr. Veeramachaneni through March 31, 2017, with the following documentation in the member's medical record:

- Body Mass Index (BMI) percentile
- Counseling or education on nutrition and diet
- Counseling or education on physical activity

Denominator: All **HPN** Temporary Assistance for Needy Families (TANF) and Nevada Check Up children 3 through 17 years of age as of March 31, 2017, who had an outpatient visit with Dr. Veeramachaneni.

On the first business day of the month, **HPN** will query a list of eligible Health Plan of Nevada Child Health Assurance Program (CHAP)-TANF and Nevada Check Up children ages 3 through 17 years who had an outpatient visit with Dr. Veeramachaneni. The associate director of clinical quality will then query the data to identify those children who already had an outpatient visit and had documentation of a BMI percentile, counseling or education on nutrition and diet, and counseling or education on physical activity. A second query will be run to identify those remaining children who had an outpatient visit with Dr. Veeramachaneni and who should have received counseling or education on nutrition and diet, received counseling or education on physical activity, and had a BMI percentile documented. This list will be sent to Dr. Veeramachaneni via a secure encrypted email. Throughout the month, Dr. Veeramachaneni's maternal child LPN supervisor will record the children who did receive the required WCC measure components.

On the last business day of the month, Dr. Veeramachaneni's maternal child LPN supervisor will send the list back to **HPN**, where the data will be entered and the rate calculated by dividing the numerator by the denominator and plotting the rate on the SMART Aim run chart.

Upon initial validation of Module 2 for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)* PIP, HSAG identified that **HPN** documented the annual HEDIS methodology for the numerator and denominator descriptions. These descriptions needed to be modified to align with the monthly rapid-cycle PIP process. In addition, the MCO needed to revise the dates on the SMART Aim run chart *x* axis to go through March 2017. **HPN**

made the necessary corrections and resubmitted the module for final validation. For the final validation, the MCO received *Achieved* scores across all evaluation elements for Module 2.

Module 3: Intervention Determination

Module 3 is the intervention determination phase of the PIP. In this module, the MCO will ask and answer the question, "What changes can we make that will result in improvement?"

Behavioral Health Hospital Readmissions

HPN completed a process map and an FMEA to determine the areas within its process with the greatest need for improvement and which would have the most impact on the intended outcomes. The MCO identified the following three subprocesses on which to focus efforts:

- Members identified as working with outpatient care and services.
- Member outpatient plan in place.
- Member participates in outpatient care and services.

Using a risk-priority numbering process to prioritize the identified failure modes within these sub-processes, **HPN** determined that the top three failure modes for which to develop interventions and test through the use of PDSA cycles in Module 4 are:

1. No plan established, and member does not gain access to care and services.
2. Member is not accessible for outreach outside the hospital.
3. Member is not identified as a frequent utilizer of inpatient services.

Upon initial validation of Module 3 for the *Behavioral Health Hospital Readmissions* PIP, HSAG identified that steps appeared to be missing in the MCO's process map when a member was denied due to medical necessity. After receiving technical assistance from HSAG, **HPN** revised its process map and made the necessary corrections, then resubmitted the module for final validation. For the final validation, the MCO received *Achieved* scores across all evaluation elements for Module 3.

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

For its *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)* PIP, **HPN** completed a process map and an FMEA to determine the areas within its processes with the greatest need for improvement and which would have the most impact on intended outcomes. The MCO identified the following three subprocesses on which to focus efforts:

- Member/parent/caregiver understanding the importance of receiving a BMI percentile, counseling for nutrition, and counseling for physical activity
- Provider documentation of BMI percentile, counseling for nutrition, and counseling for physical activity

- Provider billing for each measure (BMI percentile, counseling for nutrition, and counseling for physical activity) in the office visit claim

Using a risk-priority numbering process to prioritize identified failure modes within these subprocesses, **HPN** determined that the top two failure modes for which to develop interventions and test through the use of PDSA cycles in Module 4 are:

- Provider is completing BMI percentile, counseling for nutrition, and counseling for physical activity but not documenting in medical record.
- Provider is completing BMI percentile, counseling for nutrition, and counseling for physical activity but not billing for each submeasure.

Upon initial validation of Module 3 for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)* PIP, **HPN** received *Achieved* scores across all evaluation elements; a resubmission was not required.

At the time of this SFY 2015–2016 EQR Technical Report, **HPN** had completed its PIP cycle through Module 3. HSAG will report on each PIP's Modules 4 and 5 in the SFY 2016–2017 EQR Technical Report.

Plan Comparison

The validation findings showed that both MCOs were able to complete Modules 1 through 3 successfully and attained *Achieved* scores for all modules for both PIPs. Both **HPN** and **Amerigroup** demonstrated their ability to build internal and external quality improvement teams successfully, develop external collaborative partnerships, and use quality improvement science tools both to help identify opportunities for improvement and to develop methodologically sound projects.

Overall Recommendations for Future Module Submissions

Since the MCOs were allowed to resubmit PIP modules and incorporate HSAG recommendations, HSAG does not have recommendations for the PIP modules that were submitted and approved. For future module submissions, HSAG offers the following recommendations:

- As each MCO moves through the quality improvement process and conducts PDSA cycles, each MCO PIP team should ensure that it is communicating the MCO's reasons for making changes to intervention strategies and how these changes will lead to improvement. Without a common understanding and agreement about the causes that effect improvement, the MCO's PIP team may misdirect resources and improvement activities toward changes that do not lead to improvement.
- When planning a test of change, each MCO should be proactive with the intervention (i.e., scaling/ramping up to build confidence in the change, and eventually implementing policy to sustain changes).

- When testing an intervention, each MCO should conduct a series of thoughtful and incremental PDSA cycles to accelerate the rate of improvement.
- As each MCO tests new interventions, it should ensure that it is making a prediction in each step of the PDSA cycle and discussing the basis for the prediction. This will help keep the theory for improvement in the project in the forefront for everyone involved.
- When developing the intervention testing methodology, the MCOs should determine the best method to identify the intended effect of an intervention before testing. The intended effect of the intervention should be known up front to help determine which data need to be collected.
- When testing an intervention, the MCOs should collect detailed, process-level data to ensure collecting enough data to illustrate the effects of the intervention.
- The key driver diagram and FMEA for all PIPs should be updated as each MCO progresses through its PDSA cycles.

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

Objectives

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

Technical Methods of Data Collection and Analysis

Three populations were surveyed for **HPN** and **Amerigroup**: adult Medicaid, child Medicaid, and Nevada Check Up. DSS Research, an NCQA-certified vendor, administered the 2016 CAHPS surveys for both **HPN** and **Amerigroup**.

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

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

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

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

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

Plan-Specific Findings—Amerigroup

Table 7-1 shows **Amerigroup**'s 2015 and 2016 adult Medicaid CAHPS top-box rates. In 2016, a total of 2,499 adult members were sent a survey and 469 completed a survey.[7-1] After ineligible members were excluded, the response rate was 19.3 percent. In 2015, the average NCQA response rate for the adult Medicaid population was 27.2 percent, which was higher than **Amerigroup**'s response rate.[7-2]

Table 7-1—Amerigroup Adult Medicaid CAHPS Results

	2015 Top-Box Rates	2016 Top-Box Rates
Composite Measures		
Getting Needed Care	78.0%	77.6%
Getting Care Quickly	73.6%	76.4%
How Well Doctors Communicate	87.0%	87.5%
Customer Service	86.0%	84.7%
Shared Decision Making	79.9%	80.0%
Global Ratings		
Rating of All Health Care	45.9%	44.2%
Rating of Personal Doctor	63.3%	58.6%
Rating of Specialist Seen Most Often	55.2%	58.6%
Rating of Health Plan	47.9%	45.9%
Effectiveness of Care*		
Advising Smokers and Tobacco Users to Quit	61.1%	62.6%
Discussing Cessation Medications	28.7%	34.8%
Discussing Cessation Strategies	29.6%	32.6%

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

* These rates follow NCQA's methodology for calculating a rolling two-year average.

Indicates the 2016 rate is at least 5 percentage points greater than the 2015 national average.

Indicates the 2016 rate is at least 5 percentage points less than the 2015 national average.

Amerigroup's rates decreased between 2015 and 2016 for five of the 12 measures: *Getting Needed Care*, *Customer Service*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*. **Amerigroup**'s rates increased between 2015 and 2016 for seven measures: *Getting Care Quickly*, *How Well Doctors Communicate*, *Shared Decision Making*, *Rating of Specialist Seen Most Often*, *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and

[7-1] The total number of members who were sent a survey and who completed a survey is based on **Amerigroup**'s adult CAHPS sample only.

[7-2] 2016 NCQA national response rate information for the CAHPS 5.0 Adult Medicaid Survey was not available at the time this report was produced.

Discussing Cessation Strategies. Of these, the *Discussing Cessation Medications* 2016 measure rate was at least 5 percentage points greater than the 2015 rate.

Amerigroup's 2016 top-box rates for the adult Medicaid population were lower than the 2015 NCQA adult Medicaid national averages for 11 of the 12 measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Rating of Health Plan*, *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*. Of these, seven measures were at least 5 percentage points less than the 2015 national averages: *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Rating of Health Plan*, *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*.

Table 7-2 shows **Amerigroup**'s 2015 and 2016 general child Medicaid CAHPS top-box rates.[7-3] In 2016, a total of 4,066 general child members were sent a survey and 686 completed a survey.[7-4] After ineligible members were excluded, the response rate was 17.9 percent. In 2015, the average NCQA response rate for the child Medicaid population was 25.2 percent, which was higher than **Amerigroup**'s response rate.[7-5]

Table 7-2—Amerigroup General Child Medicaid CAHPS Results

	2015 General Child Top-Box Rates	2016 General Child Top-Box Rates
Composite Measures		
Getting Needed Care	83.1%	77.5%
Getting Care Quickly	83.9%	83.3%
How Well Doctors Communicate	91.6%	88.5%
Customer Service	82.1%	87.2%
Shared Decision Making	79.8%	77.3%
Global Ratings		
Rating of All Health Care	62.2%	68.6%
Rating of Personal Doctor	69.1%	69.2%
Rating of Specialist Seen Most Often	NA	80.0%
Rating of Health Plan	63.5%	64.5%

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

Indicates the 2016 rate is at least 5 percentage points greater than the 2015 national average.

Indicates the 2016 rate is at least 5 percentage points less than the 2015 national average.

[7-3] The child Medicaid CAHPS results presented in Table 7-2 for **Amerigroup** are based on the results of the general child population only.

[7-4] The total number of members who were sent a survey and who completed a survey is based on **Amerigroup**'s general child CAHPS sample only (i.e., does not include the CCC supplemental sample of members who were surveyed).

[7-5] 2016 NCQA national response rate information for the CAHPS 5.0 Child Medicaid with CCC Survey was not available at the time this report was produced.

Amerigroup's rates increased between 2015 and 2016 for four measures: *Customer Service*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*. Of these, *Customer Service* and *Rating of All Health Care* showed a substantial increase of more than 5 percentage points. **Amerigroup**'s rates decreased between 2015 and 2016 for four measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Shared Decision Making*. Of these, *Getting Needed Care* showed a substantial decrease of more than 5 percentage points.

Amerigroup's 2016 top-box rates for the general child Medicaid population were lower than the 2015 NCQA child Medicaid national averages for seven measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, *Shared Decision Making*, *Rating of Personal Doctor*, and *Rating of Health Plan*. Of these, one measure, *Rating of Specialist Seen Most Often*, was at least 5 percentage points greater than the 2015 national average. Three measures were at least 5 percentage points less than the 2015 national averages: *Getting Needed Care*, *Getting Care Quickly*, and *Rating of Personal Doctor*.

Table 7-3 shows **Amerigroup**'s 2015 and 2016 CCC child Medicaid CAHPS top-box rates.[7-6] In 2016, a total of 236 child members with a chronic condition completed a survey.[7-7]

Table 7-3—Amerigroup CCC Medicaid CAHPS Results

	2015 CCC Supplemental Top-Box Rates	2016 CCC Supplemental Top-Box Rates
Composite Measures		
Getting Needed Care	76.8%	79.4%
Getting Care Quickly	88.2%	81.9%
How Well Doctors Communicate	92.0%	89.8%
Customer Service	NA	NA
Shared Decision Making	NA	NA
Global Ratings		
Rating of All Health Care	60.9%	62.6%
Rating of Personal Doctor	71.0%	69.2%
Rating of Specialist Seen Most Often	NA	72.6%
Rating of Health Plan	56.8%	61.4%
CCC Composite Measures/Items		
Access to Specialized Services	58.7%	NA
Family Centered Care (FCC): Personal Doctor Who Knows Child	87.6%	89.7%

7-6 The child Medicaid CAHPS results presented in Table 7-3 for **Amerigroup** are based on the results of the CCC population only.

7-7 The total number of members who completed a survey is based on **Amerigroup**'s CCC supplemental CAHPS sample only.

Table 7-3—Amerigroup CCC Medicaid CAHPS Results		
	2015 CCC Supplemental Top-Box Rates	2016 CCC Supplemental Top-Box Rates
Coordination of Care for Children with Chronic Conditions	NA	NA
Access to Prescription Medicines	80.2%	79.2%
FCC: Getting Needed Information	89.4%	88.5%

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

Indicates the 2016 rate is at least 5 percentage points greater than the 2015 national average.

Indicates the 2016 rate is at least 5 percentage points less than the 2015 national average.

Amerigroup's rates increased between 2015 and 2016 for four reportable measures: *Getting Needed Care*, *Rating of All Health Care*, *Rating of Health Plan*, and *FCC: Personal Doctor Who Knows Child*. **Amerigroup**'s rates decreased between 2015 and 2016 for five reportable measures: *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of Personal Doctor*, *Access to Prescription Medicines*, and *FCC: Getting Needed Information*. Of these, *Getting Care Quickly* showed a substantial decrease of more than 5 percentage points.

Amerigroup's 2016 top-box rates for the CCC child Medicaid population were lower than the 2015 NCQA CCC child Medicaid national averages for eight reportable measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Health Plan*, *Access to Prescription Medicines*, and *FCC: Getting Needed Information*. Of these, three measures were at least 5 percentage points less than the 2015 national averages: *Getting Needed Care*, *Getting Care Quickly*, and *Access to Prescription Medicines*.

Table 7-4 shows **Amerigroup**'s 2015 and 2016 Nevada Check Up CAHPS top-box rates.[7-8] Since NCQA does not publish separate rates for the CHIP program, national comparisons could not be made. In 2016, a total of 1,605 Nevada Check Up general child members were sent a survey and 409 completed a survey.[7-9] After ineligible members were excluded, the response rate was 28.8 percent.

Table 7-4—Amerigroup Nevada Check Up CAHPS Results		
	2015 General Child Top-Box Rates	2016 General Child Top-Box Rates
Composite Measures		
Getting Needed Care	77.5%	76.5%
Getting Care Quickly	82.6%	81.6%
How Well Doctors Communicate	89.9%	90.8%
Customer Service	86.7%	84.5%

7-8 The Nevada Check Up CAHPS results presented in Table 7-4 for **Amerigroup** are based on the results of the general child population only.

7-9 The total number of members surveyed and who completed a survey is based on **Amerigroup**'s Nevada Check Up general child CAHPS sample only.

Table 7-4—Amerigroup Nevada Check Up CAHPS Results		
	2015 General Child Top-Box Rates	2016 General Child Top-Box Rates
Shared Decision Making	NA	78.3%
Global Ratings		
Rating of All Health Care	63.7%	60.3%
Rating of Personal Doctor	66.3%	72.7%
Rating of Specialist Seen Most Often	NA	NA
Rating of Health Plan	65.7%	68.6%
A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as Not Applicable (NA).		

Amerigroup's rates decreased between 2015 and 2016 for four measures: *Getting Needed Care*, *Getting Care Quickly*, *Customer Service*, and *Rating of All Health Care.* The rates for three measures increased between 2015 and 2016: *How Well Doctors Communicate*, *Rating of Personal Doctor*, and *Rating of Health Plan.* Of these, *Rating of Personal Doctor* showed a substantial increase of more than 5 percentage points.

Table 7-5 shows **Amerigroup**'s 2015 and 2016 Nevada Check Up CAHPS top-box rates for the CCC population.[7-10] Since NCQA does not publish separate rates for the CHIP program, national comparisons could not be made. In 2016, a total of 80 Nevada Check Up child members with a chronic condition completed a survey.[7-11]

Table 7-5—Amerigroup CCC Nevada Check Up CAHPS Results		
	2015 CCC Supplemental Top-Box Rates	2016 CCC Supplemental Top-Box Rates
Composite Measures		
Getting Needed Care	NA	NA
Getting Care Quickly	NA	NA
How Well Doctors Communicate	NA	NA
Customer Service	NA	NA
Shared Decision Making	NA	NA
Global Ratings		
Rating of All Health Care	NA	NA
Rating of Personal Doctor	NA	NA
Rating of Specialist Seen Most Often	NA	NA

[7-10] The child Medicaid CAHPS results presented in Table 7-5 for **Amerigroup** are based on the results of the Nevada Check Up CCC population only.
[7-11] The total number of members who completed a survey is based on **Amerigroup**'s Nevada Check Up CCC supplemental CAHPS sample only.

Table 7-5—Amerigroup CCC Nevada Check Up CAHPS Results		
	2015 CCC Supplemental Top-Box Rates	2016 CCC Supplemental Top-Box Rates
Rating of Health Plan	NA	NA
CCC Composite Measures/Items		
Access to Specialized Services	NA	NA
FCC: Personal Doctor Who Knows Child	NA	NA
Coordination of Care for Children with Chronic Conditions	NA	NA
Access to Prescription Medicines	NA	NA
FCC: Getting Needed Information	NA	NA
A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as Not Applicable (NA).		

Amerigroup's 2015 and 2016 rates could not be reported for the Nevada Check Up CCC population, since all measures did not meet the minimum number of responses.

Plan-Specific Findings—HPN

Table 7-6 shows **HPN**'s 2015 and 2016 adult Medicaid CAHPS top-box rates. In 2016, a total of 1,899 members were sent a survey and 271 completed a survey. After ineligible members were excluded, the response rate was 14.4 percent. In 2015, the average NCQA response rate for the adult Medicaid population was 27.2 percent, which was higher than **HPN**'s response rate.[7-12]

Table 7-6—HPN Adult Medicaid CAHPS Results

	2015 Top-Box Rates	2016 Top-Box Rates
Composite Measures		
Getting Needed Care	73.5%	73.1%
Getting Care Quickly	78.0%	70.4%
How Well Doctors Communicate	88.9%	86.5%
Customer Service	87.8%	NA
Shared Decision Making	NA	NA
Global Ratings		
Rating of All Health Care	51.4%	44.6%
Rating of Personal Doctor	61.3%	54.3%
Rating of Specialist Seen Most Often	65.1%	NA
Rating of Health Plan	56.3%	52.5%
Effectiveness of Care*		
Advising Smokers and Tobacco Users to Quit	54.4%	63.1%
Discussing Cessation Medications	28.4%	24.8%
Discussing Cessation Strategies	27.2%	26.8%

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

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

Indicates the 2016 rate is at least 5 percentage points greater than the 2015 national average.

Indicates the 2016 rate is at least 5 percentage points less than the 2015 national average.

HPN's rates decreased between 2015 and 2016 for eight of nine reportable measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Health Plan*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*. Of these, three measures showed a substantial decrease of more than 5 percentage points: *Getting Care Quickly*, *Rating of All Health Care*, and *Rating of Personal Doctor*. One measure, *Advising Smokers and Tobacco Users to Quit*, increased between 2015 and 2016. The increase was more than 5 percentage points.

[7-12] 2016 NCQA national response rate information for the CAHPS 5.0 Adult Medicaid Survey was not available at the time this report was produced.

HPN's 2016 top-box rates for the adult Medicaid population were lower than the 2015 NCQA adult Medicaid national averages for all reportable measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Health Plan*, *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*. Of these, eight measures were at least 5 percentage points less than the 2015 national average: *Getting Needed Care*, *Getting Care Quickly*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Health Plan*, *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies.*

Table 7-7 shows **HPN**'s 2015 and 2016 child Medicaid CAHPS top-box rates.[7-13] In 2016, a total of 2,372 general child members were sent a survey and 466 completed a survey.[7-14] After ineligible members were excluded, the response rate for the general child population was 20.4 percent. In 2015, the average NCQA response rate for the child Medicaid population was 25.2 percent, which was higher than **HPN**'s 2016 response rate.[7-15]

Table 7-7—HPN Child Medicaid CAHPS Results

	2015 General Child Top-Box Rates	2016 General Child Top-Box Rates
Composite Measures		
Getting Needed Care	79.2%	80.6%
Getting Care Quickly	83.7%	85.9%
How Well Doctors Communicate	92.3%	89.5%
Customer Service	NA	90.1%
Shared Decision Making	NA	78.4%
Global Ratings		
Rating of All Health Care	59.7%	68.5%
Rating of Personal Doctor	70.0%	74.4%
Rating of Specialist Seen Most Often	NA	NA
Rating of Health Plan	71.5%	74.9%

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

Indicates the 2016 rate is at least 5 percentage points greater than the 2015 national average.

Indicates the 2016 rate is at least 5 percentage points less than the 2015 national average.

HPN's rates decreased between 2015 and 2016 for one of the six reportable measures, *How Well Doctors Communicate*. **HPN**'s rates increased between 2015 and 2016 for five measures: *Getting Needed Care*, *Getting Care Quickly*, *Rating of All Health Care*, *Rating of Personal Doctor*, and

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

[7-14] The total number of members who were sent a survey and who completed a survey is based on **HPN**'s general child CAHPS sample (i.e., does not include the CCC supplemental sample of members who were sent a survey).

[7-15] 2016 NCQA national response rate information for the CAHPS 5.0 Child Medicaid with CCC Survey was not available at the time this report was produced.

Rating of Health Plan. Further, one measure, *Rating of All Health Care*, showed a substantial increase of more than 5 percentage points.

HPN's 2016 top-box rates for the general child Medicaid population were lower than the 2015 NCQA general child Medicaid national averages for four measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Rating of Personal Doctor*. Four of **HPN**'s 2016 top-box rates for the general child Medicaid population were higher than the 2015 NCQA general child Medicaid national average: *Customer Service*, *Shared Decision Making*, *Rating of All Health Care*, and *Rating of Health Plan*. *Rating of Health Plan* was at least 5 percentage points greater than the 2015 national average.

Table 7-8 shows **HPN**'s 2015 and 2016 CCC child Medicaid CAHPS top-box rates.[7-16] In 2016, a total of 267 child members with a chronic condition completed a survey.[7-17]

Table 7-8—HPN CCC Medicaid CAHPS Results

	2015 CCC Supplemental Top-Box Rates	2016 CCC Supplemental Top-Box Rates
Composite Measures		
Getting Needed Care	79.3%	76.5%
Getting Care Quickly	78.4%	85.0%
How Well Doctors Communicate	88.7%	91.8%
Customer Service	NA	NA
Shared Decision Making	79.0%	78.7%
Global Ratings		
Rating of All Health Care	54.2%	64.9%
Rating of Personal Doctor	64.8%	68.9%
Rating of Specialist Seen Most Often	61.9%	63.2%
Rating of Health Plan	62.0%	66.8%
CCC Composite Measures/Items		
Access to Specialized Services	62.6%	64.7%
FCC: Personal Doctor Who Knows Child	82.6%	88.6%
Coordination of Care for Children with Chronic Conditions	72.8%	78.5%
Access to Prescription Medicines	88.0%	89.1%
FCC: Getting Needed Information	86.3%	87.3%

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

Indicates the 2016 rate is at least 5 percentage points greater than the 2015 national average.

Indicates the 2016 rate is at least 5 percentage points less than the 2015 national average.

[7-16] The child Medicaid CAHPS results presented in Table 7-8 for **HPN** are based on the results of the CCC population only.
[7-17] The total number of members who completed a survey is based on **HPN**'s CCC supplemental CAHPS sample only.

HPN's rates increased between 2015 and 2016 for 11 measures: *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Rating of Health Plan*, *Access to Specialized Services*, *FCC: Personal Doctor Who Knows Child*, *Coordination of Care for Children with Chronic Conditions*, *Access to Prescription Medicines*, and *FCC: Getting Needed Information*. Of these, four measures showed a substantial increase of more than 5 percentage points: *Getting Care Quickly*, *Rating of All Health Care*, *FCC: Personal Doctor Who Knows Child*, and *Coordination of Care for Children with Chronic Conditions*. **HPN**'s rates decreased between 2015 and 2016 for two measures: *Getting Needed Care* and *Shared Decision Making*.

HPN's 2016 top-box rates for the CCC child Medicaid population were lower than the 2015 NCQA CCC child Medicaid national average for 10 measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Shared Decision Making*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Access to Specialized Services*, *FCC: Personal Doctor Who Knows Child*, *Access to Prescription Medicines*, and *FCC: Getting Needed Information*. Two of **HPN**'s 2016 top-box rates for the CCC child Medicaid population, *Rating of All Health Care* and *Rating of Health Plan*, were higher than the 2015 NCQA CCC child Medicaid national average. However, five measures were at least 5 percentage points less than the 2015 national average: *Getting Needed Care*, *Getting Care Quickly*, *Shared Decision Making*, *Rating of Specialist Seen Most Often*, and *Access to Specialized Services*.

Table 7-9 shows **HPN**'s 2015 and 2016 Nevada Check Up CAHPS top-box rates for the general child population.[7-18,7-19] Since NCQA does not publish separate rates for the CHIP program, national comparisons could not be made. In 2016, a total of 2,352 Nevada Check Up general child members were sent a survey and 538 completed a survey.[7-20] After ineligible members were excluded, the response rate was 32.1 percent.

Table 7-9—HPN Nevada Check Up CAHPS Results

	2015 General Child Top-Box Rates	2016 General Child Top-Box Rates
Composite Measures		
Getting Needed Care	80.8%	79.6%
Getting Care Quickly	80.3%	82.2%
How Well Doctors Communicate	90.5%	89.7%
Customer Service	88.4%	85.2%
Shared Decision Making	79.1%	73.8%

[7-18] The Nevada Check Up CAHPS results presented in Table 7-9 for **HPN** are based on the results of the general child population only.
[7-19] Due to changes to the *Shared Decision Making* composite measure, comparisons of the 2015 to 2014 top-box rate could not be performed for this CAHPS measure.
[7-20] The total number of members who were sent a survey and who completed a survey is based on **HPN**'s general child CAHPS sample only (i.e., does not include the CCC supplemental sample of members who were sent a survey).

Table 7-9—HPN Nevada Check Up CAHPS Results		
	2015 General Child Top-Box Rates	2016 General Child Top-Box Rates
Global Ratings		
Rating of All Health Care	66.3%	66.6%
Rating of Personal Doctor	68.3%	73.5%
Rating of Specialist Seen Most Often	NA	68.4%
Rating of Health Plan	72.4%	73.9%
A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as Not Applicable (NA).		

HPN's rates increased between 2015 and 2016 for four measures: *Getting Care Quickly*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*. For the remaining four reportable measures, **HPN**'s rates decreased between 2015 and 2016: *Getting Needed Care*, *How Well Doctors Communicate*, *Customer Service*, and *Shared Decision Making*. Further, one measure, *Shared Decision Making*, showed a substantial decrease of more than 5 percentage points between 2015 and 2016.

Table 7-10 shows **HPN**'s 2015 and 2016 Nevada Check Up CAHPS top-box rates for the CCC population.[7-21] Since NCQA does not publish separate rates for the CHIP program, national comparisons could not be made. In 2016, 244 Nevada Check Up child members with a chronic condition completed a survey.[7-22]

Table 7-10—HPN CCC Nevada Check UP CAHPS Results		
	2015 CCC Supplemental Top-Box Rates	2016 CCC Supplemental Top-Box Rates
Composite Measures		
Getting Needed Care	83.5%	80.9%
Getting Care Quickly	83.7%	84.2%
How Well Doctors Communicate	90.6%	90.7%
Customer Service	NA	NA
Shared Decision Making	NA	NA
Global Ratings		
Rating of All Health Care	63.3%	67.2%
Rating of Personal Doctor	68.3%	73.1%
Rating of Specialist Seen Most Often	NA	70.6%
Rating of Health Plan	67.8%	67.8%

[7-21] The child Medicaid CAHPS results presented in Table 7-10 for **HPN** are based on the results of the Nevada Check Up CCC population only.

[7-22] The total number of members who completed a survey is based on **HPN**'s Nevada Check Up CCC supplemental CAHPS sample only.

Table 7-10—HPN CCC Nevada Check UP CAHPS Results		
	2015 CCC Supplemental Top-Box Rates	2016 CCC Supplemental Top-Box Rates
CCC Composite Measures/Items		
Access to Specialized Services	NA	NA
FCC: Personal Doctor Who Knows Child	84.4%	86.7%
Coordination of Care for Children with Chronic Conditions	NA	NA
Access to Prescription Medicines	91.2%	87.7%
FCC: Getting Needed Information	93.3%	88.4%
A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as Not Applicable (NA).		

HPN's rates increased between 2015 and 2016 for five measures: *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *FCC: Personal Doctor Who Knows Child*. **HPN**'s rates decreased between 2015 and 2016 for three measures: *Getting Needed Care*, *Access to Prescription Medicines*, and *FCC: Getting Needed Information.*

Plan Comparison

Amerigroup's response rate for the adult Medicaid population was lower than the 2015 NCQA adult Medicaid average response rate by 7.9 percentage points. **Amerigroup**'s adult Medicaid CAHPS scores were below the 2015 NCQA adult Medicaid national averages for 11 of the 12 measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Rating of Health Plan*, *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*. **HPN**'s response rate for the 2016 adult Medicaid population was 12.8 percentage points lower than the 2015 NCQA adult Medicaid average response rate. **HPN**'s adult Medicaid CAHPS scores were below the 2015 NCQA adult Medicaid national averages for all reportable measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Health Plan*, *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies.*

Amerigroup's response rate for the general child Medicaid population was 7.3 percentage points lower than the average 2015 NCQA response rate for the general child Medicaid population. **Amerigroup**'s general child Medicaid CAHPS scores were below the 2015 NCQA general child Medicaid national averages for five composite measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, and *Shared Decision Making.* In addition, **Amerigroup**'s general child Medicaid CAHPS scores were below the 2015 NCQA general child Medicaid national averages for two global ratings: *Rating of Personal Doctor* and *Rating of Health Plan*. **HPN**'s response rate for the 2016 general child Medicaid population was lower by 4.8 percentage points than the 2015 NCQA general child Medicaid average response rate. **HPN**'s general child Medicaid CAHPS scores were below the 2015 NCQA general child Medicaid national averages for three reportable composite measures—*Getting Needed Care*, *Getting Care Quickly*, and *How Well Doctors Communicate*—and for one reportable global rating: *Rating of Personal Doctor*.

Amerigroup's CCC child Medicaid CAHPS scores were below the 2015 NCQA CCC child Medicaid national averages for three reportable composite measures: *Getting Needed Care*, *Getting Care Quickly*, and *How Well Doctors Communicate*. In addition, **Amerigroup**'s CCC child Medicaid CAHPS scores were below the 2015 NCQA CCC child Medicaid national averages for three global ratings—*Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*—and for two reportable CCC composite measures: *Access to Prescription Medicines* and *FCC: Getting Needed Information.* **HPN**'s CCC child Medicaid CAHPS scores were below the 2015 NCQA CCC child Medicaid national averages for four reportable composite measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Shared Decision Making.* **HPN**'s CCC child Medicaid CAHPS scores were also below the 2015 NCQA CCC child Medicaid national averages for two reportable global ratings: *Rating of Personal Doctor* and *Rating of Specialist Seen Most Often*. In addition, **HPN**'s CCC child Medicaid CAHPS scores were below the 2015 NCQA CCC child Medicaid national averages for four CCC composite measures: *Access to Specialized Services*, *FCC: Personal Doctor Who Knows Child*, *Access to Prescription Medicines*, and *FCC: Getting Needed Information.*

Amerigroup's 2016 Nevada Check Up CAHPS scores were above the 2015 Nevada Check Up CAHPS scores for three measures for the general child population: *How Well Doctors Communicate*, *Rating of Personal Doctor*, and *Rating of Health Plan*. Since NCQA does not publish separate rates

for the CHIP program, national comparisons could not be made. **HPN**'s 2016 Nevada Check Up CAHPS scores were below the 2015 Nevada Check Up CAHPS score for four composite measures for the general child population: *Getting Needed Care*, *How Well Doctors Communicate*, *Customer Service*, and *Shared Decision Making*.

Amerigroup's 2016 Nevada Check Up CCC CAHPS survey results were lower than the minimum required 100 responses; therefore, the comparisons could not be completed. Additionally, since NCQA does not publish separate rates for the CHIP program, national comparisons could not be made. **HPN**'s 2016 Nevada Check Up CCC CAHPS score was below the 2015 Nevada Check Up CCC CAHPS score for one composite measure: *Getting Needed Care*. **HPN**'s 2016 Nevada Check Up CCC CAHPS score was also below the 2015 Nevada Check Up CCC CAHPS score for two CCC composite measures: *Access to Prescription Medicines* and *FCC: Getting Needed Information.*

Overall Recommendations

HSAG recommends that each MCO continue to work with its CAHPS vendor to ensure that a sufficient number of completed surveys is obtained to enable reporting of all CAHPS measures. NCQA recommends targeting 411 completed surveys per survey administration. **Amerigroup** had measures that did not meet the minimum number of responses (i.e., 100 responses) for the CCC Medicaid population, Nevada Check Up general child population, and Nevada Check Up CCC population. **HPN** had measures that did not meet the minimum number of responses for the adult Medicaid population, general child and CCC Medicaid populations, and the CCC Nevada Check Up population. Without sufficient responses, MCOs lack information that can be critical to designing and implementing targeted interventions that can improve access to, and the quality and timeliness of, care.

For the adult population, HSAG recommends that **Amerigroup** focus quality improvement initiatives on enhancing members' experiences with *Getting Needed Care*, *Customer Service*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*, since these rates were lower than the 2015 adult CAHPS results and fell below NCQA's 2015 CAHPS adult Medicaid national averages. For the general child Medicaid population, **Amerigroup** should focus on improving *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Shared Decision Making*, since the rates for these measures were lower than the 2015 general child CAHPS results and fell below NCQA's 2015 CAHPS child Medicaid national averages. For the CCC Medicaid population, **Amerigroup** should focus on improving *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of Personal Doctor*, *Access to Prescription Medicines*, and *FCC: Getting Needed Information*, since the rates for these reportable measures were lower than the 2015 CCC child CAHPS results and fell below NCQA's 2015 CAHPS CCC child national averages. For the Nevada Check Up population, HSAG recommends that **Amerigroup** focus quality improvement initiatives on enhancing members' experiences with *Getting Needed Care*, *Getting Care Quickly*, *Customer Service*, and *Rating of All Health Care*, since the 2016 rates for these reportable measures were lower than the 2015 rates.

HSAG recommends that **HPN** focus quality improvement initiatives on enhancing members' experiences with *Getting Needed Care*, *Getting Care Quickly*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Health Plan*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies* for the adult Medicaid population, since these rates were lower than the 2015

adult CAHPS results and fell below NCQA's 2015 CAHPS adult Medicaid national averages. For the general child Medicaid population, **HPN** should focus on improving *How Well Doctors Communicate*, since the rate for this composite measure was lower than the 2015 child CAHPS result and fell below NCQA's 2015 CAHPS child Medicaid national average. For the CCC child Medicaid population, **HPN** should focus on improving *Getting Needed Care* and *Shared Decision Making*, since the rates for these measures fell below the 2015 CAHPS results and were substantially lower than the 2015 NCQA CCC child Medicaid national averages. For the Nevada Check Up population, quality improvement efforts should focus on *Shared Decision Making*, since this measure showed a substantial decrease from 2015 to 2016. For the CCC Nevada Check Up population, **HPN** should improve the *Getting Needed Care, Access to Prescription Medicines*, and *FCC: Getting Needed Information*, since the rates for these measures decreased from 2015 to 2016.

8. Health Care Guidance Program (HCGP) CAP Review

Background

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

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

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

Out of 12 standards reviewed during the compliance review, seven were found to be deficient. HSAG recommended that **McKesson**, doing business as **APH,** submit to DHCFP a corrective action plan (CAP) to remedy all deficiencies that resulted from the compliance review. **APH** was responsible for developing the CAP, obtaining DHCFP approval of the CAP, and implementing the strategies outlined in the DHCFP-approved CAP.

CAP Review Findings

In SFY 2015–2016, HSAG worked with the DHCFP staff to review several CAPs submitted by **APH** and provide the DHCFP with feedback regarding the feasibility that the **APH** proposed strategies would remedy the deficiencies noted in the compliance review. Several of the responses **APH** submitted were not acceptable to the DHCFP, which issued a closeout letter to **McKesson** in July 2015 citing the items that were not acceptable. During SFY 2015–2016, HSAG worked with the DHCFP staff to review additional strategies proposed by **APH** to remedy outstanding deficiencies.

Table 8-1 shows the standards that required a CAP, whether the DHCFP accepted the first CAP submission, and the date the DHCFP accepted the final CAP.

Table 8-1—CAPs Submitted by APH				
Standard Number	**Standard Name**	**CAP Required**	**First CAP Submission Approved by DHCFP**	**Date CAP Accepted by DHCFP**
I	Stratification of Enrollees	Yes	No	3/15/16
II	Care Management Teams	No	–	–
III	Care Planning	Yes	No	1/13/16
IV	Mental Health Care Management Services	No	–	–
V	Health Education Materials	No	–	–
VI	Nurse Triage and Call Services	Yes	Partial	12/14/15
VII	Emergency Department Redirection	No	–	–
VIII	Stakeholder Outreach and Education	No	–	–
IX	Feedback to Primary Care Providers (PCPs)	Yes	No	1/13/16
X	Provider Services	Yes	Yes	7/15/15
XI	Care Transitions	Yes	Yes	7/15/15
XII	Operational Structure and Reporting	Yes	No	12/14/15
Total CAPs		**7/12**	**2.5/7**	
A dash "–" indicates that no CAP was required.				

As noted in Table 8-1, the DHCFP monitored the deficient standards until it fully accepted the CAP submitted by **APH**. The DHCFP approved the last CAP on March 15, 2016.

9. Health Care Guidance Program Performance Measure Validation

Background

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

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

The DHCFP sought to verify that, on an annual basis, **APH** collected and reported complete and accurate performance measure data for contractually required performance measures. To verify the accuracy of **APH**'s reported rates, the DHCFP contracted with Health Services Advisory Group, Inc. (HSAG), the State's external quality review organization (EQRO), to validate the performance measure rates that **APH** calculated and reported. To ensure that the performance measure validation (PMV) activity was performed in accordance with industry standards of practice, HSAG validated **APH**'s performance measures using the external quality review (EQR) Protocol 2[9-1] developed by CMS as its guide. HSAG's PMV activity focused on the following objectives:

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

Performance Measures Validated

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

[9-1] *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 1, 2012.

Validation Results

Several aspects involved in the calculation of performance measures are crucial to the validation process. These include data retrieval, integration, data control, and source code development and documentation of performance measure calculations.

Data Retrieval

HSAG reviewed the processes **APH** used to receive, transfer, and store the source data used to calculate the measures, which included staff interview, examination of log files, and participating in a live demonstration of the VITAL system. The VITAL system is a care management workflow system developed by **McKesson Technologies, Inc.** Overall, HSAG determined that the data integration processes in place at **APH** were adequate.

Data Integration

HSAG reviewed the data integration process used by **APH**, which included a review of file consolidations or extracts, source data compared to warehouse files, data integration documentation, source code, production activity logs, and linking mechanisms. Overall, HSAG determined that the data integration processes in place at **APH** were adequate.

Data Control

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

Source Code Development and Performance Measure Documentation

HSAG conducted a line-by-line source code review for all measures except those related to Care Transitions (i.e., CCHU 3-7 and DEM) and reviewed related documentation, which included the completed Information Systems Capabilities Assessment Tool (ISCAT), computer programming code, output files, work flow diagrams, and narrative descriptions of performance measure calculations. All applicable source code was approved prior to the on-site visit. HSAG also determined that **APH**'s documentation of performance measure calculations by was adequate.

Performance Measure-Specific Rates

HSAG received the final performance measure results generated by **APH** based on latest receipt of all applicable monthly operational files on October 9, 2015. All measure results were reviewed for reasonability. Table 9-1 shows the measure-specific rates for **APH.** For several measures (i.e., Care Transitions [CCUH.2-7], Cognitive Assessment for Dementia [DEM], Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer [CAN], and Childhood Immunization Status [CIS]), **APH** did not take the necessary steps or did not

operationalize appropriate protocols/activities to obtain the information necessary to calculate the measures. Therefore, these measures were assigned a "Not Completed" in the Audit Validation Results column.

Table 9-1—Measure-Specific Rates and Validation Results for APH

Measure ID	Measure	Program Period 1 (June 1, 2014–May 30, 2015)			Audit Validation Results
		Num	Den	Rate	
CCHU.1	*Ambulatory Care-Sensitive Condition Hospital Admission (per 100,000 population)*	2408	52575	4580	**Reportable**
CCHU.2	*"Avoidable" ER Visits*	15475	34169	45.3%	**Reportable**
CCHU.3	*Care Transitions—24 hours of discharge*	NC	NC	NC	**Not Completed**
CCHU.4	*Care Transitions—7 days of discharge*	NC	NC	NC	**Not Completed**
CCHU.5	*Care Transitions—30 days of discharge*	NC	NC	NC	**Not Completed**
CCHU.6	*Care Transitions—Receipt of Transition Record to Patient*	NC	NC	NC	**Not Completed**
CCHU.7	*Transition of Care—Reconciled Medication List*	NC	NC	NC	**Not Completed**
DEM	*Cognitive Assessment for Dementia*	NC	NC	NC	**Not Completed**
NEUR	*Stroke and Stroke Rehabilitations—Discharged on Antithrombotic Therapy*	18	165	10.9%	**Reportable**
CKD	*Adult Kidney Disease—Laboratory Testing (Lipid Profile)*	0	699	0.0%	Measure calculated correctly; technical specifications may not fully identify the numerator.
CAN	*Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer*	NC	NC	NC	**Not Completed**
RA	*Disease-modifying Anti-Rheumatic Drug (DMARD) Therapy for Rheumatoid Arthritis*	118	181	65.2%	**Reportable**
OST	*Osteoporosis—Pharmacologic therapy for men and women aged 50 years and older*	228	1972	11.6%	**Reportable**
OBS	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (3–11 Years)*	403	5431	7.4%	**Reportable**
OBS	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (12–17 Years)*	300	3336	9.0%	**Reportable**
CAP	*Children and Adolescents' Access to Primary Care Practitioners (12–24 months)*	504	549	91.8%	**Reportable**
CAP	*Children and Adolescents' Access to Primary Care Practitioners (25 months–6 years)*	2925	3557	82.2%	**Reportable**
CAP	*Children and Adolescents' Access to Primary Care Practitioners (7–11 years)*	3641	4224	86.2%	**Reportable**
CAP	*Children and Adolescents' Access to Primary Care Practitioners (12–19 years)*	4794	5518	86.9%	**Reportable**

Table 9-1—Measure-Specific Rates and Validation Results for APH					
Measure ID	Measure	Program Period 1 (June 1, 2014–May 30, 2015)			Audit Validation Results
		Num	Den	Rate	
W15	*Well-Child Visits in the First 15 Months of Life (0 Visits)*	207	992	20.9%	**Reportable**
W15	*Well-Child Visits in the First 15 Months of Life (1 Visit)*	150	992	15.1%	**Reportable**
W15	*Well-Child Visits in the First 15 Months of Life (2 Visits)*	142	992	14.3%	**Reportable**
W15	*Well-Child Visits in the First 15 Months of Life (3 Visits)*	139	992	14.0%	**Reportable**
W15	*Well-Child Visits in the First 15 Months of Life (4 Visits)*	110	992	11.1%	**Reportable**
W15	*Well-Child Visits in the First 15 Months of Life (5 Visits)*	87	992	8.8%	**Reportable**
W15	*Well-Child Visits in the First 15 Months of Life (6 or more visits)*	157	992	15.8%	**Reportable**
W34	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*	1459	3021	48.3%	**Reportable**
AWC	*Adolescent Well-Care Visits*	1766	6032	29.3%	**Reportable**
CIS	*Childhood Immunization Status (Dtap)*	0	1084	NC	**Not Completed**
CIS	*Childhood Immunization Status (IPV)*	4	1084	NC	**Not Completed**
CIS	*Childhood Immunization Status (MMR)*	0	1084	NC	**Not Completed**
CIS	*Childhood Immunization Status (HiB)*	5	1084	NC	**Not Completed**
CIS	*Childhood Immunization Status (HepB)*	2	1084	NC	**Not Completed**
CIS	*Childhood Immunization Status (VZV)*	3	1084	NC	**Not Completed**
CIS	*Childhood Immunization Status (PCV)*	0	1084	NC	**Not Completed**
CIS	*Childhood Immunization Status (HepA)*	1	1084	NC	**Not Completed**
CIS	*Childhood Immunization Status (Rotavirus)*	2	1084	NC	**Not Completed**
CIS	*Childhood Immunization Status (Influenza)*	0	1084	NC	**Not Completed**
CIS	*Childhood Immunization Status (Combination #2)*	NC	NC	NC	**Not Completed**
CIS	*Childhood Immunization Status (Combination #3)*	NC	NC	NC	**Not Completed**
CIS	*Childhood Immunization Status (Combination #4)*	NC	NC	NC	**Not Completed**
CIS	*Childhood Immunization Status (Combination #5)*	NC	NC	NC	**Not Completed**
CIS	*Childhood Immunization Status (Combination #6)*	NC	NC	NC	**Not Completed**
CIS	*Childhood Immunization Status (Combination #7)*	NC	NC	NC	**Not Completed**
CIS	*Childhood Immunization Status (Combination #8)*	NC	NC	NC	**Not Completed**
CIS	*Childhood Immunization Status (Combination #9)*	NC	NC	NC	**Not Completed**
CIS	*Childhood Immunization Status (Combination #10)*	NC	NC	NC	**Not Completed**

Table 9-1—Measure-Specific Rates and Validation Results for APH					
Measure ID	Measure	Program Period 1 (June 1, 2014–May 30, 2015)			Audit Validation Results
		Num	Den	Rate	
PPC	*Timeliness of Prenatal Care*	267	1122	23.8%	**Reportable**
PPC	*Postpartum Care*	143	1122	12.7%	**Reportable**
WOP	*Weeks of Pregnancy at Time of Enrollment, ≤ 0 weeks (280 days or more prior to delivery)*	262	1451	18.1%	**Reportable**
WOP	*Weeks of Pregnancy at Time of Enrollment, 1–12 weeks (279–196 days prior to delivery)*	229	1451	15.8%	**Reportable**
WOP	*Weeks of Pregnancy at Time of Enrollment, 13–27 weeks (195–91 days prior to delivery)*	580	1451	40.0%	**Reportable**
WOP	*Weeks of Pregnancy at Time of Enrollment, 28 or more weeks (≤90 days prior to delivery)*	311	1451	21.4%	**Reportable**
WOP	*Weeks of Pregnancy at Time of Enrollment, Unknown*	69	1451	4.8%	**Reportable**
FPC	*Frequency of Ongoing Prenatal Care, <21 percent of expected visits*	702	1122	62.6%	**Reportable**
FPC	*Frequency of Ongoing Prenatal Care, 21 percent–40 percent of expected visits*	275	1122	24.5%	**Reportable**
FPC	*Frequency of Ongoing Prenatal Care, 41 percent–60 percent of expected visits*	74	1122	6.6%	**Reportable**
FPC	*Frequency of Ongoing Prenatal Care, 61 percent–80 percent of expected visits*	41	1122	3.7%	**Reportable**
FPC	*Frequency of Ongoing Prenatal Care, ≥81 percent of expected visits*	30	1122	2.7%	**Reportable**
ABA	*Adult BMI Assessment*	1271	12849	9.9%	**Reportable**
BCS	*Breast Cancer Screening*	2303	5431	42.4%	**Reportable**
CCS	*Cervical Cancer Screening*	3047	8753	34.8%	**Reportable**
COL	*Colorectal Cancer Screening*	1118	5977	18.7%	**Reportable**

Summary of Findings

This audit examined 24 measures with a total of 63 indicators, or individual rates. Of the 63 indicators, 26 rates were given a Not Completed. The rates for the other 37 indicators appeared to be appropriately calculated and reported by **APH**.

APH staff members stated that **APH** was unable to report the care transition measures CCHU 3-7 because **APH** could not fully identify the eligible population and the numerator requirements could not be adequately met with their current process. **APH**'s staff reported that **APH** may not be notified or may not receive encounter data for months after an individual's hospitalization. To mitigate this issue, **APH** staff members attempted to monitor hospitalizations for enrollees via **APH**

staffing and established relationships with hospital facilities so the facilities would report to **APH** when an enrollee was hospitalized.

All of the indicators (numerators) for the *Childhood Immunization Status* measure were underreported based solely on administrative data. Without immunization data from the State registry or medical record review, *Childhood Immunization Status* measure rates were too low to derive any effective conclusion or impact **APH** may have had on this population.

The rates for *Cognitive Assessment for Dementia (DEM)* and *Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor Positive Breast Cancer (CAN)* were also given a Not Completed. For the DEM measure, **APH** was not able to fully identify the denominator. The technical specifications for the CAN measure uses CPT II codes; however, the providers do not currently submit CPT II codes in Nevada. Therefore, the CAN measure had no members identified in the denominator and was Not Completed.

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

Overall Recommendations and Status of Recommendations

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

- **APH** should work to obtain WebIZ supplemental immunization registry data in order to calculate a rate for the *Childhood Immunization Status* measures.
  - **Update: APH** secured the necessary access to obtain WebIZ supplemental immunization registry data in the spring of 2016.
- The DHCFP should revisit the care transition measures, CCHU 3-7, to determine the likelihood that data can be obtained to report the measures. If data cannot be obtained, then the measures should be omitted or replaced with other measures.
  - **Update:** The DHCFP and HSAG staff members worked to replace the CCHU 3-7 measures with measures that **APH** could calculate. The new measures are *Follow-Up with PCP After Hospitalization—7 days* and *30 days* and *Medication Reconciliation Post-Discharge.*
- For the *Cognitive Assessment for Dementia* measure, DHCFP should consider modifying the measure specifications so that **APH** can identify the denominator.

- **Update:** The DHCFP and HSAG staff members worked to modify the codes used to specify the denominator so that it could be identified by **APH** and a rate could be generated.

- DHCFP should consider replacing or removing the measure *Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor Positive Breast Cancer (CAN)*, since CPT II codes cannot be collected.
  - **Update:** The DHCFP removed the measure *Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor Positive Breast Cancer (CAN)* from the suite of non-P4P performance measures, since CPT II codes could not be collected.

Appendix A. Technical Methods of Data Collection and Analysis

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

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

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

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

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

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

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

Guidance Program (HCGP) compliance review follow up, and HCGP performance measure validation (PMV). The objectives for each of these activities are described in the respective sections of this report.

Internal Quality Assurance Program (IQAP) Corrective Action Plan Review

The purpose of the *SFY 2014–2015 Internal Quality Assurance Program (IQAP) On-Site Review of Compliance* was to determine each MCO's compliance with federal and State managed care standards. For the *SFY 2014–2015 IQAP On-Site Review of Compliance*, HSAG reviewed each MCO's managed care and quality program activities that occurred during SFY 2013–2014. In SFY 2014–2015, HSAG reviewed the corrective action plans submitted by the MCOs and approved by the DHCFP. HSAG also identified a couple of key contractual requirements that were misinterpreted by the MCOs and made recommendations to the DHCFP as to how these areas could be clarified for the MCOs. HSAG worked with DHCFP to clarify the requirements for the MCOs so that the requirements would not be misinterpreted in the future.

Validation of Performance Improvement Projects (PIPs)

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

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

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

PIP Validation Redesigned

In July 2014, HSAG developed a new PIP framework based on a modified version of the Model for Improvement developed by Associates in Process Improvement and modified by the Institute for Healthcare Improvement. The redesigned PIP methodology was intended to improve processes and outcomes of healthcare by way of continuous quality improvement. The redesigned framework redirects MCOs to focus on small tests of change in order to determine which interventions have the greatest impact and can bring about real improvement. PIPs must meet CMS requirements; therefore, HSAG completed a crosswalk of this new framework against the Department of Health and Human Services, CMS publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.

HSAG presented the crosswalk and new PIP framework components to CMS to demonstrate how the new PIP framework aligned with the CMS validation protocols. CMS agreed that, with the pace of quality improvement science development and the prolific use of plan, do, study, act (PDSA) cycles in modern improvement projects within healthcare settings, a new approach was needed.

After meeting with the DHCFP and HSAG staff members to discuss the topics and approach, CMS gave approval for the DHCFP to implement this new PIP approach in Nevada.

PIP Components and Process

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

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

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

Approach to PIP Validation

In SFY 2015–2016, HSAG obtained the data needed to conduct the PIP validation from the MCO's module submission forms. These forms provided detailed information about each of the PIPs and the activities completed in Modules 1 through 3.

The MCO submitted each module according to the approved timeline. After the initial validation of each module, the MCO received HSAG's feedback and technical assistance and resubmitted the modules until all validation criteria were met. This method ensured that the methodology was sound before the MCO tested interventions. Currently, the MCOs are testing interventions and completing

Module 4. The Module 4 validation findings will be included in the *SFY 2016–2017 EQR Technical Report*.

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

PIP Validation Scoring

HSAG assigned a score of Achieved or Failed for each of the criteria in Modules 1 through 3. Any validation criteria not applicable (N/A) were not scored. As the PIP progresses, and at the completion of Module 5, HSAG will use the validation findings for Modules 1 through 5 criteria for each PIP to determine a confidence level representing the validity and reliability of the PIP. Using a standardized scoring methodology, HSAG will assign a level of confidence and report the overall validity and reliability of the findings as one of the following:

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

Performance Measure Validation/HEDIS Audit

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

- Teleconferences with the MCOs' personnel and vendor representatives, as necessary.
- Detailed review of the MCOs' completed responses to the NCQA Roadmap.
- On-site meetings, including the following:
  - Staff interviews.
  - Live system and procedure demonstration.
  - Documentation review and requests for additional information.
  - Primary HEDIS data source verification.
  - Programming logic review and inspection of dated job logs.

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

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

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

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

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

Table A-1—SFY 2015–2016 Performance Measures for Nevada Medicaid and Nevada Check Up				
Performance Measure		Method	Populations	
			Medicaid	Nevada Check Up
1	*Adolescent Well-Care Visits (AWC)*	Hybrid	✓	✓
2	*Ambulatory Care (AMB)*	Admin	✓	✓
3	*Annual Dental Visit (ADV)*	Admin	✓	✓
4	*Childhood Immunization Status—Combos 2–10 (CIS)*	Hybrid	✓	✓
5	*Children and Adolescents' Access to Primary Care Practitioners (CAP)*	Admin	✓	✓
6	*Comprehensive Diabetes Care—Excluding <7 indicator (CDC)*	Hybrid	✓	
7	*Follow-Up After Hospitalization for Mental Illness (FUH)*	Admin	✓	✓
8	*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity (ADHD) Medication (ADD)*	Admin	✓	✓
9	*Frequency of Ongoing Prenatal Care (FPC)*	Hybrid	✓	
10	*Human Papillomavirus Vaccine for Female Adolescents (HPV)*	Hybrid	✓	✓
11	*Immunizations for Adolescents (IMA)*	Hybrid	✓	✓
12	*Medication Management for People with Asthma (MMA)*	Admin	✓	✓
13	*Mental Health Utilization (MPT)*	Admin	✓	✓
14	*Prenatal and Postpartum Care (PPC)*	Hybrid	✓	
15	*Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)*	Admin	✓	✓
16	*Weeks of Pregnancy at Time of Enrollment (WOP)*	Hybrid	✓	
17	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)*	Hybrid	✓	✓
18	*Well-Child Visits in the First 15 Months of Life (W15)*	Hybrid	✓	✓
19	*Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)*	Hybrid	✓	✓

CAHPS Surveys

Three populations were surveyed for **HPN** and **Amerigroup**: adult Medicaid, child Medicaid, and Nevada Check Up. Decision Support Systems (DSS) Research, an NCQA-certified vendor, administered the 2016 CAHPS surveys for both **HPN** and **Amerigroup**.

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

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

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

For each of the five composite scores and CCC composite measures/items, the percentage of respondents who chose a positive response was calculated. CAHPS composite question response choices fell into one of two categories: (1) Never, Sometimes, Usually, or Always; or (2) No or Yes. A positive or top-box response for the composites and CCC composites/items was defined as a response of Usually/Always or Yes. The percentage of top-box responses is referred to as a global proportion for the composite scores and CCC composite measures/items. For the Effectiveness of Care measures, responses of Always/Usually/Sometimes were used to determine if the respondent qualified for inclusion in the numerator. The rates presented follow NCQA's methodology of calculating a rolling average using the current and prior years' results. A substantial increase or decrease is denoted by a change of 5 percentage points or more.

Health Care Guidance Program (HCGP) Corrective Action Plan Review

In SFY 2014–2015, HSAG conducted a compliance review of **McKesson**. HSAG performed the review in two phases. Phase I focused on the operational structure of key areas of the program and consisted of a desk review of documentation and information supplied by **McKesson**. Phase II consisted of a two-day on-site review, which occurred December 10–11, 2014, in **McKesson**'s Carson City, Nevada, office. As a result of the two-phase review, **McKesson**, now doing business as **APH**, was required to submit a corrective action plan (CAP) to DHCFP to correct the areas of deficiency noted from the review.

In SFY 2015–2016, HSAG reviewed the CAP submitted by **APH** and provided feedback to DHCFP regarding the areas that met the contractual requirements and those that were still out of compliance.

Health Care Guidance Program (HCGP) Performance Measure Validation

In the fall of 2015, HSAG conducted a performance measure validation (PMV) audit of **APH**, to verify the accuracy of reported rates by **APH**. HSAG validated **APH**'s performance measures using the external quality review (EQR) Protocol 2[A-4] developed by CMS as its guide. HSAG's **APH** activity focused on the following objectives:

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

HSAG validated a set of performance measures selected by DHCFP for validation. The measures primarily consisted of performance measures that were contractually required by the DHCFP, but not part of the HCGP pay-for-performance (P4P) program. These measures are herein referred to as the non-P4P measures. The DHCFP provided the specifications **APH** was required to use for calculation of the performance measures in Attachment II of the **APH** contract (RFP/Contract #1958). Table A-2 below lists the performance measures that HSAG validated under the scope of this audit. The measurement period for which the PMV was conducted was identified as Program Period 1 (i.e., June 1, 2014 through May 30, 2015).

Table A-2—Performance Measures for HCGP

Measure ID	Measure Name
CCHU.1	*Ambulatory Care—Sensitive Condition Hospital Admission*
CCHU.2	*Avoidable Emergency Room Visits*
CCHU.3-5	*Care Transitions—24 Hours, 7 Days, and 30 Days of Discharge*
CCHU.6	*Care Transitions—Receipt of Transition Record to Patient*
CCHU.7	*Transition of Care—Reconciled Medication List*

[A-4] *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 1, 2012.

Table A-2—Performance Measures for HCGP	
Measure ID	**Measure Name**
DEM	*Cognitive Assessment for Dementia*
NEUR	*Stroke and Stroke Rehabilitations—Discharged on Antithrombotic Therapy*
CKD	*Adult Kidney Disease—Laboratory Testing (Lipid Profile)*
CAN	*Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer*
RA	*Disease-modifying Anti-Rheumatic Drug (DMARD) Therapy for Rheumatoid Arthritis*
OST	*Osteoporosis—Pharmacologic therapy for men and women aged 50 years and older*
OBS	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
CAP	*Children and Adolescents' Access to Primary Care Practitioners*
W15	*Well-Child Visits in the First 15 Months of Life*
W34	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
AWC	*Adolescent Well-Care Visits*
CIS	*Childhood Immunization Status*
PPC	*Prenatal and Postpartum Care*
WOP	*Weeks of Pregnancy at Time of Enrollment*
FPC	*Frequency of Ongoing Prenatal Care*
ABA	*Adult BMI Assessment*
BCS	*Breast Cancer Screening*
CCS	*Cervical Cancer Screening*
COL	*Colorectal Cancer Screening*

Pre-audit Strategy

To assist **APH** with the validation process, HSAG provided a technical assistance webinar session to **APH** in March 2015, and provided technical assistance to **APH**'s staff throughout the audit process.

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

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

On-site Activities

On October 15, 2015, HSAG conducted the on-site visit with **APH**. HSAG auditors collected information from **APH** staff members using several methods that included interviews, system demonstration, review of data output files, primary source verification, observation of data processing, and review of data reports. The on-site activities included:

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

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

Post-on-site Activities

During the on-site visit, HSAG auditors identified several items that required follow-up from **APH**, including revision of some source code for several measures. **APH** submitted the revised source code along with revised non-P4P performance measure rates. Upon resolving all outstanding items, HSAG auditors reviewed the revised rates provided by **APH** before issuing the final report.

Appendix B. Quality Strategy Goals and Objectives Table

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

Nevada 2016–2017 Quality Strategy
Goals and Objectives for Medicaid

Unless otherwise indicated, all objectives will follow the QISMC methodology to increase rates by 10 percent (of the gap between the 2016 rate and 100 percent).

Goal 1:	Improve the health and wellness of Nevada's Medicaid population by increasing the use of preventive services.						
		AGP 2015	QISMC Goal	AGP 2016	HPN 2015	QISMC Goal	HPN 2016
Objective 1.1a:	Increase children and adolescents' access to PCPs (12–24 months).	91.14%	92.03%	94.15%	91.42%	92.28%	94.80%
Objective 1.1b:	Increase children and adolescents' access to PCPs (25 months–6 years).	81.30%	83.17%	83.55%	79.24%	81.32%	84.29%
Objective 1.1c:	Increase children and adolescents' access to PCPs (7–11 years).	85.60%	87.04%	87.12%	83.93%	85.54%	87.36%
Objective 1.1d:	Increase children and adolescents' access to PCPs (12–19 years).	81.53%	83.38%	83.76%	80.80%	82.72%	85.21%
Objective 1.2:	Increase well-child visits (0–15 months).	50.58%	55.52%	52.78%	51.58%	56.42%	53.77%
Objective 1.3:	Increase well-child visits (3–6 years).	65.66%	69.09%	66.33%	60.83%	64.75%	64.48%
Objective 1.4a:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (BMI percentile).	—	NC	64.12%	—	NC	70.32%
Objective 1.4b:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (counseling for nutrition).	—	NC	54.40%	—	NC	57.91%
Objective 1.4c:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (counseling for physical activity).	—	NC	43.75%	—	NC	52.07%
Objective 1.5:	Increase immunizations for adolescents.	—	NC	71.93%	—	NC	79.81%
Objective 1.6:	Increase annual dental visits for children.	45.62%	51.06%	53.21%	51.12%	56.01%	55.03%
Objective 1.7:	Increase human papillomavirus vaccine for female adolescents.	—	NC	24.59%	—	NC	29.68%
Objective 1.8:	Increase adolescent well-care visits.	42.13%	47.92%	38.43%	37.47%	43.72%	44.04%

Goal 1:	Improve the health and wellness of Nevada's Medicaid population by increasing the use of preventive services.						
		AGP 2015	QISMC Goal	AGP 2016	HPN 2015	QISMC Goal	HPN 2016
Objective 1.9a:	Increase childhood immunization status (Combination 2).	66.20%	69.58%	73.15%	70.80%	73.72%	74.94%
Objective 1.9b:	Increase childhood immunization status (Combination 3).	60.88%	64.79%	66.67%	66.18%	69.56%	70.32%
Objective 1.9c:	Increase childhood immunization status (Combination 4).	58.80%	62.92%	65.28%	66.18%	69.56%	70.07%
Objective 1.9d:	Increase childhood immunization status (Combination 5).	50.23%	55.21%	57.18%	53.04%	57.74%	55.72%
Objective 1.9e:	Increase childhood immunization status (Combination 6).	33.33%	40.00%	32.41%	39.42%	45.48%	38.44%
Objective 1.9f:	Increase childhood immunization status (Combination 7).	48.38%	53.54%	56.48%	53.04%	57.74%	55.72%
Objective 1.9g:	Increase childhood immunization status (Combination 8).	33.10%	39.79%	32.41%	39.42%	45.48%	38.44%
Objective 1.9h:	Increase childhood immunization status (Combination 9).	28.24%	35.42%	29.63%	32.36%	39.12%	31.14%
Objective 1.9i:	Increase childhood immunization status (Combination 10).	28.01%	35.21%	29.63%	32.36%	39.12%	31.14%

Goal 2:	Increase use of evidence-based practices for members with chronic conditions.						
		AGP 2015	QISMC Goal	AGP 2016	HPN 2015	QISMC Goal	HPN 2016
Objective 2.1:	Increase rate of HbA1c testing for members with diabetes.	81.90%	83.71%	79.63%	84.18%	85.76%	85.64%
Objective 2.2:	Decrease rate of HbA1c poor control (>9.0%) for members with diabetes. **	46.40%	41.76%	46.76%	44.53%	40.08%	45.74%
Objective 2.3:	Increase rate of HbA1c good control (<8.0%) for members with diabetes.	43.16%	48.84%	46.30%	43.80%	49.42%	46.47%
Objective 2.4:	Increase rate of eye exams performed for members with diabetes.	55.45%	59.91%	55.09%	55.96%	60.36%	56.93%
Objective 2.5:	Increase medical attention for nephropathy for members with diabetes.	75.17%	77.65%	89.58%	82.73%	84.46%	92.21%
Objective 2.6:	Increase blood pressure control (<140/90 mm Hg) for members with diabetes.	62.18%	65.96%	55.32%	70.32%	73.29%	60.83%
Objective 2.7a:	Increase medication management for people with asthma—medication compliance 50 percent.	—	NC	50.22%	—	NC	46.96%

Goal 2:	Increase use of evidence-based practices for members with chronic conditions.						
		AGP 2015	QISMC Goal	AGP 2016	HPN 2015	QISMC Goal	HPN 2016
Objective 2.7b:	Increase medication management for people with asthma—medication compliance 75 percent.	—	NC	26.84%	—	NC	24.14%

Goal 3:	Reduce and/or eliminate health care disparities for Medicaid recipients.						
		AGP 2015	QISMC Goal	AGP 2016	HPN 2015	QISMC Goal	HPN 2016
Objective 3.1:	Ensure that health plans maintain, submit for review, and annually revise cultural competency plans.	Met	Met	Met	Met	Met	Met
Objective 3.2:	Stratify data for performance measures by race and ethnicity to determine where disparities exist. Continually identify, organize, and target interventions to reduce disparities and improve access to appropriate services for the Medicaid and Nevada Check Up population.	Met	Met	Met	Met	Met	Met
Objective 3.3:	Ensure that each MCO submits an annual evaluation of its cultural competency programs to the DHCFP. The MCOs must receive a 100 percent *Met* compliance score for all criteria listed in the MCO contract for cultural competency program development, maintenance, and evaluation.	Met	Met	Met	Met	Met	Met

Goal 4:	Improve the health and wellness of new mothers and infants and increase new-mother education about family planning and newborn health and wellness.						
		AGP 2015	QISMC Goal	AGP 2016	HPN 2015	QISMC Goal	HPN 2016
Objective 4.1:	Increase the rate of postpartum visits.	46.74%	52.07%	53.16%	58.88%	62.99%	57.18%
Objective 4.2:	Increase timeliness of prenatal care.	69.77%	72.79%	75.41%	77.62%	79.86%	73.97%
Objective 4.3:	Increase frequency of prenatal care visits (≥ 81 percent of visits).	52.33%	57.10%	56.44%	51.34%	56.21%	52.07%
Objective 4.4:	Increase frequency of prenatal care visits (<21 percent of visits). **	15.81%	14.23%	17.80%	17.03%	15.33%	14.60%

Goal 5:	Increase use of evidence-based practices for members with behavioral health conditions.						
		AGP 2015	QISMC Goal	AGP 2016	HPN 2015	QISMC Goal	HPN 2016
Objective 5.1a:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication—initiation phase.	—	NC	36.68%	—	NC	46.65%
Objective 5.1b:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication—continuation and maintenance phase.	—	NC	40.91%	—	NC	58.02%
Objective 5.2:	Reduce use of multiple concurrent antipsychotics in children and adolescents. **	—	NC	0.00%	—	NC	1.80%
Objective 5.3:	Reduce behavioral health-related hospital readmissions within 30 days of discharge. (One of MCOs' PIPs. Improvement TBD by MCO PIP goals.)	*N/A	*N/A	*N/A	*N/A	*N/A	*N/A
Objective 5.4:	Increase follow-up after hospitalization for mental illness within 7 days of discharge.	53.02%	57.72%	52.99%	48.49%	53.64%	56.51%
Objective 5.5:	Increase follow-up after hospitalization for mental illness within 30 days of discharge.	63.14%	66.83%	64.55%	66.89%	70.20%	69.41%

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

Green shading indicates QISMC goal met.

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

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

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

"—" indicates that the indicator was not required in 2015.

NC indicates that QISMC goal was not calculated because a rate in 2015 was not available.

Nevada 2016–2017 Quality Strategy

Goals and Objectives for Nevada Check Up

Unless otherwise indicated, all objectives will follow the QISMC methodology to increase rates by 10 percent (of the gap between the 2016 rate and 100 percent).

Goal 1:	Improve the health and wellness of the Nevada Check Up population by increasing the use of preventive services.						
		AGP 2015	QISMC Goal	AGP 2016	HPN 2015	QISMC Goal	HPN 2016
Objective 1.1a:	Increase children and adolescents' access to PCPs (12–24 months).	95.83%	96.25%	98.73%	94.70%	95.23%	99.48%
Objective 1.1b:	Increase children and adolescents' access to PCPs (26 months–6 years).	90.48%	91.43%	89.53%	87.20%	88.48%	89.55%
Objective 1.1c:	Increase children and adolescents' access to PCPs (7–11 years).	92.62%	93.36%	92.91%	93.83%	94.45%	93.54%
Objective 1.1d:	Increase children and adolescents' access to PCPs (12–19 years).	92.18%	92.96%	88.95%	90.79%	91.71%	90.78%
Objective 1.2:	Increase well-child visits (0–15 months).	70.37%	73.33%	78.05%	60.00%	64.00%	68.00%
Objective 1.3:	Increase well-child visits (3–6 years).	71.30%	74.17%	70.28%	71.95%	74.76%	70.13%
Objective 1.4a:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (BMI percentile).	—	NC	62.04%	—	NC	72.02%
Objective 1.4b:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (counseling for nutrition).	—	NC	55.56%	—	NC	60.34%
Objective 1.4c:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (counseling for physical activity).	—	NC	47.69%	—	NC	57.18%
Objective 1.5:	Increase immunizations for adolescents.	—	NC	81.61%	—	NC	87.35%
Objective 1.6:	Increase annual dental visits for children.	64.48%	68.03%	67.05%	69.50%	72.55%	70.11%
Objective 1.7:	Increase human papillomavirus vaccine for female adolescents.	—	NC	34.11%	—	NC	42.62%
Objective 1.8:	Increase adolescent well-care visits.	56.48%	60.83%	56.34%	55.47%	59.92%	52.83%

Goal 1:	Improve the health and wellness of the Nevada Check Up population by increasing the use of preventive services.						
		AGP 2015	QISMC Goal	AGP 2016	HPN 2015	QISMC Goal	HPN 2016
Objective 1.9a:	Increase childhood immunization status (Combination 2).	74.55%	77.10%	85.90%	83.46%	85.11%	87.93%
Objective 1.9b:	Increase childhood immunization status (Combination 3).	73.64%	76.28%	78.21%	77.17%	79.45%	84.48%
Objective 1.9c:	Increase childhood immunization status (Combination 4).	73.64%	76.28%	77.56%	76.38%	78.74%	83.91%
Objective 1.9d:	Increase childhood immunization status (Combination 5).	54.55%	59.10%	68.59%	66.14%	69.53%	79.89%
Objective 1.9e:	Increase childhood immunization status (Combination 6).	45.45%	50.91%	46.79%	48.03%	53.23%	52.30%
Objective 1.9f:	Increase childhood immunization status (Combination 7).	54.55%	59.10%	67.95%	65.35%	68.82%	79.31%
Objective 1.9g:	Increase childhood immunization status (Combination 8).	45.45%	50.91%	46.79%	47.24%	52.52%	51.72%
Objective 1.9h:	Increase childhood immunization status (Combination 9).	32.73%	39.46%	42.95%	42.52%	48.27%	50.00%
Objective 1.9i:	Increase childhood immunization status (Combination 10).	32.73%	39.46%	42.95%	41.73%	47.56%	49.43%

Goal 2:	Increase use of evidence-based practices for members with chronic conditions.						
		AGP 2015	QISMC Goal	AGP 2016	HPN 2015	QISMC Goal	HPN 2016
Objective 2.1:	Increase rate of HbA1c testing for members with diabetes.	N/A	N/A	N/A	N/A	N/A	N/A
Objective 2.2:	Decrease rate of HbA1c poor control (>9.0%) for members with diabetes. **	N/A	N/A	N/A	N/A	N/A	N/A
Objective 2.3:	Increase rate of HbA1c good control (<8.0%) for members with diabetes.	N/A	N/A	N/A	N/A	N/A	N/A
Objective 2.4:	Increase rate of eye exams performed for members with diabetes.	N/A	N/A	N/A	N/A	N/A	N/A
Objective 2.5:	Increase medical attention for nephropathy for members with diabetes.	N/A	N/A	N/A	N/A	N/A	N/A
Objective 2.6:	Increase blood pressure control (<140/90 mm Hg) for members with diabetes.	N/A	N/A	N/A	N/A	N/A	N/A
Objective 2.7a:	Increase medication management for people with asthma—medication compliance 50 percent.	—	NC	47.76%	—	NC	47.62%

Goal 2:	Increase use of evidence-based practices for members with chronic conditions.						
		AGP 2015	QISMC Goal	AGP 2016	HPN 2015	QISMC Goal	HPN 2016
Objective 2.7b:	Increase medication management for people with asthma—medication compliance 75 percent.	—	NC	26.87%	—	NC	26.98%

Goal 3:	Reduce and/or eliminate health care disparities for Nevada Check Up recipients.						
		AGP 2015	QISMC Goal	AGP 2016	HPN 2015	QISMC Goal	HPN 2016
Objective 3.1:	Ensure that health plans maintain, submit for review, and annually revise cultural competency plans.	Met	Met	Met	Met	Met	Met
Objective 3.2:	Stratify data for performance measures by race and ethnicity to determine where disparities exist. Continually identify, organize, and target interventions to reduce disparities and improve access to appropriate services for the Medicaid and Nevada Check Up populations.	Met	Met	Met	Met	Met	Met
Objective 3.3:	Ensure that each MCO submits an annual evaluation of its cultural competency programs to the DHCFP. The MCOs must receive a 100 percent *Met* compliance score for all criteria listed in the MCO contract for cultural competency program development, maintenance, and evaluation.	Met	Met	Met	Met	Met	Met

Goal 4:	Improve the health and wellness of new mothers and infants and increase new-mother education about family planning and newborn health and wellness.						
		AGP 2015	QISMC Goal	AGP 2016	HPN 2015	QISMC Goal	HPN 2016
Objective 4.1:	Increase the rate of postpartum visits.	N/A	N/A	N/A	N/A	N/A	N/A
Objective 4.2:	Increase timeliness of prenatal care.	N/A	N/A	N/A	N/A	N/A	N/A
Objective 4.3:	Increase frequency of prenatal care visits (≥ 81 percent of visits).	N/A	N/A	N/A	N/A	N/A	N/A
Objective 4.4:	Increase frequency of prenatal care visits (<21 percent of visits). **	N/A	N/A	N/A	N/A	N/A	N/A

Goal 5:	Increase use of evidence-based practices for members with behavioral health conditions.						
		AGP 2015	QISMC Goal	AGP 2016	HPN 2015	QISMC Goal	HPN 2016
Objective 5.1a:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication—initiation phase.	—	NC	N/A	—	NC	39.53%
Objective 5.1b:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication—continuation and maintenance phase.	—	NC	N/A	—	NC	N/A
Objective 5.2:	Reduce use of multiple concurrent antipsychotics in children and adolescents. **	—	NC	N/A	—	NC	N/A
Objective 5.3:	Reduce behavioral health-related hospital readmissions within 30 days of discharge. (One of MCOs' PIPs. Improvement TBD by MCO PIP goals.)	N/A	NC	N/A	N/A	NC	N/A
Objective 5.4:	Increase follow-up after hospitalization for mental illness within 7 days of discharge.	N/A	NC	84.85%	N/A	NC	N/A
Objective 5.5:	Increase follow-up after hospitalization for mental illness within 30 days of discharge.	N/A	NC	93.94%	N/A	NC	N/A

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

Green shading indicates QISMC goal met.

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

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

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

"—" indicates that the indicator was not required in 2015.

NC indicates that QISMC goal was not calculated because a rate in 2015 was not available.