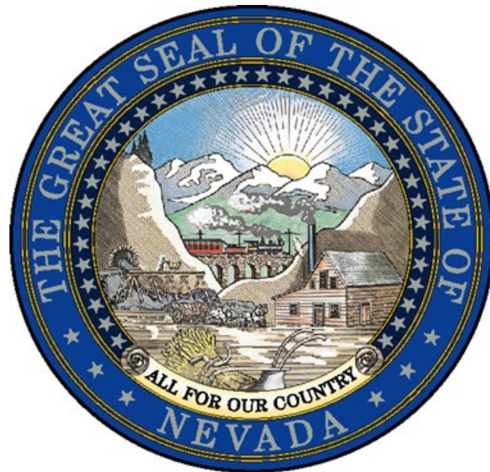

Division of Health Care Financing and Policy
Nevada Managed Care Program

State Fiscal Year 2023 External Quality Review Technical Report

January 2024

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Purpose and Overview of Report

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

DHCFP administers and oversees the Nevada Managed Care Program, which provides Medicaid and Children's Health Insurance Program (CHIP, also referred to as Nevada Check Up in Nevada) benefits to members residing in Clark and Washoe counties. The Nevada Managed Care Program's MCEs include four managed care organizations (MCOs) contracted with DHCFP to provide physical health and behavioral health services to Medicaid and Nevada Check Up members. DHCFP also contracted with one prepaid ambulatory health plan (PAHP), also known as the dental benefits administrator (DBA), to provide dental benefits for Medicaid and Nevada Check Up members. The MCOs and PAHP contracted with DHCFP during state fiscal year (SFY) 2023 are displayed in Table 1-1.

Table 1-1—MCEs in Nevada

MCO Name	MCO Short Name
Anthem Blue Cross and Blue Shield Healthcare Solutions	**Anthem**
Health Plan of Nevada[1-1]	**HPN**
Molina Healthcare of Nevada, Inc.	**Molina**
SilverSummit Healthplan, Inc.	**SilverSummit/SSHP**
PAHP Name	**PAHP Short Name**
LIBERTY Dental Plan of Nevada, Inc.	**LIBERTY**

Scope of External Quality Review Activities

To conduct the annual assessment, HSAG used the results of mandatory and optional external quality review (EQR) activities, as described in 42 CFR §438.358. The EQR activities included as part of this assessment were conducted consistent with the associated EQR protocols developed by the Centers for

[1-1] **Health Plan of Nevada** has rebranded to **UnitedHealthcare Health Plan of Nevada Medicaid** (**UnitedHealthcare HPN**) effective October 1, 2023.

Medicare & Medicaid Services (CMS) (referred to as the CMS EQR Protocols).[1-2,1-3] The purpose of the EQR activities, in general, is to improve states' ability to oversee and manage MCEs they contract with for services, and help MCEs improve their performance with respect to the quality, timeliness, and accessibility of care. Effective implementation of the EQR-related activities will facilitate State efforts to purchase high-value care and to achieve higher performing healthcare delivery systems for their Medicaid and CHIP members. For the SFY 2023 assessment, HSAG used findings from the mandatory and optional EQR activities displayed in Table 1-2 to derive conclusions and make recommendations about the quality, timeliness, and accessibility of care and services provided by each MCE. Detailed information about each activity methodology is provided in Appendix A of this report.

Table 1-2—EQR Activities

Activity	Description	CMS Protocol
Validation of Performance Improvement Projects (PIPs)	This activity verifies whether a PIP conducted by an MCE used sound methodology in its design, implementation, analysis, and reporting.	Protocol 1. Validation of Performance Improvement Projects
Performance Measure Validation (PMV)	This activity assesses whether the performance measures calculated by an MCE are accurate based on the measure specifications and State reporting requirements.	Protocol 2. Validation of Performance Measures
Compliance Review	This activity determines the extent to which a Medicaid and CHIP MCE is in compliance with federal standards and associated state-specific requirements, when applicable.	Protocol 3. Review of Compliance with Medicaid and CHIP Managed Care Regulations
Network Adequacy Validation (NAV)	This activity assesses the extent to which an MCE has met the quantitative network adequacy standards defined by the State.	Protocol 4. Validation of Network Adequacy
Encounter Data Validation (EDV)	The activity validates the accuracy and completeness of encounter data submitted by an MCE.	Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan

[1-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols,* February 2023. Available at: https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf. Accessed on: Oct 26, 2023.

[1-3] HSAG updated the EQR methodologies to align with the 2023 CMS EQR Protocols published in February 2023. However, for the SFY 2023 activities initiated with the MCEs prior to the release of the 2023 CMS EQR Protocols, HSAG adhered to the guidance published in the 2019 CMS EQR Protocols (https://www.medicaid.gov/sites/default/files/2023-03/2019-eqr-protocols-updated.pdf) and initiated discussions with DHCFP, as appropriate, to align the methodologies to the 2023 CMS EQR protocols.

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Activity	Description	CMS Protocol
Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1-4] Analysis	This activity assesses member experience with an MCE and its providers and the quality of care members receive.	Protocol 6. Administration or Validation of Quality of Care Surveys

Nevada Managed Care Program Conclusions and Recommendations

HSAG used its analyses and evaluations of EQR activity findings from the SFY 2023 activities to comprehensively assess the MCEs' performance in providing quality, timely, and accessible healthcare services to Medicaid and CHIP members. For each MCE reviewed, HSAG provides a summary of its overall key findings, conclusions, and recommendations based on the MCE's performance, which can be found in Section 3 (MCOs) and Section 4 (PAHP) of this report. The overall findings and conclusions for all MCEs were also compared and analyzed to develop overarching conclusions and recommendations for the Nevada Managed Care Program. Table 1-3 highlights substantive conclusions and actionable state-specific recommendations, when applicable, for DHCFP to drive progress toward achieving the goals of the Nevada Quality Strategy and support improvement in the quality and timeliness of, and access to healthcare services furnished to Medicaid managed care members.

Table 1-3—Programwide Conclusions and Recommendations

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Goal 1—Improve the health and wellness of Nevada's Medicaid population by increasing the use of preventive services by December 31, 2024	**Conclusions:** The Nevada Managed Care Program had adequate practices for ensuring providers were aware of its adopted practice guidelines, including guidelines for preventive care, and had implemented quality assessment and performance improvement programs, with workplans, that included interventions and initiatives for improving access to preventive services as indicated through the three-year compliance review results. The network adequacy member-to-provider ratios were also met for PCPs, PCP extenders, and pediatricians, and at least 99.8 percent of adult members could access a PCP within 10 miles or 15 minutes of their homes and at least 99.5 percent of child members could access a pediatrician within 10 miles or 15 minutes of their homes, indicating the MCOs appeared to have a sufficient number of providers to render preventive services to children and adults. However, over the past three-year period (MY 2020–MY 2022), there has been a steady decline in the percentage of adult members accessing preventive services, with the highest rate of decline for members 65 years of age and older. Additionally, although there	☒ Quality ☒ Timeliness ☒ Access

[1-4] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	had been some fluctuations within the past three-year period for the *Well-Child Visits in the First 30 Months of Life* and *Child and Adolescent Well-Care Visits* performance measures for both the Medicaid and Nevada Check Up populations, no substantial improvement has been made in the number of infants, children, and adolescents accessing preventive services. Further, there was also a decline in the prevalence of immunizations for children and adolescents over the past three years, and no objectives under Goal 1 met the minimum performance standard (MPS), indicating the Nevada Managed Care Program must continue its efforts to improve members' use of preventive services. **Recommendations:** In SFY 2023, DHCFP mandated that the MCOs implement two new PIPs to address low performance for adults' and children's preventive services. In SFY 2024, HSAG will validate the *Adults' Access to Preventive/Ambulatory Health Services (AAP)* PIP and the *Child and Adolescent Well-Care Visits (WCV)* PIP. For these PIPs, DHCFP could consider whether state-required interventions would be appropriate for the MCOs to implement that consider national and/or MCO-developed best practices to support improvement in members accessing preventive care. DHCFP could consider adding PIP interventions as a topic during one of the quarterly MCE meetings. Further, to gain a better understanding of the potential barriers to members seeking preventive care, HSAG also recommends that DHCFP collaborate with the MCOs to identify strategies to improve the CAHPS response rates so that the information obtained through the surveys provide enough data to make meaningful conclusions. As part of this initiative, DHCFP could request the MCOs to develop a three-question survey that member-facing teams could administer when on a phone call with the member and track the responses in such a way that the survey results can be accessed and then shared across all MCOs during the MCE quarterly meetings. The MCOs could indicate to members that they are trying to improve the services available and ask if the member would be willing to answer three short questions. The survey questions could include the following: • Have you been asked to take a formal survey about your experience as an [name of plan] member receiving benefits through the Nevada Managed Care Program? • If you received a survey to complete, can you share any reasons why you would not want to take the survey, or why you could not take the survey? • Is there anything you can think of that would help [name of MCO] and your providers do more to ensure you get the	

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	services you need, including regular checkups (well visits and management of chronic conditions) from your provider? The MCOs could then compile the most prevalent reasons why members may not be completing the CAHPS survey and why they may not be going to the doctor for preventive care, and subsequently develop meaningful interventions as a program to address the barriers identified. Additionally, DHCFP could evaluate the MCOs' member incentive programs and consider whether the Nevada Managed Care Program would benefit from initiating a rewards program aimed toward members' compliance with preventive care services.	
Goal 2—Increase use of evidence-based practices for members with chronic conditions by December 31, 2024	**Conclusions:** The programwide aggregate rates for the *Blood Pressure Control for Patients with Diabetes—Blood Pressure Control (<140/90 mm Hg)* measure have improved slightly from SFY 2021 to SFY 2023. The indicator rate for the *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)* measure has also demonstrated slight improvement from the SFY 2021 rate; however, performance for this indicator is trending negatively, as indicated by a decrease from SFY 2022 to SFY 2023. Additionally, although the *18–64 Years* and *Total* indicator rates for the *Kidney Health Evaluation for Patients With Diabetes* measure have improved slightly from the SFY 2021 rates, the indicator for the *65–74 Years* age group has slightly decreased in performance over time. Further, there was a decrease from the SFY 2021 rate to the SFY 2023 rate for the *Eye Exam for Patients With Diabetes* measure. Except for the 19–50 years age group, the Medicaid aggregate rates (i.e., age groups) for the *Asthma Medication Ratio* measure indicators also demonstrated a decline since the prior year for both the Medicaid and Nevada Check Up populations; and although the rate for the *Controlling High Blood* pressure measure has improved slightly since SFY 2021, the rate for SFY 2023 is below the rate from SFY 2022. Finally, under Goal 2 and the associated objectives, no programwide MPSs were attained. These findings indicate that the Nevada Managed Care Program must continue to focus efforts on improving member outcomes by ensuring members with diabetes and asthma are appropriately managing their conditions, and that members diagnosed with hypertension are controlling their high blood pressure. **Recommendations:** To understand how to best work with members and providers to increase the treatment of chronic conditions, the Nevada Managed Care Program must gain a better understanding of the barriers members face to seeking the recommended care and testing for their diseases (i.e., asthma, diabetes, high blood	☒ Quality ☒ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	pressure). HSAG recommends that DHCFP collaborate with the MCOs to identify strategies to improve the CAHPS response rates so that the information obtained through the surveys provides enough data to make meaningful conclusions. As part of this initiative, DHCFP could request the MCOs to develop a three-question survey that member-facing teams could administer when on a phone call with the member and track the responses in such a way that the survey results can be accessed and then shared across all MCOs during the MCE quarterly meetings. The MCOs could indicate to members that they are trying to improve the services available and ask if the member would be willing to answer three short questions. The survey questions could include the following: • Have you been asked to take a formal survey about your experience as an [name of plan] member receiving benefits through the Nevada Managed Care Program? • If you received a survey to complete, can you share any reasons why you would not want to take the survey, or why you could not take the survey? • Is there anything you can think of that would help [name of MCO] and your providers do more to ensure you get the services you need, including regular checkups (well visits and management of chronic conditions) from your provider? The MCOs could then compile the most prevalent reasons why members may not be completing the CAHPS survey, and why they may not be going to the doctor for preventive care, and subsequently develop meaningful interventions as a program to address the barriers identified. Additionally, DHCFP could evaluate the MCOs' member incentive programs and consider whether the Nevada Managed Care Program would benefit from initiating a rewards program aimed toward members' compliance with obtaining services intended to manage chronic conditions. DHCFP could also mandate that the MCOs, as part of their population health management programs, furnish their contracted providers with gap analyses reports that show gaps in recommended care for each of the chronic conditions and consider provider value-based payment initiatives to support providers' engagement in reducing the identified gaps in care.	

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Goal 3—Reduce misuse of opioids by December 31, 2024	**Conclusions:** For the *Use of Opioids at High Dosage* and *Use of Opioids From Multiple Providers* measures, the Medicaid aggregate rates were above the MPS, indicating the Nevada Managed Care Program achieved Objectives 3.1 and 3.2 under Goal 3. For SFY 2023, DHCFP required the MCOs to report on two new performance measures that tie to new objectives in the Quality Strategy to support continued improvement of Goal 3. For SFY 2023, no MPSs were set for the evaluation of performance; however, the MCOs performed below NCQA's Quality Compass®[1-5] Healthcare Effectiveness Data and Information Set (HEDIS)[1-6] 2022 Medicaid Health Maintenance Organization (HMO) 50th percentile benchmark for the *Risk of Continued Opioid Use* measure indicators. **Recommendations:** The Nevada Managed Care Program and its MCOs should continue efforts to monitor high-risk opioid analgesic prescribing practices and educate providers and members to mitigate the risks of opioid use disorder (OUD), opioid-related overdose, hospitalization, and opioid overdose-related mortality, and implement additional interventions as necessary to further support progress toward achieving all objectives under Goal 3.	☒ Quality ☐ Timeliness ☐ Access
Goal 4—Improve the health and wellness of pregnant women and infants by December 31, 2024	**Conclusions:** While the *Prenatal and Postpartum Care—Postpartum Care* measure indicator at the programwide level improved slightly over a three-year period (SFY 2021 through SFY 2023), the aggregated rate for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure indicator continues to decline; and the associated Quality Strategy objectives (4.1a-b) did not meet the established MPS for both of these measures. From the findings of the NAV activity, two of the four MCOs did not meet the access standard statewide for the obstetrician/gynecologist (OB/GYN) provider type, and none of the four MCOs met the standard for Washoe County. These findings indicate pregnant women may experience challenges accessing timely prenatal care due to the lack of OB/GYN providers contracted with the MCOs and available to provide services to pregnant women or women who have recently delivered. For SFY 2023, the MCOs were also required to report on three new measures to support five new objectives added to the Quality Strategy. Although MPSs for the new measures had not yet been set to evaluate the Nevada Managed Care Program, the Medicaid aggregate rates for the *Postpartum Depression Screening and Follow-Up—Depression Screening* and *Prenatal Depression Screening and Follow-Up—Screening* measure indicators were 0	☒ Quality ☒ Timeliness ☒ Access

[1-5] Quality Compass® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[1-6] HEDIS® is a registered trademark of the NCQA.

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	percent, indicating providers were not screening women for depression while pregnant or during the postpartum period using a standardized instrument. Additionally, for the three *Prenatal Immunization Status* measure indicators, all four MCOs performed below NCQA's Quality Compass HEDIS 2022 Medicaid HMO 50th percentile benchmark, indicating very few women who had delivered received influenza and tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccinations to protect their babies and themselves from serious illness and death. **Recommendations:** In SFY 2023, DHCFP mandated that the MCOs implement a new PIP to address low performance rates for prenatal and postpartum care. In SFY 2024, HSAG will validate the *Prenatal and Postpartum Care* PIP. For this PIP, DHCFP could consider whether state-required interventions would be appropriate for the MCOs to implement that consider national and/or MCO-developed best practices to support improvement in members accessing timely prenatal and postpartum care. DHCFP could consider adding PIP interventions as a topic during one of the quarterly MCE meetings, and additionally, DHCFP could request that the MCOs present on their pregnancy rewards programs and share how these programs are impacting the rates for prenatal and postpartum care. DHCFP should also work with the MCOs to educate providers on depression screening during prenatal and postpartum care and focus efforts on informing members of the importance of receiving the influenza and Tdap vaccinations during pregnancy to support positive health outcomes.	
Goal 5—Increase use of evidence-based practices for members with behavioral health conditions by December 31, 2024	**Conclusions:** For the Nevada Check Up population, the rates for the *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total,* and the *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total* measure indicators met the MPS, suggesting that the Nevada Medicaid Program and its contracted providers implemented appropriate efforts to coordinate care for many members after emergency department visits and hospitalizations for members diagnosed with substance use disorders (SUDs) and mental illnesses. However, although five out of eight objectives with MPSs for the Nevada Check Up population met the MPS, no objectives for the Medicaid population met the MPS. These findings indicate substantial opportunities for DHCFP and its contracted MCOs to ensure all members diagnosed with a mental illness and/or SUD are receiving timely follow-up appointments after ED visits and inpatient hospitalization, and are receiving adequate screenings, treatment, and medication management. With the exception of pediatric psychologists for one MCO, the Nevada Managed Care	☒ Quality ☒ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	Program had a sufficient network of behavioral health providers to render necessary services. **Recommendations:** In SFY 2023, DHCFP mandated that the MCOs implement two new PIPs to address low performance rates for the behavioral health program area. HSAG validated the design for the *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)* PIP and in SFY 2024 will also validate the *Follow-Up After Emergency Department Visit for Mental Illness (FUM)* PIP. For these PIPs, DHCFP could consider whether state-required interventions would be appropriate for the MCOs to implement that consider national and/or MCO-developed best practices to support improvement in members' access to behavioral health and SUD treatment services. DHCFP could consider adding PIP interventions as a topic during one of the quarterly MCE meetings.	
Goal 6—Increase utilization of dental services by December 31, 2024	**Conclusions:** Through the NAV activity, the Nevada Managed Care Program demonstrated that it had an adequate network of primary dental care providers to provide preventive dental services. For SFY 2023, the Nevada Managed Care Program identified three new measures for reporting; therefore, year-over-year performance could not be assessed and current performance could not be compared to MPSs as they were not yet available for the new measures. However, results from the new *Oral Evaluation, Dental Services* measure indicated that children between the ages of 8 and 9 received a comprehensive or periodic oral evaluation with a dental provider most often with a rate of 51.95 percent. Additionally, the rate for the new *Sealant Receipt on Permanent First Molars—Rate 1—At Least One Sealant* measure indicator was 55.26 percent, while *Rate 2—All Four Molars* was 38.18 percent. Further, the highest rates for the new *Topical Fluoride for Children* measure were the *Rate 1—Dental or Oral Health Services—Ages 8–9* (at 23.27 percent) and *Rate 2—Dental Services—Ages 8–9* (also at 23.27 percent), suggesting that the Nevada Managed Care Program has substantial opportunities to improve the prevalence of members in all age groups accessing preventive dental care. **Recommendations:** In SFY 2023, DHCFP required the PAHP to select one clinical and one nonclinical PIP to support the improvement in members' access to dental services. These topics selected for the PIPs include *Increase Preventive Services for Children* and *Coordination of Transportation Services.* For these PIPs, DHCFP could consider whether state-required interventions would be appropriate for the PAHP to implement that consider national best practices to support improvement in members accessing dental services. DHCFP could consider adding PIP interventions as a topic during one of the quarterly MCE meetings.	☒ Quality ☒ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Goal 7—Reduce and/or eliminate health care disparities for Medicaid members by December 31, 2024	**Conclusions:** The aggregated findings from each of the EQR activities did not produce sufficient data for HSAG to assess the impact the EQR activities had on reducing and/or eliminating healthcare disparities for Medicaid members other than by geographic location (i.e., through the NAV activity). **Recommendations:** Through its contract with the MCEs, DHCFP requires that each MCE initiate several activities focused on eliminating healthcare disparities such as implementing one mandated PIP that focuses on identifying health disparities and subsequently developing interventions aimed at reducing rates of health disparities; implementing cultural competency programs and plans; and developing population health programs, including the requirement to target clinical programs to reduce healthcare disparities based on race and ethnicity. DHCFP also encourages each MCO to obtain the Multicultural Health Care Distinction from NCQA as a way to build a strong cultural competency program, reduce health disparities, and develop culturally and linguistically appropriate member communication strategies. In addition to the initiatives already underway, HSAG recommends that DHCFP continue to require the MCEs to stratify HEDIS and other performance measure data by race and ethnicity and use the data to drive future quality improvement efforts and develop targeted interventions.	☒ Quality ☒ Timeliness ☒ Access

2. Overview of the Nevada Managed Care Program

Managed Care in Nevada

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

Table 2-1 presents the gender and age bands of Nevada Medicaid and Nevada Check Up members enrolled in the managed care catchment areas as of June 2023.

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

Gender/Age Band	June 2023 Members
Nevada Medicaid Data	
Males and Females <1 Year of Age	16,062
Males and Females 1–2 Years of Age	33,581
Males and Females 3–14 Years of Age	181,782
Females 15–18 Years of Age	23,834
Males 15–18 Years of Age	22,059
Females 19–34 Years of Age	110,412
Males 19–34 Years of Age	74,819
Females 35+ Years of Age	99,042
Males 35+ Years of Age	85,693
Total Medicaid	**647,284**
Nevada Check Up Data	
Males and Females <1 Year of Age	409
Males and Females 1–2 Years of Age	979
Males and Females 3–14 Years of Age	14,203

[2-1] The Medicaid dataset for males and females <1 year of age include members with unidentified gender. Totals for Table 2-1 reflect the whole Medicaid managed care population using the current county of residence at the time of the data pull on August 14, 2023. Table 2-2 and Table 2-3 reflect only Medicaid managed care members in Clark and Washoe counties. Enrollment data for 2023 are preliminary and subject to change.

Gender/Age Band	June 2023 Members
Nevada Medicaid Data	
Females 15–18 Years of Age	1,303
Males 15–18 Years of Age	1,275
Total CHIP	**18,169**
Total Medicaid and CHIP	**665,453**

Overview of Managed Care Entities

During the SFY 2023 review period, DHCFP contracted with four MCOs and one PAHP. These MCEs are responsible for the provision of services to Nevada Managed Care Program members. Table 2-2 and Table 2-3 provide a profile for each MCO. As Nevada has only one PAHP, the eligible population is inclusive of all Medicaid and Nevada Check Up members and therefore the PAHP, **LIBERTY**, is not displayed in the tables below.

Table 2-2—Nevada MCO Medicaid Managed Care Members[2-1]

MCO	Total Eligible Clark County	Total Eligible Washoe County
Anthem	172,512	26,301
HPN	192,516	21,054
Molina	95,098	13,192
SilverSummit	109,597	13,591
Total	**569,723**	**74,138**

Table 2-3—Nevada MCO Nevada Check Up Managed Care Members[2-1]

MCO	Total Eligible Clark County	Total Eligible Washoe County
Anthem	4,387	863
HPN	5,673	973
Molina	2,634	583
SilverSummit	2,607	428
Total	**15,301**	**2,847**

Quality Strategy

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

DHCFP's mission is to purchase and ensure the provision of quality healthcare services, including Medicaid services, to low-income Nevadans in the most efficient manner. DHCFP also seeks to promote equal access to healthcare at an affordable cost to Nevada taxpayers, to restrain the growth of healthcare costs, and to review Medicaid and other State healthcare programs to determine the potential to maximize federal revenue opportunities. DHCFP's Quality Strategy has two basic purposes: 1) to ensure compliance with federal and State statutory and regulatory requirements on quality, and 2) to go beyond compliance with the minimum statutory and regulatory requirements by implementing multiple methods for continuous quality improvement in order to raise the quality of care provided to, and received by, Medicaid and Nevada Check Up members. Further, consistent with its mission, the purpose of DHCFP's Quality Strategy is to:

- Establish a comprehensive quality improvement system that is consistent with the Triple Aim adopted by CMS to achieve better care for patients, better health for communities, and lower costs through improvement in the healthcare system.
- Provide a framework for DHCFP to design and implement a coordinated and comprehensive system to proactively drive quality throughout the Nevada Medicaid and Nevada Check Up system. The Quality Strategy promotes the identification of creative initiatives to continually monitor; assess; and improve access to care, clinical quality of care, and health outcomes of the population served.
- Identify opportunities to improve the health status of the enrolled population and improve health and wellness through preventive care services, chronic disease and special needs management, and health promotion.
- Identify opportunities to improve quality of care and quality of service and implement improvement strategies to ensure Nevada Medicaid and Nevada Check Up members have access to high-quality and culturally appropriate care.
- Identify creative and efficient models of care delivery that are steeped in best practice and make healthcare more affordable for individuals, families, and the State government.
- Improve member satisfaction with care and services.
- Ensure that individuals transitioning to managed care from fee-for-service and individuals transitioning between MCOs receive appropriate therapeutic, medical, and behavioral health services as part of the transition of care policy noted in the *Medicaid Services Manual*, Chapter 3603.21 (A)(25).

Quality Strategy Goals

In alignment with the purpose of the Quality Strategy, DHCFP established quality goals that are supported by specific objectives to continuously improve the health and wellness of Nevada Medicaid

and Nevada Check Up members. The goals and supporting objectives are measurable and take into consideration the health status of all populations served by the Nevada Managed Care Program. The overarching Quality Strategy goals and applicable program are displayed in Table 2-4. Refer to Appendix B for a detailed description of the objectives and performance measures used to support each goal.

Table 2-4—Quality Strategy Goals and Applicable Program

Quality Strategy Goals		Nevada Medicaid	Nevada Check Up
Goal 1	Improve the health and wellness of Nevada's Medicaid population by increasing the use of preventive services by December 31, 2024	✓	✓
Goal 2	Increase use of evidence-based practices for members with chronic conditions by December 31, 2024	✓	✓
Goal 3	Reduce misuse of opioids by December 31, 2024	✓	
Goal 4	Improve the health and wellness of pregnant women and infants by December 31, 2024	✓	
Goal 5	Increase use of evidence-based practices for members with behavioral health conditions by December 31, 2024	✓	✓
Goal 6	Increase utilization of dental services by December 31, 2024	✓	✓
Goal 7	Reduce and/or eliminate health care disparities for Medicaid members by December 31, 2024	✓	✓

Payment Initiative Programs

Certified Community Behavioral Health Centers

The Certified Community Behavioral Health Centers (CCBHCs) provide outpatient behavioral health services and primary care screenings and monitoring to individuals in Nevada for mental illness and SUD regardless of their ability to pay, including Nevada Medicaid and Nevada Check Up members. The Quality Incentive Payment (QIP) program for CCBHCs uses clinic-led and state-led quality measures, listed in Table 2-5, to determine quality payments that will be granted to each CCBHC based on performance year over year. DHCFP establishes the minimum patient volume in each performance measure denominator necessary for the performance measure to be valid. The QIP is composed of two payments—a payment for reporting and a payment for performance. In the first two years, the QIP will only include the payment for reporting. The QIP amount given to a CCBHC will be based on multiplying the total facility-specific bundled rate payments made to the CCBHC in the performance period by a statewide percentage for reporting requirements in the first two years and by both a statewide percentage for performance requirements and a statewide percentage for reporting requirements in subsequent years. QIPs are made to CCBHCs meeting established criteria, within one year following the end of the relevant measurement year (July 1 to June 30), and after all final data needed to calculate the QIP are received.

Table 2-5—CCBHC Performance Measures

Performance Measure	Clinic/State-Led	Source[1]	Target Goal
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	Clinic-led	CMS	90%
Major Depressive Disorder: Suicide Risk Assessment	Clinic-led	CMS	90%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	State-led	NCQA	60.1%
Follow-Up After Hospitalization for Mental Illness, Ages 21+	State-led	NCQA	7 Days–43.9% 30 days–63%
Follow-Up After Hospitalization for Mental Illness, Ages 6–21	State-led	NCQA	7 Days–43.9% 30 days–63%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	State-led	NCQA	Initiation–38.3% Engagement–11.3%
Plan All-Cause Readmission Rate*	State-led	NCQA	15.2%

* Not a federally required measure for quality improvement incentive payment
[1] Measure stewards include CMS and NCQA

The CCBHC initiative aligns to the Quality Strategy Goal 5—*Increase use of evidence-based practices for members with behavioral health conditions by December 31, 2024*. Improved access through the CCBHC initiative should show a positive impact to the progress made to DHCFP's goals under the Quality Strategy.

Patient-Centered Opioid Addiction Treatment (P-COAT) Model

The P-COAT Model is an alternative payment model designed by the American Medical Association and the American Society of Addiction Medicine. The P-COAT Model was developed to expand access and utilization of medication-assisted treatment (MAT) while also ensuring that providers are appropriately reimbursed for the services they provide. Under the current models of MAT, there are several key issues that the P-COAT Model seeks to resolve:

- Underutilization of MAT services
- Barriers to care coordination/separation in billing for medical and behavioral services
- Reimbursement may not cover all costs of providing treatment
- Administrative barriers

The goals of the P-COAT Model include:

- Create a reimbursement structure to support the full range of services physicians/clinicians provide to treat OUD
- Expand the network of providers who treat OUD

- Encourage coordinated delivery of services
- Reduce/eliminate spending for ineffective or unnecessarily expensive treatments
- Utilize evidence-based care practices that lead to improved outcomes

Nevada Medicaid is one of 15 states awarded a planning grant under the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act to fund implementation of the P-COAT Model. The planning grant phase lasted 18 months.

Due to funding issues, DHCFP has placed this payment initiative on hold. However, when this initiative is reinstated, DHCFP will evaluate the results of the implemented P-COAT Model using a series of treatment and utilization performance measures, including the following:

- Treatment Measure #1: Percentage of patients who filled and used prescribed medications throughout the month
- Treatment Measure #2: Percentage of patients who demonstrated compliance by only taking medications that are part of the written treatment plan at the end of the month
- Utilization Services Measure #1: Percentage of patients whose opioid and other drug-related lab testing during initiation of treatment is consistent with evidence-based practices
- Utilization of Services Measure #2: Risk-adjusted average number of opioid-related ED visits per patient

This initiative supports Quality Strategy Goal 3 to *reduce misuse of opioids*. Implementation of this initiative should result in an expanded network of providers who treat OUD while leading to improved outcomes through the use of evidence-based care practices.

State-Directed Payment Initiative

In SFY 2022, DHCFP received approval for a renewal from CMS for its delivery system and provider payment initiative in accordance with 42 CFR §438.6(c) for public hospital systems in Nevada in counties in which the population is 700,000 or more, the licensed professionals working in those public hospital systems, and/or the licensed professionals affiliated with accredited public medical schools in those largely populated counties. DHCFP implemented the payment initiative to help ensure the financial viability of these hospitals and licensed professionals, and to support them in maintaining and enhancing the high quality of care they provide to Medicaid members in Nevada. To evaluate the effectiveness of the state-directed payment initiative related to inpatient services, DHCFP added a performance measure in SFY 2021 to the Quality Strategy under Goal 2 to *decrease rate of adult acute inpatient stays that were followed by an unplanned readmission for any diagnosis within 30 days after discharge*. For outpatient services, effectiveness of the payment initiative aligns with Quality Strategy Goal 1—*Improve the health and wellness of Nevada's Medicaid population by increasing the use of preventive services by December 31, 2024,* and Goal 2—*Increase use of evidence-based practices for members with chronic conditions by December 31, 2024*. The MCOs are annually required to calculate the performance of the providers eligible for the payment increase based on the utilization and delivery of services to Medicaid managed care members using state-directed payment measure specifications and HEDIS data results.

HSAG HEALTH SERVICES ADVISORY GROUP

Two providers were eligible for the state-directed payment initiative in SFY 2023: University Medical Center (UMC), a public hospital, and the University of Nevada, Reno School of Medicine (UNR), a public medical school. DHCFP's expectation is that each provider's rates for each measure included in the initiative will improve over a five-year period. After the baseline year, which is calendar year (CY) 2020 for UMC and CY 2021 for UNR, DHCFP expects to see at minimum an increase of 2 percent per CY. Performance is evaluated by DHCFP annually, and results of the evaluation, including progress on meeting the associated Quality Strategy goals, are included as part of the EQR technical report.

Table 2-6 and Table 2-7 identify the Quality Strategy objectives identified in the CMS-approved Section 438.6(c) Preprint to evaluate performance of the state-directed payment initiative and the baseline rates, CY 2022[2-2] (MY 2022) rates, and the CY 2022 targets for UMC for Medicaid and the Nevada Check Up. Rates listed in green font indicate that UMC met the target for CY 2022. Rates listed in red font indicate that UMC did not meet the target for CY 2022. UMC met the targets for CY 2022 for three of the 10 Nevada Medicaid/Nevada Check Up measures, *Comprehensive Diabetes Care (CDC)—Hemoglobin A1c (HbA1c) Testing, Controlling High Blood Pressure (CBP),* and *Plan All-Cause Readmissions (PCR)—Observed Readmissions*. Based on these results, the payment initiative did not support that significant progress was made toward achieving the related Quality Strategy goals, and continued efforts should be implemented to support improvement in the seven measures which did not meet the target rate.

Table 2-6—State-Directed Payment Initiative Nevada Medicaid Performance Measures—UMC*

Measure	Objective Alignment	UMC Baseline[1]	UMC CY 2022 Rate	UMC CY 2022 Target[2]
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—BMI Percentile	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—BMI percentile	40.29%	14.29%	41.90%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Counseling for Nutrition	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—counseling for nutrition	31.31%	9.52%	32.56%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Counseling for Physical Activity	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—counseling for physical activity	28.18%	1.59%	29.31%
Comprehensive Diabetes Care (CDC)—Hemoglobin A1c (HbA1c) Testing	Increase rate of HbA1c testing for members with diabetes (CDC)	40.78%	43.77%	42.41%

[2-2] The rates were individually calculated by each MCO and submitted to DHCFP to provide to HSAG for inclusion in the EQR technical report. These rates were not validated by HSAG. HSAG used the denominators and numerators provided by DHCFP for each MCO to aggregate the CY 2022 rate for each measure.

Measure	Objective Alignment	UMC Baseline[1]	UMC CY 2022 Rate	UMC CY 2022 Target[2]
Comprehensive Diabetes Care (CDC)—HbA1c Poor Control (>9.0%)[3]	Decrease rate of HbA1c poor control (>9.0%) for members with diabetes (CDC)	21.97%	36.58%	21.09%
Controlling High Blood Pressure (CBP)	Increase rate of controlling high blood pressure (CBP)	11.95%	35.97%	12.43%
Plan All-Cause Readmissions (PCR)—Observed Readmissions[3]	Decrease rate of adult acute inpatient stays that were followed by an unplanned readmission for any diagnosis within 30 days after discharge (PCR)—Observed readmissions	11.81%	10.79%	11.34%

BMI: body mass index
* Rates in this table were derived from validated HEDIS measure rates; however, these rates were a subset of the validated measures and were not validated through the HEDIS audit process.
[1] The baseline year for UMC was CY 2020.
[2] Year-over-year targets were set at 2 percent improvement over the baseline year. Overall targets for full five-year period of state-directed payment initiative is 10 percent.
[3] A lower rate indicates better performance for this measure.
Green font indicates UMC met the target for CY 2022.
Red font indicates UMC did not meet the target for CY 2022.

Table 2-7—State-Directed Payment Initiative Nevada Check Up Performance Measures—UMC*

Measure	Objective Alignment	UMC Baseline[1]	UMC CY 2022 Rate	UMC CY 2022 Target[2]
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—BMI Percentile	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—BMI percentile	49.68%	0.00%	51.67%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Counseling for Nutrition	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—counseling for nutrition	38.92%	0.00%	40.48%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Counseling for Physical Activity	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—counseling for physical activity	35.76%	0.00%	37.19%
Comprehensive Diabetes Care (CDC)—Hemoglobin A1c (HbA1c) Testing	Increase rate of HbA1c testing for members with diabetes (CDC)	NA	NA	NA
Comprehensive Diabetes Care (CDC)—HbA1c Poor Control (>9.0%)[3]	Decrease rate of HbA1c poor control (>9.0%) for members with diabetes (CDC)	NA	NA	NA

Measure	Objective Alignment	UMC Baseline[1]	UMC CY 2022 Rate	UMC CY 2022 Target[2]
Controlling High Blood Pressure (CBP)	Increase rate of controlling high blood pressure (CBP)	NA	NA	NA
Plan All-Cause Readmissions (PCR)—Observed Readmissions[3]	Decrease rate of adult acute inpatient stays that were followed by an unplanned readmission for any diagnosis within 30 days after discharge (PCR)—Observed readmissions	NA	NA	NA

* Rates in this table were derived from validated HEDIS measure rates; however, these rates were a subset of the validated measures and were not validated through the HEDIS audit process.
[1] The baseline year for UMC was CY 2020.
[2] Year-over-year targets were set at 2 percent improvement over the baseline year. Overall targets for the full five-year period of state-directed payment initiative is 10 percent.
[3] A lower rate indicates better performance for this measure.
NA (Not Applicable) indicates the performance measure is not applicable to the Nevada Check Up population.
Green font indicates UMC met the target for CY 2022.
Red font indicates UMC did not meet the target for CY 2022.

Table 2-8 and Table 2-9 identify the Quality Strategy objectives identified in the CMS-approved Section 438.6(c) Preprint to evaluate performance of the state-directed payment initiative and the baseline rate, CY 2022[2-3] rate, and the CY 2022 target for UNR for Medicaid and Nevada Check Up. Rates listed in green font indicate that UNR met the target for CY 2022. Rates listed in red font indicate that UNR did not meet the target for CY 2022. UNR met the targets for CY 2022 for seven of the nine applicable measures. Based on these results, the payment initiative supported that significant progress was made toward achieving the related Quality Strategy goals. Continued efforts should be implemented to support improvement in the two measures which did not meet the target rate.

Table 2-8—State-Directed Payment Initiative Nevada Medicaid Performance Measures—UNR*

Measure	Objective Alignment	UNR Baseline[1]	UNR CY 2022 Rate	UNR Target[2]
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—BMI Percentile	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—BMI percentile	10.44%	19.58%	10.65%

[2-3] The rates were individually calculated by each MCO and submitted to DHCFP to provide to HSAG for inclusion in the EQR technical report. These rates were not validated by HSAG. HSAG used the denominators and numerators provided by DHCFP for each MCO to aggregate the CY 2022 rate for each measure.

Measure	Objective Alignment	UNR Baseline[1]	UNR CY 2022 Rate	UNR Target[2]
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Counseling for Nutrition	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—counseling for nutrition	10.88%	39.62%	11.10%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Counseling for Physical Activity	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—counseling for physical activity	11.99%	36.74%	12.23%
Comprehensive Diabetes Care (CDC)—Hemoglobin A1c (HbA1c) Testing	Increase rate of HbA1c testing for members with diabetes (CDC)	53.49%	24.81%	54.56%
Comprehensive Diabetes Care (CDC)—HbA1c Poor Control (>9.0%)[3]	Decrease rate of HbA1c poor control (>9.0%) for members with diabetes (CDC)	53.49%	56.20%	52.42%
Controlling High Blood Pressure (CBP)	Increase rate of controlling high blood pressure (CBP)	2.36%	3.65%	2.41%

* Rates in this table were derived from validated HEDIS measure rates; however, these rates were a subset of the validated measures and were not validated through the HEDIS audit process.

[1] The baseline year for UNR was CY 2021.

[2] Year-over-year targets were set at 2 percent improvement over the baseline year. Overall targets for the full five-year period of state-directed payment initiative is 10 percent.

[3] A lower rate indicates better performance for this measure.

Table 2-9—State-Directed Payment Initiative Nevada Check Up Performance Measures—UNR*

Measure	Objective Alignment	UNR Baseline[1]	UNR CY 2022 Rate	UNR Target[2]
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—BMI Percentile	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—BMI percentile	17.65%	20.00%	18.00%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Counseling for Nutrition	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—counseling for nutrition	14.71%	42.58%	15.00%

Measure	Objective Alignment	UNR Baseline[1]	UNR CY 2022 Rate	UNR Target[2]
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Counseling for Physical Activity	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—counseling for physical activity	14.71%	40.65%	15.00%
Comprehensive Diabetes Care (CDC)—Hemoglobin A1c (HbA1c) Testing	Increase rate of HbA1c testing for members with diabetes (CDC)	NA	NA	NA
Comprehensive Diabetes Care (CDC)—HbA1c Poor Control (>9.0%)[3]	Decrease rate of HbA1c poor control (>9.0%) for members with diabetes (CDC)	NA	NA	NA
Controlling High Blood Pressure (CBP)	Increase rate of controlling high blood pressure (CBP)	NA	NA	NA

* Rates in this table were derived from validated HEDIS measure rates; however, these rates were a subset of the validated measures and were not validated through the HEDIS audit process.
[1] The baseline year for UNR was CY 2021.
[2] Year-over-year targets were set at 2 percent improvement over the baseline year. Overall targets for the full five-year period of state-directed payment initiative is 10 percent.
[3] A lower rate indicates better performance for this measure.
NA (Not Applicable) indicates the performance measure is not applicable to the Nevada Check Up population.

Evaluation of Quality Strategy Effectiveness

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

Table 2-10 and Table 2-11 show the number of rates reported by the MCO or PAHP and the number and percentage of reported rates that achieved the DHCFP-established MPS. Of note, Goal 7—*Reduce and/or eliminate health care disparities for Medicaid members by December 31, 2024* is not evaluated through a performance measure rate and overall performance is determined as either a *Met* or *Not Met* score based on DHCFP's assessment. Therefore, this information is not included in the following tables. For additional details, please see Appendix B of this report.

Table 2-10—SFY 2023 Quality Strategy Goals and Objectives: Summary of Performance by the MCOs

	Anthem Medicaid	HPN Medicaid	Molina Medicaid	SilverSummit Medicaid	Anthem Check Up	HPN Check Up	Molina Check Up	SilverSummit Check Up
Number of Reported Rates	58	58	51	56	19	20	10	15

	Anthem Medicaid	HPN Medicaid	Molina Medicaid	SilverSummit Medicaid	Anthem Check Up	HPN Check Up	Molina Check Up	SilverSummit Check Up
Reported Rates With an Established MPS	43	43	36	42	16	17	7	13
Rates Achieving the MPS	**6**	**13**	**4**	**5**	**2**	**4**	**0**	**0**
Percentage of Rates Achieving the MPS	**14%**	**30%**	**11%**	**12%**	**13%**	**24%**	**0%**	**0%**

Table 2-11—SFY 2023 Quality Strategy Goals and Objectives: Summary of Performance by the PAHP

	LIBERTY Medicaid	LIBERTY Check Up
Number of Rates Reported	4	4
Rates With an Established MPS	0	0
Rates Achieving the MPS	**NA**	**NA**
Percentage of Rates Achieving the MPS	**NA**	**NA**

NA (Not Applicable)—For SFY 2023, the PAHP was required to report on new measures. Therefore, no MPSs were available for these new performance measures.

At the conclusion of SFY 2023, DHCFP, in collaboration with HSAG, evaluated the quality of the managed care services offered to Nevada Managed Care Program members and, subsequently, the overall effectiveness of the Quality Strategy goals through EQR-related performance results and year-over-year trending of performance measure data, when a comparison of data was appropriate. Table 2-12 presents a summary of the Nevada Managed Care Program's progress on meeting the Quality Strategy goals and objectives. The performance impact—positive (✓), negative (×) or no impact (n)—is presented by aggregated Medicaid and Nevada Check Up MY 2022 rates. Overall conclusions and future Quality Strategy updates for each goal are also presented in Table 2-12.

Table 2-12—SFY 2023 Quality Strategy Goals and Objectives Summary of Performance

Quality Strategy Goals		Performance Impact on Goals and Objectives	
1	Improve the health and wellness of Nevada's Medicaid population by increasing the use of preventive services by December 31, 2024	×	0/18 Medicaid rates met the MPS
		✓	6/18 Medicaid rates improved in performance from the prior year
		×	12/18 Medicaid rates declined in performance from the prior year
		×	0/14 Nevada Check Up rates met the MPS
		✓	3/14 Nevada Check Up rates improved in performance from the prior year
		×	11/14 Nevada Check Up rates declined in performance from the prior year

	Quality Strategy Goals	Performance Impact on Goals and Objectives
	Conclusion:	The Nevada Managed Care Program made ***minimal progress*** in meeting the objectives under Goal 1 for Medicaid and Nevada Check Up. While nine measure rates improved in performance from the prior year, no measure rates met DHCFP's established MPS, and several measure rates declined in performance, indicating many opportunities for improvement.
	Quality Strategy Updates for SFY 2024:	DHCFP to consider adding the following objectives to Goal 1, as these are 2024 mandatory Child Core Set measures: • *Developmental Screening in the First Three Years of Life (DEV-CH)* • *Lead Screening in Children (LSC)*
2	Increase use of evidence-based practices for members with chronic conditions by December 31, 2024	× 0/9 Medicaid rates met the MPS
		n 2/7 applicable Medicaid rates increased minimally in performance from the prior year
		× 5/7 applicable Medicaid rates declined in performance from the prior year or remained relatively stagnant
		× 0/1 applicable Nevada Check Up rates met the MPS
	Conclusion:	The Nevada Managed Care Program made ***no progress*** in meeting the objectives under Goal 2 for Medicaid and Nevada Check Up. No measure rates met DHCFP's established MPS, and five applicable measure rates declined in performance from the prior year, indicating many opportunities for improvement. Further, while two applicable measure rates increased from the prior year, the increase was not significant (i.e., increases of 0.06 and 0.01).
	Quality Strategy Updates for SFY 2024:	DHCFP to consider adding the following objective to Goal 2, as this is a mandatory Child Core Set measure for 2024: • *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)*
3	Reduce misuse of opioids by December 31, 2024	✓ 2/2 applicable Medicaid rates met the MPS
		✓ 2/2 applicable Medicaid rates improved in performance from the prior year
	Conclusion:	The Nevada Managed Care Program ***met*** the objectives under Goal 3 for Medicaid, as the two applicable measure rates met the MPS for the Medicaid program: • *Reduce use of opioids at high dosage (per 1,000 members) (HDO)* • *Reduce use of opioids from multiple providers (per 1,000 members) (UOP)—Multiple prescribers*
	Quality Strategy Updates for SFY 2024:	Newly developed MPSs from MY 2022 baseline data to be incorporated into Appendix B. Goals and Objectives Tracking Table for the following measures, which were newly reported by the MCOs in SFY 2023: • *Reduce the rate of adult members with at least 15 days of prescription opioids in a 30-day period (COU)* • *Reduce the rate of adult members with at least 31 days of prescription opioids in a 62-day period (COU)* The Quality Strategy on Nevada's website currently aligns Objective 5.12 to the HEDIS *Pharmacotherapy for Opioid Use Disorder (POD)* measure. However, as

	Quality Strategy Goals	Performance Impact on Goals and Objectives
		the Adult Core Set measure *Use of Pharmacotherapy for Opioid Use Disorder (OUD)* is required to be reported in 2024, the MCOs reported on the *OUD* measure for SFY 2023, and the objective in the Quality Strategy on Nevada's website will be updated to remove *POD* and add *OUD*.
4	Improve the health and wellness of pregnant women and infants by December 31, 2024	✗ 0/2 applicable Medicaid rates met the MPS
		✓ 1/2 applicable Medicaid rates improved in performance from the prior year
		✗ 1/2 applicable Medicaid rates declined in performance from the prior year
	Conclusion:	The Nevada Managed Care Program made ***minimal progress*** in meeting the objectives under Goal 4 for Medicaid. While one measure rate improved in performance from the prior year, neither of the two applicable rates met DHCFP's established MPS, with the other applicable rate declining in performance.
	Quality Strategy Updates for SFY 2024:	DHCFP to consider adding the following objective to Goal 4, as these are mandatory Child Core Set measures for 2024: • *Contraceptive Care—All Women Ages 15–20 (CCW-CH)* • *Contraceptive Care—Postpartum Women Ages 15–20 (CCP-CH)* Newly developed MPSs from MY 2022 baseline data to be incorporated into Appendix B. Goals and Objectives Tracking Table for the following measures, which were newly reported by the MCOs in SFY 2023: • *Increase the rate of deliveries in which members were screened for clinical depression during pregnancy using a standardized instrument (PND)* • *Increase the rate of deliveries in which members were screened for clinical depression using a standardized instrument during the postpartum period (PDS)* • *Increase the rate of deliveries in the measurement period in which women received influenza and tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccinations (PRS-E)*
5	Increase use of evidence-based practices for members with behavioral health conditions by December 31, 2024	✗ 0/12 applicable Medicaid rates met the MPS
		✓ 5/12 applicable Medicaid rates improved in performance from the prior year
		✗ 7/12 applicable Medicaid rates declined in performance from the prior year or remained stagnant
		✓ 3/6 applicable Nevada Check Up rates met the MPS
		✓ 3/7 applicable Nevada Check rates improved in performance from the prior year
		✗ 4/7 applicable Nevada Check Up rates declined in performance from the prior year
	Conclusion:	The Nevada Managed Care Program made ***minimal progress*** in meeting the objectives under Goal 5 for Medicaid. No measure rate met DHCFP's established MPS, and while five of the applicable measure rates improved in performance from the prior year, the other seven applicable rates declined in performance. ***Some progress*** was made in meeting the objectives under Goal 5 for Nevada Check Up, as three applicable measure rates improved in performance from the prior year and the below three measure rates met DHCFP's established MPS: • *Increase follow-up after hospitalization for mental illness (FUH)—30-day* • *Increase follow-up after ED visit for mental illness (FUM)—7-day*

Quality Strategy Goals	Performance Impact on Goals and Objectives
	• *Increase follow-up after ED visit for mental illness (FUM)—30-day* However, while still meeting the MPS, two of these measures, *FUM—7-day* and *FUM 30-day*, declined in performance from the prior year along with two other measure rates.
Quality Strategy Updates for SFY 2024:	DHCFP to consider revising the age stratifications related to objective 5.13, *Increase the rate of screening for depression and follow-up plan for members (CDF)*, to align with the Behavioral Health Adult Core Set measure. DHCFP to also consider adding the following objective to Goal 5, as this is a mandatory Behavioral Health Adult Core Set measure for 2024: • *Diabetes Care for People With Serious Mental Illness: HbA1c Poor Control (>9.0%) (HPCMI-AD)* Newly developed MPSs from MY 2022 baseline data to be incorporated into Appendix B. Goals and Objectives Tracking Table for the following measures, which were newly reported by the MCOs in SFY 2023: • *Increase the use of first-line psychosocial care for children and adolescents on antipsychotics (APP)* • *Increase the rate of inpatient residential treatment and detoxification visits or discharges for a diagnosis of substance use disorder (SUD) among patients 13 years of age and older that resulted in follow-up care for a diagnosis of SUD within 7 days (FUI)* • *Increase the rate of inpatient residential treatment and detoxification visits or discharges for a diagnosis of substance use disorder (SUD) among patients 13 years of age and older that resulted in follow-up care for a diagnosis of SUD within 30 days (FUI)* • *Increase the rate of opioid use disorder (OUD) pharmacotherapy treatment events among members ages 16 years and older that continue for at least 180 days (6 months) (OUD)* • *Increase the rate of screening for depression and follow-up plan for members (CDF)—12–17 years* • *Increase the rate of screening for depression and follow-up plan for members (CDF)—18 years and older* • *Increase the rate of screening for depression and follow-up plan for members (CDF)—12 years and older* Additionally, NCQA recommended a break in trending between MY 2022 and prior years due to significant changes in the measure specifications; therefore, the Appendix B. Goals and Objectives Tracking Table will be updated to include the MPSs for the two objectives for the *Increase follow-up after ED visit for AOD abuse (FUA)* and two objectives for the *Increase initiation and engagement of AOD abuse or dependence treatment (IET)*.

	Quality Strategy Goals	Performance Impact on Goals and Objectives
6	Increase utilization of dental services by December 31, 2024	Unable to be evaluated
	Conclusion:	Progress on meeting the objectives under Goal 6 ***could not be assessed***. For SFY 2023, the PAHP was required to report on new measures as the *Annual Dental Visit* measures were set to retire in MY 2023; therefore, the PAHP was no longer required to report rates for the related measure indicators. Additionally, no MPSs or prior rates were available for the new performance measures.
	Quality Strategy Updates for SFY 2024:	The *Annual Dental Visit (ADV)* measure will need to be removed as this is a retired measure for MY 2023. Additionally, newly developed MPSs from MY 2022 baseline data to be incorporated into Appendix B. Goals and Objectives Tracking Table for the following measures, which were newly reported by the PAHP in SFY 2023: • *Increase the rate of children under age 21 who received a comprehensive or periodic oral evaluation within the reporting year (OEV-CH)* • *Increase the rate of children ages 1 through 20 years who received at least 2 topical fluoride applications within the reporting year (TFL-CH)* • *Increase the rate of enrolled children who have ever received sealants on a permanent first molar tooth: at least one sealant by 10th birthdate (SFM-CH)* • *Increase the rate of enrolled children who have ever received sealants on a permanent first molar tooth: all four molars sealed by 10th birthdate (SFM-CH)*
7	Reduce and/or eliminate health care disparities for Medicaid members by December 31, 2024	✓ 3/3 objectives received a *Met* designation
	Conclusion:	The Nevada Managed Care Program ***met*** the objectives under Goal 7, as DHCFP determined that the MCEs met the following requirements: • Ensure that health plans maintain, submit for review, and annually revise cultural competency plans. • 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. • 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.
	Quality Strategy Updates for SFY 2024:	No updates necessary

3. Assessment of Managed Care Organization Performance

HSAG used findings across mandatory and optional EQR activities conducted during the SFY 2023 review period to evaluate the performance of the MCOs on providing quality, timely, and accessible healthcare services to Nevada Managed Care Program members. Quality, as it pertains to EQR, means the degree to which the MCOs increased the likelihood of members' desired health outcomes through structural and operational characteristics; the provision of services that were consistent with current professional, evidenced-based knowledge; and interventions for performance improvement. Access relates to members' timely use of services to achieve optimal health outcomes, as evidenced by how effective the MCOs were at successfully demonstrating and reporting on outcomes for the availability and timeliness of services.

HSAG follows a step-by-step process to aggregate and analyze data from all EQR activities and draw conclusions about the quality, timeliness, and accessibility of care furnished by each MCO.

- **Step 1**: HSAG analyzes the quantitative results obtained from each EQR activity for each MCO to identify strengths and weaknesses that may pertain to the domains of quality, timeliness, and access to services furnished by the MCO for the EQR activity.
- **Step 2**: From the information collected, HSAG identifies common themes and the salient patterns that emerge across EQR activities for each domain, and HSAG draws conclusions about the overall quality, timeliness, and accessibility of care and services furnished by the MCO.
- **Step 3**: From the information collected, HSAG identifies common themes and the salient patterns that emerge across all EQR activities as they relate to strengths and weaknesses in one or more of the domains of quality, timeliness, and accessibility of care and services furnished by the MCO.

Objectives of External Quality Review Activities

This section of the report provides the objectives and a brief overview of each EQR activity conducted in SFY 2023 to provide context for the resulting findings of each EQR activity. For more details about each EQR activity's objectives and the comprehensive methodology, including the technical methods for data collection and analysis, a description of the data obtained and the related time period, and the process for drawing conclusions from the data, refer to Appendix A.

Validation of Performance Improvement Projects

For SFY 2023, the four MCOs initiated two DHCFP-mandated PIP topics: a clinical PIP, *Improving the Rates for Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)*, and a nonclinical PIP, *Plan All-Cause Readmissions*.

HSAG's validation activities included an evaluation of the MCOs' documentation submitted to support the first phase of the PIP process, called the Design stage, to determine the overall validity of each state-

mandated PIP's methodological framework. HSAG's validation of the design of each PIP included a review of the PIP topic, Aim statement, target population, sampling methods, performance indicators, and data collection methods to ensure they were based on sound methodological principles and will support reliable reporting of measure outcomes. HSAG assigned a validation rating of *Met*, *Partially Met*, or *Not Met* to each applicable evaluation element within the Design stage of each PIP, and an overall validation rating of *Met*, *Partially Met*, or *Not Met* using the level of confidence assignment methodology defined in Appendix A.

Table 3-1 outlines the state-mandated PIP topics and the Aim statements defined by the MCOs for each PIP topic. The Aim statement helps the MCOs maintain the focus of the PIPs and sets the framework for data collection, analysis, and interpretation of the results.

Table 3-1—PIP Topic and Aim Statement

Plan Name	State-Mandated PIP Topic	MCO-Defined PIP Aim Statement
Anthem	*Improving the Rates for Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)*	Do targeted interventions increase the percentage of substance use disorder (SUD) episodes for members 13 years of age and older who had initiation of treatment within 14 days and treatment engagement within 34 days of initiation?
	Plan All-Cause Readmissions	Do targeted interventions decrease the percentage of acute inpatient or observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days for members 18 to 64 years of age?
HPN	*Initiation and Engagement of Substance Use Disorder Treatment (IET)*	Do targeted interventions increase the percentage of substance use disorder (SUD) episodes for members 13 years of age and older who had initiation of treatment within 14 days and treatment engagement within 34 days of initiation?
	Plan All-Cause Readmissions	Do targeted interventions decrease the percentage of acute inpatient or observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days for members 18 to 64 years of age?

Plan Name	State-Mandated PIP Topic	MCO-Defined PIP Aim Statement
Molina	*Initiation and Engagement of Substance Use Disorder Treatment (IET)*	Does implementing targeted strategies increase initiation of treatment within 14 days of a new SUD episode for Molina Medicaid members age 13 and older? Does implementing targeted strategies increase treatment engagement within 34 days of initiation of a new SUD episode for Molina Medicaid members age 13 and older?
	Plan All-Cause Readmissions	Do targeted interventions decrease the percentage of acute inpatient or observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days for members 18 to 64 years of age?
SilverSummit	*Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)*	Do targeted interventions increase the percentage of substance use disorder (SUD) episodes for members 13 years of age and older who had initiation of treatment within 14 days and treatment engagement within 34 days of initiation?
	Plan All-Cause Readmissions	Do targeted interventions decrease the percentage of acute inpatient or observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days for members 18 to 64 years of age?

Performance Measure Validation

For SFY 2023, DHCFP contracted with HSAG to conduct independent audits of its four contracted MCOs in alignment with NCQA's *HEDIS Compliance* Audit™[3-1] *Standards, Policies and Procedures, Volume 5*, which outlines the accepted approach for auditors to use when conducting an Information Systems Capabilities Assessment and an evaluation of compliance with performance measure specifications. All HSAG lead auditors are certified HEDIS compliance auditors (CHCAs). The PMV activity included a comprehensive evaluation of the MCOs' information systems (IS) capabilities and processes used to collect and report data for the performance measures selected by DHCFP for validation.

Table 3-2 lists the performance measures selected by DHCFP for measurement year (MY) 2022 reporting of the Medicaid and Nevada Check Up populations for the SFY 2023 PMV activity, which included a combination of HEDIS, CMS Child Core Set, and CMS Adult Core Set measures. The reported measures are divided into performance domains of care as demonstrated in the following table.

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

Table 3-2—SFY 2023 Performance Measures

Performance Measure	Measure Type		Populations	
	HEDIS	Core Set	Medicaid	Nevada Check Up
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services (AAP)	✓		✓	
Children's Preventive Care				
Child and Adolescent Well-Care Visits (WCV)	✓		✓	✓
Childhood Immunization Status (CIS)	✓		✓	✓
Immunizations for Adolescents (IMA)	✓		✓	✓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	✓		✓	✓
Well-Child Visits in the First 30 Months of Life (W30)	✓		✓	✓
Women's Health and Maternity Care				
Breast Cancer Screening (BCS)	✓	✓	✓	
Chlamydia Screening in Women (CHL)	✓		✓	✓
Postpartum Depression Screening and Follow-Up (PDS-E)	✓		✓	
Prenatal and Postpartum Care (PPC)	✓		✓	✓
Prenatal Depression Screening and Follow-Up (PND-E)	✓		✓	
Prenatal Immunization Status (PRS-E)	✓		✓	
Care for Chronic Conditions				
Asthma Medication Ratio (AMR)	✓	✓	✓	✓
Blood Pressure Control for Patients With Diabetes (BPD)	✓		✓	
Controlling High Blood Pressure (CBP)	✓	✓	✓	
Eye Exam for Patients With Diabetes (EED)	✓		✓	
Hemoglobin A1c Control for Patients With Diabetes (HBD)	✓		✓	
Kidney Health Evaluation for Patients With Diabetes (KED)	✓		✓	

Performance Measure	Measure Type		Populations	
	HEDIS	Core Set	Medicaid	Nevada Check Up
Behavioral Health				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	✓		✓	
Antidepressant Medication Management (AMM)	✓	✓	✓	
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	✓		✓	
*Follow-Up After ED Visit for Substance Use (FUA)**	✓	✓	✓	✓
*Follow-Up After ED Visit for Mental Illness (FUM)**	✓		✓	✓
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)	✓		✓	
Follow-Up After Hospitalization for Mental Illness (FUH)	✓		✓	✓
*Follow-Up Care for Children Prescribed ADHD Medication (ADD)**	✓		✓	✓
Initiation and Engagement of Substance Use Disorder Treatment (IET)	✓		✓	✓
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	✓		✓	✓
Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)		✓	✓	
Screening for Depression and Follow-Up Plan (CDF-CH/CDF-AD)		✓	✓	✓
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)			✓	✓
Utilization				
Ambulatory Care—Total (Per 1,000 Member Years) (AMB)	✓		✓	✓
Plan All-Cause Readmissions (PCR)	✓		✓	
Overuse/Appropriateness				
Risk of Continued Opioid Use (COU)	✓		✓	
Use of Opioids at High Dosage (HDO)	✓		✓	
Use of Opioids From Multiple Providers (UOP)	✓		✓	

*ADHD: attention-deficit/hyperactivity disorder; ED: emergency department

Compliance Review

DHCFP requires its contracted MCOs to undergo periodic compliance reviews to ensure that an assessment is conducted to meet mandatory EQR requirements. The reviews focus on standards identified in 42 CFR §438.358(b)(1)(iii) and applicable state-specific contract requirements. The current three-year compliance review cycle was initiated in SFY 2021 and comprised 14 program areas referred to as standards. At DHCFP's direction, HSAG conducted a review of the first seven federally required standards and requirements in Year One (SFY 2021) and a review of the remaining federally required seven standards and requirements in Year Two (SFY 2022) of the three-year compliance review cycle. This SFY 2023 (Year Three) compliance review activity consisted of a re-review of the standards that were not fully compliant during the SFY 2021 (Year One) and SFY 2022 (Year Two) compliance review activities, as indicated by the elements (i.e., requirements) that received *Not Met* scores and required corrective action plans (CAPs) to remediate the noted deficiencies. Table 3-3 outlines the standards reviewed over the three-year review cycle. Of note, **Molina** joined the Nevada Managed Care Program in the second year of the compliance review cycle (SFY 2022). As such, HSAG reviewed **Molina**'s compliance with the standards in Year Two and Year Three of the three-year cycle.

Table 3-3—Compliance Review Standards

<table>
<tr><th>Standards</th><th>Associated Federal Citation[1]</th><th>Year One (SFY 2021)[3]</th><th>Year Two (SFY 2022)</th><th>Year Three (SFY 2023)</th></tr>
<tr><td>Standard I—Disenrollment: Requirements and Limitations</td><td>§438.56</td><td>✓</td><td></td><td rowspan="14">Review of the MCEs' Implementation of Year One and Year Two CAPs</td></tr>
<tr><td>Standard II—Member Rights and Member Information</td><td>§438.10
§438.100</td><td>✓</td><td></td></tr>
<tr><td>Standard III—Emergency and Poststabilization Services</td><td>§438.114</td><td>✓</td><td></td></tr>
<tr><td>Standard IV—Availability of Services</td><td>§438.206</td><td>✓</td><td></td></tr>
<tr><td>Standard V—Assurances of Adequate Capacity and Services</td><td>§438.207</td><td>✓</td><td></td></tr>
<tr><td>Standard VI—Coordination and Continuity of Care</td><td>§438.208</td><td>✓</td><td></td></tr>
<tr><td>Standard VII—Coverage and Authorization of Services</td><td>§438.210</td><td>✓</td><td></td></tr>
<tr><td>Standard VIII—Provider Selection</td><td>§438.214</td><td></td><td>✓</td></tr>
<tr><td>Standard IX—Confidentiality</td><td>§438.224</td><td></td><td>✓</td></tr>
<tr><td>Standard X—Grievance and Appeal Systems</td><td>§438.228</td><td></td><td>✓</td></tr>
<tr><td>Standard XI—Subcontractual Relationships and Delegation</td><td>§438.230</td><td></td><td>✓</td></tr>
<tr><td>Standard XII—Practice Guidelines</td><td>§438.236</td><td></td><td>✓</td></tr>
<tr><td>Standard XIII—Health Information Systems[2]</td><td>§438.242</td><td></td><td>✓</td></tr>
<tr><td>Standard XIV—Quality Assessment and Performance Improvement Program</td><td>§438.330</td><td></td><td>✓</td></tr>
</table>

[1] The compliance review standards comprise a review of all requirements, known as elements, under the associated federal citation, including all requirements that are cross-referenced within each federal standard, as applicable (e.g., Standard X—Grievance and Appeal Systems includes a review of §438.228 and all requirements under 42 CFR Subpart F).

[2] This standard includes a comprehensive assessment of the MCE's information systems (IS) capabilities.

[3] **Molina** joined the Nevada Managed Care Program January 1, 2022; therefore, the compliance review activity was not conducted for **Molina** until Year Two of the compliance review cycle, and standards I–VII were reviewed in SFY 2023.

Network Adequacy Validation

The NAV activity for SFY 2023 included network capacity and geographic distribution analyses conducted after the MCOs identified provider categories by using the provider crosswalk HSAG developed in conjunction with DHCFP. HSAG also conducted an exploratory study of MCO data reflecting access to telehealth providers across provider categories.

To assess the capacity of each MCO's provider network, HSAG calculated the ratio of the number of providers by provider category (e.g., PCPs, cardiologists) to the number of members. Table 3-4 shows the provider categories used to assess the MCOs' compliance with the provider ratio standards in the MCO contracts with DHCFP.

Table 3-4—Provider Categories and Provider Ratio Standards

Provider Category	Provider-to-Member Ratio Standard
Primary Care Provider	1:1,500*
PCP Extenders	1:1,800
Physician Specialist	1:1,500

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

The second component of the NAV activity evaluated the geographic distribution of providers relative to each of the MCO's members. To provide a comprehensive view of geographic access, HSAG calculated the percentage of members with access within the standards for the provider categories identified in the MCO provider crosswalk. Table 3-5 shows the provider categories used to assess the MCOs' network adequacy and the associated time-distance standards.

Table 3-5—Provider Categories, Member Criteria, and Time-Distance Standards

Provider Category	Member Criteria	Time-Distance Access Standard
Primary Care Providers		
Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC)	All	15 minutes or 10 miles
Family Practice	Adults	15 minutes or 10 miles
Internal Medicine	Adults	15 minutes or 10 miles
General Practitioner	Adults	15 minutes or 10 miles
Nurse Practitioner (NP)	Adults	15 minutes or 10 miles
Physician Assistant (PA)	Adults	15 minutes or 10 miles
OB/GYN	Females 15 years or older	15 minutes or 10 miles
Pediatrician	Children	15 minutes or 10 miles

Provider Category	Member Criteria	Time-Distance Access Standard
Specialty Providers		
Endocrinologists	Adults	60 minutes or 40 miles
Endocrinologists, Pediatric	Children	60 minutes or 40 miles
Infectious Disease	Adults	60 minutes or 40 miles
Infectious Disease, Pediatric	Children	60 minutes or 40 miles
Rheumatologist	Adults	60 minutes or 40 miles
Rheumatologist, Pediatric	Children	60 minutes or 40 miles
Oncology—Medical/Surgical	Adults	45 minutes or 30 miles
Oncology—Medical/Surgical, Pediatric	Children	45 minutes or 30 miles
Oncologist/Radiologist	Adults	60 minutes or 40 miles
Behavioral Health Providers		
Psychologist	Adults	45 minutes or 30 miles
Pediatric Psychologist	Children	45 minutes or 30 miles
Psychiatrist	Adults	45 minutes or 30 miles
Board Certified Child and Adolescent Psychiatrist	Children	45 minutes or 30 miles
Qualified Mental Health Professional (QMHP)	Adults	45 minutes or 30 miles
Qualified Mental Health Professional (QMHP), Pediatric	Children	45 minutes or 30 miles
Facility Level Providers		
Hospitals, All	All	45 minutes or 30 miles
Psychiatric Inpatient Hospital	Adults	45 minutes or 30 miles
Dialysis/End Stage Renal Disease (ESRD) Facility	Adults	45 minutes or 30 miles
Pharmacy	All	15 minutes or 10 miles

To begin to understand the MCO data regarding telehealth services, HSAG requested that the MCOs identify which of their contracted providers offered telehealth services to member populations. Due to the variances in the data received from the MCOs, HSAG considered the data informational only and not reliable for including as part of the SFY 2023 network adequacy results.

Consumer Assessment of Healthcare Providers and Systems Analysis

The primary objective of the CAHPS surveys was to effectively and efficiently obtain information on experiences of adult members and parents/caretakers of child members with the healthcare they/their child received through their/their child's MCO. These surveys cover topics that are important to members, such as the communication skills of providers and the accessibility of services. The MCOs were responsible for obtaining a CAHPS vendor to administer the CAHPS surveys on their behalf. HSAG presents top-box scores, which indicate the percentage of respondents who reported positive experiences in a particular aspect of their/their child's healthcare.

Table 3-6 displays the various measures of member experience.

Table 3-6—CAHPS Measures of Member Experience

CAHPS Measures
Composite Measures
Getting Needed Care
Getting Care Quickly
How Well Doctors Communicate
Customer Service
Global Ratings
Rating of All Health Care
Rating of Personal Doctor
Rating of Specialist Seen Most Often
Rating of Health Plan
Effectiveness of Care (Adult Only)
Advising Smokers and Tobacco Users to Quit
Discussing Cessation Medications
Discussing Cessation Strategies
Children with Chronic Conditions (CCC) Composite Measures/Items (Child Only)
Access to Specialized Services
Family Centered Care (FCC): Personal Doctor Who Knows Child
Coordination of Care for Children With Chronic Conditions
Access to Prescription Medicines
FCC: Getting Needed Information

External Quality Review Activity Results

Anthem Blue Cross and Blue Shield Healthcare Solutions

Validation of Performance Improvement Projects

Performance Results

Table 3-7 displays the overall validation rating for the Design stage of each PIP topic. Table 3-7 also includes the performance indicators that will be used to track performance or improvement over the life of the PIP.

Table 3-7—Overall Validation Ratings for Anthem

PIP Topic	Validation Rating*	Performance Indicator	Performance Indicator Results		
			Baseline	R1	R2
Improving the Rates for Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	*Met*	The percentage of SUD episodes that resulted in initiation of treatment with 14 days.	—	—	—
		The percentage of SUD episodes that resulted in treatment engagement within 34 days of initiation.			
Plan All-Cause Readmissions	*Met*	The percentage of acute readmissions for any diagnosis within 30 days of the index discharge date.	—	—	—

— The PIP had not progressed to including baseline or remeasurement (R1, R2) results during SFY 2023.
*The PIP activities for SFY 2023 were initiated prior to release of the 2023 CMS EQR Protocols; therefore, HSAG adhered to the guidance published in the 2019 CMS EQR Protocols. With the release of the new protocols, HSAG updated its PIP worksheets for SFY 2024 to include the two validation ratings (i.e., overall confidence that the PIP adhered to an acceptable methodology for all phases of design and data collection, and the MCO conducted accurate data analysis and interpretation of PIP results; overall confidence that PIP produced significant evidence of improvement.)

Interventions

Anthem has established its PIP design, and the PIP will progress to the Implementation stage. During this stage, **Anthem** will evaluate and analyzes its data, identify barriers to performance, and develop interventions targeted to improve outcomes. As the PIPs did not progress to the Implementation stage in SFY 2023, **Anthem**’s causal/barrier analysis process and interventions will be reported in the next annual EQR technical report (SFY 2024).

Table 3-8 and Table 3-9 will display the barriers and interventions as documented by the MCO.

Table 3-8—Barriers Identified and Interventions Implemented/Planned for Initiation and Engagement (IET)

Barriers	Interventions
—	—
—	—

— The PIP had not progressed to the identification of barriers and the development of interventions during SFY 2023.

Table 3-9—Barriers Identified and Interventions Implemented/Planned for Plan All-Cause Readmissions

Barriers	Interventions
—	—
—	—

— The PIP had not progressed to the identification of barriers and the development of interventions during SFY 2023.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP validation against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP validation have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Anthem developed a methodologically sound design for both PIPs that met State and federal requirements. A methodologically sound design created the foundation for **Anthem** to progress to subsequent PIP stages—collecting data and carrying out interventions to positively impact performance indicator results and outcomes for the project. **[Quality]**

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any weaknesses for **Anthem**.

Why the weakness exists: No weaknesses were identified; therefore, this section is not applicable.

Recommendation: Although no significant weaknesses were identified during the SFY 2023 PIP activities, as **Anthem** progresses to the Implementation stage of the PIP, HSAG recommends that **Anthem** develop effective improvement strategies (i.e., interventions) that are designed to target the designated PIP population(s) and age group(s) to successfully improve member outcomes.

Performance Measure Validation

Performance Results

Table 3-10 and Table 3-11 display **Anthem**'s Medicaid and Nevada Check Up HEDIS and CMS Child and Adult Core Set performance measure results for MY 2020, MY 2021, and MY 2022, along with MY 2021 to MY 2022 rate comparisons and performance target ratings.

Performance for MY 2022 (SFY 2023) is indicated by symbols and color coding; **bolded** rates indicate the rate was at or above the DHCFP-established minimum performance standard (MPS); ↑ indicates the rate was above the national Medicaid 50th percentile benchmark, ↓ indicates the rate was below the national 50th percentile benchmark, green shading indicates that the rate improved by 5 percentage points from the prior year, and red shading indicates that the rate declined by 5 percentage points from the prior year.

Measures in the Utilization domain are designed to capture the frequency of services provided by the MCO. With the exception of *Ambulatory Care—Total (per 1,000 Member Years)—ED Visits—Total*, higher or lower rates in this domain do not necessarily indicate better or worse performance. Therefore, these rates are provided for information only.

Table 3-10—Medicaid SFY 2023 Performance Measure Results and Trending for Anthem

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	MY 2021–MY 2022 Rate Comparison
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services (AAP)				
Ages 20–44 Years	64.55%	62.89%	63.95%↓	1.06
Ages 45–64 Years	72.29%	70.45%	72.30%↓	1.85
*Ages 65 Years and Older^*	76.32%	68.99%	68.56%↓	-0.43
*Total^*	66.81%	65.03%	66.40%↓	1.37
Children's Preventive Care				
Childhood Immunization Status (CIS)				
Combination 3	61.80%	57.42%	57.11%↓	-0.31
Combination 7	53.53%	49.15%	51.48%↓	2.33
Combination 10	30.90%	25.55%	24.26%↓	-1.29
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	85.16%	81.27%	83.16%↑	1.89
Combination 2 (Meningococcal, Tdap, HPV)	39.42%	30.17%	32.21%↓	2.04

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	MY 2021–MY 2022 Rate Comparison
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile—Total	82.24%	80.05%	81.02%↑	0.97
Counseling for Nutrition—Total	74.21%	74.94%	72.99%↑	-1.95
Counseling for Physical Activity—Total	69.34%	72.26%	68.13%↓	-4.13
Well-Child Visits in the First 30 Months of Life (W30)				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	58.52%	58.50%	58.26%↑	-0.24
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	65.15%	60.39%	60.70%↓	0.31
Child and Adolescent Well-Care Visits (WCV)				
3–11 Years	46.99%	50.14%	50.84%↓	0.70
12–17 Years	39.02%	45.39%	45.59%↓	0.20
18–21 Years	19.63%	20.53%	20.40%↓	-0.13
Total	41.29%	44.67%	45.07%↓	0.40
Women's Health and Maternity Care				
Breast Cancer Screening (BCS)				
Breast Cancer Screening	44.67%	39.50%	40.50%↓	1.00
Chlamydia Screening in Women (CHL)				
16–20 Years	—	48.04%	49.03%↓	0.99
21–24 Years	—	61.22%	60.24%↓	-0.98
Total	—	55.65%	55.45%↑	-0.20
Postpartum Depression Screening and Follow-Up (PDS)^				
Depression Screening	—	—	0.00%	NC
Follow-Up on Positive Screen	—	—	NA	NC
Prenatal and Postpartum Care (PPC)				
Timeliness of Prenatal Care	81.75%	81.75%	83.33%↓	1.58
Postpartum Care	66.18%	71.29%	**74.27%**↓	2.98
Prenatal Depression Screening and Follow-Up (PND)^				
Screening	—	—	0.00%	NC

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	MY 2021–MY 2022 Rate Comparison
Follow Up	—	—	NA	NC
Prenatal Immunization Status (PRS)^				
Influenza	—	—	9.62%↓	NC
Tdap	—	—	19.61%↓	NC
Combination	—	—	5.64%↓	NC
Care for Chronic Conditions				
Asthma Medication Ratio (AMR)				
5–11 Years	—	81.70%	79.08%↑	-2.62
12–18 Years	—	68.08%	69.74%↑	1.66
5–18 Years (Child Core Set Total)	—	—	75.09%	NC
19–50 Years	—	55.37%	53.22%↓	-2.15
51–64 Years	—	54.71%	56.10%↓	1.39
19–64 Years (Adult Core Set Total)	—	—	54.03%	NC
Total (5–64 Years)	—	63.28%	62.05%↓	-1.23
Blood Pressure Control for Patients With Diabetes (BPD)				
Blood Pressure Control (<140/90 mm Hg)	50.61%	51.82%	60.34%↓	8.52
Controlling High Blood Pressure (CBP)				
Controlling High Blood Pressure	51.09%	53.04%	54.50%↓	1.46
Eye Exam for Patients With Diabetes (EED)				
Eye Exam (Retinal) Performed	50.85%	49.88%	55.23%↑	5.35
Hemoglobin A1c Control for Patients With Diabetes (HBD)				
*Poor HbA1c Control**	51.09%	47.45%	**39.90%**↑	-7.55
HbA1c Control (<8%)	40.63%	45.74%	**51.82%**↑	6.08
Kidney Health Evaluation for Patients With Diabetes (KED)				
18–64 Years	27.43%	28.21%	30.31%↓	2.10
65–74 Years	NA	32.20%	46.43%↑	14.23
75–85 Years	NA	NA	NA	NC
Total	27.55%	28.24%	30.45%↓	2.21

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	MY 2021–MY 2022 Rate Comparison
Behavioral Health				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	34.72%	34.31%	38.83%↓	4.52
Antidepressant Medication Management (AMM)				
Effective Acute Phase Treatment	—	52.06%	52.81%↓	0.75
Effective Continuation Phase Treatment	—	35.05%	36.17%↓	1.12
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	76.62%	76.68%	76.48%↓	-0.20
Follow-Up After Emergency Department Visit for Substance Use (FUA) [1]				
7-Day Follow-Up—Total	—	—	20.41%	NC
30-Day Follow-Up—Total	—	—	29.46%	NC
Follow-Up After Emergency Department Visit for Mental Illness (FUM)				
7-Day Follow-Up—Total	29.55%	35.58%	39.96%↓	4.38
30-Day Follow-Up—Total	40.89%	46.93%	50.22%↓	3.29
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)^				
7-Day Follow-Up—Total	—	—	29.75%↑	NC
30-Day Follow-Up—Total	—	—	50.44%↓	NC
Follow-Up After Hospitalization for Mental Illness (FUH)				
7-Day Follow-Up—Total	32.49%	28.87%	30.55%↓	1.68
30-Day Follow-Up—Total	48.72%	46.60%	48.00%↓	1.40
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
Initiation Phase	47.06%	49.38%	45.07%↑	-4.31
Continuation and Maintenance Phase	68.66%	60.81%	60.38%↑	-0.43
Initiation and Engagement of Substance Use Disorder Treatment (IET) [1]				
Initiation of SUD Treatment—Total (Total)	—	—	45.88%	NC

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	MY 2021–MY 2022 Rate Comparison
Engagement of SUD Treatment—Total (Total)	—	—	17.10%	NC
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)				
Blood Glucose and Cholesterol Testing—Total	31.27%	31.58%	32.01%↓	0.43
Screening for Depression and Follow-Up Plan (CDF-CH/CDF-AD)^				
12–17 Years	—	—	0.38%	NC
18–64 Years	—	—	1.85%	NC
65+ Years	—	—	1.79%	NC
Total (12+ Years)	—	—	1.54%	NC
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)				
1–11 Years	—	53.19%	62.50%↑	9.31
12–17 Years	—	63.41%	65.12%↑	1.71
Total	—	59.69%	**64.08%**↑	4.39
Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)^				
Rate 1: Total	—	—	53.34%	NC
Rate 2: Buprenorphine	—	—	29.08%	NC
Rate 3: Oral Naltrexone	—	—	4.78%	NC
Rate 4: Long-Acting, Injectable Naltrexone	—	—	1.79%	NC
Rate 5: Methadone	—	—	23.46%	NC
Utilization				
Ambulatory Care—Total (per 1,000 Member Years) (AMB)^**				
*ED Visits—Total**	515.75	551.08	642.32	91.24
Outpatient Visits—Total	2,957.50	3,017.10	3,265.66	248.56
Plan All-Cause Readmissions (PCR)				
*Observed Readmissions—Total**	14.42%	13.23%	12.82%	-0.41
Expected Readmissions—Total	9.83%	9.51%	9.65%	0.14
Observed/Expected (O/E) Ratio—Total	1.4675	1.3912	1.3282	-0.06
Outliers—Total	48.09	72.32	72.12	-0.20

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	MY 2021–MY 2022 Rate Comparison
Overuse/Appropriateness of Care				
Risk of Continued Opioid Use (COU)*^				
At Least 15 Days Covered—Total	—	—	7.44%↓	NC
At Least 31 Days Covered—Total	—	—	5.85%↓	NC
Use of Opioids at High Dosage (HDO)*				
Use of Opioids at High Dosage	8.90%	8.15%	**7.63%**↓	-0.52
Use of Opioids From Multiple Providers (UOP)*				
Multiple Prescribers	15.90%	20.68%	**19.36%**↓	-1.32
*Multiple Pharmacies^*	1.15%	0.52%	**0.56%**↑	0.04
*Multiple Prescribers and Multiple Pharmacies^*	0.57%	0.30%	**0.34%**↑	0.04

[1] Due to significant changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS MY 2022 and prior years. Due to the QISMC goals being based on HEDIS MY 2020 statewide aggregate rates, the MY 2022 rate was not compared to an MPS.
↑ Indicates the MY 2022 rate was above NCQA's Quality Compass HEDIS 2022 Medicaid HMO 50th percentile benchmark.
↓ Indicates the MY 2022 rate was below NCQA's Quality Compass HEDIS 2022 Medicaid HMO 50th percentile benchmark.
* A lower rate indicates better performance for this measure or indicator.
** Beginning MY 2022, this rate is reported per 1,000 member years instead of per 1,000 member months; the rates for the prior two years were converted to member years for comparison.
— Indicates that the MCO was not previously required to report this measure or that the rate is not appropriate to display due to changes in the technical specifications resulting in a break in trending.
^ Indicates MY 2022 Quality Improvement System for Managed Care (QISMC) goals are unavailable for this measure or indicator.
NC indicates the MY 2021–MY 2022 Rate Comparison could not be calculated because data are not available for both years.
NA indicates that the MCO followed the specifications, but the denominator was too small (i.e., <30) to report a valid rate.
Bolded rates indicate that the MY 2022 performance measure rate was at or above the MPS.

Indicates that the MY 2022 rate improved by 5 percentage points or more from MY 2021.

Table 3-11—Nevada Check Up SFY 2023 Performance Measure Results and Trending for Anthem

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	MY 2021–MY 2022 Rate Comparison
Children's Preventive Care				
Childhood Immunization Status (CIS)				
Combination 3	78.79%	71.33%	65.00%↑	-6.33

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	MY 2021–MY 2022 Rate Comparison
Combination 7	69.70%	66.67%	61.25%↑	-5.42
Combination 10	42.42%	35.33%	37.50%↑	2.17
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	92.94%	91.48%	90.97%↑	-0.51
Combination 2 (Meningococcal, Tdap, HPV)	57.18%	44.28%	44.48%↑	0.20
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile—Total	81.75%	83.94%	80.05%↑	-3.89
Counseling for Nutrition—Total	74.94%	76.64%	73.97%↑	-2.67
Counseling for Physical Activity—Total	69.10%	73.24%	69.59%↑	-3.65
Well-Child Visits in the First 30 Months of Life (W30)				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	71.23%	66.29%	67.61%↑	1.32
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	77.27%	72.19%	68.97%↑	-3.22
Child and Adolescent Well-Care Visits (WCV)				
3–11 Years	55.51%	56.17%	53.19%↓	-2.98
12–17 Years	48.50%	53.97%	52.64%↑	-1.33
18–21 Years	30.90%	33.52%	36.95%↑	3.43
Total	51.37%	53.95%	51.80%↑	-2.15
Women's Health and Maternity Care				
Chlamydia Screening in Women (CHL)				
16–20 Years	—	39.58%	**45.87%**↓	6.29
21–24 Years	—	NA	NA	NC
Total	—	39.58%	45.87%↓	6.29
Prenatal and Postpartum Care (PPC)				
Timeliness of Prenatal Care	—	—	NA	NC
Postpartum Care	—	—	NA	NC

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	MY 2021–MY 2022 Rate Comparison
Care for Chronic Conditions				
Asthma Medication Ratio (AMR)				
5–11 Years	—	77.14%	84.38%↑	7.24
12–18 Years	—	64.71%	NA	NC
5–18 Years (Child Core Set Total)	—	—	**81.82%**	NC
19–50 Years	—	NA	NA	NC
51–64 Years	—	NA	NA	NC
19–64 Years (Adult Core Set Total)	—	—	NA	NC
Total	—	71.01%	82.14%↑	11.13
Behavioral Health				
Follow-Up After Emergency Department Visit for Substance Use (FUA)^,1				
7-Day Follow-Up—Total	—	—	NA	NC
30-Day Follow-Up—Total	—	—	NA	NC
Follow-Up After Emergency Department Visit for Mental Illness (FUM)				
7-Day Follow-Up—Total	NA	NA	NA	NC
30-Day Follow-Up—Total	NA	NA	NA	NC
Follow-Up After Hospitalization for Mental Illness (FUH)				
7-Day Follow-Up—Total	47.50%	35.48%	NA	NC
30-Day Follow-Up—Total	67.50%	61.29%	NA	NC
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
Initiation Phase	43.59%	50.00%	45.16%↑	-4.84
Continuation and Maintenance Phase	NA	NA	NA	NC
Initiation and Engagement of Substance Use Disorder Treatment (IET)[1]				
Initiation of SUD Treatment—Total (Total)	—	—	NA	NC
Engagement of SUD Treatment—Total (Total)	—	—	NA	NC
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)				
Blood Glucose and Cholesterol Testing—Total	NA	NA	NA	NC

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	MY 2021–MY 2022 Rate Comparison
Screening for Depression and Follow-Up Plan (CDF-CH/CDF-AD)^				
12–17 Years	—	—	0.20%	NC
18–64 Years	—	—	0.47%	NC
65+ Years	—	—	NA	NC
Total (12+ Years)	—	—	0.23%	NC
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)^				
1–11 Years	—	NA	NA	NC
12–17 Years	—	NA	NA	NC
Total	—	NA	NA	NC
Utilization				
Ambulatory Care—Total (per 1,000 Member Years) (AMB)^*				
*ED Visits—Total**	187.51	191.34	309.40	118.06
Outpatient Visits—Total	2,229.63	2,308.41	2,589.87	281.46

[1] Due to significant changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS MY 2022 and prior years.
↑ Indicates the MY 2022 rate was above NCQA's Quality Compass HEDIS 2022 Medicaid HMO 50th percentile benchmark.
↓ Indicates the MY 2022 rate was below NCQA's Quality Compass HEDIS 2022 Medicaid HMO 50th percentile benchmark.
* A lower rate indicates better performance for this measure.
** Beginning MY 2022, this rate is reported per 1,000 member years instead of per 1,000 member months; the rates for the prior two years were converted to member years for comparison.
— Indicates that the MCO was not previously required to report this measure or that the rate is not appropriate to display due to changes in the technical specifications resulting in a break in trending.
^ Indicates MY 2022 QISMC goals are unavailable for this measure or indicator.
NC indicates the MY 2021–MY 2022 Rate Comparison could not be calculated because data are not available for both years.
NA indicates that the MCO followed the specifications, but the denominator was too small (i.e., <30) to report a valid rate.

Indicates that the MY 2022 rate declined by 5 percentage points or more from MY 2021.

Indicates that the MY 2022 rate improved by 5 percentage points or more from MY 2021.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Within the Women's Health and Maternity Care domain, **Anthem**'s Nevada Check Up rate for *Chlamydia Screening in Women—16–20 Years* measure indicator met the State's established MPS and demonstrated an increase in performance of more than 5 percentage points from the prior MY. This performance suggests that adolescent and young adult females in **Anthem**'s Nevada Check Up population are being screened for chlamydia in a timely manner, which is important as untreated chlamydia infections can lead to serious, irreversible complications. **[Quality, Timeliness,** and **Access]**

Strength #2: Within the Women's Health and Maternity Care domain, **Anthem**'s Medicaid rate for the *Prenatal and Postpartum Care—Postpartum Care* measure indicator met the State's established MPS, indicating these members are receiving timely, adequate postpartum care visits, which helps set the stage for long-term health and well-being of new mothers and their infants. **[Quality, Timeliness,** and **Access]**

Strength #3: Within the Care for Chronic Conditions domain, **Anthem**'s Medicaid performance for the *Blood Pressure Control for Patients With Diabetes, Eye Exam for Patients With Diabetes, Hemoglobin A1c Control for Patients With Diabetes,* and *Kidney Health Evaluation for Patients With Diabetes—65–74 Years* measure indicators demonstrated an increase of more than 5 percentage points from the prior MY. In addition, the *Hemoglobin A1c Control for Patients With Diabetes* measure indicators met the State's established MPS. This performance suggests that **Anthem**'s Medicaid members with diabetes are receiving appropriate care for chronic conditions associated with diabetes, which left unmanaged can lead to serious complications, including heart disease, stroke, hypertension, blindness, kidney disease, diseases of the nervous system, amputations, and premature death. **[Quality** and **Timeliness]**

Strength #4: Within the Care for Chronic Conditions domain for **Anthem**'s Nevada Check Up population, the *Asthma Medication Ratio—5–11 Years* measure indicator showed an increase in performance of more than 5 percentage points from the prior MY. In addition, the *Asthma Medication Ratio—5–18 Years (Child Core Set Total)* rate met the State's established MPS. This performance suggests that **Anthem**'s Nevada Check Up child and adolescent members with persistent asthma are receiving appropriate medication management, potentially reducing the need for rescue medication, as well as costs associated with emergency room visits, inpatient admissions, and missed days of school or work. **[Quality, Timeliness,** and **Access]**

Strength #5: Within the Behavioral Health domain for **Anthem**'s Medicaid population, **Anthem** met the State's established MPS for the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total* measure indicator. Additionally, **Anthem**'s Medicaid performance for the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—1–11 Years* measure indicator demonstrated an increase of more than 5 percentage points from the prior MY. This performance suggests that **Anthem**'s Medicaid children and adolescent members being treated with antipsychotic medications received psychosocial care interventions as a first-line treatment method, which may potentially reduce the risks associated with antipsychotic medications. **[Quality** and **Timeliness]**

Weaknesses and Recommendations

Weakness #1: Within the Access to Care, Children's Preventive Care, and Women's Health and Maternity Care domains for **Anthem**'s Medicaid population, although there were no significant increases or decreases (+/- 5 percentage points) from the prior MY, no measure indicator rates associated with a QISMC goal except *Prenatal and Postpartum Care—Postpartum Care* met the State's established MPS. **[Quality, Timeliness,** and **Access]**

Why the weakness exists: Although **Anthem**'s Medicaid members appear to have access to PCPs for preventive and ambulatory services, as well as children's and women's preventive services, these members were not consistently utilizing these services, which can significantly reduce non-urgent ED visits and potentially prevent more serious health and development issues from occurring, reducing healthcare costs. The low performance in these domains could also be due to disparities within **Anthem**'s populations that could impact access to care, such as language barriers, access to transportation, geographic location, and socioeconomic status. Low performance could also potentially be attributed to the lingering impact of the coronavirus disease 2019 (COVID-19) public health emergency (PHE), which may have caused healthcare provider burnout and shortages.

Recommendation: **Anthem** self-reported several interventions it put in place during MY 2023, some of which include adding *Adults Access to Preventive/Ambulatory Health Services* as a quality metric to its value-based payment program, as well as implementing an incentive program for providers not participating in a value-based payment program. **Anthem** also reported it conducts telephonic outreach to providers with messages to focus on ADHD medications and to ensure follow-up appointments are discussed with caregivers and are scheduled. Additionally, **Anthem** reported that it conducts root cause analyses to determine why child members are not receiving all recommended well-care visits and vaccines, and that it considers disparities within its populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Further, **Anthem** reported that it continues to advertise telehealth services in provider newsletters and provider education materials, and that it shares member-level detail data with contracted providers to conduct outreach and reduce member gaps in care. HSAG recommends that **Anthem** continue to educate its contracted providers, furnish them with member-level detail data, and encourage them to conduct outreach and reduce member gaps in care. **Anthem** should also continue the various interventions put in place during MY 2023, to conduct root cause analyses, and to consider disparities within its Medicaid population that may be contributing to lower performance in the Access to Care, Children's Preventive Care, and Women's Health and Maternity Care domains.

Weakness #2: Excluding the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total* measure indicator in the Behavioral Health domain for Medicaid, no measures with a QISMC goal met the State's established MPS. **[Quality, Timeliness,** and **Access]**

Why the weakness exists: Low performance within the Behavioral Health domain may potentially be due to low appointment availability for QMHPs to meet the demand, lack of transportation, or perceived social stigma related to seeking mental health services.

Recommendation: **Anthem** self-reported that it has continued with interventions and programs to address low performance in the Behavioral Health domain, implemented a post-ED discharge visit in partnership with two provider groups to improve the timeliness of follow-up visits for members with

a mental health diagnosis, and expanded its member incentive program to include a member incentive for completing a follow-up visit within seven days of ED discharge or within 30 days of a mental health inpatient discharge. HSAG recommends that **Anthem** continue these efforts and also continue to consider additional interventions based on its root cause analyses to improve performance in this domain.

Weakness #3: Within the Children's Preventive Care domain, **Anthem**'s Nevada Check Up performance for the *Childhood Immunization Status—Combination 3* and *Combination 7* measure indicators showed a decline in performance of more than 5 percentage points from the prior MY. **[Access]**

Why the weakness exists: Immunization declines may be due to disparities within **Anthem**'s Nevada Check Up population that could impact access to care, such as language barriers, access to transportation, geographic location, and socioeconomic status.

Recommendation: **Anthem** self-reported that it has implemented several interventions in a continued effort to ensure child members are receiving the recommended immunizations. Some of the interventions reported include offering member incentives for completing immunizations, piloting an after-hours clinic with one provider group to improve access to child and adolescent immunizations, as well as a value-based program that incentivizes PCPs to close gaps in care for priority HEDIS metrics, including *Childhood Immunization Status*. **Anthem** should continue its efforts to ensure child members in the Nevada Check Up population are receiving the recommended vaccines and continue to monitor and conduct root cause analyses to determine why these members are not receiving all recommended vaccines. **Anthem** should also consider disparities within this population that may have contributed to lower performance in a particular race or ethnicity, age group, ZIP Code, etc.

Compliance Review

Performance Results

Table 3-12 presents an overview of the results of the SFY 2021 and SFY 2022 compliance reviews for **Anthem**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements (i.e., requirements) it reviewed. If a requirement was not applicable to **Anthem** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all 14 standards.

Table 3-12—Summary of Standard Compliance Scores

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Disenrollment: Requirements and Limitations	7	7	7	0	0	**100%**

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard II—Member Rights and Member Information	22	22	21	1	0	**95%**
Standard III—Emergency and Poststabilization Services	10	10	10	0	0	**100%**
Standard IV—Availability of Services	10	10	10	0	0	**100%**
Standard V—Assurances of Adequate Capacity and Services	2	2	2	0	0	**100%**
Standard VI—Coordination and Continuity of Care	17	17	16	1	0	**94%**
Standard VII—Coverage and Authorization of Services	15	15	13	2	0	**87%**
Standard VIII—Provider Selection	12	12	8	4	0	**67%**
Standard IX—Confidentiality	11	11	10	1	0	**91%**
Standard X—Grievance and Appeal Systems	38	38	28	10	0	**74%**
Standard XI—Subcontractual Relationships and Delegation	7	7	7	0	0	**100%**
Standard XII—Practice Guidelines	10	10	10	0	0	**100%**
Standard XIII—Health Information Systems[1]	14	14	14	0	0	**100%**
Standard XIV—Quality Assessment and Performance Improvement Program	42	39	38	1	3	**97%**
Total	**217**	**214**	**194**	**20**	**3**	**91%**

M = Met*; *NM = Not Met*; *NA = Not Applicable
Total Elements: The total number of elements within each standard.
Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.
Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.
[1] This standard includes a comprehensive assessment of the MCO's IS capabilities.

Based on the findings from the SFY 2021 and SFY 2022 compliance review activities, **Anthem** was required to develop and submit a CAP for each element assigned a score of *Not Met*. The CAP was reviewed by DHCFP and HSAG for sufficiency, and **Anthem** was responsible for implementing each action plan in a timely manner. Table 3-13 presents an overview of the results of the SFY 2023 compliance review for **Anthem** which consisted of a comprehensive review of the MCO's implementation of each action plan. HSAG assigned a score of *Complete* or *Not Complete* to each of the individual elements that required a CAP based on a scoring methodology, which is detailed in Appendix A.

Table 3-13—Summary of Corrective Action Plan Implementation

Standard	Total CAP Elements	# CAP Elements *Complete*	# CAP Elements *Not Complete*
Standard II—Member Rights and Member Information	1	1	**0**
Standard VI—Coordination and Continuity of Care	1	1	**0**
Standard VII—Coverage and Authorization of Services	2	2	**0**
Standard VIII—Provider Selection	4	4	**0**
Standard IX—Confidentiality	1	1	**0**
Standard X—Grievance and Appeal Systems	10	7	**3**
Standard XIV—Quality Assessment and Performance Improvement Program	1	1	**0**
Total	**20**	**17**	**3**

Total CAP Elements: The total number of elements within each standard that required a CAP during the SFY 2021 and SFY 2022 compliance review activities.
 # CAP Elements *Complete*: The total number of CAP elements within each standard that were fully remediated at the time of the site review and demonstrated compliance with the requirement under review.
 # CAP Elements *Not Complete*: The total number of CAP elements within each standard that were not fully remediated at the time of the site review and/or did not demonstrate compliance with the requirement under review.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the compliance review activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the compliance review have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Anthem demonstrated that it successfully remediated 17 of 20 elements, indicating that the necessary policies, procedures, and interventions were implemented to ensure compliance with the requirements under review. Further, **Anthem** remediated all elements for six of the seven standards reviewed: Member Rights and Member Information, Coordination and Continuity of Care, Coverage and Authorization of Services, Provider Selection, Confidentiality, and Quality Assessment and Performance Improvement Program [**Quality, Timeliness,** and **Access**]

Weaknesses and Recommendations

Weakness #1: Anthem did not remediate three of the 10 elements for the Grievance and Appeal Systems standard, indicating continued gaps in the MCO's processes for acknowledgment of appeals and in providing oral notice to members when an expedited appeal request has been denied and for expedited and standard appeal resolutions. Providing proper acknowledgement of appeals and

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prompt oral notice to members as required ensures that members are properly informed of the status and resolution of their appeal in a timely manner. [**Quality, Timeliness,** and **Access**]

Why the weakness exists: Appeal case files reviewed demonstrated that for expedited appeal requests, the MCO was prematurely sending a standard appeal acknowledgement letter for expedited appeal requests before the decision was made to deny the expedited appeal resolution time frame request, resulting in the member receiving multiple acknowledgement letters and inappropriately receiving a standard appeal acknowledgement letter, which may be confusing for members. Additionally, some appeal case files reviewed did not include documentation that prompt oral notice of a decision to deny a request for an expedited appeal was provided to the member within 24 hours as required in the MCO's policy, and that attempts to provide oral notice to the member of the expedited and standard appeal resolution were not documented in the case record.

Recommendation: HSAG required **Anthem** to submit an action plan to address these findings and provide assurances that staff members were trained on requirements regarding the provision of oral notice and revisions to the appeal process to ensure members receive one acknowledgement letter for a denied request for an expedited appeal resolution. Additionally, HSAG recommends that **Anthem** consider conducting grievance and appeal case file reviews periodically, to ensure that staff are adhering to established policies and procedures for providing members with prompt oral notice and that appeal acknowledgement letters are provided to members as required.

Network Adequacy Validation

Performance Results

Table 3-14 presents **Anthem**'s network capacity analysis results and compares the provider ratios to the standards displayed in Table 3-4. Assessed provider ratios shown in green indicate the provider ratio was in compliance with the access standard, whereas provider ratios shown in red indicate the provider ratio was not in compliance with the access standard.

Table 3-14—Summary of Ratio Analysis Results for PCPs and Specialty Care Providers for Anthem

Provider Category	Providers*	Clark County Ratio	Washoe County Ratio	Statewide Ratio**
PCPs (1:1,500)	1,554	1:116	1:18	1:133
PCP Extenders (1:1,800)	2,129	1:47	1:8	1:55
Physician Specialists (1:1,500)	1,527	1:118	1:18	1:135

Note: Results shown in green font indicate the result complies with the access standard; results shown in red font indicate the result does not comply with the access standard; PCP: Primary Care Provider.

* Providers contracted statewide and contracted providers located in the Nevada Medicaid catchment areas were included in provider counts.

** Statewide ratio incorporates all Nevada counties included in the DHCFP member file submission and members enrolled with the MCO as of December 1, 2022.

Table 3-15 presents **Anthem**'s geographic network distribution analysis and presents the percentage of members who had access to provider locations within the standards displayed in Table 3-5. Assessed results shown in green indicate that the percentage of members within the access standard was in compliance, and percentages shown in red indicate a result of less than 99.0 percent.

Table 3-15—Percentage of Members With Required Access by Provider Category for Anthem

Provider Category	Clark County	Washoe County	Statewide*
Primary Care Providers			
Primary Care, Adults (10 miles/15 mins)	99.9%	99.5%	99.9%
OB/GYN (10 miles/15 mins)	99.2%	95.3%	98.5%
Pediatrician (10 miles/15 mins)	>99.9%	99.5%	99.8%
Physician Specialists			
Endocrinologist (40 miles/60 mins)	>99.9%	100%	99.9%
Endocrinologist, Pediatric (40 miles/60 mins)	>99.9%	100%	>99.9%
Infectious Disease (40 miles/60 mins)	>99.9%	100%	99.9%
Infectious Disease, Pediatric (40 miles/60 mins)	>99.9%	100%	>99.9%
Oncologist/Radiologist (40 miles/60 mins)	>99.9%	100%	99.9%
Oncologist—Medical/Surgical (30 miles/45 mins)	>99.9%	>99.9%	99.9%
Oncologist—Medical/Surgical, Pediatric (30 miles/45 mins)	>99.9%	>99.9%	99.9%
Rheumatologist (40 miles/60 mins)	>99.9%	100%	99.9%
Rheumatologist, Pediatric (40 miles/60 mins)	>99.9%	0.0%	87.5%
Behavioral Health Providers			
Board Certified Child and Adolescent Psychiatrist (30 miles/45 mins)	>99.9%	>99.9%	99.9%
Psychiatrist (30 miles/45 mins)	>99.9%	>99.9%	99.9%
Psychologist (30 miles/45 mins)	>99.9%	>99.9%	99.9%
Psychologist, Pediatric (30 miles/45 mins)	>99.9%	>99.9%	99.9%
QMHP (30 miles/45 mins)	>99.9%	100%	>99.9%
QMHP, Pediatric (30 miles/45 mins)	>99.9%	100%	>99.9%
Facility-Level Providers			
Hospitals, All (30 miles/45 mins)	>99.9%	>99.9%	99.9%
Pharmacy (10 miles/15 mins)	>99.9%	99.5%	99.9%
Psychiatric Inpatient Hospital (30 miles/45 mins)	>99.9%	>99.9%	99.9%

Provider Category	Clark County	Washoe County	Statewide*
Dialysis/ESRD Facility (30 miles/45 mins)	>99.9%	>99.9%	99.9%

Note: Results shown in green font indicate the result complies with the access standard; results shown in red font indicate that less than 99.0 percent of members had access to the provider within the time and distance access standard.
* Statewide results incorporate all Nevada counties included in the DHCFP member file submission and members enrolled with the MCO as of December 1, 2022.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the NAV findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Anthem met the provider ratio requirements for PCPs, PCP Extenders, and Physician Specialists, indicating **Anthem** had a sufficient provider network for its members to access services. **[Access]**

Strength #2: Anthem met the time-distance contract standards in Washoe County for Rheumatologist and Oncologist/Radiologist specialists and the following provider categories for adult and pediatric populations: Endocrinologist, Infectious Disease, and QMHP. **[Access]**

Strength #3: Anthem demonstrated a substantial increase in the percentage of members with a Pediatric Psychologist located within standards, from 87.9 percent in SFY 2022 to 99.9 percent in SFY 2023 statewide.[3-2] **[Access]**

Weaknesses and Recommendations

Weakness #1: Anthem did not meet the time-distance contract standards for OB/GYNs, indicating members may experience challenges accessing this provider type within an adequate time or distance from their residence. **[Access]**

Why the weakness exists: None of the four MCOs met the contract standard for OB/GYNs, suggesting a potential lack of this provider type in the counties served. OB/GYN providers may also be unwilling to contract with the MCOs due to the low reimbursement rates as reported by **Anthem**.

[3-2] For SFY 2022 EQR results, refer to the Division of Health Care Financing and Policy Nevada Managed Care Program State Fiscal Year 2022 External Quality Review Technical Report at https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Resources/AdminSupport/Reports/NV2022_EQR-TR_F1.pdf.

Recommendation: HSAG recommends that **Anthem** collaborate with DHCFP to determine whether Medicaid reimbursement rates can be increased to improve the number of OB/GYN providers willing to contract with the MCOs to provide Medicaid-covered services.

Weakness #2: **Anthem** did not meet the time-distance contract standards for Pediatric Rheumatologists in Washoe County, indicating members may experience challenges accessing this provider type within an adequate time or distance from their residence. **[Access]**

Why the weakness exists: None of the four MCOs met the contract standard for the Pediatric Rheumatologist provider type in Washoe County, indicating a lack of this provider type within this county. Specifically, there were no pediatric rheumatologists practicing in Washoe County or available for contracting.

Recommendation: HSAG recommends that **Anthem** consider collaborating with DHCFP and the other MCOs to determine whether community reinvestment funds can be used to incentivize pediatric rheumatologists to join a rheumatology clinic in Washoe County.

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results

Table 3-16 presents the 2023 CAHPS top-box scores for **Anthem**'s adult Medicaid, general child Medicaid, CCC Medicaid, Nevada Check Up general child, and Nevada Check Up CCC populations. Arrows (↓ or ↑) indicate 2023 scores that were statistically significantly higher or lower than the 2022 national average.[3-3]

Table 3-16—Summary of 2023 CAHPS Top-Box Scores for Anthem

	Adult Medicaid	General Child Medicaid	CCC Medicaid	Nevada Check Up General Child	Nevada Check Up CCC
Composite Measures					
Getting Needed Care	NA	NA	NA	NA	NA
Getting Care Quickly	NA	NA	NA	NA	NA
How Well Doctors Communicate	NA	NA	NA	NA	NA
Customer Service	NA	NA	NA	NA	NA
Global Ratings					
Rating of All Health Care	NA	73.0%	NA	NA	NA
Rating of Personal Doctor	NA	74.4%	NA	61.4% ↓	NA
Rating of Specialist Seen Most Often	NA	NA	NA	NA	NA

[3-3] 2023 national average results were not available at the time this report was produced.

	Adult Medicaid	General Child Medicaid	CCC Medicaid	Nevada Check Up General Child	Nevada Check Up CCC
Rating of Health Plan	NA	73.8%	NA	72.7%	NA
Effectiveness of Care*					
Advising Smokers and Tobacco Users to Quit	NA	—	—	—	—
Discussing Cessation Medications	NA	—	—	—	—
Discussing Cessation Strategies	NA	—	—	—	—
CCC Composite Measures/Items					
Access to Specialized Services	—	—	NA	—	NA
FCC: Personal Doctor Who Knows Child	—	—	NA	—	NA
Coordination of Care for Children With Chronic Conditions	—	—	NA	—	NA
Access to Prescription Medicines	—	—	NA	—	NA
FCC: Getting Needed Information	—	—	NA	—	NA

A minimum of 100 respondents is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of respondents are denoted as *Not Applicable (NA)*.
* These scores follow NCQA's methodology of calculating a rolling two-year average.
↑ Indicates the 2023 score is statistically significantly higher than the 2022 national average.
↓ Indicates the 2023 score is statistically significantly lower than the 2022 national average.
— Indicates the measure does not apply to the population.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the CAHPS activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine any significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: HSAG did not identify any strengths for **Anthem** for the CAHPS surveys.

Weaknesses and Recommendations

Weakness #1: Parents/caretakers of Nevada Check Up general child members had less positive overall experiences with their child's personal doctor since the score for this measure was statistically significantly lower than the 2022 NCQA Medicaid national average. **[Quality]**

Why the weakness exists: Parents/caretakers may have a difficult time getting an appointment with their child's provider or may have to talk to more than one provider, and **Anthem**'s providers may not be aware of all the needs of their child members; as a result, they may not be providing the consultative care required. Additionally, providers may not be spending enough quality time with child members or the parents/caretakers, or not satisfactorily addressing their needs.

Recommendation: HSAG recommends that **Anthem** prioritize improving parents'/caretakers' overall experiences with their child's personal doctor and determine a root cause for the lower performance. As part of this analysis, **Anthem** could determine if any outliers were identified within the data, identify primary areas of focus, and develop appropriate strategies to improve the performance. Additionally, HSAG recommends **Anthem** continue sharing the results of its respondent experiences with its contracted providers and staff members while also encouraging its contracted providers and staff members to solicit additional feedback and recommendations from its parents/caretakers of child members to improve their overall satisfaction with both **Anthem** and its contracted pediatric providers.

Weakness #2: There were less than 100 respondents for every measure for the adult Medicaid, CCC Medicaid, and Nevada Check Up CCC populations and most measures for the general child Medicaid and Nevada Check Up general child populations; therefore, results could not be reported for the applicable measures and strengths and weaknesses could not be identified for the associated populations. **[Quality, Timeliness, Access]**

Why the weakness exists: Adult members and parents/caretakers of child members are less likely to respond to the CAHPS survey. Completion of surveys may be exceptionally low on the list of priorities for members struggling with illness, unemployment, and/or other life-changing events.

Recommendation: HSAG recommends that **Anthem**, in collaboration with its CAHPS vendor, focus on increasing response rates to the CAHPS survey for all populations so there are greater than 100 respondents for each measure by continuing to educate and engage all employees to increase their knowledge of CAHPS, applying effective customer service techniques, increasing the percentage of oversampling, using innovative outreach strategies to follow up with the non-respondents, and continuing to provide awareness to members and providers during the survey period. Additionally, **Anthem**'s care management and/or other member-facing teams, such as the customer service team, could consider asking members if they know about the CAHPS survey and, if they received the survey, what barriers may prevent them from responding to the survey. These questions can be asked during routine contacts with members or when members outreach to **Anthem**. The information provided by these members could be shared with **Anthem**'s CAHPS vendor so that **Anthem** and the vendor can identify solutions to address low response rates.

Overall Conclusions for Quality, Timeliness, and Access to Healthcare Services

HSAG performed a comprehensive assessment of **Anthem**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **Anthem** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **Anthem**'s overall performance contributed to the Nevada Managed Care Program's progress in achieving the Quality Strategy goals and objectives. Table 3-17 displays each

applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided **Anthem**'s Medicaid and Nevada Check Up members.

Table 3-17—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Increase Use of Preventive Services	**Quality**, **Timeliness**, and **Access**—**Anthem** demonstrated through the three-year compliance review cycle that it had appropriate practices for ensuring providers were aware of **Anthem**'s adopted practice guidelines, which should include guidelines for preventive care, and **Anthem** appeared to have a sufficient number of PCPs to provide well-care services, as indicated through the NAV activity; however, **Anthem** did not achieve the DHCFP-established MPS for any performance measure included in the Medicaid Access to Care and Medicaid and Nevada Check Up Children's Preventive Care domains. For the Nevada Check Up population, for two *Childhood Immunization Status* measure indicator rates, **Anthem**'s performance also declined by more than 5 percentage points from SFY 2022. Additionally, many females in **Anthem**'s Medicaid population were not being screened for breast cancer and chlamydia, and performance in the Women's Health and Maternity Care domain related to these preventive services has been relatively stagnant over time for the Medicaid population. Interestingly, for females in the Nevada Check Up population, there was a significant increase in chlamydia screenings, and the *Chlamydia Screening in Women—16–20 Years* measure indicator rate met the DHCFP-established MPS, indicating there has been remarkable improvement in the number of teenaged females being tested for this sexually transmitted disease. However, since SFY 2022 (MY 2021), **Anthem** has not made significant improvement in increasing the use of most preventive services for its adult and child members. Based on these findings, **Anthem** has significant opportunities to mitigate any barriers to members receiving preventive care, and to implement interventions to support improvement in the use of preventive services for adult and child members and contribute to the Nevada Managed Care Program's progress toward achieving Goal 1 of the Quality Strategy to *improve the health and wellness of Nevada's Medicaid population by increasing the use of preventive services by December 31, 2024*. According to **Anthem**'s CAHPS results, some members were unhappy with their overall experiences with their personal doctors. As part of its improvement efforts, **Anthem** should evaluate whether members' unhappiness with their providers is impeding access to preventive care. Preventive care is crucial to staying healthy and identifying problems early on before they contribute to other issues or become harder to treat. Immunizations are also essential to prevent diseases, such as diphtheria, meningitis, measles, polio, tetanus, and whooping cough, and are a critical aspect of preventive care.
Increase Use of Evidence-Based Practices for Members With Chronic Conditions	**Quality**, **Timeliness**, and **Access**—**Anthem** demonstrated focused efforts on managing the health of its members with diabetes as indicated through significant improvement in the *Blood Pressure Control for Patients With Diabetes—Blood Pressure Control (<140/90 mm Hg)* measure indicator rate, *Eye Exam for Patients With Diabetes—Eye Exam (Retinal) Performed* measure indicator rate, both *Hemoglobin A1c Control for Patients With Diabetes* measure indicator rates, and the *Kidney Health Evaluation for Patients With Diabetes—65–74 Years* measure

Performance Area	Overall Performance Impact
	indicate rate. The *Hemoglobin A1c Control for Patients With Diabetes* measure indicator rates also met the DHCFP-established MPSs, indicating **Anthem** is contributing to the Nevada Managed Care Program's progress toward achieving the related objectives under Goal 2 of the Quality Strategy to *increase use of evidence-based practices for members with chronic conditions by December 31, 2024*. Through the NAV activity, **Anthem** demonstrated that it had a robust network of PCPs and endocrinologists, which may have contributed to members with diabetes being able to access these provider types in a timely manner for diabetes care. Although none of the *Asthma Medication Ratio* measure indicator rates under the Care for Chronic Conditions domain for Medicaid met the DHCFP-established MPSs for Nevada Check Up, the *Asthma Medication Ratio—5–18 Years* measure indicator rate met the MPS and the *Asthma Medication Ratio—5–11 Years* and *Total* rates for the Nevada Check Up population demonstrated a significant increase of more than 5 percentage points from the prior year, indicating some improvement in managing the care of its Nevada Check Up members with asthma. Conversely, the *Asthma Medication Ratio—5–11 Years*, *19–50 Years*, and *Total* measure indicator rates for the Medicaid population declined in performance from the prior year, indicating **Anthem** must continue focusing its efforts on helping all members with asthma better manage their condition with appropriate medications and contributing to the Nevada Managed Care Program's progress toward achieving the related objectives under Goal 2 of the Quality Strategy. Appropriate medication management for members with asthma could reduce the need for rescue medication and the costs associated with emergency room visits and inpatient admissions.
Reduce Misuse of Opioids	**Quality—Anthem** met the established MPS and demonstrated adequate oversight of its provider network specific to the prescribing and filling of opioids as indicated by a relatively low prevalence of high-risk opioid analgesic prescribing practices, multiple prescribers prescribing opioids, and multiple pharmacies filling the prescriptions. Through these findings, **Anthem** demonstrated its contribution to the Nevada Managed Care Program's achievement of the two related objectives under Goal 3 of the Quality Strategy to *reduce misuse of opioids by December 31, 2024,* and supported the reduction of opioid-related overdose deaths. For SFY 2023, **Anthem** was also required to report two indicators for the *Risk of Continued Opioid Use* measure. Although no MPS was yet established, **Anthem** performed below NCQA's Quality Compass HEDIS 2022 Medicaid HMO 50th percentile benchmark, indicating **Anthem** should continue its efforts to monitor high-risk opioid analgesic prescribing practices and educate its providers and members to mitigate the risk of OUD, opioid-related overdose, hospitalization, and opioid overdose-related mortality, and to further contribute to the Nevada Managed Care Program's achievement of reducing the misuse of opioids.

Performance Area	Overall Performance Impact
Improve Health and Wellness of Pregnant Women	**Quality**, **Timeliness**, and **Access**—**Anthem** met the DHCFP-established MPS for the *Prenatal and Postpartum Care—Postpartum Care* measure indicator rate under the Women's Health and Maternity Care domain for the Medicaid population; however, it did not meet the MPS for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure indicator. The lack of timely prenatal care may be due to an inadequate number of OB/GYN providers to support the number of pregnant women needing services as determined through the NAV activity, and indicate **Anthem** has continued opportunities to increase its network of OB/GYN providers and implement interventions that will result in more members seeking and having access to timely prenatal services, thus improving the likelihood of better health outcomes for mothers and their babies. For SFY 2023, **Anthem** was required to also report on three new measures, *Postpartum Depression Screening and Follow-Up*, *Prenatal Depression Screening and Follow-Up*, and *Prenatal Immunization Status*, which align to five new objectives in the Quality Strategy under Goal 4 to *improve the health and wellness of pregnant women and infants by December 31, 2024*. Although **Anthem**'s performance was not assessed against a DHCFP-established MPS since MY 2022 was the baseline rate for the new measures, **Anthem** should work with its OB/GYN providers and other providers such as PCPs, as applicable, to increase prenatal and postpartum depression screenings and to increase the percentage of members receiving the influenza, tetanus, diphtheria, and pertussis vaccines during pregnancy. Higher performance in these areas should support improved health outcomes for both mom and baby. **Anthem**'s provider-related initiatives should also assist the MCO with achieving the newly set MPSs as stipulated in Appendix B. Goals and Objectives Tracking under the New Measurement Year 2023 Minimum Performance Standards section and support the Nevada Managed Care Program's achievement of Goal 4 of the Quality Strategy.
Increase Use of Evidence-Based Practices for Members With Behavioral Health Conditions	**Quality**, **Timeliness**, and **Access**—For the Medicaid population, **Anthem** demonstrated substantial improvement in the Behavioral Health domain as indicated by improving the *Adherence to Antipsychotic Medications for Individuals with Schizophrenia*, *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*, and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—1–11 Years* and *Total* measure indicator rates by at least 3 percentage points from the prior year. Further, the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—1–11 Years* measure indicator rate demonstrated a significant improvement of 9.31 percentage points from the prior year, and one measure indicator rate, *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total*, met the DHCFP-established MPS. However, rates for the *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* measure indicator for both Medicaid and Nevada Check Up populations indicated opportunities for improvement as performance declined by more than 4 percentage points from the prior year. Further, only two of **Anthem**'s total reportable rates met the DHCFP-established MPS even though NAV activity results indicated there were enough behavioral health providers to support members' timely access to behavioral health services. In SFY 2023, **Anthem**

Performance Area	Overall Performance Impact
	effectively designed a PIP, *Improving the Rates for Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET),* as indicated by a *Met* validation rating, which should support an improvement in the health outcomes for **Anthem**'s Medicaid members with alcohol or other drug dependence. In addition to this PIP, **Anthem** should continue with its previously implemented initiatives but also assess whether there are barriers to members seeing the contracted behavioral health providers in a timely manner for services, or whether other reasons are preventing members from accessing care to treat their behavioral health or substance use diagnoses. Improvement in this program area will help support the Nevada Managed Care Program in achieving the objectives under Goal 5 of the Quality Strategy to *increase use of evidence-based practices for members with behavioral health conditions by December 31, 2024*.
Reduce/Eliminate Healthcare Disparities	**Quality**, **Timeliness**, and **Access**—The aggregated findings from **Anthem**'s EQR activities did not produce sufficient data for HSAG to assess the impact the EQR activities had or will have on reducing and/or eliminating healthcare disparities for **Anthem**'s Medicaid and Nevada Check Up members other than by geographic location (i.e., through the NAV activity). To support the reduction and elimination of healthcare disparities, **Anthem** should continue to implement interventions through its cultural competency and population health programs and plans, stratify performance measure data by race and ethnicity, and use the data to target interventions for those areas wherein performance is lowest and members can be most impacted.

HSAG HEALTH SERVICES ADVISORY GROUP

Health Plan of Nevada

Validation of Performance Improvement Projects

Performance Results

Table 3-18 displays the overall validation rating for the Design stage of each PIP topic. Table 3-18 also includes the performance indicators that will be used to track performance or improvement over the life of the PIP.

Table 3-18—Overall Validation Ratings for HPN

PIP Topic	Validation Ratings*	Performance Indicator	Performance Indicator Results		
			Baseline	R1	R2
Initiation and Engagement of Substance Use Disorder Treatment (IET)	*Met*	The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit, or medication treatment within 14 days.	—	—	—
		The engagement portion of *IET* measures the percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.			
Plan All-Cause Readmissions	*Met*	Plan all-cause readmissions.	—	—	—

— The PIP had not progressed to including baseline or remeasurement (R1, R2) results during SFY 2023.
*The PIP activities for SFY 2023 were initiated prior to release of the 2023 CMS EQR Protocols; therefore, HSAG adhered to the guidance published in the 2019 CMS EQR Protocols. With the release of the new protocols, HSAG updated its PIP worksheets for SFY 2024 to include the two validation ratings (i.e., Overall confidence that the PIP adhered to an acceptable methodology for all phases of design and data collection, and the MCO conducted accurate data analysis and interpretation of PIP results; overall confidence that PIP produced significant evidence of improvement.)

Interventions

HPN has established its PIP design, and the PIP will progress to the Implementation stage. During this stage, **HPN** will evaluate and analyze its data, identify barriers to performance, and develop interventions targeted to improve outcomes. As the PIPs did not progress to the Implementation stage in SFY 2023, **HPN**'s causal/barrier analysis process and interventions will be reported in the next annual EQR technical report (SFY 2024).

Table 3-19 and Table 3-20 will display the barriers and interventions as documented by the MCO.

Table 3-19—Barriers Identified and Interventions Implemented/Planned for Initiation and Engagement (IET)

Barriers	Interventions
—	—
—	—

— The PIP had not progressed to the identification of barriers and the development of interventions during SFY 2023.

Table 3-20—Interventions Implemented/Planned for Plan All-Cause Readmissions

Barriers	Interventions
—	—
—	—

— The PIP had not progressed to the identification of barriers and the development of interventions during SFY 2023.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP validation against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP validation have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: HPN developed a methodologically sound design for both PIPs that met State and federal requirements. A methodologically sound design created the foundation for **HPN** to progress to subsequent PIP stages—collecting data and carrying out interventions to positively impact performance indicator results and outcomes for the project. **[Quality]**

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any weaknesses for **HPN.**

Why the weakness exists: No weaknesses were identified; therefore, this section is not applicable.

Recommendation: Although no significant weaknesses were identified during the SFY 2023 PIP activities, as **HPN** progresses to the Implementation stage of the PIP, HSAG recommends that **HPN** develop effective improvement strategies (i.e., interventions) that are designed to target the designated population(s) and age group(s) to successfully improve member outcomes.

Performance Measure Validation

Performance Results

Table 3-21 and Table 3-22 show **HPN**'s Medicaid and Nevada Check Up HEDIS and CMS Child and Adult Core Set performance measure results for MY 2020, MY 2021, and MY 2022, along with MY 2021 to MY 2022 rate comparisons and performance target ratings.

Performance for MY 2022 (SFY 2023) is indicated by symbols and color coding; **bolded** rates indicate the rate was at or above the DHCFP-established MPS; ↑ indicates the rate was above the national Medicaid 50th percentile benchmark, ↓ indicates the rate was below the national 50th percentile benchmark, green shading indicates that the rate improved by 5 percentage points from the prior year, and red shading indicates that the rate declined by 5 percentage points from the prior year.

Measures in the Utilization domain are designed to capture the frequency of services provided by the MCO. With the exception of *Ambulatory Care—Total (per 1,000 Member Years)—ED Visits—Total*, higher or lower rates in this domain do not necessarily indicate better or worse performance. Therefore, these rates are provided for information only.

Table 3-21—Medicaid SFY 2023 Performance Measure Results and Trending for HPN

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	MY 2021–MY 2022 Rate Comparison
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services (AAP)				
Ages 20–44 Years	69.80%	66.38%	67.63%↓	1.25
Ages 45–64 Years	76.29%	74.57%	**76.95%**↓	2.38
Ages 65 Years and Older	81.41%	71.43%	71.03%↓	-0.40
Total	71.93%	68.93%	70.70%↓	1.77
Children's Preventive Care				
Childhood Immunization Status (CIS)				
Combination 3	69.34%	60.58%	60.34%↓	-0.24
Combination 7	62.53%	52.80%	53.77%↓	0.97
Combination 10	33.09%	27.25%	25.79%↓	-1.46
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	88.56%	83.21%	86.62%↑	3.41
Combination 2 (Meningococcal, Tdap, HPV)	47.45%	37.96%	39.66%↑	1.70

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	MY 2021–MY 2022 Rate Comparison
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile—Total	86.44%	86.58%	82.99%↑	-3.59
Counseling for Nutrition—Total	76.55%	76.68%	76.42%↑	-0.26
Counseling for Physical Activity—Total	75.14%	72.84%	73.13%↑	0.29
Well-Child Visits in the First 30 Months of Life (W30)				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	59.89%	57.43%	62.03%↑	4.60
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	68.83%	59.91%	62.38%↓	2.47
Child and Adolescent Well-Care Visits (WCV)				
3–11 Years	48.62%	50.75%	**52.63%**↓	1.88
12–17 Years	41.59%	46.03%	**47.96%**↓	1.93
18–21 Years	24.50%	20.86%	23.14%↓	2.28
Total	43.00%	44.66%	46.43%↓	1.77
Women's Health and Maternity Care				
Breast Cancer Screening (BCS)				
Breast Cancer Screening	52.01%	51.07%	**54.90%**↑	3.83
Chlamydia Screening in Women (CHL)				
16–20 Years	—	57.86%	**58.15%**↑	0.29
21–24 Years	—	62.11%	62.44%↑	0.33
Total	—	60.02%	60.30%↑	0.28
Postpartum Depression Screening and Follow-Up (PDS)^				
Depression Screening	—	—	0.00%	NC
Follow-Up on Positive Screen	—	—	NA	NC
Prenatal and Postpartum Care (PPC)				
Timeliness of Prenatal Care	87.59%	86.37%	**88.08%**↑	1.71
Postpartum Care	78.83%	74.21%	**80.29%**↑	6.08
Prenatal Depression Screening and Follow-Up (PND)^				
Screening	—	—	0.00%	NC

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	MY 2021–MY 2022 Rate Comparison
Follow Up	—	—	NA	NC
Prenatal Immunization Status (PRS)^				
Influenza	—	—	12.26%↓	NC
Tdap	—	—	26.50%↓	NC
Combination	—	—	8.00%↓	NC
Care for Chronic Conditions				
Asthma Medication Ratio (AMR)				
5–11 Years	—	77.84%	72.17%↓	-5.67
12–18 Years	—	67.40%	65.87%↓	-1.53
5–18 Years (Child Core Set Total)	—	—	69.20%	NC
19–50 Years	—	50.58%	53.09%↓	2.51
51–64 Years	—	52.41%	54.01%↓	1.60
19–64 Years (Adult Core Set Total)	—	—	53.36%	NC
Total (5–64 Years)	—	58.78%	59.14%↓	0.36
Blood Pressure Control for Patients With Diabetes (BPD)				
Blood Pressure Control (<140/90 mm Hg)	63.75%	68.37%	**67.64%**↑	-0.73
Controlling High Blood Pressure (CBP)				
Controlling High Blood Pressure	60.34%	65.69%	**64.36%**↑	-1.33
Eye Exam for Patients With Diabetes (EED)				
Eye Exam (Retinal) Performed	63.02%	57.91%	**63.75%**↑	5.84
Hemoglobin A1c Control for Patients With Diabetes (HBD)				
*Poor HbA1c Control**	38.69%	37.71%	45.26%↓	7.55
HbA1c Control (<8%)	50.12%	51.58%	46.23%↓	-5.35
Kidney Health Evaluation for Patients With Diabetes (KED)				
18–64 Years	42.02%	44.36%	**47.98%**↑	3.62
65–74 Years	42.42%	60.67%	52.86%↑	-7.81
75–85 Years	NA	NA	NA	NC
Total	42.02%	44.50%	**48.02%**↑	3.52

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	MY 2021–MY 2022 Rate Comparison
Behavioral Health				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	44.73%	43.18%	**47.96%**↓	4.78
Antidepressant Medication Management (AMM)				
Effective Acute Phase Treatment	—	54.22%	53.48%↓	-0.74
Effective Continuation Phase Treatment	—	36.61%	35.81%↓	-0.80
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	74.58%	72.69%	72.60%↓	-0.09
Follow-Up After Emergency Department Visit for Substance Use (FUA)[1]				
7-Day Follow-Up—Total	—	—	19.47%	NC
30-Day Follow-Up—Total	—	—	29.78%	NC
Follow-Up After Emergency Department Visit for Mental Illness (FUM)				
7-Day Follow-Up—Total	52.34%	44.07%	47.19%↑	3.12
30-Day Follow-Up—Total	60.81%	53.79%	54.55%↑	0.76
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)^				
7-Day Follow-Up—Total	—	—	28.28%↓	NC
30-Day Follow-Up—Total	—	—	43.72%↓	NC
Follow-Up After Hospitalization for Mental Illness (FUH)				
7-Day Follow-Up—Total	38.58%	35.73%	35.88%↓	0.15
30-Day Follow-Up—Total	56.65%	51.96%	53.75%↓	1.79
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
Initiation Phase	54.10%	54.56%	49.89%↑	-4.67
Continuation and Maintenance Phase	68.82%	72.15%	68.00%↑	-4.15
Initiation and Engagement of Substance Use Disorder Treatment (IET)[1]				
Initiation of SUD Treatment—Total (Total)	—	—	44.75%	NC

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	MY 2021–MY 2022 Rate Comparison
Engagement of SUD Treatment—Total (Total)	—	—	13.78%	NC
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)				
Blood Glucose and Cholesterol Testing—Total	33.89%	29.86%	32.02%↓	2.16
Screening for Depression and Follow-Up Plan (CDF-CH/CDF-AD)^				
12–17 Years	—	—	0.31%	NC
18–64 Years	—	—	1.25%	NC
65+ Years	—	—	3.94%	NC
Total (12+ Years)	—	—	1.05%	NC
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)				
1–11 Years	—	56.63%	50.00%↓	-6.63
12–17 Years	—	54.70%	65.63%↑	10.93
Total	—	55.50%	60.75%↓	5.25
Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)^				
Rate 1: Total	—	—	51.01%	NC
Rate 2: Buprenorphine	—	—	39.60%	NC
Rate 3: Oral Naltrexone	—	—	6.71%	NC
Rate 4: Long-Acting, Injectable Naltrexone	—	—	3.36%	NC
Rate 5: Methadone	—	—	4.70%	NC
Utilization				
Ambulatory Care—Total (per 1,000 Member Years) (AMB)^*				
*ED Visits—Total**	499.22	515.38	576.62	61.24
Outpatient Visits—Total	3,362.59	3,228.10	3,611.76	383.66
Plan All-Cause Readmissions (PCR)				
*Observed Readmissions—Total**	11.13%	9.99%	**10.41%**	0.42
Expected Readmissions—Total	9.08%	8.85%	9.05%	0.20
Observed/Expected (O/E) Ratio—Total	1.2252	1.1294	1.1499	0.02
Outliers—Total	63.96	60.09	67.04	6.95

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	MY 2021–MY 2022 Rate Comparison
Overuse/Appropriateness of Care				
Risk of Continued Opioid Use (COU)*^				
At Least 15 Days Covered—Total	—	—	7.77%↓	NC
At Least 31 Days Covered—Total	—	—	6.36%↓	NC
Use of Opioids at High Dosage (HDO)*				
Use of Opioids at High Dosage	10.00%	8.83%	8.68%↓	-0.15
Use of Opioids From Multiple Providers (UOP)*				
Multiple Prescribers	29.47%	21.57%	**21.04%**↓	-0.53
*Multiple Pharmacies^*	2.12%	1.08%	**1.19%**↑	0.11
*Multiple Prescribers and Multiple Pharmacies^*	1.23%	0.69%	**0.54%**↑	-0.15

[1] Due to significant changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS MY 2022 and prior years. Due to the QISMC goals being based on HEDIS MY 2020 statewide aggregate rates, the MY 2022 rate was not compared to an MPS.

↑ Indicates the MY 2022 rate was above NCQA's Quality Compass HEDIS 2022 Medicaid HMO 50th percentile benchmark.

↓ Indicates the MY 2022 rate was below NCQA's Quality Compass HEDIS 2022 Medicaid HMO 50th percentile benchmark.

* A lower rate indicates better performance for this measure.

** Beginning MY 2022, this rate is reported per 1,000 member years instead of member months; the rates for the prior two years were converted to member years for comparison.

— Indicates that the MCO was not previously required to report this measure or that the rate is not appropriate to display due to changes in the technical specifications resulting in a break in trending.

^ Indicates MY 2022 QISMC goals are unavailable for this measure or indicator.

NC indicates the MY 2021–MY 2022 Rate Comparison could not be calculated because data are not available for both years.

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

Bolded rates indicate that the MY 2022 performance measure rate was at or above the MPS.

Indicates that the MY 2022 rate declined by 5 percentage points or more from MY 2021.

Indicates that the MY 2022 rate improved by 5 percentage points or more from MY 2021.

Table 3-22—Nevada Check Up SFY 2023 Performance Measure Results and Trending for HPN

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	MY 2021–MY 2022 Rate Comparison
Children's Preventive Care				
Childhood Immunization Status (CIS)				
Combination 3	81.29%	75.78%	74.12%↑	-1.66
Combination 7	75.81%	68.61%	70.59%↑	1.98
Combination 10	41.94%	43.05%	37.65%↑	-5.40
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	94.07%	89.05%	92.82%↑	3.77
Combination 2 (Meningococcal, Tdap, HPV)	50.62%	47.93%	47.95%↑	0.02
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile—Total	85.97%	85.07%	81.49%↑	-3.58
Counseling for Nutrition—Total	74.93%	76.12%	75.22%↑	-0.90
Counseling for Physical Activity—Total	72.84%	72.84%	73.43%↑	0.59
Well-Child Visits in the First 30 Months of Life (W30)				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	72.45%	63.03%	**75.00%**↑	11.97
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	82.76%	73.96%	68.49%↑	-5.47
Child and Adolescent Well-Care Visits (WCV)				
3–11 Years	55.57%	52.35%	54.82%↓	2.47
12–17 Years	50.91%	52.87%	**55.26%**↑	2.39
18–21 Years	33.50%	28.69%	**39.92%**↑	11.23
Total	52.09%	50.72%	53.69%↑	2.97
Women's Health and Maternity Care				
Chlamydia Screening in Women (CHL)				
16–20 Years	—	59.62%	**51.76%**↑	-7.86
21–24 Years	—	NA	NA	NC
Total	—	59.62%	51.76%↓	-7.86

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	MY 2021–MY 2022 Rate Comparison
Prenatal and Postpartum Care (PPC)				
Timeliness of Prenatal Care	—	—	NA	NC
Postpartum Care	—	—	NA	NC
Care for Chronic Conditions				
Asthma Medication Ratio (AMR)				
5–11 Years	—	83.02%	NA	NC
12–18 Years	—	69.70%	63.04%↓	-6.66
5–18 Years (Child Core Set Total)	—	—	67.61%	NC
19–50 Years	—	NA	NA	NC
51–64 Years	—	NA	NA	NC
19–64 Years (Adult Core Set Total)	—	—	NA	NC
Total (5–64 Years)	—	75.63%	67.61%↑	-8.02
Behavioral Health				
Follow-Up After Emergency Department Visit for Substance Use (FUA)^,1				
7-Day Follow-Up—Total	—	—	NA	NC
30-Day Follow-Up—Total	—	—	NA	NC
Follow-Up After Emergency Department Visit for Mental Illness (FUM)				
7-Day Follow-Up—Total	NA	NA	NA	NC
30-Day Follow-Up—Total	NA	NA	NA	NC
Follow-Up After Hospitalization for Mental Illness (FUH)				
7-Day Follow-Up—Total	NA	57.89%	NA	NC
30-Day Follow-Up—Total	NA	81.58%	NA	NC
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
Initiation Phase	46.55%	50.85%	34.00%↓	-16.85
Continuation and Maintenance Phase	NA	NA	NA	NC
Initiation and Engagement of Substance Use Disorder Treatment (IET)1				
Initiation of SUD Treatment—Total (Total)	—	—	NA	NC
Engagement of SUD Treatment—Total (Total)	—	—	NA	NC

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	MY 2021–MY 2022 Rate Comparison
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)				
Blood Glucose and Cholesterol Testing—Total	44.90%	43.90%	42.86%↑	-1.04
Screening for Depression and Follow-Up Plan (CDF-CH/CDF-AD)^				
12–17 Years	—	—	0.25%	NC
18–64 Years	—	—	1.32%	NC
65+ Years	—	—	NA	NC
Total (12+ Years)	—	—	0.40%	NC
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)^				
1–11 Years	—	NA	NA	NC
12–17 Years	—	NA	NA	NC
Total	—	NA	NA	NC
Utilization				
Ambulatory Care—Total (per 1,000 Member Years (AMB)^*				
*ED Visits—Total**	164.48	192.71	282.16	89.45
Outpatient Visits—Total	2,341.17	2,292.59	2,666.78	374.19

[1] Due to significant changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS MY 2022 and prior years. Due to the QISMC goals being based on HEDIS MY 2020 statewide aggregate rates, the MY 2022 rate was not compared to an MPS.

↑ Indicates the MY 2022 rate was above NCQA's Quality Compass HEDIS 2022 Medicaid HMO 50th percentile benchmark.

↓ Indicates the MY 2022 rate was below NCQA's Quality Compass HEDIS 2022 Medicaid HMO 50th percentile benchmark.

* A lower rate indicates better performance for this measure.

** Beginning MY 2022, this rate is reported per 1,000 member years instead of 1,000 member months; the rates for the prior two years were converted to member years for comparison.

— Indicates that the MCO was not previously required to report this measure or that the rate is not appropriate to display due to changes in the technical specifications resulting in a break in trending.

^ Indicates MY 2022 QISMC goals are unavailable for this measure or indicator.

NC indicates the MY 2021–MY 2022 Rate Comparison could not be calculated because data are not available for both years.

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

Bolded rates indicate that the MY 2022 performance measure rate was at or above the MPS.

Indicates that the MY 2022 rate declined by 5 percentage points or more from MY 2021.

Indicates that the MY 2022 rate improved by 5 percentage points or more from MY 2021.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Within the Access to Care domain for Medicaid, **HPN** met the State's established MPS for the *Adults' Access to Preventive/Ambulatory Health Services—Ages 45–64 Years* measure indicator, indicating its adult Medicaid members are receiving preventive or ambulatory visit services with their PCPs, which can help address acute issues or manage chronic conditions. **[Quality, Timeliness,** and **Access]**

Strength #2: Within the Children's Preventive Care Domain, **HPN** met the State's established MPS for the *Child and Adolescent Well-Care Visits—3–11 Years* and *12–17 Years* measure indicators for its Medicaid population. In addition, **HPN** met the State's established MPS for the *Child and Adolescent Well-Care Visits—12–17 Years* and *18–21 Years,* and *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* for its Nevada Check Up population. Furthermore, **HPN**'s Nevada Check Up rates for the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* and *Child and Adolescent Well-Care Visits—18–21 Years* measure indicators increased more than 10 percentage points from the prior MY. This performance indicates that **HPN**'s child and adolescent Medicaid and Nevada Check Up members are receiving the appropriate well-care visits which are a critical opportunity for providers to influence health and development, as well as screening and counseling. **[Quality, Timeliness,** and **Access]**

Strength #3: Within the Women's Health and Maternity Care domain for **HPN**'s Medicaid population, **HPN** met the State's established MPS for the *Breast Cancer Screening, Chlamydia Screening in Women—16–20 Years,* and *Prenatal and Postpartum Care* measure indicators. In addition, **HPN**'s Medicaid rate for the *Prenatal and Postpartum Care—Postpartum Care* measure indicator increased more than 5 percentage points from the prior MY. This performance suggests that **HPN**'s Medicaid women members are receiving appropriate and timely screenings, potentially reducing the risk of developing more serious conditions, as well as potentially reducing healthcare costs. Additionally, although **HPN**'s Nevada Check Up rate for the *Chlamydia Screening in Women—16–20 Years* indicator decreased more than 5 percentage points, it met the State's established MPS. **[Quality, Timeliness,** and **Access]**

Strength #4: Within the Care for Chronic Conditions domain, **HPN**'s Medicaid rates for the *Blood Pressure Control for Patients With Diabetes, Controlling High Blood Pressure, Eye Exam for Patients With Diabetes,* and *Kidney Health Evaluation for Patients With Diabetes—18–64 Years* and *Total* measure indicators met the State's established MPS. In addition, **HPN**'s Medicaid rate for *Eye*

Exam for Patients With Diabetes measure indicator increased more than 5 percent from the prior MY. This performance demonstrates **HPN**'s dedication to ensuring its Medicaid members with diabetes are receiving appropriate care, which is essential to reducing risks for complications and potentially prolonging life. **[Quality, Access,** and **Timeliness]**

Strength #5: Within the Behavioral Health domain, **HPN**'s Medicaid rates for the *Adherence to Antipsychotic Medications for Individuals with Schizophrenia* measure indicator met the State's established MPS. In addition, although **HPN**'s Medicaid rate for the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—1–11 Years* measure indicator declined more than 5 percentage points from the prior MY, the *12–17 Years* rate increased more than 10 percentage points from the prior MY and the *Total* rate increased more than 5 percentage points from the prior MY. This performance demonstrates **HPN**'s dedication to ensuring its Medicaid members with behavioral health and SUDs receive appropriate care, potentially reducing costs with associated emergency department visits and inpatient stays, as well as reducing risks associated with antipsychotic medications. **[Quality, Access,** and **Timeliness]**

Strength #6: Within the Overuse/Appropriateness of Care domain for the Medicaid population, **HPN** met the State's established MPS for the *Use of Opioids from Multiple Providers* measure indicators, which shows **HPN**'s dedication to ensuring that the adult Medicaid members receiving opioid prescriptions are not being prescribed opioids for 15 or more days during the MY from multiple providers or pharmacies, potentially reducing the risk of opioid overuse and misuse, as well as reducing the risk of overdose. **[Quality** and **Timeliness]**

Weaknesses and Recommendations

Weakness #1: Within the Care for Chronic Conditions domain, **HPN**'s Medicaid performance for the *Asthma Medication Ratio—5–11 Years, Hemoglobin A1c Control for Patients With Diabetes,* and *Kidney Health Evaluation for Patients With Diabetes—65–74 Years* measure indicators demonstrated a decrease of more than 5 percentage points from the prior MY, suggesting opportunities for improving asthma medication management for children ages 5–11 years and opportunities to ensure its members with diabetes are receiving timely and appropriate care, reducing the risk of developing complicated conditions. In addition, **HPN**'s Nevada Check Up performance for the *Asthma Medication Ratio* measure indicators showed an overall decline of more than 5 percentage points from the prior MY, suggesting **HPN**'s Nevada Check Up members with asthma are not receiving appropriate medication management. **[Quality, Timeliness,** and **Access]**

Why the weakness exists: Declines in rates assessing kidney health in members with diabetes may be due to providers not educating their diabetic members on the importance of annual kidney health evaluations and informing members that diabetes is the leading cause of chronic kidney disease, which can lead to heart disease, stroke, and kidney failure. Children and adolescents with persistent asthma are not consistently receiving appropriate monitoring of their asthma medications which could be due to the need for better access to care and medication.

Recommendation: **HPN** should conduct root cause analyses to determine why its diabetic members are not receiving appropriate diabetes management and should monitor the *Hemoglobin A1c Control for Patients With Diabetes* and *Kidney Health Evaluation for Patients With Diabetes* rates. **HPN**

should also conduct root cause analyses of members with persistent asthma to determine why their asthma medications are not consistently being managed. **HPN** should also consider whether there are disparities within its population that contribute to low performance in a particular race or ethnicity, age group, ZIP Code, etc. Based on the results of its root cause analyses for these measures, **HPN** should implement interventions to improve the performance for these measures.

Weakness #2: Within the Behavioral Health domain, **HPN**'s Medicaid rate for the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—1–11 Years* measure indicator declined more than 5 percentage points from the prior MY, indicating children in this age group are not receiving psychosocial interventions as first-line treatment, which may result in being prescribed antipsychotic medications for nonpsychotic conditions and unnecessarily incurring the risks associated with antipsychotic medications. In addition, **HPN**'s Nevada Check Up rate for the *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase—Total* measure indicator decreased more than 15 percentage points from the prior MY, indicating its Nevada Check Up members with asthma are not receiving a follow-up visit with a pediatrician with prescribing authority within 30 days of their first prescription of ADHD medication. To ensure that medication is prescribed and managed correctly, it is important that children be monitored by a pediatrician with prescribing authority. **[Quality** and **Timeliness]**

Why the weakness exists: Low performance within the Behavioral Health domain may potentially be due to low appointment availability for QMHPs to meet the demand, lack of transportation, or perceived social stigma related to seeking mental health services.

Recommendation: **HPN** should conduct root cause analyses to determine why its child Medicaid members who are prescribed antipsychotics are not receiving psychosocial care as first-line treatment and why its Nevada Check Up child members with persistent asthma are not receiving appropriate follow-up for medication management. Based on root cause analyses findings, **HPN** should implement initiatives or interventions to help improve these rates.

Compliance Review

Performance Results

Table 3-23 presents an overview of the results of the SFY 2021 and SFY 2022 compliance reviews for **HPN**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements (i.e., requirements) it reviewed. If a requirement was not applicable to **HPN** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all 14 standards.

Table 3-23—Summary of Standard Compliance Scores

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Disenrollment: Requirements and Limitations	7	7	7	0	0	**100%**
Standard II—Member Rights and Member Information	22	22	20	2	0	**91%**
Standard III—Emergency and Poststabilization Services	10	10	10	0	0	**100%**
Standard IV—Availability of Services	10	10	10	0	0	**100%**
Standard V—Assurances of Adequate Capacity and Services	2	2	2	0	0	**100%**
Standard VI—Coordination and Continuity of Care	17	17	14	3	0	**82%**
Standard VII—Coverage and Authorization of Services	15	15	14	1	0	**93%**
Standard VIII—Provider Selection	12	12	10	2	0	**83%**
Standard IX—Confidentiality	11	11	10	1	0	**91%**
Standard X—Grievance and Appeal Systems	38	38	33	5	0	**87%**
Standard XI—Subcontractual Relationships and Delegation	7	7	5	2	0	**71%**
Standard XII—Practice Guidelines	10	10	7	3	0	**70%**
Standard XIII—Health Information Systems[1]	14	14	12	2	0	**86%**
Standard XIV—Quality Assessment and Performance Improvement Program	42	39	37	2	3	**95%**
Total	**217**	**214**	**191**	**23**	**3**	**89%**

M* = *Met*; *NM* = *Not Met*; *NA* = *Not Applicable
Total Elements: The total number of elements within each standard.
Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.
Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.
[1] This standard includes a comprehensive assessment of the MCO's IS capabilities.

Based on the findings from the SFY 2021 and SFY 2022 compliance review activities, **HPN** was required to develop and submit a CAP for each element assigned a score of *Not Met*. The CAP was reviewed by DHCFP and HSAG for sufficiency, and **HPN** was responsible for implementing each action plan in a timely manner. Table 3-24 presents an overview of the results of the SFY 2023 compliance review for **HPN** which consisted of a comprehensive review of the MCO's implementation of each action plan. HSAG assigned a score of *Complete* or *Not Complete* to each of the individual elements that required a CAP based on a scoring methodology, which is detailed in Appendix A.

Table 3-24—Summary of Corrective Action Plan Implementation

Standard	Total CAP Elements	# CAP Elements *Complete*	# CAP Elements *Not Complete*
Standard II—Member Rights and Member Information	2	2	**0**
Standard VI—Coordination and Continuity of Care	3	3	**0**
Standard VII—Coverage and Authorization of Services	1	0	**1**
Standard VIII—Provider Selection	2	2	**0**
Standard IX—Confidentiality	1	1	**0**
Standard X—Grievance and Appeal Systems	5	5	**0**
Standard XI—Subcontractual Relationships and Delegation	2	2	**0**
Standard XII—Practice Guidelines	3	3	**0**
Standard XIII—Health Information Systems[1]	2	2	**0**
Standard XIV—Quality Assessment and Performance Improvement Program	2	2	**0**
Total	**23**	**22**	**1**

Total CAP Elements: The total number of elements within each standard that required a CAP during the SFY 2021 and SFY 2022 compliance review activities.

 # CAP Elements *Complete*: The total number of CAP elements within each standard that were fully remediated at the time of the site review and demonstrated compliance with the requirement under review.

 # CAP Elements *Not Complete*: The total number of CAP elements within each standard that were not fully remediated at the time of the site review and/or did not demonstrate compliance with the requirement under review.

[1] This standard includes a comprehensive assessment of the MCE's IS capabilities.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the compliance review activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the compliance review have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: HPN demonstrated that it successfully remediated 22 of 23 elements, indicating that the necessary policies, procedures, and interventions were implemented to ensure compliance with the requirements under review. Further, **HPN** remediated all elements for nine of the 10 standards reviewed: Member Rights and Member Information, Coordination and Continuity of Care, Provider Selection, Confidentiality, Grievance and Appeal Systems, Subcontractual Relationships and Delegation, Practice Guidelines, Health Information Systems, and Quality Assessment and Performance Improvement Program. [**Quality, Timeliness,** and **Access**]

Weaknesses and Recommendations

Weakness #1: HPN did not remediate one element for the Coverage and Authorization of Services standard, indicating continued gaps in the MCO's processes for providing members with adverse benefit determination (ABD) notices at the time claims are denied, in whole or in part. Notices related to claim payment denials provide transparency and important information to members regarding payment for their rendered services, including potential financial liability for payment in certain circumstances (e.g., services rendered by a non-Medicaid contracted provider without a prior authorization for services), appeal rights, and awareness of possible fraudulent provider billing practices. [**Quality** and **Timeliness**]

Why the weakness exists: Although **HPN** had made progress in implementing its process for ensuring that the MCO mails a notice to the member at the time a claim payment is denied, **HPN** was unable to demonstrate that notices were presently being sent to members. Staff members indicated that as the MCO began to implement its corrective actions, the MCO determined that it needed additional resources and supports to effectively remedy the identified deficiency.

Recommendation: HSAG required **HPN** to submit an action plan to address these findings and provide assurances that **HPN** had implemented a documented process which included business requirements for mailing ABD notices when there is a partial or full denial of payment, and evidence that ABD notices for the denial of payment are being mailed at the time the decision to deny payment is made. Additionally, HSAG recommends that **HPN** consider conducting case file reviews periodically to ensure that utilization management staff and/or claims staff are adhering to established policies and procedures for providing members with ABD notices at the time a claim payment is denied.

Network Adequacy Validation

Performance Results

Table 3-25 presents **HPN**'s network capacity analysis results and compares the provider ratios to the standards displayed in Table 3-4. Assessed provider ratios shown in green indicate the provider ratio was in compliance with the access standard, whereas provider ratios shown in red indicate the provider ratio was not in compliance with the access standard.

Table 3-25—Summary of Ratio Analysis Results for PCPs and Specialty Care Providers for HPN

Provider Category	Providers*	Clark County Ratio	Washoe County Ratio	Statewide Ratio**
PCPs (1:1,500)	1,770	1:115	1:13	1:128
PCP Extenders (1:1,800)	1,110	1:103	1:11	1:114
Physician Specialists (1:1,500)	2,142	1:95	1:11	1:106

Note: Results shown in green font indicate the result complies with the access standard; results shown in red font indicate the result does not comply with the access standard; PCP: Primary Care Provider.

* Providers contracted statewide and contracted providers located in the Nevada Medicaid catchment areas were included in provider counts.

** Statewide ratio incorporates all Nevada counties included in the DHCFP member file submission and members enrolled with the MCO as of December 1, 2022.

Table 3-26 presents **HPN**'s geographic network distribution analysis and presents the presents the percentage of members who had access to provider locations within the standards displayed in Table 3-5. Assessed results shown in green indicate that the percentage of members within the access standard was in compliance, and percentages shown in red indicate a result of less than 99.0 percent.

Table 3-26—Percentage of Members With Required Access by Provider Category for HPN

Provider Category	Clark County	Washoe County	Statewide*
Primary Care Providers			
Primary Care, Adults (10 miles/15 mins)	>99.9%	99.4%	99.9%
OB/GYN (10 miles/15 mins)	99.6%	95.2%	99.0%
Pediatrician (10 miles/15 mins)	>99.9%	99.4%	99.8%
Physician Specialists			
Endocrinologist (40 miles/60 mins)	>99.9%	100%	>99.9%
Endocrinologist, Pediatric (40 miles/60 mins)	>99.9%	100%	>99.9%
Infectious Disease (40 miles/60 mins)	>99.9%	100%	>99.9%
Infectious Disease, Pediatric (40 miles/60 mins)	>99.9%	100%	>99.9%
Oncologist/Radiologist (40 miles/60 mins)	>99.9%	100%	>99.9%
Oncologist—Medical/Surgical (30 miles/45 mins)	>99.9%	100%	>99.9%
Oncologist—Medical/Surgical, Pediatric (30 miles/45 mins)	>99.9%	100%	>99.9%
Rheumatologist (40 miles/60 mins)	>99.9%	100%	99.9%
Rheumatologist, Pediatric (40 miles/60 mins)	>99.9%	0.0%	88.9%
Behavioral Health Providers			
Board Certified Child and Adolescent Psychiatrist (30 miles/45 mins)	100%	100%	>99.9%
Psychiatrist (30 miles/45 mins)	100%	100%	>99.9%
Psychologist (30 miles/45 mins)	>99.9%	100%	>99.9%
Psychologist, Pediatric (30 miles/45 mins)	>99.9%	100%	99.9%
QMHP (30 miles/45 mins)	100%	100%	>99.9%
QMHP, Pediatric (30 miles/45 mins)	100%	100%	>99.9%
Facility-Level Providers			
Hospitals, All (30 miles/45 mins)	>99.9%	100%	>99.9%
Pharmacy (10 miles/15 mins)	>99.9%	99.8%	99.9%
Psychiatric Inpatient Hospital (30 miles/45 mins)	>99.9%	100%	99.9%

Provider Category	Clark County	Washoe County	Statewide*
Dialysis/ESRD Facility (30 miles/45 mins)	>99.9%	100%	99.9%

Note: Results shown in green font indicate the result complies with the access standard; results shown in red font indicate that less than 99.0 percent of members had access to the provider within the time and distance access standard.

* Statewide results incorporate all Nevada counties included in the DHCFP member file submission and members enrolled with the MCO as of December 1, 2022.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the NAV findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: HPN met the provider ratio requirements for PCPs, PCP Extenders, and Physician Specialists, indicating **HPN** had a sufficient provider network for its members to access services. Additionally, **HPN** demonstrated an improvement of 1.4 percentage points for Washoe County members with access to Pediatricians, from 98.0 in SFY 2022 to 99.4 percent in SFY 2023.[3-4] **[Access]**

Strength #2: HPN met the time-distance contract standards in both Clark and Washoe counties for Board Certified Child and Adolescent Psychiatrists, Psychiatrists, and adult and pediatric QMHP provider types. Additionally, Washoe County met the time-distance contract standards for all behavioral health providers, eight of nine Physician Specialist providers, and three of four Facility-Level providers. **[Access]**

Weaknesses and Recommendations

Weakness #1: HPN did not meet the time-distance contract standards for the OB/GYN provider type, indicating members may experience challenges accessing this provider type within an adequate time or distance from their residence. **[Access]**

Why the weakness exists: None of the four MCOs met the contract standard for OB/GYNs, suggesting a potential lack of this provider type within the counties served and/or that OB/GYNs will not contract with the MCOs due to the low reimbursement rates as reported by one MCO.

[3-4] For SFY 2022 EQR results, refer to the Division of Health Care Financing and Policy Nevada Managed Care Program State Fiscal Year 2022 External Quality Review Technical Report at https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Resources/AdminSupport/Reports/NV2022_EQR-TR_F1.pdf.

Recommendation: HSAG recommends that **HPN** continue to review DHCFP's monthly enrolled provider list to determine if new providers are available for contracting and promote telehealth services as an option to accessing services when feasible and appropriate.

Weakness #2: **HPN** did not meet the time-distance contract standards for Pediatric Rheumatologists in Washoe County, indicating that pediatric members may experience challenges accessing this provider type within an adequate time or distance from their residence. **[Access]**

Why the weakness exists: None of the four MCOs met the contract standard for the Pediatric Rheumatologist provider type in Washoe County, indicating a lack of this provider type in this county. Specifically, there were no pediatric rheumatologists practicing in Washoe County or available for contracting.

Recommendation: HSAG recommends that **HPN** consider collaborating with DHCFP and the other MCOs to determine whether community reinvestment funds can be used to incentivize pediatric rheumatologists to join a rheumatology clinic in Washoe County.

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results

Table 3-27 presents the 2023 CAHPS top-box scores for **HPN**'s adult Medicaid, general child Medicaid, CCC Medicaid, Nevada Check Up general child, and Nevada Check Up CCC populations. Arrows (↓ or ↑) indicate 2023 scores that were statistically significantly higher or lower than the 2022 national average.[3-5]

Table 3-27—Summary of 2023 CAHPS Top-Box Scores for HPN

	Adult Medicaid	General Child Medicaid	CCC Medicaid	Nevada Check Up General Child	Nevada Check Up CCC
Composite Measures					
Getting Needed Care	NA	NA	NA	NA	NA
Getting Care Quickly	NA	NA	NA	NA	NA
How Well Doctors Communicate	NA	91.1%	93.2%	94.6%	NA
Customer Service	NA	NA	NA	NA	NA
Global Ratings					
Rating of All Health Care	NA	NA	56.1% ↓	73.5%	NA
Rating of Personal Doctor	70.8%	77.0%	72.9%	78.8%	NA
Rating of Specialist Seen Most Often	NA	NA	NA	NA	NA

[3-5] 2023 national average results were not available at the time this report was produced.

	Adult Medicaid	General Child Medicaid	CCC Medicaid	Nevada Check Up General Child	Nevada Check Up CCC
Rating of Health Plan	65.4%	75.3%	66.2%	81.5% ↑	NA
Effectiveness of Care*					
Advising Smokers and Tobacco Users to Quit	NA	—	—	—	—
Discussing Cessation Medications	NA	—	—	—	—
Discussing Cessation Strategies	NA	—	—	—	—
CCC Composite Measures/Items					
Access to Specialized Services	—	—	NA	—	NA
FCC: Personal Doctor Who Knows Child	—	—	NA	—	NA
Coordination of Care for Children With Chronic Conditions	—	—	NA	—	NA
Access to Prescription Medicines	—	—	85.5%	—	NA
FCC: Getting Needed Information	—	—	88.8%	—	NA

A minimum of 100 respondents is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of respondents are denoted as *NA*.

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

↑ Indicates the 2023 score is statistically significantly higher than the 2022 national average.

↓ Indicates the 2023 score is statistically significantly lower than the 2022 national average.

— Indicates the measure does not apply to the population.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the CAHPS activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine any significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Parents/caretakers of Nevada Check Up general child members had positive overall experiences with their child's health plan since the score for this measure was statistically significantly higher than the 2022 NCQA Medicaid national average. **[Quality]**

Weaknesses and Recommendations

Weakness #1: Parents/caretakers of CCC Medicaid child members had less positive overall experiences with all their child's healthcare since the score for this measure was statistically significantly lower than the 2022 NCQA Medicaid national average. **[Quality]**

Why the weakness exists: Parents/caretakers may not receive patient-centered communication from their child's providers and customer service staff, which impacts their patient experience. Additionally, parents/caretakes may have a difficult time getting an appointment with their child's provider, and **HPN**'s providers may not be aware of all the needs of their child members; as a result, they may not be providing the consultative care required.

Recommendation: HSAG recommends that **HPN** focus on improving provider-patient communications by distributing provider bulletins or trainings that explain the importance of providing clear explanations, listening carefully, and being considerate of parents'/caretakers' perspectives. **HPN** could consider exploring service recovery methods, which is a type of intervention used to identify and resolve dissatisfaction in customer or clinical service. Service recovery actions can range from simply listening to the upset parent/caretaker to providing solutions or making amends for problems that the parent/caretaker reported.

Weakness #2: There were less than 100 respondents for every measure for the Nevada Check Up CCC population and for most measures for the other adult and child populations; therefore, results could not be reported for the applicable measures, and strengths and weaknesses could not be identified for the associated populations. **[Quality, Timeliness, Access]**

Why the weakness exists: Adult members and parents/caretakers of child members are less likely to respond to the CAHPS survey. Completion of surveys may be exceptionally low on the list of priorities for members struggling with illness, unemployment, and/or other life-changing events. According to **HPN**, members are also survey weary due to all of the companies who now survey their customers via paper, email, and text.

Recommendation: HSAG recommends that **HPN** focus on increasing response rates to the CAHPS survey for all populations so there are greater than 100 respondents for each measure by continuing to educate and engage all employees to increase their knowledge of CAHPS, applying effective customer service techniques, increasing the percentage of oversampling, using innovative outreach strategies to follow up with non-respondents, and continuing to provide awareness to members and providers during the survey period. Additionally, **HPN**'s care management and/or other member-facing teams, such as the customer service team, could consider asking members if they know about the CAHPS survey and, if they received the survey, what barriers may prevent them from responding to the survey. These questions can be asked during routine contacts with members or when members outreach to **HPN**. The information provided by these members could be shared with **HPN**'s CAHPS vendor so that **HPN** and the vendor can identify solutions to address low response rates.

Overall Conclusions for Quality, Timeliness, and Access to Healthcare Services

HSAG performed a comprehensive assessment of **HPN**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes

within **HPN** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **HPN**'s overall performance contributed to the Nevada Managed Care Program's progress in achieving the Quality Strategy goals and objectives. Table 3-28 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided **HPN**'s Medicaid and Nevada Check Up members.

Table 3-28—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Increase Use of Preventive Services	**Quality**, **Timeliness**, and **Access**—**HPN** demonstrated through the three-year compliance review cycle that it had appropriate practices for ensuring providers were aware of its adopted practice guidelines, which should include guidelines for preventive care, and **HPN** appeared to have a sufficient number of PCPs to provide well-care services, as indicated through the NAV activity. Within the Access to Care and Children's Preventive Care domains, **HPN** met the DHCFP-established MPSs for the *Adults' Access to Preventive/Ambulatory Health Services—Ages 45–64 Years* and *Child and Adolescent Well-Care Visits—3–11 Years* and *12–17 Years* for its Medicaid population and *Well-Child Visits in the First 30 Months of Life—Well Child-Visits in the First 15 Months—Six or More Well-Child Visits* and *Child and Adolescent Well-Care Visits—12–17 Years* and *18–21 Years* for its Nevada Check Up population. Additionally, the *Well-Child Visits in the First 30 Months of Life—Well Child-Visits in the First 15 Months—Six or More Well-Child Visits* and *Child and Adolescent Well-Care Visits—18–21 Years* measure indicator rates for the Nevada Check Up population increased significantly from the prior year as demonstrated by an improvement of more than 11 percentage points for both measures. Further, many females in **HPN**'s Medicaid population were being screened for breast cancer and chlamydia as **HPN** achieved the MPS for the *Breast Cancer Screening* and *Chlamydia Screening in Women—16–20 Years* measure indicator rates under the Women's Health and Maternity Care domain. Additionally, the *Chlamydia Screening in Women—16–20 Years* measure indicator rate for the Nevada Check Up population met the MPS (although there was a significant decline in performance from the prior year). Strong performance in these areas indicates that many of **HPN**'s members were seeking preventive care. However, none of the *Childhood Immunization Status* or *Immunizations for Adolescents* measure indicator rates for the Medicaid or Nevada Check Up populations met the MPS, and the *Childhood Immunization Status—Combination 10* measure indicator rate experienced a significant decline. Further, all of the adult Access to Care measures and the *Child and Adolescent Well-Care Visits* measure indicators in the Children's Preventive Care domain for Medicaid and the *Child and Adolescent Well-Care Visits—3–11 Years* measure indicator under the Children's Preventive Care domain for the Nevada Check Up population fell below the HEDIS 2022 Medicaid HMO 50th percentile benchmark, indicating **HPN** has continued opportunities to mitigate any barriers to members receiving preventive care, and to implement interventions to support improvement in the use of preventive services for adult and child members and contribute to the Nevada Managed Care Program's progress toward achieving Goal 1 of the Quality Strategy to *improve*

Performance Area	Overall Performance Impact
	the Health and Wellness of Nevada's Medicaid population by increasing the use of preventive services by December 31, 2024. According to **HPN**'s CAHPS results, some members were unhappy with their overall experiences with their personal doctors. As part of its improvement efforts, **HPN** should evaluate whether members' unhappiness with their providers is impeding access to preventive care. Preventive care is crucial to staying healthy and identifying problems early on before they contribute to other issues or become harder to treat. Immunizations are also essential to prevent diseases, such as diphtheria, meningitis, measles, polio, tetanus, and whooping cough, and are a critical aspect of preventive care.
Increase Use of Evidence-Based Practices for Members With Chronic Conditions	**Quality**, **Timeliness**, and **Access**—**HPN** demonstrated focused efforts on managing the health of its Medicaid members with diabetes as indicated through significant improvement in the *Eye Exam for Patients With Diabetes—Eye Exam (Retinal) Performed* measure indicator rate and achievement of the DHCFP-established MPS for the *Blood Pressure Control for Patients With Diabetes—Blood Pressure Control (<140/90 mm Hg)*, *Eye Exam for Patients With Diabetes—Eye Exam (Retinal) Performed*, and *Kidney Health Evaluation for Patients With Diabetes—18–64 Years* and *Total* measure indicator rates. Through the NAV activity, **HPN** demonstrated that it had a robust network of PCPs and endocrinologists, which may have contributed to members with diabetes being able to access these provider types in a timely manner for diabetes care. These results indicate that **HPN** is contributing to the Nevada Managed Care Program's progress toward achieving the related objectives under Goal 2 of the Quality Strategy to *increase use of evidence-based practices for members with chronic conditions by December 31, 2024*. However, the *Hemoglobin A1c Control for Patients With Diabetes—Poor HbA1c Control* and *HbA1c Control (<8%),* and *Kidney Health Evaluation for Patients With Diabetes—65–74 Years* measure indicator rates did not meet the MPSs and demonstrated significant declines in performance from the prior year, indicating **HPN** has additional opportunities to help all members with diabetes get recommended tests and properly manage their care to mitigate serious complications and improve their health outcomes. Contrary to the performance related to diabetes management, none of **HPN**'s *Asthma Medication Ratio* measure indicator rates under the Care for Chronic Conditions domain for the Medicaid and Nevada Check Up populations met the DHCFP-established MPSs, and the *Asthma Medication Ratio—5–11 Years* for Medicaid and *Asthma Medication Ratio—12–18 Years*, *5–18 Years,* and *Total* measure indicator rates for the Nevada Check Up population experienced significant declines from the prior year, indicating **HPN** must initiate targeted efforts to help its members with asthma better manage their condition with appropriate medications. Appropriate medication management for members with asthma could reduce the need for rescue medications and the costs associated with emergency room visits and inpatient admissions. Improved performance in this area will also support the Nevada Managed Care Program's achievement of Goal 2.

Performance Area	Overall Performance Impact
Reduce Misuse of Opioids	**Quality**—**HPN** met the established MPS and demonstrated adequate oversight of its provider network specific to the prescribing and filling of opioids as indicated by a relatively low prevalence of multiple prescribers prescribing opioids and multiple pharmacies filling the prescriptions. Through these findings, **HPN** demonstrated its contribution to the Nevada Managed Care Program's achievement of one related objective under Goal 3 of the Quality Strategy to *reduce misuse of opioids by December 31, 2024,* and supported the reduction of opioid-related overdose deaths. However, **HPN** did not meet the MPS for the *Use of Opioids at High Dosage* measure indicator rate. Additionally, for SFY 2023, **HPN** was required to report two indicators for the *Risk of Continued Opioid Use* measure. Although no MPS was yet established for these indicators, **HPN** performed below NCQA's Quality Compass HEDIS 2022 Medicaid HMO 50th percentile benchmark. The results of these findings indicate that **HPN** should continue its efforts to monitor high-risk opioid analgesic prescribing practices and educate its providers and members to mitigate the risk of OUD, opioid-related overdose, hospitalization, and opioid overdose-related mortality, and to further contribute to the Nevada Managed Care Program's achievement of reducing the misuse of opioids.
Improve Health and Wellness of Pregnant Women	**Quality**, **Timeliness**, and **Access**—For its Medicaid population, **HPN** met the DHCFP-established MPS for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measure indicator rates under the Women's Health and Maternity Care domain, and the *Prenatal and Postpartum Care—Postpartum Care* measure indicator demonstrated a significant increase from the prior year. Both measure indicator rates also exceeded NCQA's Quality Compass HEDIS 2022 Medicaid HMO 50th percentile benchmark, further indicating **HPN**'s commitment to improving the health and well-being of new mothers and their babies, and its efforts to support the Nevada Managed Care Program's progress toward achieving Goal 4 of the Quality Strategy to *improve the health and wellness of pregnant women and infants by December 31, 2024*. Of note, **HPN** did not meet the network adequacy standard for OB/GYNs in Washoe County; however, the lack of providers did not appear detrimental to members in this county accessing timely prenatal and postpartum care. For SFY 2023, **HPN** was also required to report on three new measures, *Postpartum Depression Screening and Follow-Up*, *Prenatal Depression Screening and Follow-Up*, and *Prenatal Immunization Status*, which align to five new objectives in the Quality Strategy under Goal 4. Although **HPN**'s performance was not assessed against a DHCFP-established MPS since MY 2022 was the baseline rate for the new measures, **HPN** should work with its OB/GYN providers and other providers such as PCPs, as applicable, to increase prenatal and postpartum depression screenings and to increase the percentage of members receiving the influenza and tetanus, diphtheria, and pertussis vaccines during pregnancy. Higher performance in these areas should support improved health outcomes for both mom and baby. **HPN**'s provider-related initiatives should also assist the MCO with achieving the newly set MPSs as stipulated in Appendix B. Goals and Objectives Tracking under the New Measurement Year 2023 Minimum Performance Standards section and further support the Nevada Managed Care Program's achievement of Goal 4 of the Quality Strategy.

Performance Area	Overall Performance Impact
Increase Use of Evidence-Based Practices for Members With Behavioral Health Conditions	**Quality**, **Timeliness**, and **Access**—**HPN** demonstrated improvement in some areas in the Behavioral Health domain for the Medicaid population as indicated by an improvement of more than 3 percentage points from the prior year in the *Adherence to Antipsychotic Medications for Individuals with Schizophrenia* and *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total* measure indicator rates, and significant improvement as indicated by more than a 5 percentage point improvement in the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—12–17 Years* and *Total* measure indicator rates. The *Adherence to Antipsychotic Medications for Individuals with Schizophrenia* measure indicator rate also met the DHCFP-established MPS. However, the two measure indicators for the *Follow-Up Care for Children Prescribed ADHD Medication* for the Medicaid population indicated opportunities for improvement as the rates declined by more than 4 percentage points from the prior year. Additionally, the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—1–11 Years* measure indicator rate for Medicaid and the *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* for Nevada Check Up declined significantly from the prior year (6.63 and 16.85 percentage points, respectively). Further, only one of **HPN**'s total reportable rates under the Behavioral Health domain met the DHCFP-established MPS even though the NAV activity results indicated there are enough behavioral health providers to support members' timely access to behavioral health services. In SFY 2023, **HPN** effectively designed a PIP, *Improving the Rates for Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET),* as indicated by a *Met* validation rating, which should support an improvement in the health outcomes for **HPN**'s Medicaid members with alcohol or other drug dependence. In addition to this PIP, **HPN** should continue with its previously implemented initiatives but also assess whether there are barriers to members seeing the contracted behavioral health providers in a timely manner for services, or whether other reasons are preventing members from accessing care to treat their behavioral health and substance use diagnoses. Improvement in this program area will help support the Nevada Managed Care Program achieve the objectives under Goal 5 of the Quality Strategy to *increase use of evidence-based practices for members with behavioral health conditions by December 31, 2024*.
Reduce/Eliminate Healthcare Disparities	**Quality**, **Timeliness**, and **Access**—The aggregated findings from **HPN**'s EQR activities did not produce sufficient data for HSAG to assess the impact the EQR activities had or will have on reducing and/or eliminating healthcare disparities for **HPN**'s Medicaid and Nevada Check Up members other than by geographic location (i.e., through the NAV activity). To support the reduction and elimination of healthcare disparities, **HPN** should continue to implement interventions through its cultural competency and population health programs and plans, stratify performance measure data by race and ethnicity, and use the data to target interventions for those areas wherein performance is lowest and members can be most impacted.

Molina Healthcare of Nevada, Inc.

Validation of Performance Improvement Projects

Performance Results

Table 3-29 displays the overall validation rating for the Design stage of each PIP topic. Table 3-29 also includes the performance indicators that will be used to track performance or improvement over the life of the PIP.

Table 3-29—Overall Validation Ratings for Molina

PIP Topic	Validation Ratings*	Performance Indicator	Performance Indicator Results		
			Baseline	R1	R2
Initiation and Engagement of Substance Use Disorder Treatment (IET)	*Met*	The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit, or medication treatment within 14 days.	—	—	—
		The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.			
Plan All-Cause Readmissions	*Met*	For members 18 years of age and older, the percentage of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days	—	—	—

— The PIP had not progressed to including baseline or remeasurement (R1, R2) results during SFY 2023.
*The PIP activities for SFY 2023 were initiated prior to release of the 2023 CMS EQR Protocols; therefore, HSAG adhered to the guidance published in the 2019 CMS EQR Protocols. With the release of the new protocols, HSAG updated its PIP worksheets for SFY 2024 to include the two validation ratings (i.e., Overall confidence that the PIP adhered to an acceptable methodology for all phases of design and data collection, and the MCO conducted accurate data analysis and interpretation of PIP results; overall confidence that PIP produced significant evidence of improvement.)

Interventions

Molina has established its PIP design, and the PIP will progress to the Implementation stage. During this stage, **Molina** will evaluate and analyze its data, identify barriers to performance, and develop interventions targeted to improve outcomes. As the PIPs did not progress to the Implementation stage in

SFY 2023, **Molina**'s causal/barrier analysis process and interventions will be reported in the next annual EQR report (SFY 2024).

Table 3-30 and Table 3-31 will display the barriers and interventions as documented by the MCO.

Table 3-30—Barriers Identified and Interventions Implemented/Planned for Initiation and Engagement (IET)

Barriers	Interventions
—	—
—	—

— The PIP had not progressed to the identification of barriers and the development of interventions during SFY 2023.

Table 3-31—Barriers Identified and Interventions Implemented/Planned for All-Cause Readmissions

Barriers	Interventions
—	—
—	—

— The PIP had not progressed to the identification of barriers and the development of interventions during SFY 2023.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP validation against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP validation have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Molina developed a methodologically sound design for both PIPs that met State and federal requirements. A methodologically sound design created the foundation for **Molina** to progress to subsequent PIP stages—collecting data and carrying out interventions to positively impact performance indicator results and outcomes for the project. **[Quality]**

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any weaknesses for **Molina**.

Why the weakness exists: No weaknesses were identified; therefore, this section is not applicable.

Recommendation: Although no significant weaknesses were identified during the SFY 2023 PIP activities, as **Molina** progresses to the Implementation state of the PIP, HSAG recommends that **Molina** develop effective improvement strategies (i.e., interventions) that are designed to target the designated population(s) and age group(s) to successfully improve member outcomes.

Performance Measure Validation

Performance Results

Table 3-32 and Table 3-33 show **Molina**'s Medicaid and Nevada Check Up HEDIS and CMS Child and Adult Core Set performance measure results for MY 2022. **Molina** began accepting Medicaid members on January 1, 2022; therefore, no performance measure results are displayed for MY 2020 and MY 2021.

Performance for MY 2022 (SFY 2023) is indicated by symbols and font style; **bolded** rates indicate the rate was at or above the DHCFP-established MPS, ↑ indicates the rate was above the national Medicaid 50th percentile benchmark, and ↓ indicates the rate was below the national 50th percentile benchmark.

Measures in the Utilization domain are designed to capture the frequency of services provided by the MCO. With the exception of *Ambulatory Care—Total (per 1,000 Member Years)—ED Visits—Total*, higher or lower rates in this domain do not necessarily indicate better or worse performance. Therefore, these rates are provided for information only.

Table 3-32—Medicaid SFY 2023 Performance Measure Results for Molina

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	MY 2021–MY 2022 Rate Comparison
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services (AAP)				
Ages 20–44 Years	—	—	51.45%↓	NC
Ages 45–64 Years	—	—	55.74%↓	NC
*Ages 65 Years and Older^*	—	—	50.27%↓	NC
Total	—	—	52.66%↓	NC
Children's Preventive Care				
Childhood Immunization Status (CIS)				
Combination 3	—	—	47.60%↓	NC
Combination 7	—	—	43.67%↓	NC
Combination 10	—	—	14.85%↓	NC
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	—	—	74.49%↓	NC
Combination 2 (Meningococcal, Tdap, HPV)	—	—	28.34%↓	NC

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	MY 2021–MY 2022 Rate Comparison
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile—Total	—	—	72.26%↓	NC
Counseling for Nutrition—Total	—	—	66.91%↓	NC
Counseling for Physical Activity—Total	—	—	64.23%↓	NC
Well-Child Visits in the First 30 Months of Life (W30)				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	—	NA	NC
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	—	—	NA	NC
Child and Adolescent Well-Care Visits (WCV)				
3–11 Years	—	—	44.09%↓	NC
12–17 Years	—	—	39.84%↓	NC
18–21 Years	—	—	17.00%↓	NC
Total	—	—	38.84%↓	NC
Women's Health and Maternity Care				
Breast Cancer Screening (BCS)				
Breast Cancer Screening	—	—	NA	NC
Chlamydia Screening in Women (CHL)				
16–20 Years	—	—	47.81%↓	NC
21–24 Years	—	—	61.21%↓	NC
Total	—	—	55.33%↑	NC
Postpartum Depression Screening and Follow-Up (PDS)^				
Depression Screening	—	—	0.00%	NC
Follow-Up on Positive Screen	—	—	NA	NC
Prenatal and Postpartum Care (PPC)				
Timeliness of Prenatal Care	—	—	64.96%↓	NC
Postpartum Care	—	—	49.88%↓	NC
Prenatal Depression Screening and Follow-Up (PND)^				
Screening	—	—	0.00%	NC

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	MY 2021–MY 2022 Rate Comparison
Follow Up	—	—	NA	NC
Prenatal Immunization Status (PRS)^				
Influenza	—	—	5.04%↓	NC
Tdap	—	—	13.55%↓	NC
Combination	—	—	3.30%↓	NC
Care for Chronic Conditions				
Asthma Medication Ratio (AMR)				
5–11 Years	—	—	NA	NC
12–18 Years	—	—	NA	NC
5–18 Years (Child Core Set Total)	—	—	NA	NC
19–50 Years	—	—	NA	NC
51–64 Years	—	—	NA	NC
19–64 Years (Adult Core Set Total)	—	—	NA	NC
Total	—	—	NA	NC
Blood Pressure Control for Patients With Diabetes (BPD)				
Blood Pressure Control (<140/90 mm Hg)	—	—	44.77%↓	NC
Controlling High Blood Pressure (CBP)				
Controlling High Blood Pressure	—	—	44.04%↓	NC
Eye Exam for Patients With Diabetes (EED)				
Eye Exam (Retinal) Performed	—	—	30.90%↓	NC
Hemoglobin A1c Control for Patients With Diabetes (HBD)				
*Poor HbA1c Control**	—	—	62.29%↓	NC
HbA1c Control (<8%)	—	—	31.14%↓	NC
Kidney Health Evaluation for Patients With Diabetes (KED)				
18–64 Years	—	—	26.28%↓	NC
65–74 Years	—	—	33.33%↓	NC
75–85 Years	—	—	NA	NC
Total	—	—	26.37%↓	NC

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	MY 2021–MY 2022 Rate Comparison
Behavioral Health				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	—	—	44.50%↓	NC
Antidepressant Medication Management (AMM)				
Effective Acute Phase Treatment	—	—	48.41%↓	NC
Effective Continuation Phase Treatment	—	—	31.21%↓	NC
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	—	—	73.58%↓	NC
Follow-Up After Emergency Department Visit for Substance Use (FUA)[1]				
7-Day Follow-Up—Total	—	—	19.89%	NC
30-Day Follow-Up—Total	—	—	27.45%	NC
Follow-Up After Emergency Department Visit for Mental Illness (FUM)				
7-Day Follow-Up—Total	—	—	**50.78%**↑	NC
30-Day Follow-Up—Total	—	—	**58.01%**↑	NC
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)^				
7-Day Follow-Up—Total	—	—	27.84%↓	NC
30-Day Follow-Up—Total	—	—	42.66%↓	NC
Follow-Up After Hospitalization for Mental Illness (FUH)				
7-Day Follow-Up—Total	—	—	25.29%↓	NC
30-Day Follow-Up—Total	—	—	41.30%↓	NC
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
Initiation Phase	—	—	NA	NC
Continuation and Maintenance Phase	—	—	NA	NC
Initiation and Engagement of Substance Use Disorder Treatment (IET)[1]				
Initiation of SUD Treatment—Total (Total)	—	—	49.79%	NC

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	MY 2021–MY 2022 Rate Comparison
Engagement of SUD Treatment—Total (Total)	—	—	13.20%	NC
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)				
Blood Glucose and Cholesterol Testing—Total	—	—	37.88%↑	NC
Screening for Depression and Follow-Up Plan (CDF-CH/CDF-AD)^				
12–17 Years	—	—	0.92%	NC
18–64 Years	—	—	2.10%	NC
65+ Years	—	—	2.00%	NC
Total (12+ Years)	—	—	1.85%	NC
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)				
1–11 Years	—	—	NA	NC
12–17 Years	—	—	59.38%↓	NC
Total	—	—	**64.44%** ↑	NC
Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)^				
Rate 1: Total	—	—	57.58%	NC
Rate 2: Buprenorphine	—	—	25.00%	NC
Rate 3: Oral Naltrexone	—	—	3.28%	NC
Rate 4: Long-Acting, Injectable Naltrexone	—	—	1.02%	NC
Rate 5: Methadone	—	—	33.81%	NC
Utilization				
Ambulatory Care—Total (per 1,000 Member Years) (AMB)^				
*ED Visits—Total**	—	—	593.41	NC
Outpatient Visits—Total	—	—	2,175.17	NC
Plan All-Cause Readmissions (PCR)				
*Observed Readmissions—Total**	—	—	20.55%	NC
Expected Readmissions—Total	—	—	10.32%	NC
Observed/Expected (O/E) Ratio—Total	—	—	NA	NC
Outliers—Total	—	—	0.00	NC

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	MY 2021–MY 2022 Rate Comparison
Overuse/Appropriateness of Care				
Risk of Continued Opioid Use (COU)^*				
At Least 15 Days Covered—Total	—	—	8.06%↓	NC
At Least 31 Days Covered—Total	—	—	6.19%↓	NC
Use of Opioids at High Dosage (HDO)*				
Use of Opioids at High Dosage	—	—	11.50%↓	NC
Use of Opioids From Multiple Providers (UOP)*				
Multiple Prescribers	—	—	**20.99%**↓	NC
*Multiple Pharmacies^*	—	—	1.52%↑	NC
*Multiple Prescribers and Multiple Pharmacies^*	—	—	**0.72%**↑	NC

[1] Due to significant changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS MY 2022 and prior years. Due to the QISMC goals being based on HEDIS MY 2020 statewide aggregate rates, the MY 2022 rate was not compared to an MPS.

↑ Indicates the MY 2022 rate was above NCQA's Quality Compass HEDIS 2022 Medicaid HMO 50th percentile benchmark.

↓ Indicates the MY 2022 rate was below NCQA's Quality Compass HEDIS 2022 Medicaid HMO 50th percentile benchmark.

* A lower rate indicates better performance for this measure.

— Indicates that the MCO was not previously required to report this measure or that the rate is not appropriate to display due to changes in the technical specifications resulting in a break in trending.

^ Indicates MY 2022 QISMC goals are unavailable for this measure or indicator.

NC indicates the MY 2021–MY 2022 Rate Comparison could not be calculated because data are not available for both years.

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

Bolded rates indicate that the MY 2022 performance measure rate was at or above the MPS.

Table 3-33—Nevada Check Up SFY 2023 Performance Measure Results for Molina

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	MY 2021–MY 2022 Rate Comparison
Children's Preventive Care				
Childhood Immunization Status (CIS)				
Combination 3	—	—	NA	NC
Combination 7	—	—	NA	NC
Combination 10	—	—	NA	NC

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	MY 2021–MY 2022 Rate Comparison
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	—	—	NA	NC
Combination 2 (Meningococcal, Tdap, HPV)	—	—	NA	NC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile—Total	—	—	78.35%↓	NC
Counseling for Nutrition—Total	—	—	69.34%↓	NC
Counseling for Physical Activity—Total	—	—	66.18%↓	NC
Well-Child Visits in the First 30 Months of Life (W30)				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	—	—	NA	NC
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	—	—	NA	NC
Child and Adolescent Well-Care Visits (WCV)				
3–11 Years	—	—	44.36%↓	NC
12–17 Years	—	—	46.40%↓	NC
18–21 Years	—	—	32.52%↑	NC
Total	—	—	44.33%↓	NC
Women's Health and Maternity Care				
Chlamydia Screening in Women (CHL)				
16–20 Years	—	—	26.87%↓	NC
21–24 Years	—	—	NA	NC
Total	—	—	26.87%↓	NC
Prenatal and Postpartum Care (PPC)				
Timeliness of Prenatal Care	—	—	NA	NC
Postpartum Care	—	—	NA	NC
Care for Chronic Conditions				
Asthma Medication Ratio (AMR)				
5–11 Years	—	—	NA	NC
12–18 Years	—	—	NA	NC

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	MY 2021–MY 2022 Rate Comparison
5–18 Years (Child Core Set Total)	—	—	NA	NC
19–50 Years	—	—	NA	NC
51–64 Years	—	—	NA	NC
19–64 Years (Adult Core Set Total)	—	—	NA	NC
Total (5–64 Years)	—	—	NA	NC
Behavioral Health				
Follow-Up After Emergency Department Visit for Substance Use (FUA)^,[1]				
7-Day Follow-Up—Total	—	—	NA	NC
30-Day Follow-Up—Total	—	—	NA	NC
Follow-Up After Emergency Department Visit for Mental Illness (FUM)				
7-Day Follow-Up—Total	—	—	NA	NC
30-Day Follow-Up—Total	—	—	NA	NC
Follow-Up After Hospitalization for Mental Illness (FUH)				
7-Day Follow-Up—Total	—	—	NA	NC
30-Day Follow-Up—Total	—	—	NA	NC
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
Initiation Phase	—	—	NA	NC
Continuation and Maintenance Phase	—	—	NA	NC
Initiation and Engagement of Substance Use Disorder Treatment (IET)[1]				
Initiation of SUD Treatment—Total (Total)	—	—	NA	NC
Engagement of SUD Treatment—Total (Total)	—	—	NA	NC
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)				
Blood Glucose and Cholesterol Testing—Total	—	—	NA	NC
Screening for Depression and Follow-Up Plan (CDF-CH/CDF-AD)^				
12–17 Years	—	—	0.60%	NC
18–64 Years	—	—	0.46%	NC
65+ Years	—	—	NA	NC
Total (12+ Years)	—	—	0.57%	NC

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	MY 2021–MY 2022 Rate Comparison
*Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)^*				
1–11 Years	—	—	NA	NC
12–17 Years	—	—	NA	NC
Total	—	—	NA	NC
Utilization				
*Ambulatory Care—Total (per 1,000 Member Years) (AMB)^*				
*ED Visits—Total**	—	—	279.64	NC
Outpatient Visits—Total	—	—	1,973.16	NC

[1] Due to significant changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS MY 2022 and prior years. Due to the QISMC goals being based on HEDIS MY 2020 statewide aggregate rates, the MY 2022 rate was not compared to an MPS.
↑ Indicates the MY 2022 rate was above NCQA's Quality Compass HEDIS 2022 Medicaid HMO 50th percentile benchmark.
↓ Indicates the MY 2022 rate was below NCQA's Quality Compass HEDIS 2022 Medicaid HMO 50th percentile benchmark.
* A lower rate indicates better performance for this measure.
— Indicates that the MCO was not previously required to report this measure or that the rate is not appropriate to display due to changes in the technical specifications resulting in a break in trending.
^ Indicates MY 2022 QISMC goals are unavailable for this measure or indicator.
NC indicates the MY 2021–MY 2022 Rate Comparison could not be calculated because data are not available for both years.
NA indicates that the MCO followed the specifications, but the denominator was too small (i.e., <30) to report a valid rate.
Bolded rates indicate that the MY 2022 performance measure rate was at or above the MPS.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Within the Behavioral Health domain for **Molina**'s Medicaid population, **Molina** met the State's established MPS for the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total* measure indicator, demonstrating **Molina**'s efforts in ensuring its Medicaid members with mental health and SUDs are receiving the appropriate treatment, potentially improving health, productivity, and social outcomes, as well as reducing healthcare spending. **[Quality, Timeliness,** and **Access]**

Strength #2: Within the Overuse/Appropriateness of Care domain for **Molina**'s Medicaid population, **Molina** met the State's established MPS for the *Use of Opioids From Multiple Providers—Multiple Prescribers* and *Multiple Prescribers and Multiple Pharmacies* measure indicators, demonstrating **Molina**'s efforts in ensuring its adult Medicaid members receiving opioid prescriptions are not being prescribed opioids for 15 or more days during the MY from multiple providers or pharmacies, potentially reducing the risk of opioid overuse and misuse, as well as reducing the risk of overdose. **[Quality** and **Timeliness]**

Weaknesses and Recommendations

Weakness #1: No rates within the Access to Care, Children's Preventive Care, Women's Health and Maternity Care, Care for Chronic Conditions, and Utilization domains for **Molina**'s Medicaid population and no rates within all domains for **Molina**'s Nevada Check Up populations met the State's established MPS.

Why the weakness exists: Overall low performance could be attributed in part to MY 2022 being **Molina**'s first year as an MCO in Nevada. Low performance could also be due to disparities within its populations that could impact access to care, such as language barriers, access to transportation, geographic location, and socioeconomic status. Additionally, performance may have been impacted by the lingering impact of the COVID-19 PHE, which may have caused healthcare provider burnout and shortages.

Recommendation: HSAG recommends that **Molina** conduct root cause analyses and consider disparities within its Medicaid and Nevada Check Up populations that may be contributing to low performance in a particular race or ethnicity, age group, ZIP Code, etc. Based on root cause analyses, **Molina** should implement interventions to increase Medicaid and Nevada Check Up performance across all domains of care.

Compliance Review

Performance Results

Table 3-34 presents an overview of the results of the SFY 2022 and SFY 2023 compliance reviews for **Molina**. **Molina** joined the Nevada Managed Care Program on January 1, 2022; therefore, the review of the first seven standards was conducted in SFY 2023. The standards reviewed during the SFY 2023 compliance review are highlighted in orange and the findings, including the strengths and weaknesses that were derived from these findings, are included in this SFY 2023 EQR. For both SFYs, HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Appendix A. If a requirement was not applicable to **Molina** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all 14 standards.

Table 3-34—Summary of Standard Compliance Scores

Standard[1]	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Disenrollment: Requirements and Limitations	5	5	4	1	0	**80%**
Standard II—Member Rights and Member Information	22	22	17	5	0	**77%**
Standard III—Emergency and Poststabilization Services	10	10	10	0	0	**100%**
Standard IV—Availability of Services	10	10	10	0	0	**100%**
Standard V—Assurances of Adequate Capacity and Services	3	3	2	1	0	**67%**
Standard VI—Coordination and Continuity of Care	15	15	8	7	0	**53%**
Standard VII—Coverage and Authorization of Services	15	15	13	2	0	**87%**
Standard VIII—Provider Selection	12	11	9	2	1	**82%**
Standard IX—Confidentiality	11	11	11	0	0	**100%**
Standard X—Grievance and Appeal Systems	38	38	33	5	0	**87%**
Standard XI—Subcontractual Relationships and Delegation	7	7	7	0	0	**100%**
Standard XII—Practice Guidelines	10	10	10	0	0	**100%**
Standard XIII—Health Information Systems[2]	14	14	14	0	0	**100%**
Standard XIV—Quality Assessment and Performance Improvement Program	42	39	38	1	3	**97%**
Total	**214**	**210**	**186**	**24**	**4**	**89%**

M* = *Met*; *NM* = *Not Met*; *NA* = *Not Applicable
Total Elements: The total number of elements within each standard.
Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.
Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.
[1] As **Molina** entered the Nevada Medicaid Managed Care Program on January 1, 2022, standards I–VII were reviewed during SFY 2023.
[2] This standard includes a comprehensive assessment of the MCO's IS capabilities.

Based on the findings from the SFY 2022 compliance review activities, **Molina** was also required to develop and submit a CAP for each element assigned a score of *Not Met*. The CAP was reviewed by DHCFP and HSAG for sufficiency, and **Molina** was responsible for implementing each action plan in a timely manner. The SFY 2023 compliance review activities for **Molina** also included this CAP review. Table 3-35 presents an overview of the results of the SFY 2023 CAP review for **Molina** which consisted of a comprehensive review of the MCO's implementation of each action plan developed to mitigate the deficiencies identified in

the SFY 2022 compliance review. HSAG assigned a score of *Complete* or *Not Complete* to each of the individual elements that required a CAP based on a scoring methodology, which is detailed in Appendix A.

Table 3-35—Summary of Corrective Action Plan Implementation

Standard	Total CAP Elements	# CAP Elements *Complete*	# CAP Elements *Not Complete*
Standard VIII—Provider Selection	2	1	1
Standard X—Grievance and Appeal Systems	5	5	0
Standard XIV—Quality Assessment and Performance Improvement Program	1	1	0
Total	**8**	**7**	**1**

Total CAP Elements: The total number of elements within each standard that required a CAP during the SFY 2022 compliance review activities.

 # CAP Elements *Complete*: The total number of CAP elements within each standard that were fully remediated at the time of the site review and demonstrated compliance with the requirement under review.

 # CAP Elements *Not Complete*: The total number of CAP elements within each standard that were not fully remediated at the time of the site review and/or did not demonstrate compliance with the requirement under review.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the compliance review activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the compliance review have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Molina achieved full compliance in the Emergency and Poststabilization Services program area, demonstrating that the MCO had adequate processes in place to ensure access to, coverage of, and payment for emergency and poststabilization care services. [**Access**]

Strength #2: Molina achieved full compliance in the Availability of Services program area, demonstrating that the MCO maintained an adequate provider network that was sufficient to provide timely access to all services (e.g., primary care, specialty care, hospital and emergency services, behavioral health, and prenatal care) for its membership. **[Timeliness** and **Access]**

Strength #3: Molina demonstrated that it successfully remediated seven of eight SFY 2022 CAP elements, indicating the necessary policies, procedures, and interventions were implemented to assure compliance with the requirements under review. Further, **Molina** remediated all SFY 2022 CAP elements for two of the three standards reviewed, Grievance and Appeal Systems and Quality Assessment and Performance Improvement Program. [**Quality**]

Weaknesses and Recommendations

Weakness #1: Molina received a score of 77 percent in the Member Rights and Member Information program area, indicating members may not receive timely and adequate access to information that can assist them in accessing care and services. **[Quality**, **Timeliness**, and **Access]**

Why the weakness exists: Molina's member materials critical to obtaining services did not comply with language requirements, the member handbook and provider directory did not contain all mandatory components, and the MCO did not have a machine-readable version of its formulary available on its website.

Recommendation: HSAG required **Molina** to submit an action plan to address the deficiencies and provide assurances indicating:

- Taglines included in member materials meet the requirement for conspicuously visible font and are fully translated in the prevalent non-English language in the State.
- All written materials for potential and current members use a font size no smaller than 12-point.
- The member handbook includes required information related to fraud and abuse; disenrollment; Early and Periodic Screening, Diagnostic, and Treatment (EPSDT); and procedures for members to recommend changes to policies and services.
- A process is in place to obtain required information from Molina's provider network to be included in the provider directory (e.g., provider photos, proof of cultural compliance training, age bands of members seen, accessibility and building features, and board certifications).
- The machine-readable drug list/formulary is posted on the MCO's website.

In addition to ensuring all action plans are implemented in a timely manner, HSAG recommends that the MCO continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to member rights and member information.

Weakness #2: Molina received a score of 67 percent in the Assurances of Adequate Capacity and Services program area, demonstrating that the MCO was not sufficiently monitoring its provider network to ensure adequate access to all services for its membership. [**Access**]

Why the weakness exists: Although **Molina** provided evidence that time and distance standards were being calculated for most provider types, the MCO did not demonstrate that time and distance standards (access within 45 minutes or 30 miles) were being calculated for QMHPs during the review period.

Recommendation: HSAG required that **Molina** submit an action plan to address the deficiencies and provide assurances that QMHPs are included in network time and distance calculations. HSAG also recommends that the MCO continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to network adequacy requirements.

Weakness #3: Molina received a score of 53 percent for the Coordination and Continuity of Care program area, indicating members' care may not be effectively coordinated through the care management program. [**Quality, Timeliness, and Access**]

Why the weakness exists: Molina did not consistently complete a health needs assessment for its members to assess their healthcare needs; provide information to members and their PCPs regarding member eligibility for and/or enrollment into care management; consistently and actively collaborate with a member's formal or informal supports, when applicable; include the members' PCP or the treatment team in the development of member care plans; consistently include the member's self-reported main health concerns into the individualized goals and interventions within the care plans; consistently assess a member's need for external resources and communicate with PCPs or other providers regarding the status of the care plan; and did not ensure that revisions to the clinical portion of the care plan consistently occur in consultation with the member's PCP.

Recommendation: HSAG required **Molina** to submit a CAP to address the deficiencies and provide assurances that **Molina** will implement processes to conduct the initial screening of members' needs in the required time frames; notify a member's PCP when the member is identified as meeting the criteria for care management and subsequently enrolled into care management services; consistently document the collaboration with the member, the member's designated formal and informal supports, and the member's PCP and treatment team in developing the care plan; incorporate the member's self-reported health concerns into the goals and interventions and any identified gaps and coordination with State and county agencies in the care plan; reevaluate the member's care plan and level of care management services within the established time frames and adjust the care plan accordingly; and document ongoing communication with a member's PCP or designee and revise the clinical portion of the care plan as necessary in consultation with the PCP. Additionally, HSAG recommends that **Molina** implement methods to continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to the coordination and continuity of care for its members.

Weakness #4: Molina did not remediate one of the two SFY 2022 CAP elements for the Provider Selection standard, indicating continued gaps in the MCO's recredentialing processes. [**Quality**]

Why the weakness exists: Molina did not provide sufficient evidence that member appeals are being reviewed as part of the decision to recredential network providers.

Recommendation: HSAG required **Molina** to submit an action plan to address these findings and provide assurances that **Molina** identifies the appeal data to be considered when making recredentialing decisions, and that documentation in the recredentialing file includes a review of appeal data as part of the recredentialing decision. Additionally, HSAG recommends that the MCO continue to monitor implementation of its CAP to ensure timely, effective remediation of the deficiencies.

Network Adequacy Validation

Performance Results

Table 3-36 presents **Molina**'s network capacity analysis results and compares the provider ratios to the standards displayed in Table 3-4. Assessed provider ratios shown in green indicate the provider ratio was in compliance with the access standard, whereas provider ratios shown in red indicate the provider ratio was not in compliance with the access standard.

Table 3-36—Summary of Ratio Analysis Results for PCPs and Specialty Care Providers for Molina

Provider Category	Providers*	Clark County Ratio	Washoe County Ratio	Statewide Ratio**
PCPs (1:1,500)	1,299	1:80	1:12	1:92
PCP Extenders (1:1,800)	1,361	1:44	1:6	1:50
Physician Specialists (1:1,500)	1,180	1:88	1:13	1:101

Note: Results shown in green font indicate the result complies with the access standard; results shown in red font indicate the result does not comply with the access standard; PCP: Primary Care Provider.
* Providers contracted statewide and contracted providers located in the Nevada Medicaid catchment areas were included in provider counts.
** Statewide ratio incorporates all Nevada counties included in the DHCFP member file submission and members enrolled with the MCO as of December 1, 2022.

Table 3-37 presents **Molina**'s geographic network distribution analysis and presents the percentage of members who had access to provider locations within the standards displayed in Table 3-5. Assessed results shown in green indicate that the percentage of members within the access standard was in compliance, and percentages shown in red indicate a result of less than 99.0 percent.

Table 3-37—Percentage of Members With Required Access by Provider Category for Molina

Provider Category	Clark County	Washoe County	Statewide*
Primary Care Providers			
Primary Care, Adults (10 miles/15 mins)	99.9%	99.5%	99.9%
OB/GYN (10 miles/15 mins)	99.1%	97.6%	98.8%
Pediatrician (10 miles/15 mins)	99.9%	97.2%	99.5%
Physician Specialists			
Endocrinologist (40 miles/60 mins)	>99.9%	100.0%	99.9%
Endocrinologist, Pediatric (40 miles/60 mins)	>99.9%	100.0%	>99.9%
Infectious Disease (40 miles/60 mins)	>99.9%	100.0%	99.9%
Infectious Disease, Pediatric (40 miles/60 mins)	>99.9%	100.0%	99.9%
Oncologist/Radiologist (40 miles/60 mins)	>99.9%	100.0%	99.9%
Oncologist—Medical/Surgical (30 miles/45 mins)	>99.9%	>99.9%	99.9%
Oncologist—Medical/Surgical, Pediatric (30 miles/45 mins)	>99.9%	>99.9%	99.9%
Rheumatologist (40 miles/60 mins)	>99.9%	100.0%	99.9%
Rheumatologist, Pediatric (40 miles/60 mins)	>99.9%	0.0%	86.4%
Behavioral Health Providers			
Board Certified Child and Adolescent Psychiatrist (30 miles/45 mins)	>99.9%	>99.9%	>99.9%

Provider Category	Clark County	Washoe County	Statewide*
Psychiatrist (30 miles/45 mins)	>99.9%	>99.9%	>99.9%
Psychologist (30 miles/45 mins)	>99.9%	>99.9%	>99.9%
Psychologist, Pediatric (30 miles/45 mins)	>99.9%	0.0%	86.4%
QMHP (30 miles/45 mins)	>99.9%	100.0%	>99.9%
QMHP, Pediatric (30 miles/45 mins)	100.0%	>99.9%	>99.9%
Facility-Level Providers			
Hospitals, All (30 miles/45 mins)	>99.9%	100.0%	>99.9%
Pharmacy (10 miles/15 mins)	99.9%	99.7%	99.9%
Psychiatric Inpatient Hospital (30 miles/45 mins)	>99.9%	>99.9%	99.9%
Dialysis/ESRD Facility (30 miles/45 mins)	>99.9%	>99.9%	99.9%

Note: Results shown in green font indicate the result complies with the access standard; results shown in red font indicate that less than 99.0 percent of members had access to the provider within the time and distance access standard.
* Statewide results incorporate all Nevada counties included in the DHCFP member file submission and members enrolled with the MCO as of December 1, 2022.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the NAV findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Molina met the provider ratio requirements for PCPs, PCP Extenders, and Physician Specialists in both Clark and Washoe counties, indicating **Molina** had a sufficient provider network for its members to access services. **[Access]**

Strength #2: Molina met the time-distance contract standards in Washoe County for the Rheumatologist and Oncologist/Radiologist provider types and the following provider categories for adult and pediatric populations: Endocrinologist, Infectious Disease, and QMHP. **[Access]**

Strength #3: Molina met the time-distance contract standards in Washoe County for eight of the provider categories assessed, an improvement from FY 2022, when it did not meet any of the standards.[3-6]

[3-6] For SFY 2022 EQR results, refer to the Division of Health Care Financing and Policy Nevada Managed Care Program State Fiscal Year 2022 External Quality Review Technical Report at https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Resources/AdminSupport/Reports/NV2022_EQR-TR_F1.pdf.

Weaknesses and Recommendations

Weakness #1: Molina did not meet the time-distance contract standards for OB/GYNs, indicating members may experience challenges accessing these provider types within an adequate time or distance from their residence. **[Access]**

Why the weakness exists: The lack of contracted providers may have been the result of a delay in contracting with all of the major OB/GYN provider groups in Clark County and Washoe County. Additionally, none of the four MCOs met the contract adequacy standard for OB/GYNs, suggesting a potential lack of this provider type in Nevada, particularly in Washoe County.

Recommendation: HSAG recommends that **Molina** continue to review the DHCFP Monthly Active Provider Report to identify newly added OB/GYNs and conduct outreach to confirm the OB/GYN providers' willingness to contract with **Molina**.

Weakness #2: Molina did not meet the time-distance contract standards for the Pediatrician, Pediatric Rheumatologist, and Pediatric Psychologist provider types in Washoe County, indicating members may experience challenges accessing these provider types within an adequate time or distance from their residence. **[Access]**

Why the weakness exists: The lack of identified Pediatrician and Pediatric Rheumatologist providers may result from a lack of these provider types in Washoe County, as three of the four MCOs did not meet the contract standard for the Pediatrician provider type in this county and none of the four MCOs met the contract standard for the Pediatric Rheumatologist provider type, further suggesting limited providers in this county available for contracting. For the Pediatric Rheumatologist provider type specifically, there were no pediatric rheumatologists practicing in Washoe County or available for contracting.

Recommendation: HSAG recommends that **Molina** review DHCFP's monthly enrolled provider list to determine whether new Pediatrician providers are available in Washoe County for contracting. **Molina** should also continue its contracting efforts with Pediatric Psychologist providers in Washoe County to mitigate any access to care barriers for members needing care from this provider type. Finally, **Molina** should consider collaborating with DHCFP and the other MCOs to determine whether community reinvestment funds can be used to incentivize pediatric rheumatologists to join a rheumatology clinic in Washoe County.

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results

Table 3-38 presents the 2023 CAHPS top-box scores for **Molina**'s adult Medicaid, general child Medicaid, CCC Medicaid, Nevada Check Up general child, and Nevada Check Up CCC populations. Arrows (↓ or ↑) indicate 2023 scores that were statistically significantly higher or lower than the 2022 national average.[3-7]

[3-7] 2023 national average results were not available at the time this report was produced.

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Table 3-38—Summary of 2023 CAHPS Top-Box Scores for Molina

	Adult Medicaid	General Child Medicaid	CCC Medicaid	Nevada Check Up General Child	Nevada Check Up CCC
Composite Measures					
Getting Needed Care	NA	NA	NA	NA	NA
Getting Care Quickly	NA	NA	NA	NA	NA
How Well Doctors Communicate	NA	NA	NA	NA	NA
Customer Service	NA	NA	NA	NA	NA
Global Ratings					
Rating of All Health Care	NA	NA	NA	NA	NA
Rating of Personal Doctor	NA	NA	NA	NA	NA
Rating of Specialist Seen Most Often	NA	NA	NA	NA	NA
Rating of Health Plan	NA	NA	NA	NA	NA
Effectiveness of Care*					
Advising Smokers and Tobacco Users to Quit	NA	—	—	—	—
Discussing Cessation Medications	NA	—	—	—	—
Discussing Cessation Strategies	NA	—	—	—	—
CCC Composite Measures/Items					
Access to Specialized Services	—	—	NA	—	NA
FCC: Personal Doctor Who Knows Child	—	—	NA	—	NA
Coordination of Care for Children With Chronic Conditions	—	—	NA	—	NA
Access to Prescription Medicines	—	—	NA	—	NA
FCC: Getting Needed Information	—	—	NA	—	NA

A minimum of 100 respondents is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of respondents are denoted as *NA*.

* These scores deviate from NCQA's methodology of calculating a rolling two-year average. Rates were calculating using the current year's data only.

↑ Indicates the 2023 score is statistically significantly higher than the 2022 national average.

↓ Indicates the 2023 score is statistically significantly lower than the 2022 national average.

— Indicates the measure does not apply to the population.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the CAHPS activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine any significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: HSAG did not identify any strengths for **Molina** for the CAHPS surveys.

Weaknesses and Recommendations

Weakness #1: There were less than 100 respondents for every measure across all adult and child populations; therefore, results could not be reported and strengths and weaknesses could not be identified. **[Quality, Timeliness, Access]**

Why the weakness exists: Adult members and parents/caretakers of child members are less likely to respond to the CAHPS survey. Completion of surveys may be exceptionally low on the list of priorities for members struggling with illness, unemployment, and/or other life-changing events. Additionally, **Molina** began providing coverage to Medicaid and Nevada Check Up members effective January 1, 2022; therefore, members may not have had enough experience with **Molina** to respond to the survey.

Recommendation: HSAG recommends that **Molina** focus on increasing response rates to the CAHPS survey for all populations so there are greater than 100 respondents for each measure by educating and engaging all employees to increase their knowledge of CAHPS, applying effective customer service techniques, increasing the percentage of oversampling, using innovative outreach strategies to follow up with non-respondents, and providing awareness to members and providers during the survey period. Additionally, **Molina**'s care management and/or other member-facing teams, such as the customer service team, could consider asking members if they know about the CAHPS survey and, if they received the survey, what barriers may prevent them from responding to the survey. These questions can be asked during routine contacts with members or when members outreach to **Molina**. The information provided by these members could be shared with **Molina**'s CAHPS vendor so that **Molina** and the vendor can identify solutions to address low response rates.

Overall Conclusions for Quality, Timeliness, and Access to Healthcare Services

HSAG performed a comprehensive assessment of **Molina**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **Molina** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **Molina**'s overall performance contributed to the Nevada Managed Care Program's progress in achieving the Quality Strategy goals and objectives. Table 3-39 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided **Molina**'s Medicaid and Nevada Check Up members.

Table 3-39—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Increase Use of Preventive Services	**Quality**, **Timeliness**, and **Access**—**Molina** demonstrated through the three-year compliance review cycle that it had appropriate practices for ensuring providers were aware of its adopted practice guidelines, which should include guidelines for preventive care; however, **Molina** did not achieve the DHCFP-established MPS for any reported performance measures included in the Medicaid Access to Care or Medicaid and Nevada Check Up Children's Preventive Care domains. Additionally, **Molina** only achieved NCQA's Quality Compass HEDIS 2022 Medicaid HMO 50th percentile benchmark for one performance measure, *Child and Adolescent Well-Care Visits—18–21 Years*, for the Nevada Check Up population. **Molina** appeared to have a sufficient number of PCPs to provide well-care services; however, **Molina** members in Washoe County were not all able to access a pediatrician within 10 miles or 15 minutes of their homes as indicated through the NAV activity. Additionally, many females in **Molina**'s Medicaid population were not being screened for chlamydia as indicated by performance in the reportable *Chlamydia Screening in Women* measure indicators under the Women's Health and Maternity Care domain for the Medicaid and Nevada Check Up populations. Based on these findings, **Molina** has significant opportunities to mitigate any barriers to its members receiving preventive care, and to implement interventions to support improvement in the use of preventive services for adult and child members and contribute to the Nevada Managed Care Program's progress toward achieving Goal 1 of the Quality Strategy to *improve the Health and Wellness of Nevada's Medicaid population by increasing the use of preventive services by December 31, 2024*. Preventive care is crucial to staying healthy and identifying problems early on before they contribute to other issues or become harder to treat. Immunizations are also essential to prevent diseases, such as diphtheria, meningitis, measles, polio, tetanus, and whooping cough, and are a critical aspect of preventable care.
Increase Use of Evidence-Based Practices for Members With Chronic Conditions	**Quality**, **Timeliness**, and **Access**—Although **Molina** demonstrated that it had a robust network of PCPs and endocrinologists through the NAV activity, **Molina** did not achieve the DHCFP-established MPS or perform above NCQA's Quality Compass HEDIS 2022 Medicaid HMO 50th percentile benchmark for any reportable performance measures included in the Care for Chronic Conditions domain. As such, **Molina** must implement interventions to support improvement in the use of evidence-based practices for members diagnosed with chronic conditions (i.e., diabetes, asthma, hypertension) and contribute to the Nevada Managed Care Program's progress toward achieving Goal 2 of the Quality Strategy to *increase use of evidence-based practices for members with chronic conditions by December 31, 2024.* Proper diabetes management is important to control blood glucose and reduce risks for complications; medication management for members with asthma can reduce the need for rescue medications and the costs associated with emergency room visits and inpatient admissions; and reducing hypertension mitigates damage to members' hearts and reduces the risks for additional health problems.

Performance Area	Overall Performance Impact
Reduce Misuse of Opioids	**Quality**—**Molina** met the established MPS for two of the three indicator rates under the *Use of Opioids From Multiple Providers* (*Multiple Prescribers* and *Multiple Prescribers and Multiple Pharmacies*), and performed above NCQA's Quality Compass HEDIS 2022 Medicaid HMO 50th percentile benchmark for two of the three indicator rates (*Multiple Pharmacies* and *Multiple Prescribers and Multiple Pharmacies*), demonstrating adequate oversight of its provider network specific to the prescribing and filling of opioids as indicated by a relatively low prevalence of multiple prescribers prescribing opioids and multiple pharmacies filling the prescriptions. Through these findings, **Molina** demonstrated its contribution to the Nevada Managed Care Program's achievement of one related objective under Goal 3 of the Quality Strategy to *reduce misuse of opioids by December 31, 2024,* and supported the reduction of opioid-related overdose deaths. However, **Molina** did not meet the MPS for the *Use of Opioids at High Dosage* measure indicator rate. Additionally, for SFY 2023, **Molina** was required to report two indicators for the *Risk of Continued Opioid Use* measure. Although no MPS was yet established for these indicators, **Molina** performed below NCQA's Quality Compass HEDIS 2022 Medicaid HMO 50th percentile benchmark. The results of these findings indicate that **Molina** should monitor high-risk opioid analgesic prescribing practices and educate its providers and members to mitigate the risk of OUD, opioid-related overdose, hospitalization, and opioid overdose-related mortality, and to further contribute to the Nevada Managed Care Program's achievement of reducing the misuse of opioids.
Improve Health and Wellness of Pregnant Women	**Quality**, **Timeliness**, and **Access**—**Molina** did not achieve the DHCFP-established MPS or perform above NCQA's Quality Compass HEDIS 2022 Medicaid HMO 50th percentile benchmark for any reportable and applicable performance measures included in the Women's Health and Maternity Care domain for the Medicaid population that support Goal 4 of the Quality Strategy to *improve the health and wellness of pregnant women and infants by December 31, 2024*. Both *Prenatal and Postpartum Care* performance indicators also fell below the Medicaid aggregate rate, and as indicated through the NAV activity, pregnant members in Washoe County and outside the urban counties may have experienced issues accessing OB/GYNs near their homes. Timely and adequate prenatal and postpartum care supports long-term health and well-being of new mothers and their babies. For SFY 2023, **Molina** was also required to report on three new measures, *Postpartum Depression Screening and Follow-Up*, *Prenatal Depression Screening and Follow-Up*, and *Prenatal Immunization Status*, which align to five new objectives in the Quality Strategy under Goal 4. Although **Molina**'s performance was not assessed against a DHCFP-established MPS since MY 2022 was the baseline rate for the new measures, **Molina** should work with its OB/GYN providers and other providers such as PCPs, as applicable, to increase prenatal and postpartum depression screenings and to increase the percentage of members receiving the influenza and tetanus, diphtheria, and pertussis vaccines during pregnancy. Higher performance in these areas should support improved health outcomes for both mom and baby. **Molina**'s provider-related initiatives should also assist the MCO with achieving the newly set MPSs

Performance Area	Overall Performance Impact
	as stipulated in Appendix B. Goals and Objectives Tracking under the New Measurement Year 2023 Minimum Performance Standards section and further support the Nevada Managed Care Program's achievement of Goal 4 of the Quality Strategy.
Increase Use of Evidence-Based Practices for Members With Behavioral Health Conditions	**Quality**, **Timeliness**, and **Access**—**Molina** demonstrated strong performance in the Behavioral Health domain for the Medicaid population related to the *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total* and *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total* as these measure indicator rates met the DHCFP-established MPS and exceeded NCQA's Quality Compass HEDIS 2022 Medicaid HMO 50th percentile benchmark. The *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total* measure indicator rate also met the DHCFP-established MPS, indicating that **Molina**'s focused efforts in this program area are contributing to the achievement of the related objectives under Goal 5 of the Quality Strategy to *increase use of evidence-based practices for members with behavioral health conditions by December 31, 2024*. However, most of the measures in the Behavioral Health domain did not meet their respective MPS, indicating additional opportunities for improvement. In SFY 2023, **Molina** effectively designed a PIP, *Improving the Rates for Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET),* as indicated by a *Met* validation rating, which should support an improvement in the health outcomes for **Molina**'s Medicaid members with alcohol or other drug dependence. In addition to this PIP, **Molina** should continue with its previously implemented initiatives but also assess whether there are barriers to members seeing the contracted behavioral health providers in a timely manner for all behavioral health services, or whether other reasons are preventing members from accessing care to treat their behavioral health or substance use diagnoses. Improvement in this program area will help support the Nevada Managed Care Program achieve the objectives under Goal 5 of the Quality Strategy to *increase use of evidence-based practices for members with behavioral health conditions by December 31, 2024*.
Reduce/Eliminate Healthcare Disparities	**Quality**, **Timeliness**, and **Access**—The aggregated findings from **Molina**'s EQR activities did not produce sufficient data for HSAG to assess the impact the EQR activities had or will have on reducing and/or eliminating healthcare disparities for **Molina**'s Medicaid and Nevada Check Up members other than by geographic location (i.e., through the NAV activity). To support the reduction and elimination of healthcare disparities, **Molina** should continue to implement interventions through its cultural competency and population health programs and plans, stratify performance measure data by race and ethnicity, and use the data to target interventions for those areas wherein performance is lowest and members can be most impacted.

SilverSummit Healthplan, Inc.

Validation of Performance Improvement Projects

Performance Results

Table 3-40 displays the overall validation rating for the Design stage of each PIP topic. Table 3-40 also includes the performance indicators that will be used to track performance or improvement over the life of the PIP.

Table 3-40—Overall Validation Ratings for SilverSummit

PIP Topic	Validation Ratings*	Performance Indicator	Performance Indicator Results		
			Baseline	R1	R2
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	*Met*	The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit, or medication treatment within 14 days.	—	—	—
		The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.			
Plan All-Cause Readmissions	*Met*	For members 18 years of age and older, the percentage of acute inpatient and observation stays during the measure year that were followed by an unplanned acute readmission for any diagnosis within 30 days.	—	—	—

— The PIP had not progressed to including baseline or remeasurement (R1, R2) results during SFY 2023.
*The PIP activities for SFY 2023 were initiated prior to release of the 2023 CMS EQR Protocols; therefore, HSAG adhered to the guidance published in the 2019 CMS EQR Protocols. With the release of the new protocols, HSAG updated its PIP worksheets for SFY 2024 to include the two validation ratings (i.e., Overall confidence that the PIP adhered to an acceptable methodology for all phases of design and data collection, and the MCO conducted accurate data analysis and interpretation of PIP results; overall confidence that PIP produced significant evidence of improvement.)

Interventions

SilverSummit has established its PIP design, and the PIP will progress to the Implementation stage. During this stage, **SilverSummit** will evaluate and analyze its data, identify barriers to performance, and develop interventions targeted to improve outcomes. As the PIPs did not progress to the Implementation

stage in SFY 2023, **SilverSummit**'s causal/barrier analysis process and interventions will be reported in the next annual EQR technical report (SFY 2024).

Table 3-41 and Table 3-42 will display the barriers and interventions as documented by the MCO.

Table 3-41—Barriers Identified and Interventions Implemented/Planned for Initiation and Engagement (IET)

Barriers	Interventions
—	—
—	—

— The PIP had not progressed to the identification of barriers and the development of interventions during SFY 2023.

Table 3-42—Barriers Identified and Interventions Implemented/Planned for Plan All-Cause Readmissions

Barriers	Interventions
—	—
—	—

— The PIP had not progressed to the identification of barriers and the development of interventions during SFY 2023.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP validation against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP validation have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: SilverSummit developed a methodologically sound design for both PIPs that met State and federal requirements. A methodologically sound design created the foundation for **SilverSummit** to progress to subsequent PIP stages—collecting data and carrying out interventions to positively impact performance indicator results and outcomes for the project. **[Quality]**

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any weaknesses for **SilverSummit**.

Why the weakness exists: No weaknesses were identified; therefore, this section is not applicable.

Recommendation: Although no significant weaknesses were identified during the SFY 2023 PIP activities, as **SilverSummit** progresses to the Implementation stage of the PIP, HSAG recommends that **SilverSummit** develop effective improvement strategies (i.e., interventions) that are designed to target the designated population(s) and age group(s) to successfully improve member outcomes.

Performance Measure Validation

Performance Results

Table 3-43 and Table 3-44 show **SilverSummit**'s Medicaid and Nevada Check Up HEDIS and CMS Child and Adult Core Set performance measure results for MY 2020, MY 2021, and MY 2022, along with MY 2021 to MY 2022 rate comparisons and performance target ratings.

Performance for MY 2022 (SFY 2023) is indicated by symbols and color coding; **bolded** rates indicate the rate was at or above the DHCFP-established MPS, ↑ indicates the rate was above the national Medicaid 50th percentile benchmark, ↓ indicates the rate was below the national 50th percentile benchmark, green shading indicates that the rate improved by 5 percentage points from the prior year, and red shading indicates that the rate declined by 5 percentage points from the prior year.

Measures in the Utilization domain are designed to capture the frequency of services provided by the MCO. With the exception of *Ambulatory Care—Total (per 1,000 Member Years)—ED Visits—Total*, higher or lower rates in this domain do not necessarily indicate better or worse performance. Therefore, these rates are provided for information only.

Table 3-43—Medicaid SFY 2023 Performance Measure Results and Trending for SilverSummit

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	MY 2021–MY 2022 Rate Comparison
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services (AAP)				
Ages 20–44 Years	58.20%	55.38%	53.16%↓	-2.22
Ages 45–64 Years	69.12%	66.42%	61.75%↓	-4.67
*Ages 65 Years and Older^*	79.41%	59.23%	54.51%↓	-4.72
Total	61.54%	58.64%	55.66%↓	-2.98
Children's Preventive Care				
Childhood Immunization Status (CIS)				
Combination 3	62.29%	57.42%	54.26%↓	-3.16
Combination 7	53.77%	51.58%	46.96%↓	-4.62
Combination 10	29.20%	27.49%	21.90%↓	-5.59
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	78.59%	76.64%	77.86%↓	1.22
Combination 2 (Meningococcal, Tdap, HPV)	33.58%	27.74%	28.71%↓	0.97

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	MY 2021–MY 2022 Rate Comparison
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile—Total	78.83%	73.24%	75.18%↓	1.94
Counseling for Nutrition—Total	70.56%	66.91%	70.07%↓	3.16
Counseling for Physical Activity—Total	66.91%	61.07%	63.75%↓	2.68
Well-Child Visits in the First 30 Months of Life (W30)				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	54.96%	56.31%	52.88%↓	-3.43
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	68.08%	60.53%	57.27%↓	-3.26
Child and Adolescent Well-Care Visits (WCV)				
3–11 Years	39.99%	43.66%	43.05%↓	-0.61
12–17 Years	32.03%	35.55%	36.36%↓	0.81
18–21 Years	16.64%	16.80%	15.99%↓	-0.81
Total	33.70%	36.57%	36.70%↓	0.13
Women's Health and Maternity Care				
Breast Cancer Screening (BCS)				
Breast Cancer Screening	44.68%	40.99%	41.49%↓	0.50
Chlamydia Screening in Women (CHL)				
16–20 Years	—	46.84%	46.74%↓	-0.10
21–24 Years	—	56.73%	59.67%↓	2.94
Total	—	53.07%	54.57%↓	1.50
Postpartum Depression Screening and Follow-Up (PDS)^				
Depression Screening	—	—	0.00%	NC
Follow-Up on Positive Screen	—	—	NA	NC
Prenatal and Postpartum Care (PPC)				
Timeliness of Prenatal Care	71.53%	73.24%	66.42%↓	-6.82
Postpartum Care	58.64%	62.77%	61.07%↓	-1.70
Prenatal Depression Screening and Follow-Up (PND)^				
Screening	—	—	0.00%	NC

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	MY 2021–MY 2022 Rate Comparison
Follow Up	—	—	NA	NC
Prenatal Immunization Status (PRS)^				
Influenza	—	—	4.48%↓	NC
Tdap	—	—	10.57%↓	NC
Combination	—	—	2.81%↓	NC
Care for Chronic Conditions				
Asthma Medication Ratio (AMR)				
5–11 Years	—	72.58%	62.86%↓	-9.72
12–18 Years	—	53.19%	42.25%↓	-10.94
5–18 Years (Child Core Set Total)	—	—	52.48%	NC
19–50 Years	—	34.09%	36.00%↓	1.91
51–64 Years	—	37.66%	48.67%↓	11.01
19–64 Years (Adult Core Set Total)	—	—	39.27%	NC
Total (5–64 Years)	—	42.00%	42.49%↓	0.49
Blood Pressure Control for Patients With Diabetes (BPD)				
Blood Pressure Control (<140/90 mm Hg)	36.50%	44.28%	49.15%↓	4.87
Controlling High Blood Pressure (CBP)				
Controlling High Blood Pressure	32.85%	40.88%	53.04%↓	12.16
Eye Exam for Patients With Diabetes (EED)				
Eye Exam (Retinal) Performed	50.36%	49.39%	45.50%↓	-3.89
Hemoglobin A1c Control for Patients With Diabetes (HBD)				
*Poor HbA1c Control**	56.45%	52.07%	49.88%↓	-2.19
HbA1c Control (<8%)	37.47%	42.82%	44.04%↓	1.22
Kidney Health Evaluation for Patients With Diabetes (KED)				
18–64 Years	27.22%	28.89%	28.97%↓	0.08
65–74 Years	NA	41.18%	43.75%↑	2.57
75–85 Years	NA	NA	NA	NC
Total	27.40%	29.05%	29.13%↓	0.08

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	MY 2021–MY 2022 Rate Comparison
Behavioral Health				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	39.32%	41.14%	41.30%↓	0.16
Antidepressant Medication Management (AMM)				
Effective Acute Phase Treatment	—	54.56%	52.64%↓	-1.92
Effective Continuation Phase Treatment	—	39.57%	34.42%↓	-5.15
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	69.19%	71.56%	70.78%↓	-0.78
Follow-Up After Emergency Department Visit for Substance Use (FUA)[1]				
7-Day Follow-Up—Total	—	—	20.56%	NC
30-Day Follow-Up—Total	—	—	29.41%	NC
Follow-Up After Emergency Department Visit for Mental Illness (FUM)				
7-Day Follow-Up—Total	42.96%	40.19%	**48.49%**↑	8.30
30-Day Follow-Up—Total	53.66%	48.43%	**57.10%**↑	8.67
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)^				
7-Day Follow-Up—Total	—	—	16.60%↓	NC
30-Day Follow-Up—Total	—	—	30.71%↓	NC
Follow-Up After Hospitalization for Mental Illness (FUH)				
7-Day Follow-Up—Total	36.69%	31.07%	28.87%↓	-2.20
30-Day Follow-Up—Total	54.62%	45.99%	45.17%↓	-0.82
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
Initiation Phase	47.71%	49.02%	47.79%↑	-1.23
Continuation and Maintenance Phase	NA	NA	NA	NC
Initiation and Engagement of Substance Use Disorder Treatment (IET)[1]				
Initiation of SUD Treatment—Total (Total)	—	—	43.57%	NC

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	MY 2021–MY 2022 Rate Comparison
Engagement of SUD Treatment—Total (Total)	—	—	13.70%	NC
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)				
Blood Glucose and Cholesterol Testing—Total	25.41%	34.17%	29.39%↓	-4.78
Screening for Depression and Follow-Up Plan (CDF-CH/CDF-AD) ^				
12–17 Years	—	—	NA	NC
18–64 Years	—	—	1.72%	NC
65+ Years	—	—	3.42%	NC
Total (12+ Years)	—	—	1.73%	NC
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)				
1–11 Years	—	NA	45.24%↓	NC
12–17 Years	—	51.61%	42.65%↓	-8.96
Total	—	53.06%	43.64%↓	-9.42
Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)^				
Rate 1: Total	—	—	54.72%	NC
Rate 2: Buprenorphine	—	—	28.53%	NC
Rate 3: Oral Naltrexone	—	—	3.22%	NC
Rate 4: Long-Acting, Injectable Naltrexone	—	—	0.66%	NC
Rate 5: Methadone	—	—	25.82%	NC
Utilization				
Ambulatory Care—Total (per 1,000 Member Years) (AMB)**^				
*ED Visits—Total**	576.10	549.11	575.18	26.07
Outpatient Visits—Total	3,008.04	2,851.48	2,472.90	-378.58
Plan All-Cause Readmissions (PCR)				
*Observed Readmissions—Total**	13.58%	12.58%	**11.18%**	-1.40
Expected Readmissions—Total	10.30%	9.59%	9.63%	0.04
Observed/Expected (O/E) Ratio—Total	1.3190	1.3118	1.1608	-0.15
Outliers—Total	24.31	42.07	48.53	6.46

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	MY 2021–MY 2022 Rate Comparison
Overuse/Appropriateness of Care				
Risk of Continued Opioid Use (COU)*^				
At Least 15 Days Covered—Total	—	—	7.87%↓	NC
At Least 31 Days Covered—Total	—	—	5.88%↓	NC
Use of Opioids at High Dosage (HDO)*				
Use of Opioids at High Dosage	4.50%	4.14%	**4.88%**↓	0.74
Use of Opioids From Multiple Providers (UOP)*				
Multiple Prescribers	24.93%	17.52%	**21.43%**↓	3.91
*Multiple Pharmacies^*	0.62%	0.39%	**0.24%**↑	-0.15
*Multiple Prescribers and Multiple Pharmacies^*	0.18%	0.08%	**0.10%**↑	0.02

[1] Due to significant changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS MY 2022 and prior years. Due to the QISMC goals being based on HEDIS MY 2020 statewide aggregate rates, the MY 2022 rate was not compared to an MPS.
↑ Indicates the MY 2022 rate was above NCQA's Quality Compass HEDIS 2022 Medicaid HMO 50th percentile benchmark.
↓ Indicates the MY 2022 rate was below NCQA's Quality Compass HEDIS 2022 Medicaid HMO 50th percentile benchmark.
* A lower rate indicates better performance for this measure.
** Beginning MY 2022, this rate is reported per 1,000 member years instead of per 1,000 member months; the rates for the prior two years were converted to member years for comparison.
— Indicates that the MCO was not previously required to report this measure or that the rate is not appropriate to display due to changes in the technical specifications resulting in a break in trending.
^ Indicates MY 2022 QISMC goals are unavailable for this measure or indicator.
NC indicates the MY 2021–MY 2022 Rate Comparison could not be calculated because data are not available for both years.
NA indicates that the MCO followed the specifications, but the denominator was too small (i.e., <30) to report a valid rate.
Bolded rates indicate that the MY 2022 performance measure rate was at or above the MPS.

Indicates that the MY 2022 rate declined by 5 percentage points or more from MY 2021.

Indicates that the MY 2022 rate improved by 5 percentage points or more from MY 2021.

Table 3-44—Nevada Check Up SFY 2023 Performance Measure Results and Trending for SilverSummit

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	MY 2021–MY 2022 Rate Comparison
Children's Preventive Care				
Childhood Immunization Status (CIS)				
Combination 3	81.40%	75.51%	53.33%↓	-22.18
Combination 7	74.42%	69.39%	48.89%↓	-20.50
Combination 10	46.51%	42.86%	24.44%↓	-18.42
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	90.63%	86.02%	80.53%↑	-5.49
Combination 2 (Meningococcal, Tdap, HPV)	43.75%	26.88%	32.74%↓	5.86
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile—Total	76.64%	75.43%	46.13%↓	-29.30
Counseling for Nutrition—Total	67.88%	65.45%	38.25%↓	-27.20
Counseling for Physical Activity—Total	66.42%	62.04%	33.91%↓	-28.13
Well-Child Visits in the First 30 Months of Life (W30)				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	56.25%	NA	NA	NC
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	85.42%	69.77%	51.16%↓	-18.61
Child and Adolescent Well-Care Visits (WCV)				
3–11 Years	44.81%	43.39%	43.02%↓	-0.37
12–17 Years	40.76%	39.79%	38.44%↓	-1.35
18–21 Years	21.84%	29.91%	23.17%↓	-6.74
Total	41.56%	40.95%	39.43%↓	-1.52
Women's Health and Maternity Care				
Chlamydia Screening in Women (CHL)				
16–20 Years	—	34.15%	27.27%↓	-6.88
21–24 Years	—	NA	NA	NC
Total	—	34.15%	27.27%↓	-6.88

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	MY 2021–MY 2022 Rate Comparison
Prenatal and Postpartum Care (PPC)				
Timeliness of Prenatal Care	—	—	NA	NC
Postpartum Care	—	—	NA	NC
Care for Chronic Conditions				
Asthma Medication Ratio (AMR)				
5–11 Years	—	NA	NA	NC
12–18 Years	—	NA	NA	NC
5–18 Years (Child Core Set Total)	—	—	NA	NC
19–50 Years	—	NA	NA	NC
51–64 Years	—	NA	NA	NC
19–64 Years (Adult Core Set Total)	—	—	NA	NC
Total	—	NA	NA	NC
Behavioral Health				
Follow-Up After Emergency Department Visit for Substance Use (FUA)^,[1]				
7-Day Follow-Up—Total	—	—	NA	NC
30-Day Follow-Up—Total	—	—	NA	NC
Follow-Up After Emergency Department Visit for Mental Illness (FUM)				
7-Day Follow-Up—Total	NA	NA	NA	NC
30-Day Follow-Up—Total	NA	NA	NA	NC
Follow-Up After Hospitalization for Mental Illness (FUH)				
7-Day Follow-Up—Total	NA	NA	NA	NC
30-Day Follow-Up—Total	NA	NA	NA	NC
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
Initiation Phase	NA	NA	NA	NC
Continuation and Maintenance Phase	NA	NA	NA	NC
Initiation and Engagement of Substance Use Disorder Treatment (IET)[1]				
Initiation of SUD Treatment—Total (Total)	—	—	NA	NC
Engagement of SUD Treatment—Total (Total)	—	—	NA	NC

Performance Measure	MY 2020 Rate	MY 2021 Rate	MY 2022 Rate	MY 2021–MY 2022 Rate Comparison
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)				
Blood Glucose and Cholesterol Testing—Total	NA	NA	NA	NC
Screening for Depression and Follow-Up Plan (CDF-CH/CDF-AD)^				
12–17 Years	—	—	NA	NC
18–64 Years	—	—	0.00%	NC
65+ Years	—	—	NA	NC
Total (12+ Years)	—	—	0.00%	NC
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)^				
1–11 Years	—	NA	NA	NC
12–17 Years	—	NA	NA	NC
Total	—	NA	NA	NC
Utilization				
Ambulatory Care—Total (per 1,000 Member Years) (AMB)^**				
*ED Visits—Total**	184.90	216.27	256.66	40.39
Outpatient Visits—Total	2,021.10	1,906.61	1,873.91	-32.70

[1] Due to significant changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS MY 2022 and prior years. Due to the QISMC goals being based on HEDIS MY 2020 statewide aggregate rates, the MY 2022 rate was not compared to an MPS.

↑ Indicates the MY 2022 rate was above NCQA's Quality Compass HEDIS 2022 Medicaid HMO 50th percentile benchmark.

↓ Indicates the MY 2022 rate was below NCQA's Quality Compass HEDIS 2022 Medicaid HMO 50th percentile benchmark.

* A lower rate indicates better performance for this measure.

** Beginning MY 2022, this rate is reported per 1,000 member years instead of per 1,000 member months; the rates for the prior two years were converted to member years for comparison.

— Indicates that the MCO was not previously required to report this measure or that the rate is not appropriate to display due to changes in the technical specifications resulting in a break in trending.

^ Indicates MY 2022 QISMC goals are unavailable for this measure or indicator.

NC indicates the MY 2021–MY 2022 Rate Comparison could not be calculated because data are not available for both years.

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

Indicates that the MY 2022 rate declined by 5 percentage points or more from MY 2021.

Indicates that the MY 2022 rate improved by 5 percentage points or more from MY 2021.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Within the Care for Chronic Conditions domain, **SilverSummit**'s Medicaid rates increased more than 10 percentage points from the prior MY for the *Asthma Medication Ratio—51–64 Years* and *Controlling High Blood Pressure* measure indicators, suggesting that **SilverSummit**'s Medicaid members are receiving appropriate screenings and treatment for managing blood pressure, and that members ages 51–64 years with asthma are receiving appropriate medication management, which could reduce the need for rescue medication, as well as the costs associated with ER visits, inpatient admissions, and missed workdays. **[Quality** and **Timeliness]**

Strength #2: Within the Behavioral Health domain, **SilverSummit**'s Medicaid rates for the *Follow-Up After Emergency Department Visit for Mental Illness* measure indicators increased more than 5 percentage points from the prior MY and met the State's established MPS. This performance suggests **SilverSummit**'s Medicaid members diagnosed with mental illness or intentional self-harm received appropriate follow-up visits for mental illness, potentially reducing the number of repeat ED visits, improving physical and mental function, and increasing compliance with follow-up instructions. **[Quality, Timeliness,** and **Access]**

Strength #3: Within the Overuse/Appropriateness of Care domain for **SilverSummit**'s Medicaid population, **SilverSummit** met the State's established MPS for the *Use of Opioids at High Dosage* and *Use of Opioids From Multiple Providers* measure indicators, demonstrating **SilverSummit**'s dedication to ensuring its adult Medicaid members receiving opioid prescriptions are not being prescribed opioids for 15 or more days during the MY from multiple providers or pharmacies, potentially reducing the risk of opioid overuse and misuse, as well as reducing the risk of overdose. **[Quality** and **Timeliness]**

Strength #4: Within the Children's Preventive Care domain, **SilverSummit**'s Nevada Check Up performance for the *Immunizations for Adolescents—Combination 2* measure indicator rate increased more than 5 percentage points from the prior MY, suggesting its Nevada Check Up adolescent members are receiving the appropriate vaccines by their 13th birthday, which are a safe and effective way to protect adolescents against potential deadly diseases. **[Access** and **Timeliness]**

Weaknesses and Recommendations

Weakness #1: Within the Children's Preventive Care domain, **SilverSummit**'s Medicaid rate for the *Childhood Immunization Status—Combination 10* measure indicator decreased more than 5 percentage points from the prior MY, suggesting that not all members 2 years of age are receiving

the appropriate immunizations, which are essential for disease prevention and are a critical aspect of preventable care for children. **[Timeliness** and **Access]**

Why the weakness exists: SilverSummit's child Medicaid members 2 years of age are not receiving the recommended immunizations. Immunization declines may be due to disparities within **SilverSummit**'s Medicaid population that could impact access to care, such as language barriers, access to transportation, geographic location, and socioeconomic status.

Recommendation: SilverSummit self-reported that it has conducted root cause analyses and investigated interventions to ensure improved performance and member engagement across all domains of care, some of which include revising member and provider incentive models, developing educational materials, and a general increase in engagement practices. HSAG recommends that **SilverSummit** continue these interventions and as part of its implementation process, **SilverSummit** should conduct a timely evaluation to determine whether the member and provider rewards are resulting in increased and timely immunizations. **SilverSummit** should consider disparities within this population that may contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc.

Weakness #2: Overall performance was low within the Children's Preventive Care domain for **SilverSummit**'s Nevada Check Up population. **SilverSummit**'s rates for the *Childhood Immunization Status, Immunizations for Adolescents—Combination 1, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits,* and *Child and Adolescent Well-Care Visits—18–21 Years* measure indicator rates decreased more than 5 percentage points from the prior MY. Of note, rates for the *Childhood Immunization Status—Combination 3* and *Combination 7* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure indicators decreased more than 20 percentage points from the prior MY. This performance suggests that not all of **SilverSummit**'s Nevada Check Up child and adolescent members are receiving the recommended immunizations and well-care visits, which are important for avoiding vaccine-preventable diseases, as well as providing screening and counseling, which are important at every stage of life. **[Quality, Timeliness,** and **Access]**

Why the weakness exists: Although **SilverSummit**'s Nevada Check Up child and adolescent members appear to have access to well-care and preventive services, these members were not consistently using these services. Low performance in the Children's Preventive Care domain could be due to disparities within the MCO's population that could impact access to care, such as language barriers, access to transportation, geographic location, and socioeconomic status. Low performance could also potentially be attributed to the lingering impact of the COVID-19 PHE, which may have caused healthcare provider burnout and shortages, affecting provider availability.

Recommendation: SilverSummit self-reported that it has conducted root cause analyses and investigated interventions to ensure improved performance and member engagement across all domains of care for its populations, some of which include revising member and provider incentive models, developing educational materials, and a general increase in engagement practices. HSAG recommends that **SilverSummit** continue these interventions and as part of its implementation process, **SilverSummit** should conduct a timely evaluation to determine whether the member and

provider rewards are resulting in increased member well-child visits and timely immunizations. **SilverSummit** should consider disparities within this population that may contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc.

Weakness #3: SilverSummit did not meet the MPS for any performance measure rates in its Nevada Check Up population. Furthermore, **SilverSummit** did not meet the MPS for any performance measure rates for its Medicaid population other than the *Follow-Up After Emergency Department Visit for Mental Illness, Plan All-Cause Readmissions—Observed Readmissions—Total, Use of Opioids at High Dosage,* and *Use of Opioids From Multiple Providers* measure indicators. **[Quality, Timeliness,** and **Access]**

Why the weakness exists: Although **SilverSummit**'s Medicaid and Nevada Check Up members appear to have access to PCPs for preventive and ambulatory services, as well as children's and women's preventive services, these members were not consistently using these services, which can significantly reduce non-urgent ED visits and potentially prevent more serious health and development issues from occurring, reducing healthcare costs. Low performance in the Behavioral Health domain may potentially be due to low appointment availability for QMHPs to meet the demand, lack of transportation, or perceived social stigma related to seeking mental health services. The low overall performance across domains could also be due to disparities within **SilverSummit**'s populations that could impact access to care, such as language barriers, access to transportation, geographic location, and socioeconomic status. Additionally, low performance could potentially be attributed to the lingering impact of the COVID-19 PHE, which may have caused provider burnout and shortages, affecting provider availability.

Recommendation: SilverSummit should continue to conduct analyses on all performance measure rates that did not meet the MPS for the Medicaid and Nevada Check Up populations. HSAG recommends that **SilverSummit** monitor rates regularly and consider whether there are disparities within its populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, **SilverSummit** should implement appropriate interventions to improve performance across all domains of care. **SilverSummit** should also continue its collaboration between grievance and appeals and quality of care teams to identify possible barriers to member care and experience.

Weakness #4: Within the Women's Health and Maternity Care domain, **SilverSummit**'s Medicaid rate for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure indicator decreased more than 5 percentage points from the prior MY, indicating not all Medicaid women members are receiving timely prenatal care, which can set the stage for the long-term health of new mothers and their infants, as well as potentially prevent pregnancy-related deaths. In addition, **SilverSummit**'s Nevada Check Up rate for *Chlamydia Screening in Women—16–20 Years* decreased more than 5 percentage points from the prior MY, suggesting that not all Nevada Check Up women ages 16–20 years of age who are sexually active received at least one test for chlamydia during the MY. Untreated chlamydia infections may lead to serious, irreversible complications. **[Quality, Timeliness,** and **Access]**

Why the weakness exists: Although **SilverSummit**'s Medicaid and Nevada Check Up women members appear to have access to PCPs for women's preventive services, these members were not

consistently utilizing these services, which can significantly reduce non-urgent ED visits and potentially prevent more serious health issues from occurring, reducing healthcare costs. The low performance could also be due to disparities within the MCO's populations that could impact access to care, such as language barriers, access to transportation, geographic location, and socioeconomic status.

Recommendation: SilverSummit should conduct root cause analyses to determine why its Medicaid women members are not receiving timely prenatal care visits and why its Nevada Check Up women members who are sexually active are not receiving appropriate screening for chlamydia. **SilverSummit** should consider disparities within these populations that may be contributing to low performance for these measures.

Compliance Review

Performance Results

Table 3-45 presents an overview of the results of the SFY 2021 and SFY 2022 compliance reviews for **SilverSummit**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements (i.e., requirements) it reviewed. If a requirement was not applicable to **SilverSummit** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all 14 standards.

Table 3-45—Summary of Standard Compliance Scores

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Disenrollment: Requirements and Limitations	7	7	7	0	0	**100%**
Standard II—Member Rights and Member Information	22	22	17	5	0	**77%**
Standard III—Emergency and Poststabilization Services	10	10	10	0	0	**100%**
Standard IV—Availability of Services	10	10	9	1	0	**90%**
Standard V—Assurances of Adequate Capacity and Services	2	2	2	0	0	**100%**
Standard VI—Coordination and Continuity of Care	17	17	12	5	0	**71%**
Standard VII—Coverage and Authorization of Services	15	15	10	5	0	**67%**
Standard VIII—Provider Selection	12	12	10	2	0	**83%**
Standard IX—Confidentiality	11	11	11	0	0	**100%**
Standard X—Grievance and Appeal Systems	38	38	29	9	0	**76%**

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard XI—Subcontractual Relationships and Delegation	7	7	5	2	0	**71%**
Standard XII—Practice Guidelines	10	10	10	0	0	**100%**
Standard XIII—Health Information Systems[1]	14	14	14	0	0	**100%**
Standard XIV—Quality Assessment and Performance Improvement Program	42	39	38	1	3	**97%**
Total	**217**	**214**	**184**	**30**	**3**	**86%**

M = Met*; *NM = Not Met*; *NA = Not Applicable
Total Elements: The total number of elements within each standard.
Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.
Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.
[1] This standard includes a comprehensive assessment of the MCO's IS capabilities.

Review of Corrective Action Plan Implementation

Based on the findings from the SFY 2021 and SFY 2022 compliance review activities, **SilverSummit** was required to develop and submit a CAP for each element assigned a score of *Not Met*. The CAP was reviewed by DHCFP and HSAG for sufficiency, and **SilverSummit** was responsible for implementing each action plan in a timely manner. Table 3-46 presents an overview of the results of the SFY 2023 compliance review for **SilverSummit** which consisted of a comprehensive review of the MCO's implementation of each action plan. HSAG assigned a score of *Complete* or *Not Complete* to each of the individual elements that required a CAP based on a scoring methodology, which is detailed in Appendix A.

Table 3-46—Summary of Corrective Action Plan Implementation

Standard	Total CAP Elements	# CAP Elements *Complete*	# CAP Elements *Not Complete*
Standard II—Member Rights and Member Information	5	4	**1**
Standard IV—Availability of Services	1	1	**0**
Standard VI—Coordination and Continuity of Care	5	5	**0**
Standard VII—Coverage and Authorization of Services	5	5	**0**
Standard VIII—Provider Selection	2	2	**0**
Standard X—Grievance and Appeal Systems	9	9	**0**
Standard XI—Subcontractual Relationships and Delegation	2	2	**0**

Standard	Total CAP Elements	# CAP Elements *Complete*	# CAP Elements *Not Complete*
Standard XIV—Quality Assessment and Performance Improvement Program	1	1	**0**
Total	**30**	**29**	**1**

Total CAP Elements: The total number of elements within each standard that required a CAP during the SFY 2021 and SFY 2022 compliance review activities.
 # CAP Elements *Complete*: The total number of CAP elements within each standard that were fully remediated at the time of the site review and demonstrated compliance with the requirement under review.
 # CAP Elements *Not Complete*: The total number of CAP elements within each standard that were not fully remediated at the time of the site review and/or did not demonstrate compliance with the requirement under review.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the compliance review activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the compliance review have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: SilverSummit demonstrated that it successfully remediated 29 of 30 elements, indicating that the necessary policies, procedures, and interventions were implemented to ensure compliance with the requirements under review. Further, **SilverSummit** remediated all elements for seven of the eight standards reviewed: Availability of Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Provider Selection, Grievance and Appeal Systems, Subcontractual Relationships and Delegation, and Quality Assessment and Performance Improvement Program [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: SilverSummit did not remediate one of the five elements for the Member Rights and Member Information standard, indicating continued gaps in the MCO's processes that ensured all member materials critical to obtaining services included taglines in conspicuously visible font. [**Quality**]

Why the weakness exists: Although **SilverSummit** submitted member materials with appropriate taglines, not all member materials consistently contained taglines in a conspicuously visible font. In follow-up, **SilverSummit** provided a copy of an email exchange from the MCO to its print vendor instructing the vendor that taglines should be in a 12-point font in the provider directory. However, according to 42 CFR §438.10(d)(3), taglines should be in a conspicuously visible font. Therefore, **SilverSummit**'s provider directory taglines did not meet the intent of this requirement as they were in a 12-point font.

Recommendation: HSAG required **SilverSummit** to submit an action plan to address the deficiencies and provide assurances that all critical member materials include taglines in a conspicuously visible font. Additionally, HSAG recommends that **SilverSummit** conduct ongoing formal staff training on requirements pertaining to the development of member informational materials and audit materials regularly to confirm they continue to meet the requirements under 42 CFR §438.10.

Network Adequacy Validation

Performance Results

Table 3-47 presents **SilverSummit**'s network capacity analysis results and compares the provider ratios to the standards displayed in Table 3-4. Assessed provider ratios results shown in green indicate that the percentage of members within the access standard was in compliance, and percentages shown in red indicate a result of less than 99.0 percent.

Table 3-47—Summary of Ratio Analysis Results for PCPs and Specialty Care Providers for SilverSummit

Provider Category	Providers*	Clark County Ratio	Washoe County Ratio	Statewide Ratio**
PCPs (1:1,500)	1,928	1:63	1:8	1:71
PCP Extenders (1:1,800)	1,784	1:41	1:6	1:47
Physician Specialists (1:1,500)	1,785	1:68	1:9	1:77

Note: Results shown in green font indicate the result complies with the access standard; results shown in red font indicate the result does not comply with the access standard; PCP: Primary Care Provider.

* Providers contracted statewide and contracted providers located in the Nevada Medicaid catchment areas were included in provider counts.

** Statewide ratio incorporates all Nevada counties included in the DHCFP member file submission and members enrolled with the MCO as of December 1, 2022.

Table 3-48 presents **SilverSummit**'s geographic network distribution analysis and presents the percentage of members who had access to provider locations within the standards displayed in Table 3-5. Assessed results shown in green indicate that the percentage of members within the access standard was in compliance, and percentages shown in red indicate a result of less than 99.0 percent.

Table 3-48—Percentage of Members With Required Access by Provider Category for SilverSummit

Provider Category	Clark County	Washoe County	Statewide*
Primary Care Providers			
Primary Care, Adults (10 miles/15 mins)	99.9%	99.4%	99.8%
OB/GYN (10 miles/15 mins)	99.5%	97.5%	99.2%
Pediatrician (10 miles/15 mins)	>99.9%	97.7%	99.6%

Provider Category	Clark County	Washoe County	Statewide*
Physician Specialists			
Endocrinologist (40 miles/60 mins)	>99.9%	100.0%	99.9%
Endocrinologist, Pediatric (40 miles/60 mins)	>99.9%	100.0%	>99.9%
Infectious Disease (40 miles/60 mins)	>99.9%	100.0%	99.9%
Infectious Disease, Pediatric (40 miles/60 mins)	>99.9%	100.0%	>99.9%
Oncologist/Radiologist (40 miles/60 mins)	>99.9%	100.0%	99.9%
Oncologist—Medical/Surgical (30 miles/45 mins)	>99.9%	100.0%	99.9%
Oncologist—Medical/Surgical, Pediatric (30 miles/45 mins)	>99.9%	100.0%	99.9%
Rheumatologist (40 miles/60 mins)	>99.9%	100.0%	99.9%
Rheumatologist, Pediatric (40 miles/60 mins)	>99.9%	0.0%	88.7%
Behavioral Health Providers			
Board Certified Child and Adolescent Psychiatrist (30 miles/45 mins)	100.0%	100.0%	99.9%
Psychiatrist (30 miles/45 mins)	>99.9%	100.0%	99.9%
Psychologist (30 miles/45 mins)	>99.9%	100.0%	99.9%
Psychologist, Pediatric (30 miles/45 mins)	>99.9%	99.4%	99.8%
QMHP (30 miles/45 mins)	100.0%	100.0%	>99.9%
QMHP, Pediatric (30 miles/45 mins)	100.0%	100.0%	99.9%
Facility-Level Providers			
Hospitals, All (30 miles/45 mins)	>99.9%	100.0%	>99.9%
Pharmacy (10 miles/15 mins)	>99.9%	99.5%	>99.9%
Psychiatric Inpatient Hospital (30 miles/45 mins)	>99.9%	>99.9%	>99.9%
Dialysis/ESRD Facility (30 miles/45 mins)	>99.9%	100.0%	>99.9%

Note: Results shown in green font indicate the result complies with the access standard; results shown in red font indicate that less than 99.0 percent of members had access to the provider within the time and distance access standard.
* Statewide results incorporate all Nevada counties included in the DHCFP member file submission and members enrolled with the MCO as of December 1, 2022.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the NAV findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: SilverSummit met the provider ratio requirements for PCPs, PCP Extenders, and Physician Specialists in both Clark and Washoe counties, indicating **SilverSummit** had a sufficient provider network for its members to access services. **[Access]**

Strength #2: SilverSummit met the time-distance contract standards for Board Certified Child and Adolescent Psychiatrist, QMHP, and Pediatric QMHP in both Clark and Washoe counties. In Washoe County, **SilverSummit** met the time-distance contract standards for eight of nine physician specialists providers, five of six behavioral health providers, and two of four facility-level providers. **[Access]**

Strength #3: SilverSummit improved access to Pediatric Psychologists in Washoe County from 0 percent of residents with access in SFY 2022 to 99.4 percent of residents with access in SFY 2023. In Washoe County, **SilverSummit** met the 100 percent access standard for 15 of the provider categories, which is in an increase from seven categories in SFY 2022.[3-8] **[Access]**

Weaknesses and Recommendations

Weakness #1: SilverSummit did not meet the time-distance contract standards for Pediatric Rheumatologists, indicating members may experience challenges accessing these provider types within an adequate time or distance from their residence. **[Access]**

Why the weakness exists: None of the four MCOs met the contract standard for Pediatric Rheumatologists in Washoe County, indicating a lack of this provider type within this county. Specifically, there were no pediatric rheumatologists practicing in Washoe County or available for contracting.

Recommendation: HSAG recommends that **SilverSummit** consider collaborating with DHCFP and the other MCOs to determine whether community reinvestment funds can be used to incentivize pediatric rheumatologists to join a rheumatology clinic in Washoe County.

Weakness #2: SilverSummit did not meet the time-distance contract standard for OB/GYN and Pediatrician provider types, indicating members may experience challenges accessing those provider types within an adequate time or distance from their residence. **[Access]**

Why the weakness exists: None of the four MCOs met the contract standard for OB/GYN, specifically in Washoe County, and three of the four MCOs did not meet the contract standard for the Pediatrician provider type, further suggesting that limited providers were available for contracting.

Recommendation: HSAG recommends that **SilverSummit** continue to review DHCFP's monthly enrolled provider list to determine whether new providers are available for contracting.

3-8 For SFY 2022 EQR results, refer to the Division of Health Care Financing and Policy Nevada Managed Care Program State Fiscal Year 2022 External Quality Review Technical Report at https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Resources/AdminSupport/Reports/NV2022_EQR-TR_F1.pdf.

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results

Table 3-49 presents the 2023 CAHPS top-box scores for **SilverSummit**'s adult Medicaid, general child Medicaid, CCC Medicaid, Nevada Check Up general child, and Nevada Check Up CCC populations. Arrows (↓ or ↑) indicate 2023 scores that were statistically significantly higher or lower than the 2022 national average.[3-9]

Table 3-49—Summary of 2023 CAHPS Top-Box Scores for SilverSummit

	Adult Medicaid	General Child Medicaid	CCC Medicaid	Nevada Check Up General Child	Nevada Check Up CCC
Composite Measures					
Getting Needed Care	76.0%	NA	NA	NA	NA
Getting Care Quickly	NA	NA	NA	NA	NA
How Well Doctors Communicate	NA	NA	NA	NA	NA
Customer Service	NA	NA	NA	NA	NA
Global Ratings					
Rating of All Health Care	51.8%	NA	NA	NA	NA
Rating of Personal Doctor	63.6%	NA	NA	NA	NA
Rating of Specialist Seen Most Often	NA	NA	NA	NA	NA
Rating of Health Plan	59.3%	NA	NA	NA	NA
Effectiveness of Care*					
Advising Smokers and Tobacco Users to Quit	NA	—	—	—	—
Discussing Cessation Medications	NA	—	—	—	—
Discussing Cessation Strategies	NA	—	—	—	—
CCC Composite Measures/Items					
Access to Specialized Services	—	—	NA	—	NA
Family Centered Care (FCC): Personal Doctor Who Knows Child	—	—	NA	—	NA

[3-9] 2023 national average results were not available at the time this report was produced.

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

A minimum of 100 respondents is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of respondents are denoted as *NA*.
* These scores follow NCQA's methodology of calculating a rolling two-year average.
↑ Indicates the 2023 score is statistically significantly higher than the 2022 national average.
↓ Indicates the 2023 score is statistically significantly lower than the 2022 national average.
— Indicates the measure does not apply to the population.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the CAHPS activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine any significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: HSAG did not identify any strengths for **SilverSummit** for the CAHPS surveys.

Weaknesses and Recommendations

Weakness #1: There were less than 100 respondents for every measure for the child populations and most measures for the adult population; therefore, results could not be reported for the applicable measures and strengths and weaknesses could not be identified for the associated populations. **[Quality, Timeliness, Access]**

Why the weakness exists: Adult members and parents/caretakers of child members are less likely to respond to the CAHPS survey. Completion of surveys may be exceptionally low on the list of priorities for members struggling with illness, unemployment, and/or other life-changing events.

Recommendation: HSAG recommends that **SilverSummit** focus on increasing response rates to the CAHPS survey for all populations so there are greater than 100 respondents for each measure by educating and engaging all employees to increase their knowledge of CAHPS, using customer service techniques, oversampling, using innovative outreach strategies to follow up with non-respondents, and continuing to provide awareness to members and providers during the survey period.

Overall Conclusions for Quality, Timeliness, and Access to Healthcare Services

HSAG performed a comprehensive assessment of **SilverSummit**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **SilverSummit** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **SilverSummit**'s overall performance contributed to the Nevada Managed Care Program's progress in achieving the Quality Strategy goals and objectives. Table 3-50 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided **SilverSummit**'s Medicaid and Nevada Check Up members.

Table 3-50—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Increase Use of Preventive Services	**Quality**, **Timeliness**, and **Access**—**SilverSummit** demonstrated through the three-year compliance review cycle that it had appropriate practices for ensuring providers were aware of its adopted practice guidelines, which should include guidelines for preventive care. However, **SilverSummit** did not achieve the DHCFP-established MPS for any performance measure included in the Medicaid Access to Care and Medicaid or Nevada Check Up Children's Preventive Care domains. Additionally, for the Medicaid population, all indicator rates under the *Adults' Access to Preventive/Ambulatory Health Services* measure declined substantially, between 2.22 and 4.72 percentage points; all indicator rates under the Children's Preventive Care domain for the *Childhood Immunization Status* measure declined substantially or significantly, between 3.16 and 5.59 percentage points; and both indicator rates under the *Well-Child Visits in the First 30 Months of Life* measure declined substantially, between 3.26 and 3.43 percentage points. For the Nevada Check Up population under the Children's Preventive Care domain, all indicator rates under the *Childhood Immunization Status* declined significantly from the prior year, between 18.42 and 22.18 percentage points. Although the rate for the *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)* measure indicator improved significantly, the *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* declined significantly, by 5.49 percentage points. The three indicator rates under the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure declined significantly, between 27.20 and 29.30 percentage points. The *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* declined significantly, by 18.61 percentage points, and all indicator rates under the *Child and Adolescent Well-Care Visits* measure declined between 0.37 and 6.74 percentage points. **SilverSummit** appeared to have a sufficient number of PCPs to provide well-care services; however, not all **SilverSummit** members in Washoe County were able to access a pediatrician within 10 miles or 15 minutes of their homes as indicated through the NAV activity, which may have been a barrier to some members living in Washoe County accessing preventive services. Additionally, many females in **SilverSummit**'s Medicaid population were not being screened for breast cancer and chlamydia, and performance in the Women's

Performance Area	Overall Performance Impact
	Health and Maternity Care domain related to these preventive services has been relatively stagnant over time for the Medicaid population. For the Nevada Check Up population, both the *Chlamydia Screening in Women—16–20 Years* and *Chlamydia Screening in Women—Total* measure indicator rates declined by 6.88 percentage points, indicating many teenaged women in the Nevada Check Up population were not being tested for this sexually transmitted disease. Based on these overall findings, **SilverSummit** has significant opportunities to mitigate any barriers to members receiving preventive care, and to implement interventions to support improvement in the use of preventive services for its adult and child members and contribute to the Nevada Managed Care Program's progress toward achieving Goal 1 of the Quality Strategy to *improve the Health and Wellness of Nevada's Medicaid population by increasing the use of preventive services by December 31, 2024*. Preventive care is crucial to staying healthy and identifying problems early on before they contribute to other issues or become harder to treat. Immunizations are also essential to prevent diseases, such as diphtheria, meningitis, measles, polio, tetanus, and whooping cough, and are a critical aspect of preventable care.
Increase Use of Evidence-Based Practices for Members With Chronic Conditions	**Quality**, **Timeliness**, and **Access**—Although **SilverSummit** demonstrated that it had a robust network of PCPs and endocrinologists through the NAV activity and demonstrated significant improvement in the prior year's rates for the *Asthma Medication Ratio—51–64 Years* and *Controlling High Blood Pressure* measure indicators for the Medicaid population, it did not achieve the DHCFP-established MPS for any reportable performance measures included in the Care for Chronic Conditions domain, and the rates for the *Asthma Medication Ratio—5–11 Years* and *12–18 Years* measure indicators also declined significantly from the prior year. As such, **SilverSummit** must implement interventions to support improvement in the use of evidence-based practices for members diagnosed with chronic conditions (i.e., diabetes, asthma, hypertension) and contribute to the Nevada Managed Care Program's progress toward achieving Goal 2 of the Quality Strategy to *increase use of evidence-based practices for members with chronic conditions by December 31, 2024.* Proper diabetes management is important to control blood glucose and reduce risks for complications; medication management for members with asthma can reduce the need for rescue medications and the costs associated with emergency room visits and inpatient admissions; and reducing hypertension mitigates damage to members' hearts and reduces the risks for additional health problems.
Reduce Misuse of Opioids	**Quality—SilverSummit** met the established MPS and demonstrated adequate oversight of its provider network specific to the prescribing and filling of opioids as indicated by a relatively low prevalence of high-risk opioid analgesic prescribing practices, multiple prescribers prescribing opioids, and multiple pharmacies filling the prescriptions. Through these findings, **SilverSummit** demonstrated its contribution to the Nevada Managed Care Program's achievement of the two related objectives under Goal 3 of the Quality Strategy to *reduce misuse of opioids by December 31, 2024,* and supported the reduction of opioid-related overdose deaths. For SFY 2023, **SilverSummit** was also required

Performance Area	Overall Performance Impact
	to report two indicators for the *Risk of Continued Opioid Use* measure. Although no MPS was yet established, **SilverSummit** performed below NCQA's Quality Compass HEDIS 2022 Medicaid HMO 50th percentile benchmark, indicating **SilverSummit** should continue to monitor high-risk opioid analgesic prescribing practices and educate providers and members to mitigate the risk of OUD, opioid-related overdose, hospitalization, and opioid overdose-related mortality, and to further contribute to the Nevada Managed Care Program's achievement of reducing the misuse of opioids.
Improve Health and Wellness of Pregnant Women	**Quality**, **Timeliness**, and **Access**—**SilverSummit** did not achieve the DHCFP-established MPS or perform above NCQA's Quality Compass HEDIS 2022 Medicaid HMO 50th percentile benchmark for any reportable and applicable performance measures included in the Women's Health and Maternity Care domain for the Medicaid population that support Goal 4 of the Quality Strategy to *improve the health and wellness of pregnant women and infants by December 31, 2024*. The rate for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure indicator also declined significantly from the prior year. Further, both *Prenatal and Postpartum Care* measure indicator rates also fell well below the Medicaid aggregate rate, and as indicated through the NAV activity, pregnant members in Washoe County may have experienced issues accessing OB/GYNs near their homes. Timely and adequate prenatal and postpartum care supports long-term health and well-being of new mothers and their babies. For SFY 2023, **SilverSummit** was also required to report on three new measures, *Postpartum Depression Screening and Follow-Up*, *Prenatal Depression Screening and Follow-Up*, and *Prenatal Immunization Status*, which align to five new objectives in the Quality Strategy under Goal 4. Although **SilverSummit**'s performance was not assessed against a DHCFP-established MPS since MY 2022 was the baseline rate for the new measures, **SilverSummit** should work with its OB/GYN providers and other providers such as PCPs, as applicable, to increase prenatal and postpartum depression screenings and to increase the percentage of members receiving the influenza and tetanus, diphtheria, and pertussis vaccines during pregnancy. Higher performance in these areas should support improved health outcomes for both mom and baby. **SilverSummit**'s provider-related initiatives should also assist the MCO with achieving the newly set MPSs as stipulated in Appendix B. Goals and Objectives Tracking under the New Measurement Year 2023 Minimum Performance Standards section and further support the Nevada Managed Care Program's achievement of Goal 4 of the Quality Strategy.
Increase Use of Evidence-Based Practices for Members With Behavioral Health Conditions	**Quality**, **Timeliness**, and **Access**—**SilverSummit** demonstrated strong performance in the Behavioral Health domain related to the *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total* and *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total* measure indicator rates, which improved significantly from the prior year, met the DHCFP-established MPS, and exceeded NCQA's Quality Compass HEDIS 2022 Medicaid HMO 50th percentile benchmark. These findings indicate that **SilverSummit**'s focused efforts in this program area are contributing to the achievement of the related objectives under Goal 5 of the

Performance Area	Overall Performance Impact
	Quality Strategy to *increase use of evidence-based practices for members with behavioral health conditions by December 31, 2024*. However, the rates for the *Antidepressant Medication Management—Effective Continuation Phase Treatment* and *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—12–17 Years* and *Total* measure indicators declined significantly from the prior year, and most of the measures in the Behavioral Health domain did not meet the MPS, indicating additional opportunities for improvement. In SFY 2023, **SilverSummit** effectively designed a PIP, *Improving the Rates for Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET),* as indicated by a *Met* validation rating, which should support an improvement in the health outcomes for **SilverSummit**'s Medicaid members with alcohol or other drug dependence. In addition to this PIP, **SilverSummit** should continue with its previously implemented initiatives but also assess whether there are barriers to members seeing the contracted behavioral health providers in a timely manner for all behavioral health services, or whether other reasons are preventing members from accessing care to treat their behavioral health or substance use diagnoses. Improvement in this program area will help support the Nevada Managed Care Program in achieving the objectives under Goal 5 of the Quality Strategy to *increase use of evidence-based practices for members with behavioral health conditions by December 31, 2024*.
Reduce/Eliminate Healthcare Disparities	**Quality**, **Timeliness**, and **Access**—The aggregated findings from **SilverSummit**'s EQR activities did not produce sufficient data for HSAG to assess the impact the EQR activities had or will have on reducing and/or eliminating healthcare disparities for **SilverSummit**'s Medicaid and Nevada Check Up members other than by geographic location (i.e., through the NAV activity). To support the reduction and elimination of healthcare disparities, **SilverSummit** should continue to implement interventions through its cultural competency and population health programs and plans, stratify performance measure data by race and ethnicity, and use the data to target interventions for those areas wherein performance is lowest and members can be most impacted.

4. Assessment of Prepaid Ambulatory Health Plan Performance

HSAG used findings across mandatory EQR activities conducted during the SFY 2023 review period to evaluate the performance of the PAHP on providing quality, timely, and accessible healthcare services to Nevada Managed Care Program members. Quality, as it pertains to EQR, means the degree to which the PAHPs increased the likelihood of members' desired outcomes through structural and operational characteristics; the provision of services that were consistent with current professional, evidenced-based knowledge; and interventions for performance improvement. Access relates to members' timely use of services to achieve optimal outcomes, as evidenced by how effective the PAHPs were at successfully demonstrating and reporting on outcomes for the availability and timeliness of services.

HSAG follows a step-by-step process to aggregate and analyze data from all EQR activities and draw conclusions about the quality, timeliness, and accessibility of care furnished by the PAHP.

- **Step 1**: HSAG analyzes the quantitative results obtained from each EQR activity for the PAHP to identify strengths and weaknesses that may pertain to the domains of quality, timeliness, and access to services furnished by the PAHP for the EQR activity.
- **Step 2**: From the information collected, HSAG identifies common themes and the salient patterns that emerge across EQR activities for each domain, and HSAG draws conclusions about the overall quality, timeliness, and accessibility of care and services furnished by the PAHP.
- **Step 3**: From the information collected, HSAG identifies common themes and the salient patterns that emerge across all EQR activities as they relate to strengths and weaknesses in one or more of the domains of quality, timeliness, and accessibility of care and services furnished by the PAHP.

Objectives of External Quality Review Activities

This section of the report provides the objectives and a brief overview of each EQR activity conducted in SFY 2023 to provide context for the resulting findings of each EQR activity. For more details about each EQR activity's objectives and the comprehensive methodology, including the technical methods for data collection and analysis, a description of the data obtained and the related time period, and the process for drawing conclusions from the data, refer to Appendix A.

Validation of Performance Improvement Projects

For SFY 2023, **LIBERTY** submitted the PIP design for its selected PIP topics: a clinical PIP, *Increase Preventive Services for Children,* and a nonclinical PIP, *Coordination of Transportation Services*.

HSAG's validation activities included an evaluation of the PAHP's documentation submitted to support the first phase of the PIP process, called the Design stage, to determine the overall validity of each PIP's methodological framework. HSAG's validation of the design of each PIP included a review of the PIP topic, Aim statement, target population, sampling methods, performance indicators, and data collection

methods to ensure they were based on sound methodological principles and will support reliable reporting of measure outcomes. HSAG assigned a validation rating of *Met*, *Partially Met*, or *Not Met* to each applicable evaluation element within the Design stage of each PIP, and an overall validation rating of *Met*, *Partially Met*, or *Not Met* using the level of confidence assignment methodology defined in Appendix A.

Table 4-1 outlines the PIP topics and the Aim statements defined by the PAHP for each PIP topic. The Aim statement helps the PAHP maintain the focus of the PIPs and sets the framework for data collection, analysis, and interpretation of the results.

Table 4-1—PIP Topic and Aim Statement

Plan Name	PAHP-Selected PIP Topic	PAHP-Defined PIP Aim Statement
LIBERTY	*Increase Preventive Services for Children*	Do targeted interventions increase the percentage of eligible enrollees 0 to 20 years of age who had any topical fluoride or sealants during the measurement year?
	Coordination of Transportation Services	A. Do targeted interventions increase the success rate of transportation coordination between **LIBERTY** and the DBA's transportation vendor for enrollees to and/or from covered oral health services? B. Do targeted interventions increase the percentage of successful requests for transportation to and/or from covered oral health services that **LIBERTY** referred to and/or scheduled with the plan's transportation vendor?

Performance Measure Validation

The SFY 2023 (MY 2022) PMV activity included a comprehensive evaluation of the processes used by **LIBERTY** to collect and report data for three CMS Child Core Set performance measures selected by DHCFP for **LIBERTY**'s Medicaid and Nevada Check Up populations. Table 4-2 lists the performance measures that were validated by HSAG and the measure specifications **LIBERTY** was required to use for calculating the performance measure results.

Table 4-2—SFY 2023 Performance Measures for LIBERTY

Performance Measures	Measure Specifications*
Oral Evaluation, Dental Services (OEV-CH)	FFY 2022 Child Core Set
Sealant Receipt on Permanent First Molars (SFM-CH)	FFY 2022 Child Core Set
Topical Fluoride for Children (TFL-CH)	FFY 2022 Child Core Set

*FFY = federal fiscal year

Compliance Review

DHCFP requires its contracted PAHP to undergo periodic compliance reviews to ensure that an assessment is conducted to meet mandatory EQR requirements. The reviews focus on standards identified in 42 CFR §438.358(b)(1)(iii) and applicable state-specific contract requirements. The current three-year compliance review cycle was initiated in SFY 2021 and comprised 14 program areas referred to as standards. At DHCFP's direction, HSAG conducted a review of the first seven federally required standards and requirements in Year One (SFY 2021) and a review of the remaining federally required seven standards and requirements in Year Two (SFY 2022) of the three-year compliance review cycle. This SFY 2023 (Year Three) compliance review activity consisted of a re-review of the standards that were not fully compliant during the SFY 2021 (Year One) and SFY 2022 (Year Two) compliance review activities, as indicated by the elements (i.e., requirements) that received *Not Met* scores and required CAPs to remediate the noted deficiencies. Table 4-3 outlines the standards reviewed over the three-year review cycle.

Table 4-3—Compliance Review Standards

<table>
<tr><th>Standards</th><th>Associated Federal Citation[1]</th><th>Year One (SFY 2021)</th><th>Year Two (SFY 2022)</th><th>Year Three (SFY 2023)</th></tr>
<tr><td>Standard I—Disenrollment: Requirements and Limitations</td><td>§438.56</td><td>✓</td><td></td><td rowspan="14">Review of the PAHP's Implementation of Year One and Year Two CAPs</td></tr>
<tr><td>Standard II—Member Rights and Member Information</td><td>§438.100</td><td>✓</td><td></td></tr>
<tr><td>Standard III—Emergency and Poststabilization Services</td><td>§438.114</td><td>✓</td><td></td></tr>
<tr><td>Standard IV—Availability of Services</td><td>§438.206</td><td>✓</td><td></td></tr>
<tr><td>Standard V—Assurances of Adequate Capacity and Services</td><td>§438.207</td><td>✓</td><td></td></tr>
<tr><td>Standard VI—Coordination and Continuity of Care</td><td>§438.208</td><td>✓</td><td></td></tr>
<tr><td>Standard VII—Coverage and Authorization of Services</td><td>§438.210</td><td>✓</td><td></td></tr>
<tr><td>Standard VIII—Provider Selection</td><td>§438.214</td><td></td><td>✓</td></tr>
<tr><td>Standard IX—Confidentiality</td><td>§438.224</td><td></td><td>✓</td></tr>
<tr><td>Standard X—Grievance and Appeal Systems</td><td>§438.228</td><td></td><td>✓</td></tr>
<tr><td>Standard XI—Subcontractual Relationships and Delegation</td><td>§438.230</td><td></td><td>✓</td></tr>
<tr><td>Standard XII—Practice Guidelines</td><td>§438.236</td><td></td><td>✓</td></tr>
<tr><td>Standard XIII—Health Information Systems[2]</td><td>§438.242</td><td></td><td>✓</td></tr>
<tr><td>Standard XIV—Quality Assessment and Performance Improvement Program</td><td>§438.330</td><td></td><td>✓</td></tr>
</table>

[1] The compliance review standards comprise a review of all requirements, known as elements, under the associated federal citation, including all requirements that are cross-referenced within each federal standard, as applicable (e.g., Standard X—Grievance and Appeal Systems includes a review of §438.228 and all requirements under 42 CFR Subpart F).

[2] This standard includes a comprehensive assessment of the PAHP's IS capabilities.

HSAG HEALTH SERVICES ADVISORY GROUP

Network Adequacy Validation

The NAV activity for SFY 2023 included network capacity and geographic distribution analyses conducted after the PAHP identified provider categories by using the provider crosswalk HSAG developed in conjunction with DHCFP.

To assess the capacity of the PAHP's provider network, HSAG calculated the ratio of the number of providers by provider category (e.g., general dentists, endodontists) to the number of members.

Table 4-4 shows the provider categories used to assess the PAHP's compliance with the provider ratio standards in the PAHP contract with DHCFP.

Table 4-4—Provider Categories and Provider Ratio Standards

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

The second component of the NAV activity evaluated the geographic distribution of providers relative to each of the PAHP's members. To provide a comprehensive view of geographic access, HSAG calculated the percentage of members with access to a provider within the standards for the provider categories identified in the PAHP provider crosswalk. Table 4-5 shows the provider categories used to assess the PAHP's network adequacy and the associated time-distance standards.

Table 4-5—Provider Categories, Member Criteria, and Time-Distance Standards

Provider Category	Member Criteria	Time and Distance Access Standard to the Nearest Provider
General Dental Providers		
General Dentist	Adults	30 minutes or 20 miles
Dentist, Pediatric	Children	30 minutes or 20 miles
Mid-Level Dental Providers		
Dental Therapist	Adults	60 minutes or 40 miles
Public Health Endorsed Dental Hygienist	Adults	60 minutes or 40 miles
Dental Specialists		
Endodontist	Adults	60 minutes or 40 miles
Periodontist	Adults	60 minutes or 40 miles
Prosthodontist	Adults	60 minutes or 40 miles
Oral Surgeon	Adults	60 minutes or 40 miles

Dental Satisfaction Survey

The primary objective of the dental satisfaction survey was to effectively and efficiently obtain information on parents'/caretakers' of child members experiences with the dental care their child received through the PAHP. This survey covers topics that are important to members, such as the communication skills of dental providers and the accessibility of services. The PAHP was responsible for obtaining a CAHPS vendor to administer the dental satisfaction survey on its behalf. HSAG presents top-box scores, which indicate the percentage of respondents who reported positive experiences in a particular aspect of their child's dental care.

Table 4-6 displays the various measures of member experience.

Table 4-6—Dental Satisfaction Survey Measures of Member Experience

CAHPS Measures
Global Ratings
Rating of Regular Dentist
Rating of All Dental Care
Rating of Finding a Dentist
Rating of Dental Plan
Composite Measures
Care from Dentists and Staff
Access to Dental Care
Dental Plan Services
Individual Item Measures
Care from Regular Dentist
Would Recommend Regular Dentist
Would Recommend Dental Plan

External Quality Review Activity Results

LIBERTY Dental Plan of Nevada, Inc.

Validation of Performance Improvement Projects

Performance Results

Table 4-7 displays the overall validation ratings for the Design stage of each PIP topic. Table 4-7 also includes the performance indicators that will be used to track performance or improvement over the life of the PIP.

Table 4-7—Overall Validation Ratings for LIBERTY

PIP Topic	Validation Ratings*	Performance Indicator	Performance Indicator Results		
			Baseline	R1	R2
Increase Preventive Services for Children	*Met*	The percentage of children who received a topical fluoride application and/or sealants within the reporting year.	—	—	—
Coordination of Transportation Services	*Met*	The percentage of requests for transportation to and/or from covered oral health services **LIBERTY** referred to and/or scheduled with the plan's transportation vendor.	—	—	—
		The percentage of requests for transportation to and/or from covered oral health services that **LIBERTY** referred to and/or scheduled with the plan's transportation vendor AND where **LIBERTY** contacted the enrollee to ensure that the transportation was scheduled, and the enrollee had been notified.			

— The PIP had not progressed to including baseline or remeasurement (R1, R2) results during SFY 2023.
*The PIP activities for SFY 2023 were initiated prior to release of the 2023 CMS EQR Protocols; therefore, HSAG adhered to the guidance published in the 2019 CMS EQR Protocols. With the release of the new protocols, HSAG updated its PIP worksheets for SFY 2024 to include the two validation ratings (i.e., Overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, and the MCO conducted accurate data analysis and interpretation of PIP results; overall confidence that PIP produced significant evidence of improvement.)

Interventions

LIBERTY has established its PIP design, and the PIP will progress to the Implementation stage. During this stage, **LIBERTY** will evaluate and analyze its data, identify barriers to performance, and develop interventions targeted to improve outcomes. As the PIPs did not progress to the Implementation stage in SFY 2023, **LIBERTY**'s causal/barrier analysis process and interventions will be reported in the next annual EQR technical report (SFY 2024).

Table 4-8 and Table 4-9 will display the barriers and interventions as documented by the PAHP.

Table 4-8—Barriers Identified and Interventions Implemented/Planned for Preventive Services for Children

Barriers	Interventions
—	—
—	—

— The PIP had not progressed to the identification of barriers and the development of interventions during SFY 2023.

Table 4-9—Barriers Identified and Interventions Implemented/Planned for Coordination of Transportation Services

Barriers	Interventions
—	—
—	—

— The PIP had not progressed to the identification of barriers and the development of interventions during SFY 2023.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP validation against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP validation have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: LIBERTY developed a methodologically sound design for both PIPs that met State and federal requirements. A methodologically sound design created the foundation for **LIBERTY** to progress to subsequent PIP stages—collecting data and carrying out interventions to positively impact performance indicator results and outcomes for the project. **[Quality]**

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any weaknesses for **LIBERTY**.

Why the weakness exists: No weaknesses were identified; therefore, this section is not applicable.

Recommendation: Although no significant weaknesses were identified during the SFY 2023 PIP activities, as **LIBERTY** progresses to the Implementation stage of the PIP, HSAG recommends that **LIBERTY** develop effective strategies (i.e., interventions) that are designed to target the designated PIP populations(s) and age group(s) to successfully improve member outcomes.

Performance Measure Validation

Performance Results

Table 4-10 through Table 4-11 display **LIBERTY**'s Medicaid and Nevada Check Up CMS Child Core Set performance measure results for MY 2022. The measures selected by DHCFP are CMS Child Core Set measures; therefore, performance was not assessed against NCQA Quality Compass benchmarks. Additionally, SFY 2023 (MY 2022) is the first year **LIBERTY** reported these measures; therefore, no trending is displayed. DHCFP will determine an MPS for the QISMC goals related to these measures using the baseline rates from MY 2022, and performance will be assessed against the MPSs in SFY 2024.

Table 4-10—Medicaid SFY 2023 Performance Measure Results for LIBERTY

Performance Measures	MY 2022 Rate
Dental	
Oral Evaluation, Dental Services (OEV-CH)	
Ages <1	1.12%
Ages 1–2	19.44%
Ages 3–5	40.54%
Ages 6–7	50.41%
Ages 8–9	51.95%
Ages 10–11	50.25%
Ages 12–14	46.80%
Ages 15–18	38.08%
Ages 19–20	22.35%
Total (Ages <1–20)	39.64%
Sealant Receipt on Permanent First Molars (SFM-CH)	
Rate 1—At Least One Sealant	55.26%
Rate 2—All Four Molars	38.18%
Topical Fluoride for Children (TFL-CH)	
Rate 1—Dental or Oral Health Services—Ages 1–2	5.74%

Performance Measures	MY 2022 Rate
Rate 1—Dental or Oral Health Services—Ages 3–5	16.94%
Rate 1—Dental or Oral Health Services—Ages 6–7	22.68%
Rate 1—Dental or Oral Health Services—Ages 8–9	23.27%
Rate 1—Dental or Oral Health Services—Ages 10–11	22.16%
Rate 1—Dental or Oral Health Services—Ages 12–14	18.79%
Rate 1—Dental or Oral Health Services—Ages 15–18	12.86%
Rate 1—Dental or Oral Health Services—Ages 19–20	4.95%
Rate 1—Dental or Oral Health Services—Total (Ages <1–20)	16.25%
Rate 2—Dental Services—Ages 1–2	5.74%
Rate 2—Dental Services—Ages 3–5	16.94%
Rate 2—Dental Services—Ages 6–7	22.68%
Rate 2—Dental Services—Ages 8–9	23.27%
Rate 2—Dental Services—Ages 10–11	22.16%
Rate 2—Dental Services—Ages 12–14	18.79%
Rate 2—Dental Services—Ages 15–18	12.86%
Rate 2—Dental Services—Ages 19–20	4.95%
Rate 2—Dental Services—Total (Ages <1–20)	16.25%
Rate 3—Oral Health Services—Ages 1–2	0.00%*
Rate 3—Oral Health Services—Ages 3–5	0.00%*
Rate 3—Oral Health Services—Ages 6–7	0.00%*
Rate 3—Oral Health Services—Ages 8–9	0.00%*
Rate 3—Oral Health Services—Ages 10–11	0.00%*
Rate 3—Oral Health Services—Ages 12–14	0.00%*
Rate 3—Oral Health Services—Ages 15–18	0.00%*
Rate 3—Oral Health Services—Ages 19–20	0.00%*
Rate 3—Oral Health Services—Total (Ages <1–20)	0.00%*

* The *TFL-CH—Rate 3—Oral Health Services* measure indicator reports services provided by personnel other than dentists (e.g., Pediatricians). Since **LIBERTY** only provides services that are provided by or under the supervision of a dentist, there were no members that met the numerator criteria for this indicator; therefore, the reported rates are 0.00%.

Table 4-11—Nevada Check Up SFY 2023 Performance Measure Results for LIBERTY

Performance Measure	MY 2022 Rate
Dental	
Oral Evaluation, Dental Services (OEV-CH)	
Ages <1	2.82%
Ages 1–2	21.04%
Ages 3–5	46.13%
Ages 6–7	57.21%
Ages 8–9	59.42%
Ages 10–11	57.01%
Ages 12–14	54.00%
Ages 15–18	45.46%
Ages 19–20	24.84%
Total (Ages <1–20)	50.15%
Sealant Receipt on Permanent First Molars (SFM-CH)	
Rate 1—At Least One Sealant	62.78%
Rate 2—All Four Molars	43.46%
Topical Fluoride for Children (TFL-CH)	
Rate 1—Dental or Oral Health Services—Ages 1–2	8.17%
Rate 1—Dental or Oral Health Services—Ages 3–5	22.61%
Rate 1—Dental or Oral Health Services—Ages 6–7	30.25%
Rate 1—Dental or Oral Health Services—Ages 8–9	30.49%
Rate 1—Dental or Oral Health Services—Ages 10–11	29.67%
Rate 1—Dental or Oral Health Services—Ages 12–14	26.16%
Rate 1—Dental or Oral Health Services—Ages 15–18	17.70%
Rate 1—Dental or Oral Health Services—Ages 19–20	7.94%
Rate 1—Dental or Oral Health Services—Total (Ages <1–20)	24.14%
Rate 2—Dental Services—Ages 1–2	8.17%
Rate 2—Dental Services—Ages 3–5	22.61%
Rate 2—Dental Services—Ages 6–7	30.25%
Rate 2—Dental Services—Ages 8–9	30.49%
Rate 2—Dental Services—Ages 10–11	29.67%

Performance Measure	MY 2022 Rate
Rate 2—Dental Services—Ages 12–14	26.16%
Rate 2—Dental Services—Ages 15–18	17.70%
Rate 2—Dental Services—Ages 19–20	7.94%
Rate 2—Dental Services—Total (Ages <1–20)	24.14%
Rate 3—Oral Health Services—Ages 1–2	0.00%*
Rate 3- Oral Health Services- Ages 3–5	0.00%*
Rate 3—Oral Health Services—Ages 6–7	0.00%*
Rate 3—Oral Health Services—Ages 8–9	0.00%*
Rate 3—Oral Health Services—Ages 10–11	0.00%*
Rate 3—Oral Health Services—Ages 12–14	0.00%*
Rate 3—Oral Health Services—Ages 15–18	0.00%*
Rate 3—Oral Health Services—Ages 19–20	0.00%*
Rate 3—Oral Health Services—Total (Ages <1–20)	0.00%*

* The *TFL-CH—Rate 3—Oral Health Services* measure indicator reports services provided by personnel other than dentists (e.g., Pediatricians). Since **LIBERTY** only provides services that are provided by or under the supervision of a dentist, there were no members that met the numerator criteria; therefore, the reported rates are 0.00%.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: No strengths were identified as MY 2022 was the first year **LIBERTY** reported rates for the measures selected by the State; therefore, no trending is available and a state-established MPS has not been determined for each measure. **[Quality]**

Weaknesses and Recommendations

Weakness #1: No weaknesses were identified as MY 2022 was the first year **LIBERTY** reported rates for the measures selected by the State; therefore, no trending is available and a state-established MPS has not been determined for each measure.

Why the weakness exists: No weaknesses were identified; therefore, this section is not applicable.

Recommendation: Although no weaknesses were identified, HSAG recommends that **LIBERTY** monitor these rates regularly so that it can identify any potential barriers early in the reporting process.

Compliance Review

Performance Results

Table 4-12 presents an overview of the results of the SFY 2021 and SFY 2022 compliance reviews for **LIBERTY**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements (i.e., requirements) it reviewed. If a requirement was not applicable to **LIBERTY** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all 14 standards.

Table 4-12—Summary of Standard Compliance Scores

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Disenrollment: Requirements and Limitations	5	5	5	0	0	**100%**
Standard II—Member Rights and Member Information	18	18	17	1	0	**94%**
Standard III—Emergency and Poststabilization Services	10	10	10	0	0	**100%**
Standard IV—Availability of Services	7	7	7	0	0	**100%**
Standard V—Assurances of Adequate Capacity and Services	4	4	4	0	0	**100%**
Standard VI—Coordination and Continuity of Care	11	11	8	3	0	**73%**
Standard VII—Coverage and Authorization of Services	15	15	12	3	0	**80%**
Standard VIII—Provider Selection	12	10	10	0	2	**100%**
Standard IX—Confidentiality	11	11	11	0	0	**100%**
Standard X—Grievance and Appeal Systems	38	38	35	3	0	**92%**
Standard XI—Subcontractual Relationships and Delegation	7	7	7	0	0	**100%**
Standard XII—Practice Guidelines	8	8	8	0	0	**100%**
Standard XIII—Health Information Systems[1]	12	12	10	2	0	**83%**

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	***NM***	***NA***	
Standard XIV—Quality Assessment and Performance Improvement Program	27	24	24	0	3	**100%**
Total	**185**	**180**	**168**	**12**	**5**	**93%**

M = Met*; *NM = Not Met*; *NA = Not Applicable
Total Elements: The total number of elements within each standard.
Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.
Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.
[1] This standard includes a comprehensive assessment of the PAHP's IS capabilities.

Review of Corrective Action Plan Implementation

Based on the findings from the SFY 2021 and SFY 2022 compliance review activities, **LIBERTY** was required to develop and submit a CAP for each element assigned a score of *Not Met*. The CAP was reviewed by DHCFP and HSAG for sufficiency, and **LIBERTY** was responsible for implementing each action plan in a timely manner. Table 4-13 presents an overview of the results of the SFY 2023 compliance review for **LIBERTY** which consisted of a comprehensive review of the PAHP's implementation of each action plan. HSAG assigned a score of *Complete* or *Not Complete* to each of the individual elements that required a CAP based on a scoring methodology, which is detailed in Appendix A.

Table 4-13—Summary of Corrective Action Plan Implementation

Standard	Total CAP Elements	# CAP Elements *Complete*	# CAP Elements *Not Complete*
Standard II—Member Rights and Member Information	1	1	**0**
Standard VI—Coordination and Continuity of Care	3	3	**0**
Standard VII—Coverage and Authorization of Services	3	3	**0**
Standard X—Grievance and Appeal Systems	3	3	**0**
Standard XIII—Health Information Systems[1]	2	2	**0**
Total	**12**	**12**	**0**

Total CAP Elements: The total number of elements within each standard that required a CAP during the SFY 2021 and SFY 2022 compliance review activities.
 # CAP Elements *Complete*: The total number of CAP elements within each standard that were fully remediated at the time of the site review and demonstrated compliance with the requirement under review.
 # CAP Elements *Not Complete*: The total number of CAP elements within each standard that were not fully remediated at the time of the site review and/or did not demonstrate compliance with the requirement under review.
[1] This standard includes a comprehensive assessment of the PAHP's IS capabilities.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the compliance review activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the compliance review have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: LIBERTY demonstrated that it successfully remediated all 12 elements, indicating that the necessary policies, procedures, and interventions were implemented to ensure compliance with the Member Rights and Member Information, Coordination and Continuity of Care, Coverage and Authorization of Services, Grievance and Appeal Systems, and Health Information Systems requirements. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any substantial weaknesses for **LIBERTY** as all CAPs had been fully implemented and all requirements deemed compliant.

Why the weakness exists: As no weaknesses were identified, this section is not applicable.

Recommendation: While **LIBERTY** demonstrated that its CAPs were implemented and remediated the deficiencies identified, HSAG recommends that the PAHP continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to the Nevada Medicaid Managed Care Program. HSAG will evaluate adherence to the requirements during the next three-year compliance review cycle.

Network Adequacy Validation

Performance Results

Table 4-14 presents **LIBERTY**'s network capacity analysis results and compares the provider ratios to the standards displayed in Table 4-4. Assessed provider ratios shown in green indicate the provider ratio was in compliance with the access standard, whereas provider ratios shown in red indicate the provider ratio was not in compliance with the access standard.

Table 4-14—Summary of Ratio Analysis Results for Dental Care Providers for LIBERTY

Provider Category	Providers*	Clark County Ratio	Washoe County Ratio	Statewide Ratio**
Dental Primary Care Providers (1:1,500)	441	1:1,372	1:181	1:1,556

Note: Results shown in green font indicate the result complies with the access standard; results shown in red font indicate the result does not comply with the access standard.

* Providers contracted statewide and contracted providers located in the Nevada Medicaid catchment areas were included in provider counts.

** Statewide ratio incorporates all Nevada counties included in the DHCFP member file submission and members enrolled with the PAHP as of December 1, 2022.

Table 4-15 presents **LIBERTY**'s geographic network distribution analysis and compares the percentage of members within the access standard compared to the standards displayed in Table 4-5. Assessed results shown in green indicate that the percentage of members within the access standard was in compliance, and percentages shown in red indicate a result of less than 99.0 percent.

Table 4-15—Percentage of Members With Required Access by Provider Category for LIBERTY

Provider Category	Clark County	Washoe County	Statewide*
General Dental Providers			
General Dentist (20 miles/30 mins)	>99.9%	99.9%	99.9%
Pediatric Dentist (20 miles/30 mins)	>99.9%	99.9%	>99.9%
Mid-Level Dental Providers			
Dental Therapist (40 miles/60 mins)	NA	NA	NA
Public Health Endorsed Dental Hygienist (40 miles/60 mins)	>99.9%	0.0%	88.4%
Specialty Dental Providers			
Endodontist (40 miles/60 mins)	>99.9%	100.0%	>99.9%
Oral Surgeon (40 miles/60 mins)	>99.9%	100.0%	>99.9%
Periodontist (40 miles/60 mins)	>99.9%	0.0%	88.4%
Prosthodontist (40 miles/60 mins)	>99.9%	0.0%	88.3%

Note: Results shown in green font indicate the result complies with the access standard; results shown in red font indicate that less than 99.0 percent of members had access to the provider within the time and distance access standard.

NA (Not Applicable) indicates the PAHP did not report providers for the provider category.

* Statewide results incorporate all Nevada counties included in the DHCFP member file submission and members enrolled with the PAHP as of December 1, 2022.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the NAV findings against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: LIBERTY met the provider ratio requirements for Dental Primary Care Providers in Clark and Washoe counties, indicating **LIBERTY** had a sufficient provider network for its members to access preventive dental care. **[Access]**

Strength #2: LIBERTY met the time-distance contract standards in Washoe County for Endodontists and Oral Surgeons, and more than 99.9 percent of members in Clark County had

access within requirements for Mid-Level and Specialty Dental Providers. Members in Washoe County had improved access to Endodontists and Oral Surgeons in SFY 2023, with both provider categories now meeting the 100 percent access standard. **[Access]**

Weaknesses and Recommendations

Weakness #1: LIBERTY did not meet the statewide provider ratio standard for Dental Primary Care Providers, after doing so in SFY 2022.[4-1] This indicates that members outside Clark and Washoe counties may have limited access to preventive dental care. **[Access]**

Why the weakness exists: The lack of identified dental PCPs outside Clark and Washoe counties may result from a lack of providers available for contracting or a lack of willingness to contract with **LIBERTY** due to low reimbursement rates and high member "no show" rates as reported by the PAHP.

Recommendation: HSAG recommends that **LIBERTY** continue using DHCFP's monthly provider list to identify new dental providers and, subsequently, outreach and try to recruit them.

Weakness #2: LIBERTY did not meet the time-distance contract standards for Periodontists and Prosthodontists in Washoe County or statewide, indicating **LIBERTY** may not have a sufficient provider network for its members to access these services. From SFY 2022 to SFY 2023, the percentage of members with access to Periodontists statewide decreased more than 10 percentage points, from 99.4 percent with access to 88.4 percent with access. This result was driven by no members in Washoe County having access to a Periodontist within standards for SFY 2023. **[Access]**

Why the weakness exists: The lack of identified Periodontists and Prosthodontists may result from either a lack of providers available for contracting or an unwillingness of these specialty types to contract with **LIBERTY** due to low reimbursement rates and high member "no show" rates as reported by the PAHP.

Recommendation: HSAG recommends that **LIBERTY** continue using DHCFP's monthly provider list to identify new specialty dental providers and, subsequently, outreach and try to recruit those specialists in Clark and Washoe counties.

Weakness #3: LIBERTY did not meet the time-distance contract standards for Public Health Endorsed Dental Hygienists in Washoe County or statewide, indicating members may experience challenges accessing these provider types within an adequate time or distance from their residence. **[Access]**

Why the weakness exists: The lack of identified providers may result from a lack of available Public Health Endorsed Dental Hygienists available for contracting or because these specialty types are unwilling to contract with **LIBERTY** due to low reimbursement rates and high member "no show" rates as reported by the PAHP.

[4-1] For SFY 2022 EQR results, refer to the Division of Health Care Financing and Policy Nevada Managed Care Program State Fiscal Year 2022 External Quality Review Technical Report at https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/Resources/AdminSupport/Reports/NV2022_EQR-TR_F1.pdf.

Recommendation: HSAG recommends that **LIBERTY** continue to conduct an in-depth review of provider categories for which it did not meet the time-distance contract standards, with the goal of determining whether or not the failure of the PAHP to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area. **LIBERTY** should continue using DHCFP's monthly provider list to identify new specialty dental providers and, subsequently, outreach and try to recruit those specialists in Clark and Washoe counties.

Dental Satisfaction Survey

Performance Results

Table 4-16 presents the 2023 dental satisfaction survey top-box scores for **LIBERTY**'s child Medicaid and Nevada Check Up populations. Of note, none of the survey measures had a minimum of 100 respondents; therefore, no measure rates could be reported or assessed.

Table 4-16—Summary of Top-Box Scores for LIBERTY

	Child Medicaid	Nevada Check Up	Aggregate
Global Ratings			
Rating of Regular Dentist	NA	NA	NA
Rating of All Dental Care	NA	NA	NA
Rating of Finding a Dentist	NA	NA	NA
Rating of Dental Plan	NA	NA	NA
Composite Measures			
Care from Dentists and Staff	NA	NA	NA
Access to Dental Care	NA	NA	NA
Dental Plan Services	NA	NA	NA
Individual Item Measures			
Care from Regular Dentist	NA	NA	NA
Would Recommend Regular Dentist	NA	NA	NA
Would Recommend Dental Plan	NA	NA	NA

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

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the survey activity against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or

weakness, the findings did not determine any significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: HSAG did not identify any strengths for **LIBERTY** for the CAHPS surveys.

Weaknesses and Recommendations

Weakness #1: There were less than 100 respondents for every measure across both child populations; therefore, results could not be reported and strengths and weaknesses could not be identified. **[Quality, Timeliness, Access]**

Why the weakness exists: Parents/Caretakers of child members are less likely to respond to surveys. Completion of surveys may be exceptionally low on the list of priorities for members struggling with illness and/or other life-changing events.

Recommendation: HSAG recommends that **LIBERTY** focus on increasing response rates to the dental satisfaction survey for both populations so there are greater than 100 respondents for each measure by educating and engaging all employees to increase their knowledge of dental satisfaction surveys, applying effective customer service techniques, increasing the percentage of oversampling, using innovative outreach strategies to follow up with non-respondents, and providing awareness to members and providers during the survey period. Additionally, **LIBERTY**'s care management and/or other member-facing teams, such as the customer service team, could consider asking members if they know about the dental satisfaction survey and, if they received the survey, what barriers may prevent them from responding to the survey. These questions can be asked during routine contacts with members or when members outreach to **LIBERTY**. The information provided by these members could be shared with **LIBERTY**'s dental satisfaction survey vendor so that **LIBERTY** and the vendor can identify solutions to address low response rates.

Overall Conclusions for Quality, Timeliness, and Access to Healthcare Services

HSAG performed a comprehensive assessment of **LIBERTY**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **LIBERTY** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **LIBERTY**'s overall performance contributed to the Nevada Managed Care Program's progress in achieving the Quality Strategy goals and objectives. Table 4-17 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided **LIBERTY**'s Medicaid and Nevada Check Up members.

Table 4-17—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Increase Use of Dental Services	**Quality**, **Timeliness**, and **Access**—**LIBERTY** demonstrated through the three-year compliance review cycle that it had appropriate practices for ensuring providers were aware of its adopted practice guidelines, which should include guidelines for preventive and specialty dental care. Through the NAV activity, **LIBERTY** demonstrated that it had an adequate network of primary dental care providers in Clark County and Washoe County to provide preventive dental services. Therefore, **LIBERTY** should continue to monitor grievances to determine whether noncompliance with the statewide network adequacy standard impacts its members' timely access to services. For SFY 2023, **LIBERTY** was responsible for reporting rates for three new measures and the associated indicators. Therefore, performance related to the use of services was not comparable to the prior year, and MPSs were not available for these measures for assessing performance. The intent of the *Oral Evaluation, Dental Services* measure is to assess the prevalence of Medicaid members under 21 years of age who received a comprehensive or periodic oral evaluation with a dental provider. Results from MY 2022 indicate that children between the ages of 8 and 9 years accessed these services most often, with a rate of 51.95 percent. Additionally, the rate for the *Sealant Receipt on Permanent First Molars—Rate 1—At Least One Sealant* measure indicator was 55.26 percent, while *Rate 2—All Four Molars* was 38.18 percent. Further, the highest rates for the *Topical Fluoride for Children* measure were the *Rate 1—Dental or Oral Health Services—Ages 8–9* (at 23.27 percent) and *Rate 2—Dental Services—Ages 8–9* (also at 23.27 percent), suggesting that **LIBERTY** has substantial opportunities to improve the prevalence of members in all age groups accessing preventive dental care. In SFY 2023, **LIBERTY** effectively designed two PIPs, *Increase Preventive Services for Children* and *Coordination of Transportation Services,* as indicated by *Met* validation ratings, which should support improvement in the prevalence of dental services accessed by **LIBERTY**'s Medicaid and Nevada Check Up members. **LIBERTY**'s PIPs and other implemented initiatives should also support progress toward achieving the newly set MPSs as stipulated in Appendix B. Goals and Objectives Tracking under the New Measurement Year 2023 Minimum Performance Standards section and Goal 6 of the Quality Strategy to *increase utilization of dental services by December 31, 2024.*
Reduce/Eliminate Healthcare Disparities	**Quality**, **Timeliness**, and **Access**—The aggregated findings from **LIBERTY**'s EQR activities did not produce sufficient data for HSAG to assess the impact the EQR activities had or will have on reducing and/or eliminating healthcare disparities for **LIBERTY**'s Medicaid and Nevada Check Up members other than by geographic area (i.e., through the NAV activity). To support the reduction and elimination of healthcare disparities, **LIBERTY** should continue to implement interventions through its cultural competency and population health programs and plans, stratify performance measure data by race and ethnicity, and use the data to target interventions for those areas wherein performance is lowest and members can be most impacted.

5. Follow-Up on Prior EQR Recommendations for MCOs

From the findings of each MCO's performance for the SFY 2022 EQR activities, HSAG made recommendations for improving the quality of healthcare services furnished to members enrolled in the Nevada Managed Care Program. The recommendations provided to each MCO for the EQR activities in the *State Fiscal Year 2022 External Quality Review Technical Report* are summarized in Table 5-1, Table 5-2, Table 5-3, and Table 5-4. The MCO's summary of the activities that were either completed, or were implemented and still underway, to improve the finding that resulted in the recommendation, and as applicable, identified performance improvement, and/or barriers identified are also provided in Table 5-1, Table 5-2, Table 5-3, and Table 5-4.

Anthem Blue Cross and Blue Shield Healthcare Solutions

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

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • **Anthem** limited the number of interventions tested for each topic to just one for the duration of the PIP. **Anthem** should consider testing more than one intervention during the PIP, which will help the MCO address as many identified opportunities for improvement as possible. The MCO should apply lessons learned and knowledge gained from its efforts and HSAG's feedback throughout the PIP to future PIPs and other quality improvement activities. Lastly, **Anthem** should continue improvement efforts in the PIP topic areas and, for the successful interventions, consider spreading beyond the narrowed focus. The conclusion of a project should be used as a springboard for sustaining the improvement achieved and attaining new improvements. • Even though the SMART Aim goal was achieved, HSAG identified inaccuracies in **Anthem**'s PIP documentation, which resulted in HSAG assigning a level of *Confidence* to the *CDC HbA1c Poor Control >9.0%* PIP, instead of *High confidence*. **Anthem** should ensure that its data and interpretation of results are accurately documented in its PIP submissions. Additionally, any improvement achieved should be reasonably linked to intervention(s) tested and the outcomes data reported. • **Anthem** was unable to determine whether its implemented intervention was linked to achievement of the SMART Aim goal, which resulted in HSAG assigning a *Low confidence* level to the *Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care* PIP. **Anthem** should ensure that the intervention(s) tested have the potential to impact the desired outcomes of the PIP and be mindful of the timing of intervention initiation.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Limited Interventions Anthem met with the HSAG team to review the PIP documentation requirements. Each 2023 PIP includes at least one new intervention. Future PIPs will include at least one new intervention each calendar year. All

6 PIP (2022-2025) measures are attributed to interdisciplinary quality workgroups, which have been implemented to review and discuss lessons learned and knowledge gained from its efforts and HSAG's feedback throughout the PIP, as needed. Quality workgroup domains include Adult, Behavioral Health, and Maternal Child Health. Furthermore, PIP topics are included within Whole Health and Health Equity annual workplans in an effort to continue improvement efforts at a granular level. Future improvement efforts that are focused on a sub-set of the population will be reviewed for broader spread. The goal of a pilot will be to expand to a larger population.

- Inaccuracies in PIP documentation and implemented intervention not linked to the achievement of the SMART Aim goal.

Anthem has included the data analyst team in the entire PIP process from baseline data analysis to intervention measurement and, eventually, outcomes monitoring. Each workgroup, noted above, includes at least one data analyst. Before submitting future PIPs, the data will be reviewed by a data analyst as a prevention strategy to submitting PIPs with inaccuracies. Furthermore, all PIPs include interventions with outcomes measures that demonstrate the impact of the intervention. These customized outcomes metrics will be reported on a recurring basis (i.e.: quarterly) to leverage the Plan-Do-Study-Act process. The workgroups noted above will review intervention outcomes and provide feedback regarding adoption, adaption, or abandonment of the interventions.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
- N/A

c. Identify any barriers to implementing initiatives:
- No barriers to implementing the initiatives were identified.

HSAG Assessment: HSAG has determined that **Anthem** addressed the prior year's recommendations based on the initiatives reported to improve the processes to support newly implemented PIPs. **Anthem** initiated new PIPs in SFY 2023 and had not progressed to reporting interventions; therefore, HSAG will assess future PIP submissions and determine whether the MCO's quality improvement processes, strategies, and interventions effectively addressed these recommendations in future PIP submissions.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures

HSAG recommended the following:

- Rates for the *Adults' Access to Preventive/Ambulatory Health Services—Ages 65 Years and Older* measure indicator within the Access to Care domain for Medicaid demonstrated a decline in performance of more than 5 percentage points from the previous year, and all four measure indicator rates ranked below NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile benchmark. Additionally, rates for the two age stratifications with QISMC goals (i.e., Ages 20–44 and Ages 45–64) did not meet the MPS. **Anthem** should continue its promotion of telehealth services and/or seek alternative interventions to mitigate the impacts of COVID-19 and continue to outreach members to schedule preventive and ambulatory services. **Anthem** should also continue to conduct analyses to determine why members ages 65 years and older are not consistently accessing preventive and ambulatory services and implement appropriate interventions to improve the performance related to Access to Care measures.
- **Anthem**'s overall performance for the *Childhood Immunization Status* and *Immunizations for Adolescents* measures within the Children's Preventive Care domain for Medicaid declined. All measure indicator rates for these two measures ranked below NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile benchmark and did not meet the MPS. The decrease in performance was noted in the prior year's findings as well. **Anthem** self-reported that it conducts root cause analyses to determine why its child

members are not receiving all recommended vaccines, and that it considers disparities within its populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. **Anthem** also reported that telehealth services are advertised in provider newsletters and provider education materials, and that it also shares member-level detail data with its contracted providers to conduct outreach and reduce member gaps in care. **Anthem** should continue these efforts, and also consider additional interventions based on its root cause analyses to improve the performance related to the Children's Preventive Care domain.

- **Anthem**'s Medicaid performance for the *Breast Cancer Screening* measure demonstrated a decline of more than 5 percentage points from the prior year, which was also noted in the prior year. This indicates women were not getting breast cancer screenings for early detection of breast cancer, which may result in less effective treatment and higher healthcare costs. **Anthem** self-reported that it conducts root cause analyses to determine why its female members are not receiving preventive screenings for breast cancer, and that it considers disparities within its populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. In responses to these analyses, **Anthem** reported that it piloted telehealth kits to increase preventive screenings and scheduled events to offer mammograms. **Anthem** also reported that it shares member level detail data with its contracted providers to conduct outreach and reduce member gaps in care. **Anthem** should continue these efforts and also consider additional interventions based on its root cause analyses to improve the performance related to the Women's Health and Maternity Care domain.
- Within the Behavioral Health domain for Medicaid, **Anthem**'s performance for the *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* measure indicator demonstrated a decline of more than 5 percentage points from the prior year, indicating that not all children are being monitored after being prescribed ADHD medication, which is important to assess for the presence or absence of potential adverse effects. Monitoring adverse effects from ADHD medication allows physicians to suggest an optimal, alternative treatment. In addition, rates for the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*, *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence*, *Follow-Up After Emergency Department Visit for Mental Illness*, and *Follow-Up After Hospitalization for Mental Illness* measure indicators ranked below NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile benchmarks. **Anthem** self-reported that it has increased member and provider awareness of telehealth services through provider newsletters and provider education materials, and that HEDIS member-level detail data including race/ethnicity, age, and demographic information are also shared with its providers to conduct outreach. **Anthem** should continue its existing efforts to determine why its Medicaid child members are not consistently receiving follow-up care after being prescribed ADHD medication and implement appropriate interventions to improve outcomes for its members diagnosed with ADHD. **Anthem** should also continue to monitor performance for the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*, *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence*, *Follow-Up After Emergency Department Visit for Mental Illness*, and *Follow-Up After Hospitalization for Mental Illness* measures, and implement appropriate interventions to improve the performance related to the Behavioral Health domain.
- Within the Behavioral Health domain for Nevada Check Up, **Anthem**'s performance for the *Follow-Up After Hospitalization for Mental Illness* showed a decline of more than 5 percentage points from the prior year for the *7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* measure indicators, indicating that not all members who were hospitalized for mental health disorders received adequate and timely follow-up care. Providing follow-up care to patients after psychiatric hospitalization can improve patient outcomes, decrease the likelihood of re-hospitalization, and reduce the overall cost of outpatient care. **Anthem** should continue its efforts to educate providers on the use of telehealth services and sharing member demographic

information with providers for conducting outreach. **Anthem** should also continue conducting root cause analyses or focused studies to determine why its members who were hospitalized for mental health disorders are not receiving adequate follow-up care. Further, **Anthem** should continue to evaluate whether there are any disparities within its populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, **Anthem** should implement appropriate interventions to improve the performance related to these measures.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)

a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:

- Adults' Access to Preventive/Ambulatory Health Services

  Anthem has taken the following action in its continued effort to address Adults' Access to Preventive/Ambulatory Health Service (AAP):
  - AAP was added as a quality metric to its value-based payment program, effective 1/1/23.
  - Implemented an incentive program for providers not participating in a value-based payment program, effective 3/1/23.
  - Implemented a post-discharge bridge care program with two in-home providers in Clark County, effective 1/1/23.
  - Added live-agent telephonic outreach to its ongoing digital (text and IVR) outreach to members, effective 7/1/23.
  - Anthem continues its promotion of telehealth services during meetings with provider groups.
- Childhood Immunization Status

  Anthem has taken the following action in its continued effort to address Childhood Immunization Status (CIS):
  - Anthem piloted an after-hours, "Saturday Clinic," with a provider group to improve access to child and adolescent immunizations.
  - Anthem is collaborating with an in-home provider to recruit a provider to staff the Anthem community outreach vehicle which can serve as a mobile primary care unit capable of vaccine administration.
  - Anthem has an ongoing text message campaign outreach to members to remind them of preventive health appointments and vaccination schedule.
  - Anthem's Healthy Reward Program offers members incentives for completing qualifying health activities (e.g., immunizations) and screenings.
  - Anthem's Provider Quality Incentive Program (PQIP) is value-based payment program that incentivizes primary care providers to close gaps in care for priority HEDIS metrics (including CIS).
  - Collaboration with WIC- Co-branded collaboration promotion via WIC
  - Provider Gap in Care Dashboards are available to contracted providers and updated monthly with member-level detail data to conduct outreach and reduce member gaps in care.
  - Anthem developed and disseminated a Provider Toolkit (IMA Combo-2 HPV Series Toolkit) in collaboration with American Cancer Society.
- Breast Cancer Screening

  Anthem has taken the following action in its continued effort to address Breast Cancer Screening (BCS):

- Anthem held a community event, "Mammorama" with a mobile mammography unit on-site to provide mammograms and breast cancer screening education.
- Anthem Case Managers completed direct member outreach to schedule breast cancer screening appointments at the event and provide breast cancer screening education.
- Anthem is continuing to work with providers to increase supplemental data (EMR, STFP flat-files, and the Nevada Health Information Exchange) submission.

- Behavioral Health

  Anthem has taken the following action in its continued effort to address the Behavioral Health Domain:
  - Anthem implemented a post-ED discharge visit in partnership with two provider groups to improve the timeliness of the follow-up visit in 2023.
  - Anthem expanded its member incentive program, Healthy Rewards, to include a member incentive for completing a follow-up visit within 7-days of ED discharge or within 30-days of a Mental Health inpatient discharge.
  - Anthem has launched a Case Management (CM) program to enhance the discharge process, improve member engagement, reduce readmissions, and improve HEDIS measures for the Follow-Up After Emergency Department Visit for Mental Illness (FUM), and Follow-Up After Hospitalization for Mental Illness (FUH) measures. If a follow up appointment cannot be secured within 7/30 days of discharge Anthem's behavioral health clinical CM staff completes Follow-up After Discharge assessment telephonically or virtually, documents CM interaction as appropriate and follows respective CM process to ensure member's needs are met, and with member consent, shares assessment with outpatient providers as needed to assist in coordinating care and services.
  - Anthem created and implemented a Behavioral Health workgroup, noted above, to address prioritized behavioral health metrics.
  - Anthem has an ADHD Follow Up Care Standalone Mailing program which provides educational collateral to ensure guardians follow appropriate clinical guidelines for Physician follow-up appointments within 30 days after newly starting ADHD medication. The program also includes a Vanderbilt Assessment Scale for home and school to complete that will help facilitate discussion with the provider.
  - Anthem conducts telephonic outreach to providers with reminder messages to focus on ADHD medications education and ensuring follow-up appointments are discussed with caregivers and scheduled.
  - Anthem sends an Antipsychotic Medication Adherence Standalone Fax to prescribers which targets members who are nonadherent to antipsychotic or bipolar medications; less than 80% PDC.
  - Anthem sends a Long-Acting Injectable Antipsychotic for Non-Adherent Schizophrenia Fax to prescribers to encourage the use of LAIA in Schizophrenia patients who are non-adherent to oral therapies and have had recent schizophrenia related hospitalization.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- In comparison to MY2021, Anthem saw an increase in MY2022 performance rates for the Adherence to Antipsychotic Medications for Individuals With Schizophrenia, Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence, Follow-Up After Emergency Department Visit for Mental Illness, and Follow-Up After Hospitalization for Mental Illness measures
- Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence did achieve the Quality Compass 50th Percentile for MY2022.

c. Identify any barriers to implementing initiatives:

- No barriers to implementing the initiatives were identified.

HSAG Assessment: HSAG has determined that **Anthem** addressed the prior year's recommendations based on reported interventions implemented during MY 2023; however, results from the current EQR indicate that the initiatives were not always effective at supporting improvement.

- Within the Access to Care domain for the Medicaid *Adults' Access to Preventive/Ambulatory Health Services* measure, although all four indicator rates continued to rank below NCQA's Quality Compass HEDIS 2022 Medicaid HMO 50th percentile benchmark and rates for the two age stratifications with QISMC goals (i.e., *Ages 20–44* and *Ages 45–64*) did not meet the MPS, the rates for *Ages 20–44, Ages 45–64,* and *Total* showed a small (i.e., greater than 1 percentage point) increase from the prior MY, demonstrating that the interventions **Anthem** put in place are making a positive impact. However, the rate for members *Ages 65 Years and Older* continued to show a very minor decline (i.e., 0.43 percentage points). **Anthem** should conduct analyses to determine why members ages 65 years and older are not consistently accessing preventive and ambulatory services and implement appropriate interventions to improve the performance related to Access to Care measures.
- Within the Children's Preventive Care domain for Medicaid, although overall performance continued to decline for the *Childhood Immunization Status—Combination 3* and *Combination 10* indicators, and all measure indicators continued to rank below NCQA's Quality Compass HEDIS 2022 Medicaid HMO 50th percentile benchmarks and did not meet the MPS, the *Combination 7* indicator showed an increase of 2.33 percentage points. Additionally, both of the *Immunizations for Adolescents* indicator rates showed a small increase (i.e., *Combination 1* increased by 1.89 percentage points and *Combination 2* increased by 2.04 percentage points), and the *Combination 1* indicator ranked above NCQA's Quality Compass HEDIS 2022 Medicaid HMO 50th percentile benchmark. **Anthem** should continue its self-reported efforts that were put in place during the MY and also consider additional interventions based on the MCO's root cause analyses to improve performance in the Children's Preventive Care domain.
- **Anthem**'s Medicaid performance for the *Breast Cancer Screening* measure increased by 1 percentage point, demonstrating that the MCO's self-reported efforts have started to make a positive impact, including telehealth kits to increase preventive screenings, scheduled events to offer mammograms, and member-level detail data provided to its contracted providers to conduct outreach and reduce member gaps in care. **Anthem** should continue these efforts and continue to conduct root cause analyses to help determine additional interventions to improve performance related to the Women's Health and Maternity Care domain.
- Within the Behavioral Health domain for Medicaid, **Anthem**'s performance for the *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* measure indicator continued to decline slightly from MY 2021 and the *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* also showed a decline of 4.31 percentage points, indicating additional focus is needed to improve the care for children prescribed ADHD medication. Additionally, rates for the *Adherence to Antipsychotic Medications for Individuals with Schizophrenia*, *Follow-Up After Emergency Department Visit for Mental Illness*, and *Follow-Up After Hospitalization for Mental Illness* measure indicators continued to rank below NCQA's Quality Compass HEDIS 2022 Medicaid HMO 50th percentile benchmarks, suggesting the interventions implemented to support improvement in these areas may need to be evaluated, or additional interventions may need to be added to improve performance in this domain overall.
- Of note, **Anthem**'s performance for the *Follow-Up After Hospitalization for Mental Illness* for the *7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* measure indicators in the Behavioral Health domain for Nevada Check Up could not be assessed for improvement as the denominators were too small (i.e., <30) to report valid rates.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
HSAG recommended the following: • **Anthem** received a score of 67 percent in the Provider Selection program area, indicating that providers may not be appropriately credentialed or assessed in accordance with contractual requirements. While **Anthem** was required to develop a CAP, the MCO's credentialing committee should conduct a thorough review of providers excluded from its credentialing process and ensure credentialing requirements are developed for all providers, practitioners, and organizations, who can apply for network status. **Anthem** should also develop a crosswalk of all provider types and the specific licensing requirements required in the State of Nevada. Further, **Anthem** should conduct a root cause analysis on the deficiencies identified through the credentialing case files and determine whether any area found to be out of compliance was the result of an anomaly or if a more serious breach in policy occurred. • **Anthem** received a score of 74 percent in the Grievance and Appeal Systems program area, indicating that the MCO had not implemented a member grievance and appeal process that met all federal and contractual requirements. A total of 10 deficiencies were identified. While **Anthem** was required to develop a CAP, given the high volume of deficiencies identified in the MCO's grievance and appeal process, the MCO should conduct a comprehensive review of all policies, procedures, workflows, letter templates, and all other member grievance and appeal materials to identify any additional opportunities for improvement in this program area. **Anthem** should also conduct additional staff training once all materials have been reviewed and revised and enhance management oversight of the grievance and appeal process.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Anthem follows documented credentialing and recredentialing process/policies. Credentialing requirements, per policies, are followed for all providers which includes practitioners and organizations. • The initiative implemented is complete which was to add SUD and Addiction providers to the Nevada State Specific Addendum. • Anthem does have a crosswalk of organizational providers and the specific licensing requirements. • Credentialing staff did complete a remedial review and upon completion, the case was an anomaly. • Nevada file audits implemented and underway for sanction and exclusion checks and will reduce the amount audited based on no findings. • Grievance and Appeals (G&A) reviewed the grievance and appeal letter templates and identified additional updates needed to be made which included the development of an appeals desktop procedure which includes a letter grid detailing which letter to send in each case scenario. In addition, the grievance and appeal letters were revised and have since been approved by the state and configured in our G&A tracking system for staff to use. G&A staff received notification and training on when to use the letters after being configured in the system. Monthly audits are conducted by our internal audit team and the audit results will be reported to the Grievance and Appeal managers for review and action. Furthermore, an additional associate has been trained and added to the NV grievance team to triage grievances and resolve grievances sooner than the 90-calendar day contractual timeframe.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Having the newly approved letters configured in the system and archiving outdated letters, has helped ensure the team is no longer sending inaccurate and redundant letters. Monthly audits will confirm the accuracy of acknowledgement and resolution letters sent.
c. Identify any barriers to implementing initiatives: • At the time of the 2023 HSAG CAP Remediation Audit in May, we did not have all of the G&A letters approved by the state and configured in the G&A tracking system for the team to use. We have since added those letters to our G&A tracking system and are now available for the team to send. Monthly audits will confirm the accuracy of acknowledgement and resolution letters sent going forward.
HSAG Assessment: HSAG has determined that **Anthem** addressed the prior year's recommendations based on the MCO's reported initiatives; however, results from the current EQR indicate that the initiatives were ineffective at supporting quality improvement in the grievance and appeal systems program area. **Anthem** had not fully implemented the use of updated grievance and appeal acknowledgement and resolution letters into its tracking system at the time of the compliance site review but has reportedly done so since the site review. Therefore, HSAG recommends that **Anthem** implement and conduct routine audits of grievance and appeal files to ensure updated grievance and appeal acknowledgement and resolution letters are being used consistently.
4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation
HSAG recommended the following: • **Anthem** did not meet the time-distance contract standards for OB/GYN, Pediatric Rheumatologist, or Pediatric Psychologist, indicating members may experience challenges accessing these provider types within an adequate time or distance from their residence. **Anthem** should continue to conduct an in-depth review of provider categories in which it did not meet the time-distance contract standards, with the goal of determining whether or not the failure of the MCO to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area. **Anthem** should also continue to collaborate with the network strategy and information technology (IT) reporting teams for assistance implementing a process to identify targeted providers more quickly.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • An exception was submitted to the state on 02/07/2023. The state agreed on May 4, 2023. The exception will run through June 2023. Anthem will continue to update the state regarding recruitment activities.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Quarter over quarter results do show improvement and changes based upon membership moves, network changes, etc.
c. Identify any barriers to implementing initiatives: • Lack of providers approved by NV Medicaid for specific specialties. • Some providers will not contract with Medicaid due to low reimbursement rates.
HSAG Assessment: HSAG has determined that **Anthem** addressed the prior year's recommendations based on the MCO's reported initiatives; however, results from the current EQR indicate that similar findings were noted. Therefore, HSAG recommends that **Anthem** continue its efforts to contract with any new providers, especially OB/GYN and Pediatric Rheumatologist providers.

5. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation
HSAG recommended the following: • Errors in data files extracted for the study were observed (e.g., the *Drug Quantity* data element having the same values as the *Units of Service* data element). Consequently, the errors resulted in discrepancies in the comparative analysis. **Anthem** should implement standard quality controls to ensure accurate data extracts from its respective systems. Through the development of standard data extraction procedures and quality control, the number of errors associated with extracted data could be reduced. • **Anthem** was unable to procure all requested medical records from its contracted providers, resulting in a low medical record procurement rate. The low medical record procurement rate consequently impacted the results of the MRRs of key data elements that were evaluated. To ensure **Anthem**'s contracted provider accountability in addressing submission of medical records for auditing, inspection, and examination related to its members, **Anthem** should consider strengthening and/or enforcing its contract requirements with providers in providing the requested documentation. • Procedure codes documented in the medical records were either not found in the encounter data or were found in the encounter data but should have been coded with a different procedure code. **Anthem** should consider performing periodic medical record reviews of submitted claims to verify appropriate coding and data completeness. Any findings from these reviews should then be shared with providers through periodic education and training regarding encounter data submissions, medical record documentation, and coding practices.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • The Anthem contract and provider manual contains language requiring all providers comply with all requests to provide medical records and adherence to the provider manual. The provider manual provides details about a "standard medical record" and reiterates the provider's obligation to allow Anthem access to their records. Under the terms of the Anthem contract language Anthem may assert Breach of the Agreement if a provider is non-compliant with any provision. For additional reminder and education, Anthem publishes articles reminding providers of upcoming audits, and their obligation to provide requested records.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A
c. Identify any barriers to implementing initiatives: • Enforcing the obligation of a provider to provide all requested records by asserting Breach may jeopardize the integrity of our provider network.
HSAG Assessment: HSAG has determined that **Anthem** partially addressed the prior year's recommendations based on the MCO's reported initiatives; however, some gaps remain. **Anthem** indicated contractual obligations and sending some reminders to providers, but the MCO lacked details on the implementation of standard quality controls for data extraction and the specific practices for periodic medical record reviews. To fully address the recommendations, **Anthem** should consider providing more information on the actual procedures and quality control measures it has in place or plans to implement.

6. Prior Year Recommendation from the EQR Technical Report for CAHPS Analysis
HSAG recommended the following: • Parents/caretakers of Nevada Check Up general child members had less positive overall experiences with their child's personal doctor since the score for this measure was statistically significantly lower than the 2021 NCQA Medicaid national average. **Anthem** should prioritize improving parents'/caretakers' overall experiences with their child's personal doctor and determine a root cause for the lower performance. As part of this analysis, **Anthem** could determine if any outliers were identified within the data, identify primary areas of focus, and develop appropriate strategies to improve the performance. Additionally, **Anthem** should also continue promoting the results of its member experiences with its contracted providers and staff members and soliciting feedback and recommendations to improve parents'/caretakers' overall satisfaction with both **Anthem** and its contracted pediatric providers. • Parents/caretakers of Nevada Check Up general child members had fewer positive experiences with their child's health plan since the score for this measure was statistically significantly lower than the 2021 NCQA Medicaid national average. **Anthem** should focus on improving parents/caretakers of general child members overall experiences with Nevada Check Up by performing a root cause analysis, which could determine if there are any outliers within the data so that **Anthem** can identify the primary areas of focus and develop appropriate strategies to improve the performance. • There were less than 100 respondents for every measure for the CCC populations and most measures for the adult Medicaid, general child Medicaid, and Nevada Check Up general child populations; therefore, results could not be reported for the other measures and other strengths and weaknesses could not be identified. **Anthem** should focus on increasing response rates to the CAHPS survey for all populations so there are greater than 100 respondents for each measure by educating and engaging all employees to increase their knowledge of CAHPS, using customer service techniques, oversampling, and continuing to provide awareness to members and providers during the survey period.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Anthem's Quality Management Committee (QMC) reviewed the data collected for 2022 for member complaints, appeals, and CAHPS® (member experience survey both Adult and Child) to assess member experience. Medicaid member ratings of Anthem for Adult and Child CAHPS® are strongly related to members' ability to get the care they need when they need it (Q10). Being able to obtain needed information from customer service (Q45) and access to highly rated providers (Q36 and Q43) are all significant drivers of member experience. Additionally, a Key Driver Analysis (KDA) conducted by Center for the Study of Services (CSS) identified that the Rating of Personal Doctor measure to be the most impactful key driver for Member Satisfaction in both the Adult and Child CAHPS survey. • Through the analysis of the data, key drivers and barriers to improvement were identified. Interventions that were implemented before or during the CAHPS® 2022 data collection that continue to affect rates include: – Patient Experience Provider Training – Presentation to educate providers to enhance the patient experience during encounters. The training provides tools and techniques for communication and managing challenging situations as well as promotes the online CME course. – Customer Service Associate Training – CAHPS® 101, training that provides knowledge of the CAHPS® survey, is available to internal associates. 12,257 associates have completed the course

through August 2022. 2022 system enhancements will allow the course material to be viewed an unlimited number of times.

- Available Anthem CAHPS® Education and Collateral – Includes webinar-based training, CAHPS® measures in the HEDIS® coding booklet, Care Delivery Transformation (CDT) education for providers, and CAHPS® results in the Provider Newsletter.
- Anthem continues to encourage communication between specialist and primary care providers. The National Call Center (NCC) and 24-Hr Nurse Line reinforce appropriate utilization of lower levels of care (e.g., Urgent Care) and share options to access telehealth, mobile service providers.
- Anthem continues to complete a 40% oversample to increase response rates for the survey.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- MY2021 Adult CAHPS®
  - The Customer Service Composite and Rating of Health Plan measures increased in performance in comparison to MY2020.
  - The How Well Doctors Communicate Composite and Rating of Personal Doctor measures increased in performance in comparison to MY2020, however, did not meet reporting requirements due to not meeting the denominator (responses) threshold of ≥100.
- MY2021 Child CAHPS®
  - The Rating of Health Plan and Rating of Personal Doctor increased in performance in comparison to MY2020.

c. Identify any barriers to implementing initiatives:

- No barriers to implementing the initiatives were identified.

HSAG Assessment: HSAG has determined that **Anthem** addressed the prior year's recommendations based on the MCO's reported initiatives; however, results from the current EQR indicate that the initiatives were ineffective in supporting improved positive experiences reported by parents/caretakers or in increasing the number of respondents. Parents/caretakers of Nevada Check Up general child members had less positive overall experiences with their child's personal doctor since the score for this measure (61.4 percent) was statistically significantly lower than the 2022 NCQA Medicaid national average; therefore, HSAG recommends that **Anthem** identify additional interventions to increase the score for this measure. Additionally, there were less than 100 respondents for every measure for the adult Medicaid, CCC Medicaid, and Nevada Check Up CCC populations and for most measures for the general child Medicaid and Nevada Check Up populations whereby results could not be reported for the applicable measures. HSAG also recommends that **Anthem** implement interventions to increase response rates to the CAHPS survey for all populations.

Health Plan of Nevada

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

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • **HPN** limited the number of interventions tested for each topic to just one for the duration of the PIP. **HPN** should consider testing more than one intervention during the PIP, which will help the MCO address as many identified opportunities for improvement as possible. The MCO should apply lessons learned and knowledge gained from its efforts and HSAG's feedback throughout the PIP to future PIPs and other quality improvement activities. Lastly, **HPN** should continue improvement efforts in the PIP topic areas and, for the successful intervention, consider spreading beyond the narrowed focus. The conclusion of a project should be used as a springboard for sustaining the improvement achieved and attaining new improvements. • Although the SMART Aim goal was achieved for the *CDC HbA1c Poor Control >9.0%* PIP, the outcome was not linked to the implemented intervention, which resulted in HSAG assigning a *Low confidence* level to the PIP. **HPN** should ensure that the intervention(s) tested have the potential to impact the desired outcomes of the PIP and be mindful of the timing of intervention initiation.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • The PIP process was revised this year per guidance from HSAG. As part of that revision, and this recommendation, there are now multiple interventions designed to impact the assigned PIP measures. Where a sample population of focus was used, lessons learned will be applied to a larger population for sustained improvement.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Ongoing PIPs for 2023 are in process and we are seeing incremental improvements. HPN is too early in the cycle to draw definitive conclusions.
c. Identify any barriers to implementing initiatives: • No barriers have been identified to date.
HSAG Assessment: HSAG has determined that **HPN** addressed the prior year's recommendations based on the initiatives reported to improve the processes to support newly implemented PIPs. **HPN** initiated new PIPs in SFY 2023 and had not progressed to reporting interventions; therefore, HSAG will assess future PIP submissions and determine whether the MCO's quality improvement processes, strategies, and interventions effectively addressed these recommendations in future PIP submissions.
2. Prior Year Recommendation from the EQR Technical Report for Performance Measures
HSAG recommended the following: • Within the Access to Care domain for **HPN**'s Medicaid population, the two indicators with QISMC goals for the *Adults' Access to Preventive/Ambulatory Health Services* measure (i.e., *Ages 20–44 Years* and *Ages 45–64 Years*) did not meet the MPS, and all indicator rates ranked below NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile benchmarks. In addition, these rates have shown a steady decline when compared to the prior two years' rates. **HPN** reported that it has implemented value-based

contracts that include the *Adults' Access to Preventive/Ambulatory Health Services* measure and initiated member outreach activities to improve adults' access to preventive services. **HPN** should continue with these interventions, but also conduct timely studies to determine whether the interventions are effective. **HPN** should also determine whether additional interventions are necessary and implement, as appropriate, to improve the performance related to Access to Care measures. If COVID-19 continues to be a factor in lower performance, **HPN** should also work with its members to increase the use of telehealth services, when appropriate. • Within the Children's Preventive Care domain for **HPN**'s Medicaid population, performance for the *Childhood Immunization Status, Immunizations for Adolescents,* and *Well-Child Visits in the First 30 Months of Life—Two or More Well-Child Visits* measure indicators demonstrated a decline of more than 5 percentage points from the prior year, indicating that children are not receiving the recommended immunizations and well-child visits, which are a critical aspect of preventable care for children. **HPN** reported that it has implemented a member incentive program that rewards members for the completion of well-child visits. **HPN** should continue this intervention and, as part of its implementation process, **HPN** should conduct a timely evaluation to determine whether the member rewards program is resulting in increased member well-child visits and timely immunizations. If COVID-19 is still a factor, **HPN** should also determine interventions to reduce any COVID-19-related barriers to members accessing care and obtaining immunizations. • Within the Children's Preventive Care domain for **HPN**'s Nevada Check Up population, although all measure indicator rates ranked above NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile benchmarks, performance for the *Childhood Immunization Status—Combination 3* and *Combination 7*, *Immunizations for Adolescents—Combination 1*, and *Well-Child Visits in the First 30 Months of Life* measure indicators showed a decline of more than 5 percentage points from the prior year, indicating that fewer of **HPN**'s child and adolescent members are receiving the recommended immunizations and well-child visits, which are a critical aspect of preventable care for children. **HPN** reported that it has implemented a member incentive program that rewards members for the completion of well-child visits. **HPN** should continue this intervention and, as part of its implementation process, **HPN** should conduct a timely evaluation to determine whether the member rewards program is resulting in increased member well-child visits and timely immunizations. If COVID-19 is still a factor, **HPN** should also determine interventions to reduce any COVID-19-related barriers to members accessing care and obtaining immunizations. • **HPN**'s Medicaid performance within the Care for Chronic Conditions domain for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure indicator demonstrated a decrease of more than 5 percentage points from the prior year, suggesting that not all members with diabetes are receiving eye screenings. Eye exams are a critical aspect of care for members with diabetes as, left unmanaged, it can lead to blindness. **HPN** should update its provider Gap in Care (GIC) reports to identify diabetic members who are not receiving yearly eye exams. **HPN** may also consider conducting a root cause analysis or focused study to determine why Medicaid members with diabetes are not all receiving the recommended eye exams. **HPN** should consider if there are disparities within its populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:

- HPN continues to issue incentive payments to both members and providers for completing these services. HPN has increased the socialization of these programs and we believe it is having an impact (see results below). Additionally, call outreach to members who need an office visit and/or immunizations has increased by both the quality and Community Health Worker (CHW) teams.
- An intervention was initiated that included eye exam equipment in PCP offices for retinal eye exams on patients with diabetes. The tests are then routed to ophthalmologists for reading.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- HPN is pleased to report that the AAP measure, in both age brackets, improved from the 10th percentile to a projected 25th percentile for measurement year (MY) 2022. Incentives have been effective for both the providers and members in achieving this improvement. Later in 2023, home visits will be initiated for those members who experience barriers, such as transportation or childcare, that prevent them from making in-office appointments.
- For Medicaid children in the HPN population, we continued the incentive programs for both providers and members and are expanding the provider program. IMA Combo 2 increased by 1.7 percentage points and was only 6 members away from the 75th percentile. Well child visits (W30, rate 2) increased in 2022 2.47 percentage points and it is projected that we will increase from the 10th to the 25th percentile. Last, Combo 10 dropped again slightly by 1.46 percentage points, however we feel that increased well check visits will pull this rate up. Only 37 more members needed to be compliant to achieve the 50th percentile.
- For the Nevada Check Up population, the incentives continued to positively impact the rates. Although Combo 3 dropped slightly incompliance for 2022, Combo 7, which includes more vaccinations increased 1.98 percentage points. In IMA Combo 1, the meningococcal antigen increased by 4.31 percentage points and the Tdap increased 2.33 percentage points. Both antigens now measure at the 90th percentile for this population. Last, Well Child Visits in the First 30 Months of Life increased significantly by 11.97 percentage points and raised from the 75th to the 90th percentile. We feel that the increase in well child visits will continue to positively impact the immunization rates.
- For the Eye Exam for Patients with Diabetes (EED) measure, placement of equipment in PCP offices resulted in a significant increase by 5.84 percentage points and has placed this measure in a projected 90th percentile.

c. Identify any barriers to implementing initiatives:

- No barriers were identified.

HSAG Assessment: HSAG has determined that **HPN** addressed the prior year's recommendations based on the MCO's reported interventions implemented during MY 2023; however, results from the current EQR indicate that continued efforts may be necessary to support further improvement.

- **HPN**'s MY 2022 Medicaid performance for the *Adults' Access to Preventive/Ambulatory Health Services* measure showed improvement. Although all measure indicator rates are still ranking below NCQA's 2022 Quality Compass Medicaid HMO benchmarks, all rates except the *Ages 65 Years and Older* rate demonstrated minor increases in performance from the prior MY; the decrease in the rate for *Ages 65 Years and Older* was less than 1 percentage point. Additionally, the rate for *Ages 45–64 Years* met the State's established MPS. These improvements demonstrate that the interventions **HPN** put in place are making a positive impact. **HPN** should continue with these interventions.
- Although **HPN**'s MY 2022 Medicaid performance for *Childhood Immunization Status—Combination 3* and *Combination 7* showed very minor declines from the prior MY (i.e., <1 percentage point), *Combination 7* increased by 0.97 percentage points, the *Immunizations for Adolescents* measure indicator rates increased less than 5 percentage points, and *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for*

Age 15 Months to 30 Months—Two or More Well-Child Visits increased 2.47 percentage points. This performance demonstrates that **HPN**'s continuation of the incentive programs for providers and members are making a positive impact. **HPN** should continue with these interventions.

- **HPN**'s Nevada Check Up rates for *Childhood Immunization Status—Combination 3* continued to decline; however, the decline was less than 5 percentage points. Conversely, the *Combination 10* rate decreased more than 5 percentage points. **HPN**'s performance for *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* increased by more than 10 percentage points. Conversely, the *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* rate declined more than 5 percentage points. HSAG recommends that **HPN** continue its incentive programs for providers and members and also consider conducting additional analyses to see if there are disparities that may be impacting its Nevada Check Up child population, such as language barriers, access to transportation, geographic location, and socioeconomic status. **HPN** should also consider whether performance may have been impacted due to provider burnout and shortages as a lingering result of the COVID-19 PHE.
- **HPN**'s Medicaid rate for the *Eye Exam for Patients With Diabetes* measure increased more than 5 percentage points from the prior MY and met the State's established MPS, demonstrating that **HPN**'s placement of equipment in PCP offices positively impacted this rate.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review

HSAG recommended the following:

- **HPN** received a score of 71 percent in the Subcontractual Relationships and Delegation program area, indicating gaps in the MCO's process for ensuring its contracts or written arrangements with its delegates include all required federal and State contractual provisions. While **HPN** was required to develop a CAP, the MCO should also conduct a comprehensive review of all written arrangements with its delegates for the Nevada Managed Care Program and ensure they include all provisions required by federal and State contractual requirements. Further, **HPN** should include the provisions verbatim, when appropriate, to ensure no misinterpretation of the requirements.
- **HPN** received a score of 70 percent in the Practice Guidelines program area, indicating that the MCO had not adopted practice guidelines and protocols in accordance with all federal and State contractual requirements. While **HPN** was required to develop a CAP, the MCO should also develop processes for the adoption of practice guidelines specific to the Nevada Managed Care Program and the needs of its members. This should occur at a Nevada-based committee that includes representation of the MCO's provider network.

MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)

a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:

- HPN is reviewing all delegation agreements to ensure the provisions required by federal and State are included in the contract documents. As HPN is part of the larger UnitedHealthcare (UHC) organization, we have adopted a Regulatory Appendix used by all UHC Medicaid plans. This Regulatory Appendix is scrutinized by our legal and compliance team to ensure that the intent of the federal and State provisions remain intact.
- HPN has completed its corrective action in the Practice Guidelines program area, and has adopted practice guidelines specific to the Nevada Managed Care Program and the needs of its members. These practice

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guidelines are reviewed at a Nevada-based committee that includes representation of the MCO's provider network.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Standardized documentation of delegation agreements leads to streamlined review and approval of delegation agreements.
- No additional performance improvements have been noted due to the creation of practice guidelines.

c. Identify any barriers to implementing initiatives:

- No barriers have been identified.

HSAG Assessment: HSAG has determined that **HPN** addressed the prior year's recommendations as the MCO implemented a process to review all delegation agreements to ensure all required federal and State provisions are included in the contract documents. Additionally, **HPN** has adopted practice guidelines specific to the Nevada Managed Care Program, and these guidelines are reviewed by the local health plan level committee that includes representation from **HPN**'s provider network.

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation

HSAG recommended the following:

- **HPN** did not meet the time-distance contract standards for Pediatric Rheumatologist, indicating pediatric members may experience challenges accessing this provider type within an adequate time or distance from their residence. **HPN** should continue to conduct an in-depth review of provider categories in which it did not meet the time-distance contract standards, with the goal of determining whether or not the failure of the MCO to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area. **HPN** should also continue its efforts to contract with providers outside of the service area when there is a lack of providers in a specific county or counties, and expand the option for telehealth services, when appropriate, to reduce barriers to members accessing care.
- **HPN** did not meet the time-distance contract standards in Washoe County for the OB/GYN and Pediatrician provider types, indicating members may experience challenges accessing these provider types within an adequate time or distance from their residence. **HPN** should continue to review DHCFP's monthly enrolled provider list to determine if new providers are available in Washoe County for contracting.

MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)

a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:

- HPN continually reviews its Medicaid network to ensure time, distance, access and availability standards are met through geo access reporting, secret shopper and provider ratio reviews. We also open closed panels and recruit additional providers in areas where we find deficiencies or feel our ratios are low.
- In areas where there are a lack of Nevada-based providers, such as with Pediatric Rheumatologists in Washoe County, we have established provider contracts as close as possible, either in Las Vegas or in nearby States. We review the DHCFP's monthly enrolled provider list to determine if new providers are available for outreach. In addition, telehealth is promoted as an option whenever feasible and appropriate.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- An increased network size and increased utilization of Telehealth has provided additional opportunities for our members to be seen by providers.

c. Identify any barriers to implementing initiatives:

- Lack of specialty providers in Nevada, as a whole, is an ongoing barrier.

HSAG Assessment: HSAG has determined that **HPN** addressed the prior year's recommendations based on the MCO's reported interventions; however, since similar findings were noted in SFY 2023, **HPN** should continue its efforts to contract with any new providers as they become available, especially for OB/GYN and Pediatric Rheumatologist categories.

5. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation

HSAG recommended the following:

- Procedure codes documented in the medical records were either not found in the encounter data or were found in the encounter data but should have been coded with a different procedure code. **HPN** should consider performing periodic medical record reviews of submitted claims to verify appropriate coding and data completeness. Any findings from these reviews should then be shared with providers through periodic education and training regarding encounter data submissions, medical record documentation, and coding practices.

MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)

a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:

- Current process in our Medical Adjudication Department (MAD), a team of RN reviewers and 3 Certified Professional Coders (CPC), is to review any medical record forwarded to them for accuracy of CPT/HCPC codes billed to the medical record provided. Any review that determines a discrepancy from billed codes to documented services within the medical record is returned to the processing staff for denial of the line item(s) at issue for a corrected bill through the use of EOB message(s) back to the provider of service on their explanation of payment (EOP).

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- It is difficult to determine this. But denials for corrected billings should provider education to billing staff and providers to decrease future occurrences.

c. Identify any barriers to implementing initiatives:

- No barriers at this time

HSAG Assessment: HSAG has determined that **HPN** addressed the prior year's recommendations as the MCO seems to have a process in place to periodically review medical records for coding accuracy, which aligns with the recommendation. However, the effectiveness of this process requires further assessment and monitoring to ensure it adequately verifies appropriate coding and data completeness over time.

6. Prior Year Recommendation from the EQR Technical Report for CAHPS Analysis

HSAG recommended the following:

- Parents/caretakers of general child members had less positive overall experiences with their child's personal doctor since the score for this measure was statistically significantly lower than the 2021 NCQA Medicaid national average. **HPN** should prioritize improving parents'/caretakers' overall experiences with their child's personal doctor and determine a root cause for the lower performance. As part of this analysis, **HPN** could determine if any outliers were identified within the data, identify primary areas of focus, and develop appropriate strategies to improve the performance. Additionally, **HPN** should widely promote the

results of its member experiences with its contracted providers and staff members, and soliciting feedback and recommendations to improve parents'/caretakers' overall satisfaction with both **HPN** and its contracted pediatric providers. • There were less than 100 respondents for most measures for all populations; therefore, results could not be reported for the other measures, and other strengths and weaknesses could not be identified. **HPN** should focus on increasing response rates to the CAHPS survey for all populations so there are greater than 100 respondents for each measure by educating and engaging all employees to increase their knowledge of CAHPS, using customer service techniques, oversampling, and providing awareness to members and providers during the survey period.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • HPN continued to discuss CAHPS results with provider offices and during Joint Operations Committees (JOCs). A CAHPS/NPS work team was created where we discuss possible activities that would both increase the response rates and positive responses. A provider education piece is in process and for Q3 of 2023.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Rating of Personal Doctor increased from 85.6% to 90.1% between 2021 and 2022. There were 121 responses to the CAHPS survey.
c. Identify any barriers to implementing initiatives: • Members are survey weary due to all the companies who now survey their customers via paper, email and text. This makes it particularly difficult to obtain a valid N (number) on this survey.
HSAG Assessment: HSAG has determined that **HPN** addressed the prior year's recommendations based on the MCO's reported interventions. However, results from the SFY 2023 CAHPS activity indicate that **HPN** should continue to focus its efforts on improving response rates and positive responses.

Molina Healthcare of Nevada, Inc.

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

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects

HSAG recommended the following:

- **Molina** was a new MCO in Nevada effective January 1, 2022; therefore, the MCO did not have sufficient data to conduct PIPs in SFY 2022 and no recommendations for improvement were made by HSAG.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures

HSAG recommended the following:

- **Molina** was a new MCO in Nevada effective January 1, 2022; therefore, an audit was not conducted since the MCO did not have any MY 2021 performance measure data for review. Additionally, no recommendations for improvement were made by HSAG.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review

HSAG recommended the following:

- HSAG did not identify any substantial weaknesses for **Molina** as no program area scored at or below 80 percent compliance. Because all remediation plans were on track for implementation, HSAG did not make any recommendations for improvement.

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation

HSAG recommended the following:

- **Molina** did not meet the time-distance contract standards for OB/GYN and Pediatric Rheumatologist, indicating members may experience challenges accessing these provider types within an adequate time or distance from their residence. **Molina** should conduct an in-depth review of provider categories in which it did not meet the time-distance contract standards, with the goal of determining whether or not the failure of the MCO to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.
- **Molina** did not meet the time-distance contract standards for the Pediatrician and Dialysis/ESRD Facility provider types in Washoe County, indicating members may experience challenges accessing these provider types within an adequate time or distance from their residence. **Molina** should review DHCFP's monthly enrolled provider list to determine if new Pediatrician providers are available in Washoe County for contracting. **Molina** should also continue its contracting efforts with Dialysis/ESRD Facility providers in Washoe County to mitigate any access to care barriers for members needing dialysis and other ESRD-related care from this provider type.

MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)

a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:

- After conducting an in-depth review of provider categories based on Time and Distance, for Pediatric Rheumatology, we have contracted with the only Pediatric Rheumatologist located in Nevada (Clark County). All others are Out of State. Molina is also currently working with [provider group] on an agreement which would add around 5 additional Pediatric Rheumatology providers. Molina has secured contracts with the major OB/GYN groups within both Clark County and Washoe County to meet and

exceed state time and distance standards. For OB/GYN, we have contracted 49 groups/ 159 providers in Clark County and 10 groups/ 52 providers in Washoe County. • Molina reviewed the DHCFP Monthly Active Provider Report and for Pediatricians, we currently have 47 contracted pediatric PCPs and a total of 64 pediatricians with service locations in Washoe County. In reviewing the DHCFP Monthly Active Provider Report, there are a total of 111 Pediatric providers available in the service area. Additionally, by contracting with [provider group], this would include around 130 additional contracted Pediatric providers. For Dialysis, we were contracted with [provider group] during the reporting period and just recently also contracted with [provider group] effective 6/1/2023 providing Dialysis coverage through the 2 primary Dialysis providers in Nevada. During reporting period, Fresenius has 3 locations in Reno, 1 in Carson City and 1 in Sparks.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • We are working to contract [provider group] which would add a hospital along with adult and pediatric providers. • We have since contracted with the other large Dialysis provider, [provider group] in Nevada providing Statewide coverage for Dialysis. • In reviewing the available Pediatricians in Washoe county, Molina will review and conduct a targeted outreach to enlist additional Pediatricians to increase our current 64 of 111 providers.
c. Identify any barriers to implementing initiatives: • There are no barriers other than a shortage or providers enrolled with Nevada Medicaid and practicing in Nevada. We will continue to work with those available providers here in Nevada as well as our catchment area to continue building out the Molina network.
HSAG Assessment: HSAG has determined that **Molina** addressed the prior year's recommendations based on the MCO's reported initiatives; however, since similar findings were noted in SFY 2023, **Molina** should continue its efforts to contract with any new providers, especially for OB/GYN, Pediatrician, Pediatric Rheumatologist, and Pediatric Psychologist categories.
5. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation
HSAG recommended the following: • **Molina** began providing services to members enrolled in the Nevada Managed Care Program on January 1, 2022; therefore, since the EDV activity began prior to January 1, 2022, the SFY 2022 EDV activity did not include **Molina** as sufficient encounter data were not available during the period under review. Additionally, no recommendations for improvement were made by HSAG.
6. Prior Year Recommendation from the EQR Technical Report for CAHPS Analysis
HSAG recommended the following: • **Molina** began providing coverage to Medicaid and Nevada Check Up members effective January 1, 2022; therefore, CAHPS results are not available for SFY 2022. Additionally, no recommendations for improvement were made by HSAG.

SilverSummit Healthplan, Inc.

Table 5-4—Prior Year Recommendations and Responses for SilverSummit

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • **SilverSummit** did not achieve its goal to decrease the rate of HbA1c test results greater than 9 percent or missing HbA1c test results among male diabetic members ages 18 to 75 who have a reported HbA1c level greater than 9 percent. **SilverSummit** should apply lessons learned and knowledge gained from its intervention efforts and proceed with implementing new interventions to support quality improvement. • Incomplete data reporting and interpretation of results resulted in **SilverSummit** receiving a level of *Low confidence* on the *CDC HbA1c Poor Control >9.0%* PIP and a level of *Reported PIP results were not credible* on the *Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care* PIP. **SilverSummit** should ensure that its data and interpretation of results are complete and accurately documented in its PIP submissions. The MCO should include all intervention testing data and outcomes. **SilverSummit** must follow and report data based on the validated and approved PIP methodology. • **SilverSummit** limited the number of interventions tested for the duration of the PIP. **SilverSummit** should consider testing more than one or two interventions during the PIP study. Initiating multiple interventions will help **SilverSummit** address as many identified opportunities for improvement as possible. **SilverSummit** should also apply lessons learned and knowledge gained from its efforts and HSAG's feedback throughout the PIP to future PIPs and other quality improvement activities.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • SilverSummit has significantly revised the PIP approach to ensure multiple interventions and standardized measurement. Data will be monitored at least quarterly by QI Specialists, to ensure there is a process for validation and impact to outcomes on a recurring basis. Interventions will expand beyond focus population to make greater impact to Medicaid members and drive better performance overall. SilverSummit will follow the Plan-Do-Study-Act (PDSA) method to track intervention performance throughout the PIP duration.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • SilverSummit will submit data in June 2023 that will be used as baseline data for PIP performance.
c. Identify any barriers to implementing initiatives: • No barriers identified at this time.
HSAG Assessment: HSAG has determined that **SilverSummit** addressed the prior year's recommendations based on the initiatives reported to improve the processes to support newly implemented PIPs. **SilverSummit** initiated new PIPs in SFY 2023 and had not progressed to reporting interventions; therefore, HSAG will assess future PIP submissions and determine whether the MCO's quality improvement processes, strategies, and interventions effectively addressed these recommendations in future PIP submissions.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures
HSAG recommended the following: • Within the Access to Care domain for **SilverSummit**'s Medicaid population, all measure indicator rates for *Adults' Access to Preventive/Ambulatory Health Services* ranked below NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile benchmarks and did not meet the MPS. In addition, the *Ages 65 Years and Older* measure indicator demonstrated a significant decline of more than 20 percentage points. Preventive and ambulatory visits are an opportunity for members to receive preventive services and counseling on topics such as diet and exercise, as well as help address acute issues or manage chronic conditions. **SilverSummit** should continue its initiatives to mitigate the barriers caused by the COVID-19 PHE, including promoting and encouraging telehealth services and conducting member outreach through member newsletters, flyers, and the website. **SilverSummit** should also continue its efforts to evaluate network adequacy and implement interventions in those ZIP Codes in which there are disparities in service utilization. • With the exception of *Well-Child Visits in the First 30 Months of Life—Six or More Well-Child Visits* measure indicator, all measure rates within the Children's Preventive Care domain for **SilverSummit**'s Medicaid population ranked below NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile benchmarks. In addition, a decline in performance of more than 5 percentage points was shown for the *Immunizations for Adolescents—Combination 2*, *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total* and *Counseling for Physical Activity—Total*, and *Well-Child Visits in the First 30 Months of Life—Two or More Well-Child Visits* measure indicators. Within **SilverSummit**'s Nevada Check Up population, a decline in performance of more than 5 percentage points was shown for the *Childhood Immunization Status—Combination 3* and *Combination 7*, *Immunizations for Adolescents—Combination 2*, and *Well-Child Visits in the First 30 Months of Life—Two or More Well-Child Visits* measure indicators. This performance suggests that not all of **SilverSummit**'s Medicaid and Nevada Check Up child and adolescent members are receiving the recommended immunizations and well-care visits, which are important for avoiding vaccine-preventable diseases, as well as screening and counseling, which are important at every stage of life. **SilverSummit** should continue its "Project Neighborhood Health" initiative that was implemented to promote screenings and vaccinations in specific ZIP Codes where there are disparities in service utilization. As part of this initiative, **SilverSummit** should conduct ongoing analyses to confirm that the initiative is successful at increasing the prevalence of well-care visits and immunizations. If the intervention is not successful, **SilverSummit** should implement new interventions to improve performance in the Children's Preventive Care domain. • **SilverSummit** did not meet the MPS for any performance measure rates for its Nevada Check Up population. Furthermore, **SilverSummit** did not meet the MPS for any performance measure rates for its Medicaid population other than the *Use of Opioids at High Dosage* and *Use of Opioids From Multiple Providers* measures. **SilverSummit** should continue to conduct analyses on all performance measure rates that did not meet the MPS for the Medicaid and Nevada Check Up populations. **SilverSummit** should also monitor rates regularly and consider whether there are disparities within its populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, **SilverSummit** should implement appropriate interventions to improve performance. Further, **SilverSummit** should conduct a comprehensive review of all member grievances reported over the past 12 months to determine other factors that may have contributed to members not accessing services and implement interventions to mitigate any noted barriers.

MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)

a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:

- SilverSummit has taken significant action to investigate root causes and interventions to ensure improved performance and member engagement in care. Member and provider incentive models have been revised, educational materials developed, and a general increase in engagement practices has been implemented. Data monitoring has been standardized with an increase in cross-functional input. There is continued collaboration between grievance and appeals and quality of care teams to identify possible barriers to members care and experience. SilverSummit will also target their outreach for member-based events, identifying zip codes with potential disparities for the Medicaid population.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- SilverSummit has noted an improved response and engagement from providers, as well as year over year improvement in several key measures.

c. Identify any barriers to implementing initiatives:

- Provider access and availability; some provider offices are not able to schedule wellness appointments as soon as preferred.

HSAG Assessment: HSAG has determined that **SilverSummit** addressed the prior year's recommendations based on the MCO's reported interventions implemented during MY 2023. However, although the interventions supported that some improvement was made as indicated through an increase in the number of measure indicator rates meeting the State's established MPS, results from the current EQR also indicate that continued efforts are necessary to support further improvement.

- Within the Access to Care domain for **SilverSummit**'s Medicaid population, all measure indicator rates for *Adults' Access to Preventive/Ambulatory Health Services* continued to decline, ranked below NCQA's Quality Compass HEDIS 2022 Medicaid HMO 50th percentile benchmarks, and did not meet the MPS. Therefore, **SilverSummit** should evaluate its interventions for effectiveness and identify new strategies as necessary to support improvement in this program area.
- Within the Children's Preventive Care domain, all measure rates for **SilverSummit**'s Medicaid population ranked below NCQA's Quality Compass HEDIS 2022 Medicaid HMO 50th percentile benchmarks. Additionally, although some improvement was noted for the *Immunizations for Adolescents* measure indicator rates, all indicator rates for the *Childhood Immunization Status* measure declined. Further, while all measure indicators for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure improved, the *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits* measure indicator rate continued to decline. Within **SilverSummit**'s Nevada Check Up population, although **SilverSummit**'s *Immunizations for Adolescents—Combination 2* rate improved significantly and interventions may have supported improvement, significant declines continued for all the *Childhood Immunization Status* measure indicator rates. As such, **SilverSummit** should continue the interventions that are having positive effects on member outcomes and identify new strategies as necessary to support improvement in less successful areas.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review

HSAG recommended the following:

- **SilverSummit** received a score of 76 percent in the Grievance and Appeal Systems program area, indicating that the MCO had not implemented a member grievance and appeal process that met all federal

and contractual requirements. A total of nine deficiencies were identified. While **SilverSummit** was required to develop a CAP, given the high volume of deficiencies identified in the MCO's grievance and appeal process, the MCO should conduct a comprehensive review of all policies, procedures, workflows, letter templates, and all other member grievance and appeal materials to identify any additional opportunities for improvement in this program area. **SilverSummit** should also conduct additional staff training once all materials have been reviewed and revised, and enhance management oversight of the grievance and appeal process. • **SilverSummit** received a score of 71 percent in the Subcontractual Relationships and Delegation program area, indicating gaps in the MCO's process for ensuring its delegation agreements include all required federal and State contractual provisions. While **SilverSummit** was required to develop a CAP, the MCO should also conduct a comprehensive review of all written arrangements with its delegates for the Nevada Managed Care Program and ensure they include all provisions required by federal and State contractual requirements. Further, **SilverSummit** should include the provisions verbatim, when appropriate, to ensure no misinterpretation of the requirements. Finally, the MCO should update its formal auditing process, specifically the scoring methodology for determining when a CAP is or is not required from a delegate, to ensure deficiencies identified during the auditing process are remedied appropriately.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • SilverSummit Healthplan has already reviewed and updated many of the grievance and appeal materials to address the deficiencies identified, including performing staff training where appropriate. In addition, we are in the process of performing a comprehensive review of the program including all materials (policies, procedures, workflows, etc.) to identify any additional opportunities for improvement, as well as ways to enhance management oversight of the process. • SilverSummit conducted a comprehensive review of all written arrangements for its delegates and completed contract amendments to include the required State and federal provisions, where necessary. • Our formal auditing process (for providers delegated to perform credentialing) was reviewed and updated to require a CAP for all deficiencies identified. Our scoring methodology was also updated to include scores requiring a 30-day CAP, and those allowing for a 180-day CAP.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • We believe performance will be improved by addressing the deficiencies and ensuring our members have clear and timely information about their grievances and appeals, as required. • As a result of the delegated contract review initiative, we were able to identify updates needed to our contract attachment for Medicaid delegated vendors. This attachment now contains all the required State and federal provisions (verbatim). This will ensure that any future arrangements are fully compliant with all required provisions. • Although we have not seen performance improvement yet, we believe the updated scoring will result in a more accurate and timely credentialing process by providers.
c. Identify any barriers to implementing initiatives: • There have been no barriers to date.

- The only barriers faced with the delegated contract review initiative was timeliness with executing amendments in some cases, due to other contract updates or discussions occurring at the same time with the vendor(s). We don't feel this barrier will prevent us from completing all necessary amendments.

HSAG Assessment: HSAG has determined that **SilverSummit** addressed the prior year's recommendations through updated grievance and appeal materials and staff training and has continued to conduct a comprehensive review of its grievance and appeals processes to identify any additional opportunities for improvement; however, HSAG recommends that the MCO consider implementing file reviews for grievance and appeal cases to enhance its oversight processes for this program area. Additionally, **SilverSummit** completed a review of all written delegate arrangements and completed contract amendments to ensure that required State and federal provisions were included in these documents.

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation

HSAG recommended the following:

- **SilverSummit** did not meet the time-distance contract standards for OB/GYN, Pediatric Rheumatologist, and Pediatric Psychologist, indicating members may experience challenges accessing these provider types within an adequate time or distance from their residence. **SilverSummit** should continue to conduct an in-depth review of provider categories in which it did not meet the time-distance contract standards, with the goal of determining whether or not the failure of the MCO to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area. **SilverSummit** should also continue to review DHCFP's monthly enrolled provider file to identify providers that may be able to fill any network gaps. When providers are not available for contracting, **SilverSummit** should also continue its efforts to promote telehealth services and transportation benefits to mitigate access to care issues.
- **SilverSummit** did not meet the time-distance contract standard in Washoe County for the Pediatrician provider type, indicating child members may experience challenges accessing pediatricians within an adequate time or distance from their residence. **SilverSummit** should continue to review DHCFP's monthly enrolled provider list to determine if new providers are available in Washoe County for contracting.

MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)

a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:

- The Network team has a formal process for reviewing network adequacy on a regular basis. Each month the state report is reviewed to determine any new providers that may have enrolled in Medicaid. If a provider is identified, outreach is made to the provider to offer a contract.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Although we have not seen improvement yet, we believe the updated monitoring will result in identifying additional providers that may be enrolled in Medicaid to bring into the network.

c. Identify any barriers to implementing initiatives:

- The network team has identified members living just slightly outside of the time/distance to any Medicaid enrolled provider. This creates a barrier when no physicians are available to contract with.

HSAG Assessment: HSAG has determined that **SilverSummit** addressed the prior year's recommendations based on the MCO's reported interventions; however, since similar findings were noted in SFY 2023, the MCO should continue its efforts to contract with any new providers, especially for OB/GYN, Pediatrician, and Pediatric Rheumatologist categories.

5. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation
HSAG recommended the following: • **SilverSummit** had challenges requesting medical records from its contracted providers, resulting in a low medical record procurement rate. The low medical record procurement rate consequently impacted the results of the medical record reviews of key data elements that were evaluated. To ensure **SilverSummit**'s contracted provider accountability in addressing submission of medical records for auditing, inspection, and examination related to its members, **SilverSummit** should consider strengthening and/or enforcing its contract requirements with providers in providing the requested documentation. • Procedure codes documented in the medical records were either not found in the encounter data or were found in the encounter data but should have been coded with a different procedure code. **SilverSummit** should consider performing periodic medical record reviews of submitted claims to verify appropriate coding and data completeness. Any findings from these reviews should then be shared with providers through periodic education and training regarding encounter data submissions, medical record documentation, and coding practices.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • We are working on implementing new strategies for medical records retrieval, including using more onsite retrieval methods to increase record procurement rates for Encounter Data Validation purposes, as well as for Quality purposes. • We are currently exploring better and more efficient ways to communicate with providers on a larger scale. This includes better ways to share information, provide periodic education and training regarding medical record documentation and coding practices.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • We have started to see improvement with these methods on the Quality side, so we feel confident the same strategy will help increase record procurement rates in other areas, like Encounter Data Validation. • Once implemented, we will be monitoring for performance improvement.
c. Identify any barriers to implementing initiatives: • Our contracts include requirements for providers to submit requested documentation; however, some requested records were from providers we were no longer contracted with at the time. Providers also expressed "burn-out" from continuous record requests and other administrative requirements from all payers. These may be barriers we continue to face even with improved record procurement and provider education and training strategies.
HSAG Assessment: HSAG has determined that **SilverSummit** partially addressed the prior year's recommendations based on the MCO's reported interventions. **SilverSummit**'s efforts to implement new strategies for record retrieval and improve communication, along with its existing contract requirements, demonstrate a commitment to addressing the recommendations. However, addressing provider burnout and ensuring enforcement of contract requirements when provider relationships change may require additional measures to strengthen the MCO's approach. Additionally, while **SilverSummit** addressed strategies related to medical records retrieval and improving communication with providers, it did not specifically mention periodic medical record reviews for coding and data completeness verification. As such, HSAG recommends that **SilverSummit** review these prior recommendations and consider implementing them to ensure the medical records kept by contracted providers support the claims being submitted for payment.

6. Prior Year Recommendation from the EQR Technical Report for CAHPS Analysis

HSAG recommended the following:

- Adult members had fewer positive experiences with their health plan since the score for this measure was statistically significantly lower than the 2021 NCQA Medicaid national average. **SilverSummit** should focus on improving members' overall experiences with their health plan by performing a root cause analysis, which could determine if there are any outliers within the data so that **SilverSummit** can identify the primary areas of focus and develop appropriate strategies to improve the performance. **SilverSummit** should also continue the initiatives it has already implemented based on previous analyses, including the member concierge program, door-to-door visits by community health workers, and the promotion of urgent care and engagement with providers to offer after-hours clinics.
- The Effectiveness of Care scores were statistically significantly lower than the 2021 NCQA Medicaid national averages. **SilverSummit** should focus on quality improvement initiatives to provide medical assistance with smoking and tobacco use cessation and continue to develop efforts to promote its Health Education & Wellness smoking cessation program. **SilverSummit** should also continue with the development of a social media platform and provider materials aimed at promoting smoking cessation and the available options to stop smoking, including medication assistance.
- There were less than 100 respondents for every measure for the CCC populations and Nevada Check Up general child population, several measures for the adult Medicaid population, and every measure except *Rating of Health Plan* for the child Medicaid population; therefore, results could not be reported for the other measures and other strengths and weaknesses could not be identified. **SilverSummit** should focus on increasing response rates to the CAHPS survey for all populations so there are greater than 100 respondents for each measure by educating and engaging all employees to increase their knowledge of CAHPS, using customer service techniques, oversampling, and providing member and provider awareness during the survey period.

MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)

a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:

- **SilverSummit** is implementing various programs to improve CAHPS performance and member satisfaction. There will be an increased partnership between the QI team and CHWs to engage with members directly and identify potential concerns from our Medicaid membership. Continuous trending of grievances and quality of care ensure members' needs are addressed timely and tracked for reoccurrence. **SilverSummit** is leveraging partnerships and provider relationships to educate and create action around the member experience and improve response rates. Survey responses are reviewed during QIC and PIT meetings to promote cross-functional collaboration and build activities to support positive member engagement in care.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Plan will receive CAHPS scorecards from the Vendor in Q3 to review performance year over year.

c. Identify any barriers to implementing initiatives:

- Continued low response rate from Medicaid population for 2023.

HSAG Assessment: HSAG has determined that **SilverSummit** addressed the prior year's recommendations based on the MCO's reported interventions. However, results from the SFY 2023 CAHPS activity indicate that **SilverSummit** should continue to focus its efforts on improving response rates and positive responses.

6. Follow-Up on Prior EQR Recommendations for PAHP

From the findings of the PAHP performance for the SFY 2022 EQR activities, HSAG made recommendations for improving the quality of healthcare services furnished to members enrolled in the Nevada Managed Care Program. The recommendations provided to the PAHP for the EQR activities in the *State Fiscal Year 2022 External Quality Review Technical Report* are summarized in Table 6-1. The PAHP's summary of the activities that were either completed, or were implemented and still underway, to improve the finding that resulted in the recommendation, and as applicable, identified performance improvement, and/or barriers identified are also provided in Table 6-1.

LIBERTY Dental Plan of Nevada, Inc.

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

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • Even though the SMART Aim goal was achieved, HSAG identified calculation errors in the analysis of results, which resulted in HSAG assigning a level of *Confidence* to the *Total of Eligible Enrollees Receiving a Sealant on a Permanent Molar Tooth* PIP instead of *High confidence*. **LIBERTY** should implement validation processes to ensure its calculations of results are accurately documented in its PIP submissions.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • LIBERTY identified that specific numerator values used to calculate the overall rate measurements were not being rounded up appropriately due to an existing formula being applied instead of a whole numerical value. As a result, measurement percentages were miscalculated for the identified months on the run chart submission. LIBERTY reports this finding as an isolated incident as this specific issue has not occurred previously and has since been remediated.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • LIBERTY will implement additional quality assurance checks along with validation on finalized data to ensure that applicable numerical values and formulas are inserted as whole numbers. These quality checks will ensure that any future submissions will contain additional validation checks on final calculations.
c. Identify any barriers to implementing initiatives: • No barriers were identified.
HSAG Assessment: HSAG has determined that **LIBERTY** addressed the prior year's recommendations based on the initiatives reported to improve the processes to support newly implemented PIPs. **LIBERTY** initiated new PIPs in SFY 2023 and had not progressed to reporting interventions; therefore, HSAG will assess future PIP submissions and determine whether the PAHP's quality improvement processes, strategies, and interventions effectively addressed these recommendations in future PIP submissions.

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2. Prior Year Recommendation from the EQR Technical Report for Performance Measures
HSAG recommended the following: • For **LIBERTY**'s Medicaid population, the *Annual Dental Visit* rates for the *Ages 4–6 Years*, *Ages 15–18 Years*, and *Ages 19–20 Years* measure indicators ranked below NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile benchmarks indicating additional opportunities for **LIBERTY** to focus on members within these age groups to ensure they are receiving the oral care necessary to reduce the risks of developing oral disease in the future. **LIBERTY** should continue its efforts to identify underutilization of dental services among Medicaid and Nevada Check Up members, including any disparities within these populations, and target outreach efforts, education, school-based services, and member and provider incentive programs when and where appropriate. As part of these efforts, **LIBERTY** should regularly evaluate whether the interventions and initiatives are successful, and make revisions as necessary, to support continued improvement in the prevalence of members seeking preventive dental care.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • LIBERTY developed several initiatives that were aimed at improving access to care, utilization, and preventive services amongst members ages 0-20. • Provider Bonus Programs – Providers are provided a roster in their secure provider portal to do outreach to eligible members for the following: – 24 Month Non-utilizers ran August – September. Provider reimbursed $100 for each eligible member from their roster for performing D1206 or D1110/D1120. – Zip Code ran August – September. Provider reimbursed $100 for each eligible member in specific zip codes of disparity and underutilization for performing D1206 and D1110/D1120. – Healthcare Effectiveness Data and Information Set (HEDIS) ran October – December. Provider to outreach to HEDIS-eligible members and was reimbursed $30 for preventive services. • Healthy Behaviors Program – Non-utilizers ages 0-20 incentivized to visit the dentist and receive a $25 gift card for completing a dental appointment. • Dental Provider Partnerships – LIBERTY's Community Outreach Department partners with contracted dental providers to offer education and preventive dental services at community events and school-based programs. • Text Campaigns - Non-utilizers and aged-out foster children are sent a text journey to assist with connecting them to their dental home to receive services. • Case Management/Care Coordination – Outreach to such members as children scoring medium or high risk on caries risk assessment (CRA) and to aged-out foster children to help members with complex dental and medical needs to overcome barriers to dental care which results in better member outcomes.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • LIBERTY monitors utilization and performance measures using automated reports on an ongoing basis and analyzes the findings to evaluate programs which are targeted to increase utilization. • LIBERTY has a Population Health Workgroup to focus on health promotion and disease prevention and incorporates community-based health and wellness strategies with a strong focus on social determinants of health (SDOH), creating health equity, and supporting efforts to build more resilient communities.

c. Identify any barriers to implementing initiatives:

- Barriers include correct contact information and social determinants of health such as food insecurity, housing, lack of transportation can prevent members from accessing care.

HSAG Assessment: Based on **LIBERTY**'s reported interventions implemented in SFY 2023, HSAG has determined that **LIBERTY** addressed the prior year's recommendations. However, HSAG was unable to determine whether the interventions supported improvement as the performance measures validated in SFY 2022 were not validated for SFY 2023.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review

HSAG recommended the following:

- HSAG did not identify any substantial weaknesses for **LIBERTY** as no program area scored at or below 80 percent compliance. No recommendations for improvement were made by HSAG.

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation

HSAG recommended the following:

- **LIBERTY** did not meet the provider ratio requirements for dental specialists, indicating **LIBERTY** may not have a sufficient provider network for its members to access these services. **LIBERTY** should continue to conduct an in-depth review of provider categories in which it did not meet the time-distance contract standards, with the goal of determining whether or not the failure of the PAHP to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area. **LIBERTY** should also continue using DHCFP's monthly provider list to identify new specialty dental providers and, subsequently, outreach and try to recruit those specialists in Clark and Washoe counties.
- **LIBERTY** did not meet the time-distance contract standards for Public Health Endorsed Dental Hygienist or Prosthodontist, indicating members may experience challenges accessing these provider types within an adequate time or distance from their residence. **LIBERTY** should continue to conduct an in-depth review of provider categories in which it did not meet the time-distance contract standards, with the goal of determining whether or not the failure of the PAHP to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area. To mitigate access issues, **LIBERTY** should also continue its efforts to provide out-of-network providers to serve members when specialty services are not available from a contracted provider near the members' homes.

MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)

a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:

- LIBERTY receives an active Medicaid Provider list from the Division of Health Care Financing and Policy (DHCFP) monthly that is utilized to outreach and recruit specialists in Clark and Washoe Counties, including periodontists, endodontists, oral surgeons, and prosthodontists. Our Provider Relations (PR) team continuously recruits these specialist provider types to join our network, identifies out-of-network providers to serve members when needed, and identifies general dentists with the training and willingness to perform specialty services. We also reach out to specialists contracted with our other line of business to get them to join the Medicaid Network.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Since 4th quarter of 2021, LIBERTY has added a total of 10 oral surgeons to our network. We are currently at 99.9% for time and distance access for endodontists, pediatric dentists, and oral surgeons. We are at 88%

for periodontists and prosthodontists. For periodontists we have 100% of specialists in Clark and Washoe counties with a Medicaid Identification Number contracted and for prosthodontists we have all but one which we will continue to reach out to recruit. Since January 1, 2022, we have only had 10 member grievances filed for specialty access with current membership at approximately 700,000 members.

c. Identify any barriers to implementing initiatives:

- The main barrier is that the State of Nevada has the same requirements for Medicaid specialists' ratios as they do for general dentists' ratios which is 1:1,500. When recruiting specialists in Nevada, a high percentage do not wish to accept the reimbursement rates offered or decline to accept Medicaid membership into their offices due to the high no show rates.

HSAG Assessment: The State of Nevada removed the ratio requirement of 1 provider per 1,500 members for dental specialists and is reassessing appropriate provider-to-member ratios for Dental Specialists. In that context, HSAG has determined that **LIBERTY** addressed the prior year's recommendations for improvement. However, since similar findings were noted in SFY 2023, **LIBERTY** should continue its efforts to contract with any new providers, especially dental specialists including Public Health Endorsed Dental Hygienists, Periodontists, and Prosthodontists.

5. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation

HSAG recommended the following:

- Dental procedure codes documented in the dental records were either not found in the encounter data or were found in the encounter data but should have been coded with a different procedure code. **LIBERTY** should consider performing periodic dental record reviews of submitted claims to verify appropriate coding and data completeness. Any findings from these reviews should then be shared with providers through periodic education and training regarding encounter data submissions, dental record documentation, and coding practices.

MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)

a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:

- LIBERTY has created a secure provider portal enhancement where records requests can be requested from an office and the office can then upload the members records into their secure provider portal eliminating any potential protected health information (PHI) issues. A provider dental records training was created and placed on the secure provider portal for review at the provider's convenience. We also held an in-person network training in January with great participation. Our Provider Reference Guide (PRG) was updated to include a very comprehensive dental records section. LIBERTY receives records in several departments so random reviews are conducted as part of our daily business practices. If discrepancies or opportunities for education are identified, outreach to those offices are conducted by Provider Relations. LIBERTY has a Dental Care Management (DCM) team that uses analytics to review appropriateness of treatments and potential coding issues. If offices are identified our Dental Director provides counseling calls to the office.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):

- Through our DCM process, in 90 days from a counseling call, a comparison report is generated that compares data before and after the counseling call. Most offices show improvement, and no further action is taken. However, in cases when there is no improvement or minimal improvement, the office may be subject to more actions to rectify the issue.

c. Identify any barriers to implementing initiatives:

- Offices are not always responsive, and it takes multiple requests to get the providers to submit requested records. Provider Relations will go in-person to offices to retrieve records.

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HSAG Assessment: HSAG has determined that **LIBERTY** addressed the prior year recommendations as **LIBERTY**'s multifaceted approach to dental records management demonstrates a proactive effort to verify coding accuracy and data completeness while also providing education and support to its network providers.
6. Prior Year Recommendation from the EQR Technical Report for Member Satisfaction Survey
HSAG recommended the following: • Although **LIBERTY** attempted outreach to 16,655 members, only 4.3 percent of those members were successfully reached (724 members), which indicates a low percentage of members provided feedback about their dental experiences and their dental providers/offices, and satisfaction results may not be reflective of the entire membership. **LIBERTY** should proceed with using text messaging as an option for outreaching to members to increase the rate of members completing the surveys. **LIBERTY** could also consider member incentives to complete the Member Satisfaction Survey activity. • **LIBERTY** did not meet the 90 percent benchmark for Recommend Office. **LIBERTY** should perform a root cause analysis to determine if any outliers were identified within the data, especially as it pertains to certain dental offices; identify primary areas of focus; and develop appropriate strategies to improve the performance. Additionally, **LIBERTY** should continue to forward any identified trends in members' negative experiences to Provider Relations for counseling, widely promote these results with its contracted dental providers and staff members, and solicit feedback and recommendations to improve members' overall satisfaction with both **LIBERTY** and its contracted dental providers.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Effective reporting year 2023, LIBERTY transitioned the member satisfaction survey to our third-party vendor, [survey vendor]. Multiple methods such as mailers and telephone outreach will be conducted to help increase the response rate from members. LIBERTY submitted a member satisfaction survey strategy to the DHCFP on our efforts. • LIBERTY routes any indication of member dissatisfactions identified through our satisfaction survey to our Provider Relations Department to address with the individual provider offices. PR conducts outreach and counseling, specific to the deficiencies and monitors the provider's ongoing compliance with contractual requirements.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • LIBERTY is pending the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey results from [survey vendor] and will re-evaluate and implement additional initiatives if necessary.
c. Identify any barriers to implementing initiatives: • No barriers were identified.
HSAG Assessment: HSAG has determined that **LIBERTY** addressed the prior year's recommendations based on the MCO's reported initiatives. Of note, as **LIBERTY** changed its survey process from SFY 2022 to SFY 2023 and the survey processes are not methodologically comparable, HSAG did not assess whether **LIBERTY**'s change in survey processes supported improvement in response rates.

7. MCE Comparative Information

In addition to performing a comprehensive assessment of each MCE's performance, HSAG uses a step-by-step process methodology to compare the findings and conclusions established for each MCE to assess the Nevada Managed Care Program. Specifically, HSAG identifies any patterns and commonalities that exist across the five MCEs and the Nevada Managed Care Program, draws conclusions about the overall strengths and weaknesses of the program, and identifies areas in which DHCFP could leverage or modify its Quality Strategy to promote improvement.

EQR Activity Results

This section provides the summarized results for the mandatory EQR activities across the MCEs, when the activity methodologies and resulting findings were comparable.

Validation of Performance Improvement Projects

For the SFY 2023 validation, the MCOs submitted the design for the two DHCFP-mandated PIP topics, and the PAHP submitted the design for the two PAHP-selected PIP topics. The MCEs did not progress to the point of reporting baseline data and interventions.

Table 7-1 below provides a comparison of the overall PIP validation ratings and the scores for all PIP activities by MCE. The scoring methodology is found in Appendix A. For SFY 2023, the PIP scores were determined through HSAG's evaluation of the MCEs' documentation to support the PIP topics, PIP Aim statements, identified PIP population(s), sampling method(s), PIP indicators, and data collection procedures. All MCOs used the same comparative targeted age group for each PIP's performance indicators as defined by NCQA's HEDIS specifications. For the *IET* PIP, the age group was 13 years of age and older and for the *Plan All-Cause Readmissions* PIP, 18 to 64 years of age. The PAHP's *Increase Preventive Services for Children* PIP targeted members 0 to 20 years of age; and for the *Coordination of Transportation Services* PIP, all members were targeted regardless of age.

Table 7-1—Comparison of PIP Validation by MCE

MCE	PIP Topic and Overall PIP Validation Rating for PIP Design		Overall PIP Scores		
			Met	Partially Met	Not Met
Anthem	*Improving the Rates for Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)*	*Met*	100%	0%	0%
	Plan All-Cause Readmissions	*Met*	100%	0%	0%

MCE	PIP Topic and Overall PIP Validation Rating for PIP Design		Overall PIP Scores		
			Met	Partially Met	Not Met
HPN	*Initiation and Engagement of Substance Use Disorder Treatment (IET)*	*Met*	100%	0%	0%
	Plan All-Cause Readmissions	*Met*	100%	0%	0%
LIBERTY	*Increase Preventive Services for Children*	*Met*	100%	0%	0%
	Coordination of Transportation Services	*Met*	100%	0%	0%
Molina	*Initiation and Engagement of Substance Use Disorder Treatment (IET)*	*Met*	100%	0%	0%
	Plan All-Cause Readmissions	*Met*	100%	0%	0%
SilverSummit	*Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)*	*Met*	100%	0%	0%
	Plan All-Cause Readmissions	*Met*	100%	0%	0%

Performance Measure Validation

Table 7-2 and Table 7-3 show the HEDIS and CMS Child and Adult Core Set MY 2022 Medicaid and Nevada Check Up performance measure results for **Anthem**, **HPN**, **Molina**, and **SilverSummit**, along with the MPS for each performance measure and the Medicaid and Nevada Check Up aggregate, which represents the average of all four MCOs' performance measure rates weighted by the eligible population.

Performance for MY 2022 (SFY 2023) is indicated by symbols and color coding; **bolded** rates indicate the rate was at or above the DHCFP-established MPS; ↑ indicates the rate was above the national Medicaid 50th percentile benchmark; ↓ indicates the rate was below the national 50th percentile benchmark; green shading indicates that the rate improved by 5 percentage points from the prior year; red shading indicates that the rate declined by 5 percentage points from the prior year; and yellow shading indicates that the aggregate rate was at or above the MPS.

Measures in the Utilization domain are designed to capture the frequency of services the MCO provides. Except for *Ambulatory Care—Total (per 1,000 Member Years)—ED Visits—Total*, higher or lower rates in this domain do not necessarily indicate better or worse performance. Therefore, these rates are provided for information only.

LIBERTY's performance measures were dental focused and not comparable to the MCOs' performance measures and resulting rates; therefore, **LIBERTY**'s results are not included in the following tables.

HSAG HEALTH SERVICES ADVISORY GROUP

Table 7-2—Medicaid SFY 2023 Performance Measure Results

Performance Measure	Anthem	HPN	Molina	SilverSummit	MPS	Medicaid Aggregate†
Access to Care						
Adults' Access to Preventive/Ambulatory Health Services (AAP)						
Ages 20–44 Years	63.95%↓	67.63%↓	51.45%↓	53.16%↓	69.68%	60.55%
Ages 45–64 Years	72.30%↓	**76.95%**↓	55.74%↓	61.75%↓	76.59%	69.16%
Ages 65 Years and Older	68.56%↓	71.03%↓	50.27%↓	54.51%↓	81.35%	62.35%
Total	66.40%↓	70.70%↓	52.66%↓	55.66%↓	71.84%	63.15%
Children's Preventive Care						
Childhood Immunization Status (CIS)						
Combination 3	57.11%↓	60.34%↓	47.60%↓	54.26%↓	68.95%	57.64%
Combination 7	51.48%↓	53.77%↓	43.67%↓	46.96%↓	62.11%	51.35%
Combination 10	24.26%↓	25.79%↓	14.85%↓	21.90%↓	38.58%	24.21%
Immunizations for Adolescents (IMA)						
Combination 1 (Meningococcal, Tdap)	83.16%↑	86.62%↑	74.49%↓	77.86%↓	87.81%	83.71%
Combination 2 (Meningococcal, Tdap, HPV)	32.21%↓	39.66%↑	28.34%↓	28.71%↓	48.91%	34.89%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)						
BMI Percentile—Total	81.02%↑	82.99%↑	72.26%↓	75.18%↓	85.76%	79.38%
Counseling for Nutrition—Total	72.99%↑	76.42%↑	66.91%↓	70.07%↓	77.65%	72.79%
Counseling for Physical Activity—Total	68.13%↓	73.13%↑	64.23%↓	63.75%↓	74.96%	68.55%
Well-Child Visits in the First 30 Months of Life (W30)						
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	58.26%↑	62.03%↑	NA	52.88%↓	62.88%	58.74%
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	60.70%↓	62.38%↓	NA	57.27%↓	70.56%	60.76%
Child and Adolescent Well-Care Visits (WCV)						
3–11 Years	50.84%↓	**52.63%**↓	44.09%↓	43.05%↓	52.50%	48.72%
12–17 Years	45.59%↓	**47.96%**↓	39.84%↓	36.36%↓	45.85%	43.63%
18–21 Years	20.40%↓	23.14%↓	17.00%↓	15.99%↓	29.68%	19.90%
Total	45.07%↓	46.43%↓	38.84%↓	36.70%↓	47.37%	42.80%

Performance Measure	Anthem	HPN	Molina	SilverSummit	MPS	Medicaid Aggregate†
Women's Health and Maternity Care						
Breast Cancer Screening (BCS)						
Breast Cancer Screening	40.50%↓	**54.90%↑**	NA	41.49%↓	54.27%	47.93%
Chlamydia Screening in Women (CHL)						
16–20 Years	49.03%↓	**58.15%↑**	47.81%↓	46.74%↓	53.24%	52.21%
21–24 Years	60.24%↓	62.44%↑	61.21%↓	59.67%↓	65.10%	60.98%
Total	55.45%↑	60.30%↑	55.33%↑	54.57%↓	MNA	57.05%
Postpartum Depression Screening and Follow-Up (PDS)^						
Depression Screening	0.00%	0.00%	0.00%	0.00%	MNA	0.00%
Follow-Up on Positive Screen	NA	NA	NA	NA	MNA	NA
Prenatal and Postpartum Care (PPC)						
Timeliness of Prenatal Care	83.33%↓	**88.08%↑**	64.96%↓	66.42%↓	85.02%	80.61%
Postpartum Care	**74.27%↓**	**80.29%↑**	49.88%↓	61.07%↓	74.13%	72.25%
Prenatal Depression Screening and Follow-Up (PND)^						
Screening	0.00%	0.00%	0.00%	0.00%	MNA	0.00%
Follow Up	NA	NA	NA	NA	MNA	NA
Prenatal Immunization Status (PRS)^						
Influenza	9.62%↓	12.26%↓	5.04%↓	4.48%↓	MNA	9.02%
Tdap	19.61%↓	26.50%↓	13.55%↓	10.57%↓	MNA	19.52%
Combination	5.64%↓	8.00%↓	3.30%↓	2.81%↓	MNA	5.63%
Care for Chronic Conditions						
Asthma Medication Ratio (AMR)						
5–11 Years	79.08%↑	72.17%↓	NA	62.86%↓	MNA	74.00%
12–18 Years	69.74%↑	65.87%↓	NA	42.25%↓	MNA	64.70%
5–18 Years (Child Core Set Total)	75.09%	69.20%	NA	52.48%	75.97%	69.74%
19–50 Years	53.22%↓	53.09%↓	NA	36.00%↓	MNA	50.26%
51–64 Years	56.10%↓	54.01%↓	NA	48.67%↓	MNA	53.90%
19–64 Years (Adult Core Set Total)	54.03%	53.36%	NA	39.27%	55.66%	NA
Total (5–64 Years)	62.05%↓	59.14%↓	NA	42.49%↓	MNA	57.81%

Performance Measure	Anthem	HPN	Molina	SilverSummit	MPS	Medicaid Aggregate†
Blood Pressure Control for Patients With Diabetes (BPD)						
Blood Pressure Control (<140/90 mm Hg)	60.34%↓	**67.64%↑**	44.77%↓	49.15%↓	60.51%	59.16%
Controlling High Blood Pressure (CBP)						
Controlling High Blood Pressure	54.50%↓	**64.36%↑**	44.04%↓	53.04%↓	58.81%	57.65%
Eye Exam for Patients With Diabetes (EED)						
Eye Exam (Retinal) Performed	55.23%↑	**63.75%↑**	30.90%↓	45.50%↓	61.59%	53.81%
Hemoglobin A1c Control for Patients With Diabetes (HBD)						
*Poor HbA1c Control**	**39.90%↑**	45.26%↓	62.29%↓	49.88%↓	40.52%	46.43%
HbA1c Control (<8%)	**51.82%↑**	46.23%↓	31.14%↓	44.04%↓	50.84%	45.83%
Kidney Health Evaluation for Patients With Diabetes (KED)						
18–64 Years	30.31%↓	**47.98%↑**	26.28%↓	28.97%↓	41.69%	36.29%
65–74 Years	46.43%↑	52.86%↑	33.33%↓	43.75%↑	53.16%	46.08%
75–85 Years	NA	NA	NA	NA	MNA	NA
Total	30.45%↓	**48.02%↑**	26.37%↓	29.13%↓	41.74%	36.39%
Behavioral Health						
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)						
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	38.83%↓	**47.96%↓**	44.50%↓	41.30%↓	45.22%	42.63%
Antidepressant Medication Management (AMM)						
Effective Acute Phase Treatment	52.81%↓	53.48%↓	48.41%↓	52.64%↓	56.85%	52.95%
Effective Continuation Phase Treatment	36.17%↓	35.81%↓	31.21%↓	34.42%↓	41.55%	35.62%
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	76.48%↓	72.60%↓	73.58%↓	70.78%↓	77.29%	73.69%
Follow-Up After Emergency Department Visit for Substance Use (FUA)[1]						
7-Day Follow-Up—Total	20.41%	19.47%	19.89%	20.56%	MNA	20.12%
30-Day Follow-Up—Total	29.46%	29.78%	27.45%	29.41%	MNA	29.16%
Follow-Up After Emergency Department Visit for Mental Illness (FUM)						
7-Day Follow-Up—Total	39.96%↓	47.19%↑	**50.78%↑**	**48.49%↑**	47.85%	45.81%

Performance Measure	Anthem	HPN	Molina	SilverSummit	MPS	Medicaid Aggregate†
30-Day Follow-Up—Total	50.22%↓	54.55%↑	**58.01%↑**	**57.10%↑**	56.82%	54.40%
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)^						
7-Day Follow-Up—Total	29.75%↑	28.28%↓	27.84%↓	16.60%↓	MNA	27.41%
30-Day Follow-Up—Total	50.44%↓	43.72%↓	42.66%↓	30.71%↓	MNA	44.85%
Follow-Up After Hospitalization for Mental Illness (FUH)						
7-Day Follow-Up—Total	30.55%↓	35.88%↓	25.29%↓	28.87%↓	41.37%	30.65%
30-Day Follow-Up—Total	48.00%↓	53.75%↓	41.30%↓	45.17%↓	56.67%	47.71%
Follow-Up Care for Children Prescribed ADHD Medication (ADD)						
Initiation Phase	45.07%↑	49.89%↑	NA	47.79%↑	55.68%	47.83%
Continuation and Maintenance Phase	60.38%↑	68.00%↑	NA	NA	72.54%	63.06%
Initiation and Engagement of Substance Use Disorder Treatment (IET)[1]						
Initiation of SUD Treatment—Total (Total)	45.88%	44.75%	49.79%	43.57%	MNA	45.39%
Engagement of SUD Treatment—Total (Total)	17.10%	13.78%	13.20%	13.70%	MNA	14.89%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)						
Blood Glucose and Cholesterol Testing—Total	32.01%↓	32.02%↓	37.88%↑	29.39%↓	38.41%	32.18%
Screening for Depression and Follow-Up Plan (CDF-CH/CDF-AD)^						
12–17 Years	0.38%	0.31%	0.92%	NA	MNA	0.46%
18–64 Years	1.85%	1.25%	2.10%	1.72%	MNA	1.65%
65+ Years	1.79%	3.94%	2.00%	3.42%	MNA	2.66%
Total (12+ Years)	1.54%	1.05%	1.85%	1.73%	MNA	1.43%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)						
1–11 Years	62.50%↑	50.00%↓	NA	45.24%↓	MNA	55.03%
12–17 Years	65.12%↑	65.63%↑	59.38%↓	42.65%↓	MNA	59.87%
Total	**64.08%↑**	60.75%↓	**64.44%↑**	43.64%↓	63.72%	58.18%
Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)^						
Rate 1: Total	53.34%	51.01%	57.58%	54.72%	MNA	54.60%
Rate 2: Buprenorphine	29.08%	39.60%	25.00%	28.53%	MNA	28.38%
Rate 3: Oral Naltrexone	4.78%	6.71%	3.28%	3.22%	MNA	4.04%
Rate 4: Long-Acting, Injectable Naltrexone	1.79%	3.36%	1.02%	0.66%	MNA	1.33%

Performance Measure	Anthem	HPN	Molina	SilverSummit	MPS	Medicaid Aggregate†
Rate 5: Methadone	23.46%	4.70%	33.81%	25.82%	MNA	25.80%
Utilization						
Ambulatory Care—Total (per 1,000 Member Years) (AMB)^*						
*ED Visits—Total**	642.32	576.62	593.41	575.18	MNA	598.44
Outpatient Visits—Total	3,265.66	3,611.76	2,175.17	2,472.90	MNA	3,023.10
Plan All-Cause Readmissions (PCR)						
*Observed Readmissions—Total**	12.82%	**10.41%**	20.55%	**11.18%**	11.28%	11.56%
Expected Readmissions—Total	9.65%	9.05%	10.32%	9.63%	MNA	9.38%
O/E Ratio—Total	1.3282	1.1499	NA	1.1608	MNA	1.2317
Outliers—Total	72.12	67.04	0.00	48.53	MNA	64.92
Overuse/Appropriateness of Care						
Risk of Continued Opioid Use (COU)*^						
At Least 15 Days Covered—Total	7.44%↓	7.77%↓	8.06%↓	7.87%↓	MNA	7.69%
At Least 31 Days Covered—Total	5.85%↓	6.36%↓	6.19%↓	5.88%↓	MNA	6.08%
Use of Opioids at High Dosage (HDO)*						
Use of Opioids at High Dosage	**7.63%↓**	8.68%↓	11.50%↓	**4.88%↓**	8.23%	7.96%
Use of Opioids From Multiple Providers (UOP)*						
Multiple Prescribers	**19.36%↓**	**21.04%↓**	**20.99%↓**	**21.43%↓**	22.14%	20.60%
*Multiple Pharmacies^*	**0.56%↑**	**1.19%↑**	1.52%↑	**0.24%↑**	1.49%	0.88%
Multiple Prescribers and Multiple^ Pharmacies	**0.34%↑**	**0.54%↑**	**0.72%↑**	**0.10%↑**	0.83%	0.42%

[1] Due to significant changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS MY 2022 and prior years. Due to the QISMC goals being based on HEDIS MY 2020 statewide aggregate rates, the MY 2022 rate was not compared to an MPS.

^ Indicates HSAG calculated the MPS if prior year's data were available; however, the MPS is not tied to a QISMC goal.

† Represents performance under the Medicaid managed care program.

* A lower rate indicates better performance for this measure.

** Beginning MY 2022, this rate is reported per 1,000 member years instead of per 1,000 member months; the rates for the prior two years were converted to member years for comparison.

↑ Indicates the MY 2022 rate was above NCQA's Quality Compass HEDIS 2022 Medicaid HMO 50th percentile benchmark.

↓ Indicates the MY 2022 rate was below NCQA's Quality Compass HEDIS 2022 Medicaid HMO 50th percentile benchmark.

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

MNA indicates MY 2022 QISMC goals are unavailable for this measure or indicator.

Bolded rates indicate that the MY 2022 performance measure rate was at or above the MPS.

	Indicates that the MY 2022 rate declined by 5 percentage points or more from MY 2021.
	Indicates that the MY 2022 rate improved by 5 percentage points or more from MY 2021.
	Indicates that the Medicaid aggregate rate was at or above the MPS.

Table 7-3—Nevada Check Up SFY 2023 Performance Measure Results

Performance Measure	Anthem	HPN	Molina	SilverSummit	MPS	NV Check Up Aggregate†
Children's Preventive Care						
Childhood Immunization Status (CIS)						
Combination 3	65.00%↑	74.12%↑	NA	53.33%↓	82.36%	65.73%
Combination 7	61.25%↑	70.59%↑	NA	48.89%↓	76.15%	61.97%
Combination 10	37.50%↑	37.65%↑	NA	24.44%↓	48.22%	34.27%
Immunizations for Adolescents (IMA)						
Combination 1 (Meningococcal, Tdap)	90.97%↑	92.82%↑	NA	80.53%↑	94.17%	90.35%
Combination 2 (Meningococcal, Tdap, HPV)	44.48%↑	47.95%↑	NA	32.74%↓	57.30%	43.91%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)						
BMI Percentile—Total	80.05%↑	81.49%↑	78.35%↓	46.13%↓	85.62%	74.49%
Counseling for Nutrition—Total	73.97%↑	75.22%↑	69.34%↓	38.25%↓	77.08%	67.56%
Counseling for Physical Activity—Total	69.59%↑	73.43%↑	66.18%↓	33.91%↓	74.09%	64.36%
Well-Child Visits in the First 30 Months of Life (W30)						
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	67.61%↑	**75.00%**↑	NA	NA	73.00%	65.27%
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	68.97%↑	68.49%↑	NA	51.16%↓	82.95%	65.02%
Child and Adolescent Well-Care Visits (WCV)						
3–11 Years	53.19%↓	54.82%↓	44.36%↓	43.02%↓	59.37%	50.13%
12–17 Years	52.64%↑	**55.26%**↑	46.40%↓	38.44%↓	54.57%	49.67%
18–21 Years	36.95%↑	**39.92%**↑	32.52%↑	23.17%↓	38.72%	34.63%
Total	51.80%↑	53.69%↑	44.33%↓	39.43%↓	56.06%	48.69%
Women's Health and Maternity Care						
Chlamydia Screening in Women (CHL)						
16–20 Years	**45.87%**↓	**51.76%**↑	26.87%↓	27.27%↓	45.62%	42.48%

Performance Measure	Anthem	HPN	Molina	SilverSummit	MPS	NV Check Up Aggregate†
21–24 Years	NA	NA	NA	NA	MNA	NA
Total	45.87%↓	51.76%↓	26.87%↓	27.27%↓	MNA	42.48%
Prenatal and Postpartum Care (PPC)						
Timeliness of Prenatal Care	NA	NA	NA	NA	MNA	NA
Postpartum Care	NA	NA	NA	NA	MNA	NA
Care for Chronic Conditions						
Asthma Medication Ratio (AMR)						
5–11 Years	84.38%↑	NA	NA	NA	MNA	78.69%
12–18 Years	NA	63.04%↓	NA	NA	MNA	66.67%
5–18 Years (Child Core Set Total)	**81.82%**	67.61%	NA	NA	76.68%	72.06%
19–50 Years	NA	NA	NA	NA	MNA	NA
51–64 Years	NA	NA	NA	NA	MNA	NA
19–64 Years (Adult Core Set Total)	NA	NA	NA	NA	MNA	NA
Total (5–64 Years)	82.14%↑	67.61%↑	NA	NA	MNA	72.26%
Behavioral Health						
Follow-Up After Emergency Department Visit for Substance Use (FUA) ^,1						
7-Day Follow-Up—Total	NA	NA	NA	NA	MNA	NA
30-Day Follow-Up—Total	NA	NA	NA	NA	MNA	NA
Follow-Up After Emergency Department Visit for Mental Illness (FUM) ♦						
7-Day Follow-Up—Total	NA	NA	NA	NA	77.50%	87.50%
30-Day Follow-Up—Total	NA	NA	NA	NA	77.50%	90.63%
Follow-Up After Hospitalization for Mental Illness (FUH) ♦						
7-Day Follow-Up—Total	NA	NA	NA	NA	52.00%	51.43%
30-Day Follow-Up—Total	NA	NA	NA	NA	65.20%	74.29%
Follow-Up Care for Children Prescribed ADHD Medication (ADD)						
Initiation Phase	45.16%↑	34.00%↓	NA	NA	50.75%	39.78%
Continuation and Maintenance Phase	NA	NA	NA	NA	MNA	NA
Initiation and Engagement of Substance Use Disorder Treatment (IET) ♦,1						
Initiation of SUD Treatment—Total (Total)	NA	NA	NA	NA	MNA	42.11%
Engagement of SUD Treatment—Total (Total)	NA	NA	NA	NA	MNA	23.68%

Performance Measure	Anthem	HPN	Molina	SilverSummit	MPS	NV Check Up Aggregate†
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)						
Blood Glucose and Cholesterol Testing—Total	NA	42.86%↑	NA	NA	45.36%	38.24%
Screening for Depression and Follow-Up Plan (CDF-CH/CDF-AD)^						
12–17 Years	0.20%	0.25%	0.60%	NA	MNA	0.30%
18–64 Years	0.47%	1.32%	0.46%	0.00%	MNA	0.79%
65+ Years	NA	NA	NA	NA	MNA	NA
Total (12+ Years)	0.23%	0.40%	0.57%	0.00%	MNA	0.38%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)^ ♦						
1–11 Years	NA	NA	NA	NA	MNA	NA
12–17 Years	NA	NA	NA	NA	MNA	NA
Total	NA	NA	NA	NA	MNA	57.58%
Utilization						
Ambulatory Care—Total (per 1,000 Member Years) (AMB)^*						
*ED Visits—Total**	309.40	282.16	279.64	256.66	MNA	284.02
Outpatient Visits—Total	2,589.87	2,666.78	1,973.16	1,873.91	MNA	2,360.27

[1] Due to significant changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS MY 2022 and prior years. Due to the QISMC goals being based on HEDIS MY 2020 statewide aggregate rates, the MY 2022 rate was not compared to an MPS.

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

† Represents performance under the Nevada Check Up program.

* A lower rate indicates better performance for this measure.

** Beginning MY 2022, this rate is reported per 1,000 member years instead of per 1,000 member months; the rates for the prior two years were converted to member years for comparison.

↑ Indicates the MY 2022 rate was above NCQA's Quality Compass HEDIS 2022 Medicaid HMO 50th percentile benchmark.

↓ Indicates the MY 2022 rate was below NCQA's Quality Compass HEDIS 2022 Medicaid HMO 50th percentile benchmark.

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

MNA indicates MY 2022 QISMC goals are unavailable for this measure or indicator.

Bolded rates indicate that the MY 2022 performance measure rate was at or above the MPS.

Indicates that the MY 2022 rate declined by 5 percentage points or more from MY 2021.

Indicates that the MY 2022 rate improved by 5 percentage points or more from MY 2021.

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

Three-Year Medicaid and Nevada Check Up Aggregate Rate Trending

Table 7-4 and Table 7-5 provide a three-year comparison (i.e., MY 2020, MY 2021, and MY 2022) of the Medicaid and Nevada Check Up aggregate rates and applicable MPS for each performance measure. The Medicaid and Nevada Check Up aggregate rates represent the average of all three MCOs' performance measure rates weighted by the eligible population.

Table 7-4—Medicaid Aggregate Three-Year Rate Trending

Performance Measure	MY 2020 Medicaid Aggregate†	MY 2020 MPS	MY 2021 Medicaid Aggregate†	MY 2021 MPS	MY 2022 Medicaid Aggregate†	MY 2022 MPS
Access to Care						
Adults' Access to Preventive/Ambulatory Health Services (AAP)						
Ages 20–44 Years	66.31%	75.55%	63.48%	69.68%	60.55%	69.68%
Ages 45–64 Years	73.99%	81.82%	71.92%	76.59%	69.16%	76.59%
Ages 65 Years and Older	**79.28%**	67.19%	68.46%	81.35%	62.35%	81.35%
Total	68.71%	77.67%	65.99%	71.84%	63.15%	71.84%
Children's Preventive Care						
Childhood Immunization Status (CIS)						
Combination 3	65.50%	68.86%	58.90%	68.95%	57.64%	68.95%
Combination 7	57.90%	59.15%	51.16%	62.11%	51.35%	62.11%
Combination 10	31.75%	34.32%	26.59%	38.58%	24.21%	38.58%
Immunizations for Adolescents (IMA)						
Combination 1 (Meningococcal, Tdap)	**86.45%**	84.85%	81.84%	87.81%	83.71%	87.81%
Combination 2 (Meningococcal, Tdap, HPV)	43.23%	47.65%	33.87%	48.91%	34.89%	48.91%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)						
BMI Percentile—Total	**84.18%**	82.70%	82.70%	85.76%	79.38%	85.76%
Counseling for Nutrition—Total	**75.17%**	72.63%	75.12%	77.65%	72.79%	77.65%
Counseling for Physical Activity—Total	**72.18%**	69.60%	71.60%	74.96%	68.55%	74.96%
Well-Child Visits in the First 30 Months of Life (W30)						
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	58.75%	MNA	57.74%	62.88%	58.74%	62.88%
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	67.29%	MNA	60.18%	70.56%	60.76%	70.56%

Performance Measure	MY 2020 Medicaid Aggregate†	MY 2020 MPS	MY 2021 Medicaid Aggregate†	MY 2021 MPS	MY 2022 Medicaid Aggregate†	MY 2022 MPS
Child and Adolescent Well-Care Visits (WCV)						
3–11 Years	47.22%	MNA	49.81%	52.50%	48.72%	52.50%
12–17 Years	39.83%	MNA	44.81%	45.85%	43.63%	45.85%
18–21 Years	21.87%	MNA	20.27%	29.68%	19.90%	29.68%
Total	41.52%	MNA	43.88%	47.37%	42.80%	47.37%
Women's Health and Maternity Care						
Breast Cancer Screening (BCS)						
Breast Cancer Screening	49.19%	58.90%	46.13%	54.27%	47.93%	54.27%
Chlamydia Screening in Women (CHL)						
16–20 Years	—	—	53.43%	MNA	52.21%	53.24%
21–24 Years	—	—	61.06%	MNA	60.98%	65.10%
Total	—	—	57.61%	MNA	57.05%	MNA
Postpartum Depression Screening and Follow-Up (PDS)						
Depression Screening	—	—	—	—	0.00%	MNA
Follow-Up on Positive Screen	—	—	—	—	NA	MNA
Prenatal and Postpartum Care (PPC)						
Timeliness of Prenatal Care	83.36%	86.26%	82.78%	85.02%	80.61%	85.02%
Postpartum Care	71.25%	72.66%	71.56%	74.13%	72.25%	74.13%
Prenatal Depression Screening and Follow-Up (PND)						
Screening	—	—	—	—	0.00%	MNA
Follow Up	—	—	—	—	NA	MNA
Prenatal Immunization Status (PRS)						
Influenza	—	—	—	—	9.02%	MNA
Tdap	—	—	—	—	19.52%	MNA
Combination	—	—	—	—	5.63%	MNA
Care for Chronic Conditions						
Asthma Medication Ratio (AMR)						
5–11 Years	—	—	79.07%	MNA	74.00%	MNA
12–18 Years	—	—	66.86%	MNA	64.70%	MNA

Performance Measure	MY 2020 Medicaid Aggregate†	MY 2020 MPS	MY 2021 Medicaid Aggregate†	MY 2021 MPS	MY 2022 Medicaid Aggregate†	MY 2022 MPS
5–18 Years (Child Core Set Total)	—	—	—	—	69.74%	75.97%
19–50 Years	—	—	50.34%	MNA	50.26%	MNA
51–64 Years	—	—	51.82%	MNA	53.90%	MNA
19–64 Years (Adult Core Set Total)	—	—	—	—	51.29%	55.66%
Total (5–64 Years)	—	—	58.86%	MNA	57.81%	MNA
Blood Pressure Control for Patients With Diabetes (BPD)						
Blood Pressure Control (<140/90 mm Hg)	56.12%	MNA	59.10%	60.51%	59.16%	60.51%
Controlling High Blood Pressure (CBP)						
Controlling High Blood Pressure	54.23%	MNA	57.94%	58.81%	57.65%	58.81%
Eye Exam for Patients With Diabetes (EED)						
Eye Exam (Retinal) Performed	57.32%	61.47%	53.80%	61.59%	53.81%	61.59%
Hemoglobin A1c Control for Patients With Diabetes (HBD)						
*Poor HbA1c Control (>9.0%)**	45.02%	39.28%	43.19%	40.52%	46.43%	40.52%
HbA1c Control (<8.0%)	45.38%	53.14%	48.28%	50.84%	45.83%	50.84%
Kidney Health Evaluation for Patients With Diabetes (KED)						
18–64 Years	35.21%	MNA	36.35%	41.69%	36.29%	41.69%
65–74 Years	47.95%	MNA	47.80%	53.16%	46.08%	53.16%
75–85 Years	NA	MNA	NA	MNA	NA	MNA
Total	35.27%	MNA	36.45%	41.74%	36.39%	41.74%
Behavioral Health						
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)						
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	39.13%	46.08%	38.50%	45.22%	42.63%	45.22%
Antidepressant Medication Management (AMM)						
Effective Acute Phase Treatment	—	—	53.35%	MNA	52.95%	56.85%
Effective Continuation Phase Treatment	—	—	36.33%	MNA	35.62%	41.55%
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	74.77%	81.43%	74.37%	77.29%	73.69%	77.29%

Performance Measure	MY 2020 Medicaid Aggregate†	MY 2020 MPS	MY 2021 Medicaid Aggregate†	MY 2021 MPS	MY 2022 Medicaid Aggregate†	MY 2022 MPS
Follow-Up After Emergency Department Visit for Substance Use (FUA)[1]						
7-Day Follow-Up—Total	—	—	—	—	20.12%	MNA
30-Day Follow-Up—Total	—	—	—	—	29.16%	MNA
Follow-Up After Emergency Department Visit for Mental Illness (FUM)						
7-Day Follow-Up—Total	42.06%	47.67%	39.65%	47.85%	45.81%	47.85%
30-Day Follow-Up—Total	52.02%	55.92%	49.87%	56.82%	54.40%	56.82%
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)						
7-Day Follow-Up—Total	—	—	—	—	27.41%	MNA
30-Day Follow-Up—Total	—	—	—	—	44.85%	MNA
Follow-Up After Hospitalization for Mental Illness (FUH)						
7-Day Follow-Up—Total	34.86%	39.45%	31.55%	41.37%	30.65%	41.37%
30-Day Follow-Up—Total	51.86%	54.86%	48.34%	56.67%	47.71%	56.67%
Follow-Up Care for Children Prescribed ADHD Medication (ADD)						
Initiation Phase	**50.75%**	50.09%	51.88%	55.68%	47.83%	55.68%
Continuation and Maintenance Phase	**69.49%**	60.00%	65.90%	72.54%	63.06%	72.54%
Initiation and Engagement of Substance Use Disorder Treatment (IET)[1]						
Initiation of SUD Treatment - Total (Total)	—	—	—	—	45.39%	MNA
Engagement of SUD Treatment - Total (Total)	—	—	—	—	14.89%	MNA
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)						
Blood Glucose and Cholesterol Testing–Total	**31.57%**	25.33%	31.11%	38.41%	32.18%	38.41%
Screening for Depression and Follow-Up Plan (CDF-CH/CDF-AD)						
12–17 Years	—	—	—	—	0.46%	MNA
18–64 Years	—	—	—	—	1.65%	MNA
65+ Years	—	—	—	—	2.66%	MNA
Total (12+ Years)	—	—	—	—	1.43%	MNA
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)						
1–11 Years	—	—	55.41%	MNA	55.03%	MNA
12–17 Years	—	—	57.39%	MNA	59.87%	MNA
Total	—	—	56.61%	MNA	58.18%	63.72%

Performance Measure	MY 2020 Medicaid Aggregate†	MY 2020 MPS	MY 2021 Medicaid Aggregate†	MY 2021 MPS	MY 2022 Medicaid Aggregate†	MY 2022 MPS
Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)						
Rate 1: Total	—	—	—	—	54.60%	MNA
Rate 2: Buprenorphine	—	—	—	—	28.38%	MNA
Rate 3: Oral Naltrexone	—	—	—	—	4.04%	MNA
Rate 4: Long-Acting, Injectable Naltrexone	—	—	—	—	1.33%	MNA
Rate 5: Methadone	—	—	—	—	25.80%	MNA
Utilization						
Ambulatory Care—Total (per 1,000 Member Years) (AMB)**						
*ED Visits—Total**	514.89	MNA	534.09	MNA	598.44	MNA
Outpatient Visits—Total	3,157.42	MNA	3,095.29	MNA	3,023.10	MNA
Plan All-Cause Readmissions (PCR)						
*Observed Readmissions—Total**	12.53%	MNA	11.51%	11.28%	11.56%	11.28%
Expected Readmissions—Total	9.47%	MNA	9.18%	MNA	9.38%	MNA
O/E Ratio—Total	1.3232	MNA	1.2537	MNA	1.2317	MNA
Outliers—Total	50.53	MNA	62.76	MNA	64.92	MNA
Overuse/Appropriateness of Care						
Risk of Continued Opioid Use (COU)*						
At Least 15 Days Covered—Total	—	—	—	—	7.69%	MNA
At Least 31 Days Covered—Total	—	—	—	—	6.08%	MNA
Use of Opioids at High Dosage (HDO)*						
Use of Opioids at High Dosage	9.14%	8.63%	**8.14%**	8.23%	**7.96%**	8.23%
Use of Opioids From Multiple Providers (UOP)*						
Multiple Prescribers	24.60%	22.43%	**20.87%**	22.14%	**20.60%**	22.14%
Multiple Pharmacies	**1.66%**	3.16%	**0.82%**	1.49%	**0.88%**	1.49%
Multiple Prescribers and Multiple Pharmacies	**0.92%**	1.62%	**0.50%**	0.83%	**0.42%**	0.83%

[1] Due to significant changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS MY 2022 and prior years. Due to the QISMC goals being based on HEDIS MY 2020 statewide aggregate rates, the MY 2022 rate was not compared to an MPS.

† Represents performance under the Medicaid managed care program.

* A lower rate indicates better performance for this measure.

** Beginning MY 2022, this rate is reported per 1,000 member years instead of per 1,000 member months; the rates for the prior two years were converted to member years for comparison.

— Indicates that the MCOs were not previously required to report this measure or that the rate is not appropriate to display due to changes in the technical specifications resulting in a break in trending.
MNA indicates QISMC goals are unavailable for this measure or indicator.
NA indicates that the MCOs followed the specifications, but the denominator was too small (i.e., <30) to report a valid rate.
Bolded rates indicate that the Medicaid Aggregate performance measure rate was at or above the MPS.

Table 7-5—Nevada Check Up Aggregate Three-Year Rate Trending

Performance Measure	MY 2020 Nevada Check Up Aggregate†	MY 2020 MPS	MY 2021 Nevada Check Up Aggregate†	MY 2021 MPS	MY 2022 Nevada Check Up Aggregate†	MY 2022 MPS
Children's Preventive Care						
Childhood Immunization Status (CIS)						
Combination 3	80.40%	83.46%	74.17%	82.36%	65.73%	82.36%
Combination 7	73.50%	77.33%	68.01%	76.15%	61.97%	76.15%
Combination 10	42.47%	44.91%	40.29%	48.22%	34.27%	48.22%
Immunizations for Adolescents (IMA)						
Combination 1 (Meningococcal, Tdap)	**93.52%**	89.03%	89.68%	94.17%	90.35%	94.17%
Combination 2 (Meningococcal, Tdap, HPV)	52.56%	57.54%	45.18%	57.30%	43.91%	57.30%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)						
BMI Percentile—Total	84.02%	85.65%	83.88%	85.62%	74.49%	85.62%
Counseling for Nutrition—Total	74.53%	76.13%	75.51%	77.08%	67.56%	77.08%
Counseling for Physical Activity—Total	71.21%	73.04%	72.17%	74.09%	64.36%	74.09%
Well-Child Visits in the First 30 Months of Life (W30)						
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	70.00%	MNA	63.79%	73.00%	65.27%	73.00%
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	81.06%	MNA	73.00%	82.95%	65.02%	82.95%
Child and Adolescent Well-Care Visits (WCV)						
3–11 Years	54.85%	MNA	53.00%	59.37%	50.13%	59.37%
12–17 Years	49.52%	MNA	52.22%	54.57%	49.67%	54.57%
18–21 Years	31.91%	MNA	30.28%	38.72%	34.63%	38.72%
Total	51.18%	MNA	51.06%	56.06%	48.69%	56.06%

Performance Measure	MY 2020 Nevada Check Up Aggregate†	MY 2020 MPS	MY 2021 Nevada Check Up Aggregate†	MY 2021 MPS	MY 2022 Nevada Check Up Aggregate†	MY 2022 MPS
Women's Health and Maternity Care						
Chlamydia Screening in Women (CHL)						
16–20 Years	—	—	50.79%	MNA	42.48%	45.62%
21–24 Years	—	—	NA	MNA	NA	MNA
Total	—	—	50.79%	MNA	42.48%	MNA
Prenatal and Postpartum Care (PPC)						
Timeliness of Prenatal Care	—	—	—	—	NA	MNA
Postpartum Care	—	—	—	—	NA	MNA
Care for Chronic Conditions						
Asthma Medication Ratio (AMR)						
5–11 Years	—	—	81.52%	MNA	78.69%	MNA
12–18 Years	—	—	67.33%	MNA	66.67%	MNA
5–18 Years (Child Core Set Total)	—	—	—	—	72.06%	76.68%
19–50 Years	—	—	NA	MNA	NA	MNA
51–64 Years	—	—	NA	MNA	NA	MNA
19–64 Years (Adult Core Set Total)	—	—	—	—	NA	MNA
Total (5–64 Years)	—	—	74.09%	MNA	72.26%	MNA
Behavioral Health						
Follow-Up After Emergency Department Visit for Substance Use (FUA)[1]						
7-Day Follow-Up—Total	—	—	—	—	NA	MNA
30-Day Follow-Up—Total	—	—	—	—	NA	MNA
Follow-Up After Emergency Department Visit for Mental Illness (FUM)						
7-Day Follow-Up—Total	75.00%	79.47%	**91.89%**	77.50%	**87.50%**	77.50%
30-Day Follow-Up—Total	75.00%	82.63%	**91.89%**	77.50%	**90.63%**	77.50%
Follow-Up After Hospitalization for Mental Illness (FUH)						
7-Day Follow-Up—Total	46.67%	63.01%	44.87%	52.00%	51.43%	52.00%
30-Day Follow-Up—Total	61.33%	75.34%	**69.23%**	65.20%	**74.29%**	65.20%

Performance Measure	MY 2020 Nevada Check Up Aggregate†	MY 2020 MPS	MY 2021 Nevada Check Up Aggregate†	MY 2021 MPS	MY 2022 Nevada Check Up Aggregate†	MY 2022 MPS
Follow-Up Care for Children Prescribed ADHD Medication (ADD)						
Initiation Phase	45.28%	56.00%	50.00%	50.75%	39.78%	50.75%
Continuation and Maintenance Phase	NA	MNA	NA	MNA	NA	MNA
Initiation and Engagement of Substance Use Disorder Treatment (IET)[1]						
Initiation of SUD Treatment—Total (Total)	—	—	—	—	42.11%	MNA
Engagement of SUD Treatment—Total (Total)	—	—	—	—	23.68%	MNA
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)						
Blood Glucose and Cholesterol Testing—Total	**39.29%**	28.87%	35.71%	45.36%	38.24%	45.36%
Screening for Depression and Follow-Up Plan (CDF-CH/CDF-AD)						
12–17 Years	—	—	—	—	0.30%	MNA
18–64 Years	—	—	—	—	0.79%	MNA
65+ Years	—	—	—	—	NA	MNA
Total (12+ Years)	—	—	—	—	0.38%	MNA
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)						
1–11 Years	—	—	NA	MNA	NA	MNA
12–17 Years	—	—	NA	MNA	NA	MNA
Total	—	—	67.57%	MNA	57.58%	MNA
Utilization						
Ambulatory Care—Total (per 1,000 Member Years) (AMB)**						
*ED Visits—Total**	174.31	MNA	194.30	MNA	284.02	MNA
Outpatient Visits—Total	2,277.56	MNA	2,264.23	MNA	2,360.27	MNA

[1] Due to significant changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS MY 2022 and prior years. Due to the QISMC goals being based on HEDIS MY 2020 statewide aggregate rates, the MY 2022 rate was not compared to an MPS.

† Represents performance under the Medicaid managed care program.

* A lower rate indicates better performance for this measure.

** Beginning MY 2022, this rate is reported per 1,000 member years instead of per 1,000 member months; the rates for the prior two years were converted to member years for comparison.

— Indicates that the MCOs were not previously required to report this measure or that the rate is not appropriate to display due to changes in the technical specifications resulting in a break in trending.

MNA indicates QISMC goals are unavailable for this measure or indicator.

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

Bolded rates indicate that the Medicaid Aggregate performance measure rate was at or above the MPS.

Compliance Review

HSAG calculated the Nevada Managed Care Program's performance in each of the 14 compliance review standards that were reviewed as part of the three-year compliance review cycle. Table 7-6 compares the MCEs' compliance scores and the Nevada Managed Care Program aggregated score in each of the 14 compliance review standards.

Table 7-6—MCE and Nevada Managed Care Program Compliance Review Scores for the Three-Year Cycle (SFYs 2021–2023)

Standard[1,2]	Anthem	HPN	LIBERTY	Molina	SSHP	Nevada Managed Care Program
Standard I—Disenrollment: Requirements and Limitations	100%	100%	80%	80%	100%	**97%**
Standard II—Member Rights and Member Information	95%	91%	94%	77%	77%	**87%**
Standard III—Emergency and Poststabilization Services	100%	100%	100%	100%	100%	**100%**
Standard IV—Availability of Services	100%	100%	100%	100%	90%	**98%**
Standard V—Assurances of Adequate Capacity and Services	100%	100%	100%	67%	100%	**92%**
Standard VI—Coordination and Continuity of Care	94%	82%	73%	53%	71%	**75%**
Standard VII—Coverage and Authorization of Services	87%	93%	80%	87%	67%	**83%**
Standard VIII—Provider Selection	67%	83%	100%	82%	83%	**82%**
Standard IX—Confidentiality	91%	91%	100%	100%	100%	**96%**
Standard X—Grievance and Appeal Systems	74%	87%	92%	87%	76%	**83%**
Standard XI—Subcontractual Relationships and Delegation	100%	71%	100%	100%	71%	**89%**
Standard XII—Practice Guidelines	100%	70%	100%	100%	100%	**94%**
Standard XIII—Health Information Systems[3]	100%	86%	83%	100%	100%	**94%**
Standard XIV—Quality Assessment and Performance Improvement Program	97%	95%	100%	97%	97%	**97%**
Combined Total	**91%**	**89%**	**93%**	**89%**	**86%**	**89%**

[1] The compliance review standards comprise a review of all requirements, known as elements, under the associated federal citation, including all requirements that are cross referenced within each federal standard, as applicable (e.g., Standard IX—Grievance and Appeal Systems standard includes a review of §438.228 and all requirements under 42 CFR Subpart F).

[2] As **Molina** entered the Nevada Managed Care Program January 1, 2022, standards I—VII were reviewed during SFY 2023.

[3] The Health Information Systems standard includes an assessment of each MCE's IS capabilities.

Table 7-7 compares the number of total CAP elements, and the *Complete* and *Not Complete* elements across the MCEs and Nevada Managed Care Program for the SFY 2023 CAP implementation review.

Table 7-7—MCE and Nevada Managed Care Program Summary of 2023 CAP Implementation

MCE	Total CAP Elements	Number of CAP Elements Complete	Number of CAP Elements Not Complete	Percent Complete
Anthem	20	17	3	**85%**
HPN	23	22	1	**96%**
LIBERTY	12	12	0	**100%**
Molina*	8	7	1	**88%**
SSHP	30	29	1	**97%**
Nevada Managed Care Program Total	**93**	**87**	**6**	**94%**

* **Molina**'s Total CAP Elements included elements from standards reviewed only in SFY 2022. All other MCEs' Total CAP Elements included SFY 2021 and SFY 2022 standards and elements.

Network Adequacy Validation

Table 7-8 presents the network capacity analysis results for all MCOs and compares the provider ratios to the standards displayed in Table 3-4. Assessed provider ratios shown in green indicate the provider ratio was in compliance with the access standard, whereas provider ratios shown in red indicate the provider ratio was not in compliance with the access standard. The provider ratio analyses for **LIBERTY** were not comparable to the MCOs; therefore, the results are not included in the following table.

Table 7-8—Summary of Ratio Analysis Results for PCPs and Specialty Care Providers for All MCOs

Provider Category	Anthem		HPN		Molina		SilverSummit	
	Providers	Ratio	Providers	Ratio	Providers	Ratio	Providers	Ratio
Primary Care Provider (1:1,500)	1,554	1:133	1,770	1:128	1,299	1:92	1,928	1:71
PCP Extender (1:1,800)	2,129	1:55	1,100	1:114	1,361	1:50	1,784	1:47
Physician Specialist (1:1,500)	1,527	1:135	2,142	1:106	1,180	1:101	1,785	1:77

Note: Results shown in green font indicate the result complies with the ratio access standard; results shown in red font indicate the result does not comply with the ratio access standard.

* Statewide results incorporate all Nevada counties included in the DHCFP member file submission and members enrolled with the MCO as of December 1, 2022.

Table 7-9 presents the geographic network distribution analysis for all MCOs and compares the percentage of members within the access standard compared to the standards displayed in Table 3-5. Assessed results shown in green indicate that the percentage of members within the access standard was in compliance, and percentages shown in red indicate a result of less than 99.0 percent. The provider time-distance analyses for **LIBERTY** were not comparable to the MCOs; therefore, the results are not included in the following table.

Table 7-9—Percentage of Members With Required Access by Provider Category for All MCOs

Provider Category	Anthem	HPN	Molina	SilverSummit
Primary Care Providers				
Primary Care, Adults (10 miles/15 mins)	99.9%	99.9%	99.9%	99.8%
OB/GYN (10 miles/15 mins)	98.5%	99.0%	98.8%	99.2%
Pediatrician (10 miles/15 mins)	99.8%	99.8%	99.5%	99.6%
Physician Specialists				
Endocrinologist (40 miles/60 mins)	99.9%	>99.9%	99.9%	99.9%
Endocrinologist, Pediatric (40 miles/60 mins)	>99.9%	>99.9%	>99.9%	>99.9%
Infectious Disease (40 miles/60 mins)	99.9%	>99.9%	99.9%	99.9%
Infectious Disease, Pediatric (40 miles/60 mins)	>99.9%	>99.9%	99.9%	>99.9%
Oncologist/Radiologist (40 miles/60 mins)	99.9%	>99.9%	99.9%	99.9%
Oncologist—Medical/Surgical (30 miles/45 mins)	99.9%	>99.9%	99.9%	99.9%
Oncologist—Medical/Surgical, Pediatric (30 miles/45 mins)	99.9%	>99.9%	99.9%	99.9%
Rheumatologist (40 miles/60 mins)	99.9%	99.9%	99.9%	99.9%
Rheumatologist, Pediatric (40 miles/60 mins)	87.5%	88.9%	86.4%	88.7%
Behavioral Health Providers				
Board Certified Child and Adolescent Psychiatrist (30 miles/45 mins)	99.9%	>99.9%	>99.9%	99.9%
Psychiatrist (30 miles/45 mins)	99.9%	>99.9%	>99.9%	99.9%
Psychologist (30 miles/45 mins)	99.9%	>99.9%	>99.9%	99.9%
Psychologist, Pediatric (30 miles/45 mins)	99.9%	99.9%	86.4%	99.8%
QMHP (30 miles/45 mins)	>99.9%	>99.9%	>99.9%	>99.9%
QMHP, Pediatric (30 miles/45 mins)	>99.9%	>99.9%	>99.9%	99.9%
Facility-Level Providers				
Hospitals, All (30 miles/45 mins)	99.9%	>99.9%	>99.9%	>99.9%

Provider Category	Anthem	HPN	Molina	SilverSummit
Pharmacy (10 miles/15 mins)	99.9%	99.9%	99.9%	99.9%
Psychiatric Inpatient Hospital (30 miles/45 mins)	99.9%	99.9%	99.9%	99.9%
Dialysis/ESRD Facility (30 miles/45 mins)	99.9%	99.9%	99.9%	>99.9%

Note: Results shown in green font indicate the result complies with the access standard; results shown in red font indicate that less than 99.0 percent of members had access to the provider within the time and distance access standard.

* Statewide results incorporate all Nevada counties included in the DHCFP member file submission and members enrolled with the MCO as of December 1, 2022.

As part of the SFY 2023 NAV activity, HSAG also conducted an exploratory Telehealth Provider Analysis. This analysis was not intended to permit reliable comparisons across the MCOs; therefore, the findings from this analysis are not being presented. HSAG could not always distinguish between instances wherein the MCOs did not add the flag for a provider category because they believed telehealth services were inappropriate for that provider category, and those wherein the MCOs believed telehealth services might be appropriate but were simply not offered by any providers.

The MCOs varied widely in responding to the request for data regarding which of their providers offered telehealth services. This variation may be attributable to many external factors, and the results may not present a true or complete picture of access to telehealth services in the MCOs' networks. **HPN** unintentionally omitted telehealth data for PCPs and physician specialists; **Molina** did not identify any behavioral health providers offering telehealth services. Among MCOs providing data, telehealth engagement appeared to be greatest among individual behavioral health providers, followed by PCPs. These data suggest the potential for measuring whether telehealth is a feasible option for improving access to care, as well as a need for improvement in data collection and reporting.

Consumer Assessment of Healthcare Providers and Systems Analysis

A comparative analysis identified whether one MCO performed statistically and significantly higher or lower on each measure compared to the program average. Table 7-10 through Table 7-12 show the MCO comparison results of the adult Medicaid, child Medicaid, and Nevada Check Up populations for **Anthem**, **HPN**, **Molina**, and **SilverSummit**. **LIBERTY**'s dental satisfaction survey results are not included in the following tables, as the methodology for the survey was not consistent with CAHPS.

Table 7-10—MCO Comparisons: Adult Medicaid

	Anthem	HPN	Molina	SilverSummit	Program Average
Composite Measures					
Getting Needed Care	NA	NA	NA	76.0%	75.8%
Getting Care Quickly	NA	NA	NA	NA	74.5%
How Well Doctors Communicate	NA	NA	NA	NA	89.2%
Customer Service	NA	NA	NA	NA	89.5%

	Anthem	HPN	Molina	SilverSummit	Program Average
Global Ratings					
Rating of All Health Care	NA	NA	NA	51.8%	50.0%
Rating of Personal Doctor	NA	70.8%	NA	63.6%	63.2%
Rating of Specialist Seen Most Often	NA	NA	NA	NA	63.2%
Rating of Health Plan	NA	65.4% ↑	NA	59.3%	58.1%
Effectiveness of Care*					
Advising Smokers and Tobacco Users to Quit	NA	NA	NA	NA	58.6%
Discussing Cessation Medications	NA	NA	NA	NA	37.3%
Discussing Cessation Strategies	NA	NA	NA	NA	33.8%

A minimum of 100 respondents is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of respondents are denoted as *NA*.

* These scores follow NCQA's methodology of calculating a rolling two-year average. **Molina** only had one year of data available for these measures; therefore, the average includes two years of data for **Anthem**, **HPN**, and **SilverSummit**, and one year of data for **Molina**.

↑ Indicates the 2023 score is statistically significantly higher than the program average.

↓ Indicates the 2023 score is statistically significantly lower than the program average.

Table 7-11—MCO Comparisons: Child Medicaid

	Anthem		HPN		Molina		SilverSummit		Program Average	
	General Child	CCC	General Child	CCC	General Child	CCC	General Child	CCC	General Child	CCC
Composite Measures										
Getting Needed Care	NA	NA	NA	NA	NA	NA	NA	NA	80.5%	78.8%
Getting Care Quickly	NA	NA	NA	NA	NA	NA	NA	NA	82.7%	89.1%
How Well Doctors Communicate	NA	NA	91.1%	93.2% ↑	NA	NA	NA	NA	91.0%	88.1%
Customer Service	NA	NA	NA	NA	NA	NA	NA	NA	86.3%	84.9%
Global Ratings										
Rating of All Health Care	73.0%	NA	NA	56.1%	NA	NA	NA	NA	67.6%	55.4%
Rating of Personal Doctor	74.4%	NA	77.0%	72.9%	NA	NA	NA	NA	73.3%	67.0%
Rating of Specialist Seen Most Often	NA	NA	NA	NA	NA	NA	NA	NA	NA	60.0%
Rating of Health Plan	73.8%	NA	75.3% ↑	66.2% ↑	NA	NA	NA	NA	70.2%	60.4%
CCC Composite Measures/Items										
Access to Specialized Services	—	NA	—	NA	—	NA	—	NA	—	NA
FCC: Personal Doctor Who Knows Child	—	NA	—	NA	—	NA	—	NA	—	85.6%
Coordination of Care for Children With Chronic Conditions	—	NA	—	NA	—	NA	—	NA	—	NA
Access to Prescription Medicines	—	NA	—	85.5%	—	NA	—	NA	—	85.1%
FCC: Getting Needed Information	—	NA	—	88.8%	—	NA	—	NA	—	85.6%

A minimum of 100 respondents is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of respondents are denoted as *NA*.

↑ Indicates the 2023 score is statistically significantly higher than the program average.

↓ Indicates the 2023 score is statistically significantly lower than the program average.

— Indicates the measure does not apply to the population.

Table 7-12—MCO Comparisons: Nevada Check Up

	Anthem		HPN		Molina		SilverSummit		Program Average	
	General Child	CCC	General Child	CCC	General Child	CCC	General Child	CCC	General Child	CCC
Composite Measures										
Getting Needed Care	NA	NA	NA	NA	NA	NA	NA	NA	84.7%	NA
Getting Care Quickly	NA	NA	NA	NA	NA	NA	NA	NA	85.3%	NA
How Well Doctors Communicate	NA	NA	94.6%	NA	NA	NA	NA	NA	94.2%	NA
Customer Service	NA	NA	NA	NA	NA	NA	NA	NA	91.1%	NA
Global Ratings										
Rating of All Health Care	NA	NA	73.5%	NA	NA	NA	NA	NA	70.9%	NA
Rating of Personal Doctor	61.4% ↓	NA	78.8%	NA	NA	NA	NA	NA	73.4%	NA
Rating of Specialist Seen Most Often	NA	NA	NA	NA	NA	NA	NA	NA	74.5%	NA
Rating of Health Plan	72.7%	NA	81.5% ↑	NA	NA	NA	NA	NA	76.1%	NA
CCC Composite Measures/Items										
Access to Specialized Services	—	NA	—	NA	—	NA	—	NA	—	NA
FCC: Personal Doctor Who Knows Child	—	NA	—	NA	—	NA	—	NA	—	NA
Coordination of Care for Children With Chronic Conditions	—	NA	—	NA	—	NA	—	NA	—	NA
Access to Prescription Medicines	—	NA	—	NA	—	NA	—	NA	—	NA
FCC: Getting Needed Information	—	NA	—	NA	—	NA	—	NA	—	NA

A minimum of 100 respondents is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of respondents are denoted as *NA*.

↑ Indicates the 2023 score is statistically significantly higher than the program average.

↓ Indicates the 2023 score is statistically significantly lower than the program average.

— Indicates the measure does not apply to the population.

8. Programwide Conclusions and Recommendations

HSAG performed a comprehensive assessment of the performance of the MCEs and identified their strengths and weaknesses related to the provision of healthcare services. The aggregated findings from all EQR activities were thoroughly analyzed and reviewed across the continuum of program areas and the activities that comprise the Nevada Managed Care Program to identify programwide conclusions. HSAG presents these programwide conclusions and corresponding recommendations to DHCFP to drive progress toward achieving the goals of the Nevada Quality Strategy and support improvement in the quality, timeliness, and access to healthcare services furnished to Medicaid and Nevada Check Up members. Table 8-1 provides the programwide conclusions and recommendations.

Table 8-1—Programwide Conclusions and Recommendations

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Goal 1—Improve the health and wellness of Nevada's Medicaid population by increasing the use of preventive services by December 31, 2024	**Conclusions:** The Nevada Managed Care Program had adequate practices for ensuring providers were aware of its adopted practice guidelines, including guidelines for preventive care, and had implemented quality assessment and performance improvement programs, with workplans, that included interventions and initiatives for improving access to preventive services as indicated through the three-year compliance review results. The network adequacy member-to-provider ratios were also met for PCPs and pediatricians, at least 99.8 percent of adult members could access a PCP within 10 miles or 15 minutes of their homes, and at least 99.5 percent of child members could access a pediatrician within 10 miles or 15 minutes of their homes, indicating the MCOs appeared to have a sufficient number of providers to render preventive services to children and adults. However, over the past three-year period (MY 2020–MY 2022), there has been a steady decline in the percentage of adult members accessing preventive services, with the highest rate of decline for members 65 years and older. Additionally, although there had been some fluctuations within the past three-year period for the *Well-Child Visits in the First 30 Months of Life* and *Child and Adolescent Well-Care Visits* performance measures for both the Medicaid and Nevada Check Up populations, no substantial improvement has been made in the number of infants, children, and adolescents accessing preventive services. Further, there was also a decline in the prevalence of immunizations for children and adolescents over the past three years, and no objectives under Goal 1 met the MPS, indicating the Nevada Managed Care Program must continue its efforts to improve members' use of preventive services.	☒ Quality ☒ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	Recommendations: In SFY 2023, DHCFP mandated that the MCOs implement two new PIPs to address low performance for adults' and children's preventive services. In SFY 2024, HSAG will validate the *Adults' Access to Preventive/Ambulatory Health Services (AAP)* PIP and the *Child and Adolescent Well-Care Visits (WCV)* PIP. For these PIPs, DHCFP could consider whether state-required interventions would be appropriate for the MCOs to implement that consider national and/or MCO-developed best practices to support improvement in members accessing preventive care. DHCFP could consider adding PIP interventions as a topic during one of the quarterly MCE meetings. Further, to gain a better understanding of the potential barriers to members seeking preventive care, HSAG also recommends that DHCFP collaborate with the MCOs to identify strategies to improve the CAHPS response rates so that the information obtained through the surveys provide enough data to make meaningful conclusions. As part of this initiative, DHCFP could request the MCOs to develop a three-question survey that member-facing teams could administer when on a phone call with the member and track the responses in such a way that the survey results can be accessed and then shared across all MCOs during the MCE quarterly meetings. The MCOs could indicate to members that they are trying to improve the services available and ask if the member would be willing to answer three short questions. The survey questions could include the following: • Have you been asked to take a formal survey about your experience as an [name of plan] member receiving benefits through the Nevada Managed Care Program? • If you received a survey to complete, can you share any reasons why you would not want to take the survey, or why you could not take the survey? • Is there anything you can think of that would help [name of MCO] and your providers do more to ensure you get the services you need, including regular checkups (well visits and management of chronic conditions) from your provider? The MCOs could then compile the most prevalent reasons why members may not be completing the CAHPS survey, and why they may not be going to the doctor for preventive care, and subsequently develop meaningful interventions as a program to address the barriers identified. Additionally, DHCFP could evaluate the MCOs' member incentive programs and consider whether the Nevada Managed Care Program would benefit from initiating a rewards program aimed toward members' compliance with preventive care services.	

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Goal 2—Increase use of evidence-based practices for members with chronic conditions by December 31, 2024	**Conclusions:** The programwide aggregate rates for the *Blood Pressure Control for Patients with Diabetes—Blood Pressure Control (<140/90 mm Hg)* measure have improved slightly from SFY 2021 to SFY 2023. The indicator rate for the *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)* measure has also demonstrated slight improvement from the SFY 2021 rate; however, performance for this indicator is trending negatively, as indicated by a decrease from SFY 2022 to SFY 2023. Additionally, although the *18–64 Years* and *Total* indicator rates for the *Kidney Health Evaluation for Patients With Diabetes* measure have improved slightly from the SFY 2021 rates, the indicator for the *65–74 Years* age group has slightly decreased in performance over time. Further, the *Eye Exam for Patients With Diabetes* measure rate decreased from SFY 2021 to SFY 2023. Excluding the 19–50 years age group, the Medicaid aggregate rates (i.e., age groups) for the *Asthma Medication Ratio* measure indicators also declined since the prior year for both the Medicaid and Nevada Check Up populations; and although the rate for the *Controlling High Blood* pressure measure has improved slightly since SFY 2021, the SFY 2023 rate fell below the SFY 2022 rate. Finally, under Goal 2 and the associated objectives, no programwide MPSs were attained. These findings indicate that the Nevada Managed Care Program must continue to focus efforts on improving member outcomes by ensuring members with diabetes and asthma are appropriately managing their conditions, and that members diagnosed with hypertension are controlling their high blood pressure. **Recommendations:** To understand how to best work with members and providers to increase the treatment of chronic conditions, the Nevada Managed Care Program must gain a better understanding of the barriers members face to seeking the recommended care and testing for their diseases (i.e., asthma, diabetes, high blood pressure). HSAG recommends that DHCFP collaborate with the MCOs to identify strategies to improve the CAHPS response rates so that the information obtained through the surveys provides enough data to make meaningful conclusions. As part of this initiative, DHCFP could request the MCOs to develop a three-question survey that member-facing teams could administer when on a phone call with the member and track the responses in such a way that the survey results can be accessed and then shared across all MCOs during the MCE quarterly meetings. The MCOs could indicate to members that they are trying to improve the services available and ask if the member would be willing to answer three short questions. The survey questions could include the following:	☒ Quality ☒ Timeliness ☒ Access

<table>
<tr><th>Quality Strategy Goal</th><th>Overall Performance Impact</th><th>Performance Domain</th></tr>
<tr><td></td><td>Have you been asked to take a formal survey about your experience as an [name of plan] member receiving benefits through the Nevada Managed Care Program?
If you received a survey to complete, can you share any reasons why you would not want to take the survey, or why you could not take the survey?
Is there anything you can think of that would help [name of MCO] and your providers do more to ensure you get the services you need, including regular checkups (well visits and management of chronic conditions) from your provider?
The MCOs could then compile the most prevalent reasons why members may not be completing the CAHPS survey, and why they may not be going to the doctor for preventive care, and subsequently develop meaningful interventions as a program to address the barriers identified.
Additionally, DHCFP could evaluate the MCOs' member incentive programs and consider whether the Nevada Managed Care Program would benefit from initiating a rewards program aimed toward members' compliance with obtaining services intended to manage chronic conditions.
DHCFP could also mandate that the MCOs, as part of their population health management programs, furnish their contracted providers with gap analyses reports that show gaps in recommended care for each of the chronic conditions and consider provider value-based payment initiatives to support providers' engagement in reducing the identified gaps in care.</td><td></td></tr>
<tr><td>Goal 3—Reduce misuse of opioids by December 31, 2024</td><td>Conclusions: For the Use of Opioids at High Dosage and Use of Opioids From Multiple Providers measures, the Medicaid aggregate rates were above the MPS, indicating the Nevada Managed Care Program achieved Objectives 3.1 and 3.2 under Goal 3. For SFY 2023, DHCFP required the MCOs to report on two new performance measures that tie to new objectives in the Quality Strategy to support continued improvement of Goal 3. For SFY 2023, no MPSs were set for the evaluation of performance; however, the MCOs performed below NCQA's Quality Compass HEDIS 2022 Medicaid HMO 50th percentile benchmark for the Risk of Continued Opioid Use measure indicator rates.
Recommendations: The Nevada Managed Care Program and its MCOs should continue efforts to monitor high-risk opioid analgesic prescribing practices and educate providers and members to mitigate the risks of OUD, opioid-related overdose, hospitalization, and opioid overdose-related mortality, and implement additional interventions as necessary to further support progress toward achieving all objectives under Goal 3.</td><td>☒ Quality
☐ Timeliness
☐ Access</td></tr>
</table>

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Goal 4—Improve the health and wellness of pregnant women and infants by December 31, 2024	**Conclusions:** While the *Prenatal and Postpartum Care—Postpartum Care* measure indicator at the programwide level improved slightly over a three-year period (SFY 2021 through SFY 2023), the aggregated rate for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure indicator continued to decline; and the associated Quality Strategy objectives (4.1a–b) did not meet the established MPS for both of these measures. From the findings of the NAV activity, two of the four MCOs did not meet the access standard statewide for the OB/GYN provider type, and none of the four MCOs met the standard for Washoe County. These findings indicate pregnant women may experience challenges accessing timely prenatal care due to the lack of OB/GYN providers contracted with the MCOs and available to provide services to pregnant women or women who have recently delivered. For SFY 2023, the MCOs were also required to report on three new measures to support five new objectives added to the Quality Strategy. Although MPSs for the new measures had not yet been set to evaluate the Nevada Managed Care Program, the Medicaid aggregate rates for the *Postpartum Depression Screening and Follow-Up—Depression Screening* and *Prenatal Depression Screening and Follow-Up—Screening* measure indicators were 0 percent, indicating providers were not screening women for depression while pregnant or during the postpartum period using a standardized instrument. Additionally, for the three *Prenatal Immunization Status* measure indicators, all four MCOs performed below NCQA's Quality Compass HEDIS 2022 Medicaid HMO 50th percentile benchmark, indicating very few women who had delivered received influenza and tetanus, diphtheria toxoids, and acellular pertussis (Tdap) vaccinations to protect their babies and themselves from serious illness and death. **Recommendations:** In SFY 2023, DHCFP mandated that the MCOs implement a new PIP to address low performance rates for prenatal and postpartum care. In SFY 2024, HSAG will validate the *Prenatal and Postpartum Care* PIP. For this PIP, DHCFP could consider whether state-required interventions would be appropriate for the MCOs to implement that consider national and/or MCO-developed best practices to support improvement in members accessing timely prenatal and postpartum care. DHCFP could consider adding PIP interventions as a topic during one of the quarterly MCE meetings, and additionally, DHCFP could request that the MCOs present on their pregnancy rewards programs and share how these programs are impacting the rates for prenatal and postpartum care. DHCFP should also work with the MCOs to educate providers on depression screening during prenatal and postpartum care and focus efforts on informing members of the importance of receiving the influenza and Tdap vaccinations during pregnancy to support positive health outcomes.	☒ Quality ☒ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Goal 5—Increase use of evidence-based practices for members with behavioral health conditions by December 31, 2024	**Conclusions:** For the Nevada Check Up population, the rates for the *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total,* and the *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total* measure indicators met the MPS, suggesting that the Nevada Medicaid Program and its contracted providers implemented appropriate efforts to coordinate care for many members after emergency department visits and hospitalizations for members diagnosed with SUDs and mental illnesses. However, although five out of eight objectives with MPSs for the Nevada Check Up population met the MPS, no objectives for the Medicaid population met the MPS. These findings indicate substantial opportunities for DHCFP and its contracted MCOs to ensure all members diagnosed with a mental illness and/or SUD are receiving timely follow-up appointments after ED visits and inpatient hospitalization, and are receiving adequate screenings, treatment, and medication management. With the exception of pediatric psychologists for one MCO, the Nevada Managed Care Program had a sufficient network of behavioral health providers to render necessary services. **Recommendations:** In SFY 2023, DHCFP mandated that the MCOs implement two new PIPs to address low performance rates for the behavioral health program area. HSAG validated the design for the *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)* PIP and in SFY 2024 will also validate the *Follow-Up After Emergency Department Visit for Mental Illness (FUM)* PIP. For these PIPs, DHCFP could consider whether state-required interventions would be appropriate for the MCOs to implement that consider national and/or MCO-developed best practices to support improvement in members' access to behavioral health and SUD treatment services. DHCFP could consider adding PIP interventions as a topic during one of the quarterly MCE meetings.	☒ Quality ☒ Timeliness ☒ Access
Goal 6—Increase utilization of dental services by December 31, 2024	**Conclusions:** Through the NAV activity, the Nevada Managed Care Program demonstrated that it had an adequate network of primary dental care providers to provide preventive dental services. For SFY 2023, the Nevada Managed Care Program identified three new measures for reporting; therefore, year-over-year performance could not be assessed and current performance could not be compared to MPSs as they were not yet available for the new measures. However, results from the new *Oral Evaluation, Dental Services* measure indicated that children between the ages of 8 and 9 received a comprehensive or periodic oral evaluation with a dental provider most often, with a rate of 51.95 percent. Additionally, the	☒ Quality ☒ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	rate for the new *Sealant Receipt on Permanent First Molars—Rate 1—At Least One Sealant* measure indicator was 55.26 percent, while *Rate 2—All Four Molars* was 38.18 percent. Further, the highest rates for the new *Topical Fluoride for Children* measure were the *Rate 1—Dental or Oral Health Services—Ages 8–9* (at 23.27 percent) and *Rate 2—Dental Services—Ages 8–9* (also at 23.27 percent), suggesting that the Nevada Managed Care Program has substantial opportunities to improve the prevalence of members in all age groups accessing preventive dental care. **Recommendations:** In SFY 2023, DHCFP required the PAHP to select one clinical and one nonclinical PIP to support the improvement in members' access to dental services. These topics selected for the PIPs include *Increase Preventive Services for Children* and *Coordination of Transportation Services.* For these PIPs, DHCFP could consider whether state-required interventions would be appropriate for the PAHP to implement that consider national best practices to support improvement in members accessing dental services. DHCFP could consider adding PIP interventions as a topic during one of the quarterly MCE meetings.	
Goal 7—Reduce and/or eliminate health care disparities for Medicaid members by December 31, 2024	**Conclusions:** The aggregated findings from each of the EQR activities did not produce sufficient data for HSAG to assess the impact the EQR activities had on reducing and/or eliminating healthcare disparities for Medicaid members other than by geographic location (i.e., through the NAV activity). **Recommendations:** Through its contract with the MCEs, DHCFP requires that each MCE initiate several activities focused on eliminating healthcare disparities such as implementing one mandated PIP that focuses on identifying health disparities and subsequently developing interventions aimed at reducing rates of health disparities; implementing cultural competency programs and plans; and developing population health programs, including the requirement to target clinical programs to reduce healthcare disparities based on race and ethnicity. DHCFP also encourages each MCO to obtain the Multicultural Health Care Distinction from NCQA as a way to build a strong cultural competency program, reduce health disparities, and develop culturally and linguistically appropriate member communication strategies. In addition to the initiatives already underway, HSAG recommends that DHCFP continue to require the MCEs to stratify HEDIS and other performance measure data by race and ethnicity and use the data to drive future quality improvement efforts and develop targeted interventions.	☒ Quality ☒ Timeliness ☒ Access

Appendix A. External Quality Review Activity Methodologies

Methods for Conducting EQR Activities

Validation of Performance Improvement Projects

Activity Objectives

Validating PIPs is one of the mandatory external quality review activities described at 42 CFR §438.330(b)(1). In accordance with §438.330(d), MCEs are required to have a quality assessment and performance improvement program which includes PIPs that focus on both clinical and nonclinical areas. Each PIP must be designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction, and must include the following:

- Measuring performance using objective quality indicators
- Implementing system interventions to achieve quality improvement (QI)
- Evaluating effectiveness of the interventions
- Planning and initiating activities for increasing and sustaining improvement

Due to the timing of initiation of the PIPs, for the SFY 2023 validation, HSAG used the CMS *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019.[A-1] For future validations, HSAG will use *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023.[1-2]

HSAG's validation of PIPs includes two key components of the QI process:

1. HSAG evaluates the technical structure of the PIP to ensure that the MCEs design, conduct, and report the PIPs in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the PIP design (e.g., aim statement, population, performance indicator(s), sampling methods, and data collection methodology) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that the reported PIP results are accurate and capable of measuring sustained improvement.
2. HSAG evaluates the implementation of the PIP. Once, designed, the MCE's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the

[A-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Oct 20, 2023.

[A-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf. Accessed on: Oct 20, 2023.

identification of barriers and subsequent development of relevant interventions. Through this component, HSAG evaluates how well the MCEs improve its rates through implementation of effective processes (i.e., barriers analyses, intervention design, and evaluation results).

Technical Methods of Data Collection and Analysis

The HSAG PIP team consisted of, at a minimum, an analyst with expertise in statistics and study design and a clinician with expertise in performance improvement processes. HSAG, in collaboration with DHCFP, developed the PIP Submission Form. Each MCE completed this form and submitted it to HSAG for review. The PIP Submission Form standardized the process for submitting information regarding the PIPs and ensured that all CMS PIP protocol requirements were addressed.

For the MCE PIPs, HSAG, with DHCFP's input and approval, developed a PIP Validation Tool to ensure uniform validation of PIPs. Using this tool, HSAG evaluated each of the PIPs according to the CMS protocols. The CMS protocols identify nine steps that should be validated for each PIP.

The nine steps included in the PIP Validation Tool are listed below:

- Step 1. Review the Selected PIP Topic
- Step 2. Review the PIP Aim Statement
- Step 3. Review the Identified PIP Population
- Step 4. Review the Sampling Method
- Step 5. Review the Selected Performance Indicator(s)
- Step 6. Review the Data Collection Procedures
- Step 7. Review the Data Analysis and Interpretation of PIP Results
- Step 8. Assess the Improvement Strategies
- Step 9. Assess the Likelihood that Significant and Sustained Improvement Occurred

HSAG used the following methodology to evaluate PIPs conducted by the MCEs to determine whether a PIP was valid and to assess the percentage of compliance with CMS' protocol for conducting PIPs.

Each required step is evaluated on one or more elements that form a valid PIP. The HSAG PIP Team scores each evaluation element within a given step as *Met*, *Partially Met*, *Not Met*, *Not Applicable,* or *Not Assessed*. HSAG designates evaluation elements pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all critical elements must be *Met*. Given the importance of critical elements to the scoring methodology, any critical element that receives a *Not Met* score results in an overall validation rating for the PIP of *Not Met*. The MCEs are assigned a *Partially Met* score if 60 percent to 79 percent of all evaluation elements are *Met* or one or more critical elements are *Partially Met*. HSAG provides a General Feedback with a *Me*t validation score when enhanced documentation would have demonstrated a stronger understanding and application of the PIP steps and evaluation elements.

In addition to the validation status (e.g., *Met*) HSAG assigns the PIP an overall percentage score for all evaluation elements (including critical elements). HSAG calculates the overall percentage score by dividing the total number of elements scored as *Met* by the total number of elements scored as *Met*, *Partially Met*, and *Not Met*. HSAG also calculates a critical element percentage score by dividing the total number of critical elements scored as *Met* by the sum of the critical elements scored as *Met*, *Partially Met*, and *Not Met*.

HSAG assessed the implications of the PIP's findings on the likely validity and reliability of the results and assigned a level of confidence based on the following:

- *Met*: High confidence/confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 to 100 percent of all evaluation elements were *Met* across all activities.
- *Partially Met*: Low confidence in reported PIP results. All critical evaluation elements were *Met*, and 60 to 79 percent of all evaluation elements were *Met* across all activities; or one or more critical evaluation elements were *Partially Met*.
- *Not Met*: All critical evaluation elements were *Met*, and less than 60 percent of all evaluation elements were *Met* across all activities; or one or more critical evaluation elements were *Not Met.*

The MCEs had an opportunity to resubmit a revised PIP Submission Form and additional information in response to HSAG's initial validation scores of *Partially Met* or *Not Met* and to address any Validation Feedback, regardless of whether the evaluation element was critical or noncritical. HSAG conducted a final validation for any resubmitted PIPs. HSAG offered technical assistance to any MCE that requested an opportunity to review the initial validation scoring prior to resubmitting the PIP.

Upon completion of the final validation, HSAG prepared a report of its findings and recommendations for each MCE. These reports, which complied with 42 CFR §438.364, were provided to DHCFP and the MCEs.

Description of Data Obtained and Related Time Period

Table A-1 displays each MCO's PIP topics, data sources used for the performance indicator(s) of each PIP, and implemented interventions. For the SFY 2023 validation, the MCOs had not progressed to the point of completing a causal/barrier analysis and developing interventions for each PIP.

Table A-1—PIP Topic, Data Source, and Interventions for Each MCO

Anthem PIP Topics	Data Source	Intervention
Improving the Rates for Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	Administrative: Programmed query from claims/encounters and pharmacy data	Will be reported in the next annual EQR technical report.
Plan All-Cause Readmissions	Administrative: Programmed query from hospital claims/encounters data	Will be reported in the next annual EQR technical report.

HPN PIP Topics	Data Source	Intervention
Initiation and Engagement of Substance Use Disorder Treatment (IET)	Administrative: Programmed query from claims/encounters and pharmacy data	Will be reported in the next annual EQR technical report.
Plan All-Cause Readmissions	Administrative: Programmed query from hospital claims/encounters data	Will be reported in the next annual EQR technical report.
Molina PIP Topics	**Data Source**	**Intervention**
Initiation and Engagement of Substance Use Disorder Treatment (IET)	Administrative: Programmed query from claims/encounters and pharmacy data	Will be reported in the next annual EQR technical report.
Plan All-Cause Readmissions	Administrative: Programmed query from hospital claims/encounters data	Will be reported in the next annual EQR technical report.
SilverSummit PIP Topics	**Data Source**	**Intervention**
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	Administrative: Programmed query from claims/encounters and pharmacy data	Will be reported in the next annual EQR technical report.
Plan All-Cause Readmissions	Administrative: Programmed query from hospital claims/encounters data	Will be reported in the next annual EQR technical report.

Table A-2 displays the PAHP's PIP topics, data sources used for the performance indicator(s) of each PIP, and implemented interventions. For SFY 2023, the PAHP had not progressed to the point of completing a causal/barrier analysis and developing interventions for each PIP.

Table A-2—PIP Topic, Data Source, and Interventions

PIP Topic	Data Source	Intervention
Increase Preventive Services for Children	Administrative: Programmed query from claims/encounters data	Will be reported in the next annual EQR technical report.
Coordination of Transportation Services	Administrative: Telephone service/call center data and appointment/access data	Will be reported in the next annual EQR technical report.

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

The MCE submitted each PIP submission form according to the approved timeline. After the initial validation of the submission form, the MCE received HSAG's feedback and technical assistance and resubmitted the submission form. This process ensured that the design methodology for each PIP was sound before the MCE progressed to the next step of the PIP.

For the SFY 2023 PIP activities, the MCEs had not progressed to obtaining performance indicator data. In SFY 2024, the MCEs will calculate the baseline data for each PIP using performance measurement data from the time period of January 1, 2022, to December 31, 2022. Performance outcomes will be

remeasured in SFY 2025 and SFY 2026 using data from January 1, 2023, through December 31, 2023, and from January 1, 2024, through December 31, 2024, respectively.

Process for Drawing Conclusions

To draw conclusions about the quality, timeliness, and accessibility of care and services that the MCEs provided to members, HSAG validated the PIPs to ensure that the MCEs used a sound methodology in their design of each PIP. The process assesses the validation findings on the likely validity and reliability of the design methodology by assigning a validation score of *Met*, *Partially Met*, or *Not Met*.

Performance Measure Validation

Activity Objectives

The objective of the PMV activity is to ensure that each MCE calculates and reports performance measure rates consistent with the established specifications and that the results can be compared to one another.

DHCFP requires its MCOs to undergo a PMV audit annually. In order to meet the PMV requirements, HSAG, as the EQRO for DHCFP, conducts an NCQA HEDIS Compliance Audit for each MCO. HSAG adheres to NCQA's *HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*,[A-3] which outlines the accepted approach for auditors to use when conducting an IS capabilities assessment and an evaluation of the MCOs' ability to process medical, member, and practitioner information and measure production processes to determine compliance with HEDIS measure specifications.

For the PAHP, HSAG conducted the validation activities in accordance with CMS EQR *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity,* February 2023 (EQR Protocol 2),[A-4] which outlines the accepted approach for auditors to use when conducting an IS capabilities assessment and an evaluation of the PAHP's ability to process medical, member, and practitioner information and measure production processes to determine compliance with performance measure specifications.

Technical Methods of Data Collection and Analysis

MCOs

HSAG adhered to NCQA's *HEDIS Compliance Audit Standards, Policies, and Procedures, Volume 5*, which outlines the accepted approach for auditors to use when conducting an Information Systems

[A-3] National Committee for Quality Assurance. *HEDIS Compliance Audit Standards, Policies, and Procedures, Volume 5*. Washington D.C.; 2020.

[A-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols,* February 2023. Available at: https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf. Accessed on: Oct 20, 2023.

Capabilities Assessment and an evaluation of compliance with performance measure specifications for a plan. All HSAG lead auditors are CHCAs.

Following is a description of how HSAG obtained the data for the PMV analyses.

HSAG obtained data for the PMV analyses through the PMV activities. The PMV involved three phases: audit validation activities, audit review meetings, and follow-up and reporting. The following provides a summary of HSAG's activities with the MCOs, as applicable, within each of the audit phases. Throughout all audit phases, HSAG actively engages with the MCOs to ensure all audit requirements are met, providing technical assistance and guidance as needed. The audit process is iterative to support these entities in understanding all audit requirements and in being able to report valid rates for all required performance measures. HSAG obtained information through interactions, discussions, and formal interviews with key MCO plan staff members and through observations of system demonstrations and data processing.

Audit Validation Activities Phase (October 2022 through May 2023)

- Forwarded HEDIS MY 2022 Record of Administration, Data Management, and Processes (Roadmap) upon release from NCQA.
- Forwarded an introductory packet that included the list of performance measures selected by DHCFP for each population, the HEDIS MY 2022 Roadmap, a timeline for each of the required audit tasks, and guidance on the process requirements.
- Provided frequent communication throughout the audit season, some of which included reminders of upcoming deadlines, required processes, DHCFP reporting requirements, performance measure clarifications, and NCQA updates.
- Scheduled virtual audit review dates.
- Conducted kick-off calls to introduce the audit team, discuss the audit review agenda, provide guidance on HEDIS Compliance Audit processes, and ensure that MCOs were aware of important deadlines.
- Conducted survey sample frame validation for the CAHPS surveys required by DHCFP before the NCQA-certified survey vendor draws the final samples and administers the surveys.
- Reviewed completed HEDIS Roadmaps to assess compliance with the audit standards, and provided the Information Systems standard tracking report which listed outstanding items and areas that required additional clarification.
- Reviewed source code used for calculating the non-HEDIS performance measure rates to ensure compliance with State specifications.
- Verified NCQA Certified Measures[A-5] were used for calculating the HEDIS performance measure rates using an NCQA Certified Measure vendor or by contracting directly with NCQA to complete automated source code review (ASCR).

[A-5] HEDIS Certified Measures[SM] is a service mark of the National Committee for Quality Assurance (NCQA).

- Conducted validation for all supplemental data sources intended for reporting and provided a final supplemental data validation report that listed the types of supplemental data reviewed and the validation results.
- Conducted preliminary rate review to assess data completeness and accuracy early in the audit process to allow time for making corrections, if needed, prior to final rate submission.
- Conducted medical record review validation (MRRV) to ensure the integrity of medical record review (MRR) processes for performance measures that required medical record data for HEDIS reporting.

Audit Review Meetings Phase (January 2023 through April 2023)

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

Follow-Up and Reporting Phase (May 2023 through July 2023)

- Worked collaboratively to resolve any outstanding items and corrective actions, if applicable, and provided a final IS standard tracking report that documented the resolution of each item.
- Conducted final rate review and provided a rate analysis report that included a comparison to the preliminary rate submission and prior two years' rates (if available) and showed how the rates compared to the NCQA HEDIS MY 2021 Audit Means and Percentiles. The report also included requests for clarification on any notable changes in rates, eligible populations, and measures with rates that remained the same from year to year.
- Approved the final rates and assigned a final, audited result to each selected measure.
- Produced and provided final audit reports containing a summary of all audit activities.

PAHP

HSAG performed an audit of the PAHP's reporting processes for its Medicaid and Nevada Check Up populations. PMV involved three phases: audit validation activities, audit review, and follow-up and reporting. The following provides a summary of HSAG's activities with the PAHP within each phase. Throughout all audit phases, HSAG actively engages with the PAHP to ensure all audit requirements are met, providing technical assistance and guidance as needed. The audit process is iterative to support the PAHP in understanding all audit requirements and in being able to report valid rates for all required performance measures.

Audit Validation Phase (October 2022 through May 2023)

- Forwarded Information Systems Capabilities Assessment Tool (ISCAT) to PAHP.
- Scheduled virtual audit review date.
- Conducted kick-off call to introduce the audit team, discuss the virtual audit review agenda, provide guidance on PMV processes, and ensure that the PAHP was aware of important deadlines.
- Reviewed completed ISCAT to assess the PAHP's IS.

- Reviewed source code used for calculating the performance measure rates to ensure compliance with the technical specifications.
- Conducted validation for all supplemental data sources intended for reporting and provided a final supplemental data validation report that listed the types of supplemental data reviewed and the validation results.
- Conducted preliminary rate review to assess data completeness and accuracy early in the audit process to allow time for making corrections, if needed, prior to final rate submission.

Audit Review Meetings Phase (January 2023 through April 2023)

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

Follow-Up and Reporting Phase (May 2023 through July 2023)

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

Description of Data Obtained and Related Time Period

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

For the PAHP, these included:

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

For both the MCOs and the PAHP, HSAG also obtained information through interaction, discussion, and formal interviews with key MCO and PAHP staff members, as well as through observing system demonstrations and data processing.

Process for Drawing Conclusions

To draw conclusions about the quality, timeliness, and accessibility of care and services that the MCEs provided to members, HSAG determined results for each performance measure at the indicator level and assigned each an audit designation in alignment with the applicable guidelines for each type of audit. For the MCO HEDIS audits, HSAG assigned each performance indicator an audit designation of *Reportable (R)*, *Not Applicable (NA)*, or *Biased Rate (BR)*, according to NCQA's *HEDIS Measurement Year 2022 Volume 5: HEDIS Compliance Audit: Standards, Policies and Procedures.* For the PAHP PMV audit, HSAG assigned each performance measure indicator an audit designation of *Reportable (R)* or *Do Not Report (DNR)*, according to CMS EQR Protocol 2. HSAG further analyzed the quantitative results (e.g., performance indicator results) and qualitative results (e.g., IS data collection and reporting processes) to identify strengths and weaknesses and determine whether each strength and weakness impacted one or more of the domains of quality, timeliness, or access. HSAG considered rates that met or exceeded the state-established MPS and/or demonstrated an increase in performance of +/- 5 percent as a substantial strength; rates that did not meet the state-established MPS and/or demonstrated a decline in performance of +/- 5 percent were considered a substantial weakness. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to each MCE's Medicaid members.

Compliance Review

Activity Objectives

SFY 2021 began a new three-year compliance review cycle, in which HSAG reviewed the first half of the federal standards for compliance. The remaining federal standards were reviewed in SFY 2022. The objective of the SFY 2023 compliance review was to perform a comprehensive evaluation of the MCEs' implementation of corrective actions taken to remediate any requirements (i.e., elements) that received a *Not Met* score during the first two years of the compliance review cycle (SFYs 2021 and 2022.) Since **Molina** was a new MCO effective January 1, 2022, the SFY 2023 compliance review for **Molina** also included a review of the first half of the federal standards (standards I through VII) and associated State contract requirements.

As demonstrated in Table A-3, HSAG completed a comprehensive review of compliance with all federal requirements as stipulated in 42 CFR §438.358 within a three-year period.

Table A-3—Nevada Compliance Review Three-Year Cycle for the MCEs

Standards	Associated Federal Citation[1]	Year One (SFY 2021)[2]	Year Two (SFY 2022)	Year Three (SFY 2023)
Standard I—Disenrollment: Requirements and Limitations	§438.56	✓		Review of the MCEs' Implementation
Standard II—Member Rights and Member Information	§438.10 §438.100	✓		

Standards	Associated Federal Citation[1]	Year One (SFY 2021)[2]	Year Two (SFY 2022)	Year Three (SFY 2023)
Standard III—Emergency and Poststabilization Services	§438.114	✓		of Year One and Year Two CAPs
Standard IV—Availability of Services	§438.206	✓		
Standard V—Assurances of Adequate Capacity and Services	§438.207	✓		
Standard VI—Coordination and Continuity of Care	§438.208	✓		
Standard VII—Coverage and Authorization of Services	§438.210	✓		
Standard VIII—Provider Selection	§438.214		✓	
Standard IX—Confidentiality	§438.224		✓	
Standard X—Grievance and Appeal Systems	§438.228		✓	
Standard XI—Subcontractual Relationships and Delegation	§438.230		✓	
Standard XII—Practice Guidelines	§438.236		✓	
Standard XIII—Health Information Systems[3]	§438.242		✓	
Standard XIV—Quality Assessment and Performance Improvement Program	§438.330		✓	

[1] The compliance review standards comprise a review of all requirements, known as elements, under the associated federal citation, including all requirements that are cross-referenced within each federal standard, as applicable (e.g., Standard X—Grievance and Appeal Systems includes a review of §438.228 and all requirements under 42 CFR Subpart F).

[2] For **Molina**, these standards were reviewed during the SFY 2023 compliance review.

[3] This standard includes a comprehensive assessment of the MCE's IS capabilities.

At the conclusion of the SFY 2023 compliance reviews, for any CAP elements scored *Not Complete*, the MCEs were required to participate in mandatory technical assistance meetings with DHCFP and HSAG to further discuss the requirement(s), expectations, and appropriate action plans to bring the element(s) into compliance. The MCEs were required to update their existing CAP(s) and applicable action plans to align with the expectations addressed during the technical assistance meeting, and subsequently follow DHCFP's and HSAG's direction and implement timely interventions to fully remediate the remaining action plans. **Molina** was also required to submit a CAP for any requirements scored *Not Met* through HSAG's evaluation of **Molina**'s compliance with standards I through VII. HSAG will review the MCEs' implementation of the open CAPs during the next three-year cycle of compliance reviews.

Technical Methods of Data Collection and Analysis

Prior to beginning the SFY 2023 compliance review, HSAG developed data collection tools, referred to as compliance review tools, to document the findings from the review. The content of the tools was selected based on applicable federal and State regulations and on the requirements set forth in the contract between DHCFP and the MCEs as they related to the scope of the review, which included a review of each MCE's implementation of its CAP for each element that received a deficiency during the SFY 2021 and SFY 2022 compliance reviews and standards I through VII for **Molina**. The review processes used by HSAG to evaluate the MCE's compliance were consistent with CMS EQR Protocol 3.

For each MCE, HSAG's desk review consisted of the following activities:

Pre-Site Review Activities:

- Collaborated with DHCFP to develop the scope of work, compliance review methodology, and compliance review tools (i.e., CAP review tool, Standards review tool).
- Prepared and forwarded to the MCE a timeline, description of the compliance process, pre-site review information packet, a submission requirements checklist, and a post-site review document tracker.
- Scheduled the site review with the MCE.
- Hosted a pre-site review preparation session with all MCEs.
- Generated a list of 10 sample records for **Molina**'s case management and prior authorization denial case file reviews.
- Conducted a desk review of supporting documentation the MCE submitted to HSAG.
- Followed up with each MCE, as needed, based on the results of HSAG's preliminary desk review.
- Developed an agenda for the site review interview sessions and provided the agenda to the MCE to facilitate preparation for HSAG's review.

Site Review Activities:

- Conducted an opening conference, with introductions and a review of the agenda and logistics for HSAG's review activities.
- Interviewed MCE key program staff members.
- Conducted an IS review of the data systems that the MCEs used in their operations, applicable to the standards and elements under review.
- Conducted a review of case files to determine compliance in the program areas under review, including case management and prior authorization denial records for **Molina**.
- Conducted a closing conference during which HSAG reviewers summarized their preliminary findings, as appropriate.

Post-Site Review Activities:

- Conducted a review of additional documentation submitted by the MCE.

- Documented findings and assigned each element a score of *Complete* or *Not Complete* for the CAP review and *Met*, *Not Met*, or *NA* for the Standards review (as described in the Data Aggregation and Analysis section) within the compliance review tool.
- Prepared an MCE-specific report detailing the findings of HSAG's review.
- Conducted a mandatory technical assistance meeting with each MCE, as applicable, to review any CAP element that received a score of *Not Complete*.
- Required **Molina** to submit a CAP for any requirements under standards I through VII that were scored *Not Met*.

Data Aggregation and Analysis:

For the CAP review, HSAG used scores of *Complete* and *Not Complete* to indicate the degree to which the MCE's performance complied with the requirements. The scoring methodology is outlined below:

Complete indicates full compliance defined as *all* of the following:

- All documentation listed under a regulatory provision, or component thereof, is present.
- Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.
- Documentation, staff responses, case file reviews, and IS reviews confirmed implementation of the requirement.

Not Complete indicates noncompliance defined as *one or more* of the following:

- There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews.
- Staff members can describe and verify the existence of processes during the interviews, but documentation is incomplete or inconsistent with practice.
- Documentation, staff responses, case file documentation, and IS reviews do not demonstrate adequate implementation of the requirement.
- No documentation is present and staff members have little or no knowledge of processes or issues addressed by the regulatory provisions.
- For those provisions with multiple components, key components of the provision could not be identified and any findings of *Not Complete* would result in an overall provision finding of noncompliance, regardless of the findings noted for the remaining components.

For the review of standards I through VII for **Molina**, HSAG used scores of *Met* and *Not Met* to indicate the degree to which the MCO's performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to the MCO during the period covered by HSAG's review. This scoring methodology is consistent with CMS EQR Protocol 3. The protocol describes the scoring as follows:

Met indicates full compliance defined as *all* of the following:

- All documentation listed under a regulatory provision, or component thereof, is present.

- Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.
- Documentation, staff responses, case file reviews, and IS reviews confirmed implementation of the requirement.

Not Met indicates noncompliance defined as *one or more* of the following:

- There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews.
- Staff members can describe and verify the existence of processes during the interviews, but documentation is incomplete or inconsistent with practice.
- Documentation, staff responses, case file reviews, and IS reviews did not demonstrate adequate implementation of the requirement.
- No documentation is present and staff members have little or no knowledge of processes or issues addressed by the regulatory provisions.
- For those provisions with multiple components, key components of the provision could not be identified and any findings of *Not Met* would result in an overall provision finding of noncompliance, regardless of the findings noted for the remaining components.

As part of the CAP review for all MCEs and the review of standards I through VII for **Molina**, HSAG conducted file reviews of each MCE's records for the program areas under review (e.g., case management, prior authorization denials, credentialing, appeals) to verify that the MCE had put into practice what it had documented in policies and procedures. The file reviews were not intended to be a statistically significant representation of the MCE's files. Rather, the file reviews highlighted instances in which practices described in policy were not followed by MCE staff members. Based on the results of the file reviews, the MCE was expected to determine whether any area found noncompliance was the result of an anomaly or if a more serious breach in policy had occurred. Findings from the file reviews were documented within the applicable standard and element in the compliance review tools.

From the scores that it assigned for each of the requirements, HSAG determined the number of *Complete/Not Complete* elements (for the CAP review) and *Met/Not Met* elements (for the review of standards I through VII for **Molina**) to calculate a total compliance score for each standard under review and an overall compliance score for each applicable type of review (i.e., CAP, review of standards).

To draw conclusions about the quality, timeliness, and accessibility of care and services provided to members within the program areas under review, HSAG aggregated and analyzed the data resulting from its desk and site review activities. The data that HSAG aggregated and analyzed included:

- Documented findings describing the MCE's progress in achieving compliance with State and federal requirements.
- Scores assigned to the MCE's performance for each requirement.
- The total compliance score calculated for each of the standards included as part of the SFY 2023 compliance review.

- The overall compliance score calculated across the standards.
- Documented actions required to bring performance into compliance with the requirements for which HSAG assigned a score of *Not Complete* (CAP review) or *Not Met* (review of standards I through VII for **Molina**).
- Documented recommendations for program enhancement, when applicable.

Description of Data Obtained

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

- CAP workplans and timelines.
- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.
- Management/monitoring reports and audits.
- Narrative and/or data reports across a broad range of performance and content areas).
- Case files for prior authorization denials, care plans, credentialing and recredentialing records, grievance records, appeal records, contracts with delegated entities, etc.

HSAG obtained additional information for the compliance review through IS reviews of the MCE's data systems and through interactions, discussions, and interviews with the MCE's key staff members. Table A-4 lists the major data sources HSAG used to determine the MCE's performance in complying with requirements and the time period to which the data applied.

Table A-4—Description of MCE Data Sources and Applicable Time Period

Data Obtained	Time Period to Which the Data Applied
Documentation submitted for HSAG's desk review	CAP Review—Documentation effective as of the document submission date (i.e., April 7, 2023), including requested case files. Review of standards I through VII (**Molina**)—July 1, 2022—January 31, 2023
Information obtained from a review of a sample of care management case files (**Molina** only)	Listing of all members newly enrolled into care management on or after February 1, 2022
Information obtained from a review of a sample of prior authorization denial files (**Molina** only)	Listing of all denials between July 1, 2022, and March 15, 2023
Information obtained through interviews	May 8, 2023—May 11, 2023
Documentation submitted post-site review	May 10, 2023—May 15, 2023

Process for Drawing Conclusions

For the CAP review, to draw conclusions and provide an understanding of the strengths and weaknesses for each MCE individually, HSAG used the quantitative results (i.e., number of *Complete* and *Not Complete* elements) score calculated for each standard. As any element not achieving compliance required a formal action plan, HSAG determined each MCE's substantial strengths and weaknesses as follows:

- Strength—Any program area in which the MCE received a *Complete* score for all elements.
- Weakness—Any program area with two or more elements with a *Not Complete* score; or any program with one element that received a *Not Complete* score, but the deficiency was determined to be significant or egregious.

For the review of standards I through VII, to draw conclusions and provide an understanding of the strengths and weaknesses for **Molina**, HSAG used the results of the seven program areas reviewed, including comprehensive case file reviews for two program areas. For any program area that was determined to be out of compliance, **Molina** was required to submit a CAP.

HSAG determined **Molina**'s substantial strengths and weaknesses as follows:

- Strength—Any program area that did not require a CAP (i.e., achieved a compliance score of 100 percent)
- Weakness—Any program area that received a compliance score of less than 80 percent.

HSAG further analyzed the qualitative results of each strength and weakness (i.e., findings that resulted in the strength or weakness) to draw conclusions about the quality, timeliness, and accessibility of care and services that the MCE provided to members by determining whether each strength and weakness impacted one or more of the domains of quality, timeliness, and access. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to the MCE's Medicaid members.

Network Adequacy Validation

Activity Objectives

The objective of the NAV activity was to determine the sufficiency of each MCE's provider network to adequately provide all required services to its enrolled membership.

Under the contract for EQR, DHCFP requested that HSAG conduct a NAV of the Medicaid provider network for all MCOs and the PAHP during SFY 2023. As part of this NAV analysis, HSAG focused on two components of network adequacy validation:

- **Network Capacity Analysis**: Assessment of the capacity of the provider network relative to the number of enrolled members.

- **Geographic Network Distribution Analysis**: Evaluation of the geographic distribution of the providers relative to member populations.

Technical Methods of Data Collection and Analysis

To prepare the data for the NAV analysis, HSAG cleaned, processed, and defined the unique lists of providers, provider locations, and members for inclusion in the analysis. HSAG standardized and geo-coded all Medicaid member and provider files using Quest Analytics Suite software. For all analyses, adults were defined as those members ages 18 years or older, and children were defined as members younger than 18 years of age. Analyses for OB/GYN providers were limited to female members ages 15 years and older.

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

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

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

To provide a comprehensive view of geographic access, HSAG calculated the percentage of members within access standards for the provider categories identified in the MCE's provider crosswalk. A higher percentage of members meeting access standards indicated a better geographic distribution of the MCE's providers relative to Medicaid members.

HSAG used Quest Analytics software to calculate the duration of travel time or physical distance between the addresses of specific members for all provider categories identified in the provider crosswalks. All study results were stratified by MCE and county.

Description of Data Obtained and Related Time Period

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

Member Files

- Member enrollment and demographic files including all members served by one or more MCEs as of December 1, 2022.

Provider Data

- Provider data for providers actively enrolled in an MCE as of December 1, 2022. The MCEs classified providers to selected provider categories in alignment with the provider crosswalk, which detailed the methods for classifying each provider category.

Process for Drawing Conclusions

To draw conclusions about the quality, timeliness, and accessibility of care and services that each MCE provided to members, HSAG calculated provider-to-member ratios by provider category relative to the number of members for each MCE and the geographic distribution of providers relative to MCE members and then compared these analytic results to DHCFP's minimum network standards and identified the MCEs that failed to meet the minimum network requirements. HSAG determined each MCE's substantial strengths and weaknesses by considering the degree to which the MCE met minimum network requirements for the analyses under review.

Consumer Assessment of Healthcare Providers and Systems Analysis

MCOs

Activity Objectives

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

Technical Methods of Data Collection and Analysis

Three populations were surveyed for **Anthem**, **HPN**, **Molina**, and **SilverSummit**: adult Medicaid, child Medicaid, and Nevada Check Up. Center for the Study of Services, an NCQA-certified survey vendor, administered the 2023 CAHPS surveys for **Anthem.** SPH Analytics, an NCQA-certified survey vendor, administered the 2023 CAHPS surveys for **HPN**, **Molina**, and **SilverSummit**.

The technical method of data collection was through the CAHPS 5.1H Adult Medicaid Health Plan Survey to the adult population and the CAHPS 5.1H Child Medicaid Health Plan Survey (with the CCC

measurement set) to the child Medicaid and Nevada Check Up populations. **Anthem**, **HPN**, **Molina**, and **SilverSummit** used a mixed-mode methodology for data collection (i.e., mailed surveys followed by telephone interviews of non-respondents to the mailed surveys). For **Anthem**, **HPN**, **Molina**, and **SilverSummit**, all members selected in the sample received both an English and Spanish mail survey and had the option to complete the survey over the telephone in Spanish. For **HPN**'s, **Molina**'s, and **SilverSummit**'s adult population, respondents were also given the option of completing the survey via Internet in English or Spanish.

CAHPS Measures

The survey questions were categorized into various measures of experience. These measures included four global ratings, four composite scores, three Effectiveness of Care measures (adult population only), and five CCC composite measures/items (CCC eligible population only). The global ratings reflected patients' overall member experience with their personal doctor, specialist, health plan, and all healthcare. The composite measures were derived from sets of questions to address different aspects of care (e.g., *Getting Needed Care* and *How Well Doctors Communicate*). The Effectiveness of Care measures assessed the various aspects of providing assistance with smoking and tobacco use cessation. The CCC composite measures/items evaluated the experience of families with children with chronic conditions accessing various services (e.g., specialized services, prescription medications).

Top-Box Score Calculations

For each of the global ratings, the percentage of respondents who chose a top experience rating, or top-box response (i.e., a response value of 9 or 10 on a scale of 0 to 10) was calculated.

For each of the composite measures and CCC composite measures/items, the percentage of respondents who chose a positive, or top-box response was calculated. CAHPS composite question response choices fell into one of two categories: (1) "Never," "Sometimes," "Usually," or "Always" or (2) "No" or "Yes." A positive or top-box response for the composite measures and CCC composites/items was defined as a response of "Usually/Always" or "Yes." For the Effectiveness of Care measures, responses of "Always/Usually/Sometimes" were used to determine if the respondent qualified for inclusion in the numerator. The scores presented follow NCQA's methodology of calculating a rolling average using the current and prior year results. However, **Molina**'s scores deviated from NCQA's methodology of calculating a rolling two-year average. Rates were calculating using the current year's data only. When a minimum of 100 responses for a measure was not achieved, the result of the measure was denoted as *Not Applicable (NA)*.

NCQA National Average Comparisons

Colors and arrows were used to note substantial differences. An MCO that performed statistically significantly higher than the 2022 NCQA national average was denoted with a green upward (↑)

arrow.[A-6] Conversely, an MCO that performed statistically significantly lower than the 2022 NCQA national average was denoted with a red downward (↓) arrow. An MCO that did not perform statistically significantly higher or lower than the 2022 NCQA national average was not denoted with an arrow. Since NCQA does not publish separate scores for CHIP, national comparisons could not be made for the Nevada Check Up program.

Plan Comparisons

Statistically significant differences between the 2023 top-box scores for the adult Medicaid, child Medicaid (general child and CCC), and Nevada Check Up (general child and CCC) populations for **Anthem**, **HPN**, **Molina**, and **SilverSummit** were noted with colors and arrows. An MCO that performed statistically significantly higher than the program average (i.e., combined results of **Anthem**, **HPN**, **Molina**, and **SilverSummit**) was denoted with a green upward (↑) arrow. Conversely, an MCO that performed statistically significantly lower than the program average was denoted with a red downward (↓) arrow. An MCO that did not perform statistically significantly different than the program average was not denoted with an arrow.

Description of Data Obtained and Related Time Period

Based on NCQA protocol, adult members included as eligible for the survey were 18 years of age or older as of December 31, 2022, and child members included as eligible for the survey were 17 years of age or younger as of December 31, 2022. Adult members and parents/caretakers of child members completed the surveys from February to May 2023.

Process for Drawing Conclusions

To draw conclusions about the quality, timeliness, and accessibility of care and services that each MCO provided to members, HSAG compared each MCO's 2023 survey results to the 2022 NCQA national averages to determine if there were any statistically significant differences.

Dental Satisfaction Survey

Activity Objectives

The dental satisfaction survey activity assesses parents'/caretakers' of child members experiences with the PAHP and its dental providers, and the quality of care they receive. The goal of the dental satisfaction survey is to provide feedback that is actionable and will aid in improving parents'/caretakers' overall experiences with the dental care their child receives.

[A-6] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2022.* Washington, DC: NCQA, September 2022.

Technical Methods of Data Collection and Analysis

The technical method of data collection was through administration of a child dental survey, which was modified from the CAHPS Dental Plan Survey (currently available for the adult population only) for a child population. Press Ganey administered the 2023 dental satisfaction survey to **LIBERTY**'s child Medicaid and Nevada Check Up populations. **LIBERTY** used a mixed-mode methodology for data collection (i.e., mailed surveys followed by telephone interviews of non-respondents to the mailed surveys, plus a web-based survey). All members selected in the sample received an English or Spanish version of the survey.

Dental Satisfaction Survey Measures

The dental satisfaction survey questions were categorized into various measures of experience. These measures included four global ratings, three composite measures, and three individual item measures. The global ratings reflected parents'/caretakers' overall experience with their child's regular dentist, all dental care, ease of finding a dentist, and the dental plan. The composite measures were derived from sets of questions to address different aspects of dental care (e.g., *Care from Dentists* and *Staff and Access to Dental Care).* The individual item measures are individual questions that examine a specific area of care (e.g., *Care from Regular Dentist).*

Top-Box Score Calculations

For each of the global ratings, the percentage of respondents who chose a top experience rating, or top-box response (i.e., a response value of 9 or 10 on a scale of 0 to 10) was calculated.

For each of the composite measures and individual item measures, the percentage of respondents who chose a positive or top-box response was calculated. Composite and individual item question response choices were: (1) "Never," "Sometimes," "Usually," or "Always" or (2) "Definitely Yes," "Somewhat Yes," "Somewhat No," or "Definitely No" or (3) "Definitely Yes," "Probably Yes," "Probably No," or "Definitely No." A positive or top-box response for the composite measures and individual item measures was defined as a response of "Always" or "Definitely Yes." Scores with fewer than 100 respondents are denoted in the tables with a cross (+). When a minimum of 100 responses for a measure was not achieved, the measure result was denoted as *Not Applicable (NA)*.

Description of Data Obtained and Related Time Period

Child members included as eligible for the survey were 20 years of age or younger as of January 1, 2022. Surveys were administered from May 2022 to June 2022.

Process for Drawing Conclusions

To draw conclusions about the quality, timeliness, and accessibility of care and services that each MCO provided to members, HSAG had intended to compare the child Medicaid and Nevada Check Up results to the program aggregate (i.e., combined results of child Medicaid and Nevada Check Up) to determine if the results were statistically significantly different. However, because a minimum of 100 responses was not obtained for any measure for either the child Medicaid or Nevada Check Up population, a comparison of the results could not be completed and conclusions about the quality, timeliness, and accessibility of care and services could not be assessed.

Nevada 2022–2024 Quality Strategy
Goals and Objectives for Medicaid and Nevada Check Up

The Nevada Quality Strategy objectives were developed in alignment with national performance measures, including HEDIS and the Adult and Child Core Sets, to assess the Nevada Managed Care Program's progress in meeting its Quality Strategy goals. Performance is evaluated annually and reported through the annual EQR technical report.

To establish performance targets, DHCFP uses the QISMC methodology developed by the Department of Health & Human Services Health Care Financing Administration. Performance goals (i.e., MPS) are established by reducing by 10 percent the gap between the performance measure baseline rate and 100 percent (or 0 percent for inverse measures [i.e., lower rates indicate better performance]). For example, if the baseline rate was 55 percent, the MCE 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%). The methodology for calculating performance metrics for initiatives relating to specific provider groups (e.g., CCBHC, State-Directed Payment, and P-COAT) is included in Section 2, and performance rates are not included as part of this tracking table.

Unless otherwise indicated, DHCFP established an MPS for each objective using performance measurement data from MY 2020 Medicaid and Nevada Check Up aggregate performance data. The MPS will remain stagnant over a period of three years, then be reassessed during the triennial review of the Quality Strategy. Each objective that shows improvement equal to or greater than the performance target (i.e., MPS) is considered achieved, and suggests the Nevada Managed Care Program has made progress toward reaching the associated goal. **MPSs that were met for SFY 2023 are denoted by green shading.**

Goal 1—Improve the Health and Wellness of Nevada's Medicaid population by increasing the use of preventive services by December 31, 2024.									
			Measure Set					MPS	
Objective #	Objective Description	Measure Steward	HEDIS	Adult Core Set	Child Core Set	Medicaid Aggregate MY 2022	Nevada Check Up Aggregate MY 2022	Medicaid	Nevada Check Up
1.1a:	Increase well-child visits in the first 30 months of life (W30)—0–15 months (6 or more well-child visits)	NCQA	✓		✓	58.74%	65.27%	62.88%	73.00%
1.1b:	Increase well-child visits in the first 30 months of life (W30)—15–30 months (2 or more well-child visits)	NCQA	✓		✓	60.76%	65.02%	70.56%	82.95%
1.2a:	Increase child and adolescent well-care visits (WCV)—3–11 years	NCQA	✓		✓	48.72%	50.13%	52.50%	59.37%
1.2b:	Increase child and adolescent well-care visits (WCV)—12–17 years	NCQA	✓		✓	43.63%	49.67%	45.85%	54.57%
1.2c:	Increase child and adolescent well-care visits (WCV)—18–21 years	NCQA	✓		✓	19.90%	34.63%	29.68%	38.72%
1.3a:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—BMI percentile	NCQA	✓		✓	79.38%	74.49%	85.76%	85.62%
1.3b:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—Counseling for nutrition	NCQA	✓		✓	72.79%	67.56%	77.65%	77.08%
1.3c:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—Counseling for physical activity	NCQA	✓		✓	68.55%	64.36%	74.96%	74.09%
1.4a:	Increase immunizations for adolescents (IMA)—Combination 1	NCQA	✓		✓	83.71%	90.35%	87.81%	94.17%
1.4b:	Increase immunizations for adolescents (IMA)—Combination 2	NCQA	✓		✓	34.89%	43.91%	48.91%	57.30%

Goal 1—Improve the Health and Wellness of Nevada's Medicaid population by increasing the use of preventive services by December 31, 2024.									
			Measure Set					MPS	
Objective #	**Objective Description**	**Measure Steward**	**HEDIS**	**Adult Core Set**	**Child Core Set**	**Medicaid Aggregate MY 2022**	**Nevada Check Up Aggregate MY 2022**	**Medicaid**	**Nevada Check Up**
1.5a:	Increase childhood immunization status (CIS)—Combination 3	NCQA	✓		✓	57.64%	65.73%	68.95%	82.36%
1.5b:	Increase childhood immunization status (CIS)—Combination 7	NCQA	✓		✓	51.35%	61.97%	62.11%	76.15%
1.5c:	Increase childhood immunization status (CIS)—Combination 10	NCQA	✓		✓	24.21%	34.27%	38.58%	48.22%
1.6:	Increase breast cancer screening (BCS)	NCQA	✓	✓		47.93%	—	54.27%	—
1.7a:	Increase adults' access to preventive/ambulatory health services (AAP)—20–44 years	NCQA	✓			60.55%	—	69.68%	—
1.7b:	Increase adults' access to preventive/ambulatory health services (AAP)—45–64 years	NCQA	✓			69.16%	—	76.59%	—
1.8a:	Increase chlamydia screening in women (CHL)—16–20 years	NCQA	✓		✓	52.21%	42.48%	53.24%	45.62%
1.8b:	Increase chlamydia screening in women (CHL)—21–24 years	NCQA	✓	✓		60.98%	NA	65.10%	MNA

Goal 2—Increase use of evidence-based practices for members with chronic conditions by December 31, 2024.									
			Measure Set					MPS	
Objective #	**Objective Description**	**Measure Steward**	**HEDIS**	**Adult Core Set**	**Child Core Set**	**Medicaid Aggregate MY 2022**	**Nevada Check Up Aggregate MY 2022**	**Medicaid**	**Nevada Check Up**
2.1a:	Increase rate of HbA1c control (<8.0%) for members with diabetes (HBD)	NCQA	✓			45.83%	—	50.84%	—

Goal 2—Increase use of evidence-based practices for members with chronic conditions by December 31, 2024.									
			Measure Set					MPS	
Objective #	Objective Description	Measure Steward	HEDIS	Adult Core Set	Child Core Set	Medicaid Aggregate MY 2022	Nevada Check Up Aggregate MY 2022	Medicaid	Nevada Check Up
2.1b:	Reduce rate of HbA1c poor control (>9.0%) for members with diabetes (HBD)*	NCQA	✓	✓		46.43%	—	40.52%	—
2.2:	Increase rate of eye exams performed for members with diabetes (EED)	NCQA	✓			53.81%	—	61.59%	—
2.3:	Increase blood pressure control (<140/90 mm Hg) for members with diabetes (BPD)	NCQA	✓			59.16%	—	60.51%	—
2.4:	Increase rate of controlling high blood pressure (CBP)	NCQA	✓	✓		57.65%	—	58.81%	—
2.5a:	Increase the asthma medication ratio (AMR)—5–18 years	NCQA	✓		✓	69.74%	72.06%	75.97%	76.68%
2.5b:	Increase the asthma medication ratio (AMR)—19–64 years	NCQA	✓	✓		51.29%	NA	55.66%	MNA
2.6:	Increase kidney health evaluation for people with diabetes (KED)—18–64 years	NCQA	✓			36.29%	—	41.69%	—
2.7:	Decrease the rate of adult acute inpatient stays that were followed by an unplanned readmission for any diagnosis within 30 days after discharge (PCR)*—Observed readmissions	NCQA	✓	✓		11.56%	—	11.28%	—

Goal 3—Reduce misuse of opioids by December 31, 2024.									
			Measure Set					MPS	
Objective #	Objective Description	Measure Steward	HEDIS	Adult Core Set	Child Core Set	Medicaid Aggregate MY 2022	Nevada Check Up Aggregate MY 2022	Medicaid	Nevada Check Up
3.1:	Reduce use of opioids at high dosage (HDO)*	NCQA	✓			7.96%	—	8.23%	—
3.2:	Reduce use of opioids from multiple providers (UOP)—Multiple prescribers*	NCQA	✓			20.60%	—	22.14%	—
3.3a:	Reduce the rate of adult members with at least 15 days of prescription opioids in a 30-day period (COU)*	NCQA	✓			7.69%	—	MNA	—
3.3b:	Reduce the rate of adult members with at least 31 days of prescription opioids in a 62-day period (COU)*	NCQA	✓			6.08%	—	MNA	—

Goal 4—Improve the health and wellness of pregnant women and infants by December 31, 2024.									
Objective #	Objective Description	Measure Steward	Measure Set			Medicaid Aggregate MY 2022	Nevada Check Up Aggregate MY 2022	MPS	
			HEDIS	Adult Core Set	Child Core Set			Medicaid	Nevada Check Up
4.1a:	Increase timeliness of prenatal care (PPC)	NCQA	✓		✓	80.61%	NA	85.02%	MNA
4.1b:	Increase the rate of postpartum visits (PPC)	NCQA	✓	✓		72.25%	NA	74.13%	MNA
4.2a:	Increase the rate of deliveries in which members were screened for clinical depression during pregnancy using a standardized instrument (PND)	NCQA	✓			0.00%	—	MNA	—
4.2b:	Increase the rate of deliveries in which members received follow-up care within 30 days of a positive depression screen finding (PND)	NCQA	✓			NA	—	MNA	—

Goal 4—Improve the health and wellness of pregnant women and infants by December 31, 2024.									
Objective #	**Objective Description**	**Measure Steward**	**Measure Set**			**Medicaid Aggregate MY 2022**	**Nevada Check Up Aggregate MY 2022**	**MPS**	
			HEDIS	**Adult Core Set**	**Child Core Set**			**Medicaid**	**Nevada Check Up**
4.3a:	Increase the rate of deliveries in which members were screened for clinical depression using a standardized instrument during the postpartum period (PDS)	NCQA	✓			0.00%	—	MNA	—
4.3b:	Increase the rate of deliveries in which members received follow-up care within 30 days of a depression screen finding (PDS)	NCQA	✓			NA	—	MNA	—
4.4:	Increase the rate of deliveries in the measurement period in which women received influenza and tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccinations (PRS-E)	NCQA	✓			5.63%	—	MNA	—

Goal 5—Increase use of evidence-based practices for members with behavioral health conditions by December 31, 2024.									
			Measure Set					**MPS**	
Objective #	**Objective Description**	**Measure Steward**	**HEDIS**	**Adult Core Set**	**Child Core Set**	**Medicaid Aggregate MY 2022**	**Nevada Check Up Aggregate MY 2022**	**Medicaid**	**Nevada Check Up**
5.1a:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication (ADD)—Initiation phase	NCQA	✓		✓	47.83%	39.78%	55.68%	50.75%
5.1b:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication (ADD)—Continuation and maintenance phase	NCQA	✓		✓	63.06%	NA	72.54%	MNA
5.2:	Increase adherence to antipsychotic medications for individuals with schizophrenia (SAA)	NCQA	✓	✓		42.63%	—	45.22%	—

Goal 5—Increase use of evidence-based practices for members with behavioral health conditions by December 31, 2024.									
			Measure Set					MPS	
Objective #	Objective Description	Measure Steward	HEDIS	Adult Core Set	Child Core Set	Medicaid Aggregate MY 2022	Nevada Check Up Aggregate MY 2022	Medicaid	Nevada Check Up
5.3a:	Increase follow-up after hospitalization for mental illness (FUH)—7-day	NCQA	✓	✓	✓	30.65%	51.43%	41.37%	52.00%
5.3b:	Increase follow-up after hospitalization for mental illness (FUH)—30-day	NCQA	✓	✓	✓	47.71%	74.29%	56.67%	65.20%
5.4:	Increase diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications (SSD)	NCQA	✓	✓		73.69%	—	77.29%	—
5.5a:	Increase follow-up after ED visit for AOD abuse or dependence (FUA)—7-day†	NCQA	✓	✓	✓	20.12%†	NA	MNA	MNA
5.5b:	Increase follow-up after ED visit for AOD abuse or dependence (FUA)—30-day†	NCQA	✓	✓	✓	29.16%†	NA	MNA	MNA
5.6a:	Increase follow-up after ED visit for mental illness (FUM)—7-day	NCQA	✓	✓	✓	45.81%	87.50%	47.85%	77.50%
5.6b:	Increase follow-up after ED visit for mental illness (FUM)—30-day	NCQA	✓	✓	✓	54.40%	90.63%	56.82%	77.50%
5.7a:	Increase initiation and engagement of AOD abuse or dependence treatment (IET)—Initiation of treatment†	NCQA	✓	✓		45.39%†	42.11%†	MNA	MNA
5.7b:	Increase initiation and engagement of AOD abuse or dependence treatment (IET)—Engagement of treatment†	NCQA	✓	✓		14.89%†	23.68%†	MNA	MNA
5.8:	Increase the rate of children with and adolescents with ongoing antipsychotic medication use who had metabolic testing during the year (APM)	NCQA	✓		✓	32.18%	38.24%	38.41%	45.36%

Goal 5—Increase use of evidence-based practices for members with behavioral health conditions by December 31, 2024.									
			Measure Set					MPS	
Objective #	Objective Description	Measure Steward	HEDIS	Adult Core Set	Child Core Set	Medicaid Aggregate MY 2022	Nevada Check Up Aggregate MY 2022	Medicaid	Nevada Check Up
5.9a:	Increase the rate of antidepressant medication management (AMM)—Effective acute phase treatment	NCQA	✓	✓		52.95%	—	56.85%	—
5.9b:	Increase the rate of antidepressant medication management (AMM)—Effective continuation phase treatment	NCQA	✓	✓		35.62%	—	41.55%	—
5.10:	Increase the use of first-line psychosocial care for children and adolescents on antipsychotics (APP)	NCQA	✓		✓	58.18%	57.58%	63.72%	MNA
5.11a:	Increase the rate of inpatient, residential treatment and detoxification visits or discharges for a diagnosis of substance use disorder (SUD) among patients 13 years of age and older that resulted in follow-up care for a diagnosis of SUD within 7 days (FUI)	NCQA	✓			27.41%	—	MNA	—
5.11b:	Increase the rate of inpatient, residential treatment and detoxification visits or discharges for a diagnosis of substance use disorder (SUD) among patients 13 years of age and older that resulted in follow-up care for a diagnosis of SUD within 30 days (FUI)	NCQA	✓			44.85%	—	MNA	—
5.12:	Increase the rate of opioid use disorder (OUD) pharmacotherapy treatment events among members ages 16 and older that continue for at least 180 days (6 months) (OUD)	NCQA	✓			54.72%	—	MNA	—
5.13a:	Increase the rate of screening for depression and follow-up plan for members (CDF)—12–17 years	CMS			✓	0.46%	0.30%	MNA	MNA
5.13b:	Increase the rate of screening for depression and follow-up plan for members (CDF)—18 years and older	CMS		✓		1.34%	0.79%	MNA	MNA

Goal 6—Increase utilization of dental services by December 31, 2024[1].									
Objective #	Objective Description	Measure Steward	Measure Set			Medicaid Aggregate MY 2022	Nevada Check Up Aggregate MY 2022	MPS	
			HEDIS	Adult Core Set	Child Core Set			Medicaid	Nevada Check Up
6.1a:	Increase annual dental visits (ADV)—2–3 years	NCQA	✓			—	—	—	—
6.1b:	Increase annual dental visits (ADV)—4–6 years	NCQA	✓			—	—	—	—
6.1c:	Increase annual dental visits (ADV)—7–10 years	NCQA	✓			—	—	—	—
6.1d:	Increase annual dental visits (ADV)—11–14 years	NCQA	✓			—	—	—	—
6.1e:	Increase annual dental visits (ADV)—15–18 years	NCQA	✓			—	—	—	—
6.1f:	Increase annual dental visits (ADV)—19–20 years	NCQA	✓			—	—	—	—
6.2:	Increase the rate of children under age 21 who received a comprehensive or periodic oral evaluation within the reporting year (OEV-CH)[1]	DQA**			✓	39.64%	50.15%	MNA	MNA
6.3:	Increase the rate of children aged 1 through 20 years who received at least 2 topical fluoride applications within the reporting year (TFL-CH)[1]	DQA			✓	16.25%	24.14%	MNA	MNA
6.4a:	Increase the rate of enrolled children who have ever received sealants on a permanent first molar tooth: at least one sealant by 10th birthdate (SFM-CH)[1]	DQA			✓	55.26%	62.78%	MNA	MNA
6.4b:	Increase the rate of enrolled children who have ever received sealants on a permanent first molar tooth: all four molars sealed by 10th birthdate (SFM-CH)[1]	DQA			✓	38.18%	43.46%	MNA	MNA

Goal 7—Reduce and/or eliminate health care disparities for Medicaid members by December 31, 2024		
Objective #	**Objective Description**	**DHCFP Evaluation (Met/Not Met)**
7.1	Ensure that health plans maintain, submit for review, and annually revise cultural competency plans.	**Met**
7.2	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**
7.3	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**

[1] This goal only applies to **LIBERTY**; therefore, the rates displayed are not aggregate rates.

♦ Individual MCO denominators for this measure and/or indicator were less than 30 resulting in an "NA" audit designation; however, when the MCO rates were combined to generate the statewide aggregate rate, the denominator was large enough to be reported and subsequently compared to the MPS.

† Due to significant changes to the technical specifications for this measure, NCQA recommends a break in trending between HEDIS MY 2022 and prior years; Due to the QISMC goals being based on HEDIS MY 2020 statewide aggregate rates, the displayed rate was not compared to an MPS.

* A lower rate indicates better performance for this measure.

** Dental Quality Alliance

Dash (—) indicates that the MCO was not required to report this measure and/or the objective does not apply to the population.

MNA indicates the MPS will be established when the baseline rate is available.

NA (not applicable) indicates that the MCO followed the specifications, but the denominator was too small (i.e., <30) to report a valid rate.

New Measurement Year 2023 Minimum Performance Standards

For new performance measures required to be reported for MY 2022 in SFY 2023 and performance measures for which NCQA recommended a break in trending between MY 2022 and prior years due to significant changes in the measure specifications, DHCFP, in collaboration with HSAG, established MPSs using MY 2022 baseline data from the statewide aggregated rates. The Nevada MCEs, as applicable, will be evaluated against these MPSs in SFY 2024 (for MY 2023), and HSAG will use these MPSs to further assess the Nevada Managed Care Program's progress with achieving the associated goals and objectives outlined in the Quality Strategy. Table B-1 identifies the new MPSs developed from MY 2022 baseline data that will be used to evaluate MY 2023 performance for the related objectives. The newly developed MPSs presented in Table B-1 are for information only and will be incorporated into Appendix B. Goals and Objectives Tracking Table in the SFY 2024 annual EQR technical report.

Table B-1—Newly Developed MPSs From MY 2022 Baseline Data

Objective #	Objective Description	Measure Steward	Measure Set			Medicaid Aggregate MY 2022	Nevada Check Up Aggregate MY 2022	MPS	
			HEDIS	Adult Core Set	Child Core Set			Medicaid	Nevada Check Up
Goal 3—Reduce misuse of opioids by December 31, 2024.									
3.3a:	Reduce the rate of adult members with at least 15 days of prescription opioids in a 30-day period (COU)*	NCQA	✓			7.69%	—	6.92%	—
3.3b:	Reduce the rate of adult members with at least 31 days of prescription opioids in a 62-day period (COU)*	NCQA	✓			6.08%	—	5.47%	—
Goal 4—Improve the health and wellness of pregnant women and infants by December 31, 2024.									
4.2a:	Increase the rate of deliveries in which members were screened for clinical depression during pregnancy using a standardized instrument (PND)	NCQA	✓			0.00%	—	10.00%	—
4.3a:	Increase the rate of deliveries in which members were screened for clinical depression using a standardized instrument during the postpartum period (PDS)	NCQA	✓			0.00%	—	10.00%	—
4.4:	Increase the rate of deliveries in the measurement period in which women received influenza and tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccinations (PRS-E)	NCQA	✓			5.63%	—	15.07%	—

Objective #	Objective Description	Measure Steward	Measure Set			Medicaid Aggregate MY 2022	Nevada Check Up Aggregate MY 2022	MPS	
			HEDIS	Adult Core Set	Child Core Set			Medicaid	Nevada Check Up
Goal 5—Increase use of evidence-based practices for members with behavioral health conditions by December 31, 2024.									
5.5a:	Increase follow-up after ED visit for AOD abuse or dependence (FUA)—7-day	NCQA	✓	✓	✓	20.12%	NA	23.59%	MNA
5.5b:	Increase follow-up after ED visit for AOD abuse or dependence (FUA)—30-day	NCQA	✓	✓	✓	29.16%	NA	28.26%	MNA
5.7a:	Increase initiation and engagement of AOD abuse or dependence treatment (IET)—Initiation of treatment	NCQA	✓	✓		45.39%	42.11%	47.63%	37.69%
5.7b:	Increase initiation and engagement of AOD abuse or dependence treatment (IET)—Engagement of treatment	NCQA	✓	✓		14.89%	23.68%	21.54%	12.77%
5.10:	Increase the use of first-line psychosocial care for children and adolescents on antipsychotics (APP)	NCQA	✓		✓	58.18%	57.58%	63.72%	MNA
5.11a:	Increase the rate of inpatient, residential treatment and detoxification visits or discharges for a diagnosis of substance use disorder (SUD) among patients 13 years of age and older that resulted in follow-up care for a diagnosis of SUD within 7 days (FUI)	NCQA	✓			27.41%	—	34.67%	—
5.11b:	Increase the rate of inpatient, residential treatment and detoxification visits or discharges for a diagnosis of substance use disorder (SUD) among patients 13 years of age and older that resulted in follow-up care for a diagnosis of SUD within 30 days (FUI)	NCQA	✓			44.85%	—	50.37%	—
5.12:	Increase the rate of opioid use disorder (OUD) pharmacotherapy treatment events among members age 16 and older that continue for at least 180 days (6 months) (OUD)	NCQA	✓			54.72%	—	59.25%	—

Objective #	Objective Description	Measure Steward	Measure Set			Medicaid Aggregate MY 2022	Nevada Check Up Aggregate MY 2022	MPS	
			HEDIS	Adult Core Set	Child Core Set			Medicaid	Nevada Check Up
5.13a:	Increase the rate of screening for depression and follow-up plan for members (CDF)—12–17 years	CMS			✓	0.46%	0.30%	10.41%	10.27%
5.13b:	Increase the rate of screening for depression and follow-up plan for members (CDF)—18 years and older	CMS		✓		1.34%	0.79%	11.21%	10.71%
Goal 6—Increase utilization of dental services by December 31, 2024.									
6.2:	Increase the rate of children under age 21 who received a comprehensive or periodic oral evaluation within the reporting year (OEV-CH)[1]	DQA			✓	39.64%	50.15%	45.68%	55.14%
6.3:	Increase the rate of children aged 1 through 20 years who received at least 2 topical fluoride applications within the reporting year (TFL-CH)[1]	DQA			✓	16.25%	24.14%	24.63%	31.73%
6.4a:	Increase the rate of enrolled children who have ever received sealants on a permanent first molar tooth: at least one sealant by 10th birthdate (SFM-CH)[1]	DQA			✓	55.26%	62.78%	59.73%	66.50%
6.4b:	Increase the rate of enrolled children who have ever received sealants on a permanent first molar tooth: all four molars sealed by 10th birthdate (SFM-CH)[1]	DQA			✓	38.18%	43.46%	44.36%	49.11%

* A lower rate indicates better performance for this measure.

Dash (—) indicates that the MCE was not required to report this measure and/or the objective does not apply to the population.

[1] This objective only applies to **LIBERTY**; therefore, the rates displayed are not aggregate rates.

MNA indicates the MPS will be established when the baseline rate is available.

NA (not applicable) indicates that the MCO followed the specifications, but the denominator was too small (i.e., <30) to report a valid rate.