Division of Health Care Financing and Policy
Nevada Medicaid Managed Care

State Fiscal Year 2019–2020 External Quality Review Technical Report

October 2020

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Purpose and Overview of Report

States with Medicaid managed care delivery systems are required to annually provide an assessment of managed care entities' (MCEs') performance related to the quality of, timeliness of, and access to care and services they provide, as mandated by 42 Code of Federal Regulations (CFR) §438.364. To meet this requirement, the State of Nevada, Department of Health and Human Services, Division of Health Care Financing and Policy (the DHCFP), has contracted with Health Services Advisory Group, Inc. (HSAG), to perform the assessment and produce this annual report.

The DHCFP administers and oversees the Nevada Managed Care Program, which provides Medicaid and Children's Health Insurance Program (CHIP, also referred to as Nevada Check Up in Nevada) benefits to members residing in Clark and Washoe counties. The Nevada Managed Care Program's MCEs include three managed care organizations (MCOs) contracted with the DHCFP to provide physical health and behavioral health services to Medicaid and Nevada Check Up members. The DHCFP also contracted with one prepaid ambulatory health plan (PAHP), also known as the dental benefits administrator, to provide dental benefits for Medicaid and Nevada Check Up members. The MCOs and PAHP contracted with the DHCFP during state fiscal year (SFY) 2019–2020 are displayed in Table 1-1.

Table 1-1—MCEs in Nevada

MCO Name	MCO Short Name
Anthem Blue Cross and Blue Shield Healthcare Solutions	Anthem
Health Plan of Nevada	HPN
SilverSummit Healthplan, Inc.	SilverSummit
PAHP Name	**PAHP Short Name**
LIBERTY Dental Plan of Nevada, Inc.	LIBERTY

Scope of External Quality Review (EQR) Activities

To conduct this assessment, HSAG used the results of mandatory and optional external quality review (EQR) activities, as described in 42 CFR §438.358. The EQR activities included as part of this assessment were conducted consistent with the associated EQR protocols developed by the Centers for Medicare & Medicaid Services (CMS).[1-1] The purpose of these activities, in general, is to improve

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, October 2019*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: June 26, 2020.

states' ability to oversee and manage MCEs they contract with for services, and help MCEs improve their performance with respect to quality of, timeliness of, and access to care. Effective implementation of the EQR-related activities will facilitate State efforts to purchase high-value care and to achieve higher performing healthcare delivery systems for their Medicaid and CHIP members. For the SFY 2019–2020 assessment, HSAG used findings from the mandatory and optional EQR activities displayed in Table 1-2 to derive conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by each MCE. Detailed information about each activity methodology is provided in Appendix A of this report.

Table 1-2—EQR Activities

Activity	Description	CMS Protocol
Validation of Performance Improvement Projects (PIPs)	This activity verifies whether a PIP conducted by an MCE used sound methodology in its design, implementation, analysis, and reporting.	Protocol 1. Validation of Performance Improvement Projects
Performance Measure Validation (PMV)	This activity assesses whether the performance measures calculated by an MCE are accurate based on the measure specifications and State reporting requirements.	Protocol 2. Validation of Performance Measures
Compliance Review	This activity determines the extent to which a Medicaid and CHIP MCE is in compliance with federal standards and associated state-specific requirements, when applicable.	Protocol 3. Review of Compliance with Medicaid and CHIP Managed Care Regulations
Network Adequacy Validation (NAV)	This activity assesses the extent to which an MCE has adequate provider networks in coverage areas to deliver healthcare services to its managed care members.	Protocol 4. Validation of Network Adequacy*
Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1-2] Analysis	This activity assesses member experience with an MCE and its providers and the quality of care members receive.	Protocol 6. Administration or Validation of Quality of Care Surveys

* This activity will be mandatory effective no later than one year from the issuance of the associated EQR protocol.

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

Nevada Managed Care Program Findings and Conclusions

HSAG used its analyses and evaluations of EQR activity findings from the preceding 12 months to comprehensively assess the MCEs' performance in providing quality, timely, and accessible healthcare services to DHCFP Medicaid and CHIP members. For each MCE reviewed, HSAG provides a summary of its overall key findings, conclusions, and recommendations based on the MCEs' performance, which can be found in Section 3 and Section 4 of this report. The overall findings and conclusions for all MCEs were also compared and analyzed to develop overarching conclusions and recommendations for the Nevada Managed Care Program. Table 1-3 highlights substantive findings and actionable state-specific recommendations, when applicable, for the DHCFP to further promote its goals and objectives in its quality strategy. Refer to Section 9 for more details.

Table 1-3—Nevada Managed Care Program Substantive Findings

Program Strengths	
• Through their participation in state-mandated PIPs, the MCEs focus efforts on quality outcomes related to proper diabetes management to prevent other serious health complications, to prenatal care to prevent poor birth outcomes, and to preventive dental healthcare to mitigate cavities and reduce the risk of oral diseases. Implementing effective initiatives to improve performance in these areas has the potential to greatly impact the services and overall health outcomes of all Nevada Managed Care Program members. • Results from the three-year compliance review cycle indicated all four MCEs, **Anthem**, **HPN**, **SilverSummit**, and **LIBERTY**, have the ability to appropriately manage and adhere to the expectations established for the Medicaid managed care program through State and federal requirements, as demonstrated by SFY 2019–2020 aggregated compliance review scores being between 92 percent and 100 percent, and all previously identified deficiencies from the first 2 years in the review cycle being remediated. These high-performance scores indicate the MCEs have strong foundations in place to provide preventive and medically necessary quality and accessible healthcare services to their members. • The network adequacy analysis demonstrated that the MCEs have a sufficient number of primary care providers (PCPs) to provide primary, specialty, behavioral health, and dental services to members enrolled in the Nevada Managed Care Program.	
Program Weaknesses	
• Members are not obtaining the services they need to maintain optimal health, as demonstrated through MCE performance measure rates that are not meeting the DHCFP-mandated minimum performance standards (MPS), barriers identified through the PIP activity, and lower positive member experiences with both the health plans and doctors, as reported through CAHPS.	
Program Recommendations	
Recommendation	**Associated Quality Strategy Goal and/or Objective**
To identify the barriers members may have to accessing services and contracted providers, the DHCFP could consider conducting a program-wide secret shopper survey of PCPs and general dentists.	**Goal 1:** Improve the Health and Wellness of Nevada's Medicaid Population by Increasing Access to and the Use of Preventive Services. **Goal 7:** Increase Utilization of Dental Services

Program Recommendations	
Recommendation	**Associated Quality Strategy Goal and/or Objective**
To improve the management of chronic conditions, promote positive health outcomes, and reduce overall Medicaid spending, the DHCFP could consider requiring a state-directed quality improvement initiative that targets the most prevalent diagnosed chronic condition of combined MCE membership.	**Goal 2:** Increase Use of Evidence-Based Practices for Members With Chronic Conditions
To prevent poor birth outcomes and reduce infant mortality, the DHCFP could consider conducting a program-wide focus group of women on Medicaid who have recently given birth or are pregnant to determine potential barriers to timely access of prenatal care.	**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

2. Overview of the Nevada Managed Care Program

Managed Care in Nevada

Nevada has been operating a mandatory managed care program in two counties in the state (urban Clark and Washoe Counties) since 1998. The managed care program covers acute, primary, specialty, and behavioral healthcare services for children and families, pregnant women, and low-income adults on a mandatory basis; American Indians, children with severe emotional disturbance, and special needs children are voluntary populations. In 2017, the DHCFP procured a dental PAHP, **LIBERTY**, to serve as the DHCFP's dental benefits administrator for Clark and Washoe counties.

Table 2-1 presents the gender and age bands of Nevada Medicaid and Nevada Check Up members enrolled in all managed care catchment areas as of June 2020.

Table 2-1—Nevada Medicaid and Nevada Check Up Managed Care Demographics

Gender/Age Band	June 2020 Members
Males and Females <1 Year of Age	18,089
Males and Females 1–2 Years of Age	29,968
Males and Females 3–14 Years of Age	156,352
Females 15–18 Years of Age	19,513
Males 15–18 Years of Age	19,277
Females 19–34 Years of Age	81,782
Males 19–34 Years of Age	48,255
Females 35+ Years of Age	78,338
Males 35+ Years of Age	63,344
Total Medicaid	**514,918**
Males and Females <1 Year of Age	143
Males and Females 1–2 Years of Age	1,480
Males and Females 3–14 Years of Age	17,205
Females 15–19 Years of Age	2,649
Males 15–19 Years of Age	2,597
Total Nevada Check Up	**24,074**
Total Medicaid and Nevada Check Up*	**538,992**

* Totals for Table 2-1 were generated by the DHCFP from member data (members by age and gender band that have a capitated plan) and Table 2-2 and Table 2-3 were generated from claims data (plans by county that received a capitated payment); therefore, the table totals are not equal.

Overview of Managed Care Entities (MCEs)

During the SFY 2019–2020 review period, the DHCFP contracted with three MCOs and one PAHP. These MCEs are responsible for the provision of services to Nevada Managed Care Program members. Table 2-2 and Table 2-3 provide a profile for each MCO. As Nevada has only one PAHP, the eligible population is inclusive of all Medicaid and Nevada Check Up members and therefore is not displayed in the tables below.

Table 2-2—June 2020 Nevada MCO Medicaid Members

MCO	Total Eligible Clark County	Total Eligible Washoe County
HPN	220,731	27,608
Anthem	184,577	24,976
SilverSummit	53,015	6,923
Total*	**458,323**	**59,507**

* Totals for Table 2-1 were generated by the DHCFP from member data (members by age and gender band that have a capitated plan) and Table 2-2 and Table 2-3 were generated from claims data (plans by county that received a capitated payment); therefore, the table totals are not equal.

Table 2-3—June 2020 Nevada MCO CHIP (Nevada Check Up) Members

MCO	Total Eligible Clark County	Total Eligible Washoe County
HPN	10,921	2,544
Anthem	7,764	1,573
SilverSummit	1,739	327
Total*	**20,424**	**4,444**

* Totals for Table 2-1 were generated by the DHCFP from member data (members by age and gender band that have a capitated plan) and Table 2-2 and Table 2-3 were generated from claims data (plans by county that received a capitated payment); therefore, the table totals are not equal.

Quality Strategy

In accordance with 42 CFR §438.340, the DHCFP implemented a written quality strategy for assessing and improving the quality of healthcare and services furnished by the MCEs to Nevada Medicaid and Nevada Check Up members under the Nevada Managed Care Program.

The DHCFP's mission is to purchase and ensure the provision of quality healthcare services, including Medicaid services, to low-income Nevadans in the most efficient manner. The DHCFP also seeks to

promote equal access to healthcare at an affordable cost to Nevada taxpayers, to restrain the growth of healthcare costs, and to review Medicaid and other State healthcare programs to determine the potential to maximize federal revenue opportunities. The Nevada Department of Health and Human Services (DHHS) director has identified three priority focus areas for the Nevada Managed Care Program: prevention, early intervention, and quality treatment. Consistent with the State's mission and DHHS priority areas, the purpose of the DHCFP's Quality Strategy is to:

- Establish a comprehensive quality improvement system that is consistent with the Triple Aim adopted by CMS to achieve better care for patients, better health for communities, and lower costs through improvement in the healthcare 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 members 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 healthcare more affordable for individuals, families, and the State government.
- Improve member satisfaction with care and services.
- Ensure that persons transitioning to managed care from fee-for-service and persons transitioning between MCOs receive appropriate therapeutic, medical, and behavioral health services as part of the transition of care policy noted in the *Medicaid Services Manual*, Chapter 3603.17.

To support the priorities of the Quality Strategy, the DHCFP established quality goals and objectives to improve the health and wellness of Nevada Medicaid and Nevada Check Up members. The goals and objectives of the DHCFP's Quality Assessment and Performance Improvement Strategy (Quality Strategy) are summarized in Table 2-4.

The DHCFP has established an MPS for each objective. Further, the DHCFP established additional performance tiers that serve as "stretch goals" for each objective. The purpose of establishing the MPS and performance tiers for each objective was to create a set of reasonable targets that MCEs could achieve through continuous focus and improvement for each of the indicators that represent an objective.

Table 2-4—Nevada Medicaid MCE Goals and Objectives for Medicaid and Nevada Check Up

Goal 1:	Improve the Health and Wellness of Nevada's Medicaid Population by Increasing Access to and the Use of Preventive Services
Objective #	**Objective Description**
Objective 1.1a:	Increase children and adolescents' access to PCPs (CAP)—12–24 months
Objective 1.1b:	Increase children and adolescents' access to PCPs (CAP)—25 months–6 years
Objective 1.1c:	Increase children and adolescents' access to PCPs (CAP)—7–11 years
Objective 1.1d:	Increase children and adolescents' access to PCPs (CAP)—12–19 years
Objective 1.2:	Increase well-child visits (W15)—0–15 months
Objective 1.3:	Increase well-child visits (W34)—3–6 years
Objective 1.4a:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—BMI percentile
Objective 1.4b:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—counseling for nutrition
Objective 1.4c:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—counseling for physical activity
Objective 1.5a:	Increase immunizations for adolescents (IMA)—Meningococcal, Tdap
Objective 1.5b:	Increase immunizations for adolescents (IMA)—Meningococcal, Tdap, HPV
Objective 1.6a:	Increase childhood immunization status (CIS)—Combination 2
Objective 1.6b:	Increase childhood immunization status (CIS)—Combination 3
Objective 1.6c:	Increase childhood immunization status (CIS)—Combination 4
Objective 1.6d:	Increase childhood immunization status (CIS)—Combination 5
Objective 1.6e:	Increase childhood immunization status (CIS)—Combination 6
Objective 1.6f:	Increase childhood immunization status (CIS)—Combination 7
Objective 1.6g:	Increase childhood immunization status (CIS)—Combination 8
Objective 1.6h:	Increase childhood immunization status (CIS)—Combination 9
Objective 1.6i:	Increase childhood immunization status (CIS)—Combination 10
Objective 1.7:	Increase adolescent well-care visits (AWC)
Objective 1.8:	Increase breast cancer screening (BCS)
Objective 1.9a:	Increase adults' access to preventive/ambulatory health services (AAP)—20–44 years
Objective 1.9b:	Increase adults' access to preventive/ambulatory health services (AAP)—45–64 years
Objective 1.9c:	Increase adults' access to preventive/ambulatory health services (AAP)—65 years and older
Objective 1.9d:	Increase adults' access to preventive/ambulatory health services (AAP)—Total
Objective 2.0:	Decrease rate of adult acute inpatient stays that were followed by an unplanned readmission for any diagnosis within 30 days after discharge (PCR)*+

Goal 2:	Increase Use of Evidence-Based Practices for Members With Chronic Conditions
Objective #	**Objective Description**
Objective 2.1a:	Increase rate of HbA1c testing for members with diabetes (CDC)
Objective 2.1b:	Decrease rate of HbA1c poor control (>9.0%) for members with diabetes (CDC)*
Objective 2.1c:	Increase rate of HbA1c good control (<8.0%) for members with diabetes (CDC)
Objective 2.1d:	Increase rate of eye exams performed for members with diabetes (CDC)
Objective 2.1e:	Increase medical attention for nephropathy for members with diabetes (CDC)
Objective 2.1f:	Increase blood pressure control (<140/90 mm Hg) for members with diabetes (CDC)
Objective 2.2a:	Increase medication management for people with asthma (MMA)—medication compliance 50 percent
Objective 2.2b:	Increase medication management for people with asthma (MMA)—medication compliance 75 percent
Objective 2.3	Increase rate of controlling high blood pressure (CBP)
Goal 3:	**Improve Appropriate Use of Opioids**
Objective #	**Objective Description**
Objective 3.1:	Reduce use of opioids at high dosage (HDO)*
Objective 3.2a:	Reduce use of opioids from multiple providers (UOP)—multiple prescribers*
Objective 3.2b:	Reduce use of opioids from multiple providers (UOP)—multiple pharmacies*
Objective 3.2c:	Reduce use of opioids from multiple providers (UOP)—multiple prescribers and multiple pharmacies*
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 #	**Objective Description**
Objective 4.1:	Increase timeliness of prenatal care (PPC)
Objective 4.2:	Increase the rate of postpartum visits (PPC)
Goal 5:	**Increase Use of Evidence-Based Practices for Members With Behavioral Health Conditions**
Objective #	**Objective Description**
Objective 5.1a:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication (ADD)—initiation phase
Objective 5.1b:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication (ADD)—continuation and maintenance phase
Objective 5.2:	Reduce use of multiple concurrent antipsychotics in children and adolescents (APC)*,†
Objective 5.3:	Increase adherence to antipsychotic medications for individuals with schizophrenia (SAA)
Objective 5.4:	Increase follow-up after hospitalization for mental illness (FUH)—7-day
Objective 5.5:	Increase follow-up after hospitalization for mental illness (FUH)—30-day

Goal 5:	Increase Use of Evidence-Based Practices for Members With Behavioral Health Conditions
Objective #	**Objective Description**
Objective 5.6:	Increase diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications (SSD)
Objective 5.7a:	Increase follow-up after ED visit for AOD abuse or dependence (FUA)—7-day
Objective 5.7b:	Increase follow-up after ED visit for AOD abuse or dependence (FUA)—30-day
Objective 5.8a:	Increase follow-up after ED visit for mental illness (FUM)—7-day
Objective 5.8b:	Increase follow-up after ED visit for mental illness (FUM)—30-day
Objective 5.9a:	Increase initiation and engagement of AOD abuse or dependence treatment (IET)—initiation of treatment
Objective 5.9b:	Increase initiation and engagement of AOD abuse or dependence treatment (IET)—engagement of treatment
Objective 5.10:	Increase metabolic monitoring for children and adolescents on antipsychotics (APM) —blood glucose and cholesterol testing
Goal 6:	**Reduce and/or Eliminate Health Care Disparities for Medicaid Recipients**
Objective #	**Objective Description**
Objective 6.1:	Ensure that health plans maintain, submit for review, and annually revise cultural competency plans.
Objective 6.2:	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.
Objective 6.3:	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.
Goal 7:	**Increase Utilization of Dental Services**
Objective #	**Objective Description**
Objective 7.1:	Increase annual dental visits (ADV)
Objective 7.2:	Increase percentage of eligible members who received preventive dental services

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

† Indicates that this measure was retired by the National Committee for Quality Assurance (NCQA) and will no longer be reported in 2020 and 2021.

+ Indicates this is a new objective, and performance will be assessed in the SFY 2020–2021 EQR report.

Annual Quality Strategy Evaluation

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

Table 2-5 and Table 2-6 show the number of rates reported by the MCO or PAHP; the number of reported rates that achieved the MPS; and of those rates achieving MPS, how many reached the highest performance threshold under Tier 1, Tier 2, or Tier 3. For additional details, please see Appendix B of this report.

Table 2-5—2019–2020 Quality Strategy Goals and Objectives Summary of Performance by the MCOs

	Anthem Medicaid	HPN Medicaid	SilverSummit Medicaid	Anthem Check Up	HPN Check Up	SilverSummit Check Up
Number of Rates Reported	53	53	52	27	27	21
Rates Achieving the MPS	**15**	**20**	**4**	**18**	**13**	**2**
Rates With Highest Achievement in Tier 1	0	6	2	6	3	0
Rates With Highest Achievement in Tier 2	1	1	0	1	1	0
Rates With Highest Achievement in Tier 3	2	1	0	1	1	0

Table 2-6—2019–2020 Quality Strategy Goals and Objectives Summary of Performance by the PAHP

	LIBERTY Medicaid	LIBERTY Check Up
Number of Rates Reported	2	2
Rates Achieving the MPS	**0**	**0**
Rates With Highest Achievement in Tier 1	0	0
Rates With Highest Achievement in Tier 2	0	0
Rates With Highest Achievement in Tier 3	0	0

3. Assessment of Managed Care Organization (MCO) Performance

MCO Methodology

HSAG used findings across mandatory and optional EQR activities conducted during the SFY 2019–2020 review period to evaluate the performance of the MCOs on providing quality, timely, and accessible healthcare services to Nevada Managed Care Program members.

To identify strengths and weaknesses and draw conclusions for each MCO, HSAG analyzed and evaluated each EQR activity and its resulting findings related to the provision of healthcare services across the Nevada Managed Care Program. The composite findings for each MCO were analyzed and aggregated to identify overarching conclusions and focus areas for the MCO in alignment with the priorities of the DHCFP.

Beginning in March 2020 through the end of the SFY, the DHCFP allowed for certain flexibilities within the EQR activities in response to the coronavirus disease 2019 (COVID-19) and the environment in Nevada during this time period. These specific changes are noted where applicable.

For more details about the technical methods for data collection and analysis, refer to Appendix A.

Validation of Performance Improvement Projects (PIPs)

In state fiscal year 2016, the DHCFP implemented the rapid-cycle PIP approach. For this approach, HSAG developed four modules for the MCOs to document their projects as they moved through the different stages of the PIP process. The duration of rapid-cycle PIPs is approximately 18 months.

For this state fiscal year, all three MCOs initiated two new DHCFP-mandated PIP topics, *Comprehensive Diabetes Care (CDC) Hemoglobin A1c (HbA1c) Poor Control > 9.0%* and *Prenatal and Postpartum Care (PCC) Timeliness of Prenatal Care*. In addition to these two topics, **SilverSummit** concluded the two DHCFP-mandated topics that were initiated in state fiscal year 2018, *Follow-Up After Emergency Department Visit for Mental Health Diagnosis (FUM)* and *Increase 3–6-Year-Old Well-Child PCP Visits (W34)*. For each PIP topic, the MCOs defined a Global Aim and a specific, measurable, attainable, relevant, and timebound (SMART) Aim. The SMART Aim statement includes the narrowed population, the baseline percentage, a set goal for the project, and the end date.

Table 3-1 outlines the SMART Aim statement for each topic for all MCOs.

Table 3-1—PIP Topic and SMART Aim Statement

Plan Name	PIP Topic	SMART Aim Statement
Anthem	*Comprehensive Diabetes Care (CDC) HbA1c Poor Control > 9.0%*	By June 30, 2021, the MCO will decrease the percentage of CDC HbA1c poor control > 9.0% among eligible members 18–75 years of age, residing in Clark County, assigned to [health center*], from 60.95% to 51.43%.
Anthem	*Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care*	By June 30, 2021, **Anthem** will increase the percentage of prenatal visits among pregnant women who delivered, from 46.8% to 53.93%, residing in Clark County assigned to [provider*] by 5.13%.
HPN	*Comprehensive Diabetes Care (CDC) HbA1c Poor Control > 9.0%*	By June 30, 2021, **HPN** aims to decrease the rate of HbA1c tests greater than 9% or missing HbA1c test results among diabetic members assigned to [medical center*] from 45.63% to 34.78%.
HPN	*Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care*	By June 30, 2021, **HPN** aims to increase the rate of Medicaid deliveries completed by [OB/GYN† provider*] that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization, from 66.41% to 77.52%.
SilverSummit	*Follow-Up After Emergency Department Visit for Mental Health Diagnosis (FUM)*	By June 30, 2019, increase the rate of follow-up with any practitioner within 7 days of an emergency department discharge from [2 medical centers*] with a primary diagnosis of behavioral health from 42.9% to 75%.
SilverSummit	*Increase 3–6-Year-Old Well-Child PCP Visits (W34)*	By June 30, 2019, increase the well-child visit rate among children 3–6 years of age at [health center*] from 25.9% to 55%.
SilverSummit	*Comprehensive Diabetes Care (CDC) HbA1c Poor Control > 9.0%*	By June 30, 2021, **SilverSummit** aims to decrease the percentage of male diabetic members aged 18–75 who have had a reported HbA1c level of > 9.0% from 83% to 63%.
SilverSummit	*Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care*	By June 30, 2021, **SilverSummit**'s aim is to increase the percentage of pregnant members who have a live birth delivery planned at [hospitals*] to obtain a prenatal care visit within the first trimester of pregnancy from 5% to 25%.

* Provider names were redacted for privacy purposes.
† Obstetrics/Gynecologist

Performance Measure Validation (PMV)

To meet the PMV requirement, the DHCFP contracted with HSAG, as the external quality review organization (EQRO), to conduct an NCQA Healthcare Effectiveness Data and Information Set (HEDIS®)[3-1] Compliance Audit™[3-2] for the MCOs' Medicaid and Nevada Check Up populations. The PMV activity included a comprehensive evaluation of the MCOs' information systems (IS) capabilities and processes used to collect and report data for the performance measures selected by the DHCFP for validation.

Due to COVID-19's possible effect on HEDIS hybrid measures, specifically an MCO's ability to collect medical record data, NCQA allowed MCOs to report their audited HEDIS 2019 (measurement year [MY] 2018) hybrid rates if they were better than their HEDIS 2020 (MY 2019) hybrid rates. The DHCFP, in alignment with NCQA's direction, granted a one-year exception to allow MCOs to consider rotating hybrid measure rates. MCOs were not required to rotate all hybrid measures but were required to rotate entire measures when there were multiple indicators (e.g., Comprehensive Diabetes Care [CDC]). NCQA's Interactive Data Submission System (IDSS) was not configured to capture rotation decisions, meaning that even when a hybrid measure was rotated, the MY will say 2019.

Table 3-2 lists the performance measures selected by the DHCFP for HEDIS 2020 reporting of the Medicaid and Nevada Check Up populations. The reported measures are divided into performance domains of care as demonstrated in the table below.

Table 3-2—HEDIS Measures

HEDIS Measures	Medicaid	Nevada Check Up
Access to Care		
Adults' Access to Preventive/Ambulatory Health Services (AAP)	✓	
Children and Adolescents' Access to Primary Care Practitioners (CAP)	✓	✓
Children's Preventive Care		
Adolescent Well-Care Visits (AWC)	✓	✓
Childhood Immunization Status (CIS)	✓	✓
Immunizations for Adolescents (IMA)	✓	✓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	✓	✓
Well-Child Visits in the First 15 Months of Life (W15)	✓	✓
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)	✓	✓

[3-1] HEDIS is a registered trademark of the NCQA.
[3-2] NCQA HEDIS Compliance Audit™ is a trademark of the NCQA.

HEDIS Measures	Medicaid	Nevada Check Up
Women's Health and Maternity Care		
Breast Cancer Screening (BCS)	✓	
Prenatal and Postpartum Care (PPC)	✓	
Care for Chronic Conditions		
Comprehensive Diabetes Care (CDC)	✓	
Controlling High Blood Pressure (CBP)	✓	
Medication Management for People With Asthma (MMA)	✓	✓
Behavioral Health		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	✓	
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	✓	
Follow-Up After Emergency Department Visit for Alcohol and Other Drug (AOD) Abuse or Dependence (FUA)	✓	
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	✓	✓
Follow-Up After Hospitalization for Mental Illness (FUH)	✓	✓
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD)	✓	✓
Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)	✓	✓
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	✓	✓
Utilization		
Ambulatory Care—Total (Per 1,000 Member Months) (AMB)	✓	✓
Mental Health Utilization—Total (MPT)	✓	✓
Plan All-Cause Readmissions (PCR)	✓	
Overuse/Appropriateness		
Use of Opioids at High Dosage (HDO)	✓	
Use of Opioids from Multiple Providers (UOP)	✓	

Compliance Review

The compliance review in Nevada includes a review of 14 standards over a three-year cycle as detailed in Appendix A. SFY 2019–2020 marked the third year of the three-year cycle and comprised an evaluation of each MCO's performance in four program areas, identified in Table 3-3, which lists the standards reviewed to determine compliance with State and federal standards.

Table 3-3—Compliance Review Standards

Standard #	Standard Name	Number of Elements
XI	Internal Quality Assurance Program (IQAP)	21
XII	Cultural Competency Program	17
XIII	Confidentiality	11
XIV	Enrollment and Disenrollment	8
	Total Number of Elements	**57**

The DHCFP also required the MCOs to submit a corrective action plan (CAP) for all elements scored *Partially Met* or *Not Met* in the first two years of the three-year compliance review cycle. To ensure each MCO had implemented plans of action to remediate the previously identified deficiencies, the DHCFP requested that HSAG also conduct a follow-up review of the CAPs developed as a result of the deficiencies identified through the SFY 2017–2018 and SFY 2018–2019 compliance reviews.

Network Adequacy Validation (NAV)

The SFY 2019–2020 NAV activity included an assessment of the capacity of each MCO's provider network by calculating the member-to-provider ratio (provider ratio) by provider category relative to the number of members and by evaluating the geographic distribution of providers relative to MCO members. Table 3-4 depicts the data sources and the time period used for the analysis.

Table 3-4—Data Sources and Time Period

Data Source	Data Time Period
Member enrollment and demographic file	Members effective as of October 1, 2019
Provider data file	Providers actively enrolled with the MCO as of October 1, 2019

Provider counts for the analysis were based on unique providers and not provider locations. Geographic access calculations were derived by the percentage of members within predefined access standards and the average travel distances (driving distances in miles) and travel times (driving times in minutes) to the nearest three providers. Table 3-5 shows the provider categories used to assess the MCOs' compliance with the provider ratio standards.

Table 3-5—Provider Categories and Provider Ratio Standards

Provider Category	Provider to Member Ratio Standard
PCPs	1:1,500*
Physician Specialists	1:1,500

* If the PCP practices in conjunction with a healthcare professional, the ratio is increased to one (1) FTE PCP for every 1,800 members.

Table 3-6 shows the provider categories used to assess the MCOs' compliance with the time-distance standards.

Table 3-6—Provider Categories, Member Criteria, and Time-Distance Standards

Provider Category	Member Criteria	Time-Distance Access Standard
PCPs	Adults/Children	30 minutes or 20 miles
Specialty Providers	Adults/Children	100 minutes or 75 miles
Behavioral Health Providers	Adults/Children	60 minutes or 45 miles
Facility-Level Providers	Adults/Children	80 minutes or 60 miles

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Analysis

The CAHPS surveys ask members to report on and evaluate their experiences with healthcare. These surveys cover topics that are important to members, such as the communication skills of providers and the accessibility of services. **Anthem**, **HPN**, and **SilverSummit** were responsible for obtaining a CAHPS vendor to administer the CAHPS surveys on their behalf. The primary objective of the CAHPS surveys was to effectively and efficiently obtain information on members' experiences with their healthcare and health plan. HSAG presents top-box scores, which indicate the percentage of members who responded to the survey with positive experiences in a particular aspect of their healthcare.

EQR Activity Results

Anthem Blue Cross and Blue Shield Healthcare Solutions

Validation of Performance Improvement Projects (PIPs)

Performance Results

Table 3-7 summarizes the progress **Anthem** made in completing the four PIP modules during SFY 2019–2020.

Table 3-7—Overall Validation Rating for Anthem

PIP Topic	Module	Status
Comprehensive Diabetes Care (CDC) HbA1c Poor Control > 9.0%	1. PIP Initiation	Completed and achieved all validation criteria.
	2. Intervention Determination	Completed and achieved all validation criteria.
	3. Intervention Testing	Targeted to begin in June 2020.
	4. PIP Conclusions	Targeted for October 2021.

PIP Topic	Module	Status
Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care	1. PIP Initiation	Completed and achieved all validation criteria.
	2. Intervention Determination	Completed and achieved all validation criteria.
	3. Intervention Testing	Targeted to begin in June 2020.
	4. PIP Conclusions	Targeted for October 2021.

Anthem has progressed to testing interventions through the SMART Aim end date of June 30, 2021. For the *Comprehensive Diabetes Care HbA1c Poor Control > 9.0%* PIP, the MCO will test an intervention focused on obtaining monthly HbA1c results from the targeted providers' electronic medical records. For the *Timeliness of Prenatal Care* PIP, **Anthem** will test an intervention focused on training the targeted providers' office staff on using CPT code 0500F when coding for the initial prenatal care visit. The results from intervention testing will be reported in the next annual EQR technical report. SMART Aim outcomes for each PIP will not be reported until October 2021; therefore, outcomes for these PIPs will be included in the SFY 2021–2022 annual EQR report.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: Anthem developed methodologically sound projects and was successful at building an internal PIP team that included external partners.

Strength: Anthem used quality improvement tools to identify and prioritize opportunities for improvement within its current processes. These tools, and the results they produced, will assist the MCO in developing targeted interventions to test using Plan-Do-Study-Act (PDSA) cycles.

Weaknesses

Weakness: There were no identified weaknesses.

Recommendations: Although there were no identified weaknesses, HSAG recommends as **Anthem** determines interventions to test, the MCO consider the end date specified in the SMART Aim statement and work backwards when planning intervention testing. Careful planning is critical to allow enough time to test and refine interventions that will result in meaningful and sustained improvement. When determining interventions to test, **Anthem** should revisit the third fundamental question of the Model for Improvement, "What changes can we make that will result in improvement?" and ensure interventions tested have the potential to positively impact the quality of, timeliness of, and access to care for their members.

Performance Measure Validation (PMV)

Medicaid Performance Results

Anthem's Medicaid HEDIS 2018, 2019, and 2020 performance measure rates are presented in Table 3-8, along with year-to-year rate comparisons and performance target ratings. Measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, a decrease in the rate from 2019 to 2020 represents performance improvement and an increase in the rate from 2019 to 2020 represents performance decline. Measures in the Utilization domain are designed to capture the frequency of services provided by the MCO. With the exception of *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total*, higher or lower rates in this domain do not necessarily indicate better or worse performance. Therefore, these rates are provided for informational purposes only.

Table 3-8—Medicaid HEDIS Performance Measure Results for Anthem

HEDIS Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	2019–2020 Rate Comparison
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services (AAP)				
Ages 20–44 Years	72.55%	73.27%	73.11%	-0.16
Ages 45–64 Years	79.38%	80.05%	79.43%	-0.62
Ages 65 Years and Older	77.55%	NA	NA	NC
Total	74.69%	75.38%	75.11%	-0.27
Children and Adolescents' Access to Primary Care Practitioners (CAP)[1]				
Ages 12–24 Months	94.89%	94.78%	94.71%	-0.07
Ages 25 Months–6 Years	83.97%	84.36%	83.93%	-0.43
Ages 7–11 Years	85.98%	85.94%	86.52%	0.58
Ages 12–19 Years	83.53%	84.54%	85.08%	0.54
Children's Preventive Care				
Adolescent Well-Care Visits (AWC)				
Adolescent Well-Care Visits	51.09%	56.45%	**56.45%**[3]	0.00
Childhood Immunization Status (CIS)				
Combination 2	70.07%	72.99%	71.29%	-1.70
Combination 3	65.94%	69.83%	68.13%	-1.70
Combination 4	65.21%	69.34%	67.64%	-1.70
Combination 5	55.23%	59.85%	58.64%	-1.21
Combination 6	33.09%	34.79%	**38.93%**	4.14
Combination 7	54.74%	59.37%	58.15%	-1.22

HEDIS Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	2019–2020 Rate Comparison
Combination 8	32.85%	34.79%	**38.93%**	4.14
Combination 9	28.47%	30.41%	33.82%	3.41
Combination 10	28.22%	30.41%	33.82%	3.41
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	84.67%	89.29%	**89.29%**[3]	0.00
Combination 2 (Meningococcal, Tdap, HPV)	40.63%	41.12%	41.12%[3]	0.00
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile—Total	77.37%	82.73%	**82.73%**[3]	0.00
Counseling for Nutrition—Total	71.29%	74.21%	**74.21%**[3]	0.00
Counseling for Physical Activity—Total	67.64%	67.88%	67.88%[3]	0.00
Well-Child Visits in the First 15 Months of Life (W15)				
Six or More Well-Child Visits	68.04%	68.06%	**68.06%**[3]	0.00
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.24%	73.17%	73.17%[3]	0.00
Women's Health and Maternity Care				
Breast Cancer Screening (BCS)				
Breast Cancer Screening	50.64%	51.93%	51.64%	-0.29
Prenatal and Postpartum Care (PPC)[2]				
Timeliness of Prenatal Care	—	—	80.78%[3^]	NC
Postpartum Care	—	—	59.37%[3^]	NC
Care for Chronic Conditions				
Comprehensive Diabetes Care (CDC)				
Hemoglobin A1c (HbA1c) Testing	82.48%	77.37%	79.08%	1.71
*HbA1c Poor Control (>9.0%)**	41.61%	45.01%	51.58%	6.57
HbA1c Control (<8.0%)	50.12%	47.45%	40.15%	-7.30
Eye Exam (Retinal) Performed	53.28%	52.31%	53.04%	0.73
Medical Attention for Nephropathy	90.27%	87.59%	89.05%	1.46
Blood Pressure Control (<140/90 mm Hg)	54.26%	52.31%	37.47%	-14.84
Controlling High Blood Pressure (CBP)				
Controlling High Blood Pressure	—	52.55%	52.55%[3]	0.00

HEDIS Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	2019–2020 Rate Comparison
Medication Management for People With Asthma (MMA)				
Medication Compliance 50%—Total	55.71%	61.19%	**63.95%**	2.76
Medication Compliance 75%—Total	32.70%	35.90%	**42.39%**	6.49
Behavioral Health				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	38.05%	35.32%	45.71%	10.39
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)				
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	81.46%	80.48%	**83.30%**	2.82
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)				
7-Day Follow-Up—Total	7.22%	9.25%	10.62%	1.37
30-Day Follow-Up—Total	10.92%	13.99%	15.55%	1.56
Follow-Up After Emergency Department Visit for Mental Illness (FUM)				
7-Day Follow-Up—Total	—	28.77%	30.27%	1.50
30-Day Follow-Up—Total	—	41.41%	41.84%	0.43
Follow-Up After Hospitalization for Mental Illness (FUH)				
7-Day Follow-Up—Total	40.13%	33.52%	34.61%	1.09
30-Day Follow-Up—Total	56.26%	50.33%	50.75%	0.42
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
Initiation Phase	39.66%	46.77%	41.55%	-5.22
Continuation and Maintenance Phase	61.02%	66.10%	59.38%	-6.72
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)				
Initiation of AOD—Total	42.83%	49.65%	**48.53%**	-1.12
Engagement of AOD—Total	12.72%	14.78%	15.87%	1.09
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)				
Blood Glucose and Cholesterol Testing—Total	21.03%	23.18%	**31.71%**	8.53
Utilization				
Ambulatory Care—Total (per 1,000 Member Months) (AMB)				
*ED Visits—Total**	56.58	56.03	59.89^	3.86
Outpatient Visits—Total	287.88	288.52	291.03^	2.51

HEDIS Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	2019–2020 Rate Comparison
Mental Health Utilization—Total (MPT)				
Inpatient—Total	—	1.39%	1.46%^	0.07
Intensive Outpatient or Partial Hospitalization—Total	—	0.61%	0.77%^	0.16
Outpatient—Total	—	10.14%	11.05%^	0.91
ED—Total	—	0.50%	0.41%^	-0.09
Telehealth—Total	—	0.03%	0.09%^	0.06
Any Service—Total	—	10.68%	11.60%^	0.92
Plan All-Cause Readmissions (PCR)[2]				
Observed Readmissions—Total	—	—	13.42%^	NC
Expected Readmissions—Total	—	—	9.60%^	NC
*O/E Ratio—Total**	—	—	1.40^	NC
Overuse/Appropriateness of Care				
Use of Opioids at High Dosage (HDO)[*,2]				
Use of Opioids at High Dosage	—	—	9.18%^	NC
Use of Opioids From Multiple Providers (UOP)*				
Multiple Prescribers	—	21.55%	**21.52%**	-0.03
Multiple Pharmacies	—	1.61%	**1.60%**	-0.01
Multiple Prescribers and Multiple Pharmacies	—	0.83%	**0.84%**	0.01

[1] Due to changes in the technical specifications for this measure, NCQA recommends that trending between HEDIS 2020 and prior years be considered with caution.

[2] Due to significant changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS 2020 and prior years; therefore, prior years' rates are not displayed, and rate comparisons are not performed for this measure.

[3] In alignment with DHCFP and NCQA guidance, results for this measure were rotated with the HEDIS 2019 (MY 2018) hybrid rate.

* A lower rate indicates better performances for this measure.

— Indicates that the health plan was not previously required to report this measure or that the rate is not appropriate to display due to changes in the technical specifications.

^ Indicates HEDIS 2020 Quality Improvement System for Managed Care (QISMC) goals are unavailable for this measure.

NC indicates the 2019–2020 Rate Comparison could not be calculated because data are not available for both years.

NA indicates that the plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

Bolded rates indicate that the performance measure rate for HEDIS 2020 was at or above the MPS.

Indicates that the HEDIS 2020 rate declined by 5 percentage points or more from HEDIS 2019.

Indicates that the HEDIS 2020 rate improved by 5 percentage points or more from HEDIS 2019.

Nevada Check Up Performance Results

Anthem's Nevada Check Up HEDIS 2018, 2019, and 2020 performance measure rates are presented in Table 3-9, along with year-to-year rate comparisons and performance target ratings. Measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, a decrease in the rate from 2019 to 2020 represents performance improvement and an increase in the rate from 2019 to 2020 represents performance decline. Measures in the Utilization domain are designed to capture the frequency of services provided by the MCO. With the exception of *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total*, higher or lower rates in this domain do not necessarily indicate better or worse performance. Therefore, these rates are provided for informational purposes only.

Table 3-9—Nevada Check Up HEDIS Performance Measure Results for Anthem

HEDIS Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	2019–2020 Rate Comparison
Access to Care				
Children and Adolescents' Access to Primary Care Practitioners (CAP)[1]				
Ages 12–24 Months	99.12%	99.56%	95.94%	-3.62
Ages 25 Months–6 Years	91.10%	91.09%	**92.41%**	1.32
Ages 7–11 Years	93.08%	92.04%	**94.33%**	2.29
Ages 12–19 Years	90.11%	91.03%	**91.95%**	0.92
Children's Preventive Care				
Adolescent Well-Care Visits (AWC)				
Adolescent Well-Care Visits	65.82%	67.40%	**68.61%**	1.21
Childhood Immunization Status (CIS)				
Combination 2	90.24%	87.21%	85.27%	-1.94
Combination 3	81.71%	84.02%	**83.48%**	-0.54
Combination 4	81.71%	84.02%	83.04%	-0.98
Combination 5	75.61%	74.43%	77.23%	2.80
Combination 6	38.21%	47.95%	**50.45%**	2.50
Combination 7	75.61%	74.43%	76.79%	2.36
Combination 8	38.21%	47.95%	**50.45%**	2.50
Combination 9	36.18%	42.47%	**47.77%**	5.30
Combination 10	36.18%	42.47%	**47.77%**	5.30

HEDIS Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	2019–2020 Rate Comparison
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	90.37%	93.63%	**93.63%**[2]	0.00
Combination 2 (Meningococcal, Tdap, HPV)	54.96%	51.96%	51.96%[2]	0.00
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile—Total	84.67%	87.83%	**87.83%**[2]	0.00
Counseling for Nutrition—Total	73.48%	79.56%	**79.56%**[2]	0.00
Counseling for Physical Activity—Total	70.80%	73.48%	**73.48%**[2]	0.00
Well-Child Visits in the First 15 Months of Life (W15)				
Six or More Well-Child Visits	83.24%	82.26%	**82.26%**[2]	0.00
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	77.37%	77.62%	77.62%[2]	0.00
Care for Chronic Conditions				
Medication Management for People With Asthma (MMA)				
Medication Compliance 50%—Total	54.84%	59.62%	**66.98%**	7.36
Medication Compliance 75%—Total	30.11%	36.54%	**44.34%**	7.80
Behavioral Health				
Follow-Up After Emergency Department Visit for Mental Illness (FUM)				
7-Day Follow-Up—Total	—	NA	NA	NC
30-Day Follow-Up—Total	—	NA	NA	NC
Follow-Up After Hospitalization for Mental Illness (FUH)				
7-Day Follow-Up—Total	50.00%	NA	37.14%	NC
30-Day Follow-Up—Total	65.79%	NA	60.00%	NC
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
Initiation Phase	44.12%	42.42%	**60.00%**	17.58
Continuation and Maintenance Phase	NA	NA	NA^	NC
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)				
Initiation of AOD—Total	NA	NA	NA	NC
Engagement of AOD—Total	NA	NA	NA	NC

HEDIS Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	2019–2020 Rate Comparison
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)				
Blood Glucose and Cholesterol Testing—Total	NA	NA	**48.39%**	NC
Utilization				
Ambulatory Care—Total (per 1,000 Member Months) (AMB)				
*ED Visits—Total**	27.04	25.74	30.27^	4.53
Outpatient Visits—Total	248.86	242.04	253.13^	11.09
Mental Health Utilization—Total (MPT)				
Inpatient—Total	—	0.26%	0.40%^	0.14
Intensive Outpatient or Partial Hospitalization—Total	—	0.34%	0.21%^	-0.13
Outpatient—Total	—	6.96%	7.15%^	0.19
ED—Total	—	0.14%	0.00%^	-0.14
Telehealth—Total	—	0.00%	0.02%^	0.02
Any Service—Total	—	7.02%	7.20%^	0.18

[1] Due to changes in the technical specifications for this measure, NCQA recommends that trending between HEDIS 2020 and prior years be considered with caution.

[2] In alignment with DHCFP and NCQA guidance, results for this measure were rotated with the HEDIS 2019 (MY 2018) hybrid rate.

* A lower rate indicates better performances for this measure.

— Indicates that the health plan was not previously required to report this measure or that the rate is not appropriate to display due to changes in the technical specifications.

^ Indicates HEDIS 2020 QISMC goals are unavailable for this measure.

NC indicates the 2019–2020 Rate Comparison could not be calculated because data are not available for both years.

NA indicates that the plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

Bolded rates indicate that the performance measure rate for HEDIS 2020 was at or above the MPS.

Indicates that the HEDIS 2020 rate declined by 5 percentage points or more from HEDIS 2019.

Indicates that the HEDIS 2020 rate improved by 5 percentage points or more from HEDIS 2019.

In response to the COVID-19 pandemic and its impact on collecting medical records from some provider offices, **Anthem** opted to rotate several hybrid measures with HEDIS 2019 audited rates for both its Medicaid (i.e., *AWC*, *CBP*, *IMA*, *PPC*, *W15*, *W34*, and *WCC*) and Nevada Check Up (i.e., *IMA*, *W15*, *W34*, and *WCC*) populations. Table 3-10 displays the official HEDIS 2020 rotated rate, unofficial HEDIS 2020 hybrid rate, and the difference. This information is presented for informational purposes only.

Table 3-10—Rotated Versus Non-Rotated Hybrid HEDIS 2020 Rates for Anthem by Medicaid and Nevada Check Up Populations

HEDIS Measure	Medicaid—HEDIS 2020			Nevada Check Up—HEDIS 2020		
	Rotated Rate	Non-Rotated Rate	Difference	Rotated Rate	Non-Rotated Rate	Difference
Children's Preventive Care						
Adolescent Well-Care Visits (AWC)						
Adolescent Well-Care Visits	56.45%	50.61%	-5.84%	—	—	—
Immunizations for Adolescents (IMA)						
Combination 1 (Meningococcal, Tdap)	89.29%	88.81%	-0.48%	93.63%	93.43%	-0.20%
Combination 2 (Meningococcal, Tdap, HPV)	41.12%	40.39%	-0.73%	51.96%	51.34%	-0.62%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)						
BMI Percentile—Total	82.73%	65.69%	-17.04%	87.83%	66.18%	-21.65%
Counseling for Nutrition—Total	74.21%	55.23%	-18.98%	79.56%	54.26%	-25.30%
Counseling for Physical Activity—Total	67.88%	45.74%	-22.14%	73.48%	47.93%	-25.55%
Well-Child Visits in the First 15 Months of Life (W15)						
Six or More Well-Child Visits	68.06%	64.44%	-3.62%	82.26%	73.06%	-9.20%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)						
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.17%	70.12%	-3.05%	77.62%	76.69%	-0.93%
Women's Health and Maternity Care						
Prenatal and Postpartum Care (PPC)						
Timeliness of Prenatal Care	80.78%	77.62%	-3.16%	—	—	—
Postpartum Care	59.37%	62.29%	2.92%	—	—	—
Care for Chronic Conditions						
Controlling High Blood Pressure (CBP)						
Controlling High Blood Pressure	52.55%	36.50%	-16.05%	—	—	—

— Indicates that the rate was not rotated by the health plan; therefore, rates are not displayed, and rate comparisons are not performed.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: In the Nevada Check Up Access to Care domain, the MCO met MPS in three of four measure rates, indicating that children and young adults are able to access a PCP at least annually for preventive services and appropriate treatment as necessary to stay healthy and reduce unnecessary emergency room (ER) utilization.

Strength: Under the Care for Chronic conditions domain for both Nevada Check Up and Medicaid, the MCO demonstrated appropriate medication management of members with asthma as indicated by all four rates within the *Medication Management for People With Asthma* measure meeting MPS. This performance implies that the MCO and its contracted providers are reducing the need for rescue medications and use of the ER.

Strength: Within the Overuse/Appropriateness of Care domain, the MCO met MPS in all *Use of Opioids From Multiple Providers* measure rates, indicating that the MCO is managing the frequency of its members' use of multiple prescribers and pharmacies for opioid medications and therefore reducing potential risk for overdoses. In addition, two of the three measures for *Use of Opioids for Multiple Providers* surpassed the Tier 3 QISMC goal.

Strength: In the Nevada Check Up *Combination 1 (Meningococcal, Tdap)* surpassed the Tier 3 QISMC goal.

Weaknesses

Weakness: Although 18 of 34 rates within the Children's Preventive Care domain for Medicaid and Nevada Check Up met MPS, the remaining 16 measures performed below MPS, and eight rates also declined from the previous year. This performance suggests that many children and young adults are not getting immunizations that are essential for disease prevention.

Why the weakness exists: Although children and young adults appear to have access to PCPs for preventive and necessary services, these members are not always getting immunizations recommended by national organizations, such as the Centers for Disease Control and Prevention (CDC).

Recommendation: HSAG recommends **Anthem** conduct a root cause analysis or focused study to determine why its members are not getting all recommended immunizations as suggested by national organizations, such as the CDC. Upon identification of a root cause, **Anthem** should implement appropriate interventions to improve the performance related to Children's Preventive Care measures.

Weakness: The *Breast Cancer Screening* measure rate within the Women's Health and Maternity Care domain fell below MPS, indicating women are not getting breast cancer screenings for early detection of breast cancer, which may result in less effective treatment.

Why the weakness exists: The Access to Care measure rates for adult Medicaid members are performing below the MPS, and demonstrated a slight decline in all reported measures, suggesting members are not always able to access providers for services in a timely manner for preventive care, including breast cancer screening.

Recommendation: HSAG recommends **Anthem** conduct a root cause analysis or focused study to determine why its women members are not getting preventive screenings

for breast cancer. **Anthem** could consider if there are disparities within its populations that contribute to lower performance in a particular race or ethnicity, age group, zip code, etc. Upon identification of a root cause, **Anthem** should implement appropriate interventions to improve the performance related to Women's Health and Maternity Care.

Weakness: Anthem's Medicaid population demonstrated little change in its rates across all domains of care; however, three out of six *CDC* indicators experienced a decline in performance of more than 5 percentage points. Of note, the rate for *Blood Pressure Control (<140/90 mm Hg)* fell by more than 14 percentage points from HEDIS 2019 to HEDIS 2020.

Why the weakness exists: Although process-related diabetes indicators increased (e.g., HbA1c testing, retinal exams, and nephropathy) during HEDIS 2020 reporting, diabetes outcome measures continued to decline. This finding suggests that despite minor increases in the prevalence of preventive services, control among **Anthem**'s Medicaid diabetic population is declining. Appropriate diabetes management is critical to control blood glucose, reduce risks for complications, and prolong the life of **Anthem**'s members.

Recommendation: HSAG recommends that **Anthem** continue its *Comprehensive Diabetes Care HbA1c Poor Control > 9.0%* PIP and proceed with the development and implementation of interventions to address declining diabetes outcomes. Additionally, **Anthem** should evaluate whether lessons learned from this PIP identify the possible cause or causes attributing to the sharp decline in the *Blood Pressure Control (<140/90 mm Hg)* rate. At a minimum, **Anthem** should investigate factors that impact blood pressure control among this population.

Weakness: Within the Behavioral Health domain, both *Follow-Up Care for Children Prescribed ADHD Medication (ADD)* indicators for **Anthem**'s Medicaid population experienced a decline in performance of more than 5 percentage points.

Why the weakness exists: HSAG was unable to discern a root cause for the reason the *ADD* measure experienced such a significant decline when most measure rates within the Behavioral Health domain showed improvement.

Recommendation: Performance measures in the Behavioral Health domain generally exhibited an increase in rates with this exception of the *ADD* measure. **Anthem** should review numerator negative cases to identify the reason for the decline in the *ADD* measure rates and implement an intervention to improve performance.

Compliance Review

A review of standards shows how well an MCO has interpreted the required elements of the managed care contract and developed the necessary policies, procedures, and plans to carry out the required MCO functions.

Performance Results

Table 3-11 presents **Anthem**'s scores for each standard evaluated in the SFY 2019–2020 compliance review. Each element within a standard was scored as *Met*, *Partially Met,* or *Not Met* based on evidence found in MCO documents, policies, procedures, reports, meeting minutes, and interviews with MCO staff members.

Table 3-12 presents the results of the review conducted on **Anthem**'s CAPs that were developed to remediate the deficiencies identified through the SFY 2017–2018 and SFY 2018–2019 compliance reviews.

Table 3-11—Summary of Scores for the Compliance Standards

Standard #	Standard Name	Total Elements	Total Applicable Elements	Number of Elements				Total Compliance Score
				M	*PM*	*NM*	*NA*	
XI	IQAP	21	20	16	4	0	1	90%
XII	Cultural Competency Program	17	17	15	2	0	0	94%
XIII	Confidentiality	11	11	11	0	0	0	100%
XIV	Enrollment and Disenrollment	8	8	6	1	1	0	81%
Total Compliance Score		**57**	**56**	**48**	**7**	**1**	**1**	**92%**

M=*Met*, ***PM***=*Partially Met*, ***NM***=*Not Met*, ***NA***=*Not Applicable*

Total Elements: The total number of elements in each standard.

Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point) to the weighted number that received a score of *Partially Met* (0.5 point), then dividing this total by the total number of applicable elements.

Table 3-12—Summary of Scores for the SFY 2017–2018 and SFY 2018–2019 CAP Reviews

Standard #	Standard Name	Total CAP Elements	Total Number of Elements Scored	
			M	*NM*
I	Credentialing and Recredentialing	NA	NA	NA
II	Availability and Accessibility of Services	1	1	0
III	Subcontracts and Delegation	3	3	0
IV	Provider Dispute and Complaint Resolution	NA	NA	NA
V	Provider Information	NA	NA	NA
VI	Member Rights and Responsibilities	1	1	0
VII	Member Information	NA	NA	NA
VIII	Continuity and Coordination of Care	NA	NA	NA
IX	Grievances and Appeals	7	7	0
X	Coverage and Authorization of Services	NA	NA	NA
Total		**12**	**12**	**0**

M=*Met* and ***NM***=*Not Met*

Total CAP Elements: The total number of elements in each standard.

Total Number of Elements Scored: The number of elements that received a score of *M* or *NM* for each standard reviewed.

NA: The MCO did not have any deficiencies noted for this standard during the SFY 2017–2018 and SFY 2018–2019 reviews.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: Anthem has developed the necessary policies, procedures, plans, and systems to operationalize most of the required elements of its contract and managed care regulations under 42 CFR §438, indicating that the MCO has the capability to provide quality and accessible services to its members.

Strength: Anthem demonstrated having sufficient procedures and effective processes and policies for the use and disclosure of individually identifiable health information. New hire and annual staff trainings were comprehensive and tailored to staff interactions with members. These processes, procedures, and training programs support **Anthem** in protecting the privacy of its member data.

Strength: Anthem demonstrated a comprehensive and data-driven cultural competency program with a training component for staff and providers. Specifically, **Anthem** maintained an eLearning staff training platform comprised of multiple topics pertaining to cultural competency. Such topics included research-based strategies and practical tools to assist in the development of inclusive leadership skills and to promote behaviors that are foundational to an inclusive culture. An effective cultural competency program helps ensure that culturally competent services are being provided to **Anthem** members.

Weaknesses

Weakness: Anthem demonstrated opportunities for improvement in oversight of its IQAP. For example, **Anthem** did not engage in a total of five PIPs, as required by the DHCFP, and appeared to lack a Board of Directors and local committee direction and leadership. Further, staff had difficulties providing responses to some interview questions.

Why the weakness exists: Discussion during the compliance review identified a lack of understanding or misinterpretation of specific contract requirements. Staff members verbalized a reorganization and staff turnover that may have been a contributing factor. Additionally, the IQAP reporting to the Board of Directors occurred only once annually.

Recommendation: HSAG recommends that **Anthem** enhance oversight of its IQAP through quarterly Board of Directors and Quality Management Committee meetings. Further, **Anthem** should solicit input from the Board of Directors and the Quality Management Committee on the selection and implementation of three additional PIPs required to meet contract provisions. These PIPs should be added to **Anthem**'s IQAP program description and workplan.

Network Adequacy Validation (NAV)

Performance Results

Table 3-13 presents a summary of **Anthem**'s provider ratio analysis results compared to the provider ratio standards. For the provider categories assessed according to the standards in Table 3-13, the percentage of members with access to the provider within the time-distance standard is shown in red if they did not comply with the standard. The time-distance results are displayed in Table 3-14.

Table 3-13—Summary of Ratio Analysis Results for PCPs and Specialty Care Providers for Anthem

Provider Category	Anthem	
	Providers	Ratio
PCPs (1:1,500)	1,343	1:121
PCP Extenders (1:1,800)	1,362	1:119
Physician Specialist Providers (1:1,500)	1,412	1:112

Table 3-14—Percentage of Members Residing Within the Access Standard Areas for Anthem

Provider Category	Time-Distance Standard	Percentage of Members with Access
PCPs		
Primary Care (Adult Total)	20 miles/30 mins	99.2%
OB/GYN	20 miles/30 mins	98.9%
Pediatrician	20 miles/30 mins	99.2%
Specialty Providers		
Endocrinologist	75 miles/100 mins	99.2%
Endocrinologist, Pediatric	75 miles/100 mins	99.3%
Infectious Disease	75 miles/100 mins	99.2%
Infectious Disease, Pediatric	75 miles/100 mins	99.3%
Oncologist/Hematologist	75 miles/100 mins	99.2%
Oncologist/Hematologist, Pediatric	75 miles/100 mins	99.3%
Oncologist/Radiologist	75 miles/100 mins	99.2%
Rheumatologist	75 miles/100 mins	99.2%
Rheumatologist, Pediatric	75 miles/100 mins	88.6%
Facility-Level Providers		
Hospital	60 miles/80 mins	99.3%
Psychiatry Inpatient Hospital	60 miles/80 mins	99.1%
Dialysis/End Stage Renal Disease (ESRD) Facility	60 miles/80 mins	99.1%
Behavioral Health Providers		
Psychologist	45 miles/60 mins	99.1%
Pediatric Psychologist	45 miles/60 mins	88.6%
Licensed Clinical Social Worker (LCSW)	45 miles/60 mins	99.1%
Psychiatrist	45 miles/60 mins	99.1%
Pediatric Psychiatrist	45 miles/60 mins	99.3%

Strengths, Weaknesses, and Recommendations

Strengths

Strength: Anthem met the required provider ratio requirements for PCPs, PCP extenders, and the physician specialist providers, indicating **Anthem** has a sufficient provider network for its members to access services.

Strength: Anthem met the time-distance contract standards for all general primary care categories (PCPs, OB/GYNs, and pediatricians) and the assessed facility-level providers, indicating members had access to a provider within an adequate distance from their residence.

Weaknesses

Weakness: Anthem did not report providers in the following specialty areas: pediatric allergists and immunologists, pediatric dermatologists, oncologists/radiologists, pediatric-otolaryngologists (ENTs), pediatric physical medicine specialists, or hospice facilities, indicating members may have a barrier to accessing care at these provider types.[3-3]

Why the weakness exists: The lack of identified providers may result from either a lack of contracted providers in those specialties or from inconsistencies in identifying those provider specialties in the data.

Recommendation: HSAG recommends **Anthem** review its provider data and contracted provider list to identify if the inability to identify providers in the data is a result of a lack of contracted providers or if the providers are not appropriately identified in the data due to data mapping and/or submission issues. If a lack of contracted providers is identified, HSAG recommends **Anthem** determine if the lack of contracted providers is due to a shortage of providers in the area or an unwillingness of the providers to contract with the MCO.

Weakness: Anthem did not meet the time-distance contract standards for pediatric rheumatologists and pediatric psychologists, indicating members may not be able to access these provider types within an adequate distance from their residence.

Why the weakness exists: The lack of identified providers may result from either a lack of contracted pediatric specialty providers in those specialties or from an inability to identify those pediatric specialists in the data.

Recommendation: HSAG recommends **Anthem** conduct an in-depth review of provider categories in which it did not meet either the time-distance contract standards, with the goal of determining whether or not the failure of the MCO to meet the contract standard(s) was the result of a lack of providers or an inability to contract providers in the geographic area.

[3-3] The provider categories with no reported provider counts are not displayed in the Percentage of Members Residing Within the Access Standard Areas for Anthem table. These provider categories are listed with an "NA" in the DHCFP Nevada Medicaid Managed Care State Fiscal Year 2019–20 Network Adequacy Validation report.

CAHPS Analysis

Performance Results

Table 3-15 presents **Anthem**'s 2020 adult Medicaid, general child Medicaid, and children with chronic conditions (CCC) Medicaid CAHPS top-box scores. Table 3-15 also includes **Anthem**'s 2020 Nevada Check Up general child and CCC top-box scores.

Table 3-15—Summary of 2020 CAHPS Top-Box Scores for Anthem

	2020 Adult Medicaid	2020 General Child Medicaid	2020 CCC Medicaid Supplemental	2020 Nevada Check Up General Child	2020 Nevada Check Up CCC Supplemental
Composite Measures					
Getting Needed Care	NA	86.6%	NA	NA	NA
Getting Care Quickly	NA	93.6%	NA	NA	NA
How Well Doctors Communicate	NA	92.9%	NA	93.8%	NA
Customer Service	NA	NA	NA	NA	NA
Global Ratings					
Rating of All Health Care	43.6% ↓	71.9%	68.6%	71.4%	NA
Rating of Personal Doctor	52.2% ↓	76.0%	74.5%	74.8%	NA
Rating of Specialist Seen Most Often	NA	NA	NA	NA	NA
Rating of Health Plan	52.9% ↓	71.4%	64.2%	69.5%	NA
Effectiveness of Care*					
Advising Smokers and Tobacco Users to Quit	65.6% ↓				
Discussing Cessation Medications	38.9% ↓				
Discussing Cessation Strategies	31.3% ↓				
CCC Composite Measures/Items					
Access to Specialized Services			NA		NA
Family Centered Care (FCC): Personal Doctor Who Knows Child			NA		NA

	2020 Adult Medicaid	2020 General Child Medicaid	2020 CCC Medicaid Supplemental	2020 Nevada Check Up General Child	2020 Nevada Check Up CCC Supplemental
Coordination of Care for Children With Chronic Conditions			NA		NA
Access to Prescription Medicines			NA		NA
FCC: Getting Needed Information			92.2%		NA

A minimum of 100 responses is required for a measure to be reported as a CAHPS survey results. 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 2020 score is at least 5 percentage points higher than the 2019 national average.
↓ Indicates the 2020 score is at least 5 percentage points lower than the 2019 national average.
Indicates that the measure does not apply to the population.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: HSAG did not identify any strengths for **Anthem** for the CAHPS surveys.

Weaknesses

Weakness: There is limited data available to comprehensively evaluate member satisfaction.

Why the weakness exists: **Anthem** had measures that did not meet the minimum 100 responses for the adult Medicaid population, general child and CCC Medicaid populations, and Nevada Check Up general child and CCC populations. Due to COVID-19, **Anthem** was unable to complete the survey.

Recommendation: HSAG recommends that **Anthem** continue to work with its CAHPS vendor to obtain a sufficient number of completed surveys that will enable reporting of all CAHPS measures. NCQA recommends targeting 411 completed surveys per survey administration. **Anthem** may need to consider adding other data collection survey modes, such as telephone follow-up and/or the Internet, for the CAHPS surveys to increase response rates. HSAG also recommends **Anthem** continue texting and emailing member reminders and determine if there are other initiatives that could be implemented to increase member response rates.

Weakness: Adult members had less positive overall experiences with their health plan, personal doctor, and the healthcare they received as represented by scores for these measures being at least 5 percentage points lower than the 2019 NCQA adult Medicaid national averages. In addition, the Effectiveness of Care scores were at least 5 percentage points lower than the 2019 NCQA adult Medicaid national averages.

Why the weakness exists: The prevalence of positive adult member experience decreased in all reported measures, indicating there may have been a factor at the health plan that contributed to less positive member experience with the care and services being provided by **Anthem** and its contracted providers. Additionally, **Anthem**'s providers may not be aware of all the needs of their members and as a result may not be providing the consultative care required. As related to Effectiveness of Care, providers may not be advising members who smoke or use tobacco to quit and may not be discussing cessation medications and strategies with their adult members as much as other providers compared to national benchmarks.

Recommendation: HSAG recommends that **Anthem** focus on improving members' overall experiences with their health plan, personal doctor, and healthcare and on quality improvement initiatives to provide medical assistance with smoking and tobacco use cessation. HSAG recommends that **Anthem** prioritize two of its lowest performing measures and determine a root cause for the lower performance. As part of this analysis, **Anthem** could determine if any outliers were identified within the data, identify primary areas of focus, and develop appropriate strategies to improve the performance. **Anthem** should also continue its current initiatives, such as its partnership with National Jewish Health for smoking cessation efforts and provider training on how providers can help improve member experience.

Health Plan of Nevada

Validation of Performance Improvement Projects (PIPs)

Performance Results

Table 3-16 summarizes the progress **HPN** made in completing the four PIP modules during SFY 2019–2020.

Table 3-16—Overall Validation Rating for HPN

PIP Topic	Module	Status
Comprehensive Diabetes Care (CDC) HbA1c Poor Control > 9.0%	1. PIP Initiation	Completed and achieved all validation criteria.
	2. Intervention Determination	Completed and achieved all validation criteria.
	3. Intervention Testing	Targeted to begin in June 2020.
	4. PIP Conclusions	Targeted for October 2021.
Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care	1. PIP Initiation	Completed and achieved all validation criteria.
	2. Intervention Determination	Completed and achieved all validation criteria.
	3. Intervention Testing	Targeted to begin in June 2020.
	4. PIP Conclusions	Targeted for October 2021.

HPN has progressed to testing interventions through the SMART Aim end date of June 30, 2021. For the *Comprehensive Diabetes Care HbA1c Poor Control > 9.0%* PIP, the MCO will test an intervention that provides the targeted diabetic population with a home HbA1c testing kit. For the *Timeliness of Prenatal Care* PIP, **HPN** will test an intervention focused on educating and encouraging the targeted provider's office staff on proper billing codes that establish prenatal care during a confirmation of pregnancy visit. The results from intervention testing will be reported in the next annual EQR technical report. SMART Aim outcomes for each PIP will not be reported until October 2021; therefore, outcomes for these PIPs will be included in the SFY 2021–2022 annual EQR report.

Strengths, Weaknesses, and Recommendations

Strengths
Strength: HPN developed methodologically sound projects and was successful at building an internal PIP team that included external partners.
Strength: HPN used quality improvement tools to identify and prioritize opportunities for improvement within its current processes. These tools, and the results they produced, will assist the MCO in developing targeted interventions to test using PDSA cycles.

Weaknesses

Weakness: There were no identified weaknesses.

Recommendations: Although there were no identified weaknesses, HSAG recommends that as **HPN** determines interventions to test, the MCO consider the end date specified in the SMART Aim statement and work backwards when planning intervention testing. Careful planning is critical to allow enough time to test and refine interventions that will result in meaningful and sustained improvement. When determining interventions to test, **HPN** should revisit the third fundamental question of the Model for Improvement, "What changes can we make that will result in improvement?" and ensure interventions tested have the potential to positively impact the quality of, timeliness of, and access to care for their members.

Performance Measure Validation (PMV)

Medicaid Performance Results

HPN's Medicaid HEDIS 2018, 2019, and 2020 performance measure rates are presented in Table 3-17, along with year-to-year rate comparisons and performance target ratings. Measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, a decrease in the rate from 2019 to 2020 represents performance improvement and an increase in the rate from 2019 to 2020 represents performance decline. Measures in the Utilization domain are designed to capture the frequency of services provided by the MCO. With the exception of the *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total*, higher or lower rates in this domain do not necessarily indicate better or worse performance. Therefore, these rates are provided for informational purposes only.

Table 3-17—Medicaid HEDIS Performance Measure Results for HPN

HEDIS Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	2019–2020 Rate Comparison
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services (AAP)				
Ages 20–44 Years	73.01%	73.09%	**75.70%**	2.61
Ages 45–64 Years	80.02%	78.58%	81.68%	3.10
Ages 65 Years and Older	60.53%	33.08%	NA	NC
Total	75.50%	74.92%	**77.81%**	2.89

HEDIS Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	2019–2020 Rate Comparison
Children and Adolescents' Access to Primary Care Practitioners (CAP) [1]				
Ages 12–24 Months	93.95%	94.20%	94.52%	0.32
Ages 25 Months–6 Years	84.16%	83.38%	84.90%	1.52
Ages 7–11 Years	86.59%	86.45%	86.72%	0.27
Ages 12–19 Years	84.58%	84.83%	85.68%	0.85
Children's Preventive Care				
Adolescent Well-Care Visits (AWC)				
Adolescent Well-Care Visits	46.72%	48.66%	48.91%	0.25
Childhood Immunization Status (CIS)				
Combination 2	71.05%	72.02%	72.02%[3]	0.00
Combination 3	64.96%	68.37%	68.37%[3]	0.00
Combination 4	64.72%	67.64%	67.64%[3]	0.00
Combination 5	54.74%	60.10%	**60.10%**[3]	0.00
Combination 6	30.66%	39.42%	**39.42%**[3]	0.00
Combination 7	54.50%	59.61%	**59.61%**[3]	0.00
Combination 8	30.66%	39.42%	**39.42%**[3]	0.00
Combination 9	26.03%	35.52%	**35.52%**[3]	0.00
Combination 10	26.03%	35.52%	**35.52%**[3]	0.00
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	82.24%	89.05%	**90.51%**	1.46
Combination 2 (Meningococcal, Tdap, HPV)	42.58%	43.55%	**48.42%**	4.87
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile—Total	83.21%	78.59%	**83.45%**	4.86
Counseling for Nutrition—Total	68.37%	68.37%	71.05%	2.68
Counseling for Physical Activity—Total	65.21%	64.96%	69.34%	4.38
Well-Child Visits in the First 15 Months of Life (W15)				
Six or More Well-Child Visits	61.31%	63.75%	67.15%	3.40

HEDIS Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	2019–2020 Rate Comparison
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	70.07%	66.42%	71.53%	5.11
Women's Health and Maternity Care				
Breast Cancer Screening (BCS)				
Breast Cancer Screening	56.04%	54.13%	55.08%	0.95
Prenatal and Postpartum Care (PPC) [2]				
Timeliness of Prenatal Care	—	—	90.02%^	NC
Postpartum Care	—	—	81.51%^	NC
Care for Chronic Conditions				
Comprehensive Diabetes Care (CDC)				
Hemoglobin A1c (HbA1c) Testing	78.59%	81.02%	**84.91%**	3.89
*HbA1c Poor Control (>9.0%)**	44.77%	43.31%	41.36%	-1.95
HbA1c Control (<8.0%)	46.72%	49.64%	49.64%	0.00
Eye Exam (Retinal) Performed	59.37%	62.77%	**62.04%**	-0.73
Medical Attention for Nephropathy	87.35%	85.16%	**92.46%**	7.30
Blood Pressure Control (<140/90 mm Hg)	66.18%	63.26%	63.75%	0.49
Controlling High Blood Pressure (CBP)				
Controlling High Blood Pressure	—	62.53%	**62.77%**	0.24
Medication Management for People With Asthma (MMA)				
Medication Compliance 50%—Total	57.39%	59.39%	58.91%	-0.48
Medication Compliance 75%—Total	35.33%	36.08%	36.24%	0.16
Behavioral Health				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	41.59%	41.95%	44.00%	2.05
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)				
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	77.99%	76.38%	78.86%	2.48

HEDIS Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	2019–2020 Rate Comparison
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)				
7-Day Follow-Up—Total	10.46%	15.48%	14.52%	-0.96
30-Day Follow-Up—Total	14.29%	21.02%	18.92%	-2.10
Follow-Up After Emergency Department Visit for Mental Illness (FUM)				
7-Day Follow-Up—Total	—	47.82%	**56.53%**	8.71
30-Day Follow-Up—Total	—	57.48%	**63.92%**	6.44
Follow-Up After Hospitalization for Mental Illness (FUH)				
7-Day Follow-Up—Total	25.04%	29.11%	36.88%	7.77
30-Day Follow-Up—Total	43.18%	49.80%	53.80%	4.00
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
Initiation Phase	48.28%	52.29%	49.90%	-2.39
Continuation and Maintenance Phase	51.76%	69.77%	**68.29%**	-1.48
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)				
Initiation of AOD—Total	36.51%	40.22%	42.24%	2.02
Engagement of AOD—Total	7.91%	10.01%	10.88%	0.87
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)				
Blood Glucose and Cholesterol Testing—Total	13.13%	20.00%	**35.71%**	15.71
Utilization				
Ambulatory Care—Total (per 1,000 Member Months) (AMB)				
*ED Visits—Total**	55.15	54.66	58.85^	4.19
Outpatient Visits—Total	299.51	297.98	318.88^	20.90
Mental Health Utilization—Total (MPT)				
Inpatient—Total	—	0.82%	0.70%^	-0.12
Intensive Outpatient or Partial Hospitalization—Total	—	0.22%	0.39%^	0.17
Outpatient—Total	—	8.13%	9.30%^	1.17
ED—Total	—	0.03%	0.02%^	-0.01
Telehealth—Total	—	0.00%	0.02%^	0.02
Any Service—Total	—	8.30%	9.44%^	1.14

HEDIS Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	2019–2020 Rate Comparison
Plan All-Cause Readmissions (PCR)[2]				
Observed Readmissions—Total	—	—	14.87%^	NC
Expected Readmissions—Total	—	—	9.50%^	NC
*O/E Ratio—Total**	—	—	1.56^	NC
Overuse/Appropriateness of Care				
Use of Opioids at High Dosage (HDO)*,[2]				
Use of Opioids at High Dosage	—	—	10.36%^	NC
Use of Opioids From Multiple Providers (UOP)*				
Multiple Prescribers	—	26.56%	25.31%	-1.25
Multiple Pharmacies	—	4.26%	**3.00%**	-1.26
Multiple Prescribers and Multiple Pharmacies	—	2.12%	1.73%	-0.39

[1] Due to changes in the technical specifications for this measure, NCQA recommends that trending between HEDIS 2020 and prior years be considered with caution.

[2] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS 2020 and prior years; therefore, prior years' rates are not displayed, and rate comparisons are not performed for this measure.

[3] In alignment with DHCFP and NCQA guidance, results for this measure were rotated with the HEDIS 2019 (MY 2018) hybrid rate.

* A lower rate indicates better performances for this measure.

— Indicates that the health plan was not previously required to report this measure or that the rate is not appropriate to display due to changes in the technical specifications.

^ Indicates HEDIS 2020 QISMC goals are unavailable for this measure.

NC indicates the 2019–2020 Rate Comparison could not be calculated because data are not available for both years.

NA indicates that the plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

Bolded rates indicate that the performance measure rate for HEDIS 2020 was at or above the MPS.

Indicates that the HEDIS 2020 rate declined by 5 percentage points or more from HEDIS 2019.

Indicates that the HEDIS 2020 rate improved by 5 percentage points or more from HEDIS 2019.

Nevada Check Up Performance Results

HPN's Nevada Check Up HEDIS 2018, 2019, and 2020 performance measure rates are presented in Table 3-18, along with year-to-year rate comparisons and performance target ratings. Measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, a decrease in the rate from 2019 to 2020 represents performance improvement and an increase in the rate from 2019 to 2020 represents performance decline. Measures in the Utilization domain are designed to capture the frequency of services provided by the MCO. With the exception of the *Ambulatory Care*

(per 1,000 Member Months)—ED Visits—Total, higher or lower rates in this domain do not necessarily indicate better or worse performance. Therefore, these rates are provided for informational purposes only.

Table 3-18—Nevada Check Up HEDIS Performance Measures Results for HPN

HEDIS Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	2019–2020 Rate Comparison
Access to Care				
Children and Adolescents' Access to Primary Care Practitioners (CAP) [1]				
Ages 12–24 Months	96.33%	97.81%	**97.98%**	0.17
Ages 25 Months–6 Years	88.12%	91.10%	89.71%	-1.39
Ages 7–11 Years	92.25%	93.27%	**94.92%**	1.65
Ages 12–19 Years	90.61%	90.82%	**92.61%**	1.79
Children's Preventive Care				
Adolescent Well-Care Visits (AWC)				
Adolescent Well-Care Visits	59.61%	60.10%	64.96%	4.86
Childhood Immunization Status (CIS)				
Combination 2	85.91%	87.57%	85.62%[2]	-1.95
Combination 3	81.54%	84.32%	**83.56%**[2]	-0.76
Combination 4	81.54%	83.73%	**83.56%**[2]	-0.17
Combination 5	74.16%	76.63%	75.34%[2]	-1.29
Combination 6	44.30%	46.15%	**48.63%**[2]	2.48
Combination 7	74.16%	76.33%	75.34%[2]	-0.99
Combination 8	44.30%	46.15%	**48.63%**[2]	2.48
Combination 9	40.94%	42.01%	**45.21%**[2]	3.20
Combination 10	40.94%	42.01%	**45.21%**[2]	3.20
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	86.62%	93.92%	**97.32%**	3.40
Combination 2 (Meningococcal, Tdap, HPV)	51.82%	56.20%	56.69%	0.49
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile—Total	83.70%	83.45%	**88.81%**	5.36
Counseling for Nutrition—Total	73.48%	74.70%	73.24%	-1.46

HEDIS Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	2019–2020 Rate Comparison
Counseling for Physical Activity—Total	69.59%	72.02%	72.75%	0.73
Well-Child Visits in the First 15 Months of Life (W15)				
Six or More Well-Child Visits	68.33%	73.19%	**80.35%**	7.16
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.48%	77.62%	77.62%[2]	0.00
Care for Chronic Conditions				
Medication Management for People With Asthma (MMA)				
Medication Compliance 50%—Total	53.65%	55.22%	**59.68%**	4.46
Medication Compliance 75%—Total	34.90%	33.33%	32.26%	-1.07
Behavioral Health				
Follow-Up After Emergency Department Visit for Mental Illness (FUM)				
7-Day Follow-Up—Total	—	66.67%	NA	NC
30-Day Follow-Up—Total	—	80.00%	NA	NC
Follow-Up After Hospitalization for Mental Illness (FUH)				
7-Day Follow-Up—Total	68.57%	NA	NA	NC
30-Day Follow-Up—Total	80.00%	NA	NA	NC
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
Initiation Phase	55.36%	58.11%	55.38%	-2.73
Continuation and Maintenance Phase	NA	NA	NA^	NC
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)				
Initiation of AOD—Total	25.64%	NA	25.71%	NC
Engagement of AOD—Total	7.69%	NA	8.57%	NC
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)				
Blood Glucose and Cholesterol Testing—Total	16.67%	25.58%	21.95%	-3.63
Utilization				
Ambulatory Care—Total (per 1,000 Member Months) (AMB)				
*ED Visits—Total**	23.87	22.99	25.99^	3.00
Outpatient Visits—Total	248.74	246.47	265.66^	19.19

HEDIS Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	2019–2020 Rate Comparison
Mental Health Utilization—Total (MPT)				
Inpatient—Total	—	0.18%	0.20%^	0.02
Intensive Outpatient or Partial Hospitalization—Total	—	0.14%	0.03%^	-0.11
Outpatient—Total	—	6.55%	7.46%^	0.91
ED—Total	—	0.03%	0.01%^	-0.02
Telehealth—Total	—	0.00%	0.00%^	0.00
Any Service—Total	—	6.60%	7.52%^	0.92

[1] Due to changes in the technical specifications for this measure, NCQA recommends that trending between HEDIS 2020 and prior years be considered with caution.
[2] In alignment with DHCFP and NCQA guidance, results for this measure were rotated with the HEDIS 2019 (MY 2018) hybrid rate.
* A lower rate indicates better performances for this measure.
— Indicates that the health plan was not previously required to report this measure or that the rate is not appropriate to display due to changes in the technical specifications.
^ Indicates HEDIS 2020 QISMC goals are unavailable for this measure.
NC indicates the 2019–2020 Rate Comparison could not be calculated because data are not available for both years.
NA indicates that the plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
Bolded rates indicate that the performance measure rate for HEDIS 2020 was at or above the MPS.

Indicates that the HEDIS 2020 rate declined by 5 percentage points or more from HEDIS 2019.

Indicates that the HEDIS 2020 rate improved by 5 percentage points or more from HEDIS 2019.

In response to the COVID-19 pandemic and its impact on collecting medical records from some provider offices, **HPN** opted to rotate two hybrid measures with HEDIS 2019 audited rates for both its Medicaid (i.e., *CIS*) and Nevada Check Up (i.e., *W34*) populations. Table 3-19 displays the official HEDIS 2020 rotated rate, unofficial HEDIS 2020 hybrid rate, and the difference. This information presented for informational purposes only.

Table 3-19—Rotated Versus Non-Rotated Hybrid HEDIS 2020 Rates for HPN by Medicaid and Nevada Check Up Populations

HEDIS Measure	Medicaid—HEDIS 2020			Nevada Check Up—HEDIS 2020		
	Rotated Rate	Non-Rotated Rate	Difference	Rotated Rate	Non-Rotated Rate	Difference
Children's Preventive Care						
Childhood Immunization Status (CIS)						
Combination 2	72.02%	67.15%	-4.87%	—	—	—

HEDIS Measure	Medicaid—HEDIS 2020			Nevada Check Up—HEDIS 2020		
	Rotated Rate	Non-Rotated Rate	Difference	Rotated Rate	Non-Rotated Rate	Difference
Combination 3	68.37%	63.50%	-4.87%	—	—	—
Combination 4	67.64%	63.02%	-4.62%	—	—	—
Combination 5	60.10%	54.01%	-6.09%	—	—	—
Combination 6	39.42%	28.95%	-10.47%	—	—	—
Combination 7	59.61%	53.77%	-5.84%	—	—	—
Combination 8	39.42%	28.71%	-10.71%	—	—	—
Combination 9	35.52%	25.79%	-9.73%	—	—	—
Combination 10	35.52%	25.55%	-9.97%	—	—	—
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)						
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	—	—	—	77.62%	71.29%	-6.33%

— Indicates that the rate was not rotated by the health plan; therefore, rates are not displayed, and rate comparisons are not performed.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: HPN's Medicaid HEDIS 2020 rates remained relatively stable between HEDIS 2019 and HEDIS 2020 with more than half of the reported measures exhibiting small gains in performance, suggesting **HPN** has implemented initiatives to improve the services being provided to its members.

Strength: HPN's Nevada Check Up HEDIS 2020 rates also demonstrated stable performance between HEDIS 2019 and HEDIS 2020, with most rates experiencing increases or decreases of less than 5 percentage points. However, two indicators exhibited a large increase of greater than 5 percentage points in the Children's Preventive Care domain, including *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile–Total* and *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*. Both rates were also at or above the MPS, implying **HPN**'s contracted providers are checking children's body mass index (BMI) and providing nutrition and physical activity counseling more regularly, and children 15 months and younger are attending well-child appointments more often than they were the previous year. In addition, for both Medicaid and Nevada Check Up, *Combination 1 (Meningococcal, Tdap)* surpassed the Tier 3 QISMC goal.

Strength: HPN's Medicaid HEDIS 2020 rate within one measure in the Care for Chronic Conditions, *Comprehensive Diabetes Care—Medical Attention for Nephropathy,* met MPS and increased more than 7 percentage points from the prior year, indicating that more members diagnosed with diabetes were receiving medical attention for nephropathy through a screening test.

Strength: **HPN**'s Medicaid HEDIS 2020 rates under the *Follow-Up After Emergency Department Visit for Mental Illness* measure*, 7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*, within the Behavioral Health domain met MPS and demonstrated increases of more than 8 and 6 percentage points, respectively. Additionally, the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* increased by more than 7 percentage points from the prior year. The *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total* also increased by more than 15 percentage points from the previous year. These performance improvements demonstrate **HPN**, and its contracted providers, have prioritized members' behavioral healthcare and are ensuring members are being treated in a timely manner for behavioral health conditions.

Weaknesses

Weakness: Although there was slight improvement overall in the Access to Care measures for the Medicaid population, of the seven measure rates reported, only two rates met MPS, indicating **HPN** needs to prioritize member access to providers to ensure they are able to get their healthcare needs met in a timely manner and potentially avoid overuse of the ER.

Why the weakness exists: A lower percentage of adult and child members are going to their PCP for preventive care or appropriate treatment for medical conditions when necessary, which suggests a lack of providers available to see **HPN**'s Medicaid members. This lower performance could also suggest that members are choosing to get care elsewhere, such as through an ER, as indicated by an increase in utilization of the ER, or members are choosing to not go to the doctor at all, as implied by lower rates of CDC-recommended immunizations in child and adolescent members.

Recommendation: HSAG recommends **HPN** conduct a root cause analysis or focused study to determine why its members are not accessing their PCPs on a routine basis. Upon identification of a root cause, **HPN** should implement appropriate interventions to improve the performance related to Access to Care measures.

Weakness: Of the 17 measures reported within the Medicaid population's Children's Preventive Care domain, only nine rates met MPS, and those were primarily related to immunizations. Although the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* demonstrated more than a 5-percentage point increase, the measure rate still fell below the MPS. Additionally, for the Nevada Check Up population, of the 17 measure rates, only nine met MPS; however, there was demonstrated improvement in two measures—*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total* and *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits.* This overall lower performance suggests that many children and young adults are not getting preventive care that is essential to prevent and detect health conditions and diseases in their earlier, more treatable stages.

Why the weakness exists: Low overall performance in the *Children and Adolescents' Access to Primary Care Practitioners* and the *Adolescent Well-Care Visits* measures suggest children and adolescents are not going to their PCPs as often as suggested and therefore are most likely not receiving preventive care services.

Recommendation: HSAG recommends **HPN** conduct a root cause analysis or focused study to determine why its members are not getting all recommended preventive care services as suggested by national organizations, such as the CDC. Upon identification of a root cause, **HPN** should implement appropriate interventions to improve the performance related to Children's Preventive Care measures.

Weakness: The *Breast Cancer Screening* measure rate within the Medicaid population's Women's Health and Maternity Care domain fell below MPS, indicating women are not getting breast cancer screenings for early detection of breast cancer, which may result in less effective treatment.

Why the weakness exists: Although the *Adults' Access to Preventive/Ambulatory Health Services (AAP)* measure rate for adult Medicaid members between the ages of 20 and 44 years performed at MPS, members may not always access providers for services in a timely manner to receive preventive care services, including breast cancer screenings.

Recommendation: HSAG recommends **HPN** conduct a root cause analysis or focused study to determine why its women members are not getting preventive screenings for breast cancer. **HPN** could consider if there are disparities within its populations that contribute to lower performance in a particular race or ethnicity, age group, zip code, etc. Upon identification of a root cause, **HPN** should implement appropriate interventions to improve the performance related to the *Breast Cancer Screening* measure under the Women's Health and Maternity Care domain.

Weakness: Of the 11 Medicaid and Nevada Check Up combined measure rates within the Care for Chronic Conditions domain, only five rates met MPS, indicating members with chronic health conditions may have barriers to accessing treatment or medications to manage their symptoms and stay well.

Why the weakness exists: Although some measure rates within the Care for Chronic Conditions domain met MPS and/or demonstrated slight improvements, other measure rates did not meet MPS and demonstrated decreases in performance. Because of the variance in performance, HSAG is unable to discern the reason for overall low performance in this area.

Recommendation: HSAG recommends **HPN** conduct a root cause analysis or focused study to determine why members with chronic conditions are not getting all recommended services or medications to manage their conditions and improve their overall wellness. Upon identification of a root cause, **HPN** should implement appropriate interventions to improve the performance related to Care for Chronic Conditions measures.

Compliance Review

Performance Results

Table 3-20 presents **HPN**'s scores for each standard evaluated in the SFY 2019–2020 compliance review. Each element within a standard was scored as *Met*, *Partially Met,* or *Not Met* based on evidence found in MCO documents, policies, procedures, reports, meeting minutes, and interviews with MCO staff members. Table 3-21 presents the results of the review conducted on **HPN**'s CAPs that were developed to remediate the deficiencies identified through the SFY 2017–2018 and SFY 2018–2019 compliance reviews.

Table 3-20—Summary of Scores for the Compliance Standards

Standard #	Standard Name	Total Elements	Total Applicable Elements	Number of Elements				Total Compliance Score
				M	*PM*	*NM*	*NA*	
XI	IQAP	21	20	20	0	0	1	100%
XII	Cultural Competency Program	17	17	17	0	0	0	100%
XIII	Confidentiality	11	11	11	0	0	0	100%
XIV	Enrollment and Disenrollment	8	8	8	0	0	0	100%
Total Compliance Score		**57**	**56**	**56**	**0**	**0**	**1**	**100%**

M=*Met*, ***PM***=*Partially Met*, ***NM***=*Not Met*, ***NA***=*Not Applicable*

Total Elements: The total number of elements in each standard.

Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA.* This represents the denominator.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point) to the weighted number that received a score of *Partially Met* (0.5 point), then dividing this total by the total number of applicable elements.

Table 3-21—Summary of Scores for the SFY 2017–2018 and SFY 2018–2019 CAP Reviews

Standard #	Standard Name	Total CAP Elements	Total Number of Elements Scored	
			M	*NM*
I	Credentialing and Recredentialing	NA	NA	NA
II	Availability and Accessibility of Services	3	3	0
III	Subcontracts and Delegation	NA	NA	NA
IV	Provider Dispute and Complaint Resolution	NA	NA	NA
V	Provider Information	NA	NA	NA
VI	Member Rights and Responsibilities	NA	NA	NA
VII	Member Information	NA	NA	NA
VIII	Continuity and Coordination of Care	NA	NA	NA
IX	Grievances and Appeals	5	5	0
X	Coverage and Authorization of Services	NA	NA	NA
Total		**8**	**8**	**0**

M=*Met* and ***NM***=*Not Met*

Total CAP Elements: The total number of elements in each standard.

Total Number of Elements Scored: The number of elements that received a score of *M* or *NM* for each standard reviewed.

NA: The MCO did not have any deficiencies noted for this standard during the SFY 2017–2018 and SFY 2018–2019 reviews.

Strengths, Weaknesses, and Recommendations

Strengths	**Strength: HPN** demonstrated strong performance of all operational areas reviewed and demonstrated they had the necessary policies, procedures, and plans to operationalize all of the required elements of its contract and managed care regulations under 42 CFR §438. Staff were also knowledgeable and aligned with established policies and procedures. **HPN**'s IQAP demonstrated processes and resources to drive overall organizational improvement.
	Strength: HPN's policies and procedures were comprehensive to ensure compliance with the privacy requirements under federal rules. New employee and annual trainings were detailed and engaging. These processes, procedures, and training programs support **HPN**'s ability to protect the privacy of its member data.
	Strength: HPN's cultural competency program plan was descriptive, comprehensive, and demonstrated **HPN**'s commitment to ensuring that staff at all levels and across departments were effectively trained in cultural competency practices and principles. An effective cultural competency program helps ensure that culturally competent services are being provided to **HPN** members.
Weaknesses	**Weakness:** There were no identified weaknesses. **Recommendation:** None.

Network Adequacy Validation (NAV)

Performance Results

Table 3-22 presents a summary of **HPN**'s provider ratio analysis results compared to the provider ratio standards. For the provider categories assessed according to the standards in Table 3-22, the percentage of members with access to the provider within the time-distance standard is shown in red if they did not comply with the standard. The time-distance results are displayed in Table 3-23.

Table 3-22—Summary of Ratio Analysis Results for PCPs and Specialty Care Providers for HPN

Provider Category	HPN	
	Providers	Ratio
PCPs (1:1,500)	2,676	1:78
PCP Extenders (1:1,800)	NA	NA
Physician Specialist Providers (1:1,500)	1,884	1:111

NA indicates that the MCO did not report providers in the provider category.

Table 3-23— Percentage of Members Residing Within the Access Standard Areas for HPN

Provider Category	Time-Distance Standard	Percentage of Members with Access
PCPs		
Primary Care (Adult Total)	20 miles/30 mins	99.4%
OB/GYN	20 miles/30 mins	99.2%
Pediatrician	20 miles/30 mins	99.4%
Specialty Providers		
Endocrinologist	75 miles/100 mins	99.4%
Endocrinologist, Pediatric	75 miles/100 mins	99.4%
Infectious Disease	75 miles/100 mins	99.4%
Infectious Disease, Pediatric	75 miles/100 mins	99.4%
Oncologist/Hematologist	75 miles/100 mins	99.4%
Oncologist/Hematologist, Pediatric	75 miles/100 mins	99.4%
Oncologist/Radiologist	75 miles/100 mins	NA
Rheumatologist	75 miles/100 mins	99.4%
Rheumatologist, Pediatric	75 miles/100 mins	86.8%
Facility-Level Providers		
Hospital	60 miles/80 mins	99.4%
Psychiatry Inpatient Hospital	60 miles/80 mins	99.4%
Dialysis/ESRD Facility	60 miles/80 mins	99.4%
Behavioral Health Providers		
Psychologist	45 miles/60 mins	99.4%
Pediatric Psychologist	45 miles/60 mins	NA
LCSW	45 miles/60 mins	99.4%
Psychiatrist	45 miles/60 mins	99.4%
Pediatric Psychiatrist	45 miles/60 mins	NA

NA indicates that the MCO did not report providers in the provider category.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: HPN met the required provider ratio requirements for PCPs and the physician specialist providers indicating **HPN** has a sufficient provider network for its members to access services.

Strength: HPN met the time-distance contract standards for all general primary care categories (PCPs, OB/GYNs, and pediatricians), facility-level providers, and all reported

behavioral health providers, indicating that members had access to PCPs within an adequate distance from their residence.

Weaknesses

Weakness: **HPN** did not report providers in the following specialty areas: pediatric allergists and immunologists, pediatric dermatologists, oncologists/radiologists, ENTs, pediatric physical medicine specialists, outpatient mental health facilities, pediatric psychologists, and pediatric psychiatrists, indicating that members may have a barrier to accessing care at these provider types.[3-4]

Why the weakness exists: The lack of identified providers may result from either a lack of contracted providers in those specialties or from inconsistencies in identifying those provider specialties in the data, due to data mapping and/or submission issues.

Recommendation: HSAG recommends **HPN** review its provider data and contracted provider list to identify if the inability to identify providers in the data is a result of a lack of contracted providers or if the providers are not appropriately identified in the data. If a lack of contracted providers is identified, HSAG recommends **HPN** determine if the lack of contracted providers is due to a shortage of providers in the area or an unwillingness of the providers to contract with the MCO.

Weakness: **HPN** did not meet the time-distance contract standards for pediatric rheumatologists, indicating that children do not have access to rheumatologists within an adequate distance from their residence.

Why the weakness exists: The lack of identified providers may result from either a lack of contracted pediatric specialty providers in those specialties or from an inability to identify those pediatric specialists in the data.

Recommendation: **HPN** should conduct an in-depth review of provider categories in which **HPN** did not meet the time-distance contract standards, with the goal of determining whether or not the failure of the MCO to meet the contract standard(s) was the result of a lack of providers or an inability to contract providers in the geographic area.

[3-4] The provider categories with no reported provider counts are not displayed in the Percentage of Members Residing Within the Access Standard Areas for HPN table. These provider categories are listed with an "NA" in the DHCFP Nevada Medicaid Managed Care State Fiscal Year 2019–20 Network Adequacy Validation report.

CAHPS Analysis

Performance Results

Table 3-24 presents **HPN**'s 2020 adult Medicaid, general child Medicaid, and CCC Medicaid CAHPS top-box scores. Table 3-24 also includes **HPN**'s 2020 Nevada Check Up general child and CCC top-box scores.

Table 3-24—Summary of 2020 CAHPS Top-Box Scores for HPN

	2020 Adult Medicaid	2020 General Child Medicaid	2020 CCC Medicaid Supplemental	2020 Nevada Check Up General Child	2020 Nevada Check Up CCC Supplemental
Composite Measures					
Getting Needed Care	81.2%	89.5%	87.4%	85.9%	NA
Getting Care Quickly	79.0%	91.3%	90.7%	86.8%	NA
How Well Doctors Communicate	92.7%	93.6%	94.6%	95.4%	NA
Customer Service	87.0%	NA	NA	NA	NA
Global Ratings					
Rating of All Health Care	59.2%	69.0%	69.8%	74.7%	NA
Rating of Personal Doctor	63.2%	78.8%	76.5%	80.6%	80.7%
Rating of Specialist Seen Most Often	75.8% ↑	NA	NA	NA	NA
Rating of Health Plan	64.7%	75.6%	73.5% ↑	78.3% ↑	72.6%
Effectiveness of Care*					
Advising Smokers and Tobacco Users to Quit	65.3% ↓				
Discussing Cessation Medications	40.7% ↓				
Discussing Cessation Strategies	40.2% ↓				
CCC Composite Measures/Items					
Access to Specialized Services			NA		NA
Family Centered Care (FCC): Personal Doctor Who Knows Child			89.2%		NA
Coordination of Care for Children With Chronic Conditions			NA		NA

	2020 Adult Medicaid	2020 General Child Medicaid	2020 CCC Medicaid Supplemental	2020 Nevada Check Up General Child	2020 Nevada Check Up CCC Supplemental
Access to Prescription Medicines			88.6%		NA
FCC: Getting Needed Information			92.2%		NA

A minimum of 100 responses is required for a measure to be reported as a CAHPS survey results. 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 2020 score is at least 5 percentage points higher than the 2019 national average.
↓ Indicates the 2020 score is at least 5 percentage points lower than the 2019 national average.
Indicates that the measure does not apply to the population.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: Adult members had positive overall experiences with the specialist they saw most often. In addition, for the CCC Medicaid and Nevada Check Up general child populations, the parents/caretakers of child members had positive overall experiences with their child's health plan since the scores for this measure were at least 5 percentage points higher than the 2019 NCQA Medicaid national average.

Weaknesses

Weakness: There is limited data available to comprehensively evaluate member experiences with their providers and healthcare services.

Why the weakness exists: **HPN** had measures that did not meet the minimum 100 responses for the child populations.

Recommendation: HSAG recommends that **HPN** continue to work with its CAHPS vendor to obtain a sufficient number of completed surveys that will enable reporting of all CAHPS measures. NCQA recommends targeting 411 completed surveys per survey administration. **HPN** may need to consider adding other data collection survey modes, such as the Internet, for the CAHPS surveys to increase response rates.

Weakness: The Effectiveness of Care scores were at least 5 percentage points lower than the 2019 NCQA adult Medicaid national averages.

Why the weakness exists: **HPN**'s providers may not be advising members who smoke or use tobacco to quit and may not be discussing cessation medications and strategies with their adult members as much as other providers compared to national benchmarks.

Recommendation: HSAG recommends that **HPN** focus on quality improvement initiatives to provide medical assistance with smoking and tobacco use cessation and continue to develop efforts to promote its Health Education & Wellness smoking cessation program.

SilverSummit Healthplan, Inc.

Validation of Performance Improvement Projects (PIPs)

In SFY 2019–2020, **SilverSummit** completed all modules associated with the *Follow-Up After Emergency Department Visit for Mental Health Diagnosis (FUM)* PIP and the *Increase 3–6-Year-Old Well-Child PCP Visits (W34)* PIP. These PIPs were initiated in SFY 2018–2019 when there were five modules for the MCO to complete. This was the final validation for these PIPs.

Performance Results

Table 3-25 summarizes the SMART Aim Outcomes for the *Follow-Up After Emergency Department Visit for Mental Health Diagnosis* PIP.

Table 3-25—SMART Aim Outcomes

SMART Aim	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
By June 30, 2019, increase the rate of follow-up with any practitioner within 7 days of an emergency department discharge from [2 named medical facilities*] with a primary diagnosis of behavioral health from 42.9% to 75%.	42.9%	75.0%	25.7%	*Low Confidence*

* Provider names were redacted for privacy purposes.

For this PIP, **SilverSummit** tested the following the interventions:

- Medical facilities' computer systems to obtain the daily census for their members seen in the ER and discharged with a mental health diagnosis. The goal of this intervention was to identify members seen in the ER quickly so appropriate outreach could be conducted.
- **SilverSummit** made arrangements with a hospitalist group and the ER physicians at a medical facility for the ER physicians to notify the hospitalist group when one of **SilverSummit**'s members was admitted to the ER with a mental health diagnosis. The hospitalist group would evaluate the member to determine if the member required hospitalization or could be discharged. If the hospitalist group determined that the member could be discharged, the attending provider would assist the member in arranging the follow-up visit with any healthcare provider within seven days of discharge.
- **SilverSummit** negotiated a capitated agreement with a behavioral health provider to provide wraparound services, ensuring members would have access to needed services. The contract allowed the behavioral health provider to see **SilverSummit**'s members in the ER prior to discharge or follow up with the member to schedule the appointment within seven days. The contract also required the behavioral health provider to maintain psychiatrists and psychologists on-call 24 hours a day, allowing members access to appointments through one centralized system; provide daily triage

clinics; and allow members to have immediate access for evaluation, medication, and placement. The provider also used an integrated electronic medical record system.

SilverSummit did not achieve the SMART Aim goal, and the performance during the PIP was below the baseline rate. The MCO indicated this was due to issues such as the two medical facilities' ER physicians not notifying the hospitalist group of members' ER admissions and, therefore, the hospitalist group was unable to arrange appointments for members within seven days of discharge. When **SilverSummit** was notified of the ER admission, the lack of accurate member contact information or any contact information made it challenging for **SilverSummit** to reach out to members; therefore, scheduling the follow-up appointment within seven days following the ER discharge was not often accomplished.

SilverSummit documented the following for the *Follow-Up After Emergency Department Visit for Mental Health Diagnosis* PIP:

- It is important to secure accurate and complete member contact information for successful outreach.
- Contracting with a provider to provide specific services was key in the success of getting the members' appointments scheduled within the desired time frame.

Table 3-26 summarizes the SMART Aim Outcomes for the *Increase 3–6-Year-Old Well-Child PCP Visits* PIP.

Table 3-26—SMART Aim Outcomes

SMART Aim	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
By June 30, 2019, increase the well-child visit rate among children 3–6 years of age at [health center*] from 25.9% to 55%.	25.9%	55.0%	43.9	*Low Confidence*

* Provider names were redacted for privacy purposes.

For this PIP, **SilverSummit** tested the following the interventions:

- Outreach event for members listed on the health center's gap report (non-compliant) for well-child visits.
- Telephonic outreach campaign that focused on closing the gap for children 3 to 6 years of age who had not had a well-child visit at the health center.

SilverSummit did not achieve the SMART Aim goal. The MCO documented many challenges during this PIP related to a lack of current member contact information, the canceled outreach event, and poor participation from the health center.

SilverSummit documented the following for the *Increase 3-6-Year-Old Well-Child PCP Visits* PIP:

- If testing of outreach were to be done again, the MCO would verify phone numbers through pharmacy claims first.

Performance Results

Table 3-27 summarizes the progress **SilverSummit** made in completing the four PIP modules during SFY 2019–2020 for the new PIPs initiated.

Table 3-27—Overall Validation Rating for SilverSummit

PIP Topic	Module	Status
Comprehensive Diabetes Care (CDC) HbA1c Poor Control > 9.0%	1. PIP Initiation	Completed and achieved all validation criteria.
	2. Intervention Determination	Completed and achieved all validation criteria.
	3. Intervention Testing	Targeted to begin in June 2020.
	4. PIP Conclusions	Targeted for October 2021.
Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care	1. PIP Initiation	Completed and achieved all validation criteria.
	2. Intervention Determination	Completed and achieved all validation criteria.
	3. Intervention Testing	Targeted to begin in June 2020.
	4. PIP Conclusions	Targeted for October 2021.

SilverSummit has progressed to testing interventions through the SMART Aim end date of June 30, 2021. For the *Comprehensive Diabetes Care HbA1c Poor Control > 9.0%* PIP, the MCO will test an intervention focused on obtaining current member demographic information for the targeted population using the monthly ER visit report. Once current demographic information is obtained, the MCO will conduct telephonic outreach. For the *Timeliness of Prenatal Care* PIP, **SilverSummit** will test an intervention focused on early identification of newly pregnant members using an MCO-developed report generated on a weekly basis that includes the names, addresses, and phone numbers of all newly enrolled pregnant members. Once members are identified, the MCO will conduct outreach through phone calls and a mailed letter. The results from intervention testing will be reported in the next annual EQR technical report. SMART Aim outcomes for each PIP will not be reported until October 2021; therefore, outcomes for these PIPs will be included in the SFY 2021–2022 annual EQR report.

Strengths, Weaknesses, and Recommendations

Strengths
Strength: Through the *Follow-Up After Emergency Department Visit for Mental Health Diagnosis* and *Increase 3–6-Year-Old Well-Child PCP Visits* PIPs, **SilverSummit** identified lessons learned and knowledge gained that can be applied to future improvement efforts and activities.
Strength: SilverSummit developed methodologically sound projects and was successful at building an internal PIP team that included external partners.
Strength: SilverSummit used quality improvement tools to identify and prioritize opportunities for improvement within its current processes. These tools, and the results they produced, will assist the MCO in developing targeted interventions to test using PDSA cycles.

Weaknesses

Weakness: SilverSummit did not achieve its SMART Aim goals to increase the rate of follow-up with any practitioner within seven days of an emergency department discharge and increase the well-child visit rate among children 3 to 6 years of age at the health center.

Why the weakness exists: SilverSummit experienced multiple challenges such as lack of current member contact information and poor participation from the provider groups.

Recommendations: HSAG recommends that **SilverSummit** identify mechanisms to improve its ability to successfully outreach to members, such as looking at claims data for more current contact information. Further, **SilverSummit** should consider other provider engagement strategies, which may include financial incentives, to increase collaboration and partnerships, leading to better care coordination and services for its members.

HSAG also recommends that as **SilverSummit** determines interventions to test for its new PIPs, the MCO consider the end date specified in the SMART Aim statement and work backwards when planning intervention testing. Careful planning is critical to allow enough time to test and refine interventions that will result in meaningful and sustained improvement. When determining interventions to test, **SilverSummit** should revisit the third fundamental question of the Model for Improvement, "What changes can we make that will result in improvement?" and ensure interventions tested have the potential to positively impact the quality of, timeliness of, and access to care for their members.

Performance Measure Validation (PMV)

Medicaid Performance Results

SilverSummit's Medicaid HEDIS 2019 and 2020 rates are presented in Table 3-28, along with year-to-year rate comparisons and performance target ratings. Since **SilverSummit** was a new MCO in HEDIS 2019, HEDIS 2018 rates are not available. Measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures in the Utilization domain are designed to capture the frequency of services provided by the MCO. With the exception of the *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total*, higher or lower rates in this domain do not necessarily indicate better or worse performance. Therefore, these rates are provided for informational purposes only.

Table 3-28—Medicaid HEDIS Performance Measure Results for SilverSummit

HEDIS Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	2019–2020 Rate Comparison
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services (AAP)				
Ages 20–44 Years	—	62.35%	66.35%	4.00
Ages 45–64 Years	—	72.28%	75.54%	3.26

HEDIS Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	2019–2020 Rate Comparison
Ages 65 Years and Older	—	NA	NA	NC
Total	—	65.40%	69.38%	3.98
Children and Adolescents' Access to Primary Care Practitioners (CAP) [1]				
Ages 12–24 Months	—	88.56%	92.90%	4.34
Ages 25 Months–6 Years	—	71.50%	76.10%	4.60
Ages 7–11 Years	—	NA	78.26%	NC
Ages 12–19 Years	—	NA	75.06%	NC
Children's Preventive Care				
Adolescent Well-Care Visits (AWC)				
Adolescent Well-Care Visits	—	36.50%	40.63%	4.13
Childhood Immunization Status (CIS)				
Combination 2	—	46.25%	66.42%	20.17
Combination 3	—	43.13%	60.34%	17.21
Combination 4	—	43.13%	60.10%	16.97
Combination 5	—	34.38%	49.39%	15.01
Combination 6	—	16.25%	33.09%	16.84
Combination 7	—	34.38%	49.15%	14.77
Combination 8	—	16.25%	33.09%	16.84
Combination 9	—	13.13%	28.95%	15.82
Combination 10	—	13.13%	28.95%	15.82
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	—	67.70%	82.00%	14.30
Combination 2 (Meningococcal, Tdap, HPV)	—	19.25%	31.14%	11.89
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile—Total	—	70.56%	78.59%	8.03
Counseling for Nutrition—Total	—	66.42%	65.69%	-0.73
Counseling for Physical Activity—Total	—	60.58%	59.12%	-1.46

HEDIS Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	2019–2020 Rate Comparison
Well-Child Visits in the First 15 Months of Life (W15)				
Six or More Well-Child Visits	—	51.88%	61.31%	9.43
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	—	59.37%	59.12%	-0.25
Women's Health and Maternity Care				
Breast Cancer Screening (BCS)				
Breast Cancer Screening	—	NA	47.54%	NC
Prenatal and Postpartum Care (PPC) [2]				
Timeliness of Prenatal Care	—	—	75.91%^	NC
Postpartum Care	—	—	54.74%^	NC
Care for Chronic Conditions				
Comprehensive Diabetes Care (CDC)				
Hemoglobin A1c (HbA1c) Testing	—	79.08%	74.70%	-4.38
*HbA1c Poor Control (>9.0%)**	—	57.66%	53.04%	-4.62
HbA1c Control (<8.0%)	—	34.55%	37.71%	3.16
Eye Exam (Retinal) Performed	—	46.47%	52.55%	6.08
Medical Attention for Nephropathy	—	87.59%	85.89%	-1.70
Blood Pressure Control (<140/90 mm Hg)	—	46.23%	47.93%	1.70
Controlling High Blood Pressure (CBP)				
Controlling High Blood Pressure	—	43.55%	40.15%	-3.40
Medication Management for People With Asthma (MMA)				
Medication Compliance 50%—Total	—	NA	**67.79%**	NC
Medication Compliance 75%—Total	—	NA	**44.97%**	NC
Behavioral Health				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	—	35.06%	44.05%	8.99

HEDIS Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	2019–2020 Rate Comparison
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)				
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	78.06%	76.77%	-1.29
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)				
7-Day Follow-Up—Total	—	11.93%	14.20%	2.27
30-Day Follow-Up—Total	—	15.33%	19.05%	3.72
Follow-Up After Emergency Department Visit for Mental Illness (FUM)				
7-Day Follow-Up—Total	—	26.19%	22.97%	-3.22
30-Day Follow-Up—Total	—	35.46%	32.43%	-3.03
Follow-Up After Hospitalization for Mental Illness (FUH)				
7-Day Follow-Up—Total	—	22.40%	28.10%	5.70
30-Day Follow-Up—Total	—	36.72%	44.59%	7.87
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
Initiation Phase	—	NA	49.40%	NC
Continuation and Maintenance Phase	—	NA	NA	NC
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)				
Initiation of AOD—Total	—	46.30%	**45.43%**	-0.87
Engagement of AOD—Total	—	13.37%	12.84%	-0.53
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)				
Blood Glucose and Cholesterol Testing—Total	—	23.08%	21.24%	-1.84
Utilization				
Ambulatory Care—Total (per 1,000 Member Months) (AMB)				
*ED Visits—Total**	—	61.33	66.17^	4.84
Outpatient Visits—Total	—	258.11	286.69^	28.58
Mental Health Utilization—Total (MPT)				
Inpatient—Total	—	1.63%	1.43%^	-0.20
Intensive Outpatient or Partial Hospitalization—Total	—	0.16%	0.18%^	0.02

HEDIS Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	2019–2020 Rate Comparison
Outpatient—Total	—	12.14%	14.46%^	2.32
ED—Total	—	0.10%	0.06%^	-0.04
Telehealth—Total	—	0.06%	0.17%^	0.11
Any Service—Total	—	12.80%	14.99%^	2.19
Plan All-Cause Readmissions (PCR) [2]				
Observed Readmissions—Total	—	—	13.42%^	NC
Expected Readmissions—Total	—	—	9.73%^	NC
*O/E Ratio—Total**	—	—	1.38^	NC
Overuse/Appropriateness of Care				
Use of Opioids at High Dosage (HDO)**,[2]				
Use of Opioids at High Dosage	—	—	5.42%^	NC
Use of Opioids From Multiple Providers (UOP)*				
Multiple Prescribers	—	23.52%	32.45%	8.93
Multiple Pharmacies	—	4.37%	**2.65%**	-1.72
Multiple Prescribers and Multiple Pharmacies	—	2.81%	1.86%	-0.95

[1] Due to changes in the technical specifications for this measure, NCQA recommends that trending between HEDIS 2020 and prior years be considered with caution.

[2] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS 2020 and prior years; therefore, prior years' rates are not displayed, and rate comparisons are not performed for this measure.

* A lower rate indicates better performances for this measure.

— Indicates that the health plan was not in existence during the reporting period or was not previously required to report this measure or that the rate is not appropriate to display due to changes in the technical specifications.

^ Indicates HEDIS 2020 QISMC goals are unavailable for this measure.

NC indicates the 2019–2020 Rate Comparison could not be calculated because data are not available for both years.

NA indicates that the plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

Bolded rates indicate that the performance measure rate for HEDIS 2020 was at or above the MPS.

Indicates that the HEDIS 2020 rate declined by 5 percentage points or more from HEDIS 2019.

Indicates that the HEDIS 2020 rate improved by 5 percentage points or more from HEDIS 2019.

Nevada Check Up Results

SilverSummit's Nevada Check Up HEDIS 2019 and 2020 performance measure rates are presented in Table 3-29, along with year-to-year rate comparisons and performance target measures. Since **SilverSummit** was a new MCO in HEDIS 2019, HEDIS 2018 rates are not available. Measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures in the Utilization domain are designed to capture the frequency of services provided by the MCO. With the exception of the *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total*, higher or lower rates in this domain do not necessarily indicate better or worse performance. Therefore, these rates are provided for informational purposes only.

Table 3-29—Nevada Check Up HEDIS Performance Measures Results for SilverSummit

HEDIS Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	2019–2020 Rate Comparison
Access to Care				
Children and Adolescents' Access to Primary Care Practitioners (CAP) [1]				
Ages 12–24 Months	—	94.12%	95.52%	1.40
Ages 25 Months–6 Years	—	83.54%	88.79%	5.25
Ages 7–11 Years	—	NA	84.29%	NC
Ages 12–19 Years	—	NA	83.51%	NC
Children's Preventive Care				
Adolescent Well-Care Visits (AWC)				
Adolescent Well-Care Visits	—	45.28%	52.07%	6.79
Childhood Immunization Status (CIS)				
Combination 2	—	NA	88.24%	NC
Combination 3	—	NA	**84.31%**	NC
Combination 4	—	NA	**84.31%**	NC
Combination 5	—	NA	68.63%	NC
Combination 6	—	NA	47.06%	NC
Combination 7	—	NA	68.63%	NC
Combination 8	—	NA	47.06%	NC
Combination 9	—	NA	41.18%	NC
Combination 10	—	NA	41.18%	NC

HEDIS Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	2019–2020 Rate Comparison
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	—	NA	86.36%	NC
Combination 2 (Meningococcal, Tdap, HPV)	—	NA	33.33%	NC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile—Total	—	76.16%	73.48%	-2.68
Counseling for Nutrition—Total	—	69.59%	66.42%	-3.17
Counseling for Physical Activity—Total	—	64.72%	62.04%	-2.68
Well-Child Visits in the First 15 Months of Life (W15)				
Six or More Well-Child Visits	—	NA	76.12%	NC
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	—	59.56%	72.13%	12.57
Care for Chronic Conditions				
Medication Management for People With Asthma (MMA)				
Medication Compliance 50%—Total	—	NA	NA	NC
Medication Compliance 75%—Total	—	NA	NA	NC
Behavioral Health				
Follow-Up After Emergency Department Visit for Mental Illness (FUM)				
7-Day Follow-Up—Total	—	NA	NA	NC
30-Day Follow-Up—Total	—	NA	NA	NC
Follow-Up After Hospitalization for Mental Illness (FUH)				
7-Day Follow-Up—Total	—	NA	NA	NC
30-Day Follow-Up—Total	—	NA	NA	NC
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
Initiation Phase	—	NA	NA	NC
Continuation and Maintenance Phase	—	NA	NA^	NC
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)				
Initiation of AOD—Total	—	NA	NA	NC
Engagement of AOD—Total	—	NA	NA	NC

HEDIS Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	HEDIS 2020 Rate	2019–2020 Rate Comparison
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)				
Blood Glucose and Cholesterol Testing—Total	—	NA	NA	NC
Utilization				
Ambulatory Care—Total (per 1,000 Member Months) (AMB)				
*ED Visits—Total**	—	26.36	30.68^	4.32
Outpatient Visits—Total	—	192.98	237.83^	44.85
Mental Health Utilization—Total (MPT)				
Inpatient—Total	—	0.73%	0.23%^	-0.50
Intensive Outpatient or Partial Hospitalization—Total	—	0.05%	0.14%^	0.09
Outpatient—Total	—	7.14%	9.79%^	2.65
ED—Total	—	0.00%	0.00%^	0.00
Telehealth—Total	—	0.00%	0.09%^	0.09
Any Service—Total	—	7.30%	9.84%^	2.54

[1] Due to changes in the technical specifications for this measure, NCQA recommends that trending between HEDIS 2020 and prior years be considered with caution.
— Indicates that the health plan was not in existence during the reporting period.
^ Indicates HEDIS 2020 QISMC goals are unavailable for this measure.
NC indicates the 2019–2020 Rate Comparison could not be calculated because data are not available for both years.
NA indicates that the plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
Bolded rates indicate that the performance measure rate for HEDIS 2020 was at or above the MPS.

Indicates that the HEDIS 2020 rate declined by 5 percentage points or more from HEDIS 2019.

Indicates that the HEDIS 2020 rate improved by 5 percentage points or more from HEDIS 2019.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: Although none of the measure rates for the Medicaid population under the Children's Preventive Care domain reached MPS, most measure rates demonstrated significant improvements, with all 11 immunization rates for children and adolescents increasing more than 11 percentage points each from the prior year. This performance improvement demonstrates **SilverSummit** has prioritized efforts around ensuring its child and adolescent members are getting preventive care, including immunizations that are critical for disease prevention.

Strength: For the Medicaid population, both measure rates under the *Medication Management for People With Asthma* measure met MPS, indicating that **SilverSummit**'s contracted providers are prescribing and pharmacies are dispensing appropriate asthma-controller medications to members to help prevent the need for rescue medications, ER visits, or even hospitalization.

Weaknesses

Weakness: Of the 11 combined measure rates reported for the Medicaid and Nevada Check Up populations under the Access to Care domain, no measure rates achieved MPS. Seven of the measure rates did improve from the previous year, with one measure rate in the Nevada Check Up population, *Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years,* improving by more than 5 percentage points. However, the low overall performance in the Access to Care domain indicates members may be experiencing issues accessing providers for services.

Why the weakness exists: Adults, adolescents, and young adults are not visiting PCPs as needed to maintain optimal health. These members may have difficulties finding a provider that accepts Medicaid or may be choosing to not go to the doctor.

Recommendation: HSAG recommends **SilverSummit** conduct a root cause analysis or focused study to determine why its members are not accessing contracted providers for services. **SilverSummit** could consider if there are disparities within its populations that contribute to lower performance in a particular race or ethnicity, age group, zip code, etc. Upon identification of a root cause, **SilverSummit** should implement appropriate interventions to improve the performance related to the Access to Care domain.

Weakness: For the Medicaid population, the *Breast Cancer Screening* measure rate under the Women's Health and Maternity Care domain fell below MPS, indicating women are not getting breast cancer screenings for early detection of breast cancer, which may result in less effective treatment.

Why the weakness exists: The Access to Care measure rates for adult Medicaid members are performing below the MPS, suggesting that members are not always able to access providers for preventive services in a timely manner.

Recommendation: HSAG recommends **SilverSummit** conduct a root cause analysis or focused study to determine why its women members are not getting preventive screenings for breast cancer. **SilverSummit** could consider if there are disparities within its populations that contribute to lower performance in a particular race or ethnicity, age group, zip code, etc. Upon identification of a root cause, **SilverSummit** should implement appropriate interventions to improve the performance related to Women's Health and Maternity Care.

Weakness: Although one rate under the *Comprehensive Diabetes Care* measure within the Care for Chronic Conditions domain improved by more than 6 percentage points from the prior year, none of the six rates for the Medicaid population reached MPS. Additionally, three of the measure rates demonstrated a decline from the previous year, suggesting control among **SilverSummit**'s Medicaid diabetic population is also declining. Appropriate diabetes management is critical to control blood glucose, reduce risks for complications, and prolong the life of **SilverSummit**'s members.

Why the weakness exists: The Access to Care measure rates for adult Medicaid members are performing below the MPS, implying that members are not always able to access PCPs for services and may not be getting the services that are needed to screen for complications and subsequently manage their diabetes.

Recommendation: HSAG recommends **SilverSummit** conduct a root cause analysis to determine why its members with diabetes are not getting the appropriate care to manage their diabetes. Upon identification of a root cause, **SilverSummit** should implement at least two interventions to improve performance related to diabetes management.

Weakness: Although one measure, *Adherence to Antipsychotic Medications for Individuals with Schizophrenia,* within the Medicaid population improved almost 9 percentage points from the previous year, and the two measure rates under *Follow-Up After Hospitalization for Mental Illness* each demonstrated more than a 5 percentage increase from the prior year, only one of the 12 reported measures within the Behavioral Health domain achieved MPS, indicating members with behavioral health conditions may not be accessing behavioral health providers, as appropriate, to stay mentally well.

Why the weakness exists: Although HSAG could not discern a root cause for why the behavioral health measures are not meeting MPS, a lack of follow-up visits with mental health providers after ER use and hospitalization could indicate there is a lack of coordination of care between **SilverSummit** and the hospital, or there could be challenges with contacting members post-discharge due to outdated member contact information.

Recommendation: HSAG recommends **SilverSummit** conduct a focused review to determine if there is a correlation between members who are denominator positive who also may be experiencing barriers to receiving coordinated benefits due to discharge practices or inaccurate contact information. Based on these results, **SilverSummit** could implement interventions to mitigate the barriers.

Weakness: **SilverSummit**'s Medicaid 2020 rates for the *Use of Opioids From Multiple Providers—Multiple Prescribers* measure exhibited a 9 percentage point decline between HEDIS 2019 and HEDIS 2020, indicating that members are being prescribed opioids from multiple prescribers.

Why the weakness exists: Members are being prescribed opioids from multiple prescribers, suggesting that members may be drug seeking and that **SilverSummit** and **SilverSummit**'s contracted providers are not monitoring co-prescribing patterns effectively. Additionally, since *Multiple Pharmacies* rate met MPS, **SilverSummit** and **SilverSummit**'s pharmacies may not be monitoring for multiple filled opioid prescriptions.

Recommendation: HSAG recommends that **SilverSummit** conduct a targeted review of members receiving opioids from four or more providers and identify prescription patterns and patient profiles driving measure rates. Once identified, exploratory root cause analyses can be performed to identify systemic or member or provider issues that contribute to increased prescriptions by multiple providers and/or processes to identify and disrupt the pattern.

Compliance Review

Performance Results

Table 3-30 presents **SilverSummit**'s scores for each standard evaluated in the SFY 2019–2020 compliance review. Each element within a standard was scored as *Met*, *Partially Met,* or *Not Met* based on evidence found in MCO documents, policies, procedures, reports, meeting minutes, and interviews with MCO staff members. Table 3-31 presents the results of the review conducted on **SilverSummit**'s CAPs developed to remediate the deficiencies identified through the SFY 2017–2018 and SFY 2018–2019 compliance reviews.

Table 3-30—Summary of Scores for the Compliance Standards

Standard #	Standard Name	Total Elements	Total Applicable Elements	Number of Elements				Total Compliance Score
				M	*PM*	*NM*	*NA*	
XI	IQAP	21	20	19	1	0	1	98%
XII	Cultural Competency Program	17	17	15	2	0	0	94%
XIII	Confidentiality	11	11	11	0	0	0	100%
XIV	Enrollment and Disenrollment	8	8	5	2	1	0	75%
Total Compliance Score		**57**	**56**	**50**	**5**	**1**	**1**	**94%**

M=*Met*, ***PM***=*Partially Met*, ***NM***=*Not Met*, ***NA***=*Not Applicable*

Total Elements: The total number of elements in each standard.

Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point) to the weighted number that received a score of *Partially Met* (0.5 point), then dividing this total by the total number of applicable elements.

Table 3-31—Summary of Scores for the SFY 2017–2018 and SFY 2018–2019 CAP Reviews

Standard #	Standard Name	Total CAP Elements	Total Number of Elements Scored	
			M	*NM*
I	Credentialing and Recredentialing	NA	NA	NA
II	Availability and Accessibility of Services	1	1	0
III	Subcontracts and Delegation	NA	NA	NA
IV	Provider Dispute and Complaint Resolution	NA	NA	NA
V	Provider Information	NA	NA	NA
VI	Member Rights and Responsibilities	3	3	0
VII	Member Information	1	1	0

Standard #	Standard Name	Total CAP Elements	Total Number of Elements Scored	
			M	*NM*
VIII	Continuity and Coordination of Care	3	3	0
IX	Grievances and Appeals	2	2	0
X	Coverage and Authorization of Services	1	1	0
	Total	**11**	**11**	**0**

M=*Met* and ***NM***=*Not Met*

Total CAP Elements: The total number of elements in each standard.

Total Number of Elements Scored: The number of elements that received a score of M or NM for each standard reviewed

NA: The MCO did not have any deficiencies noted for this standard during the SFY 2017–2018 and SFY 2018–2019 reviews.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: SilverSummit demonstrated they had the necessary policies, procedures, and plans to operationalize most of the required elements of its contract and managed care regulations under 42 CFR §438.

Strength: SilverSummit's confidentiality- and privacy-related policies and procedures were very detailed and demonstrated effective training and monitoring processes, through staff audits and provider record reviews to ensure member information is protected and remains confidential in accordance with the Health Insurance Portability and Accountability Act of 1996 privacy laws. **SilverSummit** also demonstrated an effective process for investigation of incidents as to whether they rise to the level of a breach. These processes, procedures, and training programs support **SilverSummit**'s ability to protect the privacy of its member data.

Strength: For being a newer plan in Nevada, **SilverSummit** demonstrated a comprehensive IQAP, and staff were very knowledgeable about its policies, procedures, and quality initiatives. Additionally, **SilverSummit**'s annual evaluation demonstrated a thoughtful analysis of various activities, with consideration of trends across activities.

Strength: SilverSummit's internal and external cultural competency training and education program was thorough and demonstrated the plan's commitment to ensuring members are provided culturally competent services.

Weaknesses

Weakness: SilverSummit lacked a mechanism to inform members on how to contact the plan when requesting a "with cause" disenrollment. The Notice of Disenrollment template letter contained confusing language, which may impact a member's ability to properly pursue next steps in the disenrollment process.

Why the weakness exists: The member handbook inaccurately informed members to contact an external entity to request disenrollment with the plan as opposed to contacting the MCO. The Notice of Disenrollment template letter inaccurately informed members to seek an appeal through the State fair hearing as opposed to seeking an appeal with the MCO.

Recommendation: **SilverSummit** should review all member informational materials to ensure that adequate and correct information regarding the disenrollment process is provided to members.

Network Adequacy Validation (NAV)

Performance Results

Table 3-32 presents a summary of **SilverSummit**'s provider ratio analysis results compared to the provider ratio standards. For the provider categories assessed according to the standards in Table 3-33, the percentage of members with access to the provider within the time-distance standard is shown in red if they did not comply with the standard. The time-distance results are displayed in Table 3-30.

Table 3-32—Summary of Ratio Analysis Results for PCPs and Specialty Care Providers for SilverSummit

Provider Category	SilverSummit	
	Providers	Ratio
PCPs (1:1,500)	1,916	1:22
PCP Extenders (1:1,800)	1,346	1:31
Physician Specialist Providers (1:1,500)	1,150	1:36

Table 3-33—Percentage of Members Residing Within the Access Standard Areas for SilverSummit

Provider Category	Time-Distance Standard	Percentage of Members with Access
PCPs		
Primary Care (Adult Total)	20 miles/30 mins	99.0%
OB/GYN	20 miles/30 mins	98.7%
Pediatrician	20 miles/30 mins	98.7%
Specialty Providers		
Endocrinologist	75 miles/100 mins	99.1%
Endocrinologist, Pediatric	75 miles/100 mins	99.0%
Infectious Disease	75 miles/100 mins	99.1%
Infectious Disease, Pediatric	75 miles/100 mins	99.0%
Oncologist/Hematologist	75 miles/100 mins	99.1%

Provider Category	Time-Distance Standard	Percentage of Members with Access
Oncologist/Hematologist, Pediatric	75 miles/100 mins	99.0%
Oncologist/Radiologist	75 miles/100 mins	99.1%
Rheumatologist	75 miles/100 mins	99.1%
Rheumatologist, Pediatric	75 miles/100 mins	87.1%
Facility-Level Providers		
Hospital	60 miles/80 mins	99.1%
Psychiatry Inpatient Hospital	60 miles/80 mins	99.1%
Dialysis/ESRD Facility	60 miles/80 mins	99.1%
Behavioral Health Providers		
Psychologist	45 miles/60 mins	99.1%
Pediatric Psychologist	45 miles/60 mins	87.1%
LCSW	45 miles/60 mins	99.1%
Psychiatrist	45 miles/60 mins	99.1%
Pediatric Psychiatrist	45 miles/60 mins	99.0%

NA indicates that the MCO did not report providers in the provider category.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: SilverSummit met the required provider ratio requirements for PCPs, PCP extenders, and the physician specialist providers, indicating that **SilverSummit** has a sufficient provider network for its members to access services.

Strength: SilverSummit met the time-distance contract standards for all general primary care categories (PCPs, OB/GYNs, and pediatricians) and facility-level providers, indicating members had access to PCPs within an adequate distance from their residence.

Weaknesses

Weakness: SilverSummit did not report providers in the following specialty areas: pediatric dermatologists, geriatrics, oncologists/radiologists, pediatric vision care providers, and substance abuse facilities/clinics, indicating members may have a barrier to accessing care at these provider types.[3-5]

[3-5] The provider categories with no reported provider counts are not displayed in the Percentage of Members Residing Within the Access Standard Areas for SilverSummit table. These provider categories are listed with an "NA" in the DHCFP Nevada Medicaid Managed Care State Fiscal Year 2019–20 Network Adequacy Validation report.

Why the weakness exists: The lack of identified providers may result from either a lack of contracted providers in those specialties or from inconsistencies in identifying those provider specialties in the data, due to data mapping and/or data submission issues.

Recommendation: HSAG recommends that **SilverSummit** review its provider data and contracted provider list to identify if the inability to identify providers in the data is a result of a lack of contracted providers or if the providers are not appropriately identified in the data. If a lack of contracted providers is identified, HSAG recommends **SilverSummit** determine if the lack of contracted providers is due to a shortage of providers in the area or an unwillingness of providers to contract with the MCO.

Weakness: SilverSummit did not meet the time-distance contract standards for pediatric rheumatologists and pediatric psychologists, indicating children do not have access to rheumatologists and psychologists within an adequate distance from their residence.

Why the weakness exists: The lack of identified providers may result from either a lack of contracted pediatric specialty providers in those specialties or from an inability to identify those pediatric specialists in the data.

Recommendation: SilverSummit should conduct an in-depth review of provider categories in which **SilverSummit** did not meet either the time-distance contract standards, with the goal of determining whether or not the failure of the MCO to meet the contract standard(s) was the result of a lack of providers or an inability to contract providers in the geographic area.

CAHPS Analysis

Performance Results

Table 3-34 presents **SilverSummit**'s 2020 adult Medicaid, general child Medicaid, and CCC Medicaid CAHPS top-box scores. Table 3-34 also includes **SilverSummit**'s 2020 Nevada Check Up general child and CCC top-box scores.

Table 3-34—Summary of 2020 CAHPS Top-Box Scores for SilverSummit

	2020 Adult Medicaid	2020 General Child Medicaid	2020 CCC Medicaid Supplemental	2020 Nevada Check Up General Child	2020 Nevada Check Up CCC Supplemental
Composite Measures					
Getting Needed Care	NA	NA	NA	NA	NA
Getting Care Quickly	NA	NA	NA	NA	NA
How Well Doctors Communicate	NA	NA	NA	NA	NA
Customer Service	NA	NA	NA	NA	NA

	2020 Adult Medicaid	2020 General Child Medicaid	2020 CCC Medicaid Supplemental	2020 Nevada Check Up General Child	2020 Nevada Check Up CCC Supplemental
Global Ratings					
Rating of All Health Care	NA	70.0%	NA	NA	NA
Rating of Personal Doctor	NA	69.7% ↓	NA	NA	NA
Rating of Specialist Seen Most Often	NA	NA	NA	NA	NA
Rating of Health Plan	51.8% ↓	70.9%	NA	NA	NA
Effectiveness of Care*					
Advising Smokers and Tobacco Users to Quit	NA				
Discussing Cessation Medications	NA				
Discussing Cessation Strategies	NA				
CCC Composite Measures/Items					
Access to Specialized Services			NA		NA
Family Centered Care (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 results. 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 2020 score is at least 5 percentage points higher than the 2019 national average.

↓ Indicates the 2020 score is at least 5 percentage points lower than the 2019 national average.

Indicates that the measure does not apply to the population.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: HSAG did not identify any strengths for **SilverSummit** for the CAHPS surveys.

Weaknesses

Weakness: There is limited data available to comprehensively evaluate member experiences with their providers and healthcare services.

Why the weakness exists: **SilverSummit** had numerous measures that did not meet the minimum 100 responses for the adult Medicaid population, general child and CCC Medicaid populations, and Nevada Check Up general child and CCC populations. Due to COVID-19, **SilverSummit**'s survey return rate and the vendor's ability to conduct outreach to members was impacted.

Recommendation: HSAG recommends that **SilverSummit** continue to work with its CAHPS vendor to obtain a sufficient number of completed surveys that will enable reporting of all CAHPS measures. NCQA recommends targeting 411 completed surveys per survey administration. **SilverSummit** may need to consider adding other data collection survey modes, such as the Internet, for the CAHPS surveys to increase response rates. **SilverSummit** should also determine if its previous initiatives, such as using colored envelopes, increasing the number of oversampling, and conducting extra member calls, improved the rate of respondents and if those methods should continue for the next survey.

Weakness: Adult members had less positive overall experiences with their health plan. In addition, for the general child Medicaid population, parents/caretakers of child members had less positive overall experiences with their child's personal doctor. The scores for these measures were at least 5 percentage points lower than the 2019 NCQA Medicaid national averages.

Why the weakness exists: Adult members are reporting a more negative experience with their health plan, which could be due to a perceived lack of communication or satisfactory resolution of members' concerns. Additionally, parents/caretakers of general child members are reporting a more negative experience with their child's personal doctor compared to national benchmarks, which could indicate that providers are not spending enough quality time with members or that members perceive that providers are not satisfactorily addressing member needs.

Recommendation: HSAG recommends that **SilverSummit** focus on improving members' overall experiences with their health plan and parents/caretakers of child members' overall experiences with children's personal doctors, through continued initiatives such as improved prior authorization processes, promotion of urgent care and after hours clinics, implementation of the member concierge program, provider education, and grievance analyses. Additionally, HSAG recommends widely promoting the results of its member experiences with its contracted providers and staff and soliciting feedback and recommendations to improve members' overall satisfaction with both **SilverSummit** and its contracted providers.

4. Assessment of Prepaid Ambulatory Health Plan (PAHP) Performance

PAHP Methodology

HSAG used findings across mandatory EQR activities conducted during the SFY 2019–2020 review period to evaluate the performance of the PAHP on providing quality, timely, and accessible healthcare services to Nevada Managed Care Program members.

To identify strengths and weaknesses and draw conclusions for the PAHP, HSAG analyzed and evaluated each EQR activity and its resulting findings related to the provision of healthcare services across the Nevada Managed Care Program. The composite findings for the PAHP were analyzed and aggregated to identify overarching conclusions and focus areas for the PAHP in alignment with the priorities of the DHCFP.

Beginning in March 2020 through the end of the SFY, the DHCFP allowed for certain flexibilities within the EQR activities in response to COVID-19 and the environment in Nevada during this time period. These specific changes will be noted where applicable.

For more details about the technical methods for data collection and analysis, refer to Appendix A.

Validation of Performance Improvement Projects (PIPs)

In state fiscal year 2016, the DHCFP implemented the rapid-cycle PIP approach. For this approach, HSAG developed four modules for the PAHP to document their projects as they moved through the different stages of the PIP process. The duration of rapid-cycle PIPs is approximately 18 months.

For this state fiscal year, **LIBERTY** concluded its two PIPs, *Improve Caries Risk Assessment Completion Rate* and *Annual Dental Visits*, which were initiated in SFY 2018–2019 when there were five modules for the PAHP to complete. This was the final validation for these PIPs. For each of these topics, the PAHP defined a Global Aim and a SMART Aim. The SMART Aim statement includes the narrowed population, the baseline percentage, a set goal for the project, and the end date.

Table 4-1 outlines the SMART Aim statement for each topic completed by the PAHP.

Table 4-1—PIP Topic and SMART Aim Statement

PIP Title	SMART Aim Statement
Improve Caries Risk Assessment Completion Rate	By December 31, 2019, increase the percentage of completed caries risk assessments (CRAs) for children 1–6 years of age seen at [2 pediatric dentists*] from 0.22% to 12.0%.
Annual Dental Visits	By December 31, 2019, increase the percentage of 1-year-old children assigned to [dental provider*] who have a dental visit completed from 0.40% to 10.4%.

* Provider names were redacted for privacy purposes.

Performance Measure Validation (PMV)

The 2020 PMV activity included a comprehensive evaluation of the processes used by **LIBERTY** to collect and report data for two performance measures selected by the DHCFP for **LIBERTY**'s Medicaid and Nevada Check Up populations. Table 4-2 lists the performance measures that HSAG validated and the measure specifications **LIBERTY** was required to use for calculating the performance measure rates.

Table 4-2—LIBERTY Medicaid and Nevada Check Up Performance Measures for Validation

Performance Measures	Measure Specifications
Annual Dental Visit (ADV)	HEDIS 2020
Percentage of Eligibles Who Received Preventive Dental Services (PDENT)	CMS Child Core Set

Compliance Review

The compliance review in Nevada includes a review of 14 standards over a three-year cycle as detailed in Appendix A. SFY 2019–2020 marked the third year of the three-year cycle and comprised an evaluation of the PAHP's performance in four program areas, identified in Table 4-3, which lists the standards reviewed to determine compliance with State and federal standards.

Table 4-3—Compliance Review Standards

Standard #	Standard Name	Number of Elements
XI	IQAP	20
XII	Cultural Competency Program	7
XIII	Confidentiality	11
XIV	Enrollment and Disenrollment	3
	Total Number of Elements	**41**

The DHCFP also required the PAHP to submit a CAP for all elements scored *Partially Met* or *Not Met* in the first two years of the three-year compliance review cycle. To ensure that the PAHP had implemented plans of action to remediate the previously identified deficiencies, the DHCFP requested that HSAG also conduct a follow-up review of the CAP developed as a result of the deficiencies identified through the SFY 2018–2019 compliance review, which also included a review of the relevant deficiencies that had been noted in the PAHP's Readiness Review completed in November 2017.

Network Adequacy Validation (NAV)

The SFY 2019–2020 NAV activity included an assessment of the capacity of the PAHP's dental provider network by calculating the member-to-provider ratio (provider ratio) by provider category relative to the number of members, and by evaluating the geographic distribution of providers relative to the PAHP's members. Table 4-4 depicts the data sources and the time period used for the analysis.

Table 4-4—Data Sources and Time Period

Data Source	Data Time Period
Member enrollment and demographic file	Members effective as of October 1, 2019
Provider data file	Providers actively enrolled with the PAHP as of October 1, 2019

Provider counts for the analysis were based on unique providers and not provider locations. Geographic access calculations were derived by the percentage of members within predefined access standards and the average travel distances (driving distances in miles) and travel times (driving times in minutes) to the nearest three providers. Table 4-5 shows the provider categories used to assess the PAHP's compliance with the provider ratio standards.

Table 4-5—PAHP Provider Categories and Provider Ratio Standards

Provider Category	Provider to Member Ratio Standard
Dental Primary Care	1:1,500
Dental Specialists	1:1,500

Table 4-6 shows the provider categories used to assess the PAHP's compliance with the time-distance standards.

Table 4-6—PAHP Provider Category, Member Criteria, and Time-Distance Standard

Provider Category	Member Criteria	Time-Distance Access Standard
Dental Providers	Adults/Children	30 minutes or 20 miles

EQR Activity Results

LIBERTY Dental Plan of Nevada, Inc.

Validation of Performance Improvement Projects (PIPs)

Performance Results

Table 4-7 summarizes the SMART Aim outcomes for the *Improve Caries Risk Completion Assessment* PIP.

Table 4-7—SMART Aim Outcomes

SMART Aim	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
Percentage of completed caries risk assessments for children 1–6 years of age at [2 pediatric dentists*].	0.22%	12.0%	85.4%	*High Confidence*

* Provider names were redacted for privacy purposes.

For this PIP, **LIBERTY** tested the following intervention:

- An education-based intervention that focused on conducting on-site training on how to complete a CRA and providing office staff members with a certificate of completion following the training.

LIBERTY established a goal of increasing the percentage of completed CRAs for children 1 to 6 years of age seen at two targeted practices from 0.22 percent to 12.0 percent. **LIBERTY** exceeded the baseline percentage of 0.22 percent starting in March of 2018 and exceeded the goal of 12.0 percent in May 2018. The improvement continued for the duration of the PIP, with the highest rate achieved of 85.4 percent.

LIBERTY documented the following for the *Improve Caries Risk Assessment Completion Rate* PIP:

- Providing consistent and up-to-date education to all dental providers will result in continued increases in completed CRAs.
- Provider incentive-based fax blast communication had a significant impact on the quality of completed CRAs.
- The PAHP will expand the CRA training to all providers who are not performing at an acceptable rate.

Table 4-8 summarizes the SMART Aim Outcomes for the *Annual Dental Visits* PIP.

Table 4-8—SMART Aim Outcomes

SMART Aim	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
Percentage of children 1 year of age and younger, assigned to [dental provider*], who completed an annual dental visit.	0.40%	10.4%	2.82%	*Low Confidence*

* Provider names were redacted for privacy purposes.

For this PIP, **LIBERTY** tested the following intervention:

- Member telephonic outreach. **LIBERTY** set out to contact the parents or guardians of members 1 year of age and younger, assigned to the dental provider, who had not had a scheduled visit in the calendar year. During the call, **LIBERTY** informed the parent or guardian of the importance of

completing a dental exam before the age of 2 and assessed the awareness and satisfaction they had with their assigned dental provider.

LIBERTY established a goal of increasing the percentage of children 1 year of age and younger, assigned to the dental provider, who completed an annual dental visit from 0.4 percent to 10.4 percent. **LIBERTY** did not achieve the SMART Aim goal of 10.4 percent. Although the goal was not achieved, the PAHP demonstrated improvement over the three-month baseline period for 17 of the 21 reporting months.

LIBERTY documented the following for the *Annual Dental Visits* PIP:

- Having a stable and consistent targeted population is essential for future intervention testing.
- Deficiencies in a targeted population will produce unsatisfactory results for intervention testing.
- Member contact and outreach barriers have a significant negative impact on outcomes if not addressed.

Strengths, Weaknesses, and Recommendations

Strengths	**Strength: LIBERTY** identified lessons learned and knowledge gained that can be applied to future improvement efforts and activities.
Weaknesses	**Weakness:** Although **LIBERTY** demonstrated some improvement based on its *Annual Dental Visits* PIP, the SMART Aim goal was not reached. **Why weakness exists:** The SMART Aim goal was not reached due to deficiencies in the PIP's targeted population and inaccurate member contact information. **Recommendation:** HSAG recommends **LIBERTY** leverage claims data to identify updated member contact information and maintain the information within its health information system since contact information is overlaid with each uploaded enrollment file. **LIBERTY** should also continue to apply the lessons learned and knowledge gained from its efforts and HSAG's feedback throughout the PIP process to future PIPs and other quality improvement activities.

Performance Measure Validation (PMV)

Performance Results

The 2019 and 2020 rates for **LIBERTY**'s Medicaid and Nevada Check Up populations are presented in Table 4-9 and Table 4-10, along with rate comparisons.

Table 4-9—Medicaid Performance Measure Results for LIBERTY

Performance Measure	PMV 2019 Rate	PMV 2020 Rate	2019–2020 Rate Comparison
Annual Dental Visit (ADV)			
Ages 2–3 Years	36.27%	37.49%	1.22
Ages 4–6 Years	53.43%	55.40%	1.97
Ages 7–10 Years	59.78%	62.06%	2.28
Ages 11–14 Years	55.21%	57.50%	2.29
Ages 15–18 Years	46.44%	48.83%	2.39
Ages 19–20 Years	30.98%	32.81%	1.83
Total (Ages 2–20 Years)	50.67%	52.79%	2.12
Percentage of Eligibles Who Received Preventive Dental Services (PDENT)			
Total (Ages 1–20 Years)	39.76%	39.30%	-0.46

Table 4-10—Nevada Check Up Performance Measure Results for LIBERTY

Performance Measure	PMV 2019 Rate	PMV 2020 Rate	2019–2020 Rate Comparison
Annual Dental Visit (ADV)			
Ages 2–3 Years	46.96%	49.65%	2.69
Ages 4–6 Years	68.23%	70.04%	1.81
Ages 7–10 Years	73.60%	77.04%	3.44
Ages 11–14 Years	69.44%	72.05%	2.61
Ages 15–18 Years	59.33%	62.32%	2.99
Ages 19–20 Years	43.35%	51.55%	8.20
Total (Ages 2–20 Years)	66.33%	69.42%	3.09
Percentage of Eligibles Who Received Preventive Dental Services (PDENT)			
Total (Ages 1–20 Years)	54.01%	56.69%	2.68

Indicates that the HEDIS 2020 rate declined by 5 percentage points or more from HEDIS 2019.

Indicates that the HEDIS 2020 rate improved by 5 percentage points or more from HEDIS 2019.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: LIBERTY's Medicaid and Nevada Check Up 2020 rates showed improvement across measure rates, with the exception of the Medicaid *Percentage of Eligibles Who Received Preventive Dental Services* rate, which experienced a minor decline. The Nevada Check Up population experienced an increase of more than 5 percentage points to its *Annual Dental Visit* rates for the 19 to 20 years of age stratification.

Weaknesses

Weakness: Although most rates demonstrated a slight improvement, no measure rate within either the *Annual Dental Visit* or *Percentage of Eligibles Who Received Preventive Dental Services* Measures met MPS, indicating members are not accessing dentists for preventive treatment, early diagnosis of dental disease, or education about properly caring for teeth to prevent future problems.

Why the weakness exists: Although it appears that **LIBERTY** has a sufficient network of general dentists, members may experience barriers to accessing these providers or members are choosing to not use their dental benefits.

Recommendations: HSAG recommends **LIBERTY** conduct a root cause analysis or focused study to determine whether barriers exist to members obtaining regular dental care. Further, HSAG recommends that **LIBERTY** conduct a grievance analysis to identify any systemic issues or challenges that may be impacting access to care.

Compliance Review

Performance Results

Table 4-11 presents **LIBERTY**'s scores for each standard evaluated in the SFY 2019–2020 compliance review. Each element within a standard was scored as *Met*, *Partially Met,* or *Not Met* based on evidence found in the PAHP's documents, policies, procedures, reports, meeting minutes, and interviews with PAHP staff members. Table 4-12 presents the results of the review conducted on **LIBERTY**'s CAP developed to remediate the deficiencies identified through the SFY 2018–2019 compliance review. The critical deficiencies noted in standards I through V were remediated through the Readiness Review process conducted in 2017.

Table 4-11—Compliance Review Standards

Standard #	Standard Name	Total Elements	Total Applicable Elements	Number of Elements				Total Compliance Score
				M	*PM*	*NM*	*NA*	
XI	IQAP	20	20	18	2	0	0	95%
XII	Cultural Competency Program	7	7	6	1	0	0	93%
XIII	Confidentiality	11	11	11	0	0	0	100%

Standard #	Standard Name	Total Elements	Total Applicable Elements	Number of Elements				Total Compliance Score
				M	*PM*	*NM*	*NA*	
XIV	Enrollment and Disenrollment	3	1	1	0	0	2	100%
Total Compliance Score		**41**	**39**	**36**	**3**	**0**	**2**	**96%**

M=*Met*, ***PM***=*Partially Met*, ***NM***=*Not Met*, ***NA***=*Not Applicable*

Total Elements: The total number of elements in each standard.

Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point) to the weighted number that received a score of *Partially Met* (0.5 point), then dividing this total by the total number of applicable elements.

Table 4-12—Summary of Scores for the SFY 2018–2019 CAP Review

Standard #	Standard Name	Total CAP Elements	Total Number of Elements Scored	
			M	*NM*
VI	Member Rights and Responsibilities	NA	NA	NA
VII	Member Information	NA	NA	NA
VIII	Continuity and Coordination of Care	2	2	0
IX	Grievances and Appeals	13	13	0
X	Coverage and Authorization of Services	6	6	0
Total		**21**	**21**	**0**

M=*Met* and *NM*=*Not Met*

Total CAP Elements: The total number of elements in each standard.

Total Number of Elements Scored: The number of elements that received a score of *M* or *NM* for each standard reviewed.

NA: The PAHP did not have any deficiencies noted for this standard during the SFY 2018–2019 review.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: LIBERTY demonstrated they had the necessary policies, procedures, and plans to operationalize most of the required elements of its contract and managed care regulations under 42 CFR §438.

Strength: LIBERTY had comprehensive confidentiality- and privacy-related policies and procedures. Additionally, the new and annual employee trainings were detailed. **LIBERTY** implemented a best practice of daily floor checks of staff work areas to ensure adherence to protecting member information. These policies, practices, and trainings ensure sensitive member information is being protected.

Strength: **LIBERTY**'s cultural competency program plan was descriptive, thorough, and adequately conveyed Culturally and Linguistically Appropriate Services standards and mechanisms for ensuring the delivery of culturally competent services to its members.

Weaknesses

Weakness: Stakeholder involvement and direction in **LIBERTY**'s IQAP was not well documented. Additionally, an opportunity exists for **LIBERTY** to enhance engagement of providers in its quality activities and initiatives to help support overall performance of the program and member satisfaction with dental services.

Why the weakness exists: While **LIBERTY** provided its governing body quarterly memos of the IQAP, there appeared to be a lack of meaningful documented discussion of the Board of Director's oversight and direction of the IQAP. Additionally, documentation was not available to confirm that **LIBERTY** provided meaningful information about the performance of its quality activities and healthcare outcomes to its provider network.

Recommendation: HSAG recommends that **LIBERTY** maintain thorough meeting minutes of discussions with members of the governing body pertaining the IQAP. **LIBERTY** should also implement a mechanism of providing performance and outcome data to its provider network. For example, it should provide an annual summary of **LIBERTY**'s IQAP evaluation.

Network Adequacy Validation (NAV)

Performance Results

Table 4-13 presents a summary of **LIBERTY**'s provider ratio analysis results compared to the provider ratio standards. For the provider categories assessed according to the standards in Table 4-13, the percentage of members with access to the provider within the time-distance standard is shown in red if they did not comply with the standard. The time-distance results are displayed in Table 4-14.

Table 4-13—Summary of Ratio Analysis Results by Provider Category for LIBERTY

Provider Category	LIBERTY	
	Providers	Ratio
Dental Primary Care Providers (1:1,500)	338	1:1,416
Dental Specialists Providers (1:1,500)	18	1:26,586
Mid-Level Dental Providers	NA	NA

NA indicates that the PAHP did not report providers in the provider category.

Table 4-14—Summary of Time Distance Standard Results for Providers Categories for LIBERTY

Provider Category	Time-Distance Standard	LIBERTY
General Dental Providers		
General Dentist	20 miles/30 mins	99.4%
Pediatric Dentist	20 miles/30 mins	99.4%
Specialty Dental Providers		
Endodontist	20 miles/30 mins	98.9%
Periodontist	20 miles/30 mins	86.1%
Prosthodontist	20 miles/30 mins	87.1%
Oral Surgeon	20 miles/30 mins	99.2%
Orthodontist	20 miles/30 mins	NA
Mid-Level Dental Providers		
Dental Hygienist	20 miles/30 mins	NA
Dental Therapist	20 miles/30 mins	NA

NA indicates that the PAHP did not report providers in the provider category.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: LIBERTY met the overall provider ratio requirements for general dental providers, indicating **LIBERTY** has an adequate network of dentists to provide dental services to its members.

Strength: LIBERTY met the time-distance contract standards for all general dentists, pediatric dentists, endodontists, and oral surgeons, indicating members are able to access these dental provider types within an adequate distance from their residence.

Weaknesses

Weakness: LIBERTY did not meet the provider ratio requirements for dental specialists, indicating members may have challenges accessing specialty dental care.

Why the weakness exists: LIBERTY only contracts with 18 dental specialists. The lack of identified dental specialists may result from either a lack of contracted dental specialists or from an inability to identify those dental specialists in the data, due to data mapping and/or data submission issues.

Recommendation: LIBERTY should conduct an in-depth review of dental specialist categories, with the goal of determining whether or not the failure of the PAHP to meet the contract standard(s) was the result of a lack of available providers or an inability to contract providers in the geographic area.

Weakness: **LIBERTY** did not report any dental hygienists or dental therapists, indicating that members are unable to see these provider types for dental services.

Why the weakness exists: In order to be identified as a dental therapist, the provider must have a degree from a Commission on Dental Accreditation (CODA)-accredited university. As of the date of this analysis, CODA had not granted accreditation to a dental therapy program; therefore, there may be a lack of these provider types that are accredited and available to contract with **LIBERTY**.

Recommendation: HSAG recommends **LIBERTY** continue to monitor the member's access to dental hygienists and dental therapists as more dental therapy programs become accredited and dental therapists are available to provide services to the member.

Weakness: **LIBERTY** did not meet the time-distance contract standards for periodontists and prosthodontists, indicating members were unable to access these provider types within an adequate distance from their residence.

Why the weakness exists: The lack of identified dental providers may result from either a lack of contracted dental specialty providers or from an inability to identify those dental specialists in the data, due to data mapping and/or data submission issues.

Recommendation: **LIBERTY** should conduct an in-depth review of dental specialist categories in which **LIBERTY** did not meet the time-distance contract standards, with the goal of determining whether or not the failure of the PAHP to meet the contract standard(s) was the result of a lack of available providers or an inability to contract providers in the geographic area.

5. Follow-Up on Prior EQR Recommendations for MCOs

From the findings of each MCO's performance for the SFY 2018–2019 EQR activities, HSAG made recommendations for improving the quality of healthcare services furnished to members enrolled in the Nevada Managed Care Program. The recommendations provided to each MCO for the EQR activities in the *State Fiscal Year 2018–2019 External Quality Review Technical Report* are summarized in Table 5-1, Table 5-2, and Table 5-3. The MCO's summary of the activities that were implemented to support performance improvement are also provided in Table 5-1, Table 5-2, and Table 5-3.

Anthem Blue Cross and Blue Shield Healthcare Solutions

Table 5-1—Prior Year Recommendations and Responses for Anthem

1. Prior Year Recommendation from the EQR Technical Report for Compliance Review:
HSAG recommended the following: • Ensure that written notice is provided to affected members within the required time frame in cases in which a PCP has been terminated from the health plan. • Ensure that its written process describing the processing time frames for appeals is consistent with contractual and federal requirements. • Ensure that its process and time frames for service authorizations and denials are consistent with contractual and federal requirements.
MCE's Response *(Note—The narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • **Anthem** internal staff and interdepartmental education on the time frame and outcomes of completing a service form for a terminated provider was completed in the Q2 2019. Ongoing education of new staff to the department regarding member notification within 15 calendar days has been implemented. Introductions and confirmation of steps has been provided to **Anthem**'s enrollment team. Quarterly look back quality checks to assure process is correct takes place at the end of each quarter. • **Anthem** previously reviewed its appeal policy and made the revisions necessary to accurately reflect appeal processing time frames. The Policy and Procedure Committee and all appropriate internal departments reviewed the revised policy and approved the changes. The policy was then shared and discussed with appropriate NV G&A appeal staff. Specific appeal staff members were designated to handle all member appeals to ensure they are handled timely. • Furthermore, the Appeals Manager started conducting an internal quality review of random appeal cases every month to ensure appeals are timely processed according to contractual and federal requirements. • **Anthem**'s precertification of requested services core process was revised on July 5, 2019, containing the required process and time frames for service authorizations and denials provision. **Anthem** staff was provided with the updated policy and staff training was conducted on August 15, 2019. **Anthem** continues to follow current process in compliance with previous contractual updates.

1. Prior Year Recommendation from the EQR Technical Report for Compliance Review:
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Since meeting with the Appeals Team to discuss appeal time frames and starting internal quality audits, metrics have shown an improvement from an average of 93.7% in Q1 to 98% in Q2 for appeal resolution and an improvement from 78% in Q1 to 93% in Q2 for appeal acknowledgment.
c. Identify any barriers to implementing initiatives: • Ongoing efforts continue to ensure all internal departments route cases immediately to G&A to ensure timely processing of appeals.
HSAG Assessment: HSAG has determined that the MCO addressed the prior recommendations. HSAG recommends that the MCO continue to monitor and implement mechanisms to further increase adherence to time frame standards.

2. Prior Year Recommendation from the EQR Technical Report for Validation of Performance Measures–NCQA HEDIS Compliance Audit (Medicaid):
HSAG recommended the following: • **Anthem** should investigate the reasons for declines in rates of 5 percentage points or more for the following Medicaid measures: – *Comprehensive Diabetes Care—HbA1c Testing* – *Follow-Up After Hospitalization for Mental Illness*
MCE's Response *(Note—The narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • **Anthem** monitored measures with rate declines more than 5 percentage points or more from PY and included on the quality improvement workplan and benchmark monthly reporting and directed multiple interventions toward improved performance, continued interventions included; Provider Quality Incentive Program (PQIP), member incentives, texting and IVR campaigns, medical records reviews, provider relations and quality collaboration for provider education, BH post-discharge follow-up calls, BH CM HOPE pre-discharge program, case management teams access to HealthHIE admission discharge and transfer (ADT) data, and CM CDC in-patient HbA1C testing program. These goals are monitored on a monthly basis by the Quality Management department, HEDIS manager, regional data manager, and HEDIS data analytics for gaps in care closures in monthly benchmark data.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • *Comprehensive Diabetes Care—HbA1c Testing*: Demonstrated a 1.71 percentage point increase from MY 2018 to MY 2019 interventions included: PQIP, member incentives, texting and IVR campaigns, medical records reviews, provider relations and quality collaboration for provider education, case management (CM) access to HealthHIE admission discharge and transfer (ADT) data, and CM CDC in-patient HbA1C testing were successful and have continued as best practices in 2020. • Follow-Up After Hospitalization for Mental Illness: Demonstrated a 0.41 percentage point increase to the 30-day rate and a 1.09 percentage point increase for the 7-day rate interventions; member incentives, texting and IVR campaigns, medical records reviews, provider relations and quality

2. Prior Year Recommendation from the EQR Technical Report for Validation of Performance Measures–NCQA HEDIS Compliance Audit (Medicaid):
collaboration for provider education, BH post discharge follow-up calls, BH case management and BH CM HOPE program access to HealthHIE admission discharge and transfer (ADT) data and hospital census data were successful and have continued as best practices in 2020.
c. Identify any barriers to implementing initiatives: • Both identified measures continue to fall below the 50th percentile as member compliance, member contact info, and the DNC lists continue to present challenges in closing gaps in care. Additionally, COVID in 2020 continues to impact members accessing care. Increased member engagement, promoting telehealth services and provider and member education will continue to be a primary focus.
HSAG Assessment: HSAG has determined that the MCO addressed the prior recommendations. As the MCO continues to fall below the 50th percentile, the MCO should continue its interventions to increase performance rates.

3. Prior Year Recommendation from the EQR Technical Report for PIPs:
HSAG recommended the following: • Continue to look for methods and/or processes to obtain updated correct member contact information as this continues to be an ongoing documented challenge. • Ensure the approved SMART Aim measure data collection methodology is followed for the duration of the PIP.
MCE's Response *(Note—The narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • **Anthem** contracted with an external vendor, LexisNexis Risk Solutions, to assist obtaining member contact information through searching public records and supplying **Anthem**'s Quality Management (QM) department with monthly data files. Additionally, **Anthem**'s Quality Management department collaborates with provider organizations to conduct member outreach and schedule healthcare appointments, enabling **Anthem** to secure members' most current contact information. On a monthly basis, **Anthem** supplies individual provider organizations with a member-level scorecard noting each member's outstanding gaps in care, primary and alternative contact information, and the member's preferred language. Providers' staff utilize this list for member outreach, as well as to update contact information and return the list to **Anthem** via SFTP. Finally, in October 2020, **Anthem** will be launching a new, digital member incentive platform for which members must register in order to participate. Members are able to update contact information in the portal, and updated information will be transmitted by the vendor to **Anthem**. • **Anthem**'s QM department initiated weekly *NV HEDIS Data Management Touch Base* meetings, during which the QM and Data Analytics teams review progress of the most current HEDIS metrics associated with **Anthem**'s performance improvement projects (PIPs). In this way, **Anthem** is able to evaluate, in real time, and conform to the SMART Aim outlined in the PIPs.

3. Prior Year Recommendation from the EQR Technical Report for PIPs:
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • **Anthem**'s evaluation of the member data supplied by vendor, LexisNexis Risk Solutions, did not increase member contact and the contract with LexisNexis Risk Solutions was terminated. Although it is too soon to evaluate the efficacy of **Anthem**'s collaboration with provider organizations regarding member outreach, there is anecdotal information suggesting that providers' patient rosters contain more current member phone numbers than the monthly state-generated 834 file. **Anthem** intends to monitor this project and compare gaps in care closure to the provider outreach efforts. • During the weekly *NV HEDIS Data Management Touch Base* meeting, the team reviews quantitative and qualitative study results and findings, which include: – Initial and repeat measurements of identified indicators; – Statistical significance of differences between baseline and repeat measurements; – Factors that influence the comparability of initial and repeat measurements; – Factors that may affect the validity of the findings; – Analysis of the study results; – Comparison with benchmark data; – Follow-up activities are discussed and planned. These meetings contribute to **Anthem** regularly analyzing data and staying on course with SMART Aim data collection methodology throughout the duration of PIPs.
c. Identify any barriers to implementing initiatives: • Data received from **Anthem**'s vendor, LexisNexis Risk Solutions, did not contribute to meaningful performance improvement regarding capturing member contact information. • The number of **Anthem**'s members electing "Do Not Call" status disallows telephonic and text outreach. Consequently, **Anthem**'s Quality Management department is collaborating with providers, who are not bound by "Do Not Call" requirements, to conduct member outreach and schedule healthcare appointments. During these provider-member interactions, updated member contact information is obtained. **Anthem** worked with provider organizations to establish SFTP sites to easily and confidentially exchange member-level data files; configuring the SFTPs took time to complete. • **Anthem** did not experience any barriers to implementing weekly *NV HEDIS Data Management Touch Base* meetings.
HSAG Assessment: HSAG has determined the MCO addressed the prior recommendations but recommends that **Anthem** proceed with its plan to allow members to update their contact information through the member portal, as this mechanism could support improvement in the ability to contact members.

4. Prior Year Recommendation from the EQR Technical Report for CAHPS:
HSAG recommended the following: • **Anthem** should continue to work with its CAHPS vendor to obtain a sufficient number of completed surveys that will enable reporting of all CAHPS measures. NCQA recommends targeting 411 completed surveys per survey administration. **Anthem** had measures that did not meet the minimum 100 responses for the adult Medicaid population, general child and CCC Medicaid populations, and Nevada Check Up general child and CCC populations. • For the adult Medicaid population, **Anthem** should focus on improving members' overall satisfaction with their healthcare, personal doctor, and specialists and on quality improvement initiatives to provide medical assistance with smoking and tobacco use cessation. In addition, **Anthem** should focus on improving members' access to and timeliness of care and on how well doctors communicate with members. The following measures were at least 5 percentage points lower than the 2018 NCQA adult Medicaid national averages: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*. • For the general child Medicaid population, **Anthem** should focus on improving *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Rating of All Health Care*, since the rates for these measures were at least 5 percentage points lower than the 2018 NCQA child Medicaid national averages. For the CCC Medicaid population, **Anthem** had four reportable measures: *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Health Plan*, and *FCC: Getting Needed Information*. **Anthem** should focus on improving *Rating of All Health Care*, *Rating of Personal Doctor*, and *FCC: Getting Needed Information*, since the rates were at least 5 percentage points lower than the 2018 NCQA CCC Medicaid national averages. • CAHPS measures like *Getting Needed Care* and *Getting Care Quickly* are access-related and lower rates indicate a perception that members cannot obtain needed care with providers or obtain services as quickly as desired. As part of its follow-up to HSAG recommendations in the 2019 technical report, **Anthem** detailed several key performance improvement strategies targeted at improving CAHPS response rates and the top-box rates for the CAHPS measures. HSAG encouraged **Anthem** to evaluate those interventions to determine if they are having the desired effect.
MCE's Response *(Note—The narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: **Anthem** NV continues to largely oversample the CAHPS survey by 80% for Adults and 145% for the Child Medicaid General Population for increasing response rates. Continue to send text and email messaging to entire population to remind members that their opinion counts and if they receive a survey to please fill it out. NA is assigned to CAHPS survey categories when the response rate is less than 100. In 2019 the Child survey decreased from 3 NA categories to 1 NA category and the Adult Survey decreased from 2 NA categories to 1 NA categories for lack of response rates. **Anthem** reviewed its 2019 CAHPS survey results and created CAHPS Regional workgroups specifically to address Child and Adult measures performing below the Medicaid national averages to share knowledge, develop strategies and initiates to address key underperforming measures and develop best practices. • Continued CAHPS Provider CME provider education

4. Prior Year Recommendation from the EQR Technical Report for CAHPS:
• Continued partnership with National Jewish Health (NJH) to provider smoking cessation program • Continued texting program for smoking cessation education and quit smoking referrals to NJH • Continue Voice of the Customer survey and analysis for first call resolutions • Created and implemented in 2019 new provider training material for the patient experience to educate providers on *How Well Doctors Communicate* • Continued text and email reminder campaigns timely with survey • Continued promotion of Live Health Online and 24-hour Nurse Help Line • Implemented Quarter 3 of 2020 a post provider text survey campaign
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • 2020 survey severely affected by COVID and was stopped prior to completion, **Anthem** will use caution when comparing results for any meaningful trending as response rates were severely affected. • Currently awaiting responses to newly implemented Post Provider Text survey to obtain feedback and provide any necessary interventions for actionable feedback obtained.
c. Identify any barriers to implementing initiatives: • 2020 COVID impact not being able to complete survey, interruption in access to care, delay in member messaging until after July 2020, and provider time limitations due to shifting priorities related to COVID are all barriers identified in 2020. Increased member engagement, promoting telehealth services, and provider education will continue to be a primary focus.
HSAG Assessment: HSAG has determined that the MCO has addressed the prior recommendations; however, due to continued low response rates, HSAG recommends that the MCO continue to develop initiatives to improve member response rates so that member satisfaction can be gauged more comprehensively.

5. Prior Year Recommendation from the EQR Technical Report for NAV:
HSAG recommended the following: • HSAG's provider capacity analysis identified numerous spelling variations and/or special characters for the MCOs' data values for provider type, specialty, and credentials. **Anthem** should assess available data values in their provider data systems and standardize available data value options.
MCE's Response *(Note—The narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: **Anthem** utilized our Facets system to pull the specialty code descriptions for the crosswalk data extract. The system is utilized by multiple **Anthem** markets, which contains set provider descriptions with several abbreviations. We are currently in discussions with our Enterprise reporting team to utilize a created Nevada specific crosswalk for Nevada reporting that would contain fully spelled out code descriptions.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): NA
c. Identify any barriers to implementing initiatives: NA

5. Prior Year Recommendation from the EQR Technical Report for NAV:
HSAG Assessment: HSAG has determined that the MCO has partially addressed the prior recommendations since it is currently in discussions with its corporate partner to create a Nevada-specific crosswalk. HSAG recommends that the MCO continue to prioritize Nevada-specific provider data submission criteria to ensure it is able to report provider data in accordance with DHCFP preferences.

6. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation:
HSAG recommended the following: • HSAG identified, from both the DHCFP and the MCOs, errors in the data files extracted for the study. HSAG recommended that the DHCFP and the MCOs consider implementing standard quality controls to ensure accurate data extracts from their respective systems. Through the development of standard data extraction procedures and quality control, the number of errors associated with extracted data could be reduced. HSAG suggested that minimum data quality checks include the following: – Extract data according to the data submission requirements document. – Verify that control totals are reasonable for each requested data file. – Determine if duplicate records are expected and/or reasonable. – Determine if the distribution and population of data field values are expected and/or reasonable. – Check all records to identify any data fields with missing values.
MCE's Response *(Note—The narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: An **Anthem** reporting team intake process is in place that can accommodate requests for data extracts. The data submission requirements will be outlined directly from the audit request to the Reporting team's intake form. The request will specify distinct records based on applicable key data elements. Upon receipt, the business analyst will conduct data and totals comparison analysis with current plan operations performance metrics and completed encounter submissions to the DHCFP. All variances will be analyzed and corrected, where applicable, and the data extract completed.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): NA
c. Identify any barriers to implementing initiatives: NA
HSAG Assessment: HSAG has determined that the MCO has addressed the prior recommendations.

Health Plan of Nevada

Table 5-2—Prior Year Recommendations and Responses for HPN

1. Prior Year Recommendation from the EQR Technical Report for Compliance:
HSAG recommended the following: • **HPN** should implement mechanisms to ensure that when applicable, notification for an extension is sent to the member and that the notification contains the required information. • **HPN** should ensure that for expedited resolution for appeals, it resolves expedited appeals and provides notice as expeditiously as the member's health condition requires, not to exceed 72 hours after **HPN** receives the expedited appeal request. • **HPN** should ensure that it provides notice of action to the member and the member's provider by the date of the action.
MCE's Response *(Note—The narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented and any activities still underway to address the finding that resulted in the recommendation)***: • Although there has been no need to extend an expedited request since the audit, the process listed in the corrective action plan was finalized. **HPN** has re-adopted the HCO 100 policy in its entirety. The Health Plan has also since updated the SOP MCD-01 (5-20-20) and SOP ADT-01 (5-4-20). The policy provisions continue to be communicated to staff so they understand the process if it is ever needed. Additionally, the extension letter template (LUPHM003) has been updated to reflect guidance in the HCO 100 policy and related SOPs. The extension letter includes the reasons for the delay, how the delay will benefit the member, the additional information required to make a decision, and instructions for filing a grievance. • Training is periodically provided to the team that includes the following direction when documentation is received in the PA Department: – Documents received in the PA Department should be reviewed to identify required action. – If the document is a request for an appeal, fax document to the Appeals Department fax #: 702-266-8813. – Clerical staff may hand-deliver if the document is too large to fax. – Clerical staff document appeal on log. – Document is housed in the department (in a secure file) for 6 months. This verbal reminder of the current process is understood by the team, and they have demonstrated the steps since the training. To date, all appeals received in the PA department have been handled according to the documented process. • To ensure that the notice of action to the member and the member's provider occur by the date of action we implemented the following. The processing documents, Member Disenrollment SOP and WRHCO 284 have been revised by their respective owners to indicate that in the event of a request for disenrollment, the member will be sent a written notice on the date of the decision. The documents have been approved by the Policy Committee and employees have been trained regarding the process. This change is complete as of August 9, 2019. In addition, we also implemented a process to log the disenrollment requests and track the various reasons for the request and the dates of the communication.

1. Prior Year Recommendation from the EQR Technical Report for Compliance:
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • There has been no need to extend an expedited request since the audit, but staff have been educated should it become necessary. • No late submissions have occurred.
c. Identify any barriers to implementing initiatives: No barriers were identified.
HSAG Assessment: HSAG has determined that the MCO has addressed the prior recommendations.

2. Prior Year Recommendation from the EQR Technical Report for Validation of Performance Measures–NCQA HEDIS Compliance Audit (Medicaid):
HSAG recommended the following: • **HPN** should investigate the reason for the decline in rate of more than 5 percentage points for the *Adults' Access to Preventive/Ambulatory Health Services—Ages 65 Years and Older* measure.
MCE's Response *(Note—The narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: After reviewing the data regarding the members in this measure, it was determined that these members were erroneously grafted into the AAP measure due untimely eligibility data from the state. Members were not eligible for Medicaid during the measurement year, but data was not received from the state until after the measurement year, which resulted in ineligible members in the AAP sample.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): NA
c. Identify any barriers to implementing initiatives: NA
HSAG Assessment: HSAG has determined that the MCO has addressed the prior recommendations.

3. Prior Year Recommendation from the EQR Technical Report for PIPs:
HSAG recommended the following: • **HPN** should continue to look for methods and/or processes to obtain updated correct member contact information as this continues to be an ongoing documented challenge. • **HPN** should ensure the approved SMART Aim measure data collection methodology is followed for the duration of the PIP.
MCE's Response *(Note—The narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: **HPN** has looked for additional sources of accurate member demographics including WEBIZ, Nevada HIE, and internal case management systems such as ICM.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): NA
c. Identify any barriers to implementing initiatives: NA

3. Prior Year Recommendation from the EQR Technical Report for PIPs:
HSAG Assessment: HSAG has determined that the MCO has addressed the prior recommendations; however, HSAG recommends that the MCO continue to address outdated member contact information or determine other interventions for improving performance that does not include member outreach through mail or telephone. For example, the MCO could focus its efforts on working directly with providers to improve performance.

4. Prior Year Recommendation from the EQR Technical Report for CAHPS:
HSAG recommended the following: • **HPN** 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. **HPN** had measures that did not meet the minimum number of responses for the general child and CCC Medicaid populations and Nevada Check Up general child and CCC populations. 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. • **HPN** should focus its quality improvement initiatives on enhancing members' experiences with *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies* for the adult Medicaid population, since these rates were at least 5 percentage points lower than the 2018 NCQA adult Medicaid national averages. • For the general child Medicaid population, **HPN** should focus on improving *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, and *Rating of Personal Doctor*, since the rates were lower than the 2018 NCQA child Medicaid national averages. For the CCC Medicaid population, **HPN** should focus on improving *How Well Doctors Communicate* and *FCC: Getting Needed Information*, since the rates for these measures were at least 5 percentage points lower than the 2018 NCQA CCC Medicaid national averages.
MCE's Response *(Note—The narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: Extensive education was conducted for provider groups to understand the value of communication between provider and patient. Education was conducted by the provider services department along with the Medicaid Clinical Practice Consultants. Providers were also educated on the importance of screening for tobacco use and given resources to the plans Health Education & Wellness smoking cessation program. Members and provider groups were also educated on the plans NOW clinic app, which is a telemedicine platform, along with urgent care hours and locations.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): In 2019 the plan did not have any measures that did not meet the minimum required responses.
c. Identify any barriers to implementing initiatives: NA
HSAG Assessment: HSAG has determined that the MCO has addressed the prior recommendations.

5. Prior Year Recommendation from the EQR Technical Report for NAV:
HSAG recommended the following: • HSAG's provider capacity analysis identified numerous spelling variations and/or special characters for the MCOs' data values for provider type, specialty, and credentials. **HPN** should assess available data values in their provider data systems and standardize available data value options.
MCE's Response *(Note—The narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: The health plan has implemented a new database called eVIPs. Elimination of numerous spelling variations and/or special characters have been implemented due to the eVIPs system having standard formats built in and accessed via drop-down selections for numerous fields, which include a provider's type. Additional training is being provided for all employees with the ability to enter data into eVIPs to ensure non-drop down fields are entered with a consistent format. In addition, to help eliminate possible spelling variation errors, it has been determined that one specific department (Network Operations) will enter a majority of all demographic information, with the exception of credentialing and specific contracting data. There will also be an audit process for all data entered.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): Through the current and ongoing iteration testing of the eVIPs system, it has been identified that numerous spelling variations are not present; however, true determination of such elimination cannot be fully evaluated until the transition is live and in production for a min. of 6 months to 1 year.
c. Identify any barriers to implementing initiatives: Possible barriers would only stem from the amount of employees with writable access to the eVIPs system and manually typing in non-drop-down fields in various formats. However, this to can be controlled and thus potentially eliminated through the auditing process performed by the Network Operations Department and as stated above, educational training for staff employees.
HSAG Assessment: HSAG has determined that the MCO has addressed the prior recommendations.

6. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation:
HSAG recommended the following: • HSAG identified, from both the DHCFP and the MCOs, errors in the data files extracted for the study. HSAG recommended that the DHCFP and the MCOs consider implementing standard quality controls to ensure accurate data extracts from their respective systems. Through the development of standard data extraction procedures and quality control, the number of errors associated with extracted data could be reduced. HSAG suggested that minimum data quality checks include the following: – Extract data according to the data submission requirements document. – Verify that control totals are reasonable for each requested data file. – Determine if duplicate records are expected and/or reasonable. – Determine if the distribution and population of data field values are expected and/or reasonable. – Check all records to identify any data fields with missing values.

6. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation:
MCE's Response *(Note—The narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: Extract data according to the data submission requirements: The Encounter Data Validation Study Report, dated March 2019, was conducted in SFY 2017–2018. Encounter data with dates of service July 1, 2016–June 30, 2017 were used for analysis in this study. In 2018, **Health Plan of Nevada** retired its previous encounter management software, in place at the time of the encounter validation study, and replaced it with Edifecs Encounter Manager software. In order to ensure data submission requirements were incorporated, the GAP analysis for this implementation utilized the 2018 encounter companion guides and was later updated to include requirements of the State's MMIS upgrade. • Verify that control totals are reasonable for each requested data file: The Edifecs encounter management system automatically cross-checks the adjudication system every night. Any discrepancies are logged and investigated by a team at the health plan. • Determine if duplicate records are expected and/or reasonable. The health plan claims system determines if a claim is a duplicate and will deny the claim if found to be duplicate. **Health Plan of Nevada** has researched and identified a number of instances where legitimate claims for multiples of the same type of service are paid by the health plan, for example, when multiple injections are given in the same day, and the encounter is rejected as a duplicate. **Health Plan of Nevada** currently sends all finalized claims, including those that will be denied as duplicates in this scenario. **Health Plan of Nevada** is currently working with the State and DXC to find a solution for this issue. • Determine if the distribution and population of data field values are expected and/or reasonable: All outbound encounters are automatically checked and edited against internal business rules, the implementation guide, and companion guides to ensure proper submission. • Conduct for all records a check to identify any data fields with missing values: As with the question above, all outbound encounters are automatically checked and edited against internal business rules, the implementation guide, and companion guides to ensure proper submission.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): Reporting from the Edifecs encounter management system indicates that **Health Plan of Nevada** is meeting the contractually required standard of 97% acceptance rate.
c. Identify any barriers to implementing initiatives: Although the implementation of the Edifecs encounter management system has provided improved encounter generation, response, and reporting, more consistent communication and feedback from the DHCFP and DXC would allow the health plan to reconcile discrepancies in reporting and ensure that all processes are meeting expectations.
HSAG Assessment: HSAG has determined that the MCO has addressed the prior recommendations.

SilverSummit Healthplan, Inc.

Table 5-3—Prior Year Recommendations and Responses for SilverSummit

1. Prior Year Recommendation from the EQR Technical Report for Compliance Review:
HSAG recommended the following: • **SilverSummit** should inform members of the procedures for using nonemergency transportation and provide an explanation of how transportation is provided. • **SilverSummit** should develop mechanisms to ensure that the member's case file contains documentation indicating the PCP is: – Informed when a member is identified as meeting care management criteria. – Informed when a member is enrolled in care management services. – Involved in a member's care plan development. • **SilverSummit** should ensure that all assessments completed for members enrolled in care management are comprehensive and assess the member's cultural and linguistic needs and that person-centered treatment plans are developed within the time frame required by the DHCFP contract. • **SilverSummit** should ensure that all standard appeals are resolved and that notice is given within 30 days of the date the MCO received the appeal. • **SilverSummit** should ensure that appeal acknowledgement letters are sent to the member as required. • **SilverSummit** ensure that a decision is made within the required time frame for all service authorization requests.
MCE's Response *(Note—The narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • SSHP reviewed its online *Member Handbook* and added additional language informing members of the procedures for using nonemergency transportation, as well as an explanation of how the transportation is provided. • To ensure that member case files contained appropriate PCP documentation, SSHP initiated a process to retrain and reeducate all care managers on the requirements of notifying the member's PCP when the member has been identified as meeting care management criteria and has been enrolled in care management. Team meetings were held in March and again in April of 2019 to explain the process of informing the PCPs by mailing an enrollment welcome letter that included all pertinent information regarding the members. Training also included the requirement to complete and mail the person-centered care plan to the PCPs and explained that the intent of the enrollment letter, along with the care plan, is to allow the members' PCPs to be involved with SSHP in the members' care management. To ensure this process was being followed as outlined, an audit tool was developed and put into place for quarterly care management file audits of each care manager. All audited files had to meet the active status criteria, with 3-5 files pulled per each care manager. Results of the quarterly audits were then reviewed individually with each care manager by management. Opportunities for improvement were identified during these reviews. These process improvements remain in place and ongoing. • To ensure comprehensive member assessments, SSHP initiated a process to retrain and reeducate all care managers on the requirements of including an assessment of the member's cultural and linguistic

1. Prior Year Recommendation from the EQR Technical Report for Compliance Review:
needs as a component of the comprehensive health risk assessment and that a person-centered care plan is developed within the time frame required by the State contract. Team meetings were held in March and again in April of 2019 to explain the process of including these components, along with a demonstration of where the section for the cultural and linguistic assessment is found on the actual assessment template. These meetings also included retraining on the time sensitive development of the care plan. To ensure this process was being followed as outlined, an audit tool was developed and put into place for quarterly care management file audits of each care manager. All files audited had to meet the active status criteria, with 3-5 files pulled per each care manager. Results of the quarterly audits were then reviewed individually with each care manager by management. Opportunities for improvements were identified during these reviews. These process improvements remain in place and ongoing. • The G&A department implemented a process to review all received appeals on a weekly basis to ensure timely resolution and timely notification; this review is also completed with vendor appeals. Monthly reports are provided to both the State (regarding resolution TAT) and Compliance (for both acknowledgment and resolution TAT). • The G&A department endeavors to send all acknowledgment letters within 3 business days of receipt to always remain complaint with timeliness requirements. Resolution notices are sent within 24 hours of resolution, but not to exceed 30 days TAT. • To ensure that Medical Management remains compliant with service authorization timeliness requirements, the following initiatives were implemented: 1. Management reviews the standard turnaround time report that is provided by corporate and updates it daily. This report provides detail at the member level for all authorizations that have been entered into our TruCare documentation system and indicates whether they met NCQA timeliness requirements (72 hours for urgent requests, 14 days for standard requests, and 24 hours for concurrent requests.) This report also provides detail at the employee level and the management team can utilize this report to educate identified staff. Management reviews this report no less than weekly, and up to daily as applicable. All turnaround times are reported to the State monthly for all service requests. 2. Management monitors multiple systems to ensure that work is being not only distributed daily, but the work is being completed on time. Management monitors work queues in our documentation system each day to ensure that any work approaching turnaround time deadlines are completed on that business day. 3. Management also monitors an additional backlog report provided by corporate on a daily basis. This report identifies authorizations in the system either that have identified mistakes within them causing them to continue to "age," or those that were not closed appropriately, also causing them to "age." These reports are very beneficial to ensure that turnaround times continue to be met. This report is monitored daily by the UM Management Staff.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • There was no noted change in performance because of members being informed of the procedures for using nonemergency transportation or for how transportation is provided. • Since implementation of the initiatives to ensure that member case files contained appropriate PCP documentation, our record audits have shown a significant favorable increase in meeting the targeted requirements. Of the files reviewed during the HSAG survey, none had evidence that the enrollment letter and/or a care plan letter had been sent to the PCP. Since that time, a representative sampling of 25 care management files across all levels of care management were reviewed for follow-up for this

1. Prior Year Recommendation from the EQR Technical Report for Compliance Review:
specific performance improvement; these files were pulled from July of 2019 to present. The file review showed that 23 of 25 files had evidence of a welcome letter to the member (92%), 17 of the 25 files had evidence of the enrollment letter to the PCP (68%), and 15 of the 25 files had evidence of the care plan letter to the PCP (60%). • Following the implementation of measures to ensure comprehensive member assessments, our file audits have shown a markedly favorable increase in meeting the requirements listed above. During the HSAG survey, 1 file of the 10 files reviewed did not include the assessment of the member's cultural and linguistic needs and 2 of the 10 files did not include the care plan within the 90-day time frame. Since that time, a representative sampling of 25 care management files across all levels of care management were reviewed for follow-up for this specific performance improvement; the files were pulled from July 2019 to present. The results showed that 25 of the 25 files included the assessment of the members' cultural and linguistic needs (100%), and 25 of the 25 files included the completed person-centered care plan within the time frame as required by the State contract (100%). • There were no noted performance improvements related to the appeal resolution or acknowledgement processes. • Because of the implementation and continuation of initiatives to address service authorization timeliness, the turnaround time has seen consistent and continuing improvement from early 2018. Turnaround time compliance in 2020 has been January 97.30%, February 97.60%, March 98.19%, April 97.95%, May 97.30%, June 95.78%, July 96.12%.
c. Identify any barriers to implementing initiatives: • For members who had received a hard copy of the *Member Handbook* with their new member welcome packet prior to SSHP updating its online *Member Handbook*, SSHP needed to mail a postcard informing those members of the information that was added to our online *Member Handbook*. • Barriers to ensuring that member case files contained appropriate PCP documentation were noted at two different levels. The first identified barrier was that not all care managers are maintaining compliance with the requirements and will again need to be retrained and reeducated, with one-on-one management meetings to review findings and to reinforce the need to be consistent with this State contractual agreement. The complex care managers, however, were very consistent in meeting the requirements of this standard. The second barrier is lack of PCP participation in the person-centered care plan. The care plan letter along with the actual care plan is mailed to the PCPs; however, the PCPs very rarely, if ever, are open to engage with the members' MCO-based care management team. Ongoing efforts will continue, regardless. • No barriers to implementing measures to ensure comprehensive assessments and timely care plan development were noted. • There were no barriers noted related to the appeal resolution or acknowledgement processes. • The only barrier identified related to service authorization timeliness has been ensuring that timeliness is met when requests are made late in the business week and which could fail timeliness requirements over the weekend. Medical Management staff historically worked Monday through Friday. SSHP implemented prior authorization team coverage on Saturdays, which has significantly affected our metrics, particularly for urgent authorization requests. Timeliness for these requests was in the low 90% range prior to this implementation; timeliness is now in the mid to high 90% subsequent to Saturday coverage. Medical Management is assessing the addition of another concurrent team member for Saturdays as well.
HSAG Assessment: HSAG has determined that the MCO has addressed the prior recommendations.

2. Prior Year Recommendation from the EQR Technical Report for PIPs:
HSAG recommended the following: • **SilverSummit** should test interventions through a series of thoughtful and incremental PDSA cycles. The MCO's PIP team should ensure it communicates the reasons for making changes to intervention strategies and how those changes will lead to improvement. • When planning a test of change, **SilverSummit** should think proactively (i.e., scale/ramp up to build confidence in the change and eventually implement policy to sustain changes). • When developing the intervention testing methodology, **SilverSummit** should determine the best method for identifying the intended effect of an intervention prior to testing. The intended effect of the intervention should be known up front to help determine which data need to be collected. • **SilverSummit** should ensure it is making a prediction in each plan step of the PDSA cycle and discussing the basis for the prediction. • **SilverSummit** should update the key driver diagram and failure modes and effects analysis (FMEA) as it moves through the intervention testing process.
MCE's Response *(Note—The narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • In 2019, the Quality Department hired a new Quality Improvement Coordinator II, who is a nurse, to be responsible for the PIPs. This nurse had extensive experience in PDSA cycles. In taking over the PIPs, she was instrumental in ensuring that accurate communication was documented related to the reasons for making changes to any intervention strategies and how these changes would lead to improvement. For the 2019–2020 PIPs, we have not made any changes to our intervention strategies to date and therefore have not conducted any planning in testing this initiative. For 2019–2020, a subgroup of staff from the PIT Committee was established to collaborate on deciding on a prediction for each step of the PDSA cycle and the basis of the prediction, interventions, and testing methodology for our two State PIPs. They also ensure we clearly identified what data needs to be collected for the interventions and testing of the interventions. In addition, the QI Coordinator developed a workflow for each module of the PIPs to ensure that all steps are completed within each module, which requires that the key driver diagram and FMEA be updated as we move through the intervention testing process.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Not applicable, as we have just submitted Module 3 (which includes testing of interventions) and began testing our first intervention for both PIPs on 08/01/2020.
c. Identify any barriers to implementing initiatives: • The Quality Improvement Coordinator II that we hired has transitioned to another position within SSHP and, secondary to COVID, we will be unable to hire a replacement until possibly January 2021. During this time, the VP of Quality and HEDIS Manager, who will now manage the PIPs, are new to the process, which may be a barrier until they are current with the process. However, the former QI Coordinator II is available to assist if needed.

2. Prior Year Recommendation from the EQR Technical Report for PIPs:
HSAG Assessment: HSAG has determined that the MCO has addressed the prior recommendations; however, HSAG recommends that staff working on PIPs take educational courses or review published materials to better understand the PDSA cycles of performance improvement.

3. Prior Year Recommendation from the EQR Technical Report for CAHPS:
HSAG recommended the following: • **SilverSummit** should continue working 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. **SilverSummit** had measures that did not meet the minimum number of responses for the adult Medicaid population, general child and CCC Medicaid populations, and Nevada Check Up general child and CCC populations. 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 Medicaid and general child Medicaid populations, **SilverSummit** should focus on improving members' overall satisfaction with their healthcare, personal doctor, and health plan, since the rates for these measures were at least 5 percentage points lower than the 2018 NCQA adult and child Medicaid national averages.
MCE's Response *(Note—The narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: To increase response rate for surveys, SSHP worked with our CAHPS vendor and included activities such as a raspberry envelope for mailing the survey to capture the member's attention, increased the number of oversampling capture more surveys, conducted extra vendor outreach to members to remind them to mail and/or re-mail the survey. SSHP initiated a Member Satisfaction Committee that included applicable departments and developed a master action plan based on CAHPS results for identified areas of opportunity. From the master action plan, individual department action plans were developed for each area of opportunity. The Member Satisfaction Committee meets monthly with each department individually to discuss updates and progress on action plans. The following action plans were initiated to increase member satisfaction: • For satisfaction with personal doctor: develop patient education materials around common medications prescribed that providers could give to their members explaining pros and cons of medicine; provide providers with patient education materials that reinforce topics the provider educated member about and that reinforced that the provider heard member concerns; develop a "question checklist" on specific diseases to be used by members when speaking to their providers; develop a guide for providers on when a patient should be referred and referral requirements, if applicable; encourage PCPs to implement open access scheduling for urgent and f/u care. • For satisfaction with the health plan: evaluate precertification, authorization, and appeals process for high turnover rates; distribute listings of urgent care and after hour clinics to members; promote Nurse on Call lines, PCPs, and pediatric and OB/GYN practices that offer evening and weekend hours; review grievance information for areas of opportunity; provide member educational materials to help during their visits with their providers; ensure any messaging related to denial of treatment is

3. Prior Year Recommendation from the EQR Technical Report for CAHPS:
understood and appropriate for a lay person; implement a short IVR survey to members within days of their calling the customer service to explore/assess their recent experiences; and develop a new member concierge program.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Adult Medicaid survey: Rating of health plan improved by 11.1% for a score of 75.4%, 27th percentile rank for 2019 QC Benchmark (benchmark summary rate 77.6%); rating of healthcare improved by 3.3% for score of 68.6%, 6th percentile for 2019 QC Benchmark (benchmark summary rate 75.4%); and rating of personal doctor improved 5.1% for score of 54.3%, but remained below 5th percentile for 2019 QC Benchmark (benchmark summary rate 67.5%). • Medicaid Child (CHIP) with CCC: Rating of health plan improved by 13.3% for a score of 82.4%, 11th percentile of 2019 QC benchmarks (benchmark summary rate 86.5%), rating of healthcare improved by 16.8% for a score of 88.2%, 49th percentile 2019 QC benchmark (benchmark summary rating 87.5%); rating of personal doctor improved by 6.6% with score of 75.0%, 25th percentile of 2019 QC benchmark (benchmark summary rating 77.3%). • Medicaid Child with CCC: Rating of health plan improved by 13.2% for a score of 87.2%, 52% percentile for 2019 QC benchmark (benchmark summary rate is 86.5%); rating of healthcare improved by 19.4% for a score of 89.0%, 60th percentile of 2019 QC benchmark (benchmark summary rating is 87.5%); rating of personal doctor improved by 10.9% for score of 69.7% but still remained below the 5th percentile for the 2019 QC benchmark (benchmark summary rating is 77.3%).
c. Identify any barriers to implementing initiatives: • COVID-19 affected our return rate and affected our vendor's ability to conduct outreach to members, as Centene made a declaration to all health plans to avoid member abrasion by avoiding "excessive" telephone outreach to members, including requesting survey completion, as this was/is not a priority during a pandemic. SSHP concentrated our efforts more on assisting members with community resources, access to care, education about the pandemic, and staying safe.
HSAG Assessment: HSAG has determined that the MCO has addressed the prior recommendations.

4. Prior Year Recommendation from the EQR Technical Report for NAV:
HSAG recommended the following: • HSAG's provider capacity analysis identified numerous spelling variations and/or special characters for the MCO's data values for provider type, specialty, and credentials. **SilverSummit** should assess available data values in their provider data systems and standardize available data value options.
MCE's Response *(Note—The narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • The health plan implemented additional quality checks to identify and remove duplicate records created by similar addresses and similar specialties. The health plan also created and hired a new position to monitor provider data loading and reporting. The health plan also utilizes LexisNexis to identify data discrepancies and performs outreach to providers to confirm current location and roster information.

4. Prior Year Recommendation from the EQR Technical Report for NAV:
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The health plan has been able to reduce the number of incorrect/duplicate records being loaded by implementing additional quality assurance measures on updated provider roster loads; specific metrics have not been tracked for reporting purposes.
c. Identify any barriers to implementing initiatives: • The data constraints in the systems utilized do not always allow for the desired level of scrutiny in identifying duplicate and/or erroneous information. Because the data systems are maintained by our corporate IT team and shared with multiple inter-company health plans, requests for tighter constraints require multiple levels of review to ensure consistency and acceptance across multiple platforms and plans.
HSAG Assessment: HSAG has determined that the MCO has addressed the prior recommendations; however, HSAG recommends that the MCO continue to prioritize Nevada-specific provider data submission criteria to ensure it is able to report provider data in accordance with DHCFP preferences and maintain the level of scrutiny desired to ensure accurate information.

5. Prior Year Recommendation from the EQR Technical Report for NAV:
HSAG recommended the following: • HSAG identified, from both the DHCFP and the MCOs, errors in the data files extracted for the study. HSAG recommended that the DHCFP and the MCOs consider implementing standard quality controls to ensure accurate data extracts from their respective systems. Through the development of standard data extraction procedures and quality control, the number of errors associated with extracted data could be reduced. HSAG suggested that minimum data quality checks include the following: – Extract data according to the data submission requirements document. – Verify that control totals are reasonable for each requested data file. – Determine if duplicate records are expected and/or reasonable. – Determine if the distribution and population of data field values are expected and/or reasonable. – Check all records to identify any data fields with missing values.
MCE's Response *(Note—The narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • SSHP utilized the data submission requirements document to categorize provider data for submission to HSAG. The health plan is creating additional quality checks based on the crosswalk provided to ensure alignment and consistency with the DHCFP, to verify and compare totals for reasonableness, to validate reasons for multiple records (such as multiple locations and/or multiple specialties), and to identify and validate any missing or null values.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • As a result of refining the queries and implementing additional quality checks, the health plan has noted a reduction in the amount of manual corrections needed when pulling network adequacy.

5. Prior Year Recommendation from the EQR Technical Report for NAV:
c. Identify any barriers to implementing initiatives: • As noted in our response to Recommendation 4, corporate-maintained systems create barriers to implementing changes without first obtaining additional review and approvals across other internal entities.
HSAG Assessment: HSAG has determined that the MCO has addressed the prior recommendations; however, HSAG recommends that the MCO continue to prioritize Nevada-specific data submission criteria to ensure it is able to report provider data in accordance with DHCFP preferences and maintain the level of scrutiny desired to ensure accurate information.

6. Follow-Up on Prior EQR Recommendations for PAHP

From the findings of the PAHP performance for the SFY 2018–2019 EQR activities, HSAG made recommendations for improving the quality of healthcare services furnished to members enrolled in the Nevada Managed Care Program. The recommendations provided to the PAHP for the EQR activities in the *State Fiscal Year 2018–2019 External Quality Review Technical Report* are summarized in Table 6-1. The PAHP's summary of the activities that were implemented to support performance improvement are also provided in Table 6-1.

LIBERTY Dental Plan of Nevada, Inc.

Table 6-1—Prior Year Recommendations and Responses for LIBERTY

1. Prior Year Recommendation from the EQR Technical Report for Compliance Review:
HSAG recommended the following: • It was noted during the file reviews that the dental record request letter to the provider included instructions that providers could email the dental records containing protected health information (PHI) to the PAHP. It was unclear if encrypted and secure email would be used and **LIBERTY** did not instruct the provider to use secure methods to transmit PHI. During **LIBERTY**'s Readiness Review completed in 2017, this issue was also noted. **LIBERTY** submitted a CAP that included revisions to the dental request letter template instructing the provider that email encryption must be used if the dental provider chose to send dental records via email; however, the CAP was not implemented. While **LIBERTY**'s email system may be secure and its emails encrypted, these conditions may not be true for a dental provider. An increased risk for a breach of PHI when transmitting dental records via unsecured email remains a serious concern. HSAG recommended that **LIBERTY** staff members have further discussion with DHCFP staff members to determine next steps to address this matter.
MCE's Response *(Note— the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: On 10/28/2019, **LIBERTY** met with DHCFP to discuss this matter and submitted a corrective action plan to DHCFP on 11/1/2019. On 12/5/2019, DHCFP informed **LIBERTY** that the appropriate actions had been taken and that DHCFP considered the issue resolved. A list of corrective actions **LIBERTY** has taken to address the issue include, but are not limited to: • Implementation of the approved Medical Records Request Form • Completion of an Impact Assessment • Updates to **LIBERTY**'s *Electronic Protected Health Information Transmission P&P* • Provider Education
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): To date, no breaches resulting from this error have been identified or reported.

1. Prior Year Recommendation from the EQR Technical Report for Compliance Review:
c. Identify any barriers to implementing initiatives: NA
HSAG Assessment: HSAG has determined that the PAHP has addressed the prior year recommendations.

2. Prior Year Recommendation from the EQR Technical Report for PIPs:
HSAG recommended the following: • As **LIBERTY** progresses to testing interventions through a series of thoughtful and incremental PDSA cycles, the PAHP's PIP team should ensure it communicates the reasons for making changes to intervention strategies and how those changes will lead to improvement. • When planning a test of change, **LIBERTY** should think proactively (i.e., scaling/ramping up to build confidence in the change and eventually implementing policy to sustain changes). • When developing the intervention testing methodology, **LIBERTY** should determine the best method for identifying the intended effect of an intervention prior to testing. The intended effect of the intervention should be known up front to help determine which data need to be collected. • As **LIBERTY** tests new interventions, it should ensure it is making a prediction in each *Plan* step of the PDSA cycle and discusses the basis for the prediction. • The key driver diagram and FMEA for both PIPs should be updated as **LIBERTY** moves through the intervention testing process.
MCE's Response *(Note— the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: As a result of HSAG's prior year recommendations, **LIBERTY** was able to complete its intervention testing on the two previously selected measures (1. *Improve Caries Risk Assessment Completion Rate* and 2. *Improve Annual Dental Visits*). Each intervention's goals were designed on improving the rate for each study measure. The goals and results were monitored on a quarterly basis and reported to HSAG.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): Measure 1 (*Improve Caries Risk Assessment Completion Rate*) showed the following results: **LIBERTY** established a goal of increasing the percentage of completed CRAs for children one to six years of age seen at Kid Dental LLC and Smile Reef Pediatric Dentistry from 0.22 percent to 12.0 percent. For this PIP, **LIBERTY** exceeded the baseline percentage of 0.22 percent starting in March of 2018 and exceeded the goal of 12.0 percent in May 2018. The improvement continued for the duration of the PIP with the highest rate achieved of 85.4 percent. Measure 2 (*Improve Annual Dental Visits*) showed the following results: **LIBERTY** established a goal of increasing the percentage of children one year of age and younger, assigned to Palm Valley Dental, who completed an annual dental visit from 0.4 percent to 10.4 percent. **LIBERTY** executed the PIP according to the approved methodology; however, the SMART Aim goal of 10.4 percent was not achieved. Although the goal was not achieved, **LIBERTY** demonstrated improvement over the three-month baseline period for 17 of the 21 reporting months.

2. Prior Year Recommendation from the EQR Technical Report for PIPs:
c. Identify any barriers to implementing initiatives: **LIBERTY** identified the following barriers that were present throughout the lifecycles of both measures: 1. Having a stable and consistent targeted population is essential for future intervention testing. 2. Deficiencies in a targeted population will produce unsatisfactory results for intervention testing. 3. Member contact and outreach barriers have a significant negative impact on outcomes if not addressed.
HSAG Assessment: HSAG has determined that the PAHP addressed the prior recommendations.

3. Prior Year Recommendation from the EQR Technical Report for Validation of Performance Measures–NCQA HEDIS Compliance Audit (Medicaid and Nevada Check Up):
HSAG recommended the following: **Medicaid** • **LIBERTY** fell below the MPS by approximately 7 percentage points for the *Annual Dental Visit—Total* measure rate in HEDIS 2019 for the Medicaid population. The *Percentage of Eligibles Who Received Preventive Dental Services* measure is a first-year measure and should be monitored for performance. **Nevada Check Up** • **LIBERTY** fell below the MPS by approximately 5 percentage points for the *Annual Dental Visit—Total* measure rate in HEDIS 2019 for the Nevada Check Up population. The *Percentage of Eligibles Who Received Preventive Dental Services* measure is a first-year measure and should be monitored for performance.
MCE's Response *(Note— the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: **LIBERTY** has put activities in place directed toward improving performance measures. The results are being monitored on a quarterly/annual basis. • Recipient Engagement – Texting campaigns – Member resources – Website enhancements • Provider Engagement – Bonus Program – Value Based Program – Online portal enhancements • Community Outreach – Promote benefit utilization and education through food pantries, health and wellness fairs, oral health presentations, resource tables, and social media – Partnerships with Community Based Organizations – Community Smiles Program

3. Prior Year Recommendation from the EQR Technical Report for Validation of Performance Measures–NCQA HEDIS Compliance Audit (Medicaid and Nevada Check Up):
• Data Collection − Performance is measured through monitoring and analysis of CMS 416 and HEDIS® reports − Automated reports are generated on an ongoing basis − Reviewed on a quarterly basis year over year
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): Based on the latest performance measure scores, we are seeing improvement so far from all activities implemented and continue to do so. Demonstrated 2.12 percent increase for the *Annual Dental Visits* for the Medicaid population. Demonstrated 3.09 percent increase for the *Annual Dental Visits* for the Nevada Check Up population.
c. Identify any barriers to implementing initiatives: An identified potential barrier to implementing initiatives is the impact of the COVID-19 pandemic.
HSAG Assessment: HSAG determined that the PAHP has addressed the prior recommendations.

7. MCO Comparative Information

In addition to performing a comprehensive assessment of the performance of each MCO, HSAG compared the findings and conclusions established for each MCO to assess the Nevada Managed Care Program. The overall findings of the MCOs were used to identify the overall strengths and weaknesses of the Nevada Managed Care Program and to identify areas in which the DHCFP could leverage or modify the State's Quality Strategy to promote improvement.

MCO EQR Activity Results

This section provides the summarized results for the mandatory EQR activities across the MCOs.

Validation of Performance Improvement Projects (PIPs)

For the SFY 2019–2020 validation, the MCOs completed Module 1 and Module 2 for the new DHCFP-mandated PIP topics, and **SilverSummit** also submitted Module 4 and Module 5 for PIPs initiated in SFY 2018–2019 for final validation. Table 7-1 below provides a comparison of the validation scores, by MCO.

Table 7-1—Comparison of Validation by MCO

PIP Title	Anthem PIP Module Results	HPN PIP Module Results	SilverSummit PIP Module Results
Comprehensive Diabetes Care HbA1c Poor Control > 9.0%	Module #1: All evaluation elements *Achieved* Module #2: All evaluation elements *Achieved*	Module #1: All evaluation elements *Achieved* Module #2: All evaluation elements *Achieved*	Module #1: All evaluation elements *Achieved* Module #2: All evaluation elements *Achieved*
Prenatal and Postpartum Care (PCC) Timeliness of Prenatal Care	Module #1: All evaluation elements *Achieved* Module #2: All evaluation elements *Achieved*	Module #1: All evaluation elements *Achieved* Module #2: All evaluation elements *Achieved*	Module #1: All evaluation elements *Achieved* Module #2: All evaluation elements *Achieved*
Follow-Up After Emergency Department Visit for Mental Health Diagnosis	Not Applicable	Not Applicable	Module 4 #1: 3 of 5 evaluation elements *Achieved* *Module 4 #2:* 4 of 5 evaluation elements *Achieved*

PIP Title	Anthem PIP Module Results	HPN PIP Module Results	SilverSummit PIP Module Results
			Module 4 #3: 4 of 5 evaluation elements *Achieved* Module #5: 1 of 3 evaluation elements *Achieved* The SMART Aim goal was not achieved, resulting in *Low Confidence rating*
Increase Well-Child Visits for Children 3–6 Years of Age	Not Applicable	Not Applicable	Module 4: 4 of 5 evaluation elements *Achieved* Module 5: 1 of 3 evaluation elements *Achieved* The SMART Aim goal was not achieved, resulting in *Low Confidence rating*

Performance Measure Validation (PMV)

Medicaid Findings

Table 7-2 shows, by MCO, the HEDIS 2020 Medicaid performance measure rate results and the MPS for **Anthem**, **HPN**, and **SilverSummit** and the Medicaid aggregate, which represents the average of all three MCOs' measure rates weighted by the eligible population. Measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures in the Utilization domain are designed to capture the frequency of services the MCO provides. Except for the *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total*, higher or lower rates in this domain do not necessarily indicate better or worse performance. Therefore, these rates are provided for informational purposes only.

Table 7-2—HEDIS 2020 Results for Medicaid

HEDIS Measure	Anthem	HPN	SilverSummit	MPS	Medicaid Aggregate†
Access to Care					
Adults' Access to Preventive/Ambulatory Health Services (AAP)♦					
Ages 20–44 Years	73.11%	**75.70%**	66.35%	75.55%	73.74%

HEDIS Measure	Anthem	HPN	SilverSummit	MPS	Medicaid Aggregate†
Ages 45–64 Years	79.43%	81.68%	75.54%	81.82%	80.28%
Ages 65 Years and Older	NA	NA	NA	67.19%	75.00%
Total	75.11%	**77.81%**	69.38%	77.67%	75.95%
Children and Adolescents' Access to Primary Care Practitioners (CAP)					
Ages 12–24 Months	94.71%	94.52%	92.90%	94.93%	94.40%
Ages 25 Months–6 Years	83.93%	84.90%	76.10%	85.66%	83.89%
Ages 7–11 Years	86.52%	86.72%	78.26%	87.69%	86.29%
Ages 12–19 Years	85.08%	85.68%	75.06%	85.77%	85.03%
Children's Preventive Care					
Adolescent Well-Care Visits (AWC)					
Adolescent Well-Care Visits	**56.45%**	48.91%	40.63%	53.52%	50.92%
Childhood Immunization Status (CIS)					
Combination 2	71.29%	72.02%	66.42%	73.55%	71.35%
Combination 3	68.13%	68.37%	60.34%	68.86%	67.71%
Combination 4	67.64%	67.64%	60.10%	68.45%	67.11%
Combination 5	58.64%	**60.10%**	49.39%	59.46%	58.79%
Combination 6	**38.93%**	**39.42%**	33.09%	38.58%	38.79%
Combination 7	58.15%	**59.61%**	49.15%	59.15%	58.32%
Combination 8	**38.93%**	**39.42%**	33.09%	38.48%	38.79%
Combination 9	33.82%	**35.52%**	28.95%	34.42%	34.42%
Combination 10	33.82%	**35.52%**	28.95%	34.32%	34.42%
Immunizations for Adolescents (IMA)					
Combination 1 (Meningococcal, Tdap)	**89.29%**	**90.51%**	82.00%	84.85%	89.57%
Combination 2 (Meningococcal, Tdap, HPV)	41.12%	**48.42%**	31.14%	47.65%	44.80%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)					
BMI Percentile—Total	**82.73%**	**83.45%**	78.59%	82.70%	82.88%
Counseling for Nutrition—Total	**74.21%**	71.05%	65.69%	72.63%	71.99%
Counseling for Physical Activity—Total	67.88%	69.34%	59.12%	69.60%	68.16%

HEDIS Measure	Anthem	HPN	SilverSummit	MPS	Medicaid Aggregate†
Well-Child Visits in the First 15 Months of Life (W15)					
Six or More Well-Child Visits	**68.06%**	67.15%	61.31%	67.99%	66.89%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)					
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.17%	71.53%	59.12%	74.37%	71.42%
Women's Health and Maternity Care					
Breast Cancer Screening (BCS)					
Breast Cancer Screening	51.64%	55.08%	47.54%	58.90%	53.77%
Prenatal and Postpartum Care (PPC)					
Timeliness of Prenatal Care	80.78%	90.02%	75.91%	MNA	84.73%
Postpartum Care	59.37%	81.51%	54.74%	MNA	69.62%
Care for Chronic Conditions					
Comprehensive Diabetes Care (CDC)					
Hemoglobin A1c (HbA1c) Testing	79.08%	**84.91%**	74.70%	81.98%	81.92%
*HbA1c Poor Control (>9.0%)**	51.58%	41.36%	53.04%	39.28%	46.01%
HbA1c Control (<8.0%)	40.15%	49.64%	37.71%	53.14%	45.22%
Eye Exam (Retinal) Performed	53.04%	**62.04%**	52.55%	61.47%	58.03%
Medical Attention for Nephropathy	89.05%	**92.46%**	85.89%	89.55%	90.65%
Blood Pressure Control (<140/90 mm Hg)	37.47%	63.75%	47.93%	65.72%	53.16%
Controlling High Blood Pressure (CBP)					
Controlling High Blood Pressure	52.55%	**62.77%**	40.15%	55.58%	57.14%
Medication Management for People With Asthma (MMA)					
Medication Compliance 50%—Total	**63.95%**	58.91%	**67.79%**	61.04%	61.25%
Medication Compliance 75%—Total	**42.39%**	36.24%	**44.97%**	40.84%	39.00%
Behavioral Health					
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)					
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	45.71%	44.00%	44.05%	46.08%	44.80%

HEDIS Measure	Anthem	HPN	SilverSummit	MPS	Medicaid Aggregate†
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)					
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	**83.30%**	78.86%	76.77%	81.43%	80.38%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)					
7-Day Follow-Up—Total	10.62%	14.52%	14.20%	18.21%	13.00%
30-Day Follow-Up—Total	15.55%	18.92%	19.05%	21.60%	17.67%
Follow-Up After Emergency Department Visit for Mental Illness (FUM)					
7-Day Follow-Up—Total	30.27%	**56.53%**	22.97%	47.67%	42.49%
30-Day Follow-Up—Total	41.84%	**63.92%**	32.43%	55.92%	51.59%
Follow-Up After Hospitalization for Mental Illness (FUH)					
7-Day Follow-Up—Total	34.61%	36.88%	28.10%	39.45%	34.40%
30-Day Follow-Up—Total	50.75%	53.80%	44.59%	54.86%	50.83%
Follow-Up Care for Children Prescribed ADHD Medication (ADD)					
Initiation Phase	41.55%	49.90%	49.40%	50.09%	46.63%
Continuation and Maintenance Phase	59.38%	**68.29%**	NA	60.00%	62.82%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)					
Initiation of AOD—Total	**48.53%**	42.24%	**45.43%**	45.24%	45.24%
Engagement of AOD—Total	15.87%	10.88%	12.84%	18.94%	13.19%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)					
Blood Glucose and Cholesterol Testing—Total	**31.71%**	**35.71%**	21.24%	25.33%	31.92%
Utilization					
Ambulatory Care—Total (per 1,000 Member Months) (AMB)					
*ED Visits—Total**	59.89	58.85	66.17	MNA	60.06
Outpatient Visits—Total	291.03	318.88	286.69	MNA	304.51
Mental Health Utilization—Total (MPT)					
Inpatient—Total	1.46%	0.70%	1.43%	MNA	1.08%

HEDIS Measure	Anthem	HPN	SilverSummit	MPS	Medicaid Aggregate†
Intensive Outpatient or Partial Hospitalization—Total	0.77%	0.39%	0.18%	MNA	0.51%
Outpatient—Total	11.05%	9.30%	14.46%	MNA	10.55%
ED—Total	0.41%	0.02%	0.06%	MNA	0.18%
Telehealth—Total	0.09%	0.02%	0.17%	MNA	0.07%
Any Service—Total	11.60%	9.44%	14.99%	MNA	10.89%
Plan All-Cause Readmissions (PCR)					
Observed Readmissions—Total	13.42%	14.87%	13.42%	MNA	14.13%
Expected Readmissions—Total	9.60%	9.50%	9.73%	MNA	9.57%
*O/E Ratio—Total**	1.40	1.56	1.38	MNA	1.48
Overuse/Appropriateness of Care					
Use of Opioids at High Dosage (HDO)*					
Use of Opioids at High Dosage	9.18%	10.36%	5.42%	MNA	9.59%
Use of Opioids From Multiple Providers (UOP)*					
Multiple Prescribers	**21.52%**	25.31%	32.45%	22.43%	24.78%
Multiple Pharmacies	**1.60%**	**3.00%**	**2.65%**	3.16%	2.54%
Multiple Prescribers and Multiple Pharmacies	**0.84%**	1.73%	1.86%	1.62%	1.47%

♦ Individual plan denominators for this indicator were less than 30 resulting in a "NA" audit designation. However, when the plan rates were combined generate the statewide aggregate rate, the denominator was large enough to be reported and subsequently compared to the MPS.

† Represents performance under the Medicaid managed care program.

* A lower rate indicates better performance for this measure.

NA indicates that the plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

MNA Indicates HEDIS 2020 QISMC goals are unavailable for this measure.

Bolded rates indicate that the MCO performance measure rate for HEDIS 2020 was at or above the MPS.

Indicates that the HEDIS 2020 rate declined by 5 percentage points or more from HEDIS 2019.

Indicates that the HEDIS 2020 rate improved by 5 percentage points or more from HEDIS 2019.

Indicates that the Medicaid Aggregate rate was at or above the MPS.

Nevada Check Up Findings

Table 7-3 shows, by MCO, the HEDIS 2020 Nevada Check Up performance measure rate results and the MPS for **Anthem**, **HPN**, and **SilverSummit** and the Nevada Check Up aggregate, which represents the average of all three MCOs' measure rates weighted by the eligible population. Measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures in the Utilization domain are designed to capture the frequency of services the MCO provides. Except for the *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total*, higher or lower rates in this domain do not necessarily indicate better or worse performance. Therefore, these rates are provided for informational purposes only.

Table 7-3—HEDIS 2020 Results for Nevada Check Up

HEDIS Measure	Anthem	HPN	SilverSummit	MPS	NV Check Up Aggregate
Access to Care					
Children and Adolescents' Access to Primary Care Practitioners (CAP)					
Ages 12–24 Months	95.94%	**97.98%**	95.52%	97.78%	96.87%
Ages 25 Months–6 Years	**92.41%**	89.71%	88.79%	90.45%	90.71%
Ages 7–11 Years	**94.33%**	**94.92%**	84.29%	93.31%	94.36%
Ages 12–19 Years	**91.95%**	**92.61%**	83.51%	91.41%	92.10%
Children's Preventive Care					
Adolescent Well-Care Visits (AWC)					
Adolescent Well-Care Visits	**68.61%**	64.96%	52.07%	65.46%	65.46%
Childhood Immunization Status (CIS)					
Combination 2	85.27%	85.62%	88.24%	89.07%	85.71%
Combination 3	**83.48%**	**83.56%**	**84.31%**	83.46%	83.60%
Combination 4	83.04%	**83.56%**	**84.31%**	83.46%	83.42%
Combination 5	77.23%	75.34%	68.63%	77.33%	75.49%
Combination 6	**50.45%**	**48.63%**	47.06%	47.40%	49.21%
Combination 7	76.79%	75.34%	68.63%	77.33%	75.31%
Combination 8	**50.45%**	**48.63%**	47.06%	47.40%	49.21%
Combination 9	**47.77%**	**45.21%**	41.18%	44.91%	45.86%
Combination 10	**47.77%**	**45.21%**	41.18%	44.91%	45.86%

HEDIS Measure	Anthem	HPN	SilverSummit	MPS	NV Check Up Aggregate
Immunizations for Adolescents (IMA)					
Combination 1 (Meningococcal, Tdap)	**93.63%**	**97.32%**	86.36%	89.03%	95.52%
Combination 2 (Meningococcal, Tdap, HPV)	51.96%	56.69%	33.33%	57.54%	53.88%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)					
BMI Percentile—Total	**87.83%**	**88.81%**	73.48%	85.65%	87.67%
Counseling for Nutrition—Total	**79.56%**	73.24%	66.42%	76.13%	75.37%
Counseling for Physical Activity—Total	**73.48%**	72.75%	62.04%	73.04%	72.51%
Well-Child Visits in the First 15 Months of Life (W15)					
Six or More Well-Child Visits	**82.26%**	**80.35%**	76.12%	77.38%	80.50%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)					
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	77.62%	77.62%	72.13%	77.63%	77.31%
Care for Chronic Conditions					
Medication Management for People With Asthma (MMA)					
Medication Compliance 50%—Total	**66.98%**	**59.68%**	NA	58.64%	62.08%
Medication Compliance 75%—Total	**44.34%**	32.26%	NA	40.00%	36.58%
Behavioral Health					
Follow-Up After Emergency Department Visit for Mental Illness (FUM)					
7-Day Follow-Up—Total	NA	NA	NA	79.47%	59.26%
30-Day Follow-Up—Total	NA	NA	NA	82.63%	66.67%
Follow-Up After Hospitalization for Mental Illness (FUH)					
7-Day Follow-Up—Total	37.14%	NA	NA	63.01%	41.43%
30-Day Follow-Up—Total	60.00%	NA	NA	75.34%	70.00%
Follow-Up Care for Children Prescribed ADHD Medication (ADD)					
Initiation Phase	**60.00%**	55.38%	NA	56.00%	56.10%
Continuation and Maintenance Phase	NA	NA	NA	MNA	NA
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)					
Initiation of AOD—Total	NA	25.71%	NA	38.33%	27.59%
Engagement of AOD—Total	NA	8.57%	NA	18.33%	8.62%

HEDIS Measure	Anthem	HPN	SilverSummit	MPS	NV Check Up Aggregate
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)					
Blood Glucose and Cholesterol Testing—Total	**48.39%**	21.95%	NA	28.87%	32.93%
Utilization					
Ambulatory Care—Total (per 1,000 Member Months) (AMB)					
*ED Visits—Total**	30.27	25.99	30.68	MNA	27.97
Outpatient Visits—Total	253.13	265.66	237.83	MNA	258.61
Mental Health Utilization—Total (MPT)					
Inpatient—Total	0.40%	0.20%	0.23%	MNA	0.28%
Intensive Outpatient or Partial Hospitalization—Total	0.21%	0.03%	0.14%	MNA	0.11%
Outpatient—Total	7.15%	7.46%	9.79%	MNA	7.55%
ED—Total	0.00%	0.01%	0.00%	MNA	0.00%
Telehealth—Total	0.02%	0.00%	0.09%	MNA	0.02%
Any Service—Total	7.20%	7.52%	9.84%	MNA	7.60%

* A lower rate indicates better performance for this measure.
NA indicates that the plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
MNA indicates HEDIS 2020 QISMC goals are unavailable for this measure.
Bolded rates indicate that the MCO performance measure rate for HEDIS 2020 was at or above the MPS.

Indicates that the HEDIS 2020 rate declined by 5 percentage points or more from HEDIS 2019.

Indicates that the HEDIS 2020 rate improved by 5 percentage points or more from HEDIS 2019.

Indicates that the Medicaid Aggregate rate was at or above the MPS.

Compliance Review

HSAG calculated the Nevada Managed Care Program overall performance in each of the four performance areas. Table 7-4 compares the program average compliance score in each of the four performance areas with the compliance score achieved by each MCO. The percentages of requirements met for each of the four standards reviewed during the SFY 2019–2020 compliance review are provided.

Table 7-4—Summary of SFY 2019–2020 Compliance Review Results

Standard	Anthem	HPN	SilverSummit	Nevada Medicaid Program
Standard XI—IQAP	90%	100%	98%	96%
Standard XII—Cultural Competency Program	94%	100%	94%	96%
Standard XIII—Confidentiality	100%	100%	100%	100%
Standard XIV—Enrollment and Disenrollment	81%	100%	75%	85%
Total Compliance Score	**92%**	**100%**	**94%**	**95%**

Total Compliance Score—Elements scored *Met* were given full value (1 point each) and for *Partially Met a partial score* (0.5 point). The point values were then totaled, and the sum was divided by the number of applicable elements to derive percentage scores for each MCO's standards and for the Nevada Managed Care Program.

Network Adequacy Validation (NAV)

Table 7-5 presents a summary of the provider ratio analysis results compared to the provider ratio standards for all MCOs. For the provider categories assessed according to the standards in Table 7-5, the percentage of members with access to the provider within the time-distance standard is shown in red if they did not comply with the standard. These MCO comparative time distance standard results for each provider type are documented in Table 7-6.

Table 7-5—Summary of Ratio Analysis Results for PCPs and Specialty Care Providers for All MCOs

Provider Category	Anthem		HPN		SilverSummit	
	Providers	Ratio	Providers	Ratio	Providers	Ratio
PCPs (1:1,500)	1,343	1:121	2,676	1:78	1,916	1:22
PCP Extenders (1:1,800)	1,362	1:119	NA	NA	1,346	1:31
Physician Specialist Providers (1:1,500)	1,412	1:112	1,884	1:111	1,150	1:36

NA indicates that the MCO did not report providers in the provider category.

Table 7-6—Percentage of Members Residing Within the Access Standard Areas for All MCOs

Provider Category	Time-Distance Standard	Anthem	HPN	SilverSummit
PCPs				
Primary Care (Adult Total)	20 miles/30 mins	99.2%	99.4%	99.0%
OB/GYN	20 miles/30 mins	98.9%	99.2%	98.7%
Pediatrician	20 miles/30 mins	99.2%	99.4%	98.7%

Provider Category	Time-Distance Standard	Anthem	HPN	SilverSummit
Specialty Providers				
Endocrinologist	75 miles/100 mins	99.2%	99.4%	99.1%
Endocrinologist, Pediatric	75 miles/100 mins	99.3%	99.4%	99.0%
Infectious Disease	75 miles/100 mins	99.2%	99.4%	99.1%
Infectious Disease, Pediatric	75 miles/100 mins	99.3%	99.4%	99.0%
Oncologist/Hematologist	75 miles/100 mins	99.2%	99.4%	99.1%
Oncologist/Hematologist, Pediatric	75 miles/100 mins	99.3%	99.4%	99.0%
Oncologist/Radiologist	75 miles/100 mins	99.2%	NA	99.1%
Rheumatologist	75 miles/100 mins	99.2%	99.4%	99.1%
Rheumatologist, Pediatric	75 miles/100 mins	88.6%	86.8%	87.1%
Facility-Level Providers				
Hospital	60 miles/80 mins	99.3%	99.4%	99.1%
Psychiatry Inpatient Hospital	60 miles/80 mins	99.1%	99.4%	99.1%
Dialysis/ESRD Facility	60 miles/80 mins	99.1%	99.4%	99.1%
Behavioral Health Providers				
Psychologist	45 miles/60 mins	99.1%	99.4%	99.1%
Pediatric Psychologist	45 miles/60 mins	88.6%	NA	87.1%
LCSW	45 miles/60 mins	99.1%	99.4%	99.1%
Psychiatrist	45 miles/60 mins	99.1%	99.4%	99.1%
Pediatric Psychiatrist	45 miles/60 mins	99.3%	NA	99.0%

NA indicates that the MCO did not report providers in the provider category.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Analysis

A comparative analysis identified whether one MCO performed statistically and significantly higher or lower on each measure compared to the program average. Table 7-7 shows a summary of the statistically significant findings (noted with arrows) from the plan comparisons of the adult Medicaid, child Medicaid, and Nevada Check Up populations for **Anthem**, **HPN**, and **SilverSummit**. Please note, no measures had a statistically significantly higher or lower score than the program average for **Anthem** and **SilverSummit**; therefore, these MCOs are not included in Table 7-7.

Table 7-7—Summary of Plan Comparisons

2020 Adult Medicaid	2020 General Child Medicaid	2020 CCC Medicaid Supplemental	2020 Nevada Check Up General Child	2020 Nevada Check Up CCC Supplemental
HPN				
↑ *Rating of All Health Care*				
↑ *Rating of Specialist Seen Most Often*				
↑ *Rating of Health Plan*			↑ *Rating of Health Plan*	

↑ Indicates the 2020 score is statistically significantly higher than the program average.

Indicates no measures for the population were statistically significantly higher or lower than the program average.

8. PAHP Comparative Information

The DHCFP has contracted with a single PAHP as the dental benefits administrator for the Nevada Managed Care Program. Therefore, there is no comparative information available. The overall results of the PAHP will be included in the overall assessment of the Nevada Medicaid managed care program.

9. Program-wide Conclusions and Recommendations

Program-wide Conclusions and Recommendations

HSAG performed a comprehensive assessment of the performance of each MCE and of the overall strengths and weaknesses of the Nevada Managed Care Program related to the provision of healthcare services. All components of each EQR activity and the resulting findings were thoroughly analyzed and reviewed across the continuum of program areas and activities that comprise the Nevada Managed Care Program.

Strengths

Through this all-inclusive assessment of aggregated performance, HSAG identified areas of strength in the program.

- Through their participation in state-mandated PIPs, the MCEs focus efforts on quality outcomes related to proper diabetes management to prevent other serious health complications, prenatal care to prevent poor birth outcomes, and preventive dental healthcare to mitigate cavities and reduce the risks of oral diseases. Implementing effective initiatives to improve performance in these areas has the potential to greatly impact the services and overall health outcomes of all Nevada Managed Care Program members.
  - *Comprehensive Diabetes Care HbA1c Poor Control > 9.0%* PIP—All three MCOs successfully developed a PIP with SMART Aim goals and interventions that have the potential to reduce the complications associated with diabetes and prevent additional diseases such as stroke, hypertension, and kidney disease. All three MCOs failed to meet the MPS, and one MCO demonstrated a significant decline in the *Comprehensive Diabetes Care HbA1c Poor Control > 9.0%* HEDIS measure; therefore, the implementation of interventions associated with this PIP should help members manage diabetes while also improving performance in this area.
  - *Timeliness of Prenatal Care* PIP—All three MCOs designed a PIP with SMART Aim goals and interventions that have the potential to prevent complications that can affect both the health of mother and baby before, during, and after pregnancy. All three MCOs failed to meet the MPS or demonstrate significant improvement over the past year in the *Timeliness of Prenatal Care* HEDIS measure; therefore, implementation of this PIP should support improved birth outcomes and improved HEDIS rates in this area.
  - *Improve Caries Risk Assessment Completion Rate* PIP—The PAHP concluded this PIP and exceeded its SMART Aim goal to improve the percentage of completed CRAs by 12 percent, but through continued improvement achieved a highest rate of 85.4 percent, therefore reducing the prevalence of young children developing tooth decay. Sustaining and spreading the PIP to other dental providers should support improvement in the dental health of all members, program-wide.

- Results from the three-year compliance review cycle indicated all four MCEs, **Anthem**, **HPN**, **SilverSummit**, and **LIBERTY**, have the ability to appropriately manage and adhere to the expectations established for the Medicaid managed care program through State and federal requirements, as demonstrated by SFY 2019–2020 aggregated compliance review scores being between 92 percent and 100 percent and all previously identified deficiencies from the first two years in the review cycle being remediated. These high-performance scores indicate the MCEs have strong foundations in place to provide preventive and medically necessary quality and accessible healthcare services to their members.
  - The program-wide overall MCO compliance score was 95 percent, with **HPN** scoring 100 percent in all standards reviewed, indicating the MCOs have the processes, procedures, and systems in place to effectively implement the managed care functions required by 42 CFR §438, meet the requirements in their contracts with the DHCFP, and provide services in support of the Medicaid and Nevada Check Up medical assistance programs.
  - The PAHP's overall compliance score was 96 percent, indicating the PAHP has the processes, procedures, and systems in place to manage the dental benefits for the Medicaid and Nevada Check Up medical assistance programs.
  - All MCEs scored 100 percent in the Confidentiality standard, and 93 percent or better in the Cultural Competency standard, indicating that members' health information is being appropriately used and disclosed in accordance with federal requirements and that members are receiving services in a culturally competent manner.
- The network adequacy analysis demonstrated the MCEs have a sufficient number of PCPs to provide primary, specialty, behavioral health, and dental services to members enrolled in the Nevada Managed Care Program.
  - All MCEs met the provider to member ratio requirements and most of the time and distance standards for PCPs, specialty providers, facility-level providers, behavioral health providers, and/or general dental providers as applicable.

Weaknesses

HSAG's comprehensive assessment of the MCEs and the Nevada Managed Care Program also identified areas of focus that represent significant opportunities for improvement within the program.

- Members are not obtaining the services they need to maintain optimal health, as demonstrated through MCE performance measure rates that did not meet the DHCFP-mandated MPS, barriers identified through the PIP activity, and lower positive member experiences with both the health plans and doctors, as reported through CAHPS.
  - All of the HEDIS domains, including Access to Care, Children's Preventive Care, Women's Health and Maternity Care, Care for Chronic Conditions, and Behavioral Health, identified substantial opportunities for improvement as many of the MCE and the program-wide aggregated rates were below the MPS. All of the MCOs had adequate provider and member ratios and met time and distance standards as indicated through the network adequacy analysis; however, the performance rates within the HEDIS domains suggest Medicaid and Nevada Check

Up members are experiencing barriers to obtaining services unrelated to the capacity of the provider network.

- The PAHP's performance measures, *Annual Dental Visits* and *Percentage of Eligibles Who Received Preventive Dental Services*, did not meet MPS for all age groups. Additionally, the *Annual Dental Visits* PIP revealed challenges with member outreach, which could contribute to the PAHP's inability to influence member adherence to recommended services.
- Lower member satisfaction with providers and the health plans, as reported through CAHPS, could deter members from seeking care and also lessen the likelihood that members are going to reach out to their health plan for assistance.
- Although all MCEs have satisfactory quality assessment and performance improvement programs in place to drive quality improvement, as indicated through the compliance review activity, the quality initiatives and activities do not appear to be targeting the areas necessary to influence and subsequently result in positive, measurable outcomes.

Quality Strategy Recommendations for the Nevada Managed Care Program

The Nevada Quality Assessment and Performance Improvement Strategy (Quality Strategy) is designed to improve the health outcomes of its Medicaid members by continually improving the delivery of quality healthcare to all Medicaid and Nevada Check Up members served by the Nevada Medicaid managed care programs. The DHCFP's Quality Strategy provides the framework to accomplish the DHCFP's overarching goal of designing and implementing a coordinated and comprehensive system to proactively drive quality throughout the Nevada Medicaid and Check Up system. In consideration of the goals of the Quality Strategy and the comparative review of findings for all activities, HSAG recommends the following quality improvement initiatives, which target the identified specific areas within the DHCFP's Quality Strategy.

Goal 1—Improve the Health and Wellness of Nevada's Medicaid Population by Increasing Access to and the Use of Preventive Services

Goal 7—Increase Utilization of Dental Services

To improve program-wide performance in support of Goal 1 and Goal 7, HSAG recommends the following:

- The DHCFP could consider conducting a program-wide secret shopper survey of PCPs and general dentists to identify barriers that members may have to accessing services and contracted providers, such as whether the provider is accepting new patients, wait times for new and established patient appointments, and correct provider contact information.
  - The secret shopper survey could be administered by the DHCFP or each of the MCEs for a time-limited basis, using a standardized survey tool that captures data that can be aggregated across the program.

  - The results of the survey could be analyzed to determine if there is a systemic issue causing access barriers or if there are particular provider groups or counties that are more problematic for members to obtain a timely appointment.
  - The DHCFP and the MCEs could implement strategies to mitigate the identified barriers to care.

Goal 2—Increase Use of Evidence-Based Practices for Members With Chronic Conditions

To improve statewide performance in support of Goal 2, HSAG recommends the following:

- The DHCFP could consider requiring a state-directed quality improvement initiative that targets the most prevalent diagnosed chronic condition of combined MCE membership, with aims to improve the management of chronic conditions, promote positive health outcomes, and reduce overall Medicaid spending.
  - The DHCFP could direct its contracted MCOs to submit a data file that may contain the following: total member count with primary diagnosis of diabetes, asthma, hypertension, schizophrenia, bipolar, alcohol/drug abuse dependence, or ADHD; expenditures; and care management status.
  - The DHCFP and the MCOs could then aggregate the data to determine which condition should be targeted and has the potential to have the greatest measurable impact on HEDIS rates and positive member outcomes.
  - The DHCFP and the MCOs could then implement a collaborative, program-wide intervention to support improvement across the program.

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

To improve statewide performance in support of Goal 4, HSAG recommends the following:

- To identify the barriers members may have to accessing services and contracted providers, the DHCFP could consider conducting a program-wide focus group of women on Medicaid who have recently given birth or are pregnant to determine potential barriers to timely access of prenatal care.
  - Each MCO could identify and outreach to women who are pregnant or have delivered while enrolled in the MCO to participate in the focus group.
  - The DHCFP and/or the MCOs could offer an incentive for the women to attend the focus group discussion.
  - The DHCFP and/or the MCOs could assign a moderator to ask a predefined set of questions that focus on member experience while pregnant, including experiences with obtaining timely appointments, barriers to receiving care, perception of member/provider relationship, etc.
  - The DHCFP and/or the MCOs could leverage the information gained from the focus group to identify potential barriers women are experiencing when seeking prenatal care and develop interventions to eliminate those barriers and support program improvement.

Appendix A. External Quality Review Activity Methodologies

MCO Activity Methodologies

Validation of Performance Improvement Projects (PIPs)

Activity Objectives

The DHCFP requires its MCOs to conduct PIPs annually. The topics for the SFY 2019–2020 PIP validation cycle were:

- *Comprehensive Diabetes Care HbA1c Poor Control > 9.0%*
- *Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care*
- *Follow-Up After Emergency Department Visit for Mental Illness (FUM)* (**SilverSummit** only)
- *Increase the Rate of Well Child Visits, 3–6 Years of Life (W34)* (**SilverSummit** only)

The topics selected by the DHCFP addressed CMS requirements related to quality outcomes—specifically, the quality and timeliness of and access to care and services.

For each PIP topic, the MCOs defined a Global and SMART Aim. The SMART Aim statement includes the narrowed population, the baseline rate, a set goal for the project, and the end date. HSAG provided the following parameters to the MCOs for establishing the SMART Aim for each PIP:

- **S**pecific: The goal of the project: What is to be accomplished? Who will be involved or affected? Where will it take place?
- **M**easurable: The indicator to measure the goal: What is the measure that will be used? What is the current data figure (i.e., count, percent, or rate) for that measure? What do you want to increase/decrease that number to?
- **A**ttainable: Rationale for setting the goal: Is the achievement you want to attain based on a particular best practice/average score/benchmark? Is the goal attainable (not too low or too high)?
- **R**elevant: The goal addresses the problem to be improved.
- **T**ime-bound: The timeline for achieving the goal.

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 reasonably linked to the quality improvement strategies and activities the MCO conducted during the PIP. HSAG's scoring methodology evaluated whether the MCO executed a methodologically sound improvement project and confirmed that any achieved improvement could be clearly linked to the quality improvement strategies implemented by the MCO.

Technical Methods of Data Collection and Analysis

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

For this PIP framework, HSAG developed five modules with an accompanying reference 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 on the quality improvement activities reasonably thought to impact the SMART Aim. Interventions are identified using tools such as process mapping, FMEA, 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 outcomes, presents comparisons of successful and unsuccessful interventions, lessons learned, and the plan to spread and sustain successful changes for improvement achieved.

Approach to PIP Validation

HSAG obtained the data needed to conduct the PIP validation from each MCO's module submission forms. These forms provided detailed information about each of the PIPs and the activities completed.

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 process ensured that the methodology was sound before the MCO progressed to the next phase of the PIP.

During validation, HSAG determined if criteria for each module were *Achieved.* Any validation criteria not applicable (*NA*) were not scored. As the PIP progressed, and at the completion of Module 4 or Module 5 (version pending), HSAG used the validation findings from across all modules completed to determine a level of confidence representing the validity and reliability of the PIP. Using a standardized

scoring methodology, HSAG assigned a level of confidence and reported the overall validity and reliability of the findings as one of the following:

- ***High confidence*** = The PIP was methodologically sound, the SMART Aim was achieved, the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested, and the MCO accurately summarized the key findings.
- ***Confidence*** = The PIP was methodologically sound, the SMART Aim was achieved, and the MCO accurately summarized the key findings. However, some, but not all, quality improvement processes conducted and/or intervention(s) tested were clearly linked to the demonstrated improvement.
- ***Low confidence*** = (A) The PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes conducted and/or intervention(s) tested 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.

Description of Data Obtained and Related Time Period

In SFY 2019–2020, HSAG obtained the data needed to conduct the PIP validation from each MCO's module submission forms. These forms provided detailed information about each of the PIPs and the activities completed.

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 achieved. This process ensured that the methodology was sound before the MCO progressed to the next phase of the PIP.

Performance Measure Validation (PMV)

Activity Objectives

The DHCFP requires its MCOs to undergo a PMV audit on an annual basis. In order to meet the PMV requirements, HSAG, as the EQRO for the DHCFP, conducts an NCQA HEDIS Compliance Audit for each MCO. HSAG adheres to NCQA's *HEDIS Compliance Audit Standards, Policies, and Procedures, Volume 5*, which outlines the accepted approach for auditors to use when conducting an IS capabilities assessment and an evaluation of MCOs' ability to process medical, member, and practitioner information and measure production processes to determine compliance with HEDIS measure specifications. The goal of the HEDIS Audit is to ensure accurate and reliable data. All of HSAG's lead auditors are Certified HEDIS Compliance Auditors.

Technical Methods of Data Collection and Analysis

HSAG performed an audit of the MCOs' HEDIS reporting processes for their Medicaid and Nevada Check Up populations. PMV involved three phases: off-site, on-site, and post-on-site. The following

provides a summary of the methods and information sources used by HSAG to conduct the audit within each of the validation phases.

Off-Site Validation Phase (October 2019 through May 2020)

- Forwarded HEDIS 2020 Record of Administration, Data Management, and Processes (Roadmap) upon release from NCQA.
- Conducted annual HEDIS updates webinar to review the audit timeline and discuss any changes to the measures, technical specifications, and processes.
- Scheduled on-site visit dates.
- Conducted kick-off calls to introduce the audit team, discuss the on-site agenda, provide guidance on HEDIS audit and PMV processes, and ensure that the MCOs were aware of important deadlines.
- Conducted survey sample frame validation for the MCOs and provided the final survey sample frame validation results report that indicated if the sample frames were approved for reporting.
- Reviewed completed HEDIS Roadmaps to assess compliance with the audit standards and provided the IS standard tracking report that listed outstanding items and areas that required additional clarification.
- Reviewed source code used for calculating the HEDIS performance measure rates to ensure compliance with the technical specifications, unless the MCO used a vendor whose measures were certified by NCQA.
- Conducted validation for all supplemental data sources intended for reporting and provided a final supplemental data validation report that listed the types of supplemental data reviewed and the validation results.
- Conducted preliminary rate review to assess data completeness and accuracy early in the audit process to allow time for making corrections, if needed, prior to final rate submission.
- Conducted medical record review validation to ensure the integrity of medical record review processes for performance measures that required medical record data for HEDIS reporting.

On-Site Validation Phase (January 2020 through April 2020)

- Conducted virtual on-site audits to assess capabilities to collect and integrate data from internal and external sources and produce reliable performance measure results.
- Provided preliminary audit findings.

Post-On-Site Validation Phase (May 2020 through July 2020)

- Worked collaboratively to resolve any outstanding items and corrective actions, if applicable, and provided a final IS standard tracking report that documented the resolution of each item.
- Conducted final rate review and provided a rate analysis report that included a comparison to the preliminary rate submission and prior two years' rates (if available) and showed how the rates compared to the NCQA HEDIS 2019 Audit Means, Percentiles, and Ratios. The report also included

requests for clarification on any notable changes in rates, eligible populations, and measures with rates that remained the same from year to year.

- Approved the final rates and assigned a final, audited result to each selected measure.
- Produced and provided final audit reports containing a summary of all audit activities.

Description of Data Obtained and Related Time Period

Through the methodology, HSAG obtained a number of different information sources to conduct the PMV according to NCQA's established HEDIS deadlines. These included:

- HEDIS Record of Administration, Data Management. and Processes (Roadmap).
- Source code, computer programming, and query language (if applicable) used to calculate the selected measures.
- Supporting documentation such as file layouts, system flow diagrams, system log files, and policies and procedures.
- Re-abstraction of a sample of medical records selected by HSAG auditors.

HSAG also obtained information through interaction, discussion, and formal interviews with key MCO staff members, as well as through observing demonstrations and data processing.

Compliance Review

Activity Objectives

The purpose of the SFY 2019–2020 Compliance Review was to assess each MCO's compliance with the federal compliance review standards and the State contract requirements found in the DHCFP Contract 3260. Over the three-year review cycle, HSAG completed a comprehensive review of compliance with all federal requirements as stipulated in 42 CFR §438.358, and as demonstrated in Table A-1.

Table A-1—Nevada Compliance Review Cycle for Nevada MCOs

Standard	Year 1 SFY 2017–2018	Year 2 SFY 2018–2019	Year 3 SFY 2019–2020
Provider Network Management			
I. Credentialing and Recredentialing	✓		
II. Availability and Accessibility of Services	✓		
III. Subcontracts and Delegation	✓		
IV. Provider Dispute and Complaint Resolution	✓		
V. Provider Information	✓		

Standard	Year 1 SFY 2017–2018	Year 2 SFY 2018–2019	Year 3 SFY 2019–2020
Member Services and Experiences			
VI. Member Rights and Responsibilities		✓	
VII. Member Information		✓	
VIII. Continuity and Coordination of Care		✓	
IX. Grievances and Appeals		✓	
X. Coverage and Authorization of Services		✓	
Managed Care Operations			
XI. Internal Quality Assurance Program			✓
XII. Cultural Competency Program			✓
XIII. Confidentiality			✓
XIV. Enrollment and Disenrollment			✓
XV. Program Integrity*			✓*

* Standard XV—Program Integrity was not reviewed by HSAG as the State conducted this review.

Technical Methods of Data Collection and Analysis

Before beginning the compliance review, HSAG developed data collection tools to document the review. The requirements in the tools were selected based on applicable federal and State regulations and requirements outlined in the contract between the DHCFP and the MCOs. HSAG conducted the following activities as part of the compliance review:

Prereview activities included:

- Developing the compliance review tools.
- Preparing and forwarding to each MCO a customized desk review form, instructions for completing the form, and instructions for submitting the requested documentation to HSAG for its desk review.
- Developing the MCE questionnaire.
- Conducting a technical assistance session to assist the MCO in preparing for the compliance review.
- Scheduling the review.
- Developing the agenda for the review.
- Providing the detailed agenda and the data collection (compliance review) tool to each MCO to facilitate preparation for HSAG's review.
- Conducting a desk review of documents. HSAG conducted a desk review of key documents and other information obtained from the DHCFP and of documents that each MCO submitted to HSAG. The desk review enabled HSAG reviewers to increase their knowledge and understanding of each MCO's operations, identify areas needing clarification, and begin compiling information before the virtual review.

Virtual review activities included:[A-1]

- An opening conference with introductions and a review of the agenda and logistics for HSAG's review activities.
- A review of the data systems that each MCO used in its operations, which includes, but is not limited to, quality improvement tracking and quality measure reporting.
- Interviews conducted with each MCO's key administrative and program staff members.
- A closing conference during which HSAG reviewers summarized their general findings.

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

Post-review activities: HSAG reviewers aggregated findings to produce a comprehensive compliance review report. In addition, HSAG created a CAP template that contained the findings and required actions for each element scored *Partially Met* or *Not Met*. When submitting its CAP to the DHCFP, the MCO must use this template to propose its plan to bring all elements scored *Partially Met* or *Not Met* into compliance with the applicable standard(s).

HSAG used scores of *Met*, *Partially Met*, and *Not Met* to indicate the degree to which each MCO's performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to an MCO during the period covered by HSAG's review. This scoring methodology is consistent with CMS' final protocol, *EQR Protocol 3: Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity,* October 2019.[A-2] The protocol describes the scoring as follows:

- ***Met*** indicates full compliance defined as *both* of the following:
  - All documentation listed under a regulatory provision, or component thereof, was present.
  - Staff members were able to provide responses to reviewers that were consistent with each other and with the documentation.
- ***Partially Met*** indicates partial compliance defined as *either* of the following:
  - Compliance with all documentation requirements existed, but staff members were unable to consistently articulate processes during interviews.
  - Staff members were able to describe and verify the existence of processes during the interview, but documentation was incomplete or inconsistent with practice.

[A-1] Due to COVID-19, the on-site review was conducted virtually through a Webex session.

[A-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: June 8, 2020.

- ***Not Met*** indicates noncompliance defined as *either* of the following:
  - No documentation was present, and staff members had little or no knowledge of processes or issues addressed by the regulatory provisions.
  - For those provisions with multiple components, key components of the provision could not be identified, and any findings of *Not Met* or *Partially Met* resulted in an overall finding of noncompliance, regardless of the findings noted for the remaining components.

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

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

Aggregating the Scores

To draw conclusions about the quality and timeliness of, and access to, care and services that the MCO provided to members, HSAG aggregated and analyzed the data resulting from desk and virtual review activities. The data that HSAG aggregated and analyzed included the following:

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

Based on the results of the data aggregation and analysis, HSAG prepared and forwarded draft reports to DHCFP staff members for their review and comment prior to issuing final reports.

Description of Data Obtained and Related Time Period

To assess each MCO's compliance with federal regulations, State rules, and contract requirements, HSAG obtained information from a wide range of written documents produced by the MCOs, including, but not limited to:

- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.

- The provider manual and other MCO communication to providers and subcontractors.
- Narrative and/or data reports across a broad range of performance and content areas.
- Written plans that guide specific operational areas, which included, but were not limited to, utilization management, quality management, health management, and cultural competency.
- An MCE questionnaire.

HSAG obtained additional information for the compliance review through interaction, discussions, and interviews with each MCO's key staff members during the virtual review. The SFY 2019–2020 Compliance Review focused on the requirements for managed care operations. The review period was July 1, 2019, through December 31, 2019.

Network Adequacy Validation (NAV)

Activity Objectives

Under the contract for EQR, the DHCFP requested that HSAG conduct a baseline NAV of the Medicaid provider network for all MCOs during SFY 2019–2020. As part of this NAV analysis, HSAG focused on two components of network adequacy validation:

- **Network Capacity Analysis:** Assessment of the capacity of the provider network relative to the number of enrolled members.
- **Geographic Network Distribution Analysis:** Evaluation of the geographic distribution of the providers relative to member populations.

Technical Methods of Data Collection and Analysis

To prepare the data for the NAV analysis, HSAG cleaned, processed, and defined the unique lists of providers, provider locations, and members for inclusion in the analysis. HSAG standardized and geo-coded all Medicaid member and provider files using Quest Analytics Suite software. For all analyses, adults were defined as those members ages 18 years or older, and children were defined as members younger than 18 years of age. Analyses for OB/GYN providers were limited to female members ages 18 years and older.

Similarly, provider networks were restricted based on the type of analysis. Ratio analyses were based on unique providers, deduplicated by National Provider Identifier (NPI) and restricted to provider offices located in the State of Nevada or within Nevada Managed Care Program catchment areas. Each MCO's full provider network was included in time-distance analyses regardless of provider office location. Individual providers with multiple practice locations were only counted once in the ratio analysis; however, each individual office location was counted in the time-distance analysis.

Provider Capacity Analysis: To assess the capacity of a given MCO's provider network, HSAG calculated the member-to-provider ratio (provider ratio) by provider category (e.g., PCPs, cardiologists) relative to the number of members. The provider ratio represents a summary statistic used to highlight the overall capacity of an MCO's provider network to deliver services to Medicaid members. A lower provider ratio suggests the potential for greater network access since a larger pool of providers is available to render services to individuals. Provider counts for this analysis were based on unique providers and not provider locations.

Geographic Network Distribution Analysis: The second dimension of this study evaluated the geographic distribution of providers relative to MCO members. While the previously described provider capacity analysis identified the degree to which each MCO's provider network infrastructure was sufficient in both number of providers and variety of specialties, the geographic network distribution analysis evaluated whether or not the number of provider locations in an MCO's provider network was appropriately distributed for the MCOs' Medicaid population.

To provide a comprehensive view of geographic access, HSAG calculated the following two spatially derived metrics for the provider categories identified in the provider crosswalks:

- Percentage of members within predefined access standards: A higher percentage of members meeting access standards indicates a better geographic distribution of MCO providers relative to Medicaid members.
- Average travel distances (driving distances in miles) and travel times (driving times in minutes) to the nearest three providers: A shorter driving distance or travel time indicates greater accessibility to providers since members must travel fewer miles or minutes to access care.

HSAG used Quest Analytics software to calculate the duration of travel time or physical distance between the addresses of specific members and their nearest one-to-three providers for all provider categories identified in the provider crosswalks. All study results are stratified by MCO.

Description of Data Obtained and Related Time Period

The DHCFP and MCOs provided Medicaid member demographic information and provider network files, respectively, to HSAG for use in the baseline NAV analysis. HSAG provided detailed data requirements documents to the DHCFP and the plans for the requested data, in alignment with the following criteria:

- Member Files
  - Member enrollment and demographic files including all members served by one or more MCOs as of October 1, 2019.
- Provider Data
  - Provider data for providers actively enrolled in an MCO as of October 1, 2019. The plans classified providers to selected provider categories in alignment with the provider crosswalk, which detailed the methods for classifying each provider category.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) Analysis

Activity Objectives

This activity assesses member experience with an MCO and its providers, and the quality of care they receive. The goal of the CAHPS Health Plan Surveys is to provide feedback that is actionable and will aid in improving members' overall experiences.

Technical Methods of Data Collection and Analysis

Three populations were surveyed for **Anthem**, **HPN**, and **SilverSummit**: adult Medicaid, child Medicaid, and Nevada Check Up. Center for the Study of Services, an NCQA-certified vendor, administered the 2020 CAHPS surveys for **Anthem**. SPH Analytics, an NCQA-certified vendor, administered the 2020 CAHPS surveys for **SilverSummit** and **HPN**.

The technical method of data collection was through the CAHPS 5.0H Adult Medicaid Health Plan Survey to the adult population and the CAHPS 5.0H Child Medicaid Health Plan Survey (with the CCC measurement set) to the child Medicaid and Nevada Check Up populations. **Anthem** used a mail-only methodology for data collection. **HPN** and **SilverSummit** used a mixed-mode methodology for data collection (i.e., mailed surveys followed by telephone interviews of non-respondents to the mailed surveys). Respondents were given the option of completing the survey in Spanish. For **Anthem**, members were only given the option to call the telephone number provided on the survey cover letter if they wanted to complete the survey in Spanish. For **HPN** and **SilverSummit**, all members selected in the sample received both an English and Spanish mail survey and had the option to complete the survey over the telephone in Spanish.

CAHPS Measures

The survey questions were categorized into various measures of member experience. These measures included four global ratings, four 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 member experience with their personal doctor, specialist, health plan, and all healthcare. The composite measures 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 experience 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.

Top-Box Score Calculations

For each of the four global ratings, the percentage of respondents who chose the top experience 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 or top-box score).

For each of the five composite measures 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 composite measures 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 measures 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 scores presented follow NCQA's methodology of calculating a rolling average using the current and prior year results. When a minimum of 100 responses for a measure was not achieved, the result of the measure was denoted as Not Applicable (NA).

NCQA National Average Comparisons

A substantial increase or decrease is denoted by a change of 5 percentage points or more. Colors are used to note substantial differences. Green indicates a top-box score that was at least 5 percentage points higher than the 2019 NCQA national average.[A-3] Red indicates a top-box score that was at least 5 percentage points lower than the 2019 NCQA national average. Since NCQA does not publish separate rates for CHIP, national comparisons could not be made for the Nevada Check Up program.

Plan Comparisons

Statistically significant differences between the 2020 top-box scores for the adult Medicaid, child Medicaid (general child and CCC), and Nevada Check Up populations for **Anthem**, **HPN**, and **SilverSummit** are noted with arrows. An MCO that performed statistically significantly higher than the program average is denoted with an upward (↑) arrow. Conversely, an MCO that performed statistically significantly lower than the program average is denoted with a downward (↓) arrow. An MCO that is not statistically significantly different than the program average is not denoted with an arrow.

Description of Data Obtained and Related Time Period

Based on NCQA protocol, adult members included as eligible for the survey were 18 years of age or older as of December 31, 2019, and child members included as eligible for the survey were 17 years of age or younger as of December 31, 2019. Adult members and parents or caretakers of child members completed the surveys from February to May 2020.

[A-3] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2019.* Washington, DC: NCQA, September 2019.

PAHP Activity Methodologies

Validation of Performance Improvement Projects (PIPs)

Activity Objectives

The DHCFP requires its PAHP to conduct PIPs annually. The topics for the SFY 2019–2020 PIP validation cycle were:

- *Annual Dental Visits.*
- *Improve Caries Risk Assessment Completion Rate.*

The topics selected by the DHCFP addressed CMS requirements related to quality outcomes—specifically, the quality and timeliness of, and access to, care and services.

For each PIP topic, the PAHP defined a Global and SMART Aim. The SMART Aim statement includes the narrowed population, the baseline rate, a set goal for the project, and the end date. HSAG provided the following parameters to the PAHP for establishing the SMART Aim for each PIP:

- **S**pecific: The goal of the project: What is to be accomplished? Who will be involved or affected? Where will it take place?
- **M**easurable: The indicator to measure the goal: What is the measure that will be used? What is the current data figure (i.e., count, percent, or rate) for that measure? What do you want to increase/decrease that number to?
- **A**ttainable: Rationale for setting the goal: Is the achievement you want to attain based on a particular best practice/average score/benchmark? Is the goal attainable (not too low or too high)?
- **R**elevant: The goal addresses the problem to be improved.
- **T**ime-bound: The timeline for achieving the goal.

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 reasonably linked to the quality improvement strategies and activities the PAHP conducted during the PIP. HSAG's scoring methodology evaluated whether the PAHP executed a methodologically sound improvement project and confirmed that any achieved improvement could be clearly linked to the quality improvement strategies implemented by the PAHP.

Technical Methods of Data Collection and Analysis

The key concepts of the rapid-cycle PIP framework include forming a core PIP team, setting aims, establishing measures, determining interventions, testing interventions, and spreading successful changes. The core component of this approach involves testing changes on a small scale, using a series of PDSA cycles and applying rapid-cycle learning principles over the course of the improvement project

to adjust intervention strategies so that improvement can occur more efficiently and lead to long-term sustainability. The duration of rapid-cycle PIPs is 18 months.

For this PIP framework, HSAG developed five modules with an accompanying reference guide. Prior to issuing each module, HSAG held technical assistance sessions with the PAHP 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 are identified using tools such as process mapping, FMEA, 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 PAHP summarizes key findings and outcomes, presents comparisons of successful and unsuccessful interventions, lessons learned, and the plan to spread and sustain successful changes for improvement achieved.

Approach to PIP Validation

HSAG obtained the data needed to conduct the PIP validation from the PAHP's module submission forms. These forms provided detailed information about each of the PIPs and the activities completed.

The PAHP submitted each module according to the approved timeline. After the initial validation of each module, the PAHP received HSAG's feedback and technical assistance and resubmitted the modules until all validation criteria were met. This process ensured that the methodology was sound before the PAHP progressed to the next phase of the PIP.

During validation, HSAG determined if criteria for each module were *Achieved.* Any validation criteria *NA* were not scored. As the PIP progressed, and at the completion of Module 4 and Module 5, HSAG used the validation findings from across all modules completed to determine a level of confidence representing the validity and reliability of the PIP. Using a standardized scoring methodology, HSAG assigned a level of confidence and reported the overall validity and reliability of the findings as one of the following:

- ***High confidence*** = The PIP was methodologically sound, the SMART Aim was achieved, the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested, and the PAHP accurately summarized the key findings.

- ***Confidence*** = The PIP was methodologically sound, the SMART Aim was achieved, and the PAHP accurately summarized the key findings. However, some, but not all, quality improvement processes conducted and/or intervention(s) tested were clearly linked to the demonstrated improvement.
- ***Low confidence*** = (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes conducted and/or intervention(s) tested 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.

Description of Data Obtained and Related Time Period

In SFY 2019–2020, HSAG obtained the data needed to conduct the PIP validation from the PAHP's module submission forms. These forms provided detailed information about each of the PIPs and the activities completed.

The PAHP submitted each module according to the approved timeline. After the initial validation of each module, the PAHP received HSAG's feedback and technical assistance and resubmitted the modules until all validation criteria were achieved. This process ensured that the methodology was sound before the PAHP progressed to the next phase of the PIP.

Performance Measure Validation (PMV)

Activity Objectives

The DHCFP requires the PAHP to undergo a PMV audit on an annual basis. HSAG, as the EQRO for the PAHP, conducted the validation activities in accordance with CMS publication, *EQR Protocol 2: Validation of Performance Measures: A Mandatory EQR-Related Activity,* October 2019,[A-4] which outlines the accepted approach for auditors to use when conducting an IS capabilities assessment and an evaluation of the PAHP's ability to process medical, member, and practitioner information and measure production processes to determine compliance with performance measure specifications. The goal of the validation is to ensure accurate and reliable data are reported.

Technical Methods of Data Collection and Analysis

HSAG performed an audit of the PAHP's reporting processes for its Medicaid and Nevada Check Up populations. PMV involved three phases: off-site, on-site, and post-on-site. The following provides a summary of the methods and information sources used by HSAG to conduct the audit within each of the validation phases.

[A-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures: A Mandatory EQR-Related Activity,* October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Mar 9, 2020.

Off-Site Validation Phase (October 2019 through May 2020)

- Forwarded Information Systems Capabilities Assessment Tool (ISCAT) to PAHP.
- Scheduled virtual site visit date.
- Conducted kick-off call to introduce the audit team, discuss the virtual site visit agenda, provide guidance on PMV processes, and ensure that the PAHP was aware of important deadlines.
- Reviewed completed ISCAT to assess the PAHP's IS.
- Reviewed source code used for calculating the performance measure rates to ensure compliance with the technical specifications.
- Conducted validation for all supplemental data sources intended for reporting and provided a final supplemental data validation report that listed the types of supplemental data reviewed and the validation results.
- Conducted preliminary rate review to assess data completeness and accuracy early in the audit process to allow time for making corrections, if needed, prior to final rate submission.

On-Site Validation Phase (January 2020 through April 2020)

- Conducted virtual site visit to assess the PAHP's capabilities to collect and integrate data from internal and external sources and produce reliable performance measure results.
- Provided preliminary audit findings.

Post-On-Site Validation Phase (May 2020 through July 2020)

- Worked collaboratively to resolve any outstanding items and corrective actions, if applicable.
- Conducted final rate review and provided a rate analysis report that included a comparison to the preliminary rate submission and prior years' rates (if available). The report also included requests for clarification on any notable changes in rates, eligible populations, and measures with rates that remained the same from year to year.
- Approved the final rates and assigned a final, audited result to each selected measure.
- Produced and provided a final audit report containing a summary of all audit activities.

Description of Data Obtained and Related Time Period

Through the methodology, HSAG obtained a number of different information sources to conduct the PMV. These included:

- ISCAT.
- Source code, computer programming, and query language (if applicable) used to calculate the selected measures.
- Supporting documentation such as file layouts, system flow diagrams, system log files, and policies and procedures.

HSAG also obtained information through interaction, discussion, and formal interviews with key PAHP staff members, as well as through observing demonstrations and data processing.

Compliance Review

Activity Objectives

The purpose of the SFY 2019–2020 Compliance Review was to determine the PAHP's compliance with federal and State managed care standards related to managed care operations. The purpose of this review was to also ensure that all action plans put in place to remediate the deficiencies were implemented and that all elements within each of the standards reviewed were compliant. Over the three-year review cycle, HSAG completed a comprehensive review of compliance with all federal requirements as stipulated in 42 CFR §438.358, and as demonstrated in Table A-2. The PAHP also went through a comprehensive Readiness Review in 2017, which included all federal standards, to confirm its readiness to provide dental services to Medicaid and Nevada Check Up members. The Year 1 standards were reviewed as part of this Readiness Review, which was completed in November 2017, and not as a separate compliance review process.

Table A-2—Nevada Compliance Review Cycle for the PAHP

Standard	Year 1 SFY 2017–2018	Year 2 SFY 2018–2019	Year 3 SFY 2019–2020
Provider Network Management			
I. Credentialing and Recredentialing	✓		
II. Availability and Accessibility of Services	✓		
III. Subcontracts and Delegation	✓		
IV. Provider Dispute and Complaint Resolution	✓		
V. Provider Information	✓		
Member Services and Experiences			
VI. Member Rights and Responsibilities		✓	
VII. Member Information		✓	
VIII. Continuity and Coordination of Care		✓	
IX. Grievances and Appeals		✓	
X. Coverage and Authorization of Services		✓	
Managed Care Operations			
XI. Internal Quality Assurance Program			✓
XII. Cultural Competency Program			✓
XIII. Confidentiality			✓
XIV. Enrollment and Disenrollment			✓
XV. Program Integrity*			✓*

* Standard XV—Program Integrity was not reviewed by HSAG as the State conducted this review.

Technical Methods of Data Collection and Analysis

HSAG used scores of *Met*, *Partially Met*, and *Not Met* to indicate the degree to which the PAHP's performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to the PAHP during the period covered by HSAG's review. This scoring methodology is consistent with CMS' final protocol, *EQR Protocol 3: Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity,* October 2019.[A-5] The protocol describes the scoring as follows:

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

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

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

[A-5] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: June 8, 2020.

Aggregating the Scores

To draw conclusions about the quality and timeliness of, and access to, care and services that the PAHP provided to members, HSAG aggregated and analyzed the data resulting from desk and virtual review activities. The data that HSAG aggregated and analyzed included the following:

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

Based on the results of the data aggregation and analysis, HSAG prepared and forwarded the draft report to the DHCFP staff members for their review and comment prior to issuing the final report.

Description of Data Obtained and Related Time Period

To assess the PAHP's compliance with federal regulations, State rules, and contract requirements, HSAG obtained information from a wide range of written documents produced by the PAHP, including, but not limited to:

- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.
- The provider manual and other communication to providers and subcontractors.
- Narrative and/or data reports across a broad range of performance and content areas.
- Written plans that guide specific operational areas, which included, but were not limited to, utilization management, quality management, dental health management, and cultural competency.
- An MCE questionnaire.

HSAG obtained additional information for the compliance review through interaction, discussions, and interviews with the PAHP's key staff members during the virtual review. The review period was July 1, 2019, through December 31, 2019. Additionally, the SFY 2019–2020 Compliance Review included a review of elements that were found to be deficient in SFY 2018–2019.

Network Adequacy Validation (NAV)

Activity Objectives

Under the contract for EQR, the DHCFP requested that HSAG conduct a baseline NAV of the Medicaid provider network for the PAHP during SFY 2019–2020. As part of this NAV analysis, HSAG focused on two components of NAV:

- **Network Capacity Analysis:** Assessment of the capacity of the PAHP provider network relative to the number of enrolled members.
- **Geographic Network Distribution Analysis:** Evaluation of the geographic distribution of the PAHP dental providers relative to member populations.

Technical Methods of Data Collection and Analysis

To prepare the data for the NAV analysis, HSAG cleaned, processed, and defined the unique lists of dental providers, dental provider locations, and members for inclusion in the analysis. HSAG standardized and geo-coded all Medicaid member and provider files using Quest Analytics Suite software. For all analyses, adults were defined as those members ages 18 years or older, and children were defined as members younger than 18 years of age.

Similarly, provider networks were restricted based on the type of analysis. Ratio analyses were based on unique providers, deduplicated by NPI and restricted to provider offices located in the State of Nevada or within Nevada Managed Care Program catchment areas. The PAHP's full provider network was included in time-distance analyses regardless of provider office location. Individual dental providers with multiple practice locations were only counted once in the ratio analysis; however, each individual office location was counted in the time-distance analysis.

Provider Capacity Analysis: To assess the capacity of the PAHP's provider network, HSAG calculated the member-to-provider ratio (provider ratio) by dental provider category (e.g., general dentists, endodontists) relative to the number of members. The provider ratio represents a summary statistic used to highlight the overall capacity of the PAHP's provider network to deliver services to Medicaid members. A lower provider ratio suggests the potential for greater network access since a larger pool of providers is available to render services to individuals. Provider counts for this analysis were based on unique providers and not provider locations.

Geographic Network Distribution Analysis: The second dimension of this study evaluated the geographic distribution of providers relative to PAHP members. While the previously described provider capacity analysis identified the degree to which the PAHP's provider network infrastructure was sufficient in both number of providers and variety of specialties, the geographic network distribution analysis evaluated whether or not the number of provider locations in the PAHP's provider network was appropriately distributed for the PAHP's Medicaid population.

To provide a comprehensive view of geographic access, HSAG calculated the following two spatially derived metrics for the provider categories identified in the provider crosswalks:

- Percentage of members within predefined access standards: A higher percentage of members meeting access standards indicates a better geographic distribution of PAHP dental providers relative to Medicaid members.
- Average travel distances (driving distances in miles) and travel times (driving times in minutes) to the nearest three providers: A shorter driving distance or travel time indicates greater accessibility to providers since members must travel fewer miles or minutes to access care.

HSAG used Quest Analytics software to calculate the duration of travel time or physical distance between the addresses of specific members and their nearest one-to-three providers for all provider categories identified in the provider crosswalks.

Description of Data Obtained and Related Time Period

The DHCFP and the PAHP provided Medicaid member demographic information and provider network files, respectively, to HSAG for use in the baseline NAV analysis. HSAG provided detailed data requirements documents to the DHCFP and the plans for the requested data, in alignment with the following criteria:

- Member Files
  - Member enrollment and demographic files including all members served by the PAHP as of October 1, 2019.
- Provider Data
  - Provider data for providers actively enrolled in the PAHP as of October 1, 2019. The plans classified providers to selected provider categories in alignment with the provider crosswalk, which detailed the methods for classifying each provider category.

Nevada 2019–2020 Quality Strategy
Goals and Objectives for Medicaid

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

Goal 1:	Improve the Health and Wellness of Nevada's Medicaid Population by Increasing the Use of Preventive Services							
Objective	**QISMC Objective**	**Anthem 2020**	**HPN 2020**	**SilverSummit 2020**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
1.1a:	Increase children and adolescents' access to PCPs (CAP)—12–24 months	94.71%	94.52%	92.90%	94.93%	95.50%	96.06%	96.62%
1.1b:	Increase children and adolescents' access to PCPs (CAP)—25 months–6 years	83.93%	84.90%	76.10%	85.66%	87.26%	88.85%	90.44%
1.1c:	Increase children and adolescents' access to PCPs (CAP)—7–11 years	86.52%	86.72%	78.26%	87.69%	89.06%	90.42%	91.79%
1.1d:	Increase children and adolescents' access to PCPs (CAP)—12–19 years	85.08%	85.68%	75.06%	85.77%	87.35%	88.93%	90.51%
1.2:	Increase well-child visits (W15)—0–15 months	**68.06%**	67.15%	61.31%	67.99%	71.54%	75.10%	78.66%
1.3:	Increase well-child visits (W34)—3–6 years	73.17%	71.53%	59.12%	74.37%	77.22%	80.06%	82.91%
1.4a:	Increase weight assessment and counseling for nutrition and physical activity for children/ adolescents (WCC)—BMI percentile	**82.73%**	**83.45%**	78.59%	82.70%	84.62%	86.55%	88.47%
1.4b:	Increase weight assessment and counseling for nutrition and physical activity for children/ adolescents (WCC)—counseling for nutrition	**74.21%**	71.05%	65.69%	72.63%	75.67%	78.71%	81.75%

Goal 1:	Improve the Health and Wellness of Nevada's Medicaid Population by Increasing the Use of Preventive Services							
Objective	**QISMC Objective**	**Anthem 2020**	**HPN 2020**	**SilverSummit 2020**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
1.4c:	Increase weight assessment and counseling for nutrition and physical activity for children/ adolescents (WCC)—counseling for physical activity	67.88%	69.34%	59.12%	69.60%	72.98%	76.35%	79.73%
1.5a:	Increase immunizations for adolescents (IMA)—Meningococcal, Tdap	**89.29%**	**90.51%**	82.00%	84.85%	86.54%	88.22%	89.90%
1.5b:	Increase immunizations for adolescents (IMA)—Meningococcal, Tdap, HPV	41.12%	**48.42%**	31.14%	47.65%	53.46%	59.28%	65.10%
1.6a:	Increase childhood immunization status (CIS)—Combination 2	71.29%	72.02%	66.42%	73.55%	76.49%	79.43%	82.37%
1.6b:	Increase childhood immunization status (CIS)—Combination 3	68.13%	68.37%	60.34%	68.86%	72.32%	75.78%	79.24%
1.6c:	Increase childhood immunization status (CIS)—Combination 4	67.64%	67.64%	60.10%	68.45%	71.95%	75.46%	78.96%
1.6d:	Increase childhood immunization status (CIS)—Combination 5	58.64%	**60.10%**	49.39%	59.46%	63.97%	68.47%	72.98%
1.6e:	Increase childhood immunization status (CIS)—Combination 6	**38.93%**	**39.42%**	33.09%	38.58%	45.40%	52.23%	59.05%
1.6f:	Increase childhood immunization status (CIS)—Combination 7	58.15%	**59.61%**	49.15%	59.15%	63.69%	68.23%	72.77%
1.6g:	Increase childhood immunization status (CIS)—Combination 8	**38.93%**	**39.42%**	33.09%	38.48%	45.31%	52.15%	58.98%
1.6h:	Increase childhood immunization status (CIS)—Combination 9	33.82%	**35.52%**	28.95%	34.42%	41.70%	48.99%	56.28%

Goal 1:	Improve the Health and Wellness of Nevada's Medicaid Population by Increasing the Use of Preventive Services							
Objective	**QISMC Objective**	**Anthem 2020**	**HPN 2020**	**SilverSummit 2020**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
1.6i:	Increase childhood immunization status (CIS)—Combination 10	33.82%	**35.52%**	28.95%	34.32%	41.62%	48.91%	56.21%
1.7:	Increase adolescent well-care visits (AWC)	**56.45%**	48.91%	40.63%	53.52%	58.68%	63.85%	69.01%
1.8:	Increase breast cancer screening (BCS)	51.64%	55.08%	47.54%	58.90%	63.46%	68.03%	72.60%
1.9a:	Increase adults' access to preventive/ambulatory health services (AAP)—20–44 years	73.11%	**75.70%**	66.35%	75.55%	78.26%	80.98%	83.70%
1.9b:	Increase adults' access to preventive/ambulatory health services (AAP)—45–64 years	79.43%	81.68%	75.54%	81.82%	83.84%	85.86%	87.88%
1.9c:	Increase adults' access to preventive/ambulatory health services (AAP)—65 years and older	NA	NA	NA	67.19%	70.83%	74.48%	78.12%
1.9d:	Increase adults' access to preventive/ambulatory health services (AAP)—Total	75.11%	**77.81%**	69.38%	77.67%	80.15%	82.63%	85.11%

Goal 2:	Increase Use of Evidence-Based Practices for Members With Chronic Conditions							
Objective	**QISMC Objective**	**Anthem 2020**	**HPN 2020**	**SilverSummit 2020**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
2.1a:	Increase rate of HbA1c testing for members with diabetes (CDC)	79.08%	**84.91%**	74.70%	81.98%	83.98%	85.99%	87.99%
2.1b:	Decrease rate of HbA1c poor control (>9.0%) for members with diabetes (CDC)*	51.58%	41.36%	53.04%	39.28%	34.91%	30.55%	26.18%
2.1c:	Increase rate of HbA1c good control (<8.0%) for members with diabetes (CDC)	40.15%	49.64%	37.71%	53.14%	58.34%	63.55%	68.76%

Goal 2:	Increase Use of Evidence-Based Practices for Members With Chronic Conditions							
Objective	**QISMC Objective**	**Anthem 2020**	**HPN 2020**	**SilverSummit 2020**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
2.1d:	Increase rate of eye exams performed for members with diabetes (CDC)	53.04%	**62.04%**	52.55%	61.47%	65.75%	70.03%	74.31%
2.1e:	Increase medical attention for nephropathy for members with diabetes (CDC)	89.05%	**92.46%**	85.89%	89.55%	90.71%	91.87%	93.03%
2.1f:	Increase blood pressure control (<140/90 mm Hg) for members with diabetes (CDC)	37.47%	63.75%	47.93%	65.72%	69.53%	73.34%	77.15%
2.2a:	Increase medication management for people with asthma (MMA)—medication compliance 50 percent	**63.95%**	58.91%	**67.79%**	61.04%	65.37%	69.70%	74.03%
2.2b:	Increase medication management for people with asthma (MMA)—medication compliance 75 percent	**42.39%**	36.24%	**44.97%**	40.84%	47.42%	53.99%	60.56%
2.3:	Increase rate of controlling high blood pressure (CBP)	52.55%	**62.77%**	40.15%	55.58%	60.51%	65.45%	70.38%

Goal 3:	Improve Appropriate Use of Opioids							
Objective	**QISMC Objective**	**Anthem 2020**	**HPN 2020**	**SilverSummit 2020**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
3.1:	Reduce use of opioids at high dosage (HDO)*,†	9.18%	10.36%	5.42%	MNA	MNA	MNA	MNA
3.2a:	Reduce use of opioids from multiple providers (UOP)—multiple prescribers*	**21.52%**	25.31%	32.45%	22.43%	19.94%	17.44%	14.95%
3.2b:	Reduce use of opioids from multiple providers (UOP)—multiple pharmacies*	**1.60%**	**3.00%**	**2.65%**	3.16%	2.81%	2.46%	2.11%
3.2c:	Reduce use of opioids from multiple providers (UOP)—multiple prescribers and multiple pharmacies*	**0.84%**	1.73%	1.86%	1.62%	1.44%	1.26%	1.08%

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	**Objective Description**	**Anthem 2020**	**HPN 2020**	**SilverSummit 2020**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
4.1:	Increase timeliness of prenatal care (PPC)†	80.78%	90.02%	75.91%	MNA	MNA	MNA	MNA
4.2:	Increase the rate of postpartum visits (PPC)†	59.37%	81.51%	54.74%	MNA	MNA	MNA	MNA

Goal 5:	Increase Use of Evidence-Based Practices for Members With Behavioral Health Conditions							
Objective	**QISMC Objective**	**Anthem 2020**	**HPN 2020**	**SilverSummit 2020**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
5.1a:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication (ADD)—initiation phase	41.55%	49.90%	49.40%	50.09%	55.63%	61.18%	66.72%
5.1b:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication (ADD)—continuation and maintenance phase	59.38%	**68.29%**	NA	60.00%	64.45%	68.89%	73.34%
5.3:	Increase adherence to antipsychotic medications for individuals with schizophrenia (SAA)	45.71%	44.00%	44.05%	46.08%	52.07%	58.06%	64.05%
5.4:	Increase follow-up after hospitalization for mental illness (FUH)—7-day	34.61%	36.88%	28.10%	39.45%	46.18%	52.90%	59.63%
5.5:	Increase follow-up after hospitalization for mental illness (FUH)—30-day	50.75%	53.80%	44.59%	54.86%	59.87%	64.89%	69.90%
5.6:	Increase diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications (SSD)	**83.30%**	78.86%	76.77%	81.43%	83.50%	85.56%	87.62%
5.7a:	Increase follow-up after ED visit for AOD abuse or dependence (FUA)—7-day	10.62%	14.52%	14.20%	18.21%	27.30%	36.38%	45.47%

Goal 5:	Increase Use of Evidence-Based Practices for Members With Behavioral Health Conditions							
Objective	**QISMC Objective**	**Anthem 2020**	**HPN 2020**	**SilverSummit 2020**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
5.7b:	Increase follow-up after ED visit for AOD abuse or dependence (FUA)—30-day	15.55%	18.92%	19.05%	21.60%	30.31%	39.02%	47.73%
5.8a:	Increase follow-up after ED visit for mental illness (FUM)—7-day	30.27%	**56.53%**	22.97%	47.67%	53.49%	59.30%	65.12%
5.8b:	Increase follow-up after ED visit for mental illness (FUM)—30-day	41.84%	**63.92%**	32.43%	55.92%	60.82%	65.71%	70.61%
5.9a:	Increase initiation and engagement of AOD abuse or dependence treatment (IET)—initiation of treatment	**48.53%**	42.24%	**45.43%**	45.24%	51.33%	57.41%	63.50%
5.9b:	Increase initiation and engagement of AOD abuse or dependence treatment (IET)—engagement of treatment	15.87%	10.88%	12.84%	18.94%	27.94%	36.95%	45.96%
5.10:	Increase metabolic monitoring for children and adolescents on antipsychotics (APM)—blood glucose and cholesterol testing	**31.71%**	**35.71%**	21.24%	25.33%	33.62%	41.92%	50.22%

Goal 6:	Reduce and/or Eliminate Health Care Disparities for Medicaid Recipients				
Objective	**Objective Description**	**Anthem**	**HPN**	**SilverSummit**	**MPS**
6.1:	Ensure that health plans maintain, submit for review, and annually revise cultural competency plans.	Met	Met	Met	Met
6.2:	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

Goal 6:	Reduce and/or Eliminate Health Care Disparities for Medicaid Recipients				
Objective	**Objective Description**	**Anthem**	**HPN**	**SilverSummit**	**MPS**
6.3:	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

* A lower rate indicates better performances for this measure.

† Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS 2020 and prior years. Due to the QISMC goals being based on HEDIS 2019 statewide aggregate rates, where applicable, comparisons to QISMC goals should be considered with caution.

— Indicates that the health plan was not required to report this measure.

MNA indicates the HEDIS 2020 QISMC goals are unavailable for this measure.

NA indicates that the plan followed the specifications, but the denominator was too small (<30) to report a valid rate.

Bolded rates indicate that the performance measure rate for HEDIS 2020 was at or above the MPS.

Indicates that the HEDIS 2020 rate surpassed the Tier 3 QISMC goal.

Nevada 2019–2021 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 baseline rate and 100 percent).

Goal 1:	Improve the Health and Wellness of Nevada's Nevada Check Up Population by Increasing the Use of Preventive Services							
Objective	**QISMC Objective**	**Anthem 2020**	**HPN 2020**	**SilverSummit 2020**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
1.1a:	Increase children and adolescents' access to PCPs (CAP)—12–24 months	95.94%	**97.98%**	95.52%	97.78%	98.02%	98.27%	98.52%
1.1b:	Increase children and adolescents' access to PCPs (CAP)—25 months–6 years	**92.41%**	89.71%	88.79%	90.45%	91.51%	92.57%	93.63%
1.1c:	Increase children and adolescents' access to PCPs (CAP)—7–11 years	**94.33%**	**94.92%**	84.29%	93.31%	94.06%	94.80%	95.54%
1.1d:	Increase children and adolescents' access to PCPs (CAP)—12–19 years	**91.95%**	**92.61%**	83.51%	91.41%	92.36%	93.32%	94.27%
1.2:	Increase well-child visits (W15)—0–15 months	**82.26%**	**80.35%**	76.12%	77.38%	79.90%	82.41%	84.92%
1.3:	Increase well-child visits (W34)—3–6 years	77.62%	77.62%	72.13%	77.63%	80.11%	82.60%	85.08%
1.4a:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—BMI percentile	**87.83%**	**88.81%**	73.48%	85.65%	87.25%	88.84%	90.44%
1.4b:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—counseling for nutrition	**79.56%**	73.24%	66.42%	76.13%	78.78%	81.44%	84.09%
1.4c:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—counseling for physical activity	**73.48%**	72.75%	62.04%	73.04%	76.03%	79.03%	82.02%

Goal 1:	Improve the Health and Wellness of Nevada's Nevada Check Up Population by Increasing the Use of Preventive Services							
Objective	**QISMC Objective**	**Anthem 2020**	**HPN 2020**	**SilverSummit 2020**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
1.5a:	Increase immunizations for adolescents (IMA)—Meningococcal, Tdap	**93.63%**	**97.32%**	86.36%	89.03%	90.25%	91.47%	92.69%
1.5b:	Increase immunizations for adolescents (IMA)—Meningococcal, Tdap, HPV	51.96%	56.69%	33.33%	57.54%	62.26%	66.97%	71.69%
1.6a:	Increase childhood immunization status (CIS)—Combination 2	85.27%	85.62%	88.24%	89.07%	90.29%	91.50%	92.72%
1.6b:	Increase childhood immunization status (CIS)—Combination 3	**83.48%**	**83.56%**	**84.31%**	83.46%	85.30%	87.13%	88.97%
1.6c:	Increase childhood immunization status (CIS)—Combination 4	83.04%	**83.56%**	**84.31%**	83.46%	85.30%	87.13%	88.97%
1.6d:	Increase childhood immunization status (CIS)—Combination 5	77.23%	75.34%	68.63%	77.33%	79.85%	82.37%	84.89%
1.6e:	Increase childhood immunization status (CIS)—Combination 6	**50.45%**	**48.63%**	47.06%	47.40%	53.24%	59.09%	64.93%
1.6f:	Increase childhood immunization status (CIS)—Combination 7	76.79%	75.34%	68.63%	77.33%	79.85%	82.37%	84.89%
1.6g:	Increase childhood immunization status (CIS)—Combination 8	**50.45%**	**48.63%**	47.06%	47.40%	53.24%	59.09%	64.93%
1.6h:	Increase childhood immunization status (CIS)—Combination 9	**47.77%**	**45.21%**	41.18%	44.91%	51.03%	57.15%	63.27%
1.6i:	Increase childhood immunization status (CIS)—Combination 10	**47.77%**	**45.21%**	41.18%	44.91%	51.03%	57.15%	63.27%
1.7:	Increase adolescent well-care visits (AWC)	**68.61%**	64.96%	52.07%	65.46%	69.30%	73.13%	76.97%

Goal 1:	Improve the Health and Wellness of Nevada's Nevada Check Up Population by Increasing the Use of Preventive Services							
Objective	**QISMC Objective**	**Anthem 2020**	**HPN 2020**	**SilverSummit 2020**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
1.8:	Increase breast cancer screening (BCS)	—	—	—	—	—	—	—
1.9a:	Increase adults' access to preventive/ambulatory health services (AAP)—20–44 years	—	—	—	—	—	—	—
1.9b:	Increase adults' access to preventive/ambulatory health services (AAP)—45–64 years	—	—	—	—	—	—	—
1.9c:	Increase adults' access to preventive/ambulatory health services (AAP)—65 years and older	—	—	—	—	—	—	—
1.9d:	Increase adults' access to preventive/ambulatory health services (AAP)—Total	—	—	—	—	—	—	—

Goal 2:	Increase Use of Evidence-Based Practices for Members With Chronic Conditions							
Objective	**QISMC Description**	**Anthem 2020**	**HPN 2020**	**SilverSummit 2020**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
2.1a:	Increase rate of HbA1c testing for members with diabetes (CDC)	—	—	—	—	—	—	—
2.1b:	Decrease rate of HbA1c poor control (>9.0%) for members with diabetes (CDC)*	—	—	—	—	—	—	—
2.1c:	Increase rate of HbA1c good control (<8.0%) for members with diabetes (CDC)	—	—	—	—	—	—	—
2.1d:	Increase rate of eye exams performed for members with diabetes (CDC)	—	—	—	—	—	—	—
2.1e:	Increase medical attention for nephropathy for members with diabetes (CDC)	—	—	—	—	—	—	—
2.1f:	Increase blood pressure control (<140/90 mm Hg) for members with diabetes (CDC)	—	—	—	—	—	—	—

Goal 2:	Increase Use of Evidence-Based Practices for Members With Chronic Conditions							
Objective	**QISMC Description**	**Anthem 2020**	**HPN 2020**	**SilverSummit 2020**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
2.2a:	Increase medication management for people with asthma (MMA)—medication compliance 50 percent	**66.98%**	**59.68%**	NA	58.64%	63.23%	67.83%	72.42%
2.2b:	Increase medication management for people with asthma (MMA)—medication compliance 75 percent	**44.34%**	32.26%	NA	40.00%	46.66%	53.33%	60.00%
2.3:	Increase rate of controlling high blood pressure (CBP)	—	—	—	—	—	—	—

Goal 3:	Improve Appropriate Use of Opioids							
Objective	**QISMC Objective**	**Anthem 2020**	**HPN 2020**	**SilverSummit 2020**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
3.1:	Reduce use of opioids at high dosage (HDO)*,†	—	—	—	—	—	—	—
3.2a:	Reduce use of opioids from multiple providers (UOP)—multiple prescribers*	—	—	—	—	—	—	—
3.2b:	Reduce use of opioids from multiple providers (UOP)—multiple pharmacies*	—	—	—	—	—	—	—
3.2c:	Reduce use of opioids from multiple providers (UOP)—multiple prescribers and multiple pharmacies*	—	—	—	—	—	—	—

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	**QISMC Objective**	**Anthem 2020**	**HPN 2020**	**SilverSummit 2020**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
4.1:	Increase timeliness of prenatal care (PPC)†	—	—	—	—	—	—	—
4.2:	Increase the rate of postpartum visits (PPC)†	—	—	—	—	—	—	—

Goal 5:	Increase Use of Evidence-Based Practices for Members With Behavioral Health Conditions							
Objective	**QISMC Objective**	**Anthem 2020**	**HPN 2020**	**SilverSummit 2020**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
5.1a:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication (ADD)—initiation phase	**60.00%**	55.38%	NA	56.00%	60.89%	65.78%	70.67%
5.1b:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication (ADD)—continuation and maintenance phase	NA	NA	NA	MNA	MNA	MNA	MNA
5.3:	Increase adherence to antipsychotic medications for individuals with schizophrenia (SAA)	—	—	—	—	—	—	—
5.4:	Increase follow-up after hospitalization for mental illness (FUH)—7-day	37.14%	NA	NA	63.01%	67.12%	71.23%	75.34%
5.5:	Increase follow-up after hospitalization for mental illness (FUH)—30-day	60.00%	NA	NA	75.34%	78.08%	80.82%	83.56%
5.6:	Increase diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications (SSD)	—	—	—	—	—	—	—
5.7a:	Increase follow-up after ED visit for AOD abuse or dependence (FUA)—7-day	—	—	—	—	—	—	—
5.7b:	Increase follow-up after ED visit for AOD abuse or dependence (FUA)—30-day	—	—	—	—	—	—	—
5.8a:	Increase follow-up after ED visit for mental illness (FUM)—7-day	NA	NA	NA	79.47%	81.75%	84.03%	86.31%
5.8b:	Increase follow-up after ED visit for mental illness (FUM)—30-day	NA	NA	NA	82.63%	84.56%	86.49%	88.42%
5.9a:	Increase initiation and engagement of AOD abuse or dependence treatment (IET)—initiation of treatment	NA	25.71%	NA	38.33%	45.18%	52.04%	58.89%

Goal 5:	Increase Use of Evidence-Based Practices for Members With Behavioral Health Conditions							
Objective	**QISMC Objective**	**Anthem 2020**	**HPN 2020**	**SilverSummit 2020**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
5.9b:	Increase initiation and engagement of AOD abuse or dependence treatment (IET)—engagement of treatment	NA	8.57%	NA	18.33%	27.41%	36.48%	45.56%
5.10:	Increase metabolic monitoring for children and adolescents on antipsychotics (APM)—blood glucose and cholesterol testing	**48.39%**	21.95%	NA	28.87%	36.78%	44.68%	52.58%

Goal 6:	Reduce and/or Eliminate Health Care Disparities for Medicaid Recipients				
Objective	**Objective Description**	**Anthem**	**HPN**	**SilverSummit**	**MPS**
6.1:	Ensure that health plans maintain, submit for review, and annually revise cultural competency plans.	Met	Met	Met	Met
6.2:	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
6.3:	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

* A lower rate indicates better performances for this measure.

† Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS 2020 and prior years. Due to the QISMC goals being based on HEDIS 2019 statewide aggregate rates, where applicable, comparisons to QISMC goals should be considered with caution.

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Nevada 2019–2021 Quality Strategy
Goals and Objectives for LIBERTY Dental

Medicaid

Goal 7:	Increase Utilization of Dental Services					
Objective	**QISMC Objective**	**LIBERTY 2020**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
7.1	Increase annual dental visits (ADV)	52.79%	57.62%	62.33%	67.04%	71.75%
7.2	Increase percentage of eligible members who received preventive dental services	39.30%	45.78%	51.81%	57.83%	63.86%

Nevada Check Up

Goal 7:	Increase Utilization of Dental Services					
Objective	**QISMC Objective**	**LIBERTY 2020**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
7.1	Increase annual dental visits (ADV)	69.42%	71.63%	74.78%	77.94%	81.09%
7.2	Increase percentage of eligible members who received preventive dental services	56.69%	58.61%	63.21%	67.81%	72.41%