State of Nevada
Department of Health and Human Services

Division of Health Care Financing and Policy

Quality Assessment and Performance Improvement Strategy (Quality Strategy)

2019–2021

HSAG HEALTH SERVICES ADVISORY GROUP

Contents

Summary

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

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

- The Annual External Quality Review Technical Report
  - http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Members/BLU/FY2015_EQR_Technical_Report.pdf
- The DHCFP Medicaid and Check Up Fact Book
  - http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Resources/Medicaid%20and%20Nevada%20check%20Up%20Fact%20Book1.pdf
- The Medicaid State Plan
  - http://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSP/MSPHome/
- Medicaid Managed Care Organization (MCO) Contracts and Amendments
  - On file at the DHCFP

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

To demonstrate compliance with the Centers for Medicare & Medicaid Services (CMS) Quality Strategy Toolkit for States, the DHCFP created a crosswalk (Attachment C) that lists each of the required and recommended elements of state quality strategies, and the corresponding section of the DHCFP Quality Strategy and/or DHCFP/MCO Contract that addresses the required or recommended elements. The CMS Quality Strategy Toolkit for States may be accessed at https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care-quality/state-quality-strategies/index.html.

1. Introduction

Overview

History of Program

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

In April 1997, Nevada implemented voluntary managed care with several vendors. It contracted with **Health Plan of Nevada** (**HPN**) and **Amil International** (**Amil**) to provide services in Clark County, and with **Hometown Health Plan** to provide services in Washoe County through 2001.

In 2002, contracts were procured again with **Nevada Health Solutions** and **HPN** in both Clark and Washoe counties. **Anthem Blue Cross and Blue Shield Healthcare Solutions** (**Anthem**) and **HPN** won the contracts when Medicaid procured them again in November 2006. **Anthem** left the Nevada market in January 2009 and was replaced by **Amerigroup Nevada, Inc.** (**Amerigroup**), which was later acquired by **Anthem**. In 2012, the State of Nevada, Department of Health and Human Services (DHHS), Division of Health Care Financing and Policy (the DHCFP) reprocured the managed care contracts, with services to begin July 1, 2013. Both **HPN** and **Amerigroup** were selected to serve as the MCOs in Clark and Washoe counties through June 30, 2017. In 2016, the DHCFP reprocured the managed care contracts, with services to begin July 1, 2017. The following bidders were selected to serve in Clark and Washoe counties: **HPN**; **Anthem**, previously known as, **Amerigroup**; and **SilverSummit Healthplan Inc.** (**SilverSummit**). In 2017, the DHCFP procured a dental prepaid ambulatory health plan (PAHP), **LIBERTY Dental Plan of Nevada, Inc.** (**LIBERTY**), to serve as the DHCFP's dental benefits administrator (DBA) for Clark and Washoe counties.

Because the federal requirements for managed care entities are the same, regardless of the managed care vendor reviewed, this DHCFP Quality Strategy refers to MCOs and the DBA/PAHP collectively as "managed care entities" or MCEs. For any deviation, this strategy will specify to which MCE the description refers.

In accordance with 42 Code of Federal Regulations (CFR) §438.350 and §438.356, each State that contracts with MCOs and PAHPs must ensure that a qualified external quality review organization (EQRO) performs an annual external quality review (EQR) for each contracting MCO and PAHP. In accordance with these rules, the DHCFP contracted with Health Services Advisory Group, Inc. (HSAG), as the EQRO for the State of Nevada to conduct the mandatory EQR activities as set forth in 42 CFR §438.358. HSAG has served as the State's EQRO since 1999.

Program Eligibility

The State of Nevada managed care program requires the enrollment of recipients found eligible for Medicaid coverage under the Family Medical Coverage (FMC) as well as applications for medical assistance under the modified adjusted gross income (MAGI) medical eligibility group. The managed care program allows voluntary enrollment for the following recipients (these categories of enrollees are not subject to mandatory lock-in enrollment provisions):

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

Program Demographics

The Division of Welfare and Supportive Services carries out the eligibility and aid code determination functions for the Medicaid and Nevada Check Up applicant and eligible population. In January 2014, the DHCFP expanded Medicaid coverage to persons with incomes up to 138 percent of the federal poverty level, which was allowed under the Affordable Care Act. The number of persons who enrolled in Medicaid as a result of the expansion greatly exceeded the DHCFP's original expectations. Most newly eligible persons reside in the managed care catchment areas; therefore, the managed care program experienced significant increases in enrollment compared to prior years. For example, in June 2013, enrollment in managed care was 193,455; in June 2017, enrollment had grown to 489,091, which is more than a 150 percent increase.

Table 1-1 presents the gender and age bands of Nevada Medicaid- and Children's Health Insurance Program (CHIP)-enrolled recipients enrolled in all managed care catchment areas as of June 2018.

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

Gender/Age Band	June 2018 Members
Medicaid	
Males and Females <1 Year of Age	18,465
Males and Females 1–2 Years of Age	29,165
Males and Females 3–14 Years of Age	147,946

Gender/Age Band	June 2018 Members
Females 15–18 Years of Age	17,452
Males 15–18 Years of Age	16,959
Females 19–34 Years of Age	71,311
Males 19–34 Years of Age	41,632
Females 35+ Years of Age	67,379
Males 35+ Years of Age	54,604
Total Medicaid	**464,913**
CHIP	
Males and Females <1 Year of Age	169
Males and Females 1–2 Years of Age	1,647
Males and Females 3–14 Years of Age	17,345
Females 15–18 Years of Age	2,524
Males 15–18 Years of Age	2,493
Total CHIP	**24,178**
Total Medicaid and CHIP	**489,091**

Table 1-2 presents enrollment of Medicaid recipients by MCO and county for June 2018.

Table 1-2—June 2018 Nevada MCO Medicaid Recipients

MCO	Total Eligible Clark County	Total Eligible Washoe County
HPN	218,980	29,690
Anthem	145,880	19,415
SilverSummit	44,029	6,919
Total	**408,889**	**56,024**

Table 1-3 presents enrollment of CHIP recipients in the Nevada Check Up program by MCO and by county for June 2018.

Table 1-3—June 2018 Nevada MCO CHIP (Nevada Check Up) Recipients

MCO	Total Eligible Clark County	Total Eligible Washoe County
HPN	11,300	2,585
Anthem	7,036	1,352
SilverSummit	1,582	323
Total	**19,918**	**4,260**

DHHS Vision

The DHHS' vision is to promote early intervention, prevention, and quality treatment for Nevadans.

DHCFP Mission

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

Process for Quality Strategy Development, Review, and Revision

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

The DHCFP's initial Quality Strategy was submitted to the Centers for Medicare & Medicaid Services (CMS) for review and approval in 2008. CMS reviewed the document and provided input, and the DHCFP revised the document based on CMS' input. The DHCFP submitted a revised Quality Strategy in 2009, and CMS approved the document. Since then, the DHCFP's Quality Strategy has been revised at least every three years, with each revised Quality Strategy made publicly available on the DHCFP website at http://dhcfp.nv.gov/Resources/AdminSupport/Reports/CaseloadData/.

Quality Strategy Development

With input provided by Nevada Medicaid MCEs, external stakeholders, and the Medical Care Advisory Committee (MCAC), the DHCFP identified goals and objectives used for the Nevada managed care program. Those goals are supported by performance measures (each performance measure serves as an objective) used to measure health plan performance in achieving the goals identified in the Quality Strategy. The DHCFP uses the Healthcare Effectiveness Data and Information Set (HEDIS®)[1-1] to develop, collect, and report data for most performance measures.

Ongoing Review of the Quality Strategy

The DHCFP's EQRO is contractually required to validate the MCOs' HEDIS information and the DBA's performance measures. The DHCFP tracks the MCEs' performance for each of the required performance measures and reports the information annually in the EQR technical report. Additionally,

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

the MCEs are required to track their own performance and report achievements and opportunities for improvement in each MCE's quality evaluation, which is submitted annually to the DHCFP by each MCE.

For areas that require a specialized focus and targeted performance improvement interventions, the DHCFP requires the MCEs to conduct ongoing performance improvement projects (PIPs). The purpose of PIPs is to achieve significant, sustained improvement in both clinical and nonclinical areas through ongoing measurements and intervention. PIPs provide a structured method of assessing and improving processes, and thereby outcomes, of care for the population that each MCE serves. The DHCFP's EQRO validates the MCEs' PIPs annually and submits to the DHCFP validation findings, conclusions, and recommendations to improve PIP interventions and outcomes for the following year's PIP review cycle. Throughout the year, the MCEs are required to conduct and report on interim measurements to determine if PIP interventions are successful. The MCEs report on their intervention evaluation efforts during quarterly meetings with the DHCFP and the EQRO. The ongoing evaluation and exchange of information regarding PIP interventions and barriers enable the MCEs to target performance improvement efforts in specified areas. The DHCFP uses the results of the PIP validation findings to assess each MCE's achievement of goals and to make modifications to the Quality Strategy based on the MCEs' performance, if necessary.

The DHCFP monitors each MCE's compliance with its contract, and with the goals and objectives identified in the Quality Strategy, via the internal quality assurance program (IQAP) compliance review. The DHCFP's EQRO, HSAG, conducts IQAP compliance reviews annually. The purpose of the reviews is to determine an MCE's understanding and application of the Balanced Budget Act of 1997 (BBA) and contractually required standards from a review of documents, observations, and interviews with key health plan staff, as well as file reviews conducted during the on-site compliance review. In state fiscal year (SFY) 2017–2018, the DHCFP and HSAG initiated a new three-year cycle of reviews to complete a comprehensive review of compliance with State and federal standards within the three-year period. The full review schedule is detailed in Table 1-4.

Table 1-4—Nevada IQAP Compliance Review Cycle for Managed Care

Standard	Year 1 SFY 2017–2018 SFY 2020–2021	Year 2 SFY 2018–2019 SFY 2021–2022	Year 3 SFY 2019–2020 SFY 2022–2023
Provider Network Management			
1. Credentialing and Recredentialing	✓		
2. Availability and Accessibility of Services	✓		
3. Subcontracts and Delegation	✓		
4. Provider Dispute and Complaint Resolution	✓		
5. Provider Information	✓		

Standard	Year 1 SFY 2017–2018 SFY 2020–2021	Year 2 SFY 2018–2019 SFY 2021–2022	Year 3 SFY 2019–2020 SFY 2022–2023
Member Services and Experiences			
6. Member Rights and Responsibilities		✓	
7. Member Information		✓	
8. Continuity and Coordination of Care		✓	
9. Grievances and Appeals		✓	
10. Coverage and Authorization of Services		✓	
Managed Care Operations			
11. Internal Quality Assurance Program			✓
12. Cultural Competency Program			✓
13. Confidentiality and Recordkeeping			✓
14. Enrollment and Disenrollment			✓
15. Program Integrity			✓

As part of the IQAP compliance review, HSAG produces a comprehensive IQAP compliance review report for each MCE. The IQAP compliance review report enables each MCE to implement remediation plans to correct any areas of deficiency found during the IQAP compliance review. The report also helps the DHCFP determine each MCE's compliance with the contract and identify areas of the contract that need to be modified or strengthened to ensure that the MCE complies with the standards.

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

Quality Strategy Evaluation and Revision

The DHCFP and its EQRO evaluate the effectiveness of the Quality Strategy and report on the evaluations in the annual EQR technical report. The DHCFP updates the Quality Strategy, at least triennially, based on each MCE's performance; stakeholder input and feedback; achievement of goals; changes resulting from legislative, State, federal, or other regulatory authority; and/or significant changes to the programmatic structure of the Nevada Medicaid program. Each revised Quality Strategy is submitted to CMS. The DHCFP staff host public workshops wherein they solicit feedback from Nevada Medicaid stakeholders, including the Medical Care Advisory Committee, and the public during the revision phase of the Quality Strategy. Prior to submitting a revised Quality Strategy to CMS, the DHCFP invites public comment and feedback on the Quality Strategy via the DHCFP's website.

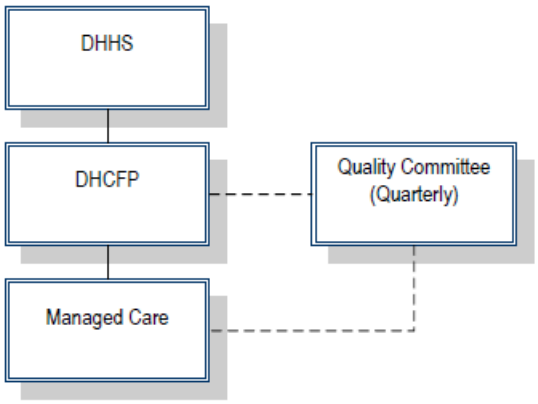
The DHCFP revises the Quality Strategy to reflect changes in scope and identified needs. The DHCFP defines significant changes to the Quality Strategy that require input from recipients and stakeholders as:

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

Oversight and Governance of the Quality Strategy

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

Figure 1-1—Nevada DHCFP Quality Improvement Organizational Structure



Quality Strategy Purpose, Scope, and Goals

Purpose of the Quality Strategy

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

- Establish a comprehensive quality improvement system that is consistent with the National Quality Strategy and CMS Triple Aim to achieve better care for patients, better health for communities, and lower costs through improvement in the health care system.

- Provide a framework for the DHCFP to 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 continuously monitor, assess, and improve access to care, clinical quality of care, and health outcomes of the population served.
- Identify opportunities for improvement in the health outcomes of the enrolled population and improve health and wellness through preventive care services, chronic disease and special needs management, and health promotion.
- Identify opportunities to improve quality of care and quality of service, and implement improvement strategies to ensure Nevada Medicaid and Nevada Check Up recipients have access to high quality and culturally appropriate care.
- Identify creative and efficient models of care delivery that are steeped in best practice and make health care more affordable for individuals, families, and the state government.
- Improve recipient satisfaction with care and services.
- Ensure that persons transitioning to managed care from fee-for-service (FFS) 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 (MSM), Chapter 3603.17.

Scope of Quality Strategy

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

- All Medicaid and Nevada Check Up managed care recipients in all demographic groups and in all service areas for which the MCEs are approved to provide Medicaid and Nevada Check Up managed care services. The DHCFP works in accordance with the State's tribal consultation policy for Native Americans who voluntarily enroll in managed care and who are members of federally recognized tribes.
- All aspects of care—including accessibility, availability, level of care, continuity, appropriateness, timeliness, and clinical effectiveness of care and services covered by Nevada Medicaid managed care and the Nevada Check Up program.
- All aspects of the MCEs' performance related to access to care, quality of care, and quality of service, including networking, contracting, and credentialing; medical record-keeping practices; environmental safety and health; health and disease management; and health promotion.
- All services covered—including preventive care services, primary care, specialty care, ancillary care, emergency services, chronic disease and special needs care, dental services, mental health services, diagnostic services, pharmaceutical services, skilled nursing care, home health care, and prescription drugs.
- All professional and institutional care in all settings, including inpatient, outpatient, and home settings.
- All providers and any other delegated or subcontracted provider type.

- All aspects of the MCEs' internal administrative processes related to service and quality of care—including customer services, enrollment services, provider relations, confidential handling of medical records and information, case management services, utilization review activities, preventive health services, health education, information services, and quality improvement.

Quality Strategy Goals and Objectives

Consistent with the National Quality Strategy and epidemiological and prevalence data displayed in Table 1-5, the DHCFP established quality goals and objectives to improve the health and wellness of Nevada Medicaid and Nevada Check Up members. Unless otherwise indicated, all objectives will follow the Quality Improvement System for Managed Care (QISMC) methodology to improve rates. Table 1-5 details the quality goals and objectives for the Nevada Medicaid managed care program.

Table 1-5—Nevada Medicaid MCO 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

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 1.6i:	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
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)

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

† Indicates that this measure was retired by NCQA and will no longer be reported in 2020 and 2021.

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

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

In 2018, the DHCFP established a minimum performance standard (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 MCOs could achieve through continuous focus and improvement for each of the indicators that represent an objective. This will allow the DHCFP to use this methodology, as appropriate, in the development of its quality rating system.

Strategy for Meeting Goals and Objectives

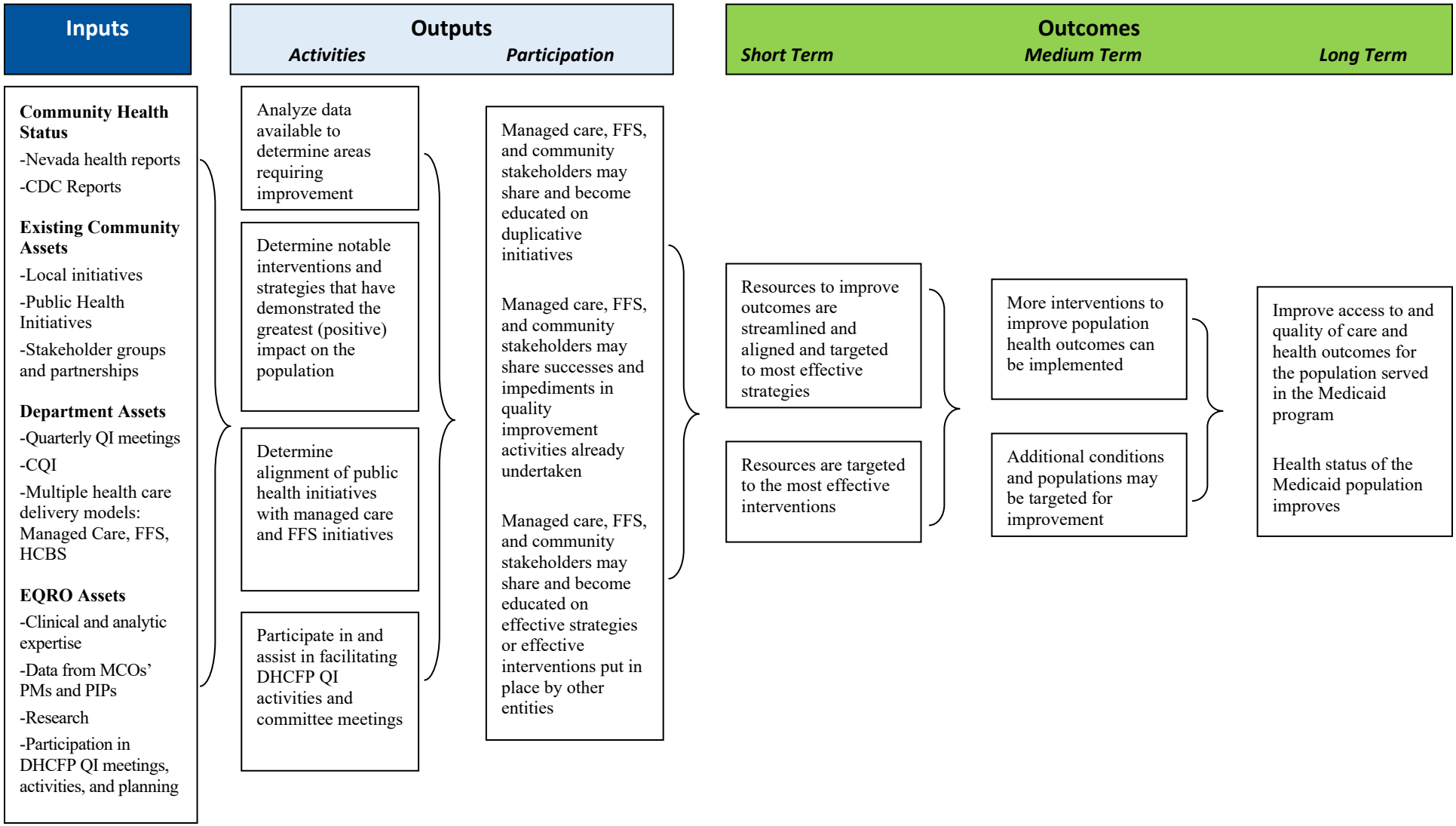
The methods employed by the DHCFP to achieve these goals include:

- Developing and maintaining collaborative strategies among State agencies and external partners to improve health education and health outcomes, manage vulnerable and at-risk members, and improve access to services for all Nevada Medicaid and Nevada Check Up recipients.
- Using additional performance measures, performance improvement projects, contract compliance monitoring, and emerging practice activities to drive improvement in member health care outcomes.

- Strengthening evidence-based prevention, wellness, and health management initiatives to improve members' health status and achievement of personal health goals.
- Enhancing member services and member satisfaction with services.
- Improving health information technology to ensure that information retrieval and reporting are timely, accurate, and complete.
- Working collaboratively with other Department of Health and Human Service divisions and community resources to improve access to and quality of care and health outcomes of the populations served by Medicaid.

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

Figure 1-2—DHCFP's Logic Model for Improving Health Outcomes



CDC – Centers for Disease Control and Prevention; CQI – continuous quality improvement; HCBS – home and community-based services; PM – performance measure

Medicaid Contract Provisions (42 CFR §438.66)

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

The DHCFP monitors all aspects of the managed care program, including the performance of each MCE in at least the following areas:

- Administration and management
- Appeal and grievance systems
- Claims management
- Enrollee materials and customer services, including activities of the beneficiary support system
- Finance, including medical loss ratio reporting
- Information systems, including encounter data reporting
- Marketing
- Medical management, including utilization management and case management
- Program integrity
- Provider network management, including provider directory standards
- Availability and accessibility of services, including network adequacy standards
- Quality improvement
- Other contract provisions, as needed

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

Use of National Performance Measures and Performance Measure Reporting

Performance Measure Reporting

The DHCFP uses HEDIS data whenever possible to measure the MCEs' performance with specific indices of quality, timeliness, and access to care. The DHCFP's EQRO conducts NCQA HEDIS Compliance Audits™[1-2] of the MCOs annually and reports the HEDIS results to the DHCFP as well as to NCQA. The DHCFP's EQRO also conducts annual performance measure validation of the dental PAHP, **LIBERTY**. As part of the EQR annual technical report, the EQRO trends each MCO's rates

[1-2] NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

over time and also performs a comparison of the MCOs' rates as well as a comparison of each MCO's rates to the established MPS and performance tiers. The EQRO will use trending to compare **LIBERTY**'s rates year-over-year to determine if improvement in the dental-related measures is occurring.

Children's Health Insurance Program Reauthorization Act

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

Medicaid and CHIP Program (MACPro) System Reporting

In 2016, the DHCFP began reporting in the MACPro system the results for adult, child, and maternal and infant health quality measures it collects. The DHCFP continually works with the CMS to report all available data as part of CMS' state quality reporting initiatives.

Use of Corrective Action Plans (42 CFR §438.340[b][7])

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

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

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

Quality and Appropriateness of Care (42 CFR §438.340[a])

Procedures for Age, Sex, Race, Ethnicity, Disability Status and Primary Language Data Collection and Communication (42 CFR §438.340[b][6])

To comply with the regulatory requirement for state procedures for race, ethnicity, and primary language spoken (CFR §438.206–§438.210), the DHCFP requires the MCEs to participate in Nevada's efforts to promote the delivery of service in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds. The DHCFP continually monitors how age, sex, race, ethnicity, disability status and the primary language of enrollees are collected, coded, and entered into the system to ensure that this information is compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and with CMS requirements to improve the delivery of services in a culturally competent manner. The DHCFP provides demographic information for age, sex, race, ethnicity, disability status, and primary language spoken to the health plans as part of the member eligibility file. Health plans are required to use the data in their efforts to identify and overcome health disparities.

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

As part of their cultural competency initiatives, the MCEs examine disparities through analysis of their performance measures and PIPs. The MCEs examine performance measures used as indicators for assessing achievement of the State's Quality Strategy goals and objectives, which are detailed in Section 1. The MCEs are required to stratify PIP and performance measure data by race/ethnicity to identify disparities and opportunities to overcome barriers that impede improvement. Based on their findings, the MCEs incorporate specific interventions for race and ethnicity to improve indicator rates. Further, the MCEs are required to document stratification findings and planned interventions to reduce health care disparities in their annual CCP evaluation and Quality Strategy evaluation. Both documents are submitted to the DHCFP annually for review and approval.

Identification of Members With Special Health Care Needs (42 CFR §438.340[b][9])

The DHCFP monitors quality and appropriateness of services for children with special health care needs through compliance monitoring activities and regular review of the MCEs' deliverables. The DHCFP monitors quarterly reports and tracks and trends results to determine patterns of utilization, and monitors performance of each MCE. The DHCFP monitors services provided to children with special health care needs to identify the need for continued services throughout treatment to ensure that all services are medically necessary according to federal Medicaid regulations at CFR §440.110.

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

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

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

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

Current School-Based Services

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

Eligibility

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

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

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

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

Arrangement for External Quality Review (42 CFR §438.340[b][4])

In accordance with 42 CFR §438.356, the DHCFP contracts with HSAG as its EQRO to conduct the mandatory and optional EQR activities as set forth in 42 CFR §438.358.

Mandatory EQR Activities

To evaluate the quality and timeliness of, and access to, the services covered under the MCE contract, the DHCFP's EQRO conducts mandatory EQR activities for the Nevada Medicaid and Nevada Check Up program. DHCFP has determined that the mandatory activities completed by the EQRO do not duplicate activities performed by private accreditation. DHCFP has contracted with its EQRO to perform the following:

- **Compliance monitoring evaluation.** The DHCFP's EQRO conducts comprehensive, internal IQAP on-site reviews of compliance of the MCEs at least once in a three-year period. The DHCFP's EQRO reviews MCE compliance with standards established by the State for access to care, structure and operations, and quality measurement and improvement. These standards are as stringent as the federal Medicaid managed care standards described in 42 CFR §438, which address requirements related to access, structure and operations, and measurement and improvement. Compliance is also determined through review of individual files to evaluate implementation of standards.
- **Validation of performance measures.** In accordance with 42 CFR §438.340(b)(3)(i), the DHCFP requires MCEs to submit performance measurement data as part of their quality assessment and performance improvement (QAPI) programs. To comply with 42 CFR §438.358(b)(1)(ii), the DHCFP's EQRO validates the performance measures through NCQA HEDIS Compliance Audits for MCOs and performance measure validation audits for the DBA/PAHP. The NCQA HEDIS Compliance Audits focus on the ability of the MCEs to accurately process claims and encounter data, pharmacy data, laboratory data, enrollment (or membership) data, and provider data. The DHCFP's EQRO validates each of the performance measures identified by the State to evaluate their accuracy as reported by, or on behalf of, the MCE. As part of the NCQA HEDIS Compliance Audits and performance measure validation audits, the DHCFP's EQRO also explores the issue of completeness of claims and encounter data to improve rates for the performance measures.
- **Validation of PIPs.** As described in 42 CFR §438.340(b)(3)(ii), the DHCFP requires MCEs to conduct PIPs in accordance with 42 CFR §438.330(d). PIPs must be designed to achieve significant and sustained improvement in clinical and nonclinical areas of care through ongoing measurement and intervention, and they must be designed to have a favorable effect on health outcomes and enrollee satisfaction. In accordance with 42 CFR §438.358(b)(1)(i), the DHCFP's EQRO validates PIPs required by the State to comply with the requirements of 42 CFR §438.330(d). The DHCFP's EQRO validation determines if PIPs were designed to achieve improvement in clinical and nonclinical care, and if the PIPs would have a favorable effect on health outcomes and enrollee satisfaction.
- **Network Adequacy Validation.** In accordance with 42 CFR §438.358(b)(1)(iv), the DHCFP's EQRO performs validation of MCE network adequacy. The analysis evaluates three dimensions of access and availability:
  - Capacity—provider-to-recipient ratios for Nevada's provider networks as defined by each MCE contract.
  - Geographic network distribution—time/distance analysis for applicable provider specialties and average distance (miles) to the closest provider as defined by each MCE contract.

– Appointment availability—average length of time (number of days) to see a provider as defined by each MCE contract.

Optional EQR Activities

The DHCFP's EQRO conducts the following optional EQR activities for the Nevada Medicaid and Nevada Check Up program:

- Evaluate the State's Quality Strategy and the managed care program's achievement of goals and objectives identified in the strategy.
- Provide an analysis of the results of Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[2-1] activities conducted by the MCEs.
- Provide technical assistance to the DHCFP with activities related to managed care as well as the fee-for-service program
- Conduct encounter data validation of MCE encounter data.

EQR Technical Reporting

The BBA, Public Law 105-33, requires states to prepare an annual technical report that describes the manner in which data were aggregated and analyzed and how conclusions were drawn as to the quality and timeliness of, and access to, care and services furnished by the states' MCEs. The DHCFP's EQRO produces the EQR technical report, which presents all mandatory and optional EQR activities performed.

The EQR technical report includes a review of recipients' access to care and the quality of services received by recipients of Title XIX, Medicaid, and Title XXI, Nevada Check Up. In accordance with 42 CFR §438.364, the report includes the following information for each mandatory activity conducted:

- Assessment of quality, timeliness, and access to the care furnished by the MCE
- Activity objectives
- Technical methods of data collection and analysis
- Description of data obtained
- Conclusions drawn from the data
- Assessment of MCE strengths and weaknesses, as well as recommendations for improvements
- Methodologically appropriate comparative information about all MCEs in the program

The DHCFP uses the information obtained from each of the EQR activities, as well as the information presented in the EQR technical report, to make programmatic changes and modifications to the DHCFP Quality Strategy. The EQR technical report also contains a chapter that describes the EQRO's

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

evaluation of the State's QAPI program. The chapter includes the Quality Strategy Goals and Objectives Tracking Table, which lists the goals and objectives described in Section 1 of the Quality Strategy and the MCE's achievement of each objective. The most recent EQR technical report may be accessed at: http://dhcfp.nv.gov/Resources/AdminSupport/Reports/CaseloadData/.

State Monitoring and Evaluation of MCE Requirements (42 CFR §438.340[b][3][i])

Performance Measures Used to Assess Members' Timely Access to Appropriate Health Care (42 CFR §438.330[c][1][i])

The DHCFP uses HEDIS to develop, collect, and report data for most performance measures for MCOs. The DHCFP uses dental measures from the CMS Child Core Measure Set for the DBA. The DHCFP's EQRO is contractually required to validate MCEs' performance measures. The DHCFP tracks MCE performance for each of the required performance measures using the Quality Strategy Goals and Objectives Tracking Table, as described later in this section. The DHCFP identified the following indicators to measure MCEs' success in improving access to care and quality and timeliness of services provided to Nevada Medicaid and Nevada Check Up recipients.

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

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

MCO HEDIS Measures	Medicaid	Check Up	Child Core	Adult Core
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services (AAP)				
Ages 20–44 Years	X	–	–	–
Ages 45–64 Years	X	–	–	–
Ages 65 Years and Older	X	–	–	–
Total	X	–	–	–
Children and Adolescents' Access to Primary Care Practitioners (CAP)				
Ages 12—24 Months	X	X	X	–
Ages 25 Months–6 Years	X	X	X	–
Ages 7–11 Years	X	X	X	–
Ages 12–19 Years	X	X	X	–

MCO HEDIS Measures	Medicaid	Check Up	Child Core	Adult Core
Children's Preventive Care				
Adolescent Well-Care Visits (AWC)				
Adolescent Well-Care Visits	X	X	X	–
Childhood Immunization Status (CIS)				
Combination 2	X	X	X	–
Combination 3	X	X	X	–
Combination 4	X	X	X	–
Combination 5	X	X	X	–
Combination 6	X	X	X	–
Combination 7	X	X	X	–
Combination 8	X	X	X	–
Combination 9	X	X	X	–
Combination 10	X	X	X	–
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	X	X	X	–
Combination 2 (Meningococcal, Tdap, HPV)	X	X	X	–
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile—Total	X	X	X	–
Counseling for Nutrition—Total	X	X	X	–
Counseling for Physical Activity—Total	X	X	X	–
Well-Child Visits in the First 15 Months of Life (W15)				
Six or More Well-Child Visits	X	X	X	–
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	X	X	X	–
Women's Health and Maternity Care				
Breast Cancer Screening (BCS)				
Breast Cancer Screening	X	–	–	X
Prenatal and Postpartum Care (PPC)				
Timeliness of Prenatal Care	X	–	–	X
Postpartum Care	X	–	–	X
Care for Chronic Conditions				
Comprehensive Diabetes Care (CDC)				
HbA1c Testing	X	–	–	X

MCO HEDIS Measures	Medicaid	Check Up	Child Core	Adult Core
*HbA1c Poor Control (>9.0%)**	X	–	–	X
HbA1c Control (<8.0%)	X	–	–	–
Eye Exam (Retinal) Performed	X	–	–	–
Medical Attention for Nephropathy	X	–	–	–
Blood Pressure Control (<140/90 mm Hg)	X	–	–	–
Controlling High Blood Pressure (CBP)				
Controlling High Blood Pressure	X	–	–	X
Medication Management for People With Asthma (MMA)				
Medication Compliance 50%—Total	X	X	–	–
Medication Compliance 75%—Total	X	X	–	–
Behavioral Health				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	X	X	–	–
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	X	–	–	X
Follow-Up After ED Visit for AOD Abuse or Dependence (FUA)				
7-Day Follow-Up—Total	X	–	–	–
30-Day Follow-Up—Total	X	–	–	–
Follow-Up After ED Visit for Mental Illness (FUM)				
7-Day Follow-Up	X	X	X	X
30-Day Follow-Up	X	X	X	X
Follow-Up After Hospitalization for Mental Illness (FUH)				
7-Day Follow-Up	X	X	X	X
30-Day Follow-Up	X	X	X	X
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
Initiation Phase	X	X	X	–
Continuation and Maintenance Phase	X	X	X	–
Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)				
Initiation of AOD Treatment—Total	X	–	–	X
Engagement of AOD Treatment—Total	X	–	–	X

MCO HEDIS Measures	Medicaid	Check Up	Child Core	Adult Core
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)				
Total	X	X	–	–
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)				
*Total**	X	X	X	–
Utilization				
Ambulatory Care (per 1,000 Member Months) (AMB)				
*ED Visits—Total**	X	X	X	–
Outpatient Visits—Total	X	X	X	–
Mental Health Utilization—Total (MPT)				
Inpatient—Total	X	X	–	–
Intensive Outpatient or Partial Hospitalization—Total	X	X	–	–
Outpatient—Total	X	X	–	–
ED—Total	X	X	–	–
Telehealth—Total	X	X	–	–
Any Service—Total	X	X	–	–
Plan All-Cause Readmissions (PCR)				
*Plan All-Cause Readmissions**	X	–	–	X
Overuse/Appropriateness of Care				
Use of Opioids at High Dosage (HDO)				
*Use of Opioids at High Dosage**	X	–	–	–
Use of Opioids From Multiple Providers (UOP)*				
Multiple Prescribers	X	–	–	–
Multiple Pharmacies	X	–	–	–
Multiple Prescribers and Multiple Pharmacies	X	–	–	–

* A lower rate indicates better performances for this measure.

DBA HEDIS Measures	Medicaid	Check Up	Child Core	Adult Core
Oral Health				
Annual Dental Visit (ADV)				
Total	X	X	–	–
Percentage of Eligibles Who Received Preventive Dental Services				
Total	X	X	X	–

Standards for Access to Care

The contracts between the DHCFP and the MCEs detail Nevada Medicaid standards for access to care, as outlined in Subpart D of the Medicaid Managed Care Rules and Regulations. The DHCFP's standards are at least as stringent as those specified in 42 CFR §438.206–§438.210. The MCEs are required to implement the following standards for access to care:

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

In addition, DHCFP will continue to monitor access to care through enrollee and provider feedback and develop innovative ways to expand availability of services. Please see Attachment A for the DHCFP's timeline for monitoring MCEs. Attachment B, Quality Strategy Goals and Objectives Tracking Grid, serves as the State's profile for monitoring MCEs' performance against the goals and objectives outlined in this Quality Strategy.

The DHCFP's contract with its Medicaid managed care organizations and all applicable amendments may be accessed by contacting the DHCFP.

Standards for Structure and Operations

The contracts between the DHCFP and the MCEs detail Nevada Medicaid standards for structure and operations, as outlined in Subpart D of the Medicaid Managed Care Rules and Regulations. The DHCFP's standards are at least as stringent as those specified in 42 CFR §438.10, §438.54–§438.56, and §438.214–§438.242. The MCEs are required to implement the following standards for structure and operations:

- Provider selection and credentialing (42 CFR §438.214)
- Enrollee information (42 CFR §438.10)
- Confidentiality (42 CFR §438.224)
- Enrollment and disenrollment (42 CFR §438.54 and §438.56)
- Grievance systems (42 CFR §438.228 and 42 CFR §438 Subpart F)
- Subcontractual relationships and delegation (42 CFR §438.230)

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

Measurement and Improvement Standards

The contracts between the DHCFP and the MCEs detail Nevada Medicaid standards for measurement and improvement, as outlined in Subpart D of the Medicaid Managed Care Rules and Regulations. The

DHCFP's standards are at least as stringent as those specified in 42 CFR §438.236–242. The MCEs are required to implement the following standards for measurement and improvement:

- Practice Guidelines (42 CFR §438.236)
- Quality assessment and performance improvement program (42 CFR §438.330)
- Health information systems (42 CFR §438.242)

Performance Improvement Projects (PIPs)

As described in 42 CFR §438.330(b)(1), the DHCFP requires MCEs to conduct PIPs annually, in accordance with 42 CFR §438.330(d). PIPs must be designed to achieve significant and sustained improvement in clinical and nonclinical areas of care through ongoing measurement and intervention and to have a favorable effect on health outcomes and enrollee satisfaction. In accordance with 42 CFR §438.358(b)(1)(i), the DHCFP's EQRO validates PIPs required by the State and 42 CFR §438.330(b)(1) on an annual basis.

The primary objective of PIP validation is to determine compliance with the requirements of 42 CFR §438.330(b)(1) and 42 CFR §438.330(d)(2)(i–iv), including:

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

Table 2-2 lists the Nevada MCO PIPs to be completed in 2019.

Table 2-2—Nevada MCO PIPs

Performance Improvement Project	HPN	Anthem	SilverSummit
Increase Follow-Up After Emergency Room Visit for Mental Illness Within 7 Days	X	X	X
Increase Well-Child Visits for Children 3–6 Years of Age	X	X	X

Table 2-3 lists the Nevada Dental PIPs.

Table 2-3—Nevada Dental PIPs

Performance Improvement Project	LIBERTY
Improve Caries Risk Assessment Completion Rate	X
Increase Annual Dental Visits	X

In 2016, the DHCFP's EQRO worked with the DHCFP, CMS, and the MCEs to implement a rapid-cycle improvement (RCI) approach to PIPs. The purpose of the RCI PIPs is to place greater emphasis on

improving both health care outcomes and processes through the integration of quality improvement science. The approach guides MCEs through a process using a rapid-cycle improvement method to pilot and continually test small changes rather than implementing one large transformation at once. Performing small tests of change requires fewer resources and allows more flexibility to make adjustments throughout the improvement process. By piloting on a smaller scale, MCEs can determine the effectiveness of several changes prior to expanding successful interventions.

The EQRO continually assesses and validates the approaches used by the MCEs ongoing, and annually reports the results of PIPs to the DHCFP. The DHCFP uses PIP results to assess each MCE's achievement of goals and to make any necessary modifications to the Quality Strategy based on each MCE's performance.

Measurement of Recipient Satisfaction

Annually, the MCOs administer a CAHPS survey, unless the requirement is waived by the DHCFP due to an EQRO-performed survey. The primary objective of the CAHPS survey is to obtain information on the level of satisfaction patients have with their health care experiences. CAHPS surveys ask recipients to report on and evaluate their experiences with health care. These surveys cover topics important to recipients, such as the communication skills of providers and the accessibility of services.

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

Annually, the DBA is required to conduct a member satisfaction survey of all populations served in the program and submit the results to the DHCFP. The DHCFP's EQRO analyzes the results as part of the annual Quality Strategy evaluation that is reported in the annual EQR technical report.

State Monitoring and Evaluation of MCEs' Contractual Compliance (42 CFR §438.66)

Compliance Review (42 CFR §438.358[b][1][iii])

According to 42 CFR §438.358, which describes the activities related to external quality reviews, a state or its EQRO must conduct a review within a three-year period to determine a Medicaid MCE's compliance with standards established by the state for access to care, structure and operations, and quality measurement and improvement. The review must include those standards detailed in 42 CFR §438 Subpart D as well as those detailed in 42 CFR §438.330. To meet this requirement, the DHCFP contracts with its EQRO to perform a comprehensive review of compliance of the MCEs.

The purpose of the compliance review is to determine each MCE's compliance with various quality assessment/improvement standards in 15 areas of compliance. The 15 compliance standards are derived from requirements in the *Department of Human Resources Division of Health Care Financing and Policy Request for Proposal No. 3260 for Medicaid Managed Care Organization Services* and all attachments; as well as the Code of Federal Regulations. The 15 compliance standards are listed below:

- Credentialing and Recredentialing
- Availability and Accessibility of Services
- Subcontracts and Delegation
- Provider Dispute and Complaint Resolution
- Provider Information
- Member Rights and Responsibilities
- Member Information
- Continuity and Coordination of Care
- Grievance and Appeals
- Coverage and Authorization of Services
- Internal Quality Assurance Program (IQAP)
- Cultural Competency Program
- Confidentiality and Record Keeping
- Enrollment and Disenrollment
- Program Integrity

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

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

[2-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Feb 19, 2019.

Health Information Systems (42 CFR §438.242)

Health Information Technology (42 CFR §438.242)

On February 1, 2019, the DHCFP implemented Stage 3 of Medicaid Management Information Systems (MMIS) new interChange system with its partner DXC Technology. The Stage 3 release included the core functionality for processing of claims, financial, managed care, contact management tracking system (call tracking), third party liability, and an upgraded data warehouse for reporting. The upgraded MMIS will enable more efficient data collection on enrollee and provider characteristics as well as collection and maintenance of encounter data.

Goals and Objectives Tracking Table (42 CFR §438.242)

To continually track the progress of achieving the goals and objectives outlined in the Quality Strategy, the DHCFP developed the Quality Strategy Goals and Objectives Tracking Table (Quality Strategy Tracking Table). The Quality Strategy Tracking Table lists each of the goals and objectives and corresponding performance measures used to measure achievement of the goals and objectives. The DHCFP and its EQRO update the Quality Strategy Tracking Table annually. In addition to sharing the revised table with the MCEs, the Medicaid and Nevada Check Up administration, and other stakeholders, the DHCFP's EQRO incorporates the Quality Strategy Tracking Table as Appendix B of the annual EQR technical report.

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

3. Improvement Interventions

The DHCFP quality improvement program embodies a continuous quality improvement (CQI) process and problem-solving approach applied to specific and measurable performance indicators and operational activities. The CQI process is used to (1) monitor access to care, timeliness and quality of care, and operational performance; (2) identify opportunities for improvement that exist throughout the Nevada Medicaid program; (3) implement intervention strategies to improve outcomes and performance; (4) evaluate interventions to determine successfulness; and (5) reassess performance through remeasurement to identify new opportunities for improvement. To ensure that a consistent process for CQI is applied, the DHCFP has adopted the W. Edwards Deming cycle of performance improvement—Plan-Do-Study-Act (PDSA).[3-1] The PDSA cycle follows a systematic series of steps for gaining knowledge about how to improve a process or outcome. The PDSA cycle, depicted in Figure 3-1, is defined as:

1. **Plan:** Define the objective, interventions, questions, and hypotheses that will answer the following questions: *Who? What? Where? When?* Data collection should be targeted toward answering the questions.
2. **Do:** Carry out the plan (and interventions) by collecting data and beginning data analyses.
3. **Study:** Complete the data analysis and compare results to predictions to determine if interventions were successful or if opportunities for improvement still exist. Summarize what was learned.
4. **Act:** Plan the next cycle. If interventions were successful, plan to extend or standardize them. If interventions were not successful, replace them with new interventions intended to bring about truly improved processes or outcomes.

Figure 3-1—DHCFP PDSA Cycle

[3-1] The W. Edwards Deming Institute. PDSA Cycle. Available at: https://deming.org/explore/p-d-s-a. Accessed on: Feb 25, 2019.

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

- Maintaining a robust quality improvement framework that encompasses a continuous quality improvement approach, as described above.
- Using HEDIS and other performance measures, as described in Section II, to continually assess each MCE's achievement of the goals and objectives described in Section I.
- Implementing PIPs, which measure and assess targeted performance improvement interventions on specific topics.
- Monitoring CAHPS results and other satisfaction survey data to determine how satisfied Nevada Medicaid recipients are with care and services they receive.
- Monitoring the MCEs' quality improvement activities and compliance with contractual requirements to verify if the MCEs are appropriately implementing federal and State contractual standards.
- Facilitating cross-agency collaborative meetings to identify opportunities to improve service delivery and to leverage resources to achieve common goals.
- Trending performance measure results to ensure that the MCEs' performance is improving over time.
- Implementing other initiatives, as needed, to adhere to changes in federal policy.
- Studying the healthcare disparities among racial and ethnic groups to implement targeted and culturally competent interventions to ensure that all Medicaid and Nevada Check Up recipients have access to high-quality care.
- Studying the healthcare disparities among members with special health care needs as well as by age, sex, or disability status to implement targeted interventions to ensure that all Medicaid and Nevada Check Up recipients have access to high-quality care.

4. Evaluation of Effectiveness

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

Annual Evaluation of the Quality Strategy (42 CFR §438.340[c][2])

The annual evaluation includes an assessment of:

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

Quality Tools Used to Evaluate Quality Strategy

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

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

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

Quality Strategy Revision

The DHCFP updates the Quality Strategy at least triennially to incorporate new goals and objectives for the following years. The DHCFP updates the Quality Strategy more often, as needed, to reflect changes in State or federal policy that impact the Medicaid or Nevada Check Up programs and changes to managed care population. Prior to each update, the DHCFP solicits stakeholder input on the goals and objectives of the Quality Strategy. Once input is received and consensus is reached by all stakeholders, the Quality Strategy is finalized, shared with all pertinent stakeholders, sent to CMS, and posted on the DHCFP Web site for public view. The DHCFP invites public comment by way of public workshops and by emailing the DHCFP at techhelp@dhcfp.nv.gov.

5. MCE Quality Improvement Presentations

In the second quarter of each fiscal year, the DHCFP's EQRO highlights the MCEs' performance related to the access to and timeliness and quality of services furnished by the MCEs and discovered through the mandatory EQR activities. The summary of EQR activities includes a profile of MCE performance measure rates, PIP results, compliance review results, and network adequacy validation results. DHCFP's EQRO presents the summary during the fall MCE Quarterly Quality meeting each year. At this meeting staff members from each MCE, the DHCFP, and the EQRO discuss the areas of strength noted for each MCE as well as opportunities for improvement. The meeting attendees also discuss opportunities for collaboration between the DHCFP and the MCEs to drive managed care program enhancements that lead to improved member health outcomes.

As part of the EQRO's presentation during the fall quarterly meeting, MCEs are given MCE-specific assignments to present the quality activities occurring at each MCE during future meetings. The MCE assignments are based on high and low performance areas for each MCE. MCE presentations include, but are not limited to:

- Successful interventions used to positively impact performance measures, as evidenced by an improvement of 5 percentage points or more.
- Barrier analyses performed to identify the potential causes that impacted performance measures such that they resulted in a significant decline in performance.
- Program and health policies that impact the delivery of services.
- Rapid-cycle improvement tools used to test the efficacy of interventions used in PIPs and other quality improvement projects.

The presentations provided by the MCEs foster ongoing dialogue among HSAG, MCE, and the DHCFP staff members regarding the interventions that had the greatest impact on the Medicaid population. The discussions regarding each MCE's barrier analyses also highlight unsuccessful strategies employed by the MCEs that require improvement. Further, staff members from the MCEs, the DHCFP, and HSAG discuss State health policies that have the potential to impact performance measures, both positively and negatively. This type of discussion is most useful for the DHCFP staff members who are not necessarily involved in the managed care program but are involved in the maintenance of State health policies that impact managed care members. Because the DHCFP and the MCEs find this exercise helpful, the DHCFP's EQRO continues to facilitate these discussions during the quarterly quality meetings and use information garnered from the annual evaluation of the goals and objectives outlined in the Quality Strategy to fuel the presentation requests.

6. Emerging Practices and Collaboration

In November 2009, the DHCFP submitted its 2010–2011 Quality Strategy to CMS for review and implemented it in 2010. Since that time, the DHCFP, its EQRO, and the MCEs have continually monitored the goals and objectives of the Quality Strategy during teleconference and quarterly face-to-face MCE meetings. Extending beyond managed care, DHCFP has engaged in other Medicaid collaborative quality initiatives that further enhance the Medicaid program in Nevada. Since the last revision of this Quality Strategy, the DHCFP has highlighted the following quality improvement initiatives and emerging practices.

Quality Initiatives and Emerging Practices

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

Another method used by the DHCFP to promote best and emerging practices among the MCEs is to ensure that the State's contractual requirements for the MCEs are at least as stringent as those described in Subpart D of the BBA regulations for access to care, structure and operations, and quality measurement and improvement (42 CFR §438.206–§438.242). The DHCFP actively promotes the use of nationally recognized protocols, standards of care, and performance targets by which health plan performance is measured.

Collaborative Quality Initiatives—DHCFP and MCEs

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

Encounter Data Validation (EDV) Study

High-quality encounter data from Nevada MCEs are necessary to evaluate and improve quality of care, assess utilization, develop appropriate capitation rates, and establish acceptable rates of performance. To identify the opportunities for improvement that exist with MCE encounter data, the DHCFP contracted

with its EQRO to conduct an EDV study of MCE encounter data. The purpose of the study is to determine the accuracy and completeness of MCE encounter data compared to the data included in the DHCFP's data warehouse. Further, the EDV study evaluates medical record data to validate that is consistent with what was submitted to the MCE and ultimately to the DHCFP. The results from the EDV study will enable the DHCFP and the MCEs to identify inconsistencies between the two sets of data—individual MCE data and the DHCFP's data—and determine what system improvements must be made to improve encounter data quality.

MCE Annual Quality Improvement Evaluation

The MCEs are required to submit an annual evaluation of the quality improvement program and activities employed by the MCE for the previous year. The MCEs' annual evaluations include trends and statistical information that describe and depict the performance for each quality activity and associated indicators developed by the MCE. Annual evaluations also include an analysis and evaluation of clinical and related service areas requiring improvement for each of the quality measures that pertain to the population. The DHCFP requires the MCEs to provide an evaluation of each of the Nevada Medicaid and Nevada Check Up quality measures. As part of this effort, the MCEs are required to stratify performance measure rates by race and ethnicity. After stratifying the data, the MCEs are required to identify any health care disparities among the groups and develop a plan targeting interventions to reduce and/or eliminate disparities for members and increase performance measure rates overall. DHCFP's EQRO reviews the annual quality evaluations submitted by each MCE to verify that the MCE stratified data according to the parameters set by the DHCFP and deployed interventions to further reduce or eliminate health disparities while improving performance measure rates.

Disparities in Health Care

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

The MCEs, in cooperation with the DHCFP, are required to develop and implement cultural CCPs that encourage delivery of services in a culturally competent way to all recipients, including those with limited English proficiency and diverse cultural and ethnic backgrounds. The MCEs are also required to ensure that appropriate foreign language versions of all member materials are developed and available to members, and to provide interpreter services for members whose primary language is not English. The DHCFP reviews and approves all member materials as part of a readiness review for all new MCEs entering the Nevada Medicaid managed care program.

As part of their cultural competency initiatives, the MCEs examine disparities through analysis of their performance measures and PIPs. The MCEs also examine indicators used for assessing achievement of the Quality Strategy goals and objectives. The MCEs stratify PIP and performance measure data by race/ethnicity to identify disparities and opportunities to overcome barriers that impede improvement. Based on their findings, the MCEs incorporate specific interventions for race and ethnicity to improve

indicator rates. Furthermore, the MCEs are required to document stratification findings and planned interventions to reduce health care disparities in their annual cultural competency plan evaluation and Quality Strategy evaluation. Both documents are submitted to the DHCFP annually for review and approval.

7. Ongoing Challenges and Opportunities to Improve

Data Collection: Challenges and Opportunities

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

- The DHCFP is completing an evaluation of alternative service delivery models which aim to achieve better care for patients, better health for its communities, and lower costs through improvement in the healthcare system.
  - **Opportunity:** The DHCFP is evaluating different service delivery options for its Medicaid program. One option under consideration is the expansion of the managed care program, which could include expanding statewide—including additional services not currently covered by managed care, expanding the population served by managed care, or increasing the number of managed care plans participating in the program.

Challenges to Improving Care and Opportunities to Overcome Those Challenges

There are multiple challenges and barriers to improving the quality of care and access to services for the members served in the Medicaid and Nevada Check Up programs. Following are some ongoing challenges and opportunities to overcome those challenges for improving care within the Nevada Medicaid program.

- The MCEs report many challenges related to lack of member understanding of appropriate care and appropriate settings for care. MCEs also report lack of provider understanding of proper methods for documenting services and coding of claims for HEDIS reporting as well as inappropriate referrals of services. The MCEs have outreached to members to inquire why some seek primary care services in emergency departments rather than urgent care or primary care provider offices. In a focus group discussion, members reported not realizing a difference between emergency room and urgent care centers—except that emergency departments are open and accessible 24 hours per day, 7 days per week. Further, members reported that after seeking care at an emergency room for a bone fracture or sutures, they were counseled by emergency room staff to return to the emergency room for cast or suture removal.
  - **Opportunity:** The MCEs will continue to engage in educational campaigns for both members and providers. The MCEs will continue to meet with providers in their offices to discuss proper charting and coding of services and outreach to members to advise members to seek services in primary care provider (PCP) offices or urgent care centers. Further, the MCEs have requested to work with the DHCFP staff to meet with the hospital association to discuss non-emergent care sought by Medicaid members in the emergency room.

- Additional challenges faced by the State of Nevada also result from some of the highest State revenue-generating entities—casinos. Nevada's casino industry encourages unhealthy behavior in certain casinos by advertising free alcohol and cigarettes to individuals while they gamble. While the advertising campaigns encourage unhealthy behavior, the MCEs and the DHCFP are not able to discourage the use of these advertising campaigns.
  - **Opportunity:** The expansion of Medicaid eligibility to cover more persons provided Nevada with the unique opportunity to provide Medicaid coverage to persons who previously did not have health care coverage and thus did not have the same access to preventive services and health education materials and tools that Medicaid members do. Since Medicaid expansion, MCEs continue to educate the expansion population on healthy behaviors, including offering preventive care services and providing care management to members with chronic health conditions.
- According to the Federal Register, 42 CFR Parts 412 and 413, section §412.64, titled "Frontier States," Nevada is a frontier state. This means that access to physicians is limited in rural areas. "Frontier state" is a state wherein at least 50 percent of counties contain less than six people per square mile. The low density of the populations within Nevada counties makes it difficult to locate providers near members and encourages members to travel a distance for medical care. Further, the University of Nevada, Reno School of Medicine reports that Nevada ranked 47 nationally for active physicians per 100,000 population.
  - **Opportunity:** Governor Sandoval signed a bill in June 2015 authorizing $27 million for the University of Nevada School of Medicine, Las Vegas to combat physician shortages in the State. The funding will enable Nevada to bring a medical school to southern Nevada, benefitting the surrounding communities. The school launched in the fall 2017 with 60 students.
  - **Opportunity:** Outreach initiatives to retain physicians who train in the State are having beneficial effects. The University of Nevada, Reno School of Medicine reported that in 2017, 76.7 percent of physicians who completed both undergraduate and graduate medical education in State are currently practicing in Nevada.[7-1]

[7-1] Bowen, T., University of Nevada, Reno School of Medicine report addresses statewide physician shortage, shows growth. July 2018. Available at: https://med.unr.edu/news/archive/2018/physician-workforce-in-nevada. Accessed on: Feb 4, 2019.

Attachment A. Quality Monitoring Schedule

DHCFP Quality Monitoring Activity	DHCFP Monitoring Schedule
Enrollee and Provider Grievance and Appeals Reporting (DHCFP)	
MCE/Subcontractor Grievance Reporting Form	Quarterly
Notice of Action (NOA) Reporting Form	Quarterly
MCE Appeals Reporting Form	Quarterly
Subcontractor's Appeals Reporting Form	Quarterly
MCE Provider Dispute Reporting Form	Quarterly
Subcontractor's Provider Dispute Reporting Form	Quarterly
Quality Assurance Reporting (DHCFP)	
Maternal and Birth Data Report (Medicaid)	Quarterly
Maternal and Birth Data Report (Check Up)	Quarterly
Dental Report, Provider	Monthly
Dental Report, Patient	Monthly
Dental Report, Service Count and Cost	Monthly
CMS 416 Report	Quarterly/Annually
Member High-Cost Report	Quarterly
Hospital Adequacy Report	Quarterly
Network Adequacy Report	Quarterly
Dental Network Adequacy Report	Quarterly
Annual Quality Description, Work Plan, and Evaluation (MCE submission to DHCFP)	Annually
SED/SMI Consent, Determination, and Disenrollment (DHCFP)	
SED/SMI Consent Form	Per Contract Guidelines
SED/SMI Determination Form	Per Contract Guidelines
Request for Managed Care Disenrollment	Per Contract Guidelines
Annual Evaluation of Cultural Competency Program (CCP) (MCEs)	
Submit Annual Evaluation of CCP to DHCFP	Annually
DHCFP Evaluation of MCE CCPs	Annually

DHCFP Quality Monitoring Activity	DHCFP Monitoring Schedule
Annual Evaluation of Quality Strategy (DHCFP)	
DHCFP Evaluation of Quality Strategy	At Least Annually
DHCFP Quality Strategy Revision	As Needed

EQRO Quality Monitoring Activity	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
HEDIS Audit												
Annual HEDIS Schedule, Site Visit, Audit, and Reports	←									→		
PIP Validation												
Annual PIP Schedule, Validation, and Reports					←							→
Monitoring and Evaluation of MCE Contractual Compliance												
EQR Monitoring of MCE Contract Compliance						Annually						
Monitoring Access and Availability of Providers												
Provider Network Access and Availability Study						Annually						
Encounter Data Validation												
Encounter Data Validation Study						As Needed						
MCE Quarterly Quality Meetings												
Quality Improvement Presentations						Quarterly						

Nevada 2019–2021 Quality Strategy
Goals and Objectives for Medicaid

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

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**	**HEDIS 2018 Statewide Average**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
Objective 1.1a:	Increase children and adolescents' access to PCPs (CAP)—12–24 months	94.37%	94.93%	95.50%	96.06%	96.62%
Objective 1.1b:	Increase children and adolescents' access to PCPs (CAP)—25 months–6 years	84.07%	85.66%	87.26%	88.85%	90.44%
Objective 1.1c:	Increase children and adolescents' access to PCPs (CAP)—7–11 years	86.32%	87.69%	89.06%	90.42%	91.79%
Objective 1.1d:	Increase children and adolescents' access to PCPs (CAP)—12–19 years	84.19%	85.77%	87.35%	88.93%	90.51%
Objective 1.2:	Increase well-child visits (W15)—0–15 months	64.43%	67.99%	71.54%	75.10%	78.66%
Objective 1.3:	Increase well-child visits (W34)—3–6 years	71.52%	74.37%	77.22%	80.06%	82.91%
Objective 1.4a:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—BMI percentile	80.78%	82.70%	84.62%	86.55%	88.47%
Objective 1.4b:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—counseling for nutrition	69.59%	72.63%	75.67%	78.71%	81.75%
Objective 1.4c:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—counseling for physical activity	66.22%	69.60%	72.98%	76.35%	79.73%
Objective 1.5a:	Increase immunizations for adolescents (IMA)—Meningococcal, Tdap	83.17%	84.85%	86.54%	88.22%	89.90%
Objective 1.5b:	Increase immunizations for adolescents (IMA)—Meningococcal, Tdap, HPV	41.83%	47.65%	53.46%	59.28%	65.10%
Objective 1.6a:	Increase childhood immunization status (CIS)—Combination 2	70.61%	73.55%	76.49%	79.43%	82.37%
Objective 1.6b:	Increase childhood immunization status (CIS)—Combination 3	65.40%	68.86%	72.32%	75.78%	79.24%
Objective 1.6c:	Increase childhood immunization status (CIS)—Combination 4	64.94%	68.45%	71.95%	75.46%	78.96%
Objective 1.6d:	Increase childhood immunization status (CIS)—Combination 5	54.96%	59.46%	63.97%	68.47%	72.98%

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**	**HEDIS 2018 Statewide Average**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
Objective 1.6e:	Increase childhood immunization status (CIS)—Combination 6	31.75%	38.58%	45.40%	52.23%	59.05%
Objective 1.6f:	Increase childhood immunization status (CIS)—Combination 7	54.61%	59.15%	63.69%	68.23%	72.77%
Objective 1.6g:	Increase childhood immunization status (CIS)—Combination 8	31.64%	38.48%	45.31%	52.15%	58.98%
Objective 1.6h:	Increase childhood immunization status (CIS)—Combination 9	27.13%	34.42%	41.70%	48.99%	56.28%
Objective 1.6i:	Increase childhood immunization status (CIS)—Combination 10	27.02%	34.32%	41.62%	48.91%	56.21%
Objective 1.7:	Increase adolescent well-care visits (AWC)	48.35%	53.52%	58.68%	63.85%	69.01%
Objective 1.8:	Increase breast cancer screening (BCS)	54.33%	58.90%	63.46%	68.03%	72.60%
Objective 1.9a:	Increase adults' access to preventive/ambulatory health services (AAP)—20–44 Yrs	72.83%	75.55%	78.26%	80.98%	83.70%
Objective 1.9b:	Increase adults' access to preventive/ambulatory health services (AAP)—45–64 Yrs	79.80%	81.82%	83.84%	85.86%	87.88%
Objective 1.9c:	Increase adults' access to preventive/ambulatory health services (AAP)—65 Years and older	63.54%	67.19%	70.83%	74.48%	78.12%
Objective 1.9d:	Increase adults' access to preventive/ambulatory health services (AAP)—Total	75.19%	77.67%	80.15%	82.63%	85.11%
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)*	TBD†**	TBD	TBD	TBD	TBD
Goal 2:	**Increase Use of Evidence-Based Practices for Members With Chronic Conditions.**					
Objective #	**Objective Description**	**HEDIS 2018 Statewide Average**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
Objective 2.1a:	Increase rate of HbA1c testing for members with diabetes (CDC)	79.98%	81.98%	83.98%	85.99%	87.99%
Objective 2.1b:	Decrease rate of HbA1c poor control (>9.0%) for members with diabetes (CDC)*	43.64%	39.28%	34.91%	30.55%	26.18%
Objective 2.1c:	Increase rate of HbA1c good control (<8.0%) for members with diabetes (CDC)	47.93%	53.14%	58.34%	63.55%	68.76%
Objective 2.1d:	Increase rate of eye exams performed for members with diabetes (CDC)	57.19%	61.47%	65.75%	70.03%	74.31%
Objective 2.1e:	Increase medical attention for nephropathy for members with diabetes (CDC)	88.39%	89.55%	90.71%	91.87%	93.03%
Objective 2.1f:	Increase blood pressure control (<140/90 mm Hg) for members with diabetes (CDC)	61.91%	65.72%	69.53%	73.34%	77.15%
Objective 2.2a:	Increase medication management for people with asthma (MMA)—medication compliance 50 percent	56.71%	61.04%	65.37%	69.70%	74.03%

Goal 2:	Increase Use of Evidence-Based Practices for Members With Chronic Conditions.					
Objective #	**Objective Description**	**HEDIS 2018 Statewide Average**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
Objective 2.2b:	Increase medication management for people with asthma (MMA)—medication compliance 75 percent	34.27%	40.84%	47.42%	53.99%	60.56%
Objective 2.3:	Increase rate of controlling high blood pressure (CBP)	50.64%	55.58%	60.51%	65.45%	70.38%
Goal 3:	**Improve Appropriate Use of Opioids.**					
Objective #	**Objective Description**	**HEDIS 2019 Statewide Average†**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
Objective 3.1:	Reduce use of opioids at high dosage (HDO)*	7.43%	6.69%	5.94%	5.20%	4.46%
Objective 3.2a:	Reduce use of opioids from multiple providers (UOP)—multiple prescribers*	24.92%	22.43%	19.94%	17.44%	14.95%
Objective 3.2b:	Reduce use of opioids from multiple providers (UOP)—multiple pharmacies*	3.51%	3.16%	2.81%	2.46%	2.11%
Objective 3.2c:	Reduce use of opioids from multiple providers (UOP)—multiple prescribers and multiple pharmacies*	1.80%	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**	**HEDIS 2018 Statewide Average**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
Objective 4.1:	Increase timeliness of prenatal care (PPC)	75.41%	77.87%	80.33%	82.79%	85.25%
Objective 4.2:	Increase the rate of postpartum visits (PPC)	60.51%	64.46%	68.41%	72.36%	76.31%
Goal 5:	**Increase Use of Evidence-Based Practices for Members With Behavioral Health Conditions.**					
Objective #	**Objective Description**	**HEDIS 2018 Statewide Average**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
Objective 5.1a:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication (ADD)—initiation phase	44.54%	50.09%	55.63%	61.18%	66.72%
Objective 5.1b:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication (ADD)—continuation and maintenance phase	55.56%	60.00%	64.45%	68.89%	73.34%

Goal 5:	Increase Use of Evidence-Based Practices for Members With Behavioral Health Conditions.					
Objective #	**Objective Description**	**HEDIS 2018 Statewide Average**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
Objective 5.2:	Reduce use of multiple concurrent antipsychotics in children and adolescents (APC)*	NA‡	NA‡	NA‡	NA‡	NA‡
Objective 5.3:	Increase adherence to antipsychotic medications for individuals with schizophrenia (SAA)	40.09%	46.08%	52.07%	58.06%	64.05%
Objective 5.4:	Increase follow-up after hospitalization for mental illness (FUH)—7-day	32.72%	39.45%	46.18%	52.90%	59.63%
Objective 5.5:	Increase follow-up after hospitalization for mental illness (FUH)—30-day	49.84%	54.86%	59.87%	64.89%	69.90%
Objective 5.6:	Increase diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications (SSD)	79.37%	81.43%	83.50%	85.56%	87.62%
Objective 5.7a:	Increase follow-up after ED visit for AOD abuse or dependence (FUA)—7-day	9.12%	18.21%	27.30%	36.38%	45.47%
Objective 5.7b:	Increase follow-up after ED visit for AOD abuse or dependence (FUA)—30-day	12.89%	21.60%	30.31%	39.02%	47.73%
Objective 5.8a:	Increase follow-up after ED visit for mental illness (FUM)—7-day	41.86%	47.67%	53.49%	59.30%	65.12%
Objective 5.8b:	Increase follow-up after ED visit for mental illness (FUM)—30-day	51.02%	55.92%	60.82%	65.71%	70.61%
Objective 5.9a:	Increase initiation and engagement of AOD abuse or dependence treatment (IET)—initiation of treatment	39.16%	45.24%	51.33%	57.41%	63.50%
Objective 5.9b:	Increase initiation and engagement of AOD abuse or dependence treatment (IET)—engagement of treatment	9.93%	18.94%	27.94%	36.95%	45.96%
Objective 5.10:	Increase metabolic monitoring for children and adolescents on antipsychotics (APM)	17.03%	25.33%	33.62%	41.92%	50.22%
Goal 6:	**Reduce and/or Eliminate Health Care Disparities for Medicaid Recipients.**					
Objective #	**Objective Description**	**HEDIS 2018 Statewide Average**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
Objective 6.1:	Ensure that health plans maintain, submit for review, and annually revise cultural competency plans.	Met	Met	Met	Met	Met
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.	Met	Met	Met	Met	Met
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.	Met	Met	Met	Met	Met

Goal 7:	Increase Utilization of Dental Services.					
Objective #	**Objective Description**	**HEDIS 2017** Statewide Average**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
Objective 7.1:	Increase annual dental visits (ADV)	52.91%	57.62%	62.33%	67.04%	71.75%
Objective 7.2:	Increase percentage of eligible members who received preventive dental services	39.76%	45.78%	51.81%	57.83%	63.86%

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

† The statewide average for Objective 2.0 will be collected in HEDIS 2020 as a baseline period, and performance goals will be calculated in SFY 2021.*

† The statewide averages were established based on HEDIS 2019 data.

‡ Indicates that this measure is not applicable (NA) and has been retired by NCQA and rates will no longer be reported by the MCOs.

*** The statewide average for Objective 7.2 is based on SFY 2019 data.*

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 Access to and the Use of Preventive Services.					
Objective #	**Objective Description**	**HEDIS 2018 Statewide Average**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
Objective 1.1a:	Increase children and adolescents' access to PCPs (CAP)—12–24 months	97.53%	97.78%	98.02%	98.27%	98.52%
Objective 1.1b:	Increase children and adolescents' access to PCPs (CAP)—25 months–6 years	89.39%	90.45%	91.51%	92.57%	93.63%
Objective 1.1c:	Increase children and adolescents' access to PCPs (CAP)—7–11 years	92.57%	93.31%	94.06%	94.80%	95.54%
Objective 1.1d:	Increase children and adolescents' access to PCPs (CAP)—12–19 years	90.45%	91.41%	92.36%	93.32%	94.27%
Objective 1.2:	Increase well-child visits (W15)—0–15 months	74.87%	77.38%	79.90%	82.41%	84.92%
Objective 1.3:	Increase well-child visits (W34)—3–6 years	75.14%	77.63%	80.11%	82.60%	85.08%
Objective 1.4a:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—BMI percentile	84.06%	85.65%	87.25%	88.84%	90.44%
Objective 1.4b:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—counseling for nutrition	73.48%	76.13%	78.78%	81.44%	84.09%
Objective 1.4c:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—counseling for physical activity	70.04%	73.04%	76.03%	79.03%	82.02%
Objective 1.5a:	Increase immunizations for adolescents (IMA)—Meningococcal, Tdap	87.81%	89.03%	90.25%	91.47%	92.69%
Objective 1.5b:	Increase immunizations for adolescents (IMA)—Meningococcal, Tdap, HPV	52.82%	57.54%	62.26%	66.97%	71.69%
Objective 1.6a:	Increase childhood immunization status (CIS)—Combination 2	87.86%	89.07%	90.29%	91.50%	92.72%
Objective 1.6b:	Increase childhood immunization status (CIS)—Combination 3	81.62%	83.46%	85.30%	87.13%	88.97%
Objective 1.6c:	Increase childhood immunization status (CIS)—Combination 4	81.62%	83.46%	85.30%	87.13%	88.97%
Objective 1.6d:	Increase childhood immunization status (CIS)—Combination 5	74.81%	77.33%	79.85%	82.37%	84.89%
Objective 1.6e:	Increase childhood immunization status (CIS)—Combination 6	41.55%	47.40%	53.24%	59.09%	64.93%
Objective 1.6f:	Increase childhood immunization status (CIS)—Combination 7	74.81%	77.33%	79.85%	82.37%	84.89%

Goal 1:	Improve the Health and Wellness of Nevada's Nevada Check Up Population by Increasing Access to and the Use of Preventive Services.					
Objective #	**Objective Description**	**HEDIS 2018 Statewide Average**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
Objective 1.6g:	Increase childhood immunization status (CIS)—Combination 8	41.55%	47.40%	53.24%	59.09%	64.93%
Objective 1.6h:	Increase childhood immunization status (CIS)—Combination 9	38.79%	44.91%	51.03%	57.15%	63.27%
Objective 1.6i:	Increase childhood immunization status (CIS)—Combination 10	38.79%	44.91%	51.03%	57.15%	63.27%
Objective 1.7:	Increase adolescent well-care visits (AWC)	61.62%	65.46%	69.30%	73.13%	76.97%
Objective 1.8:	Increase breast cancer screening (BCC)	NA	NA	NA	NA	NA
Objective 1.9a:	Increase adults' access to preventive/ambulatory health services (AAP)—20–44 Yrs	NA	NA	NA	NA	NA
Objective 1.9b:	Increase adults' access to preventive/ambulatory health services (AAP)—45–64 Yrs	NA	NA	NA	NA	NA
Objective 1.9c:	Increase adults' access to preventive/ambulatory health services (AAP)—65 Years and older	NA	NA	NA	NA	NA
Objective 1.9d:	Increase adults' access to preventive/ambulatory health services (AAP)—Total	NA	NA	NA	NA	NA
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)*	NA	NA	NA	NA	NA
Goal 2:	**Increase Use of Evidence-Based Practices for Members With Chronic Conditions.**					
Objective #	**Objective Description**	**HEDIS 2018 Statewide Average**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
Objective 2.1a:	Increase rate of HbA1c testing for members with diabetes (CDC)	NA	NA	NA	NA	NA
Objective 2.1b:	Decrease rate of HbA1c poor control (>9.0%) for members with diabetes (CDC)*	NA	NA	NA	NA	NA
Objective 2.1c:	Increase rate of HbA1c good control (<8.0%) for members with diabetes (CDC)	NA	NA	NA	NA	NA
Objective 2.1d:	Increase rate of eye exams performed for members with diabetes (CDC)	NA	NA	NA	NA	NA
Objective 2.1e:	Increase medical attention for nephropathy for members with diabetes (CDC)	NA	NA	NA	NA	NA
Objective 2.1f:	Increase blood pressure control (<140/90 mm Hg) for members with diabetes (CDC)	NA	NA	NA	NA	NA

Goal 2:	Increase Use of Evidence-Based Practices for Members With Chronic Conditions.					
Objective #	**Objective Description**	**HEDIS 2018 Statewide Average**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
Objective 2.2a:	Increase medication management for people with asthma (MMA)—medication compliance 50 percent	54.04%	58.64%	63.23%	67.83%	72.42%
Objective 2.2b:	Increase medication management for people with asthma (MMA)—medication compliance 75 percent	33.33%	40.00%	46.66%	53.33%	60.00%
Objective 2.3:	Increase rate of controlling high blood pressure (CBP)	NA	NA	NA	NA	NA
Goal 3:	**Improve Appropriate Use of Opioids.**					
Objective #	**Objective Description**	**HEDIS 2018 Statewide Average**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
Objective 3.1:	Reduce use of opioids at high dosage (HDO)*	NA	NA	NA	NA	NA
Objective 3.2a:	Reduce use of opioids from multiple providers (UOP)—multiple prescribers*	NA	NA	NA	NA	NA
Objective 3.2b:	Reduce use of opioids from multiple providers (UOP)—multiple pharmacies*	NA	NA	NA	NA	NA
Objective 3.2c:	Reduce use of opioids from multiple providers (UOP)—multiple prescribers and multiple pharmacies*	NA	NA	NA	NA	NA
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**	**HEDIS 2018 Statewide Average**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
Objective 4.1:	Increase timeliness of prenatal care (PPC)	NA	NA	NA	NA	NA
Objective 4.2:	Increase the rate of postpartum visits (PPC)	NA	NA	NA	NA	NA

Goal 5:	Increase Use of Evidence-Based Practices for Members With Behavioral Health Conditions.					
Objective #	**Objective Description**	**HEDIS 2018 Statewide Average**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
Objective 5.1a:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication (ADD)—initiation phase	51.11%	56.00%	60.89%	65.78%	70.67%
Objective 5.1b:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication (ADD)—continuation and maintenance phase	NA	NA	NA	NA	NA
Objective 5.2:	Reduce use of multiple concurrent antipsychotics in children and adolescents (APC)*	NA†	NA†	NA†	NA†	NA†
Objective 5.3:	Increase adherence to antipsychotic medications for individuals with schizophrenia (SAA)	NA	NA	NA	NA	NA
Objective 5.4:	Increase follow-up after hospitalization for mental illness (FUH)—7-day	58.90%	63.01%	67.12%	71.23%	75.34%
Objective 5.5:	Increase follow-up after hospitalization for mental illness (FUH)—30-day	72.60%	75.34%	78.08%	80.82%	83.56%
Objective 5.6:	Increase diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications (SSD)	NA	NA	NA	NA	NA
Objective 5.7a:	Increase follow-up after ED visit for AOD abuse or dependence (FUA)—7-day	NA	NA	NA	NA	NA
Objective 5.7b:	Increase follow-up after ED visit for AOD abuse or dependence (FUA)—30-day	NA	NA	NA	NA	NA
Objective 5.8a:	Increase follow-up after ED visit for mental illness (FUM)—7-day	77.19%	79.47%	81.75%	84.03%	86.31%
Objective 5.8b:	Increase follow-up after ED visit for mental illness (FUM)—30-day	80.70%	82.63%	84.56%	86.49%	88.42%
Objective 5.9a:	Increase initiation and engagement of AOD abuse or dependence treatment (IET)—initiation of treatment	31.48%	38.33%	45.18%	52.04%	58.89%
Objective 5.9b:	Increase initiation and engagement of AOD abuse or dependence treatment (IET)—engagement of treatment	9.26%	18.33%	27.41%	36.48%	45.56%
Objective 5.10:	Increase metabolic monitoring for children and adolescents on antipsychotics (APM)	20.97%	28.87%	36.78%	44.68%	52.58%

Goal 6:	Reduce and/or Eliminate Health Care Disparities for Nevada Check Up Recipients.					
Objective #	**Objective Description**	**HEDIS 2018 Statewide Average**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
Objective 6.1:	Ensure that health plans maintain, submit for review, and annually revise cultural competency plans.	Met	Met	Met	Met	Met
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.	Met	Met	Met	Met	Met
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.	Met	Met	Met	Met	Met
Goal 7:	**Increase Utilization of Dental Services.**					
Objective #	**Objective Description**	**HEDIS 2017** Statewide Average**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
Objective 7.1:	Increase annual dental visits (ADV)	68.48%	71.63%	74.78%	77.94%	81.09%
Objective 7.2:	Increase percentage of eligible members who received preventive dental services	54.01%	58.61%	63.21%	67.81%	72.41%

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

† Indicates that this measure has been retired by NCQA and rates will no longer be reported by the MCOs.

NA indicates that information was not available at the time of this report.

*** The statewide average for Objective 7.2 is based on SFY 2019 data.*

Nevada DHCFP Quality Strategy
Crosswalk to 42 CFR §438.340—Managed Care State Quality Strategy

The following table lists the required elements for State Quality Strategies, according to 42 CFR §438.340(a–d) and corresponding sections in the DHCFP Quality Strategy and the DHCFP/MCO contract, which address each required element.

Nevada DHCFP 2019—2021 Quality Strategy Crosswalk to 42 CFR §438.340—Managed Care State Quality Strategy			
Regulatory Requirement	**Reference**	**Description**	**Corresponding Document and Page Reference or Comment**
General Rule			
§438.340(a)	• General Rule	Each State contracting with an MCO, PIHP, or PAHP as defined in §438.2 or with a PCCM entity as described in §438.310(c)(2) must draft and implement a written quality strategy for assessing and improving the quality of health care and services furnished by the MCO, PIHP, PAHP, or PCCM entity.	NV Quality Strategy—pgs. 1-1–7-2 Contract Section 3.11
Elements of the State Quality Strategy			
§438.340(b)(1)	• Network Adequacy and Clinical Practice Guidelines	At a minimum, the State's quality strategy must include the following: The state-defined network adequacy and availability of services standards for MCOs, PIHPs, and PAHPs required by §§438.68 and 438.206 and examples of evidence-based clinical practice guidelines the State requires in accordance with §438.236.	NV Quality Strategy—pgs. 2-4, 2-5 Contract Section 3.4.2.7, 3.10.8.2, 3.10.16.7, 3.10.17

Nevada DHCFP 2019—2021 Quality Strategy Crosswalk to 42 CFR §438.340—Managed Care State Quality Strategy			
Regulatory Requirement	**Reference**	**Description**	**Corresponding Document and Page Reference or Comment**
§438.340(b)(2)	• Goals and Objectives	At a minimum, the State's quality strategy must include the following: The State's goals and objectives for continuous quality improvement which must be measurable and take into consideration the health status of all populations in the State served by the MCO, PIHP, and PAHP.	NV Quality Strategy—pgs. 1-9–1-12 Contract Section 3.10
§438.340(b)(3)(i)	• Quality Metrics and Performance Targets	At a minimum, the State's quality strategy must include a description of: The quality metrics and performance targets to be used in measuring the performance and improvement of each MCO, PIHP, and PAHP with which the State contracts, including but not limited to, the performance measures reported in accordance with §438.330(c). The State must identify which quality measure(s) and performance outcomes the State will publish at least annually on the website required under §438.10(c)(3).	NV Quality Strategy—pgs. 1-4, 1-5, 1-12, 1-14, 3-2 Contract Sections 3.9.2.1, 3.9.2.2, 3.10.8, 3.11.2.2(5)
§438.340(b)(3)(ii)	• Performance Improvement Projects	At a minimum, the State's quality strategy must include a description of: The performance improvement projects to be implemented in accordance with §438.330(d), including a description of any interventions the State proposes to improve access, quality, or timeliness of care for beneficiaries enrolled in an MCO, PIHP, or PAHP.	NV Quality Strategy—pgs. 1-5, 1-12, 2-11, 2-12, 3-2 Contract Sections 3.10.1, 3.10.2, 3.10.7–3.10.7.6, 3.10.7.10, 3.10.8.3(B), 3.17.4.
§438.340(b)(4)	• Annual External Independent Review	At a minimum, the State's quality strategy must include the following: Arrangements for annual, external independent reviews, in accordance with §438.350, of the quality outcomes and timeliness of, and access to, the services covered under each MCO, PIHP, PAHP, and PCCM entity (described in §438.310(c)(2)) contract. [See page 1 for §438.310(c)(2)].	NV Quality Strategy—pgs. 1-1, 1-5, 1-14, 2-4, 2-5, 2-13, 2-14 Contract Sections 3.4.12.2, 3.11.2.2(A)(4), 3.17.4, 3.19.1

Nevada DHCFP 2019—2021 Quality Strategy Crosswalk to 42 CFR §438.340—Managed Care State Quality Strategy			
Regulatory Requirement	**Reference**	**Description**	**Corresponding Document and Page Reference or Comment**
§438.340(b)(5)	• Transition of Care Policy	At a minimum, the State's quality strategy must include the following: A description of the State's transition of care policy required under §438.62(b)(3).	NV Quality Strategy—pg. 1-8
§438.340(b)(6)	• Identifying, Evaluating, and Reducing Health Disparities	At a minimum, the State's quality strategy must include the following: The State's plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status. States must identify this demographic information for each Medicaid enrollee and provide it to the MCO, PIHP or PAHP at the time of enrollment. For purposes of this paragraph (b)(6), "disability status" means whether the individual qualified for Medicaid on the basis of a disability.	NV Quality Strategy—pgs. 2-1, 2-2, 2-3, 3-2 Contract Sections 3.10.8.3(D), 3.11.2.2(A)(2)
§438.340(b)(7)	• Sanctions	At a minimum, the State's quality strategy must include the following: For MCOs, appropriate use of intermediate sanctions that, at a minimum, meet the requirements of subpart I of this part.	NV Quality Strategy—pg. 1-15 Contract Sections 3.5.7.3(F)(1)(d), 3.9.3.3, 3.11.2.2(A)(7), 3.15.4.7, 3.19.7, 3.21
§438.340(b)(8)	• Assessing Outcomes for PCCM entities	At a minimum, the State's quality strategy must include the following: A description of how the State will assess the performance and quality outcomes achieved by each PCCM entity described in §438.310(c)(2).	N/A
§438.340(b)(9)	• Identification of Persons Needing Long-term Services and Supports and Persons with Special Needs	At a minimum, the State's quality strategy must include the following: The mechanisms implemented by the State to comply with §438.208(c)(1) (relating to the identification of persons who need long-term services and supports or persons with special health care needs)	NV Quality Strategy—pgs. 1-2, 1-14, 2-2, 2-3 Contract Section 3.11.2.2(A)(1)

Nevada DHCFP 2019—2021 Quality Strategy Crosswalk to 42 CFR §438.340—Managed Care State Quality Strategy			
Regulatory Requirement	**Reference**	**Description**	**Corresponding Document and Page Reference or Comment**
§438.340(b)(10)	• Non-duplication of EQR Activities	At a minimum, the State's quality strategy must include the following: The information required under §438.360(c) (relating to non-duplication of EQR activities)	NV Quality Strategy—pg. 2-4
§438.340(b)(11)	• Definition of Significant Change	At a minimum, the State's quality strategy must include the following: The State's definition of a "significant change" for the purposes of paragraph (c)(3)(ii) of this section.	NV Quality Strategy—pg. 1-7 Contract Section 3.11.2.1(E)
Development, Evaluation, and Revision			
§438.340(c)(1)(i)	• Public Comment	In drafting or revising its quality strategy, the State must: Make the strategy available for public comment before submitting the strategy to CMS for review, including: Obtaining input from the Medical Care Advisory Committee (established by §431.12 of this chapter), beneficiaries, and other stakeholders.	NV Quality Strategy—pgs. 1-6, 4-1, 4-2 Contract Section 3.11.2.1(B)
§438.340(c)(1)(ii)	• Consulting with Tribes	In drafting or revising its quality strategy, the State must: If the State enrolls Indians in the MCO, PIHP, or PAHP, consulting with tribes in accordance with the State's tribal consultation policy.	NV Quality Strategy—pg. 1-8
§438.340(c)(2)	• Updating Quality Strategy	In drafting or revising its quality strategy, the State must: Review and update the quality strategy as needed, but no less than once every 3 years.	NV Quality Strategy—pgs. 1-6, 4-2
§438.340(c)(2)(i)	• Evaluation of the Effectiveness of the Quality Strategy	This review must include an evaluation of the effectiveness of the quality strategy conducted within the previous 3 years.	NV Quality Strategy—pgs. 1-6, 1-7, 4-1, 4-2

Nevada DHCFP 2019—2021 Quality Strategy Crosswalk to 42 CFR §438.340—Managed Care State Quality Strategy			
Regulatory Requirement	**Reference**	**Description**	**Corresponding Document and Page Reference or Comment**
§438.340(c)(2)(ii)	• Quality Strategy Review Posted to Website	The State must make the results of the review available on the website required under §438.10(c)(3).	NV Quality Strategy—pgs. 1-4, 4-2
§438.340(c)(2)(iii)	• Recommendations to the Quality Strategy	Updates to the quality strategy must take into consideration the recommendations provided pursuant to §438.364(a)(4).	NV Quality Strategy—pgs. 1-6, 4-2
§438.340(c)(3)(i)	• Submitting the Quality Strategy to CMS	In drafting or revising its quality strategy, the State must: Submit to CMS the following: A copy of the initial strategy for CMS comment and feedback prior to adopting it in final.	NV Quality Strategy—pg. 1-4 Contract Section 3.11.2.1(E)
§438.340(c)(3)(ii)	• Submitting Revised Quality Strategies to CMS	In drafting or revising its quality strategy, the State must: Submit to CMS the following: A copy of the revised strategy whenever significant changes, as defined in the State's quality strategy per paragraph (b)(11) of this section, are made to the document, or whenever significant changes occur within the State's Medicaid program.	NV Quality Strategy—pg. 1-6 Contract Section 3.11.2.1(E)
Availability			
§438.340(d)	• Availability of the Final Quality Strategy on the Website	The State must make the final quality strategy available on the website required under §438.10(c)(3).	NV Quality Strategy—pg. 1-4, 4-2