State of Nevada
Department of Health and Human Services

Division of Health Care Financing and Policy

Quality Strategy

2025–2027

—Draft Copy for Review—

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1. Introduction

Background

In accordance with Title 42 of the Code of Federal Regulations (42 CFR) §438.340(a) and 42 CFR §457.1240(e), and the *Medicaid and Children's Health Insurance Program (CHIP) Managed Care Quality Strategy Toolkit*[1-1] (Quality Strategy Toolkit), the Centers for Medicare & Medicaid Services (CMS) requires state Medicaid and CHIP agencies that contract with managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs), and certain primary care case management (PCCM) entities to develop and maintain a Medicaid and CHIP quality strategy to assess and improve the quality of healthcare and services provided by managed care entities (MCEs). The State of Nevada, Department of Health and Human Services (DHHS), Division of Health Care Financing and Policy (DHCFP), administers and oversees the Nevada Medicaid managed care program, which provides Medicaid and CHIP (referred to as Nevada Check Up) benefits to members residing in Clark and Washoe counties.[1-2] In alignment with DHCFP's mission, the written quality strategy is the foundational managed care tool that articulates managed care priorities, including goals and objectives to improve the quality of healthcare services.

DHCFP Mission and Strategic Goals

DHCFP's mission is to purchase and provide quality healthcare services, including Medicaid services, to low-income Nevadans in the most efficient manner. Further, DHCFP 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 maximize potential federal revenue.

To support its mission, DHCFP created the following the strategic goals through the Nevada DHCFP Strategic Plan.[1-3]

- Promote health coverage for all Nevadans
- Increase access to and use of primary care and preventive services
- Improve the quality of and access to behavioral health services available to members

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[1-1] Centers for Medicare & Medicaid Services. *Medicaid and Children's Health Insurance Program (CHIP) Managed Care Quality Strategy Toolkit*, June 2021. Available at: https://www.medicaid.gov/medicaid/downloads/managed-care-quality-strategy-toolkit.pdf. Accessed on: July 2, 2024.

[1-2] During the 82nd legislative session, DHCFP received State approval in its budget to finance the expansion of the Medicaid managed care program to all counties in the state pursuant to Nevada Revised Statute §422.273. This expansion begins on January 1, 2026, with the implementation of the next managed care contract period, resulting in about a 10 percent increase in Medicaid recipients served by Nevada's Medicaid managed care program.

[1-3] Nevada Department of Health and Human Services Division of Health Care Financing and Policy. Strategic Plan, July 2019–June 2021. Available at: https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/About/ExternalStrategicPlanOnePager.pdf. Accessed on: July 2, 2024.

- Ensure all pregnant women, children, and parents have the support they need for a strong start
- Plan to support healthy aging for Nevadans
- Develop a comprehensive strategy for prescription drug coverage and pricing

Quality Strategy Purpose, Scope, and Goals

Purpose of the Quality Strategy

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 (CQI) in order to raise the quality of care provided to, and received by, Medicaid and Nevada Check Up members. Further, consistent with its mission and the Nevada DHCFP Strategic Plan, the purpose of DHCFP's Quality Strategy is to also:

- Establish a comprehensive quality improvement system that is consistent with CMS' National Quality Strategy[1-4] priorities to advance health equity and whole-person care; engage individuals and communities to become partners in their care; achieve zero preventable harm; enable a responsive and resilient healthcare system to improve quality; improve quality and health outcomes across the care journey; align and coordinate across programs and care settings; accelerate and support the transition to a digital and data-driven healthcare system; and transform healthcare using science, analytics, and technology.
- Provide a framework for DHCFP to implement a coordinated and comprehensive system to proactively drive quality throughout the Nevada Medicaid and Nevada Check Up system. The Quality Strategy promotes the identification of creative initiatives to continuously monitor, assess, and improve access to care, clinical quality of care, and health outcomes of the population served.
- Identify opportunities for improvement in the health outcomes of the enrolled population and improve health and wellness through preventive care services, chronic disease and special needs management, and health promotion.
- Identify opportunities to improve quality of care and quality of services, 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.

[1-4] CMS National Quality Strategy. Available at: https://www.cms.gov/medicare/quality/meaningful-measures-initiative/cms-quality-strategy. Accessed on: July 2, 2024.

Scope of the Quality Strategy

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

- All Medicaid and Nevada Check Up managed care members in all demographic groups and in all service areas for which the MCEs are approved to provide Medicaid and Nevada Check Up managed care services. DHCFP works in accordance with the State's tribal consultation policy for Native Americans who voluntarily enroll in managed care and who are members of federally recognized tribes.
- All aspects of care—including quality, accessibility, availability, level of care, continuity, appropriateness, timeliness, and clinical effectiveness of care and services (e.g., health and disease management, health promotion) covered by Nevada Medicaid managed care and the Nevada Check Up program.
- All services covered—including, but not limited to, preventive care services, primary care, specialty care, ancillary care, emergency services, chronic disease and special needs care, dental services, mental health services, diagnostic services, pharmaceutical services, skilled nursing care, home healthcare, and prescription drugs.
- All professional and institutional care in all settings, including inpatient, outpatient, and home settings.
- All providers and any other delegated or subcontracted provider type.
- All aspects of the MCEs' internal administrative processes related to service and quality of care—including customer services, enrollment services, provider relations, confidential handling of medical records and information, care management services, utilization review activities, preventive health services, health education, information services, and quality improvement.

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 Medicaid managed care program. The overarching Quality Strategy goals and applicable program are displayed in Table 1-1.

Table 1-1—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, 2027	✓	✓
Goal 2	Increase use of evidence-based practices for members with chronic conditions by December 31, 2027	✓	✓
Goal 3	Reduce misuse of opioids and other prescribed medications by December 31, 2027	✓	✓
Goal 4	Improve the health and wellness of pregnant women and infants by December 31, 2027	✓	✓
Goal 5	Increase use of evidence-based practices for members with behavioral health conditions by December 31, 2027	✓	✓
Goal 6	Increase utilization of dental services by December 31, 2027	✓	✓
Goal 7	Reduce and/or eliminate health care disparities for Medicaid members by December 31, 2027	✓	✓
Goal 8	Improve positive outcomes for members with long-term services and supports (LTSS) needs by December 31, 2027	✓	

Methods for Meeting Quality Strategy Goals

The methods employed by DHCFP to achieve the Quality Strategy goals include:

- Developing and maintaining collaborative strategies among State agencies and external partners, including providers and community-based organizations, to improve quality of care, health education and health outcomes, manage vulnerable and at-risk members, and improve access to services for all Nevada Medicaid and Nevada Check Up members.
- Using performance measures, performance improvement projects (PIPs), contract compliance monitoring, member experience surveys, network adequacy and availability of services standards, clinical practice guidelines (CPGs), alternative payment methods, MCE quality assessment and performance improvement (QAPI) programs,[1-5] and state-driven quality improvement initiatives to drive improvement in member healthcare outcomes.
- Strengthening evidence-based prevention, wellness, and health management initiatives to improve members' health status and achievement of personal health goals.
- Enhancing member services and member satisfaction with services.
- Improving health information technology to ensure that information retrieval and reporting are timely, accurate, and complete.
- Revising MCE contracts to support CQI in program areas such as population health and care management, network adequacy, QAPI, and member enrollment and disenrollment.

[1-5] QAPI programs are referred to as Internal Quality Assurance Programs (IQAPs) in Nevada.

2. Background and Structure of Nevada's Medicaid Program

Overview

Nevada was the first state to use a state plan amendment (SPA) to develop a mandatory Medicaid managed care program. Under the terms of a SPA, a state ensures that individuals will have a choice of at least two MCOs in each geographic area. Since 1998, Nevada has had two geographic areas, the urban areas of Clark and Washoe counties, covered by mandatory Medicaid managed care. Since this time, DHCFP has periodically reprocured the MCO managed care contracts, with the most recent procurement occurring in 2021. Additionally, since 2017, DHCFP has contracted with a dental PAHP to serve as the dental benefits administrator (DBA) for Medicaid managed care members in Clark and Washoe counties. The most recent procurement for the dental PAHP was in 2022.

Description of Managed Care Entities

Table 2-1 and Table 2-2 describe the MCEs' contracts with DHCFP as of January 1, 2025. Because the federal requirements for MCOs and PAHPs are predominantly the same, regardless of the managed care vendor reviewed, the DHCFP Quality Strategy refers to MCOs and the DBA collectively as MCEs. For any deviation, this strategy will specify to which MCE the description refers.

Table 2-1—MCE Names and Covered Benefits

MCE Long Name	MCE Short Name	Covered Benefits
Anthem Blue Cross and Blue Shield Healthcare Solutions	Anthem	Primary, acute, specialty and behavioral health services, and prescription drugs[2-1]
UnitedHealthcare Health Plan of Nevada Medicaid	UnitedHealthcare HPN	
SilverSummit Healthplan, Inc.	SilverSummit	
Molina Healthcare of Nevada, Inc.	Molina	
LIBERTY Dental Plan of Nevada, Inc.	LIBERTY	Dental services

[2-1] The MCO's contract with DHCFP allows In Lieu of Services (ILOS) or Settings benefits for Institution for Mental Diseases (IMD) and Housing Supports and Services as optional benefits that the MCOs may provide. The MCOs' contract with DHCFP outlines the requirements and criteria for each of these optional benefits. The MCOs may also propose to DHCFP additional ILOS or Settings for services or settings covered under the contract. DHCFP will evaluate the proposed ILOS or Settings to determine if such proposals are medically appropriate and cost-effective alternatives. To the extent DHCFP finds the proposed ILOS or Settings appropriate, the MCO will be permitted to offer those ILOS or Settings to members.

Table 2-2—MCE Descriptions

MCE	MCE Type	Program Enrollment	Program	Operating Authority	Included Populations
Anthem	MCO	2009	Medicaid, CHIP	1932(a)	• Parents and other caretaker relatives • Pregnant women (with income no more than 185 percent of the federal poverty level [FPL], and benefits continuing up to 12 months postpartum) • Children under age 19 (inclusive of deemed newborns under §435.117) • Former foster care youth (up to age 26) • Adult group (nonpregnant individuals ages 19–64 not eligible for Medicare with income no more than 133 percent of FPL • Transitional medical assistance (includes adults and children, if not eligible under §435.116, §435.118, or §435.119) • Extended Medicaid due to spousal support collections
UnitedHealthcare HPN	MCO	1997	Medicaid, CHIP	1932(a)	
SilverSummit	MCO	2017	Medicaid, CHIP	1932(a)	
Molina	MCO	2022	Medicaid, CHIP	1932(a)	
LIBERTY	DBA	2018	Medicaid, CHIP	1915(b), 1932(a)	

Program Eligibility

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

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

Medicaid recipients in child welfare and foster care, recipients receiving services in an Intermediate Care Facility with Intellectual Disabilities (ICF/ID), recipients receiving services in a nursing facility for more than 180 calendar days, recipients admitted to a swing bed stay in an acute care hospital over 45 calendar days, recipients receiving hospice services,[2-2] and recipients enrolled in a 1915(c) home and

[2-2] Nevada Check Up members in hospice do not get disenrolled from the MCOs. Hospice services are billed to the fee-for-service (FFS) program.

community-based services (HCBS) waiver program are excluded from the enrollment in the Medicaid and Nevada Check Up managed care program.

Program Membership Demographics

Table 2-3 presents the gender and age bands of Nevada Medicaid and Nevada Check Up members enrolled in all managed care catchment areas as of June 1, 2024.

Table 2-3—Nevada Medicaid and Nevada Check Up Managed Care Demographics†

Gender/Age Band	Member Enrollment
Nevada Medicaid*	
Males and Females <1 Year of Age‡	14,235
Males and Females 1–2 Years of Age	29,766
Males and Females 3–14 Years of Age	157,180
Females 15–18 Years of Age	19,259
Males 15–18 Years of Age	16,233
Females 19–34 Years of Age	95,558
Males 19–34 Years of Age	64,914
Females 35+ Years of Age	80,577
Males 35+ Years of Age	72,427
Total Nevada Medicaid	**550,149**
Nevada Check Up	
Males and Females <1 Year of Age	889
Males and Females 1–2 Years of Age	2,041
Males and Females 3–14 Years of Age	23,650
Females 15–18 Years of Age	1,075
Males 15–18 Years of Age	1,082
Total Nevada Check Up	**28,737**
Total Nevada Medicaid and Nevada Check Up♦	**578,886**

* Please note that Medicaid has the age range of 15–18 years of age while Nevada Check Up has the age range of 15–19 years of age.

‡ The Medicaid dataset for males and females <1 year of age includes recipients with unidentified gender.

♦ Enrollment data are preliminary and subject to change. Data Source: Nevada Medicaid Data Warehouse.

† Totals for Table 2-3 reflect the whole Medicaid managed care population using the current county of residence at the time of the data pull on July 15, 2024. This includes members who may have moved outside of a managed care covered service area in the month of June 2024. Table 2-4 and Table 2-5 below reflect only Medicaid managed care members in Clark and Washoe counties.

Table 2-4 and Table 2-5 provide a member enrollment profile for each MCO as of June 1, 2024. As Nevada has only one PAHP, the eligible population is inclusive of all Nevada Medicaid and Nevada Check Up members and therefore is not displayed in the tables below.

Table 2-4—MCO Nevada Medicaid Members

MCO	Total Enrolled Clark County	Total Enrolled Washoe County
Anthem	153,103	24,433
UnitedHealthcare HPN	166,982	18,114
Molina	77,159	10,662
SilverSummit	86,315	11,031
Total♦	**483,559**	**64,240**

♦ Data for 2024 are preliminary and subject to change. Data Source: Nevada Medicaid Data Warehouse.

Table 2-5—MCO Nevada Check Up Members

MCO	Total Enrolled Clark County	Total Enrolled Washoe County
Anthem	7,668	1,332
UnitedHealthcare HPN	9,445	1,376
Molina	3,697	739
SilverSummit	3,910	524
Total♦	**24,720**	**3,971**

♦ Data for 2024 are preliminary and subject to change. Data Source: Nevada Medicaid Data Warehouse.

3. Quality of Care Activities and Initiatives

Quality Assessment and Performance Improvement

DHCFP's quality improvement program embodies a CQI process and problem-solving approach applied to specific and measurable performance indicators and operational activities. The CQI process is used to (1) monitor access to care, timeliness and quality of care, and operational performance; (2) identify opportunities for improvement that exist throughout the Nevada Medicaid managed care program; (3) implement intervention strategies to improve outcomes and performance; (4) evaluate interventions to determine effectiveness; and (5) reassess performance through remeasurement to identify new opportunities for improvement.

To support DHCFP's CQI efforts, each MCE is required to have an ongoing QAPI program in Nevada. The MCEs' QAPI programs must objectively and systematically monitor and evaluate the quality and appropriateness of care and services provided to members through quality-of-care studies and related activities, and pursue opportunities for improvement on an ongoing basis. Each QAPI program must include, but is not limited to, the following components:

- Use of quality indicators, including Healthcare Effectiveness Data and Information Set (HEDIS®)[3-1] data and CMS' Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set)[3-2] and Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set)[3-3] performance measures to continually assess each MCE's achievement of the goals and objectives described in Appendix B—Goals and Objectives Tracking.
- Implementation of PIPs, which measure and assess targeted performance improvement interventions on specific topics.
- Mechanisms to detect over- and underutilization of services.
- Use of clinical care standards/practice guidelines.
- Analysis of clinical care, including interventions specifically designed to reduce or eliminate disparities in healthcare.
- Assessment of member satisfaction to determine how satisfied Nevada Medicaid managed care members are with care and services they receive.
- Implementation and assessment of plans of correction.
- Evaluation of the continuity and effectiveness of the QAPI program.

3-1 HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

3-2 Centers for Medicare & Medicaid Services. *Adult Health Care Quality Measures*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/adult-health-care-quality-measures/index.html. Accessed on: July 3, 2024.

3-3 Centers for Medicare & Medicaid Services. *Children's Health Care Quality Measures*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/childrens-health-care-quality-measures/index.html. Accessed on: July 3, 2024.

DHCFP contractually requires the MCEs' QAPI programs to align with DHCFP's Quality Strategy.

- The QAPI programs must encompass all levels of the MCEs' organizations and have a clear linkage to the Quality Strategy.
- The MCEs must submit performance improvement measurement data annually using standard measures required by DHCFP, including those that incorporate the requirements of 42 CFR §438.330(a)(2) and the Quality Strategy.
- The QAPI program must monitor and evaluate, at a minimum, care and services in certain priority areas of concern identified through the Quality Strategy.
- QAPI program studies and other activities must monitor quality of care against clinical care or health service delivery standards or practice guidelines required by the Quality Strategy.
- The QAPI program must include how PIPs relate to the MCEs' other population health initiatives and the Quality Strategy.

DHCFP monitors the MCEs' progress in achieving the goals and objectives in their QAPI programs and the State's Quality Strategy. If DHCFP cannot confirm an MCE's progress toward compliance, DHCFP will notify and give the MCE the opportunity to demonstrate evidence of progress and compliance before seeking to impose monetary penalties or other remedies under the contract.

Metrics and Performance Targets for Goals and Objectives

DHCFP, in collaboration with its contracted external quality review organization (EQRO), establishes minimum performance standards (MPSs) for all objectives under goals 1 through 6, and Goal 8. The purpose of establishing the MPS for each objective is to create a set of reasonable targets that MCEs can achieve through continuous focus and improvement for each of the performance measures that represent an objective under a specific Quality Strategy goal. DHCFP's MPSs are located in Appendix B—Goals and Objectives Tracking.

In addition to developing objectives with a quantitative MPS, DHCFP also establishes objectives aimed at reducing and/or eliminating healthcare disparities in alignment with Goal 7. Rather than establishing an MPS, DHCFP assesses the MCEs' adherence to contract requirements surrounding cultural competency and reducing disparities through an annual cultural competency program evaluation and other related initiatives. DHCFP assigns a designation of *Met* or *Not Met* to these objectives.

Use of National Performance Measures

DHCFP uses HEDIS and the Adult Core Set and Child Core Set performance measures to assess the MCEs' performance with specific indices of quality, timeliness, and access to care. DHCFP's EQRO conducts an independent audit of each MCO in alignment with National Committee for Quality Assurance's (NCQA's) HEDIS Compliance Audit™[3-4] standards, policies, and procedures to assess the

[3-4] NCQA HEDIS Compliance Audit ™ is a trademark of the National Committee for Quality Assurance (NCQA).

validity of the DHCFP-selected performance measures for the Medicaid and Nevada Check Up populations. DHCFP's EQRO also conducts annual performance measure validation (PMV) of the DBA. As part of the annual external quality review (EQR) required under 42 CFR §438.350, the EQRO trends each MCO's performance measure rates over time and also compares each MCO's rates to the established MPS and Medicaid aggregate rate. The EQRO also uses trending to compare the DBA's performance measure rates over time for the dental-related measures. Additionally, the EQRO evaluates each MCE's performance to determine progress in meeting the goals and objectives included as part of the Quality Strategy. Performance outcomes are documented in the Quality Strategy Goals and Objectives Tracking table, as included in Appendix B and the annual EQR technical report.

DHCFP also supports CMS' collection of consistent performance measure data from states through its collection and reporting of CMS' Adult Core Set and Child Core Set healthcare quality measures. DHCFP uses published Core Set data to evaluate Nevada's performance against national performance to identify additional opportunities for improvement in the Nevada Medicaid managed care program.

Table 3-1 identifies the performance measures DHCFP uses to monitor and evaluate progress in meeting the Quality Strategy goals and objectives. DHCFP selected a set of HEDIS measures including Adult Core Set and Child Core Set measures with non-HEDIS age stratifications, and additional Adult Core Set and Child Core Set measures that support the overarching Quality Strategy goals. Additional performance measures are also used to assess state-directed payment initiatives. The state-directed payment initiative objectives are noted with an "s."

Table 3-1—MCE Performance Measures for Nevada Medicaid and 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, 2027.					
Objective #	**Objective Description**	**Measure Steward**	**Measure Set**		
			HEDIS	**Adult Core Set**	**Child Core Set**
1.1a	Increase well-child visits in the first 30 months of life (W30)—0–15 months (6 or more well-child visits)	NCQA	✓		✓
1.1b	Increase well-child visits in the first 30 months of life (W30)—15–30 months (2 or more well-child visits)	NCQA	✓		✓
1.2a	Increase child and adolescent well-care visits (WCV)—3–11 years	NCQA	✓		✓
1.2b	Increase child and adolescent well-care visits (WCV)—12–17 years	NCQA	✓		✓
1.2c	Increase child and adolescent well-care visits (WCV)—18–21 years	NCQA	✓		✓
1.3a[s]	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—BMI percentile	NCQA	✓		✓
1.3b[s]	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—Counseling for nutrition	NCQA	✓		✓
1.3c[s]	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—Counseling for physical activity	NCQA	✓		✓

Goal 1—Improve the health and wellness of Nevada's Medicaid population by increasing the use of preventive services by December 31, 2027.					
Objective #	**Objective Description**	**Measure Steward**	**Measure Set**		
			HEDIS	**Adult Core Set**	**Child Core Set**
1.4a	Increase immunizations for adolescents (IMA)—Combination 1 (Meningococcal, influenza and tetanus, diphtheria toxoids, and acellular pertussis [Tdap])	NCQA	✓		✓
1.4b	Increase immunizations for adolescents (IMA)—Combination 2 (Meningococcal, Tdap, human papillomavirus [HPV])	NCQA	✓		✓
1.5a	Increase childhood immunization status (CIS)—Combination 3 (diphtheria, tetanus, and pertussis [DTaP]; inactivated polio vaccine [IPV]; measles, mumps, and rubella [MMR]; Haemophilus influenzae type b [HiB]; Hepatitis B [Hep B]; Varicella-Zoster virus [VZV]; polycythemia vera [PCV])	NCQA	✓		✓
1.5b	Increase childhood immunization status (CIS)—Combination 7 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hepatitis A [Hep A], rotavirus vaccine [RV])	NCQA	✓		✓
1.5c	Increase childhood immunization status (CIS)—Combination 10 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A, RV, Influenza)	NCQA	✓		✓
1.6	Increase breast cancer screening (BCS-E)	NCQA	✓	✓	
1.7a	Increase adults' access to preventive/ambulatory health services (AAP)—20–44 years	NCQA	✓		
1.7b	Increase adults' access to preventive/ambulatory health services (AAP)—45–64 years	NCQA	✓		
1.8a	Increase chlamydia screening in women (CHL)—16–20 years	NCQA	✓		✓
1.8b	Increase chlamydia screening in women (CHL)—21–24 years	NCQA	✓	✓	
1.9	Increase the rate of developmental screening in the first three years of life (DEV-CH)	OSHU			✓
1.10	Increase the rate of lead screening in children (LSC)	NCQA	✓		✓

OSHU (Oregon Health and Science University)
[S] State-directed payment objective

Goal 2—Increase use of evidence-based practices for members with chronic conditions by December 31, 2027.					
Objective #	**Objective Description**	**Measure Steward**	**Measure Set**		
			HEDIS	**Adult Core Set**	**Child Core Set**
2.1a	Increase rate of glycemic status (<8.0%) for members with diabetes (GSD)	NCQA	✓		
2.1b[S]	Reduce rate of glycemic status (>9.0%) for members with diabetes (GSD)*	NCQA	✓	✓	
2.2	Increase blood pressure control (<140/90 mm Hg) for members with diabetes (BPD)	NCQA	✓		
2.3[S]	Increase rate of controlling high blood pressure (CBP)	NCQA	✓	✓	

Goal 2—Increase use of evidence-based practices for members with chronic conditions by December 31, 2027.					
Objective #	Objective Description	Measure Steward	Measure Set		
			HEDIS	Adult Core Set	Child Core Set
2.4a	Increase the asthma medication ratio (AMR)—5–18 years	NCQA	✓		✓
2.4b	Increase the asthma medication ratio (AMR)—19–64 years	NCQA	✓	✓	
2.5[S]	Decrease the rate of adult acute inpatient stays that were followed by an unplanned acute readmission for any diagnosis within 30 days after discharge (PCR)*—Observed readmissions	NCQA	✓	✓	

* Indicates an inverse performance indicator where a lower rate demonstrates better performance for this measure.
[S] State-directed payment objective

Goal 3— Reduce misuse of opioids and other prescribed medications by December 31, 2027.					
Objective #	Objective Description	Measure Steward	Measure Set		
			HEDIS	Adult Core Set	Child Core Set
3.1	Reduce use of opioids at high dosage (HDO)*	NCQA	✓		
3.2	Reduce use of opioids for >15 days from multiple providers (UOP)—Multiple prescribers*	NCQA	✓		
3.3a	Reduce the rate of adult members with at least 15 days of prescription opioids in a 30-day period (COU)	NCQA	✓		
3.3b	Reduce the rate of adult members with at least 31 days of prescription opioids in a 62-day period (COU)	NCQA	✓		
3.4a	Increase the rate of avoidance of antibiotic treatment for acute bronchitis/bronchiolitis (AAB)—3 months to 17 years	NCQA	✓		✓
3.4b	Increase the rate of avoidance of antibiotic treatment for acute bronchitis/bronchiolitis (AAB)—18 years and older	NCQA	✓	✓	
3.5[S]	Improve safe use of opioids—Concurrent prescribing	CMS	NA		

* Indicates an inverse performance indicator where a lower rate demonstrates better performance for this measure.
[S] State-directed payment objective
NA (Not Applicable)

Goal 4—Improve the health and wellness of pregnant women and infants by December 31, 2027.					
Objective #	Objective Description	Measure Steward	Measure Set		
			HEDIS	Adult Core Set	Child Core Set
4.1a	Increase timeliness of prenatal care (PPC)—Under age 21	NCQA	✓		✓
4.1b	Increase timeliness of prenatal care (PPC)	NCQA	✓		
4.1c	Increase the rate of postpartum visits (PPC)—Under age 21	NCQA	✓		✓
4.1d	Increase the rate of postpartum visits (PPC)	NCQA	✓		
4.2a	Increase the rate of deliveries in which members were screened for clinical depression during pregnancy using a standardized instrument (PND-E)	NCQA	✓		

Goal 4—Improve the health and wellness of pregnant women and infants by December 31, 2027.					
Objective #	**Objective Description**	**Measure Steward**	**Measure Set**		
			HEDIS	**Adult Core Set**	**Child Core Set**
4.2b	Increase the rate of deliveries in which members received follow-up care within 30 days of a positive depression screen finding during pregnancy (PND-E)	NCQA	✓		
4.3a	Increase the rate of deliveries in which members were screened for clinical depression using a standardized instrument during the postpartum period (PDS-E)	NCQA	✓		
4.3b	Increase the rate of deliveries in which members received follow-up care within 30 days of a positive depression screen finding during the postpartum period (PDS-E)	NCQA	✓		
4.4	Increase the rate of deliveries in the measurement period in which members received influenza and Tdap vaccinations (PRS-E)	NCQA	✓		
4.5a	Increase the rate of contraceptive care (CCW-CH)—Most or moderately effective contraception for all women ages 15–20	OPA			✓
4.5b	Increase the rate of contraceptive care (CCW-CH)—Long-acting reversible contraception for all women ages 15–20	OPA			✓
4.6a	Increase the rate of contraceptive care (CCP-CH)—Most or moderately effective contraception for postpartum women ages 15–20 within 3 days of delivery	OPA			✓
4.6b	Increase the rate of contraceptive care (CCP-CH)—Most or moderately effective contraception for postpartum women ages 15–20 within 90 days of delivery	OPA			✓
4.6c	Increase the rate of contraceptive care (CCP-CH)—Long-acting reversible contraception for postpartum women ages 15–20 within 3 days of delivery	OPA			✓
4.6d	Increase the rate of contraceptive care (CCP-CH)—Long-acting reversible contraception for postpartum women ages 15–20 within 90 days of delivery	OPA			✓
4.7[S]	Reduce unexpected complications in term newborns (PC-06)	CMQCC	NA		

OPA (U.S. Office of Population Affairs)
CMQCC (California Maternal Quality Care Collaborative)
[S] State-directed payment objective
NA (Not Applicable)

Goal 5—Increase use of evidence-based practices for members with behavioral health conditions by December 31, 2027.					
Objective #	**Objective Description**	**Measure Steward**	**Measure Set**		
			HEDIS	**Adult Core Set**	**Child Core Set**
5.1a	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication (ADD)—Initiation phase	NCQA	✓		✓

Goal 5—Increase use of evidence-based practices for members with behavioral health conditions by December 31, 2027.					
Objective #	**Objective Description**	**Measure Steward**	**Measure Set**		
			HEDIS	**Adult Core Set**	**Child Core Set**
5.1b	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication (ADD)—Continuation and maintenance phase	NCQA	✓		✓
5.2	Increase adherence to antipsychotic medications for individuals with schizophrenia (SAA)	NCQA	✓	✓	
5.3a	Increase follow-up after hospitalization for mental illness (FUH)—7-day—6 to 17 years	NCQA	✓		✓
5.3b	Increase follow-up after hospitalization for mental illness (FUH)—7-day—18 years and older	NCQA	✓	✓	
5.3c	Increase follow-up after hospitalization for mental illness (FUH)—30-day—6 to 17 years	NCQA	✓		✓
5.3d	Increase follow-up after hospitalization for mental illness (FUH)—30-day—18 years and older	NCQA	✓	✓	
5.4	Increase diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications (SSD)	NCQA	✓	✓	
5.5a	Increase follow-up after emergency department (ED) visit for substance use (FUA)—7-day—13 to 17 years	NCQA	✓		✓
5.5b	Increase follow-up after ED visit for substance use (FUA)—7-day—18 years and older	NCQA	✓	✓	
5.5c	Increase follow-up after ED visit for substance use (FUA)—30-day—13 to 17 years	NCQA	✓		✓
5.5d	Increase follow-up after ED visit for substance use (FUA)—30-day—18 years and older	NCQA	✓	✓	
5.6a	Increase follow-up after ED visit for mental illness (FUM)—7-day—6 to 17 years	NCQA	✓		✓
5.6b	Increase follow-up after ED visit for mental illness (FUM)—7-day—18 years and older	NCQA	✓	✓	
5.6c	Increase follow-up after ED visit for mental illness (FUM)—30-day—6 to 17 years	NCQA	✓		✓
5.6d	Increase follow-up after ED visit for mental illness (FUM)—30-day—18 years and older	NCQA	✓	✓	
5.7a	Increase initiation and engagement of substance use disorder (SUD) treatment (IET)—Initiation of SUD treatment	NCQA	✓	✓	
5.7b	Increase initiation and engagement of SUD treatment (IET)—Engagement of SUD treatment	NCQA	✓	✓	
5.8	Increase the rate of children with and adolescents with ongoing antipsychotic medication use who had metabolic testing during the year (APM)	NCQA	✓		✓
5.9a	Increase the rate of antidepressant medication management (AMM)—Effective acute phase treatment	NCQA	✓	✓	

Goal 5—Increase use of evidence-based practices for members with behavioral health conditions by December 31, 2027.					
Objective #	**Objective Description**	**Measure Steward**	**Measure Set**		
			HEDIS	**Adult Core Set**	**Child Core Set**
5.9b	Increase the rate of antidepressant medication management (AMM)—Effective continuation phase treatment	NCQA	✓	✓	
5.10	Increase the use of first-line psychosocial care for children and adolescents on antipsychotics (APP)	NCQA	✓		✓
5.11a	Increase the rate of acute inpatient hospitalizations, residential treatment, or withdrawal management visits for a diagnosis of SUD among members 13 years of age and older that resulted in a follow-up visit or service for SUD within 7 days (FUI)	NCQA	✓		
5.11b	Increase the rate of acute inpatient hospitalizations, residential treatment, or withdrawal management visits for a diagnosis of SUD among members 13 years of age and older that resulted in a follow-up visit or service for SUD within 30 days (FUI)	NCQA	✓		
5.12	Increase the rate of adult Medicaid beneficiaries with an opioid use disorder (OUD) who filled a prescription or were administered or dispensed an FDA-approved medication for the disorder (OUD)	CMS		✓	
5.13a	Increase the rate of screening for depression and follow-up plan for members (CDF)—12–17 years	CMS			✓
5.13b	Increase the rate of screening for depression and follow-up plan for members (CDF)—18 years and older	CMS		✓	
5.14	Decrease the rate of hemoglobin A1c (HbA1c) poor control (>9.0%) for people with diabetes and serious mental illness (HPCMI-AD)*	NCQA		✓	
5.15[S]	Track the hours of physical restraint use (HBIPS-2)	TJC	NA		
5.16[S]	Track the hours of seclusion use (HBIPS-3)	TJC	NA		

* Indicates an inverse performance indicator where a lower rate demonstrates better performance for this measure.
TJC (The Joint Commission)
[S] State-directed payment objective
NA (Not Applicable)

Goal 6—Increase utilization of dental services by December 31, 2027.					
Objective #	**Objective Description**	**Measure Steward**	**Measure Set**		
			HEDIS	**Adult Core Set**	**Child Core Set**
6.1	Increase the rate of enrolled children under age 21 who received a comprehensive or periodic oral evaluation within the measurement year (OEV)	DQA			✓
6.2a	Increase the rate of enrolled children ages 1 through 20 years who received at least two topical fluoride applications as dental or oral health services, within the measurement year (TFL)	DQA			✓

Goal 6—Increase utilization of dental services by December 31, 2027.					
Objective #	Objective Description	Measure Steward	Measure Set		
			HEDIS	Adult Core Set	Child Core Set
6.2b	Increase the rate of enrolled children ages 1 through 20 years who received at least two topical fluoride applications as dental services, within the measurement year (TFL)	DQA			✓
6.2c	Increase the rate of enrolled children ages 1 through 20 years who received at least two topical fluoride applications as oral health services, within the measurement year (TFL)	DQA			✓
6.3a	Increase the rate of enrolled children who have ever received sealants on permanent first molar teeth: at least one sealant by 10th birthdate (SFM)	DQA			✓
6.3b	Increase the rate of enrolled children who have ever received sealants on permanent first molar teeth: all four molars sealed by 10th birthdate (SFM)	DQA			✓

DQA (Dental Quality Alliance)

Goal 7—Reduce and/or eliminate health care disparities for Nevada Medicaid members by December 31, 2027.	
Objective #	Objective Description
7.1	Ensure that health plans maintain, submit for review, and annually revise cultural competency plans.
7.2	Stratify data for performance measures by race, ethnicity, sex, and geography 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.
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.

Goal 8—Improve positive outcomes for members with long-term services and supports (LTSS) needs by December 31, 2027.		
Objective #	Objective Description	Measure Steward
8.1[S]	Reduce the percentage of long stay nursing facility residents with high-risk/unstageable pressure ulcers (N045.01)	CMS
8.2[S]	Improve percent of long-term care hospital (LTCH) patients with an admission and discharge functional assessment and a care plan that addresses function.	CMS
8.3[S]	Assess discharges to the community following a post-acute stay (post-acute care measure for inpatient rehabilitation facilities)	CMS

[S] State-directed payment objective

LTSS Performance Measures

DHCFP contracts the MCOs to perform limited LTSS as medically necessary, such as personal care services, home health services, nursing facility services, and private duty nursing. LTSS must be

authorized based on a member's current health needs assessment (HNA) and consistent with the member's person-centered care plan. However, members enrolled in a 1915(c) HCBS waiver program are excluded from the Medicaid managed care program and instead are managed directly by DHCFP. Therefore, DHCFP does not have specific LTSS performance measures for the Nevada Medicaid managed care program, apart from one performance objective under Goal 8 that was established to support DHCFP's nursing facility state-directed payment initiative impacting nursing facilities. In addition to requiring the MCOs to assess the quality and appropriateness of care furnished to members using LTSS, including an assessment of care between care settings and a comparison of services and supports received with those set forth in the member's treatment plan, DHCFP contractually requires the MCOs to identify, report, and remediate critical incidents. All critical incidents must be reported within one business day of the MCO becoming aware of the incident to the MCOs' Critical Incident Management Systems, and the MCOs are required to track and trend critical incident data for use in assessing the quality and appropriateness of care furnished to members receiving LTSS. DHCFP monitors all critical incidents reported by the MCOs to ensure appropriate follow-up and resolution.

Public Posting of Quality Measures and Performance Outcomes

In accordance with 42 CFR §438.340(b)(3)(i) and 42 CFR §457.1240(e), DHCFP reports and publicly posts performance measures at the MCE level as well as at the state level through the annual EQR technical report. The performance measures included in the technical report comprise all measures that align to the goals and objectives in this Quality Strategy. Each MCE's progress in achieving established performance metrics is documented in a Goals and Objectives Tracking table included as part of the annual EQR technical report. The quality measures and performance outcomes selected by DHCFP as most meaningful to demonstrate the quality of care and quality of services provided to Nevada Medicaid managed care members are available in the annual EQR technical report published on DHCFP's website at: https://dhcfp.nv.gov/Resources/AdminSupport/Reports/CaseloadData/. DHCFP also publicly posts the Managed Care Program Annual Report (MCPAR) for Nevada, which includes a report on individual MCE performance measure ratings in the domains of primary care access and preventive care, maternal and perinatal health, care of acute and chronic conditions, behavioral health care, overuse and appropriateness of care, utilization, and dental and oral health services. The MCPAR is also available at: https://dhcfp.nv.gov/Resources/AdminSupport/Reports/CaseloadData/.

Payment Incentive 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 SUDs 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 3-2, 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. DHCFP provides QIPs to CCBHCs meeting established criteria, within one year following the end of the relevant measurement year (July 1 to June 30), and after it receives all final data needed to calculate the QIP. CCBHCs can receive up to 5 percent of annual prospective payment system (PPS) payments for reporting the appropriate data for the two clinic-led measures and six state-led measures quarterly. Additionally, CCBHCs can receive up to 10 percent of annual PPS payments by achieving the appropriate performance for the following clinic-led and state-led measures:

- Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment—1%
- Adult Major Depressive Disorder (MDD): Suicide Risk Assessment—1%
- Adherence to Antipsychotic Medications for Individuals With Schizophrenia—1%
- Follow-Up After Hospitalization for Mental Illness, Ages 21+—1%
- Follow-Up After Hospitalization for Mental Illness, Ages 6–21—1%
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment—1%
- Plan All-Cause Readmission Rate—2%
- State Directed Crisis Measure—2%

The CCBHCs must reach the target goal or achieve gap improvement on the measure as indicated:

> 10% Annual Reduction in CCBHC Specific Gap = [(Incentive Target Goal – Prior Year Performance) x 10%] + Prior Year Performance

Table 3-2 describes the CCBHC performance measures.

Table 3-2—CCBHC Performance Measures

Performance Measure	Clinic/State-Led	Source	Target Goal
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	Clinic-led	Mathematica Policy Research (MPR)	90%
Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	Clinic-led	MPR	90%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	State-led	CMS	60.1%
Follow-Up After Hospitalization for Mental Illness, Ages 21+	State-led	NCQA	7 days–43.9% 30 days–63%

Performance Measure	Clinic/State-Led	Source	Target Goal
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%
State Directed Crisis Measure	State-led	Public Health Supportive Services (PH-SS)	25%

The CCBHC initiative aligns to the Nevada DHCFP Strategic Plan goal to *improve the quality of and access to behavioral health services available to members* and Quality Strategy Goal 5 to *increase use of evidence-based practices for members with behavioral health conditions*. Improved access through the CCBHC initiative should show a positive impact to the progress made to DHCFP's goals under the Strategic Plan and Quality Strategy.

State-Directed Payment Initiatives

Public Hospital Systems

In state fiscal year (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 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 to *improve the health and wellness of Nevada's Medicaid population by increasing the use of preventive services*. 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.

Three providers are currently eligible for the state-directed payment initiative: University Medical Center (UMC), a public hospital; University of Nevada Las Vegas School of Medicine (UNLV), a public medical school; 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, CY 2021 for UNR, and CY 2023 for UNLV, 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 3-3 identifies the Quality Strategy objectives identified in the CMS-approved Section 438.6(c) Preprint to evaluate performance of the state-directed payment initiative.

Table 3-3—State-Directed Payment Initiative Nevada Medicaid Performance Measures and Objectives

Measure	Objective Alignment
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—BMI [body mass index] *Percentile*	Objective 1.3a: Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—BMI percentile
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Counseling for Nutrition	Objective 1.3b: Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—Counseling for nutrition
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Counseling for Physical Activity	Objective 1.3c: Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—Counseling for physical activity
Glycemic Status Assessment for Patients With Diabetes (GSD)—Glycemic Status >9.0%	Objective 2.1b: Glycemic Status Assessment for Patients With Diabetes (GSD)—Glycemic Status >9.0%
Controlling High Blood Pressure (CBP)	Objective 2.3: Increase rate of controlling high blood pressure (CBP)
Plan All-Cause Readmissions (PCR)—Observed Readmissions	Objective 2.5: 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

Private Hospital Tax

In SFY 2023 and SFY 2024, DHCFP received approval from CMS for its delivery system and provider payment initiative in accordance with 42 CFR §438.6(c) for an enhanced rate of reimbursement for all private hospitals eligible for the directed payment based on the provider class as defined in the Medicaid State plan. The classes are: Acute, Psychiatric, Long Term Acute Care, Rehabilitation, and Critical Access Hospitals. All private hospital providers in a class will receive a uniform add-on reimbursement per inpatient day and per outpatient encounter. DHCFP implemented a provider tax to manage the add-on reimbursement. This payment arrangement will ensure that Nevada hospitals will continue to be able to maintain access to health services and continue to provide high quality, culturally sensitive care. To evaluate the effectiveness of the state-directed payment initiative, DHCFP will aim to advance Goal 2 to *increase use of evidence-based practices for members with chronic conditions*; Goal 3 to *reduce misuse of opioids and other prescribed medications*; Goal 4 to *improve the health and wellness of pregnant*

women and infants; and Goal 5 to *increase use of evidence-based practices for members with behavioral health conditions*.

As part of the Private Hospital Tax state-directed payment, DHCFP is conducting a Nevada Hospital Quality Collaborative to communicate processes for fostering value-based payment at Nevada hospitals; provide helpful information to inform decisions about the future of the payment arrangements; and provide opportunities for each hospital class to focus on value-based payment efforts. The Nevada Hospital Quality Collaborative goals are to improve the value of Nevada's health system through aligning incentives via alternative payment models; incorporate a population health approach to improve outcomes in maternal, behavioral, and primary care; and identify and address health inequities among populations.

Table 3-4 identifies the Quality Strategy objectives identified in the CMS-approved Section 438.6(c) Preprint to evaluate performance of the state-directed payment initiative.

Table 3-4—State-Directed Payment Initiative Nevada Medicaid Performance Measures and Objectives

Measure	Objective Alignment
Percent of LTCH Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function	Objective 8.2: Improve percent of LTCH patients with an admission and discharge functional assessment and a care plan that addresses function.
Discharge to Community-Post Acute Care Measure for Inpatient Rehabilitation Facilities	Objective 8.3: Assess discharges to the community following a post-acute stay (post-acute care measure for inpatient rehabilitation facilities)
PC-06: Unexpected Complications in Term Newborns	Objective 4.7: Reduce unexpected complications in term newborns (PC-06)
Safe Use of Opioids—Concurrent Prescribing	Objective 4.8: Improve safe use of opioids—Concurrent prescribing
Hospital-Based Inpatient Psychiatric (HBIPS)-2: Hours of Physical Restraint Use	Objective 5.15: Track the hours of physical restraint use (HBIPS-2)
HBIPS-3: Hours of Seclusion Use	Objective 5.16: Track the hours of seclusion use (HBIPS-3)

Nursing Facilities

In CY 2023, with a revision in CY 2024, DHCFP submitted a Section 438.6(c) Preprint application to CMS for its delivery system and provider payment initiative in support of payment arrangements to nursing facilities based on facilities' number of bed days in a given quarter, acuity of patients at the facility, a set of quality metrics, and the accuracy of the MDS. Hospital-based facilities and Nevada State Veteran Homes are excluded. The state-directed payment will provide supplemental payment for nursing facility residents covered under the Nevada Medicaid managed care program. The directed payments are designed to incentivize and support the eligible nursing facilities to work toward improvement of quality of care for the Medicaid population. The program targets a main domain of nursing home improvement through avoidance of negative care events. To evaluate the effectiveness of the state-directed payment initiative, DHCFP added a performance measure to the Quality Strategy under Goal 8 to *reduce the percentage of long stay nursing*

facility residents with high-risk/unstageable pressure ulcers. The MCOs are annually required to calculate the performance of the providers eligible for the payment increase based on the delivery of services to Medicaid managed care members using state-directed payment measure specifications and the related performance measure data results. The performance target is to reduce the baseline rate of 2 percent by 0.5 percent using the Quality Improvement System for Managed Care (QISMC) methodology published by CMS in 1998. Table 3-5 identifies the Quality Strategy objective identified in the CMS-approved Section 438.6(c) Preprint to evaluate performance of the state-directed payment initiative.

Table 3-5—State-Directed Payment Initiative Nevada Medicaid Performance Measure and Objective

Measure	Objective Alignment
Percent of Residents with Pressure Ulcers-Long Stay; CMS ID: N045.01	Objective 8.1: Reduce the percentage of long stay nursing facility residents with high-risk/unstageable pressure ulcers

Bonus Incentive Payments

In CY 2024, DHCFP implemented three Bonus Incentive Payments (BIPs) to increase the MCOs' investment in, and members' access to, primary care; foster the expansion of value-based payment design; improve members' access to family planning counseling and long-acting reversible contraceptives (LARCs); and increase screening, testing, and treatment of syphilis among pregnant women and infants. Through the Primary Care, Value Based Purchasing, and Maternal and Infant Health Promotion BIPs, the MCOs are eligible to receive bonus payments up to a DHCFP-disclosed percentage for each BIP based on the total approved capitated payments if the MCOs are able to meet the defined performance goals outlined by DCHFP in an annual Bonus Incentive Payments for Medicaid Managed Care Contract memo. DHCFP will continue to monitor and expand the BIPs, and implement new BIPs as appropriate, based on the priorities of the State each SFY, as funding is available.

Performance Improvement Projects and Interventions

DHCFP requires MCEs to conduct PIPs annually in accordance with 42 CFR §438.330(d). The MCEs' PIPs must be designed to achieve significant and sustained improvement in clinical and nonclinical areas of care through ongoing measurement and intervention and to have a favorable effect on health outcomes and member satisfaction. Specifically, each PIP must include:

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

To support quality improvement, DHCFP requires the MCOs to annually conduct and report on a minimum of three clinical PIPs and three nonclinical PIPs. Clinical PIPs include projects focusing on prevention and care of acute and chronic conditions, maternal and child health outcomes, high-volume services, high-risk services, and continuity and coordination of care. Nonclinical PIPs include projects focusing on availability, accessibility, and cultural competency of services; interpersonal aspects of care; and appeals and grievances. The MCOs must also participate in one statewide PIP focusing on reduction of African American maternal and infant morbidity and mortality. Further, the MCOs must ensure that two of its implemented PIPs also consider at least two of the below topic areas:

- Increasing access to and use of primary care and preventive services across the covered population
- Improving quality of and access to behavioral health services
- Reducing preventable 30-day hospital readmissions
- Health-related social needs (HRSN) and health equity

DHCFP also requires its DBA to annually conduct and report on a minimum of one clinical PIP and one nonclinical PIP. The clinical PIP must focus on prevention and care of acute and chronic conditions, high-volume services, high-risk services, or continuity and coordination of care. The nonclinical PIP must focus on availability, accessibility, and cultural competency of services; interpersonal aspects of care; and appeals, grievances, or other complaints.

DHCFP contracts with its EQRO to validate the MCEs' clinical and nonclinical PIPs annually. Through the PIP validation process, the EQRO assesses its overall confidence that the PIP adhered to acceptable methodology for all phases of design and data collection, and conducted accurate data analysis and interpretation of PIP results. The EQRO also provides its overall confidence that the PIP produced evidence of significant improvement. DHCFP uses the PIP results to assess each MCE's achievement of goals and to make any necessary modifications to the Quality Strategy based on each MCE's performance at the conclusion of each PIP cycle. The DHCFP-mandated PIP topics (i.e., goals for improvement) are described in Table 3-6.

Table 3-6—Nevada MCE PIPs

MCE	Performance Improvement Project	DHCFP Driven Interventions
MCO	*Increase rates of follow up after emergency department (ED) visit for adults and children 6 years of age and older with a diagnosis of mental illness and who received a follow-up visit for mental illness*	DHCFP requires the Prenatal and Postpartum Care PIP intervention(s) to target racial and ethnic disparities.
MCO	*Increase rates of child and adolescent well-care visits among members eligible for these services*	
MCO	*Reduce preventable hospital readmissions*	
MCO	*Improve rates of prenatal and postpartum care for pregnant women in Medicaid managed care* Note: This PIP satisfies the contract requirement for conducting a PIP that relates to improving the rates of maternity and infant mortality and morbidity in Medicaid managed care.	
MCO	*Improve access to care for Medicaid enrollees with substance use disorder(s) in the Medicaid managed care program*	
MCO	*Improve access to care for Medicaid enrollees to preventive and ambulatory health services*	
DBA	*Increase preventive services for children*	
DBA	*Increase coordination of transportation services*	

Transition of Care Policy

DHCFP makes its transition of care policy publicly available through its contracts with the MCOs and the Medicaid Services Manual (MSM) Section 3603.20 and provides instructions to members on how to access continued services during a transition from the FFS program to an MCO or from one MCO to another MCO. To ensure that there is no interruption of any covered service, DHCFP requires the MCOs to be responsible for members as soon as they are enrolled and the MCO is aware that the member is in treatment. The MCOs must have policies and procedures to smoothly transition members from FFS or from one MCO to another MCO, including members with medical conditions such as high-risk pregnancy, major organ or tissue transplantation services in process, chronic or terminal illness, intractable pain, and/or behavioral or mental health conditions. Transition policies and procedures must also include members who, at the time of enrollment, are receiving chemotherapy and/or radiation therapy, significant outpatient treatment or dialysis, prescription medications or durable medical equipment (DME), behavioral health services, LTSS (such as personal care services and/or home health services), and/or other services not included in the Nevada Medicaid or Nevada Check Up SPAs but covered by Medicaid under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) for children and as otherwise described under 42 CFR §438.210.

Additionally, members who at enrollment are scheduled for inpatient surgery(ies), are currently in the hospital, have prior authorization for procedures and/or therapies for dates after their transition to the

new MCO, and/or have post-surgical follow-up visits scheduled after their transition to the new MCO must have continued access to these services without delay.

Further, MCOs are responsible for transferring or receiving relevant patient information, medical records, and other pertinent materials to the new MCO or current FFS provider. Prior to transferring a member, the MCO must send the receiving MCO information regarding the member's condition. Nevada's MSM can be accessed at https://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/MSMHome/

Disparities Plan and Initiatives

To comply with the regulatory requirements for State procedures for age, sex, race, ethnicity, disability status, and primary language spoken (CFR §438.206–§438.210), DHCFP requires the MCEs to participate in Nevada's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. DHCFP continually monitors how age, sex, race, ethnicity, disability status, and the primary language of members are collected, coded, and entered into Medicaid managed care systems to ensure that this information is compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and with CMS requirements to improve the delivery of services to members in a culturally competent manner. DHCFP provides demographic information for age, sex, race/ethnicity, and primary language spoken to the MCEs as part of the member eligibility file, and the MCEs are expected to use the data to analyze potential disparities in their membership through quality improvement efforts. Through the MCE contracts specifically, DHCFP requires the MCEs to develop and maintain the ability to collect and report data on race, ethnicity, sex, primary language, and disability status for their membership. The MCEs are also required to maintain a Population Health program and strategies, and a Cultural Competency program and plan. Further, the MCEs are contractually mandated to address disparities through EQR activities. These programs and activities support DHCFP's initiatives to address health disparities and support Quality Strategy Goal 7 to *reduce and/or eliminate health care disparities for Medicaid recipients*.

Population Health Program and Strategies

The MCEs are required through contract to develop a Population Health program that establishes population health goals and targeted annual improvements that are aligned with this Quality Strategy. The program must align the efforts and resources of the MCEs' Care Management programs (i.e., disease management, care coordination, case management, and programs that address HRSN and racial and ethnic disparities in healthcare); quality management; and the MCEs' value-based contracting strategies to achieve population health improvements. Each MCE must provide interventions to address the following:

- Keeping members healthy through a spectrum of primary and preventive care
- Use of the principles of population health management to prevent chronic disease and identify and manage members with emerging risk for chronic conditions

- Coordination of care along the continuum of health and well-being and assurance of safety and access to services across settings
- Managing members who are high utilizers of services and with multiple chronic conditions
- Effective utilization of these principles to maintain or improve the physical and psychosocial well-being of members through cost-effective and tailored health solutions, incorporating all risk levels across the care continuum

On an annual basis, each MCE must also submit a Population Health Annual Strategy to DHCFP. As part of this strategy, the MCE must provide:

- An overview of the stratification algorithm used to risk-stratify the membership, including the following: the data sources utilized; how socio-economic and HRSN factors are considered in the algorithm; and how cultural, ethnic, and racial factors are considered in the algorithm.
- A description of how HRSN are integrated into the Population Health program.
- A description of the approach to identify and address racial and ethnic disparities in healthcare, including a description of how information is used to design targeted clinical programs to improve healthcare disparities based on race and/or ethnicity, and training provided to staff related to addressing racial and ethnic disparities, diversity, and inclusion.

Cultural Competency Program and Plan

The MCEs are required through contract to also develop and implement a Cultural Competency program and plan to provide effective, equitable, understandable, and respectful quality care and services that are responsive to the diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs of their membership. Each MCE's Cultural Competency program must include processes to:

- Support a culturally and linguistically diverse governance, leadership, and workforce that are responsible to the population in the service area.
- Educate and train governance, leadership, and workforce on culturally and linguistically appropriate policies and practices on an ongoing basis.

On an annual basis, each MCE must also develop a written plan that describes how care and services will be delivered in a culturally competent manner. As part of the written plan, the MCE must include:

- The goals and objectives of the MCE's cultural competency program that align to the goals and objectives described in this Quality Strategy.
- How it plans to recruit and retain staff members who can meet the cultural needs of the MCE's membership, and cultural competence must be included as part of job descriptions.
- The process to obtain member and stakeholder feedback that will be used to improve the cultural competency program and cultural support provided by clinical and member services programs.

- The method for the ongoing evaluation of the cultural diversity of its membership, including maintaining an up-to-date demographic and cultural profile of the MCE's members. A regular assessment of needs and/or disparities is performed, which is used to plan for and implement services that respond to the distinct cultural and linguistic characteristics of the MCE's membership.
- A regular evaluation of each MCE's provider network, outreach services, and other programs to improve accessibility and quality of care for its membership. The plan must also describe the provision and coordination needed for linguistic and disability-related services.
- A process to evaluate the plan annually to determine its effectiveness and identify opportunities for improvement. The evaluation may, for example, focus on comparative member satisfaction surveys, outcomes for certain cultural groups, member grievances, provider feedback, and/or MCE employee surveys.

Disability Status

DHCFP aligns its definition of "disability" with that of the Supplemental Security Income (SSI) program. Any deviation from the SSI program's definition is outlined under Attachment 2.2-A of the Nevada Medicaid SPA, which delineates the groups covered and the agencies responsible for eligibility determinations. The SPA is located at https://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSP/MSPHome/. Nevada is an SSI criteria state, indicating that the Division of Welfare and Supportive Services (DWSS), as the department responsible for determining Medicaid eligibility, accepts the SSI program's approval of benefits as eligibility for Medicaid based on SSI eligibility. DWSS staff members access the on-demand, real-time SOLQi interface to verify SSI status. Individuals with an aid code[3-5] indicating SSI are exempt from the Nevada Medicaid managed care program.

EQR Activities

Through the EQR-related activities, the MCEs examine disparities through analysis of their performance measure and PIP-related data and outcomes. Through HEDIS and Core Set measures, the MCEs stratify performance measure data by member age. Further, DHCFP supports NCQA's expansion of the race and ethnicity stratification to HEDIS measures and requires the MCEs to report stratified data in compliance with the HEDIS technical specifications published by NCQA. Additionally, DHCFP supports CMS' requirements to report a subset of child and adult Core Set measures by race and ethnicity, sex, and geography. By leveraging HEDIS and CMS Core Set reporting, DHCFP aims to advance health equity within the Nevada Medicaid managed care program. The stratification of performance measure data will also assist the MCEs in the development of strategies and initiatives to further support their Population Health and Cultural Competency programs. Additionally, DHCFP is requiring each MCO to participate in a state-mandated PIP to address maternal and infant health disparities within the African American population. Further, each MCO must include in its QAPI program description how each implemented PIP relates to its population health initiatives and this Quality Strategy.

[3-5] Aid codes are used to identify the type of medical assistance for which Medicaid recipients are eligible.

Identification of Persons Who Need LTSS or Persons With Special Health Care Needs

DHCFP ensures that MCEs implement a process to assess all members upon enrollment. Children and adults with special health care needs are identified through an HNA process. CSHCN are children who have, or are at risk for, chronic physical, developmental, behavioral, or emotional conditions; also require health and related services of a type and amount beyond that required by children in general; and are receiving services through family-centered, community-based, coordinated care systems receiving grant funds under Section 501(a)(1)(D) of Title V of the Social Security Act (SSA) (known as Nevada Early Intervention Program [NEIP]). Members who are identified as having special healthcare needs are required by DHCFP to be enrolled into the MCEs' care coordination or care management programs, depending on each member's level of needs. Members in care coordination and care management programs are monitored closely, and the MCEs are required to ensure that members receive and follow a treatment plan.

DHCFP has identified priority conditions that warrant care management services. The MCOs must provide care management to members diagnosed with the following priority conditions:

- Congestive heart failure
- Coronary arterial disease
- Hypertension (excluding mild hypertension)
- Diabetes
- Chronic obstructive pulmonary disease
- Asthma
- High-risk or high-cost SUDs, including OUDs
- Members with co-morbid (physical and behavioral health) conditions
- Children with SED and adults with serious mental illness
- CSHCN
- High-risk pregnancy, including members who are pregnant and have an SUD or history of SUD
- Severe cognitive and/or developmental limitation
- Human immunodeficiency virus
- Members with complex conditions such as cystic fibrosis, cerebral palsy, sickle cell anemia, etc.
- Justice involved populations that are not enrolled in targeted care management
- Members in supportive housing
- Homeless/transient status

Additionally, through the HNA or comprehensive assessment processes, the MCOs will identify members needing LTSS. Through these assessment processes, the MCOs develop person-centered treatment plans that identify members' LTSS and community support needs. The MCOs are contracted with DHCFP to provide certain LTSS services to Medicaid managed care members, including skilled nursing facility services, private duty nursing services, personal care services, and home health services.

Members enrolled in a 1915(c) HCBS waiver program are excluded from the Medicaid managed care program. Therefore, any members identified by the MCOs as needing LTSS not covered under the MCOs are referred to DHCFP for potential disenrollment from the Medicaid managed care program.

Measurement of Member Experience

Annually, the MCEs are required through contract to conduct periodic surveys of member satisfaction with services through administration of the Consumer Assessment of Health Plans and Systems (CAHPS®)[3-6] survey or other survey approved by DHCFP. The primary objective of the CAHPS survey is to obtain information on the level of satisfaction members have with their healthcare and dental care experiences and the accessibility and timeliness of services. These surveys cover topics important to members, such as the communication skills of providers, the accessibility of services, and their satisfaction with the MCE.

The Nevada MCEs survey three populations: adult Medicaid, child Medicaid, and Nevada Check Up, as well as a CAHPS survey for children with chronic conditions. DHCFP uses CAHPS survey information to measure members' experience and satisfaction with their MCEs and providers, and the quality, availability, and accessibility of their care and services.

DHCFP's EQRO analyzes the findings of each CAHPS survey completed by the MCEs and incorporates an assessment of performance for each MCE in the annual EQR technical report.

[3-6] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

4. Monitoring and Compliance

Network Adequacy and Availability of Services

The Nevada MCE contracts include network adequacy and appointment standards to ensure that MCEs adhere to the requirements identified in 42 CFR §438.68, §438.206, and §438.207.

Network Adequacy Standards

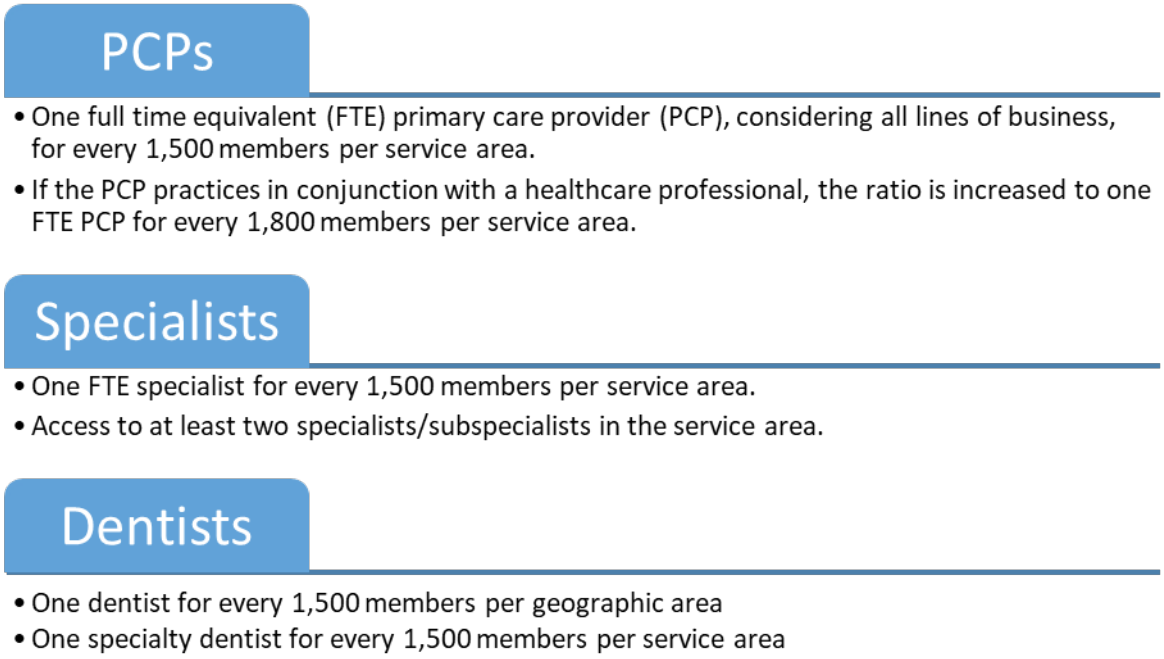
DHCFP requires its MCEs to meet certain geographic network distribution time and distance standards for applicable provider specialties. MCEs must ensure that members have access to these specific provider types within the maximum time and distance standards as listed in Table 4-1.

Table 4-1—Time and Distance Standards

Provider Specialty Area	Maximum Time in Minutes	Maximum Distance in Miles
Primary Care (adult)	15	10
Pediatrics	15	10
Hospitals	45	30
Obstetrics/Gynecology	15	10
Endocrinology (adult and pediatric)	60	40
Infectious Diseases (adult and pediatric)	60	40
Oncology—Medical/Surgical (adult and pediatric)	45	30
Oncology—Radiation/Radiology (adult and pediatric)	60	40
Rheumatology (adult and pediatric)	60	40
Psychiatrist (adult)	45	30
Board Certified Child and Adolescent Psychiatrist	45	30
Psychologist (adult and pediatric)	45	30
Qualified Mental Health Professional (QMHP) (adult and pediatric)	45	30
Outpatient Dialysis	45	30
Pharmacy	15	10
General Dentistry/Adult and Pediatric	30	20

DHCFP also ensures that MCEs demonstrate that they have the capacity to serve the expected enrollment in their contracted service areas in accordance with access to care standards. The MCEs must offer an appropriate range for primary care, specialty services, and dental care, and maintain a network that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. The MCEs are required to meet the following provider-to-member ratios as displayed in Figure 4-1.

Figure 4-1—Provider-to-Member Ratio Standards



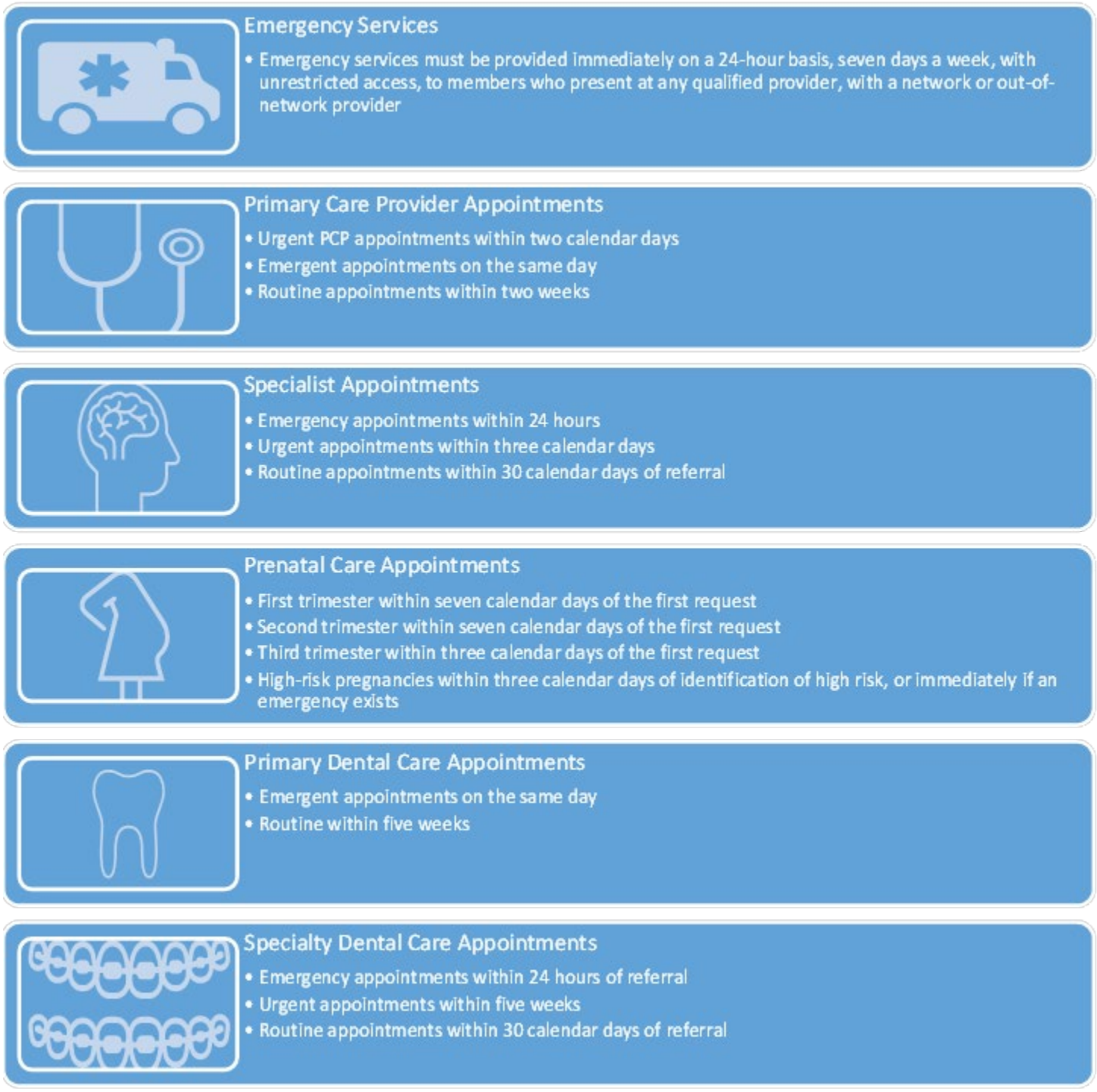
Eligible American Indian/Alaska Native members can also access services at Indian Health Service facilities and Tribal Clinics while enrolled with the MCEs.

To assess the MCEs' compliance with the DHCFP-defined network adequacy standards, DHCFP contracts with its EQRO to perform annual network adequacy validation activities. DHCFP also monitors network adequacy through quarterly MCE GeoAccess reports and monthly/quarterly MCE grievance reports.

Timely Appointment Standards

MCEs must make all services available 24 hours per day, seven days a week, when medically necessary. The MCEs must ensure that member access to covered services is consistent with the degree of urgency and require its network providers to meet State requirements for timely access to care and services through timely appointment standards listed in Figure 4-2.

Figure 4-2–Timely Appointment Standards



To assess compliance with timely appointment standards, the DBA is required to conduct an annual secret shopper survey across its provider network to identify appointment standards and access to

services for dental providers consistent with the appointment standards identified in the DBA's contract with DHCFP. The MCOs are required to conduct semiannual member focus groups related to barriers in care as part of the Access to Care Monitoring Plan to identify appointment standards and access to services for primary care providers (PCPs), behavioral health, and prenatal obstetric providers consistent with the appointment standards identified in the MCOs' contract with DHCFP.

Clinical Practice Guidelines

DHCFP maintains an MSM, which is a compilation of regulations adopted under Nevada Revised Statutes (NRS) 422.2368 and 422.2369. Throughout the MSM, DHCFP has outlined multiple current national CPGs, treatment protocols, and standards of care to optimize patient care. The MCEs are required to provide medically necessary services in accordance with the MSM. Examples of CPGs, treatment protocols, and standards of care within the MSM include, but are not limited to:

- Advisory Committee on Immunization Practices (ACIP)
- Substance Abuse and Mental Health Services Administration (SAMHSA), American Society of Addiction Medicine (ASAM) Treatment Improvement Protocols
- American College of Obstetricians and Gynecologists (ACOG) and/or U.S. Preventive Services Task Force (USPSTF) Practice Guidelines
- National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology, Breast Cancer
- Association of Orthodontists Clinical Practice Guidelines for Orthodontics and Dentofacial Orthopedics
- Dietary Guidelines for Americans published by the Secretaries of the Department of Health and Human Services (DHHS) and the United States Department of Agriculture
- Centers for Disease Control and Prevention (CDC), the American Academy of Pediatrics (AAP), and Behavior Analyst Certification Board (BACB) Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers

The MSM is available at https://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/MSMHome/.

DHCFP also includes in its contracts with the MCEs requirements for evidence-based CPGs. MCEs must adopt CPGs and protocols that are based on valid and reliable clinical evidence or a consensus of healthcare professionals in the particular field; consider the needs of members; are adopted in consultation with contracting network providers; are reviewed and updated periodically, as appropriate, to reflect the current practice standards; and include prior authorization requirements that are documented and applied in a manner that complies with requirements for parity in mental health and SUD benefits while focusing on the process and outcomes of healthcare delivery, as well as access to care.

MCEs disseminate CPGs to all affected providers prior to the contract start date, and upon request, to members and potential members. In addition, MCEs submit to DHCFP for review and prior approval the CPGs the MCEs intend to use and require network providers to apply designated CPGs and protocols.

DHCFP requires that the MCEs ensure that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the CPGs.

Each MCE must also include in its QAPI evaluation description how the MCE meets the requirements for the development and dissemination of CPGs and a summary of the MCE's utilization review oversight structure that monitors utilization practice against adopted CPGs. Additionally, the MCEs' QAPI programs must use the CPGs to evaluate the quality of care provided by the MCEs' provider networks and report such evaluation results to DHCFP at least annually.

Medicaid Contract Provisions

To assess the quality and appropriateness of care and services for Nevada Medicaid managed care members, DHCFP regularly reviews the MCEs' reports and deliverables as required by the contract. DHCFP monitors all aspects of the Medicaid managed care program through its State monitoring and/or EQR-related activities, including the performance of each MCE in at least the following areas:

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

DHCFP and/or the EQRO reviews all deliverables submitted by the MCEs and, as applicable, requires revisions until DHCFP approves the deliverables as complete and fully compliant with the contract. DHCFP and/or the EQRO may request corrective action plans (CAPs) from the MCEs in cases for which compliance monitoring and/or deliverable reviews do not demonstrate adequate performance. The CAPs submitted by the MCEs must clearly state objectives, the individual and/or department responsible, and time frames allowed to remedy the identified deficiencies. The required list of deliverables is located in Appendix A.

Additionally, DHCFP contracts with its EQRO to a perform comprehensive review of compliance of the MCEs within a three-year review cycle to determine compliance with federal standards and applicable State contract requirements. The review includes those standards detailed in 42 CFR §438 Subpart D as well as those detailed in 42 CFR §438.100, §438.114, and §438.330. Compliance reviews adhere to

guidelines detailed in CMS' EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023.[4-1]

The current three-year cycle commenced in 2024. The compliance reviews for the DHCFP-contracted MCEs comprise 14 program areas and a comprehensive review of all IS included under each program area. Table 4-2 outlines the standards as part of the compliance review cycle. Future compliance review cycles will follow a similar schedule.

Table 4-2—Compliance Review Standards

Standards	Associated Federal Citation[1]		Year One (SFY 2024)	Year Two (SFY 2025)	Year Three (SFY 2026)
	Medicaid	CHIP			
Standard I—Disenrollment: Requirements and Limitations	§438.56	§457.1212	✓		Review of the MCE's Year One and Year Two Corrective Action Plans (CAPs)
Standard II—Member Rights and Member Information	§438.10 §438.100	§457.1207 §457.1220	✓		
Standard III—Emergency and Poststabilization Services	§438.114	§457.1228	✓		
Standard IV—Availability of Services	§438.206	§457.1230(a)	✓		
Standard V—Assurances of Adequate Capacity and Services	§438.207	§457.1230(b) §457.1218	✓		
Standard VI—Coordination and Continuity of Care	§438.208	§457.1230(c)	✓		
Standard VII—Coverage and Authorization of Services	§438.210	§457.1230(d)	✓		
Standard VIII—Provider Selection	§438.214	§457.1233(a)		✓	
Standard IX—Confidentiality	§438.224	§457.1233(e)		✓	
Standard X—Grievance and Appeal Systems	§438.228	§457.1260		✓	
Standard XI—Subcontractual Relationships and Delegation	§438.230	§457.1233(b)		✓	
Standard XII—Practice Guidelines	§438.236	§457.1233(c)		✓	
Standard XIII—Health Information Systems[2]	§438.242	§457.1233(d)		✓	
Standard XIV—Quality Assessment and Performance Improvement Program	§438.330	§457.1240		✓	

[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 IS capabilities.

[4-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: July 5, 2024.

The compliance review results assist DHCFP in identifying any areas of the contract that need modification or strengthening to ensure that the MCEs can achieve the goals identified in the Quality Strategy. DHCFP's EQRO also assists DHCFP with a review of CAPs submitted by the MCEs to correct areas found to be deficient during the compliance review. The CAP review process requires MCEs to submit progress updates identifying whether their plans of action are *complete*, *on track for completion*, or *not on track for completion*, and the action steps completed and any barriers to completion.

Intermediate Sanctions

DHCFP includes provisions within the MCE contracts that indicate that DHCFP may impose sanctions on MCEs for reasons specified in 42 CFR §438.700, as well as additional areas of noncompliance. Sanctions that may be imposed include intermediate sanctions, such as civil penalties, appointment of temporary management, and suspensions of all new enrollment. Additional sanctions may include monetary penalties and imposition of plans of correction. Except as provided in 42 CFR §438.706(c), before imposing any of the intermediate sanctions specified in the MCE contract, DHCFP will provide the MCE with written notice that explains the basis and nature of the sanction and any other appeal rights that DHCFP elects to provide.

During the current contract period effective January 1, 2022, there have been no sanctions imposed on any of Nevada's contracted MCEs.

5. External Quality Review Arrangements

EQR Arrangements

In accordance with 42 CFR §438.350 and §438.356, each state that contracts with MCOs, PIHPs, and PAHPs must ensure that a qualified EQRO performs an annual EQR for each contracting MCE. In accordance with these rules, DHCFP contracted with Health Services Advisory Group, Inc. (HSAG), as the sole EQRO for the State of Nevada to conduct mandatory and optional EQR activities as set forth in 42 CFR §438.358. HSAG has served as DHCFP's EQRO since 1999, with the current contract effective through June 30, 2027, with the option of two one-year extensions.

EQR Activities

To evaluate the quality and timeliness of, and access to, the services covered under the MCE contracts, DHCFP's EQRO conducts mandatory and optional EQR activities for the Nevada Medicaid and Nevada Check Up programs following the EQR protocols set forth in the CMS publication, *CMS External Quality Review (EQR) Protocols,* February 2023.[5-1] DHCFP has contracted with its EQRO to perform the following:

Mandatory EQR Activities

- **Validation of Performance Improvement Projects.** As described in 42 CFR §438.340(b)(3)(ii), DHCFP requires MCEs to conduct PIPs in accordance with 42 CFR §438.330(d). PIPs must be designed to achieve significant and sustained improvement in clinical and nonclinical areas of care through ongoing measurement and intervention, and they must be designed to have a favorable effect on health outcomes and member satisfaction. In accordance with 42 CFR §438.358(b)(1)(i), DHCFP's EQRO validates PIPs required by DHCFP to comply with the requirements of 42 CFR §438.330(d). DHCFP's EQRO validation determines if PIPs were designed to achieve improvement in clinical and nonclinical care, and if the PIPs would have a favorable effect on health outcomes and member satisfaction.
- **Validation of Performance Measures.** In accordance with 42 CFR §438.340(b)(3)(i), DHCFP requires MCEs to submit performance measurement data as part of their QAPI programs. To comply with 42 CFR §438.358(b)(1)(ii), DHCFP's EQRO validates the performance measures through HEDIS Compliance Audits for MCOs and performance measure validation (PMV) audits for the DBA. The HEDIS Compliance Audits and the EQRO's PMV audits focus on the ability of the MCEs to accurately process claims and encounter data, pharmacy data, laboratory data, enrollment

[5-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: July 5, 2024.

(or membership) data, and provider data. DHCFP's EQRO evaluates each MCE's completed Information Systems Capabilities Assessment Tool (ISCAT) and validates each of the performance measures identified by DHCFP to evaluate their accuracy as reported by, or on behalf of, the MCE. As part of the HEDIS Compliance Audits and PMV audits, DHCFP's EQRO also explores the issue of completeness of claims and/or other source data, as applicable, to improve rates for the performance measures.

- **Review of Compliance With Medicaid and CHIP Managed Care Regulations.** DHCFP's EQRO conducts comprehensive, site reviews of compliance of the MCEs at least once in a three-year cycle. DHCFP's EQRO reviews MCE compliance with federal requirements identified in 42 CFR §438.358(b)(1)(iii) and associated standards established by DHCFP. In addition to a review of a wide range of documents including, but not limited to, policies and procedures, member and provider materials, and various assessments, reports, and evaluations, compliance is further determined through review of individual case files and system demonstrations, as well as interviews of key staff members, to evaluate implementation of standards. DHCFP, in collaboration with its EQRO, will also impose corrective actions for any compliance review standards that are not fully compliant (<100 percent).
- **Validation of Network Adequacy.** In accordance with 42 CFR §438.358(b)(1)(iv), DHCFP's EQRO performs validation of MCE network adequacy to comply with the requirements set forth in 42 CFR §438.68 and 42 CFR §438.14(b)(1). The validation process includes determining whether the network standards, as defined by DHCFP, were met in accordance with DHCFP's established provider-to-member ratios, maximum travel time or distance to providers, and timely appointment standards through a validation of the data and methods used by the MCEs to assess network adequacy, validating the results and generating a validation rating, and reporting the validation to DHCFP and the MCEs.

Optional EQR Activities

- **Validation of Encounter Data.** In accordance with 42 CFR §438.358(c)(1), DHCFP's EQRO conducts an encounter data validation (EDV) study. The EDV study is conducted based on three evaluation activities designed to evaluate the completeness and accuracy of DHCFP's encounter data:
  - IS review—assessment of DHCFP's and/or the MCEs' IS and processes, including an evaluation of each MCE's completed ISCAT.
  - Comparative analysis—analysis of DHCFP's electronic encounter data completeness and accuracy through a comparative analysis between DHCFP's electronic encounter data and the data extracted from the MCEs' data systems.
  - Medical/dental records review—analysis of DHCFP's electronic encounter data completeness and accuracy through a comparison between DHCFP's electronic encounter data and the medical/dental records. Conducting a medical/dental record review is contingent upon whether the IS review and comparative analysis indicate that the completeness and accuracy of DHCFP's encounter data are sufficient.
- **Administration or Validation of Quality of Care Surveys.** In accordance with 42 CFR §438.358(c)(2), the MCEs are responsible for obtaining a CAHPS vendor to administer the CAHPS

survey on their behalf. The CAHPS surveys ask members to report on and evaluate their experiences with healthcare. DHCFP's EQRO presents and analyzes the results of the MCEs' member experience surveys as part of the annual EQR.

EQR Technical Reporting

The *Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality* Final Rule[5-2] requires states to prepare an annual technical report that describes the manner in which data were aggregated and analyzed and how conclusions were drawn as to the quality and timeliness of, and access to, care and services furnished by the states' MCEs. DHCFP's EQRO produces the EQR technical report, which presents all mandatory and optional EQR activities performed over the previous SFY.

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

- Assessment of quality, timeliness, and access to the care furnished by each MCE
- Activity objectives
- Technical methods of data collection and analysis
- Description of data obtained
- Conclusions drawn from the data
- Assessment of each MCE's strengths and weaknesses
- Recommendations for improving the quality of healthcare services furnished by each MCE, including how DHCFP can target goals and objectives in the Quality Strategy to support program improvement
- Methodologically appropriate comparative information about all MCEs in the program
- An assessment of the degree to which each MCE has addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR

DHCFP uses the information obtained from each of the EQR activities, as well as the information presented in the EQR technical report, to make programmatic changes and modifications to DHCFP's Quality Strategy. The EQR technical report also includes the EQRO's evaluation of DHCFP's Quality Strategy, as further described in sections 6 and 7 of this Quality Strategy. The most recent and historical EQR technical reports may be accessed at: http://dhcfp.nv.gov/Resources/AdminSupport/Reports/CaseloadData/.

[5-2] Federal Register. *Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality*, Final Rule, May 2024. Available at: https://www.federalregister.gov/documents/2024/05/10/2024-08085/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care-access-finance. Accessed on: July 5, 2024.

EQR Non-Duplication Option

42 CFR §438.360 of the Managed Care Rule addresses the nonduplication of mandatory activities with Medicare or accreditation reviews, which is intended to provide additional flexibility and reduce administrative burden on MCEs and states while ensuring that relevant information is available to EQROs for the annual EQR. Specifically, it allows a state to use information from a Medicare or private accreditation review of an MCE in place of generating that information through one or more of three mandatory EQR-related activities. While the MCOs are required to be accredited by NCQA and the DBA is accredited through the Utilization Review Accreditation Commission (URAC), DHCFP has elected not to use the nonduplication option, and instead has chosen to have its EQRO conduct comprehensive PIP validations, PMVs, and compliance reviews.

6. Process for Quality Strategy Development, Review, and Revision

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

DHCFP's initial Quality Strategy was submitted to CMS for review and approval in 2008. Since then, DHCFP's Quality Strategy has been revised at least every three years and more often when significant changes occurred within Nevada's Medicaid program. The Quality Strategy, including the goals and objectives, are also reviewed annually, and DHCFP will continue to update the Quality Strategy when significant changes to the Nevada Medicaid managed care program occur and/or on a triennial basis and provide to CMS as required. Each revision of the Quality Strategy is made publicly available on the DHCFP website at http://dhcfp.nv.gov/Resources/AdminSupport/Reports/CaseloadData/.

Quality Strategy Development

DHCFP contracts with its EQRO to assist in the ongoing review and development of the Quality Strategy. DHCFP and its EQRO follow a 10-step process for developing the Quality Strategy, which is similar to the nine-step process described in CMS' Quality Strategy Toolkit. The 10-step Quality Strategy development process conducted by DHCFP and its EQRO includes:

- **Step 1:** Convene an interdisciplinary team, including DHCFP and EQRO participants.
- **Step 2:** Review all applicable federal quality strategy regulations in 42 CFR §438.340, the CMS-published Medicaid and CHIP Managed Care Quality Strategy Toolkit, and national quality strategies.
- **Step 3:** Gather information and resources from DHCFP, its EQRO, and other sources as needed.
- **Step 4:** Draft the Quality Strategy.
- **Step 5:** Present draft Quality Strategy to the Medicaid Advisory Committee (MAC) and update the Quality Strategy, as indicated.
- **Step 6:** Publish the draft Quality Strategy for public comment and tribal consultation and update the Quality Strategy, as indicated. The Quality Strategy will be posted for stakeholder feedback at the three-year renewal, even if significant changes to the Quality Strategy do not occur.
- **Step 7:** Submit the Quality Strategy to CMS.
- **Step 8:** Revise the Quality Strategy based on CMS' feedback.
- **Step 9:** Post the final Quality Strategy on DHCFP's website.
- **Step 10:** Review and update the Quality Strategy at least once every three years, and as needed whenever significant changes occur. Prior to finalizing a revised or renewed Quality Strategy, DHCFP will submit a copy of the revised Quality Strategy to CMS at a minimum of every three years and when significant changes are made.

With input provided by Nevada Medicaid MCEs, external stakeholders, and the MAC, DHCFP identifies goals and objectives for the Nevada Medicaid managed care program. These goals are supported by performance measures (each performance measure serves as an objective) used to measure MCE performance in achieving the goals identified in the Quality Strategy. DHCFP and its MCEs primarily use HEDIS and the Medicaid and CHIP Adult Core Set and Child Core Set measure specifications to collect and report data for most performance measures.

Oversight and Governance of the Quality Strategy

DHCFP maintains ultimate authority and responsibility for the maintenance and annual evaluation of the Quality Strategy and prioritizes the quality improvement efforts undertaken by the Nevada Medicaid managed care program to support the Quality Strategy goals. However, as depicted in Figure 6-1, DHCFP also solicits input on the Quality Strategy from various divisions within DHHS, members of the MAC, and contracted MCEs through regular workgroup meetings.

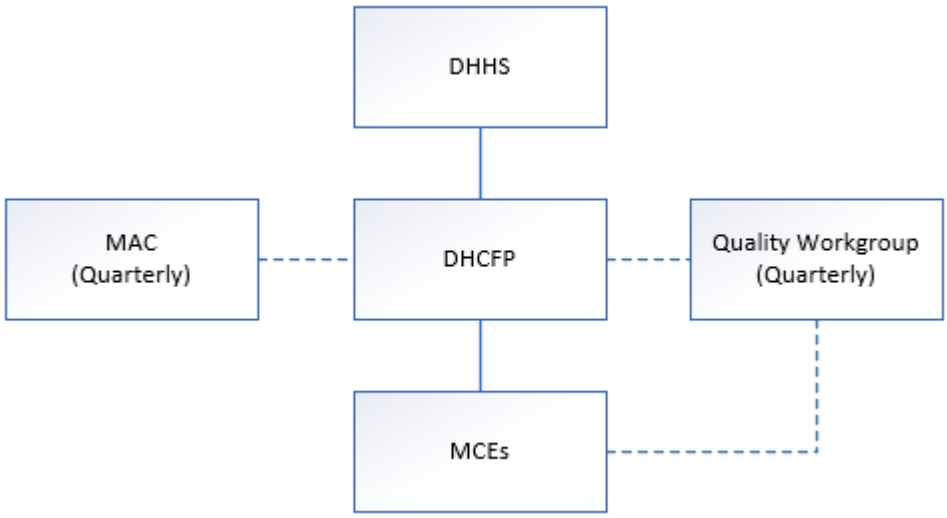
Department of Health and Human Services—DHHS is an office of the executive branch of State government and is led by a director appointed by the Nevada governor. DHHS is one of the largest departments in State government comprised of five divisions: DHCFP, Aging and Disability Services, Child and Family Services, Public and Behavioral Health, and Welfare and Supportive Services. DHHS is also responsible for several critical programs managed through the Director's Office such as the Nevada Governor's Council on Developmental Disabilities, the Tribal Liaison Office, the Office of Minority Health and Equity, and the Grants Management Unit. DHHS priorities and programs are considered in the development and maintenance of the Quality Strategy.

Medicaid Advisory Committee—The MAC is an advisory committee to the State Medicaid Administrator concerning health and medical care services in Nevada. The MAC aligns to the required membership and composition outlined in 42 CFR §431.12.

The MAC offers specialized advice on various components of Nevada's Medicaid managed care program, including the Quality Strategy.

MCEs and Quality Workgroup—DHCFP maintains a Quality Workgroup that meets quarterly, and includes representatives from DHCFP, representatives from each contracted MCE, and DHCFP's EQRO. During these meetings, the workgroup attendees review and discuss performance measure results, PIP results, member experience and engagement, program compliance, quality-related initiatives, and Quality Strategy goals and objectives. Further, the MCEs are required to present information on quality improvement results, barrier analyses, and planned quality improvement activities to be implemented to overcome barriers that impede performance. MCEs, through contract provisions, are also required to align their QAPI, Population Health, Care Management, and Cultural Competency programs to the Quality Strategy and submit monthly and quarterly grievance and appeal reports and annual performance improvement measurement data to support the annual Quality Strategy evaluation. Figure 6-1 displays the quality improvement structure for the Nevada Medicaid managed care program.

Figure 6-1—Nevada DHCFP Quality Improvement Organizational Structure



Updates for Significant Changes

At a minimum, DHCFP reviews progress on the Quality Strategy goals and objectives at least annually and updates the Quality Strategy at least triennially to incorporate new goals and objectives for the following years. However, DHCFP updates the Quality Strategy more often, as needed, to reflect changes in State or federal policy that impact the Medicaid or Nevada Check Up programs and/or changes to the Medicaid managed care population. DHCFP defines significant changes to the Quality Strategy as:

- Any change resulting from legislative, State, federal, or other regulatory authority.
- Any change that triggers public comment, tribal consultation, and input from Nevada's MAC.
- Adding populations to Medicaid managed care or enrolling a managed care population into a new program.
- Any change in membership demographics or the provider network that DHCFP determines would impact the structure and operations of the Medicaid managed care program.
- Any change to the delivery system and provider payment initiatives under the MCE Medicaid managed care contracts.
- Any change to the Quality Strategy's defined goals, including adding or removing goals and objectives. Objectives that are modified due to changes in national performance measure specifications are not considered a "significant change" when an objective is replaced by a similar national performance measure. Additionally, adding the MPS for objectives currently listed with a dash (—) in the MPS column of the Goals and Objectives Tracking table in Appendix B is also not considered a "significant change."

Changes to formatting, dates, or other similar edits are defined as "insignificant," as well as regulatory/legislative changes that do not change the intent or content of the requirements contained within the Quality Strategy. Changes to the details included in the appendices of the Quality Strategy will also be considered insignificant, except when a change is made to a Quality Strategy goal or objective in Appendix B that meets DHCFP's definition of significant change. Appendices will be regularly updated as needed in the version of the Quality Strategy posted online.

Public and Tribal Comment Process

DHHS is committed to partnering with the 28 Tribal Nations, Bands, and Colonies within the State of Nevada through a Tribal Consultation Process Agreement (Agreement). This Agreement establishes and strengthens ties and relationships with the tribal governments as well as provides education and outreach. The Agreement between DHHS, Tribal Nations, Indian Health Service, and Tribal and Urban Indian Organizations was signed and became effective in March 2010. The guiding principle of the agreement is to ensure that open and meaningful communication occurs in a timely manner for consultation between the parties regarding high-level policy changes that significantly impact Tribal Nations in Nevada. Policy changes that significantly impact Tribal Nations refer to actions that have substantial tribal implications with direct effects on one or more Tribal Nations, on the relationship between the State of Nevada and Tribal Nations, or on the distribution of roles and responsibilities between the State of Nevada and Tribal Nations. American Indians/Alaska Natives are a voluntary Medicaid managed care population in Nevada; therefore, prior to each Quality Strategy revision, DHCFP solicits input from Nevada Tribal Nations on the Quality Strategy goals and objectives.

In addition to soliciting input from DHHS, the MAC, and through tribal consultation, DHCFP also publishes the draft Quality Strategy for a 30-day public comment period before finalizing the Quality Strategy.

DHCFP invites public comment and tribal consultation by way of public workshops, tribal consultation meetings, and by emailing DHCFP at dhcfp@dhcfp.nv.gov. Once the public comment period ends and consensus is reached by all stakeholders, including the MAC, members, and Tribal Nations, the Quality Strategy is finalized, shared with all pertinent stakeholders, sent to CMS, and posted on DHCFP's website for public view.

DHCFP made this Quality Strategy available for public and tribal comment in September 2024. A summary of comments and input received and subsequent revisions to the Quality Strategy, based on public and tribal feedback, is located in Appendix C.

Review and Evaluation of the Quality Strategy

DHCFP and its EQRO review and evaluate the implementation and effectiveness of the Quality Strategy and publish the results of the evaluation through each annual EQR technical report. DHCFP updates the Quality Strategy, at least triennially, based on each MCE's performance; stakeholder input and

feedback; achievement of goals; changes resulting from legislative, State, federal, or other regulatory authority; and/or significant changes to the programmatic structure of the Nevada Medicaid managed care program. Each revised Quality Strategy is submitted to CMS for review and feedback.

Annual Evaluation

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

The annual Quality Strategy evaluation includes an assessment of:

- The effectiveness of quality interventions and remediation strategies during the previous year (demonstrated by improvements in care and services) and trending of performance measure data.
- The appropriateness of the program structure, processes, and objectives.
- The identification of program limitations and barriers to performance improvement.
- The evaluation of findings from internal activities, including quality improvement committees and workgroups; member complaints, grievances, and appeals; and provider complaints and issues, when trends and/or focus areas are identified by DHCFP and/or other stakeholders through these activities.
- EQRO recommendations resulting from the previous year's EQR activities and subsequent actions implemented by the MCEs and DHCFP as a result of those recommendations.
- Feedback obtained from DHCFP administration, the MCEs, the provider community, advocacy groups, Medicaid members, and other internal and external stakeholders.
- Current goals and objectives within the Quality Strategy to determine whether these goals and objectives will continue to support program improvement.

Tools Used to Evaluate Quality Strategy

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

- The annual EQR technical report findings.
- Validated PIP results.
- Validated performance measure results.
- Validated network adequacy results.
- EDV results.

- MCE compliance review results.
- Ongoing review of contractually required MCE deliverables.
- Member grievance and appeal information.
- MCE cultural competency and QAPI programs.
- Stakeholder feedback emailed to DHCFP via DHCFP's website.

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

Further, in an effort to promote and meet the Quality Strategy goals and objectives, DHCFP contractually requires each MCE's managed care program to align with the Quality Strategy goals and objectives through its QAPI program, Population Health program, and Cultural Competency program. Annually, DHCFP assesses each MCE's QAPI program evaluation to ensure that each MCE continually monitors and evaluates its own achievement of goals and objectives to improve the accessibility, timeliness, and quality of services provided to Medicaid and Nevada Check Up members. DHCFP provides feedback to the MCEs regarding programmatic strengths identified from the review of each MCE's QAPI program and opportunities to improve the structure and direction of its quality program to further support the goals and objectives of DHCFP's Quality Strategy.

7. Evaluation of Quality Strategy

As indicated in Section 6 of this Quality Strategy, DHCFP reviews progress on each Quality Strategy goal and objective on an annual basis through findings from the annual EQR conducted by the EQRO and published in the annual EQR technical report. Each annual EQR technical report includes a Goals and Objectives Tracking table, which includes performance measures (Quality Strategy objectives for each goal), baseline data for each performance measure, and each performance measure's calculated rate for the time period under review that is used to evaluate the progress of each goal for the Medicaid and Nevada Check Up populations.

The EQR technical report also includes an Evaluation of Quality Strategy Effectiveness section. This section contains the number of performance measure rates reported by each MCE that align to the Quality Strategy; the number of reported performance measure rates that achieved the established MPS; and of those performance measure rates achieving MPS, how many reached the highest performance threshold set by DHCFP. DHCFP, with assistance from its EQRO, compares the baseline data for each performance measure along with the results from the Goals and Objectives Tracking table, as well as performance results from other initiatives outlined in the Quality Strategy and reported through each annual EQR-related deliverable (i.e., PIPs, PMV, compliance review, NAV) and the annual EQR, as well as any state-directed initiatives (e.g., state-directed payment initiatives) to evaluate the quality of the managed care services offered to Nevada Medicaid managed care members and, subsequently, the overall effectiveness of the Quality Strategy goals and objectives. To assist DHCFP in these efforts, the EQRO provides DHCFP with a narrative assessment of the State's progress in meeting or making progress toward meeting the Quality Strategy goals and objectives and provides recommendations for revisions DHCFP can make to its Quality Strategy to support program improvement. DHCFP staff members meet internally, at least annually, to review the EQR technical report findings and other informational sources (e.g., HEDIS and Core Set measure changes, Nevada Medicaid priorities and initiatives) to determine whether revisions to the Quality Strategy goals and objectives are warranted.

Progress on Meeting Quality Strategy Goals and Objectives

DHCFP and its EQRO evaluated the overall effectiveness of the Quality Strategy in place for the time period of 2022–2024 to assess the quality of healthcare and services provided by the MCEs over the past three years, and specifically, progress made toward achieving the Quality Strategy goals and objectives. As indicated through barriers identified by the MCEs, challenges in meeting or making progress on the Quality Strategy goals and objectives were a lack of specialty providers in Nevada and some providers refusing to contract with the Medicaid managed care program due to low reimbursement rates. Some provider offices were also at capacity and were unable to schedule appointments as soon as preferred, or in accordance with DHCFP-established standards. Additionally, many members face HRSN (e.g., food insecurity, housing, and/or lack of transportation), which can prevent members from prioritizing health and dental care. Further, making contact with members to provide education has historically been challenging for the MCEs due to outdated or inaccurate contact information. The end of the public

health emergency and the Nevada Medicaid continuous enrollment conditions demanded a robust communication campaign. As Nevada resumed normal eligibility operations, it was critical to obtain updated contact information for members to ensure they received their renewal packet. Nevada Medicaid developed a webform in English and Spanish that can be accessed by Nevada members to change contact information. DHCFP urged the MCEs to embed the webpage link and/or Quick Response (QR) code(s) in their communication to their members. DHCFP also obtained waiver approval from CMS under section 1902(e)(14)(A) of the Social Security Act. The waiver allows Nevada Medicaid to accept updated member contact information from MCEs without additional confirmation from the individual. For this initiative, DHCFP created a standardized Member Change of Status Report, which is transmitted weekly. Since the implementation of these activities, contact information changes have increased to reduce member coverage interruptions.

At the conclusion of SFY 2023, DHCFP, in collaboration with HSAG, evaluated the quality of the managed care services offered to Nevada Medicaid 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 7-1 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 7-1, and the complete evaluation, including the Goals and Objectives Tracking table, is published in the *SFY 2023 External Quality Review Technical Report* finalized in January 2024 and posted to DHCFP's website at http://dhcfp.nv.gov/Resources/AdminSupport/Reports/CaseloadData/.

Table 7-1—Quality Strategy Evaluation

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
	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:	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)*

Quality Strategy Goals		Performance Impact on Goals and Objectives
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:	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 for >15 days from multiple providers (per 1,000 members) (UOP)—Multiple prescribers*
	Quality Strategy Updates:	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 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*.

Quality Strategy Goals		Performance Impact on Goals and Objectives
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:	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* • *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 Goals		Performance Impact on Goals and Objectives
	Quality Strategy Updates:	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:	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:	No updates necessary

Table 7-2 and Table 7-3 display the number of Quality Strategy objectives (performance measures) with an established MPS and the number of performance measures by MCO and the DBA that met the established MPS. As demonstrated by the results, a very low percentage of performance measures met the established benchmarks, indicating that very little progress was made toward meeting most of the Quality Strategy goals.

Table 7-2—Summary of Performance by the MCOs

	Anthem Medicaid	United-Healthcare HPN Medicaid	Molina Medicaid	SilverSummit Medicaid	Anthem Check Up	United-Healthcare HPN Check Up	Molina Check Up	SilverSummit Check Up
Number of Reported Rates	58	58	51	56	19	20	10	15
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 7-3—2021 Summary of Performance by the DBA

	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, as the previous measures (objectives) were retired by NCQA. Therefore, no MPSs were available for these new performance measures.

For the SFY 2023 PIP validation, the MCOs submitted the design for the two DHCFP-mandated PIP topics, and the DBA submitted the design for the two PAHP-selected PIP topics. The MCEs did not progress to the point of reporting baseline data and interventions; therefore, the results of the PIPs were not available for use in assessing whether progress was made in achieving the goals of the Quality Strategy.

Revisions to Quality Strategy Goals and Objective Based on Evaluation

Through results of the annual EQR, including the evaluation of the Quality Strategy, and based on new priorities and initiatives of DHCFP and changes in HEDIS and Adult Core Set and Child Core Set measures, DHCFP and its EQRO revised the goals and objectives included as part of this Quality Strategy effective between the time period of 2025–2027. These revisions included:

- Minor revisions to the goal statement for Goal 3 to describe the focus areas of DHCFP and its contracted MCEs more appropriately.

- Minor revisions to all goals to include target date.
- Development of a new goal, Goal 8, to support state-directed payment initiatives.
- Removal of objectives that were aligned to retired HEDIS measures.
- Addition of objectives that align with new HEDIS measures that support the current goals.
- Addition of objectives that align with mandatory Adult Core Set and Child Core Set measures that support the current goals.
- Addition of HEDIS and Core Set measure objectives to further support program areas needing additional improvement or program areas with minimal objectives to measure improvement.
- Addition of objectives that align with new state-directed payment initiatives.
- Addition of updated/new MPSs to support the time period for the Quality Strategy goals.

DHCFP Actions on External Quality Review Recommendations

In accordance with 42 CFR §438.364(a)(4), DHCFP's EQRO develops an EQR technical report that includes recommendations for improving the quality of healthcare services furnished by each MCE contracted with DHCFP to provide services to Nevada Medicaid and Nevada Check Up managed care members. These recommendations include how DHCFP can target goals and objectives in this Quality Strategy to better support improvement in the quality and timeliness of, and access to healthcare services furnished to Medicaid managed care members. Table 7-4 includes high level recommendations that the EQRO made to DHCFP in support of the Quality Strategy goals and the subsequent actions taken by DHCFP to support program improvement and progress in meeting the goals of the Quality Strategy.

Table 7-4—EQRO Recommendations

SFY 2022–SFY and 2023 Summarized EQRO Recommendations	DHCFP Actions
DHCFP could consider whether state-required interventions would be appropriate for the MCEs to implement for the PIPs mandated by DHCFP.	At this time, DHCFP has mandated that the MCOs stratify the data for the Prenatal and Postpartum Care PIP by race and ethnicity, and implement interventions to target identified disparities. During the April 2022 MCE quarterly meeting, DHCFP also discussed the importance of stratifying data for all PIPs and implementing interventions that target those populations with the greatest impact. DHCFP will continue to evaluate whether state-required interventions would support improvement in specific topic areas.
DHCFP could collaborate with the MCEs to identify strategies to improve the CAHPS response rates so that the information obtained through the surveys provide enough data to make meaningful conclusions.	DHCFP, in collaboration with its EQRO, facilitated a discussion with the MCEs during the April 2024 MCE quarterly meeting about how CAHPS response rates can be improved, and discussed the barriers the MCEs' CAHPS vendors are experiencing when conducting the survey and ways to possibly mitigate those barriers.

SFY 2022–SFY and 2023 Summarized EQRO Recommendations	DHCFP Actions
DHCFP could review the MCEs' planned PIP interventions prior to MCE implementation and provide feedback on any planned interventions to ensure the interventions will support the goal of the PIPs and demonstrate improvement in member outcomes.	DHCFP will consult with its EQRO to determine the process for reviewing the MCEs' interventions prior to MCE implementation.
DHCFP should continue to require the MCEs to stratify the HEDIS and other performance measure data by race and ethnicity and use the data to drive future quality improvement efforts and develop targeted interventions.	As NCQA and CMS publish expectations for stratifying performance measure data by race and ethnicity, DHCFP has or will mandate that the MCEs comply with these expectations.
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 improve care.	DHCFP has implemented Bonus Incentive Payments for CY 2024 for the MCOs to promote efforts to increase member access to primary care, expand value-based payment designs, improve member access to family planning counseling and long acting reversable contraceptives, and increase screening, testing and treatment of syphilis among pregnant women and infants. DHCFP will continue to evaluate whether other incentive programs could benefit the program.

Appendix A. Quality Monitoring Schedule

DHCFP Quality Monitoring Activity	DHCFP Monitoring Schedule
Annual Evaluation of Quality Strategy (DHCFP)	
DHCFP Evaluation of Quality Strategy	At Least Annually
DHCFP Quality Strategy Revision	At Least Triennially and As Needed
MCE Quarterly Quality Meetings	
Quality Improvement Presentations	Quarterly
Request for Proposal (RFP) Annual Compliance	
Balance Sheet—Assets, Liabilities, and Equities	Annually
Statement of Revenue, Expenses and Equity	Quarterly/Annually
Medical Loss Ratio Report	Annually
Independent Audit Report (Certified Public Accountant)	Annually
Financial	
Very Low Birth Weight (VLBW) Submissions	On Occurrence
Maternity Kick Payment—Sixth Omnibus Budget Reconciliation Act (SOBRA)	On Occurrence
Retrocap Payment	Monthly
Stop Loss Submissions	On Occurrence
Excess Capitation	Monthly
Third Party Liability	Monthly
Disproportionate Share Hospital (DSH)	Annually
Program Integrity	
Listing of Contractor Officers and Directors	Annually
Provider Termination Report	Monthly
Provider List (Provider Enrollment)	Monthly
Related Party Transactions	Annually
Embezzlement and Theft Report	On Occurrence
FWA (Fraud, Waste, and Abuse) Provider Referral Report (Form)	On Occurrence
FWA Recipient Referral Report (Form)	On Occurrence
Provider Investigations List	Monthly
Recipient Investigations List	Monthly
Provider Preventable Conditions	Monthly
FWA Overpayments	Monthly

DHCFP Quality Monitoring Activity	DHCFP Monitoring Schedule
Overpayments Related to Administrative Errors	Monthly
Attestation of Monthly Reports 309-313	Monthly
Comprehensive Compliance Plan Assessment Report	Annually
Compliance Plan Review Tool with Attachment 4	Annually
Managed Care Quality Assurance (MCQA)	
Network Adequacy Report	Quarterly
Summary Report of Cultural Competency Plan (CCP)	Annually
Federally Qualified Health Center (FQHC) Report	Quarterly
Geographical Access Report	Quarterly
Recipient Change of Status	On Occurrence
Promotional Activities Report	Bi-Annually
Clean Claims Report	Monthly
CMS 416 EPSDT Report (XIX and XXI)	Annually
Pharmacy Rebate Claims Files	Monthly
Pharmacy Rebate Providers	Monthly
Pharmacy Rebate Claim Errors	Monthly
Case Management Report	Monthly
IMD 15–Day Report	Monthly
Internal Quality Assurance Program Applicant Data Report	Annually
Internal Quality Assurance Program Description	Annually
Internal Quality Assurance Program Effectiveness Report	Annually
Utilization Management Program Description and Work Plan	Annually
Single Case Agreement Report	Monthly
ABA (Applied Behavioral Analysis) Service Utilization	Quarterly
ABA (Applied Behavioral Analysis) Prior Authorization	Quarterly
Hearings—Grievances and Appeals	
Subcontractor Member Grievance Report	Monthly/Quarterly
Member Appeal Resolution Report	Monthly/Quarterly
Provider Dispute Resolution Report	Monthly/Quarterly
Appeal Detail Report	Monthly/Quarterly
Notice of Action (NOA) Report	Monthly/Quarterly
EQRO	
PIP Validation Report	Annually
HEDIS MCO Compliance Audits Report	Annually

DHCFP Quality Monitoring Activity	DHCFP Monitoring Schedule
DBA PMV Report	Annually
Compliance Review Report	Annually
Network Adequacy Validation Report	Annually
Encounter Data Validation Report	At Least Triennially
EQR Technical Report	Annually
Forms	
Member Managed Care (MC) Disenrollment (Form)	On Occurrence
Provider Attestation (Form)	On Occurrence
Serious Emotional Disturbance (SED)—Serious Mental Illness (SMI) Consent (Form)	On Occurrence
SED–SMI Determination (Form)	On Occurrence
SED–SMI MC Disenrollment (Form)	On Occurrence
Data Quality	Quarterly
False Claims Act Attestation	Annually
Community Reinvestment	Annually
Population Health Annual Strategy	Annually
Care Management	Annually
Care Coordination	Quarterly/Annually
Case Management	Quarterly
Provider Call Center Performance Standards (Affidavit)	Monthly
Member Services Performance Standards (Affidavit)	Monthly

Nevada 2025–2027 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 Adult and Child Core Sets[B-1], to assess the Nevada Medicaid managed care program's progress in meeting its Quality Strategy goals. Performance is evaluated on an annual basis 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 and state-directed payments) are included in Section 3 and performance rates are not included as part of the Goals and Objectives Tracking table.

Unless otherwise indicated, DHCFP established an MPS for each objective using performance measurement data from MY 2023 Medicaid and Nevada Check Up aggregate performance data. The MPSs will remain stagnant over a period of three years, and then be reassessed during the next 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 Medicaid managed care program has made progress towards reaching the associated goal.

DHCFP also defined objectives that specifically align to state-directed payment initiatives. Performance with the state-directed payment initiatives is evaluated annually and documented within the EQR technical report. Therefore, the MPS associated specifically with the state-directed payments are not identified within Appendix B—Goals and Objectives Tracking.

B-1 Mandatory or voluntary Core Set measures were included. For some measures, age stratifications align with HEDIS, while others may align with the Core Set measure age stratifications.

Goal 1—Improve the health and wellness of Nevada's Medicaid population by increasing the use of preventive services by December 31, 2027.							
Objective #	Objective Description	Measure Steward	Measure Set			MPS	
			HEDIS	Adult Core Set	Child Core Set	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	✓		✓	**61.40%**	**71.21%**
1.1b	Increase well-child visits in the first 30 months of life (W30)—15–30 months (2 or more well-child visits)	NCQA	✓		✓	**65.12%**	**68.27%**
1.2a	Increase child and adolescent well-care visits (WCV)—3–11 years	NCQA	✓		✓	**56.24%**	**58.86%**
1.2b	Increase child and adolescent well-care visits (WCV)—12–17 years	NCQA	✓		✓	**51.40%**	**55.81%**
1.2c	Increase child and adolescent well-care visits (WCV)—18–21 years	NCQA	✓		✓	**30.43%**	**40.05%**
1.3a[s]	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—BMI percentile	NCQA	✓		✓	**85.06%**	**84.86%**
1.3b[s]	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—Counseling for nutrition	NCQA	✓		✓	**77.30%**	**77.19%**
1.3c[s]	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—Counseling for physical activity	NCQA	✓		✓	**73.83%**	**75.21%**
1.4a	Increase immunizations for adolescents (IMA)—Combination 1 (Meningococcal, Tdap)	NCQA	✓		✓	**83.86%**	**91.69%**
1.4b	Increase immunizations for adolescents (IMA)—Combination 2 (Meningococcal, Tdap, HPV)	NCQA	✓		✓	**38.78%**	**48.00%**
1.5a	Increase childhood immunization status (CIS)—Combination 3 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV)	NCQA	✓		✓	**58.97%**	**72.90%**
1.5b	Increase childhood immunization status (CIS)—Combination 7 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A, RV)	NCQA	✓		✓	**52.94%**	**69.52%**
1.5c	Increase childhood immunization status (CIS)—Combination 10 (DTaP, IPV, MMR, HiB, Hep B, VZV, PCV, Hep A, RV, Influenza)	NCQA	✓		✓	**27.41%**	**34.44%**
1.6	Increase breast cancer screening (BCS-E)	NCQA	✓	✓		**50.94%**	—
1.7a	Increase adults' access to preventive/ambulatory health services (AAP)—20–44 years	NCQA	✓			**64.51%**	—
1.7b	Increase adults' access to preventive/ambulatory health services (AAP)—45–64 years	NCQA	✓			**71.87%**	—

Goal 1—Improve the health and wellness of Nevada's Medicaid population by increasing the use of preventive services by December 31, 2027.							
Objective #	Objective Description	Measure Steward	Measure Set			MPS	
			HEDIS	Adult Core Set	Child Core Set	Medicaid	Nevada Check Up
1.8a	Increase chlamydia screening in women (CHL)—16–20 years	NCQA	✓		✓	**58.21%**	**57.42%**
1.8b	Increase chlamydia screening in women (CHL)—21–24 years	NCQA	✓	✓		**65.44%**	—
1.9	Increase the rate of developmental screening in the first three years of life (DEV-CH)	OSHU			✓	**35.44%**	**38.76%**
1.10	Increase the rate of lead screening in children (LSC)	NCQA	✓		✓	**32.85%**	**37.43%**

OSHU (Oregon Health and Science University)
[s] State-directed payment initiative.
Dash (—) indicates that the objective does not apply to the population, the statewide denominator was too small to establish the MPS, or baseline data were not available to establish the MPS. If applicable, the MPS will be established when the baseline rate is available.

Goal 2—Increase use of evidence-based practices for members with chronic conditions by December 31, 2027.							
Objective #	Objective Description	Measure Steward	Measure Set			MPS	
			HEDIS	Adult Core Set	Child Core Set	Medicaid	Nevada Check Up
2.1a	Increase rate of glycemic status (<8.0%) for members with diabetes (GSD)	NCQA	✓			**54.12%**	—
2.1b[s]	Reduce rate of glycemic status (>9.0%) for members with diabetes (GSD)*	NCQA	✓	✓		**39.02%**	—
2.2	Increase blood pressure control (<140/90 mm Hg) for members with diabetes (BPD)	NCQA	✓			**63.72%**	—
2.3[s]	Increase rate of controlling high blood pressure (CBP)	NCQA	✓	✓		**63.67%**	—
2.4a	Increase the asthma medication ratio (AMR)—5–18 years	NCQA	✓		✓	**63.14%**	**67.30%**
2.4b	Increase the asthma medication ratio (AMR)—19–64 years	NCQA	✓	✓		**51.40%**	—
2.5[s]	Decrease the rate of adult acute inpatient stays that were followed by an unplanned acute readmission for any diagnosis within 30 days after discharge (PCR)*—Observed readmissions	NCQA	✓	✓		**9.77%**	—

*Indicates an inverse performance indicator where a lower rate demonstrates better performance for this measure.
[s] State-directed payment initiative.
Dash (—) indicates that the objective does not apply to the population, the statewide denominator was too small to establish the MPS, or baseline data were not available to establish the MPS. If applicable, the MPS will be established when the baseline rate is available.

Goal 3— Reduce misuse of opioids and other prescribed medications by December 31, 2027.							
Objective #	Objective Description	Measure Steward	Measure Set			MPS	
			HEDIS	Adult Core Set	Child Core Set	Medicaid	Nevada Check Up
3.1	Reduce use of opioids at high dosage (HDO)*	NCQA	✓			**7.30%**	—
3.2	Reduce use of opioids for >15 days from multiple providers (UOP)—Multiple prescribers*	NCQA	✓			**20.34%**	—
3.3a	Reduce the rate of adult members with at least 15 days of prescription opioids in a 30–day period (COU)	NCQA	✓			**6.89%**	—
3.3b	Reduce the rate of adult members with at least 31 days of prescription opioids in a 62–day period (COU)	NCQA	✓			**5.38%**	—
3.4a	Increase the rate of avoidance of antibiotic treatment for acute bronchitis/bronchiolitis (AAB)—3 months to 17 years	NCQA	✓		✓	**74.53%**	**60.97%**
3.4b	Increase the rate of avoidance of antibiotic treatment for acute bronchitis/bronchiolitis (AAB)—18 years and older	NCQA	✓	✓		**55.70%**	—
3.5[s]	Improve safe use of opioids—Concurrent prescribing	CMS	NA			**SDP**	**NA**

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

[s] State-directed payment initiative.

SDP (state-directed payment)—indicates MPS is established through the CMS-approved state-directed payment preprint. Performance is tracked through the annual EQR technical report.

NA (Not Applicable)

Dash (—) indicates that the objective does not apply to the population, the statewide denominator was too small to establish the MPS, or baseline data were not available to establish the MPS. If applicable, the MPS will be established when the baseline rate is available.

Goal 4—Improve the health and wellness of pregnant women and infants by December 31, 2027.							
Objective #	Objective Description	Measure Steward	Measure Set			MPS	
			HEDIS	Adult Core Set	Child Core Set	Medicaid	Nevada Check Up
4.1a	Increase timeliness of prenatal care (PPC)—Under age 21	NCQA	✓		✓	**64.13%**	—
4.1b	Increase timeliness of prenatal care (PPC)		✓			**81.98%**	—
4.1c	Increase the rate of postpartum visits (PPC)—Under age 21	NCQA	✓		✓	**61.91%**	—
4.1d	Increase the rate of postpartum visits (PPC)		✓			**75.48%**	—
4.2a	Increase the rate of deliveries in which members were screened for clinical depression during pregnancy using a standardized instrument (PND-E)	NCQA	✓			**10.21%**	—

Goal 4—Improve the health and wellness of pregnant women and infants by December 31, 2027.							
Objective #	Objective Description	Measure Steward	Measure Set			MPS	
			HEDIS	Adult Core Set	Child Core Set	Medicaid	Nevada Check Up
4.2b	Increase the rate of deliveries in which members received follow-up care within 30 days of a positive depression screen finding during pregnancy (PND-E)	NCQA	✓			—	—
4.3a	Increase the rate of deliveries in which members were screened for clinical depression using a standardized instrument during the postpartum period (PDS-E)	NCQA	✓			**10.04%**	—
4.3b	Increase the rate of deliveries in which members received follow-up care within 30 days of a positive depression screen finding during the postpartum period (PDS-E)	NCQA	✓			—	—
4.4	Increase the rate of deliveries in the measurement period in which members received influenza and Tdap vaccinations (PRS-E)	NCQA	✓			**16.33%**	—
4.5a	Increase the rate of contraceptive care (CCW-CH)—Most or moderately effective contraception for all women ages 15–20	OPA			✓	**20.96%**	**18.16%**
4.5b	Increase the rate of contraceptive care (CCW-CH)—Long-acting reversible contraception for all women ages 15–20	OPA			✓	**11.50%**	**10.86%**
4.6a	Increase the rate of contraceptive care (CCP-CH)—Most or moderately effective contraception for postpartum women ages 15–20 within 3 days of delivery	OPA			✓	**12.85%**	—
4.6b	Increase the rate of contraceptive care (CCP-CH)—Most or moderately effective contraception for postpartum women ages 15–20 within 90 days of delivery	OPA			✓	**43.58%**	—
4.6c	Increase the rate of contraceptive care (CCP-CH)—Long-acting reversible contraception for postpartum women ages 15–20 within 3 days of delivery	OPA			✓	**10.54%**	—
4.6d	Increase the rate of contraceptive care (CCP-CH)—Long-acting reversible contraception for postpartum women ages 15–20 within 90 days of delivery	OPA			✓	**19.79%**	—
4.7[s]	Reduce unexpected complications in term newborns (PC-06)	CMQCC	NA			**SDP**	**NA**

OPA (U.S. Office of Population Affairs)
CMQCC (California Maternal Quality Care Collaborative)
[s] State-directed payment initiative.
SDP (state-directed payment)—indicates MPS is established through the CMS-approved state-directed payment preprint. Performance is tracked through the annual EQR technical report.
NA (Not Applicable)
Dash (—) indicates that the objective does not apply to the population, the statewide denominator was too small to establish the MPS, or baseline data were not available to establish the MPS. If applicable, the MPS will be established when the baseline rate is available.

Goal 5—Increase use of evidence-based practices for members with behavioral health conditions by December 31, 2027.							
Objective #	Objective Description	Measure Steward	Measure Set			MPS	
			HEDIS	Adult Core Set	Child Core Set	Medicaid	Nevada Check Up
5.1a	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication (ADD)—Initiation phase	NCQA	✓		✓	**55.68%**	**51.54%**
5.1b	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication (ADD)—Continuation and maintenance phase	NCQA	✓		✓	**68.32%**	—
5.2	Increase adherence to antipsychotic medications for individuals with schizophrenia (SAA)	NCQA	✓	✓		**44.86%**	—
5.3a	Increase follow-up after hospitalization for mental illness (FUH)—7–day—6 to 17 years	NCQA	✓		✓	**50.11%**	**60.69%**
5.3b	Increase follow-up after hospitalization for mental illness (FUH)—7–day—18 years and older	NCQA	✓	✓		**37.58%**	—
5.3c	Increase follow-up after hospitalization for mental illness (FUH)—30–day—6 to 17 years	NCQA	✓		✓	**69.10%**	**81.38%**
5.3d	Increase follow-up after hospitalization for mental illness (FUH)—30–day—18 years and older	NCQA	✓	✓		**52.09%**	—
5.4	Increase diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications (SSD)	NCQA	✓	✓		**79.71%**	—
5.5a	Increase follow-up after ED visit for substance use (FUA)—7–day—13 to 17 years	NCQA	✓		✓	**22.86%**	—
5.5b	Increase follow-up after ED visit for substance use (FUA)—7–day—18 years and older	NCQA	✓	✓		**25.72%**	—
5.5c	Increase follow-up after ED visit for substance use (FUA)—30–day—13 to 17 years	NCQA	✓		✓	**26.25%**	—
5.5d	Increase follow-up after ED visit for substance use (FUA)—30–day—18 years and older	NCQA	✓	✓		**34.81%**	—
5.6a	Increase follow-up after ED visit for mental illness (FUM)—7–day—6 to 17 years	NCQA	✓		✓	**75.87%**	**86.16%**
5.6b	Increase follow-up after ED visit for mental illness (FUM)—7–day—18 years and older	NCQA	✓	✓		**48.23%**	—
5.6c	Increase follow-up after ED visit for mental illness (FUM)—30–day—6 to 17 years	NCQA	✓		✓	**82.14%**	**88.46%**

Goal 5—Increase use of evidence-based practices for members with behavioral health conditions by December 31, 2027.							
Objective #	Objective Description	Measure Steward	Measure Set			MPS	
			HEDIS	Adult Core Set	Child Core Set	Medicaid	Nevada Check Up
5.6d	Increase follow-up after ED visit for mental illness (FUM)—30–day—18 years and older	NCQA	✓	✓		**56.28%**	—
5.7a	Increase initiation and engagement of SUD treatment (IET)—Initiation of SUD treatment	NCQA	✓	✓		**51.73%**	**39.08%**
5.7b	Increase initiation and engagement of SUD treatment (IET)—Engagement of treatment	NCQA	✓	✓		**23.89%**	**21.08%**
5.8	Increase the rate of children with and adolescents with ongoing antipsychotic medication use who had metabolic testing during the year (APM)	NCQA	✓		✓	**43.18%**	**40.79%**
5.9a	Increase the rate of antidepressant medication management (AMM)—Effective acute phase treatment	NCQA	✓	✓		**59.17%**	—
5.9b	Increase the rate of antidepressant medication management (AMM)—Effective continuation phase treatment	NCQA	✓	✓		**43.47%**	—
5.10	Increase the use of first-line psychosocial care for children and adolescents on antipsychotics (APP)	NCQA	✓		✓	**59.08%**	**62.69%**
5.11a	Increase the rate of acute inpatient hospitalizations, residential treatment, or withdrawal management visits for a diagnosis of SUD among members 13 years of age and older that resulted in a follow-up visit or service for SUD within 7 days (FUI)	NCQA	✓			**35.90%**	—
5.11b	Increase the rate of acute inpatient hospitalizations, residential treatment, or withdrawal management visits for a diagnosis of SUD among members 13 years of age and older that resulted in a follow-up visit or service for SUD within 30 days (FUI)	NCQA	✓			**51.54%**	—
5.12	Increase the rate of adult Medicaid beneficiaries with an OUD who filled a prescription or were administered or dispensed an FDA-approved medication for the disorder (OUD)	CMS		✓		**57.21%**	—
5.13a	Increase the rate of screening for depression and follow-up plan for members (CDF)—12–17 years	CMS			✓	**10.54%**	**10.41%**
5.13b	Increase the rate of screening for depression and follow-up plan for members (CDF)—18 years and older	CMS		✓		**12.53%**	**11.73%**
5.14	Decrease the rate of HbA1c poor control (>9.0%) for people with diabetes and serious mental illness (HPCMI-AD)*	NCQA		✓		**44.35%**	—

Goal 5—Increase use of evidence-based practices for members with behavioral health conditions by December 31, 2027.							
Objective #	Objective Description	Measure Steward	Measure Set			MPS	
			HEDIS	Adult Core Set	Child Core Set	Medicaid	Nevada Check Up
5.15[s]	Track the hours of physical restraint use (HBIPS-2)	TJC	NA			**SDP**	**NA**
5.16[s]	Track the hours of seclusion use (HBIPS-3)	TJC	NA			**SDP**	**NA**

* Indicates an inverse performance indicator where a lower rate demonstrates better performance for this measure.
TJC (The Joint Commission)
[s] State-directed payment initiative.
SDP (state-directed payment)—indicates MPS is established through the CMS-approved state-directed payment preprint. Performance is tracked through the annual EQR technical report.
NA (Not Applicable)
Dash (—) indicates that the objective does not apply to the population, the statewide denominator was too small to establish the MPS, or baseline data were not available to establish the MPS. If applicable, the MPS will be established when the baseline rate is available.

Goal 6—Increase utilization of dental services by December 31, 2027.							
Objective #	Objective Description	Measure Steward	Measure Set			MPS	
			HEDIS	Adult Core Set	Child Core Set	Medicaid	Nevada Check Up
6.1	Increase the rate of enrolled children under age 21 who received a comprehensive or periodic oral evaluation within the measurement year (OEV)	DQA			✓	**45.78%**	**56.17%**
6.2a	Increase the rate of enrolled children ages 1 through 20 years who received at least two topical fluoride applications as dental or oral health services, within the measurement year (TFL)	DQA			✓	**25.57%**	**33.29%**
6.2b	Increase the rate of enrolled children ages 1 through 20 years who received at least two topical fluoride applications as dental services, within the measurement year (TFL)	DQA			✓	**25.37%**	**33.08%**
6.2c	Increase the rate of enrolled children ages 1 through 20 years who received at least two topical fluoride applications as oral health services, within the measurement year (TFL)	DQA			✓	**10.02%**	**10.02%**
6.3a	Increase the rate of enrolled children who have ever received sealants on permanent first molar teeth: at least one sealant by 10th birthdate (SFM)	DQA			✓	**61.02%**	**64.58%**
6.3b	Increase the rate of enrolled children who have ever received sealants on permanent first molar teeth: all four molars sealed by 10th birthdate (SFM)	DQA			✓	**44.47%**	**46.68%**

DQA (Dental Quality Alliance)

Goal 7—Reduce and/or eliminate health care disparities for Nevada Medicaid members by December 31, 2027.		
Objective #	**Objective Description**	**DHCFP Evaluation (Met/Not Met)**
7.1	Ensure that health plans maintain, submit for review, and annually revise cultural competency plans.	
7.2	Stratify data for performance measures by race, ethnicity, sex, and geography 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.	
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.	

Goal 8—Improve positive outcomes for members with long-term services and supports (LTSS) needs by December 31, 2027.				
Objective #	**Objective Description**	**Measure Steward**	**MPS**	
			Medicaid	**Nevada Check Up**
8.1	Reduce the percentage of long stay nursing facility residents with high-risk/unstageable pressure ulcers (N045.01)	CMS	SDP	NA
8.2[s]	Improve percent of LTCH patients with an admission and discharge functional assessment and a care plan that addresses function	CMS	SDP	NA
8.3[s]	Assess discharges to the community following a post-acute stay (post-acute care measure for inpatient rehabilitation facilities)	CMS	SDP	NA

[s] State-directed payment initiative.
SDP (state-directed payment)—indicates MPS is established through the CMS-approved state-directed payment preprint. Performance is tracked through the annual EQR technical report.
NA (Not Applicable

Appendix C. Quality Strategy Public Comments

DHCFP posted the draft Quality Strategy for public comment on its website from September 6, 2024, through October 7, 2024. DHCFP values the insights and recommendations provided by its stakeholders to help support quality improvement of its Medicaid managed care program and uses the information from its stakeholders, as applicable, to further assess areas of its program that may benefit from additional quality initiatives and interventions. DHCFP received comments from [insert the number of commenters] on the proposed Nevada 2025–2027 Quality Strategy. The commenter(s) stated, [Include the statements here:]

DHCFP appreciates the commenters feedback and recommendations and [describe any actions DHCFP will take based on commenters feedback and/or recommendations]

Appendix D. Quality Strategy and Regulatory Reference Crosswalk

Nevada Quality Strategy
Crosswalk to CMS Toolkit

Each state contracting with an MCO, PIHP, PAHP, or PCCM entity must draft and implement a written quality strategy for assessing and improving the quality of healthcare and services furnished by the MCO, PIHP, PAHP, or PCCM entity, per §438.340(a) and §457.1240(e). The following table lists the required elements and the processes for developing state quality strategies as required by 42 CFR §438.340(b), 42 CFR §438.340(c), 42 CFR §438.340(d), and the June 2021 *Medicaid and Children's Health Insurance Program (CHIP) Managed Care Quality Strategy Toolkit*; and the corresponding sections in the Nevada Quality Strategy that address each requirement.

Regulatory Reference	Requirement Description	Page or Link Reference
42 CFR §438.340(b)(1)	The State's quality strategy includes the state-defined network adequacy and availability of services standards for MCOs, PIHPs, and PAHPs required by §§438.68 and 438.206 and examples of evidence-based clinical practice guidelines the State requires in accordance with §438.236.	Pages 4-1 through 4-4
42 CFR §438.340(b)(2)	The State's quality strategy includes goals and objectives for continuous quality improvement which must be measurable and take into consideration the health status of all populations in the State served by the MCO, PIHP, PAHP, and PCCM entity described in § 438.310(c)(2).	Pages 1-3 through 1-4 Appendix B
42 CFR §438.340(b)(3)(i)	The State's quality strategy includes a description of the quality metrics and performance targets to be used in measuring the performance and improvement of each MCO, PIHP, PAHP, and PCCM entity described in §438.310(c)(2) with which the State contracts, including but not limited to, the performance measures reported in accordance with §438.330(c). The State must identify which quality measures and performance outcomes the State will publish at least annually on the website required under §438.10(c)(3).	Pages 3-2 through 3-9 Appendix B EQR Technical Report: https://dhcfp.nv.gov/Resources/AdminSupport/Reports/CaseloadData/

Regulatory Reference	Requirement Description	Page or Link Reference
42 CFR §438.340(b)(3)(ii)	The State's quality strategy includes a description of the performance improvement projects to be implemented in accordance with §438.330(d), including a description of any interventions the State proposes to improve access, quality, or timeliness of care for beneficiaries enrolled in an MCO, PIHP, or PAHP.	Pages 3-15 through 3-16
42 CFR §438.340(b)(4)	Arrangements for annual, external independent reviews, in accordance with §438.350, of the quality outcomes and timeliness of, and access to, the services covered under each MCO, PIHP, PAHP, and PCCM entity (described in §438.310[c] [2]) contract.	Pages 5-1 through 5-4
42 CFR §438.340(b)(5)	A description of the State's transition of care policy required under §438.62(b)(3).	Page 3-16 Medicaid Services Manual: https://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/MSMHome/
42 CFR §438.340(b)(6)	The State's plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status. For purposes of this paragraph (b)(6), "disability status" means, at a minimum, whether the individual qualified for Medicaid on the basis of a disability. States must include in this plan the State's definition of disability status and how the State will make the determination that a Medicaid enrollee meets the standard including the data source(s) that the State will use to identify disability status.	Pages 3-17 through 3-19 Medicaid State Plan: https://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSP/MSPHome/
42 CFR §438.340(b)(7)	For MCOs, appropriate use of intermediate sanctions that, at a minimum, meet the requirements of subpart I of this part.	Page 4-7
42 CFR §438.340(b)(8)	The mechanisms implemented by the State to comply with §438.208(c)(1) (relating to the identification of persons who need long-term services and supports or persons with special health care needs).	Pages 3-20 through 3-21
42 CFR §438.340(b)(9)	The information required under §438.360(c) (relating to nonduplication of EQR activities).	Page 5-4
42 CFR §438.340(b)(10)	The State's definition of a "significant change" for the purposes of paragraph (c)(3)(ii) of this section.	Pages 6-3 through 6-4

Regulatory Reference	Requirement Description	Page or Link Reference
42 CFR §438.340(c)(1)(i)(ii)	In drafting or revising its quality strategy, the State must make the strategy available for public comment before submitting the strategy to CMS for review, including obtaining input from the Medical Care Advisory Committee (established by §431.12 of this chapter), beneficiaries, and other stakeholders. If the State enrolls Indians in the MCO, PIHP, PAHP, or PCCM entity described in §438.310(c)(2), consulting with Tribes in accordance with the State's Tribal consultation policy.	Pages 6-1 through 6-5
42 CFR §438.340(c)(2)(i)(ii)(iii)	In drafting or revising its quality strategy, the State must review and update the quality strategy as needed, but no less than once every 3 years. This review must include an evaluation of the effectiveness of the quality strategy conducted within the previous 3 years. The State must make the results of the review available on the Web site required under § 438.10(c)(3). Updates to the quality strategy must take into consideration the recommendations provided pursuant to §438.364(a)(4).	Pages 6-1 through 6-6 Pages 7-1 through 7-9 EQR Technical Report: https://dhcfp.nv.gov/Resources/AdminSupport/Reports/CaseloadData/
42 CFR §438.340(c)(3)(i)(ii)	In drafting or revising its quality strategy, the State must submit to CMS a copy of the initial strategy for CMS comment and feedback prior to adopting it in final, and a copy of the revised strategy whenever significant changes, as defined in the state's quality strategy per paragraph (b)(11) of this section, are made to the document, or whenever significant changes occur within the State's Medicaid program. Per the May 2024 Managed Care Rule, the State must also submit a copy of the Quality Strategy to CMS during the three-year renewal even if no significant changes are made.	Pages 6-1 through 6-6
42 CFR §438.340(d)	The State must make the final quality strategy available on the Web site required under §438.10(c)(3).	State Quality Strategy: https://dhcfp.nv.gov/Resources/AdminSupport/Reports/CaseloadData/