State of Nevada
Department of Health and Human Services

Division of Health Care Financing and Policy

Quality Assessment and Performance Improvement Strategy (Quality Strategy)

2016–2017

Table of Contents

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

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

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

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

To demonstrate compliance with the Centers for Medicare & Medicaid Services (CMS) Quality Strategy Toolkit for States, the DHCFP created a crosswalk (Attachment D) that lists each of the required and recommended elements of state quality strategies, and the corresponding section of the DHCFP Quality Strategy and/or DHCFP/MCO Contract that addresses the required or recommended elements. The CMS Quality Strategy Toolkit for States may be accessed at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/Quality-Strategy-Toolkit-for-States.pdf.

Overview

History of Program

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

In April 1992, Medicaid initiated a limited-enrollment primary care case management (PCCM) program, the first managed care program in Nevada. The PCCM program was implemented on a voluntary basis. Nevada contracted with **University Medical Center** (**UMC**), **Nevada Health Solutions**, and **Community Health Center** in both Clark County (Las Vegas) and Washoe County (Reno) for managed care services. The PCCM contract with **UMC** was terminated in the first quarter of 1997, and the remaining PCCM contracts were phased out per legislation in July 1999. In April 1997, voluntary managed care became effective again with several vendors. The State of Nevada, Department of Health and Human Resources, Division of Health Care Financing and Policy (DHCFP), contracted with **Health Plan of Nevada** (**HPN**) and **Amil International** (**Amil**) to provide services in Clark County, and with **Hometown Health Plan** to provide services in Washoe County. In addition, the DHCFP contracted with **Nevada Health Solutions**, offered by **NevadaCare**, **United Health Care**, and **HPN**, to provide services in both Clark and Washoe counties. Nevada discontinued voluntary managed care for most recipients in December 1998; however, these health plans continued to provide services to Nevada recipients when the Nevada Legislature passed Senate Bill 559, requiring that Medicaid develop a mandatory managed care program to curtail rising costs of health care. These mandatory Medicaid managed care contracts stayed in effect, with several renewals, through 2001.

In 2002, the DHCFP procured contracts again with **Nevada Health Solutions** and **HPN** in both Clark and Washoe counties. **Anthem** and **HPN** won the contract when Medicaid procured the contracts in November 2006. **Anthem** left the Nevada market in January 2009 and was replaced by **Amerigroup**. In 2013, the DHCFP reprocured contracts with **Amerigroup** and **HPN** in both Clark and Washoe counties. **Amerigroup** and **HPN** are the current the MCOs in Clark and Washoe counties.

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

Program Eligibility

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

- AM—Parents and Caretakers
- AM1—Expanded Parent and Caretakers
- CH—Poverty Level Children and Pregnant Women
- CH1—Expanded Children's Group Ages 6–18 Years
- CH5—Omnibus Budget Reconciliation Act (OBRA)
- CA—Childless Adults, Without Dependents, Ages 19–64 Years
- TR—Transitional Medicaid
- PM—Post Medical
- NC—Nevada Check Up–State CHIP Program for Children Under 19 Years

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

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

Program Demographics

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

Table 1-1 presents the gender and age bands of Nevada Medicaid- and CHIP-enrolled recipients in fiscal year (FY) 2015. The majority of members for both Medicaid and CHIP were children between 3 and 14 years of age.

Table 1-1—Nevada Medicaid and CHIP Managed Care Demographics
July 1, 2014–June 30, 2015

Gender/Age Band	June 2015 Members
Medicaid	
Males and Females <1 Year of Age	16,476
Males and Females 1–2 Years of Age	25,083
Males and Females 3–14 Years of Age	127,678
Females 15–18 Years of Age	13,842
Males 15–18 Years of Age	13,346
Females 19–34 Years of Age	56,490
Males 19–34 Years of Age	32,644
Females 35+ Years of Age	54,794
Males 35+ Years of Age	44,279
Gender Not Yet Recorded	351
Total Medicaid	**384,983**
CHIP	
Males and Females <1 Year of Age	212
Males and Females 1–2 Years of Age	1,126
Males and Females 3–14 Years of Age	12,958
Females 15–18 Years of Age	1,878
Males 15–18 Years of Age	1,899
Total CHIP	**18,073**
Total Medicaid and CHIP	**403,056**

Table 1-2 presents enrollment of Medicaid recipients by MCO and county for June 2015.

Table 1-2—June 2015 Nevada MCO Medicaid Recipients

MCO	Total Eligible Clark County	Total Eligible Washoe County
HPN	184,767	33,209
Amerigroup	143,882	23,125
Total	**328,649**	**56,334**

Table 1-3 presents enrollment of CHIP recipients in the Nevada Check Up program by MCO and county for June 2015.

Table 1-3—June 2015 Nevada MCO CHIP (Nevada Check Up) Recipients

MCO	Total Eligible Clark County	Total Eligible Washoe County
HPN	8,763	2,215
Amerigroup	5,787	1,308
Total	**14,550**	**3,523**

Table 1-4 presents the ethnic composition of Nevada MCO Medicaid recipients in June 2015.

Table 1-4—June 2015 Nevada MCO Medicaid Ethnic Composition

Ethnicity	Total Eligible Clark County	Total Eligible Washoe County
Asian or Pacific Islander Non-Hispanic	12,751	1,598
Black Non-Hispanic	75,706	2,828
Hispanic	64	15
Am Indian/Alaskan Non-Hispanic	1,216	598
Am Indian/Alaskan and White	380	142
Asian and White	1,149	203
Black African Am and White	3,103	458
Am Indian/Alaskan and Black	1,031	114
Other Non-Hispanic	24,361	2,901
Asian/Pacific Islander Hispanic	774	208
Black Hispanic	976	76
Am Indian/Alaskan Hispanic	191	39
White Hispanic	115,321	18,776
White Non-Hispanic	91,626	28,378
Total	**328,649**	**56,334**

Table 1-5 presents the ethnic composition of CHIP recipients in the Nevada Check Up program for June 2015.

Table 1-5—June 2015 Nevada MCO CHIP (Nevada Check Up) Ethnic Composition

Ethnicity	Total Enrolled Clark County	Total Enrolled Washoe County
Asian or Pacific Islander Non-Hispanic	797	112
Black Non-Hispanic	1,346	47
Hispanic	0	0
Am Indian/Alaskan Non-Hispanic	53	47
Am Indian/Alaskan and White	6	1
Asian and White	72	18
Black African Am and White	108	28
Am Indian/Alaskan and Black	49	3
Other Non-Hispanic	1,124	183
Asian/Pacific Islander Hispanic	39	22
Black Hispanic	36	5
Am Indian/Alaskan Hispanic	8	6
White Hispanic	7,962	2,039
White Non-Hispanic	2,950	1,012
Total	**14,550**	**3,523**

Table 1-6 presents the top 10 most costly diagnosis groupings for the Medicaid and Nevada Check Up population for all ages for FY 2014–2015.

Table 1-6—Nevada Division of Health Care Financing and Policy
Based on Data with Service Dates July 1, 2014–June 30, 2015 (1)
Males and Females; All Age Bands
All Services—Excluding Prescription Drugs and Dental
Diagnosis Groupings Based on Primary ICD-9 Codes

Group Code	Rank	Highest Cost Diagnosis Codes	Diagnosis Group / Highest Cost Diagnosis Description (2)	Portion of Diagnosis Group Costs (3)	Patients (4)	Paid Amount (5)	Paid Amount Per Patient
O01	1		Live Newborn and Routine Infant Check	100.00%	118,268	$55,684,237	$471
		V20.2	Routine Infant Or Child Health Check	37.37%	116,094	$20,809,877	$179
		V30.01	Single Liveborn, Born In Hospital, Delivered By Cesarean Section	30.27%	3,857	$16,856,798	$4,370
K07	2		Normal Delivery and Related Care	100.00%	15,440	$37,008,602	$2,397
		650	Normal Delivery	23.52%	3115	$8,705,155	$2,795
		654.21	Previous Cesarean Delivery, Delivered, With Or Without Mention Of Antepartum Condition	19.77%	1571	$7,316,535	$4,657
I04	3		Other GI disorders	100.00%	30,731	$30,556,410	$994
		521.00	Dental Caries, Unspecified	16.96%	4920	$5,183,474	$1,054
		577.0	Acute Pancreatitis	10.40%	704	$3,177,640	$4,514
M03	4		Diseases of the spine—Dorsopathies (neck, back, disc disease, etc.)	100.00%	30,530	$21,929,469	$718
		724.2	Lumbago	17.56%	13711	$3,851,826	$281
		722.10	Displacement Of Lumbar Intervertebral Disc Without Myelopathy	9.31%	2783	$2,041,317	$733
K06	5		Complications Mainly Related to Pregnancy	100.00%	12,577	$20,037,797	$1,593
		645.11	Post Term Pregnancy, Delivered, With Or Without Mention Of Antepartum Condition	15.39%	850	$3,083,439	$3,628
		644.21	Early Onset Of Delivery, Delivered, With Or Without Mention Of Antepartum Condition	8.66%	386	$1,735,476	$4,496
E07	6		Affective psychoses	100.00%	12,010	$19,477,443	$1,622
		296.33	Major Depressive Affective Disorder, Recurrent Episode, Severe, Without Mention Of Psychotic Behavior	19.56%	2330	$3,809,624	$1,635
		296.90	Unspecified Episodic Mood Disorder	10.86%	2,292	$2,114,682	$923
H01	7		Diseases of the upper respiratory tract	100.00%	98,259	$19,338,437	$197
		465.9	Acute Upper Respiratory Infections Of Unspecified Site	24.29%	43,496	$4,697,369	$108
		462	Acute Pharyngitis	9.55%	18,003	$1,847,492	$103
F06	8		Disorders of the eyes	100.00%	100,722	$17,258,769	$171
		367.1	Myopia	16.12%	32,899	$2,782,200	$85
		367.9	Unspecified Disorder Of Refraction And Accommodation	13.24%	21582	$2,285,649	$106
A01	9		Infections, General	100.00%	27,785	$15,064,283	$542
		038.9	Unspecified Septicemia	46.50%	790	$7,005,201	$8,867
		079.99	Unspecified Viral Infection	6.54%	8858	$985,020	$111
H04	10		Other pulmonary disease—Pneumonia and Influenza and other non-specified pulmonary conditions	100.00%	8,381	$14,238,464	$1,699
		518.81	Acute Respiratory Failure	33.07%	1028	$4,708,908	$4,581
		486	Pneumonia, Organism Unspecified	30.27%	3,419	$4,309,866	$1,261
			All Other Diagnosis Groups	100.00%	317,745	$418,228,772	$1,316
Total					**383,941**	**$668,822,683**	**$1,742**
Total Member Months							

(1) Includes claims paid through December 30, 2015 for HPN & Amerigroup.

(2) This column lists descriptions of the most costly diagnosis groups as well as descriptions of the two most costly diagnoses within that group.

(3) This column identifies the percentage of the total cost for that diagnosis group which is attributable to the given diagnosis code.

(4) This field identifies the number of unique members who were assigned primary diagnosis codes in that line item. Members can be in multiple line items.

(5) Paid amount includes all services, excluding prescription drug and dental.

Table 1-7 presents the top prescription drug expenditures for the Medicaid and Nevada Check Up population for all ages for FY 2014–2015.

Table 1-7—Nevada Division of Health Care Financing and Policy
Based on Rx Data with Fill Dates July 1, 2014–June 30, 2015
Paid Through December 16, 2015
Males and Females; All Age Bands

NDC	Drug Name	Drug Class	Total Cost
61958150101	SOVALDI	Hepatitis C Agents	$5,972,086
61958120101	STRIBILD	Antiretrovirals	$5,700,620
61958180101	HARVONI	Hepatitis C Agents	$5,563,362
00088221905	LANTUS SOLOSTAR	Insulin—Long Acting	$5,009,232
00173068220	VENTOLIN HFA	Short Acting Beta Agonists	$3,606,991
15584010101	ATRIPLA	Antiretrovirals	$3,227,696
61958070101	TRUVADA	Antiretrovirals	$2,899,867
00088222033	LANTUS	Insulin—Long Acting	$2,359,981
00186037020	SYMBICORT	Long Acting Beta Agonist + ICS Combos	$2,226,403
61958110101	COMPLERA	Antiretrovirals	$2,201,090
00002879959	HUMALOG KWIKPEN	Insulin—Short/Intermediate Acting	$2,148,794
		All Other Rx Expenditures	**127,663,130**
		Total Rx Expenditures	**$168,579,252**

DHHS Vision

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

DHCFP Mission

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

Process for Quality Strategy Development, Review, and Revision

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

Quality Strategy Development

With input provided by Nevada Medicaid MCOs, the DHCFP developed performance measures used to measure health plan performance in achieving the goals and objectives identified in the Quality Strategy. Public input and the epidemiological and utilization data, detailed in Table 1-6 and Table 1-7, serve as the basis for selecting performance measures to improve the health and wellness of Nevada's Medicaid and Nevada Check Up population. The DHCFP uses the Healthcare Effectiveness Data and Information Set (HEDIS®[1-1]) to develop, collect, and report data for most performance measures.

Ongoing Review of the Quality Strategy

The DHCFP's EQRO is contractually required to validate the MCOs' HEDIS information. The DHCFP tracks the MCOs' performance for each of the required performance measures and reports the information annually in the external quality review (EQR) technical report. Additionally, the MCOs are required to track their own performance and report achievements and opportunities for improvement in an MCO quality evaluation, which is submitted annually to the DHCFP by each MCO.

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

The DHCFP monitors each MCO's compliance with its contract, and with the goals and objectives identified in the Quality Strategy, via an internal quality assurance program (IQAP) on-site review of compliance with various quality assessment/improvement standards. The DHCFP's EQRO conducts IQAP reviews at least once every three years. The purpose of the reviews is to determine an MCO's understanding and application of Balanced Budget Act of 1997 (BBA) and contractually required standards from a review of documents, observations, and interviews with key health plan staff, as well as file reviews conducted during the on-site evaluation. The IQAP review includes an assessment of each MCO's quality improvement (QI) structure. This structure is necessary to facilitate quality

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

improvement and ongoing assessment of performance measures and PIPs. This enables the DHCFP and the MCOs to assess each MCO's performance in achieving quality goals and objectives identified in the Quality Strategy. The IQAP report enables the MCOs to implement remediation plans to correct any areas of deficiency found during the IQAP review. The report also helps the DHCFP determine each MCO's compliance with the contract and identify areas of the contract that need to be modified or strengthened to ensure that an MCO complies with the standards.

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

Quality Strategy Evaluation and Revision

The DHCFP and its EQRO evaluate the effectiveness of the Quality Strategy and report on the evaluations in the annual EQR technical report. The DHCFP updates the Quality Strategy, at least biennially, based on each MCO's performance; stakeholder input and feedback; achievement of goals; changes resulting from legislative, State, federal, or other regulatory authority; and/or significant changes to the programmatic structure of the Nevada Medicaid program. DHCFP staffs host public workshops wherein DHCFP staffs solicit feedback from Nevada Medicaid stakeholders and the public during the revision phase of the Quality Strategy. Additionally, the DHCFP invites public comment and feedback on the Quality Strategy throughout the biennium. The DHCFP Quality Strategy is located at: http://dhcfp.nv.gov/Members/BLU/MCOMain/.

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

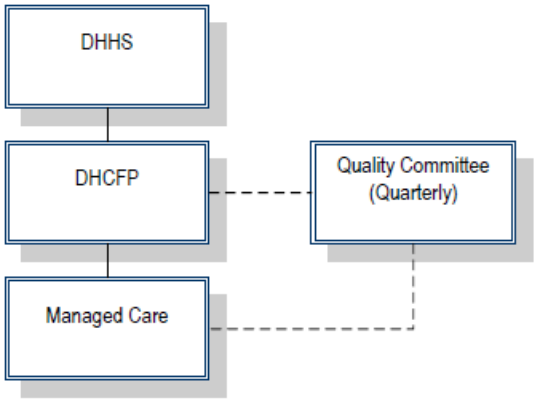
- Any change to the Quality Strategy resulting from legislative, State, federal, or other regulatory authority.
- Any change in membership demographics of 50 percent or greater within one year.
- Any change in the provider network of 50 percent or greater within one year.

Oversight and Governance of the Quality Strategy

As depicted in Figure 1-1, under the advisement of the Department of Health and Human Services, the DHCFP maintains ultimate authority and responsibility for the maintenance and annual evaluation of the Quality Strategy. The DHCFP maintains a Quality Committee, which meets during the quarterly face-to-face MCO meeting. During these meetings, the DHCFP and MCO staffs review and discuss performance measure results, PIP results, and Quality Strategy goals and objectives. Further, the MCOs are required to present

information on quality improvement results, barrier analyses, and planned quality improvement activities to be implemented to overcome barriers that impede performance.

Figure 1-1—Nevada DHCFP
Quality Improvement Organizational Structure



Quality Strategy Purpose, Scope, and Goals

Purpose of the Quality Strategy

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

- Establish a comprehensive quality improvement system that is consistent with the National Quality Strategy and CMS Triple Aim to achieve better care for patients, better health for communities, and lower costs through improvement in the health care system.
- Provide a framework for the DHCFP to implement a coordinated and comprehensive system to proactively drive quality throughout the Nevada Medicaid and Nevada Check Up system. The Quality Strategy promotes the identification of creative initiatives to continuously monitor, assess, and improve access to care, clinical quality of care, and health outcomes of the population served.
- Identify opportunities for improvement in the health outcomes of the enrolled population and improve health and wellness through preventive care services, chronic disease and special needs management, and health promotion.
- Identify opportunities to improve quality of care and quality of service, and implement improvement strategies to ensure Nevada Medicaid and Nevada Check Up recipients have access to high quality and culturally appropriate care.
- Identify creative and efficient models of care delivery that are steeped in best practice and make health care more affordable for individuals, families, and the state government.
- Improve recipient satisfaction with care and services.

Scope of Quality Strategy

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

- All Medicaid and Nevada Check Up managed care recipients in all demographic groups and in all service areas for which the MCOs are approved to provide Medicaid and Nevada Check Up managed care services.
- All aspects of care—including accessibility, availability, level of care, continuity, appropriateness, timeliness, and clinical effectiveness of care and services covered by Nevada Medicaid managed care and the Nevada Check Up program.
- All aspects of the MCOs' performance related to access to care, quality of care, and quality of service, including networking, contracting, and credentialing; medical record-keeping practices; environmental safety and health; health and disease management; and health promotion.
- All services covered—including preventive care services, primary care, specialty care, ancillary care, emergency services, chronic disease and special needs care, dental services, mental health services, diagnostic services, pharmaceutical services, skilled nursing care, home health care, and prescription drugs.
- All professional and institutional care in all settings, including inpatient, outpatient, and home settings.
- All providers and any other delegated or subcontracted provider type.
- All aspects of the MCOs' internal administrative processes related to service and quality of care—including customer services, enrollment services, provider relations, confidential handling of medical records and information, case management services, utilization review activities, preventive health services, health education, information services, and quality improvement.
- All Medicaid members who are enrolled in the State's care management organization (CMO) program and receive care management services via the Health Care Guidance Program (HCGP). Additional detail about the Nevada Comprehensive Care Waiver (NCCW) and HCGP is provided in Attachment C of this report.

Quality Strategy Goals and Objectives

Consistent with the National Quality Strategy and epidemiological and prevalence data displayed in Table 1-6 and the prescription drug expenditure data in Table 1-7, the DHCFP established the following quality goals and objectives to improve the health and wellness of Nevada Medicaid and Nevada Check Up members. The goals and objectives established for the HCGP are described in Attachment C of this report. Unless otherwise indicated, all objectives will follow the Quality Improvement System for Managed Care (QISMC) methodology to increase rates by 10 percent.

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

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

Objective 1.1b: Increase children's and adolescents' access to PCPs (26 months–6 years).

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

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

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

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

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

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

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

Objective 1.5: Increase immunizations for adolescents.

Objective 1.6: Increase annual dental visits for children.

Objective 1.7: Increase human papillomavirus vaccine for female adolescents.

Objective 1.8: Increase adolescent well-care visits.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Objective 4.1: Increase the rate of postpartum visits.

Objective 4.2: Increase timeliness of prenatal care.

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

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

Goal 5: Increase use of evidence-based practices for members with behavioral health conditions.

Objective 5.1a: Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication—initiation phase.

Objective 5.1b: Increase follow-up care for children prescribed ADHD medication—continuation and maintenance phase.

Objective 5.2: Reduce use of multiple concurrent antipsychotics in children and adolescents.**

Objective 5.3: Reduce behavioral health-related hospital readmissions within 30 days of discharge. (Improvement based on MCO PIP goals.)

Objective 5.4: Increase follow-up after hospitalization for mental illness—7 days.

Objective 5.5: Increase follow-up after hospitalization for mental illness—30 days.

Goal 6: Increase reporting of CMS quality measures.

Objective 6.1: Increase the number of CMS adult core measures reported to the Medicaid and CHIP Program (MACPro) System.

Objective 6.2: Increase the number of CMS child core measures reported to MACPro.

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

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

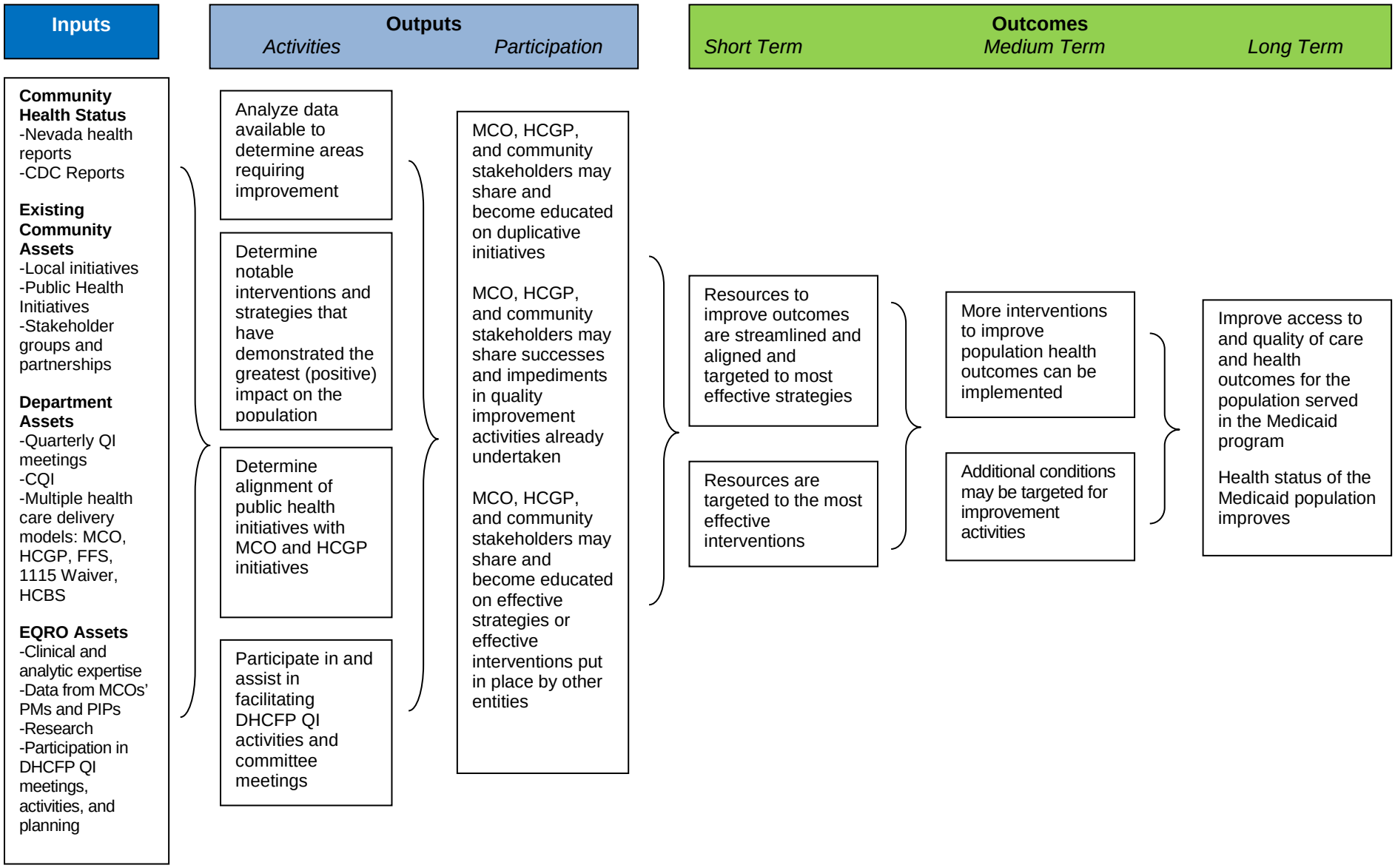
Strategy for Meeting Goals and Objectives

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

- Developing and maintaining collaborative strategies among State agencies and external partners to improve health education and health outcomes, manage vulnerable and at-risk members, and improve access to services for all Nevada Medicaid and Nevada Check Up recipients.
- Using additional performance measures, performance improvement projects, contract compliance monitoring, and emerging practice activities to drive improvement in member health care outcomes.
- Strengthening evidence-based prevention, wellness, and health management initiatives to improve members' health status and achievement of personal health goals.
- Enhancing member services and member satisfaction with services.
- Improving health information technology to ensure that information retrieval and reporting are timely, accurate, and complete.
- Working collaboratively with other Department of Health divisions and community resources to improve access to and quality of care and health outcomes of the populations served by Medicaid.

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

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



Medicaid Contract Provisions (42 CFR 438.204[a])

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

The DHCFP reviews the MCOs' deliverables throughout the year to evaluate their compliance with the contract in the following areas:

- Operational and structural policies and procedures
- Member outreach information and materials
- Provider information, materials, and contracting
- Grievance and appeals procedures and reporting
- IQAP program
- Cultural competency
- Program integrity

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

Use of National Performance Measures and Performance Measure Reporting

Performance Measure Reporting

The DHCFP uses HEDIS data whenever possible to measure the MCOs' performance with specific indices of quality, timeliness, and access to care. The DHCFP's EQRO conducts HEDIS compliance audits of the MCOs on an annual basis and reports the HEDIS results to DHCFP as well as to NCQA. As part of the EQR Annual Technical Report, the EQRO performs a comparison of the rates between the MCOs and also compares the individual health plan and aggregate rates with available Medicaid percentile data published by NCQA.

Children's Health Insurance Program Reauthorization Act

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

Medicaid and CHIP Program (MACPro) System Reporting

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

Use of Corrective Action Plans (42 CFR 438.204[e])

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

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

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

Quality and Appropriateness of Care (42 CFR 438.204[b][1])

Procedures for Race, Ethnicity, and Primary Language Data Collection and Communication (42 CFR 438.204[b][2])

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

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

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

care disparities in their annual CCP evaluation and Quality Strategy evaluation. Both of these documents are submitted to the DHCFP annually for review and approval.

Identification of Members With Special Health Care Needs (42 CFR 438.204[b][1])

The DHCFP monitors quality and appropriateness of services for children with special health care needs through compliance monitoring activities and regular review of the MCOs' deliverables. The DHCFP monitors quarterly reports and tracks and trends results to determine patterns of utilization, and monitors performance of the health plan. The State Health Division and the DHCFP host a monthly teleconference call with their early intervention community providers to facilitate stakeholder involvement and collaboration. The DHCFP also monitors services provided to children with special health care needs to identify the need for continued services throughout treatment to ensure that all services are medically necessary according to federal Medicaid regulations at CFR 440.110.

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

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

Once a child is eligible, an Individualized Family Service Plan (IFSP) must be developed within 45 days of the referral to determine the child's program and service needs. The IDEA specifies that services must be available to a child based on his or her individual needs. NEIS provides these services in accordance with the IFSP, which determines the frequency and intensity needed (e.g., one service per week for 60 minutes). This plan is reviewed and updated at least every 6 months. NEIS ensures that all services are provided by appropriately licensed personnel. Per the IDEA, services must be provided in a "natural environment," which includes home, child care, and community settings.

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

Current School-Based Services

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

Eligibility

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

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

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

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

- The care coordination staff or designated health plan staff completes a contract-required quarterly report and forwards it to the DHCFP within 45 days after the close of the quarter.

Arrangement for External Quality Review (42 CFR 438.204[d])

In accordance with 42 CFR 438.356, the DHCFP contracts with Health Services Advisory Group, Inc. (HSAG) as its EQRO to conduct the mandatory and optional EQR activities as set forth in 42 CFR 438.358.

Mandatory EQR Activities

To evaluate the quality and timeliness of, and access to, the services covered under the MCO contract, the DHCFP's EQRO conducts the following mandatory EQR activities for the Nevada Medicaid and Nevada Check Up program:

- **Compliance monitoring evaluation.** The DHCFP's EQRO conducts comprehensive, internal IQAP on-site reviews of compliance of the MCOs at least once in a three-year period. The DHCFP's EQRO reviews MCO compliance with standards established by the State for access to care, structure and operations, and quality measurement and improvement. In accordance with 42 CFR 438.204(g), these standards are as stringent as the federal Medicaid managed care standards described in 42 CFR 438, which address requirements related to access, structure and operations, and measurement and improvement. Compliance is also determined through review of individual files to evaluate implementation of standards.
- **Validation of performance measures.** In accordance with 42 CFR 438.240(b)(2), the DHCFP requires MCOs to submit performance measurement data as part of their quality assessment and performance improvement (QAPI) programs. To comply with 42 CFR 438.358(b)(2), the DHCFP's EQRO validates the performance measures through HEDIS compliance audits. The HEDIS compliance audits focus on the ability of the MCOs to accurately process claims and encounter data, pharmacy data, laboratory data, enrollment (or membership) data, and provider data. The DHCFP's EQRO validates each of the performance measures identified by the State to evaluate their accuracy as reported by, or on behalf of, the MCO. As part of the HEDIS compliance audits, the DHCFP's EQRO also explores the issue of completeness of claims and encounter data to improve rates for the performance measures.
- **Validation of PIPs.** As described in 42 CFR 438.240(b)(1), the DHCFP requires MCOs to conduct PIPs in accordance with 42 CFR 438.240(d). PIPs must be designed to achieve significant and sustained improvement in clinical and nonclinical areas of care through ongoing measurement and intervention, and they must be designed to have a favorable effect on health outcomes and enrollee satisfaction. In accordance with 42 CFR 438.358(b)(1), the DHCFP's EQRO validates PIPs required by the State to comply with the requirements of 42 CFR 438.240(b)(1). The DHCFP's EQRO validation determines if PIPs were designed to achieve improvement in clinical and nonclinical care, and if the PIPs would have a favorable effect on health outcomes and enrollee satisfaction.

Optional EQR Activities

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

- Evaluate the State's Quality Strategy and the managed care program's achievement of goals and objectives identified in the strategy.
- Provide an analysis of the results of CAHPS®[2-1] activities conducted by the MCOs.
- Provide technical assistance to the DHCFP with activities related to the NCCW program, the fee-for-service care management program that resulted from Nevada's section 1115(a) Medicaid research and demonstration waiver approved by CMS. The DHCFP contracted with a CMO to provide care management services to the enrolled population through the HCGP. The EQRO's technical assistance activities include:
  1. Implementing the NCCW Quality Strategy, developed in response to the requirements included in the 1115 Research and Demonstration Waiver special terms and conditions.
  2. Participating in quarterly meetings with the HCGP vendor to ensure that quality-related activities remain on track. DHCFP's EQRO also developed a set of quality modules that the HCGP vendor must use to guide its quality-related presentations during the quarterly meetings.
  3. Revising the *NCCW 1115 Demonstration Evaluation Design Plan*.
  4. Performing a compliance review of the HCGP vendor six months after operations commenced to verify that the HCGP vendor complied with its contract.
  5. Performing source code review of the programming code used to calculate pay for performance measures used for the NCCW program (to be calculated by the DHCFP's actuary).
- Conduct an evaluation of Nevada's Medicaid provider network. The purpose of the analysis was to estimate the provider network capacity, geographic distribution, and appointment availability of the MCOs' and fee-for-service networks. The analysis evaluated three dimensions of access and availability:
  - Capacity—provider-to-recipient ratios for Nevada's provider networks.
  - Geographic network distribution—time/distance analysis for applicable provider specialties and average distance (miles) to the closest provider.
  - Appointment availability—average length of time (number of days) to see a provider, for both MCOs and fee-for-service.

EQR Technical Reporting

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

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

all mandatory and optional EQR activities performed, although the EQRO is not currently contracted to perform the optional activities that are specifically detailed in 42 CFR 438.204(d).

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

- Activity objectives
- Technical methods of data collection and analysis
- Description of data obtained
- Conclusions drawn from the data

The report also includes an assessment of MCO strengths and weaknesses, as well as recommendations for improvements. The DHCFP uses the information obtained from each of the mandatory EQR activities, as well as the information presented in the EQR technical report, to make programmatic changes and modifications to the DHCFP Quality Strategy. The EQR technical report also contains a chapter that describes the EQRO's evaluation of the State's QAPI program. The chapter includes the Quality Strategy Goals and Objectives Tracking Table, which lists the goals and objectives described in Section 1 of the Quality Strategy and the MCO's achievement of each objective. The most recent EQR technical report may be accessed at: http://dhcfp.nv.gov/Members/BLU/MCOMain/.

State Monitoring and Evaluation of MCO Requirements (42 CFR 438.204[b][3])

Performance Measures Used to Assess Members' Timely Access to Appropriate Health Care (42 CFR 438.204[c])

The DHCFP uses HEDIS to develop, collect, and report data for most performance measures. The DHCFP's EQRO is contractually required to validate MCOs' HEDIS information. The DHCFP tracks MCO performance for each of the required performance measures using the Performance Tracking Tool, as described later in this section. In collaboration with the MCOs, the DHCFP identified the following indicators to measure MCOs' success in improving access to care and quality and timeliness of services provided to Nevada Medicaid and Nevada Check Up recipients.

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

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

MCO HEDIS Measures				
Required HEDIS Measures	**Medicaid**	**Check Up**	**Child Core Set**	**Adult Core Set**
Access to Care				
Children and Adolescents' Access to Primary Care Practitioners (CAP)				
12–24 Months	X	X	X	-
25 Months–6 Years	X	X	X	-
7–11 Years	X	X	X	-
12–19 Years	X	X	X	-
Annual Dental Visit (ADV)				
Total	X	X	-	-
Children's Preventive Care				
Adolescent Well-Care Visits (AWC)				
Adolescent Well-Care Visits	X	X	X	-
Childhood Immunization Status (CIS)				
Combination 2	X	X	X	-
Combination 3	X	X	X	-
Combination 4	X	X	X	-
Combination 5	X	X	X	-
Combination 6	X	X	X	-
Combination 7	X	X	X	-
Combination 8	X	X	X	-
Combination 9	X	X	X	-
Combination 10	X	X	X	-
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap/Td)	X	X	X	-
Well-Child Visits in the First 15 Months of Life (W15)				
Six or More Well-Child Visits	X	X	X	-
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	X	X	X	-
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile (Total)	X	X	X	-
Counseling for Nutrition (Total)	X	X	X	-
Counseling for Physical Activity (Total)	X	X	X	-
Human Papillomavirus Vaccine for Female Adolescents (HPV)				
Human Papillomavirus Vaccine for Female Adolescents	X	X	X	-
Maternity Care				
Prenatal and Postpartum Care (PPC)				
Timeliness of Prenatal Care	X	-	X	X
Postpartum Care	X	-	X	X
Frequency of Ongoing Prenatal Care (FPC)				
<21 Percent of Expected Visits	X	-	X	-
≥81 Percent of Expected Visits	X	-	X	-

MCO HEDIS Measures				
Required HEDIS Measures	**Medicaid**	**Check Up**	**Child Core Set**	**Adult Core Set**
Care for Chronic Conditions				
Comprehensive Diabetes Care (CDC)				
Hemoglobin A1c (HbA1c) Testing	X	-	-	X
HbA1c Poor Control (>9.0%)	X	-	-	X
HbA1c Control (<8.0%)	X	-	-	-
Eye Exam (Retinal) Performed	X	-	-	-
Medical Attention for Nephropathy	X	-	-	-
Blood Pressure Control (<140/90 mm Hg)	X	-	-	-
Medication Management for People with Asthma (MMA)				
Medication Compliance 50% (Total)	X	X	X	-
Medication Compliance 75% Total)	X	X	X	-
Behavioral Health				
Follow-Up After Hospitalization for Mental Illness (FUH)				
7-Day Follow-Up	X	X	X	X
30-Day Follow-Up	X	X	X	X
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
Initiation Phase	X	X	X	-
Continuation and Maintenance (C&M) Phase	X	X	X	-
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)				
Total	X	X	-	-
Utilization and Diversity of Membership				
Mental Health Utilization (MPT)				
Any Service (Total)	X	X	-	-
Inpatient (Total)	X	X	-	-
Intensive Outpatient or Partial Hospitalization (Total)	X	X	-	-
Outpatient or ED (Total)	X	X	-	-
Ambulatory Care (AMB)				
Outpatient Visits	X	X	X	-
ED Visits	X	X	X	-
Weeks of Pregnancy at Time of Enrollment (WOP)				
Prior to 0 Weeks	X	-	-	-
1–12 Weeks	X	-	-	-
13–27 Weeks	X	-	-	-
28 or More Weeks of Pregnancy	X	-	-	-
Unknown	X	-	-	-

Standards for Access to Care

The contracts between the DHCFP and the MCOs detail Nevada Medicaid standards for access to care, as outlined in Subpart D of the Medicaid Managed Care Rules and Regulations. The DHCFP's standards are at least as stringent as those specified in 42 CFR 438.200–438.242. The MCOs are required to implement the following standards for access to care:

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

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

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

Standards for Structure and Operations

The contracts between the DHCFP and the MCOs detail Nevada Medicaid standards for structure and operations, as outlined in Subpart D of the Medicaid Managed Care Rules and Regulations. The DHCFP's standards are at least as stringent as those specified in 42 CFR 438.200–438.230. The MCOs are required to implement the following standards for structure and operations:

- Provider selection and credentialing (42 CFR 438.214)
- Enrollee information (42 CFR 438.218)
- Confidentiality (42 CFR 438.224)
- Enrollment and disenrollment (42 CFR 438.226)
- Grievance systems (42 CFR 438.228)
- Subcontractual relationships and delegation (42 CFR 438.230)

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

Measurement and Improvement Standards

The contracts between the DHCFP and the MCOs detail Nevada Medicaid standards for measurement and improvement, as outlined in Subpart D of the Medicaid Managed Care Rules and Regulations. The DHCFP's standards are at least as stringent as those specified in 42 CFR 438.236–242. The MCOs are required to implement the following standards for measurement and improvement:

- Practice Guidelines (42 CFR 438.236)
- Quality assessment and performance improvement program (42 CFR 438.240)
- Health information systems (42 CFR 438.242)

Performance Improvement Projects (PIPs)

As described in 42 CFR 438.240(b)(1), the DHCFP requires MCOs to conduct PIPs annually, in accordance with 42 CFR 438.240(d). PIPs must be designed to achieve significant and sustained improvement in clinical and nonclinical areas of care through ongoing measurement and intervention and to have a favorable effect on health outcomes and enrollee satisfaction. In accordance with 42 CFR 438.358(b)(1), the DHCFP's EQRO validates PIPs required by the State and 42 CFR 438.240(b)(1).

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

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

Table 2-2 lists the Nevada Medicaid and Nevada Check Up PIPs planned for 2016–2017.

Table 2-2—Nevada Medicaid and Nevada Check Up PIPs

Performance Improvement Project	Health Plan of Nevada	Amerigroup	Medicaid	Check Up
Reducing Behavioral Health-Related Hospital Readmissions Within 30 Days of Discharge	X	X	X	X
Improving Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	X	X	X	X

In 2016, the DHCFP's EQRO worked with the DHCFP, CMS, and the MCOs to implement a rapid-cycle improvement (RCI) approach to PIPs. The purpose of the RCI PIPs is to place greater emphasis on improving both health care outcomes and processes through the integration of quality improvement science. The approach guides MCOs through a process using a rapid-cycle improvement method to pilot and continually test small changes rather than implementing one large transformation at once. Performing small tests of change requires fewer resources and allows more flexibility to make adjustments throughout the improvement process. By piloting on a smaller scale, MCOs have the opportunity to determine the effectiveness of several changes prior to expanding successful interventions.

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

Measurement of Recipient Satisfaction

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

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

State Monitoring and Evaluation of MCOs' Contractual Compliance (42 CFR 438.204[3])

Compliance Review (42 CFR 438.204[g])

According to 42 CFR 438.358, which describes the activities related to external quality reviews, a state or its EQRO must conduct a review within a three-year period to determine a Medicaid MCO's compliance with standards established by the state for access to care, structure and operations, and quality measurement and improvement. In accordance with 42 CFR 438.204(g), these standards must be as stringent as the federal Medicaid managed care standards described in 42 CFR 438, which address requirements related to access, structure and operations, and measurement and improvement. To meet this requirement, the DHCFP contracts with its EQRO to perform a comprehensive on-site review of compliance of the MCOs.

The purpose of the compliance review is to determine each MCO's compliance with various quality assessment/improvement standards in 14 areas of compliance. The 14 compliance standards are derived from requirements in the *Department of Human Resources Division of Health Care Financing and Policy Request for Proposal No. 1988 for Medicaid Managed Care Organization Services* and all attachments effective July 1, 2013; as well as the Code of Federal Regulations. The 14 compliance standards are listed below:

- Internal Quality Assurance Program (IQAP)
- Credentialing and Recredentialing
- Member Rights and Responsibilities
- Member Information
- Availability and Accessibility of Services
- Continuity and Coordination of Care
- Grievance and Appeals

- Subcontracts and Delegation
- Cultural Competency Program
- Coverage and Authorization of Services
- Provider Dispute Resolution
- Confidentiality and Record Keeping
- Provider Information
- Enrollment and Disenrollment

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

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

Health Information Systems (42 CFR 438.204[f])

Health Information Technology (42 CFR 438.204[f])

The Nevada Provider Incentive Program (NPIP) for electronic health records (EHRs) is an incentive program for Nevada health care providers to receive payments for becoming meaningful users of certified EHR technology. The goal of NPIP is to give providers access to enhanced Medicaid funds to offset the cost of implementing certified EHR technology. This funding is designed to promote the adoption of certified EHR technology and ultimately provide improved quality of care for Medicaid beneficiaries and increased cost efficiencies within the Medicaid enterprise. As of July 2015, a total of 455 providers and 30 hospitals have received over $41,796,479 in payments from NPIP.

[2-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: February 19, 2013.

Goals and Objectives Tracking Table (42 CFR 438.204[f])

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

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

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

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

Figure 3-1—DHCFP PDSA Cycle

[3-1] For more information about PDSA, please see https://www.deming.org/theman/theories/pdsacycle.

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

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

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

Annual Evaluation of the Quality Strategy (42 CFR 438.204[d])

The annual evaluation includes an assessment of:

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

Quality Tools Used to Evaluate Quality Strategy

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

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

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

Quality Strategy Revision

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

In the second quarter of each FY, the DHCFP and its EQRO highlight the MCOs' performance with the mandatory EQR activities. The summary of EQR activities includes a profile of MCO performance measure rates, PIP results, and compliance with standard or corrective action plan results from the previous fiscal year. The summary of FY 2014–2015 MCO strengths and opportunities for improvement are highlighted below. For additional detail, please see the FY 2014–2015 EQR Technical Report at: http://dhcfp.nv.gov/Members/BLU/MCOMain/.

Summary of Amerigroup Strengths

Multiple vaccination combinations of the Medicaid performance measure, *Childhood Immunization Status*, were identified as strengths for **Amerigroup** based on rate improvements greater than 5 percentage points over time.

- Childhood Immunization Status—Combinations 4, 7, 8, 9, and 10

All Nevada Check Up rates were higher than the corresponding Medicaid reported rates. The following Nevada Check Up performance measures were identified as strengths for **Amerigroup** based on rate improvements greater than 5 percentage points over time.

- Childhood Immunization Status—Combinations 4 and 8
- Lead Screening in Children
- Well-Child Visits in the First 15 Months of Life—Six or More Visits

Amerigroup's *Reducing Avoidable Emergency Room Visits* PIP is also considered a strength because the MCO made statistically significant improvement for both indicators and sustained that improvement for one indicator.

Summary of Amerigroup Opportunities for Improvement

The following Medicaid performance measures were identified as opportunities for improvement for **Amerigroup** based on a decline in performance of greater than 5 percentage points over time.

- Well-Child Visits in the First 15 Months of Life—Six or More Visits
- Annual Dental Visits—Combined Rate
- Prenatal and Postpartum Care—Timeliness of Prenatal Care and Postpartum Care
- Frequency of Ongoing Prenatal Care—<20% Visits and ≥ 81% Visits

- Use of Appropriate Medications for People With Asthma—12–18 Years, 19–50 Years, *and* Combined

The following Nevada Check Up performance measures were identified as opportunities for improvement for **Amerigroup** based on a decline in performance of greater than 5 percentage points over time.

- Childhood Immunization Status—Combinations 2, 3, 5, and 9
- Annual Dental Visits—Combined Rate
- Children's and Adolescents' Access to PCPs (25 Months–6 Years)
- Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life

Due to the lack of statistically significant improvement for both indicators of the **Amerigroup** *Diabetes Management* PIP, the two indicators used for the *Diabetes Management* PIP are considered opportunities for improvement for the MCO.

Summary of HPN Strengths

The following Medicaid performance measures were identified as strengths for **HPN** based on rate improvements of greater than 5 percentage points over time.

- Childhood Immunization Status—Combinations 4, 6, 7, 8, 9, and 10
- Lead Screening in Children
- Adolescent Well-Child Visits
- Comprehensive Diabetes Care—Monitoring for Nephropathy
- Use of Appropriate Medications for People With Asthma—12–18 Years *and* 19–50 Years
- Follow-up After Hospitalization for Mental Illness—30 Days

All comparable Nevada Check Up rates but one (*Use of Appropriate Medications for People With Asthma—12–18 Years*) were higher than the corresponding Medicaid reported rates. Multiple vaccination combinations of the Nevada Check Up performance measure, *Childhood Immunization Status*, were identified as strengths for **HPN** based on rate improvements greater than 5 percentage points over time.

- Childhood Immunization Status–Combinations 4, 6, 7, 8, 9, and 10

HPN's *Reducing Avoidable Emergency Room Visits* PIP is also considered a strength because the MCO made statistically significant improvements for both indicators and sustained that improvement over time.

Summary of HPN Opportunities for Improvement

The following Medicaid performance measures were identified as opportunities for improvement for **HPN** based on rate declines in performance of at least 5 percentage points over time.

- Annual Dental Visits—Combined Rate
- Prenatal and Postpartum Care—Timeliness of Prenatal Care and Postpartum Care
- Frequency of Ongoing Prenatal Care—<20% Visits and ≥ 81% Visits

The following Nevada Check Up performance measures were identified as opportunities for improvement for **HPN** based on a decline in performance of greater than 5 percentage points over time.

- Childhood Immunization Status—Combo 3
- Lead Screening in Children
- Annual Dental Visits—Combined Rate
- Children's and Adolescents' Access to PCPs (25 Months—6 Years)
- Use of Appropriate Medications for People With Asthma (12–18 Years)

MCO Causal Barrier Presentation

In the quarter following the presentation of EQR results, each MCO is required to present to the DHCFP and the EQRO quality improvement activities underway to capitalize on strengths and to address opportunities for improvement identified through an evaluation of the prior year's performance measure rates. Each MCO is required to describe and present on the following:

- *Types of interventions or QI initiatives used to positively impact measures that yielded the greatest improvement.*
- *QI tools (e.g., root cause analysis, Ishikawa diagram) and techniques used to evaluate measures that have declined.*
- *Identified causes for declines.*
- *Classification of new or existing causes or issues—For reoccurring issues, the MCO must pinpoint and describe new interventions that the MCO will implement to overcome barriers and improve rates.*
- *Evaluation plan the MCO has put in place to evaluate the effectiveness of planned interventions—Without an evaluation plan, the DHCFP holds that the MCO cannot determine whether to modify or discontinue existing interventions or implement new strategies, thereby reducing the likelihood of achieving desired goals and improving performance.*

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

Quality Initiatives and Emerging Practices

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

Another method used by the DHCFP to promote best and emerging practices among the MCOs is to ensure that the State's contractual requirements for the MCOs are at least as stringent as those described in Subpart D of the BBA regulations for access to care, structure and operations, and quality measurement and improvement (42 CFR 438.204[g]). The DHCFP actively promotes the use of nationally recognized protocols, standards of care, and benchmarks by which health plan performance is measured.

MCO-Specific Quality Initiatives

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

Health Plan of Nevada (HPN)

HPN implemented the following strategic quality initiatives.

- **Citibank cards** were issued to incentivize children to receive well-care visits and seek medical attention at the pediatrician's office.
- **Network Core Reports** were issued for providers to identify the member-specific outcomes and whether preventive screenings had occurred for empaneled members.
- **Cribs for Kids** was implemented to deploy cribs, or other equipment needed by new moms, to moms that completed the required number of prenatal and postpartum care visits within the required time frames.
- **HPV Postcards** were administered to members who started the HPV series of shots but had not completed the series. The outreach initiative showed an increase of 5 percentage points in less than one year.
- **Quality Provider Awards** were issued to providers who were recognized as high performers among their peers. The performance measures used as metrics for the program included A1c levels, pediatric immunization compliance, and lowest rate of cesarean section births.
- **Pay for Performance** program was conceptualized and contracts were issued. The program will incentivize high-volume primary care providers' (PCPs') offices to increase HEDIS rates for members empaneled with the PCP.
- **Now Clinic** was approved, which will provide telemedicine services to initiate engagement within the Medicaid population and encourage PCP visits for routine care.
- **Asthma Protocol** was identified, which would allow for the disease management nurse to start a member on corticosteroid on behalf of the provider for better asthma control.
- **Teddy Bear Ticket** program is planned to connect children, who are waiting in urgent care waiting rooms, to pediatricians who have offices in the same building. When a child and family are sitting in the urgent care waiting room, the nurse from the pediatric office greets and walks the family to the pediatric office exam room, where the child is immediately seen by a pediatrician. The effort is meant to connect children to more appropriate care with physicians who specialize in pediatrics.

Amerigroup

Amerigroup implemented the following strategic quality initiatives.

- **Obstetrician (OB) Provider Profiles** were continued, wherein the medical director or a nurse from **Amerigroup** meets with OB providers to discuss cesarean section rates and prenatal and postpartum care visit rates.
- **Postpartum Visit Encounter Submission Incentive Plan** to increase submission of prenatal and postpartum visit encounters to the MCO. **Amerigroup** reported a 4 percentage point increase in postpartum visits.
- **My Advocate Program** continued from the prior year and provided text and verbal messaging to provide proactive and culturally appropriate communication and coaching to pregnant women during their pregnancies.
- **Taking Care of Baby and Me** program provided monetary incentives for first trimester and ongoing prenatal care visits, in addition to automated outreach calls.

- **Member Meet and Greet** was expanded to include weekly mini meets at CVS pharmacies in addition to the meetings held at locations with the top 10 ZIP codes as well as with the highest missed opportunities for health screenings and preventive care. The events were also held at Nevada Health Centers and Walnut community centers.
- **Transition Care** program was implemented as part of a population management program to reduce emergency department use and hospital readmissions within 30 days. For approximately 30 days after a member is discharged from the hospital, the team of nonclinical coordinators serve as surrogate family members to individuals who were hospitalized and assist the member with obtaining medications, setting appointments for follow-up care, coordinating transportation, and coordinating housing to promote stabilization for the member after discharge from the hospital.
- **Provider Group 1:1** with **Amerigroup** medical director to talk about missed opportunities and ways to increase performance measure rates.
- **Dedicated Data Analyst** who is dedicated to the quality management department and is responsible for quality-related reporting.

Collaborative Quality Initiatives—DHCFP and MCOs

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

Reducing Avoidable Emergency Room (ER) Visits Work Group

Over the last four years, the DHCFP and MCOs have worked to examine avoidable ER usage and the frequency at which some members accessed ERs. Upon analyzing data to determine where health care spending could reasonably be reduced and use of preventive services could be increased, the DHCFP discovered that nearly 25 percent of all ER visits in managed care had been nonemergent, using the New York University (NYU) algorithm for classifying ER claims into categories based on primary diagnosis. As part of the collaborative PIP activities, HSAG facilitated work group discussions aimed at analyzing data and identifying the reasons Medicaid recipients frequented the ER inappropriately. At the direction of HSAG and the DHCFP, the MCOs examined ER use patterns and discovered that a number of members inappropriately used the ER for primary care instead of establishing a relationship and "medical home" with a PCP. An analysis of diagnoses showed that many of the ER visits were nonemergent or emergent but treatable by a PCP. The Reducing Avoidable ER Visits Work Group was formed and continued to meet regularly to develop interventions to reduce inappropriate and/or avoidable ER utilization. To identify the individuals who would likely benefit from targeted care manager interventions (or re-education on establishing a relationship with a PCP), the DHCFP tasked the MCOs with identifying the number of individuals who visited the ER at least three or

more times in a three-month period during the last calendar quarter of 2010. The MCOs were required to stratify these data by gender, age, race/ethnicity, time of day, county, and diagnostic category to determine which populations could benefit from more targeted interventions.

After stratifying individuals who frequented the ER, the MCOs hosted focus groups with members who were frequent users. During the focus groups, the MCOs learned that members were not aware of the difference between urgent and emergent care and many did not know that the MCOs offered 24-hour nurse triage telephone lines that could answer members' health-related questions after 5 p.m. The MCO's staff also made telephone inquiries to members who returned to the ER within seven to 10 days of an initial visit. Many members reported that the ER staff informed members to return to the ER for follow-up care, such as removing sutures, obtaining medications, or removing casts.

The MCOs conducted further risk-stratification analyses on frequent ER users to determine needs for complex care management or disease management. Members who fit the criteria for complex care or disease management were enrolled in disease or care management programs. The MCOs also initiated educational campaigns to new and existing members. New and existing members received educational telephone calls from the MCO's staff, who explained the appropriate uses of the ER and when to contact the 24-hour nurse advice line.

FY 2015 was the third remeasurement year for the *Avoidable Emergency Room Visit* PIP. **HPN** reported significant improvements in avoidable ER visits for both the Medicaid and Nevada Check Up populations compared to the baseline measurement. **Amerigroup** also reported significant improvements.

Medicaid Expansion Quality Tracking

In January 2014, the DHCFP expanded Medicaid coverage to persons with incomes up to 138 percent of the federal poverty level, which was allowed under the Affordable Care Act. The number of persons who enrolled in Medicaid as a result of the expansion greatly exceeded the DHCFP's original expectations. The majority of newly eligible persons reside in the managed care catchment areas; therefore, both MCOs have experienced significant increases in enrollment since January 2014. The MCOs report that many of the newly eligible persons who have chronic conditions, such as kidney disease, heart failure, and diabetes, have not properly managed their illness. To obtain a more accurate representation of the HEDIS rates for the Medicaid expansion population and its impact on HEDIS rates, the DHCFP has asked the MCOs to report 2015 Medicaid HEDIS rates for the following populations: (1) With Medicaid Expansion Population Included, and (2) Without Medicaid Expansion Included. This has enabled the MCOs to produce rates that are comparable to the previous year (i.e., without Medicaid expansion) and also to establish a baseline from which future comparisons can be made for the With Medicaid Expansion Population Included group.

Encounter Data Validation (EDV) Study

High-quality encounter data from Nevada MCOs are necessary to evaluate and improve quality of care, assess utilization, develop appropriate capitation rates, and establish acceptable rates of performance. To identify the opportunities for improvement that exist with MCO encounter data, the DHCFP contracted with Meyers and Stauffer to conduct an EDV study of MCO encounter data. The purpose of the study is to determine the accuracy and completeness of MCO encounter data compared to the data included in the DHCFP's data warehouse. The period under review is calendar year 2013. The results from the EDV study will enable the DHCFP and the MCOs to identify inconsistencies between the two sets of data—individual MCO data and the DHCFP's data—and determine what system improvements must be made to improve encounter data quality.

Nationwide CAHPS Survey

In the summer of 2014, the DHCFP began working with its subcontractor and CMS in support of the nationwide survey of access to care and experiences of care among adult Medicaid enrollees. The survey was conducted in the fall of 2014. Once they are released, the DHCFP will use the results from the CMS nationwide survey to determine the types of quality improvement activities that should be incorporated into the quality program.

MCO Annual Quality Improvement Evaluation

The MCOs are required to submit an annual evaluation of the quality improvement program and activities employed by the MCO for the previous year. The MCOs' annual evaluations include trends and statistical information that describe and depict the performance for each quality activity and associated indicators developed by the MCO. Annual evaluations also include an analysis and evaluation of clinical and related service areas requiring improvement for each of the quality measures that pertain to the population. The DHCFP requires the MCOs to provide an evaluation of each of the Nevada Medicaid and Nevada Check Up quality measures. As part of this effort, the MCOs are required to stratify performance measure rates by race and ethnicity. After stratifying the data, the MCOs are required to identify any health care disparities among the groups and develop a plan targeting interventions to reduce and/or eliminate disparities for members and increase performance measure rates overall. During the SFY 2014–2015 compliance review, HSAG verified that both MCOs stratified data according to the parameters set by the DHCFP and have deployed interventions to further reduce or eliminate health disparities while improving rates for each of the performance measures.

Disparities in Health Care

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

The MCOs, in cooperation with the DHCFP, are required to develop and implement cultural CCPs that encourage delivery of services in a culturally competent way to all recipients, including those with limited English proficiency and diverse cultural and ethnic backgrounds. The MCOs are also required to ensure that appropriate foreign language versions of all member materials are developed and available to members, and to provide interpreter services for members whose primary language is not English. The DHCFP reviews and approves all member materials as part of a readiness review for all new MCOs entering the Nevada Medicaid managed care program. During SFY 2014–2015 HSAG conducted a comprehensive review of each MCO's cultural competency program. Both MCOs provided evidence that each met the cultural competency objectives identified in this Quality Strategy and developed a plan for the following year's cultural competency activities.

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

As part of the collaborative effort by the DHCFP and MCOs to reduce disparities in health care and improve access to care for Native Americans, the DHCFP hosted a meeting at the beginning of SFY 2014–2015, wherein a member of the Reno Sparks Tribal Health Center presented information about the barriers that exist for Native Americans in accessing services coordinated by the MCOs. The DHCFP, MCOs, and the tribal health center committed to having ongoing discussions about how to build awareness and reduce barriers to care for Native Americans and improve collaboration between Nevada Medicaid and tribal health care services.

Nevada Medicaid Collaborative Quality Initiatives

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

State Innovations Model

CMS approved Nevada's State Innovation Model (SIM) Round Two application to improve population health in Nevada. The State was awarded $2 million to design SIM. The grant period began February 1, 2015, and runs for 12 months. The grant provides financial and

technical support to DHCFP for the design of multipayer health care payment and service delivery models that will accomplish the CMS Triple Aim.

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

Balancing Incentive Payments Program

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

Money Follows the Person (MFP)

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

- Rebalance and redesign the states' long term care systems.
- Effectively transition individuals from qualified institutional settings to qualified residences in communities.
- Accomplish six benchmarks.
  1. Transition a total of 524 individuals.
  2. Increase state Medicaid expenditures for Home and Community-Based Services during each year of the demonstration.

3. Rebalance Nevada's method of nursing home financing.
4. Increase participation in self-directed option (individuals control their own services and supports).
5. Integrate into a single, statewide case management system that supports MFP requirements and quality of care.
6. Consolidate quality assurance efforts to ensure high-quality service delivery in an efficient and effective manner.

Nevada has already accomplished the following:

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

Medicaid Incentives for Prevention of Chronic Diseases (MIPCD)

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

1. Nesting incentives in the diabetes disease management programs conducted by Nevada's Medicaid MCOs. MCO enrollees with diabetes will be incentivized to receive evidence-based preventive health services known to be effective in improved management of diabetes and covered under the Nevada Medicaid state plan.
2. Linking approximately 600 adults diagnosed with diabetes and 540 adults at risk of developing type 2 Diabetes enrolled in fee for service Medicaid with evidence-based programs through the Lied Clinic Outpatient Facility at University Medical Center of Southern Nevada, the Southern Nevada Health District, or the YMCA of Southern Nevada.
3. Providing support and facilitation of critical behavioral change and risk reduction for 950 children at risk of heart disease in fee for service Medicaid. The support and services are provided through a multidisciplinary evidenced-based program conducted by Nevada's largest pediatric cardiology practice, and a nationally recognized program based on research funded by the National Institute of Health and the Centers for Disease

Control. All program participants will receive incentives to demonstrate positive changes and associated health outcomes over time.

The MIPCD participants have gone through the programs, achieved goals, earned points, and redeemed incentives. The Grants Management Unit at DHCFP is in the process of drafting closeout procedures for the grant and summarizing the results of the grant activities, which will be included in the SFY 2015–2016 EQR Technical Report.

Data Collection: Challenges and Opportunities

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

- Ensuring that accurate and complete encounter data are recorded in the State's Medicaid Management Information System (MMIS). Nevada's MMIS is the second oldest MMIS in the nation, making it an antiquated system that leaves little flexibility for robust reporting and enhancements. Due to multiple challenges with file formats and coding between the fiscal intermediary and the MCOs, the DHCFP has been unable to validate the volume of encounters reported by the MCOs.
  - **Opportunity:** The DHCFP contracted with a vendor to conduct an encounter data validation activity to better understand the accuracy and completeness of the State's encounter data system compared to the information contained in the MCOs' claims system. The DHCFP is considering various quality improvement initiatives to improve the accuracy and completeness of the DHCFP's encounter data system.
- The Department of Health and Human Services is completing an evaluation of alternative service delivery models which aim to achieve better care for patients, better health for our communities, and lower costs through improvement in the health care system.
  - **Opportunity:** The DHCFP is evaluating different service delivery options for its Medicaid program. One option under consideration is the expansion of the managed care program, which could include expanding Statewide—including additional services not currently covered by managed care, expanding the population served by managed care, or increasing the number of managed care plans participating in the program.
  - **Opportunity:** The state of Nevada was awarded a multi-million dollar State Innovation Model (SIM) design grant from the Center for Medicare and Medicaid Innovation (CMMI) in December 2014 to implement a statewide, multi-player State Health System Innovation Plan (SHSIP) to reward health care providers for quality instead of quantity of services by instituting value-based purchasing models across public and private payers. The Multi-Player Collaborative (MPC) collectively brings 700,000 Nevadans, or approximately 25 percent of the State's population, to the initiative.

Challenges to Improving Care and Opportunities to Overcome those Challenges

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

- The MCOs report many challenges related to lack of member understanding of appropriate care and appropriate settings for care. MCOs also report lack of provider understanding of proper methods for documenting services and coding of claims for HEDIS reporting as well as inappropriate referrals of services. Both MCOs have outreached to members to inquire why some seek primary care services in emergency departments rather than urgent care or primary care provider offices. In a focus group discussion, members reported not realizing a difference between emergency room and urgent care centers—except that emergency departments are open and accessible 24 hours per day, 7 days per week. Further, members reported that after seeking care at an emergency room for a bone fracture or sutures, they were counseled by emergency room staff to return to the emergency room for cast or suture removal.
  - **Opportunity:** The MCOs will continue to engage in educational campaigns for both members and providers. The MCOs will continue to meet with providers in their offices to discuss proper charting and coding of services and outreach to members to advise members to seek services in primary care provider (PCP) offices or urgent care centers. Further, the MCOs have requested to work with the DHCFP staff to meet with the hospital association to discuss non-emergent care sought by Medicaid members in the emergency room.
- Additional challenges faced by the State of Nevada also result from some of the highest State revenue-generating entities—casinos. Nevada's casino industry encourages unhealthy behavior in certain casinos by advertising free alcohol and cigarettes to individuals while they gamble. While the advertising campaigns encourage unhealthy behavior, the MCOs and the DHCFP are not able to discourage the use of these advertising campaigns.
  - **Opportunity:** The expansion of Medicaid eligibility to cover more persons provided Nevada with the unique opportunity to provide Medicaid coverage to persons who previously did not have health care coverage and thus did not have the same access to preventive services and health education materials and tools that Medicaid members do. Since Medicaid expansion, MCOs continue to educate the expansion population on healthy behaviors, including offering preventive care services and providing care management to members with chronic health conditions.
- According to the Federal Register, 42 CFR Parts 412 and 413, section 412.64, entitled "Frontier States," Nevada is a frontier state. This means that access to physicians is limited in rural areas. "Frontier state" is a state wherein at least 50 percent of counties contain less than six people per square mile. The low density of the populations within Nevada counties makes it difficult to locate providers in close proximity to members and encourages members to travel a distance for medical care. Further, Nevada is experiencing a shortage of health professionals. According to the 2013 Elders Count Nevada,[7-1] the following shortages remain:
- Active physicians—Although from 2000 to 2010 the number of new students enrolled in Nevada medical schools grew by 273.7 percent (nationally enrollment

[7-1] Broadus, A.D., Sacks, T.M., & Fadali, E.R. (2013). Elders Count Nevada. University of Nevada, Reno: Sanford Center for Aging. Available at: http://www.medicine.nevada.edu/healthsciences/EldersCount2013.pdf. Accessed on: November 27, 2013.

grew by 22.9 percent), Nevada ranks 45th in the nation for number of active physicians per 100,000 in population.

- Registered nurses—Nevada is last in the nation in number of registered nurses (RNs), with 605 nurses per 100,000 in population as compared to 874 per 100,000 nationally. Nevada also moved to last in the nation in number of nurse practitioners, 44th for dentists, and 39th for physician assistants.
  - **Opportunity:** Governor Sandoval signed a bill in June 2015 authorizing $27 million for the University of Nevada School of Medicine, Las Vegas in an effort to combat physician shortages in the State. The funding will enable Nevada to bring a medical school to southern Nevada, benefitting the surrounding communities. The school plans to launch fall 2017 with 60 students, with the option to expand to as many as 180 students in the future.

Attachment A. 2016–2017 Activities Timeline

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

EQRO Quality Monitoring Activity	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
HEDIS Audit												
Annual HEDIS Schedule, Site Visit, Audit, and Reports	←	—	—	—	—	—	—	—	—	→		
PIP Validation												
Annual PIP Schedule, Validation, and Reports					←	—	—	—	—	—	—	→
Monitoring and Evaluation of MCO Contractual Compliance												
EQR Monitoring of MCO Contract Compliance	Triennially											
Monitoring Access and Availability of Providers												
Provider Network Access and Availability Study	As needed											

Nevada 2016–2017 Quality Strategy
Goals and Objectives for Medicaid

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

Goal 1:	Improve the health and wellness of Nevada's Medicaid and Check Up population by increasing the use of preventive services.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 1.1a:	Increase children's and adolescents' access to PCPs (12–24 months).						
Objective 1.1b:	Increase children's and adolescents' access to PCPs (26 months–6 years).						
Objective 1.1c:	Increase children's and adolescents' access to PCPs (7–11 years).						
Objective 1.1d:	Increase children's and adolescents' access to PCPs (12–19 years).						
Objective 1.2:	Increase well-child visits (0–15 months).						
Objective 1.3:	Increase well-child visits (3–6 years).						
Objective 1.4a:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (BMI percentile).						
Objective 1.4b:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (counseling for nutrition).						
Objective 1.4c:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (counseling for physical activity).						
Objective 1.5:	Increase immunizations for adolescents.						
Objective 1.6:	Increase annual dental visits for children.						
Objective 1.7:	Increase human papillomavirus vaccine for female adolescents.						
Objective 1.8:	Increase adolescent well-care visits.						
Objective 1.9:	Increase childhood immunization status (all combos, 2–10).						

Goal 2:	Increase use of evidence-based practices for members with chronic conditions.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 2.1:	Increase rate of HbA1c testing for members with diabetes.						
Objective 2.2:	Decrease rate of HbA1c poor control (>9.0%) for members with diabetes.**						
Objective 2.3:	Increase rate of HbA1c good control (<8.0%) for members with diabetes.						
Objective 2.4:	Increase rate of eye exams performed for members with diabetes.						
Objective 2.5:	Increase medical attention for nephropathy for members with diabetes.						
Objective 2.6:	Increase blood pressure control (<140/90 mm Hg) for members with diabetes.						
Objective 2.7a:	Increase medication management for people with asthma—medication compliance 50 percent.						
Objective 2.7b:	Increase medication management for people with asthma—medication compliance 75 percent.						
Goal 3:	**Reduce and/or eliminate health care disparities for Medicaid and Nevada Check Up recipients.**						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 3.1:	Ensure that health plans maintain, submit for review, and annually revise cultural competency plans.						
Objective 3.2:	Stratify data for performance measures and avoidable emergency room utilization by race and ethnicity to determine where disparities exist. Continually identify, organize, and target interventions to reduce disparities and improve access to appropriate services for the Medicaid and Nevada Check Up population.						
Objective 3.3:	Ensure that each MCO submits an annual evaluation of their 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 4:	Improve the health and wellness of new mothers and infants and increase new-mother education about family planning and newborn health and wellness.						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 4.1:	Increase the rate of postpartum visits.						
Objective 4.2:	Increase timeliness of prenatal care.						
Objective 4.3:	Increase frequency of prenatal care visits (≥ 81 percent of visits).						
Objective 4.4:	Increase frequency of prenatal care visits (<21 percent of visits).**						
Goal 5:	**Increase use of evidence-based practices for members with behavioral health conditions.**						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 5.1a:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication—initiation phase.						
Objective 5.1b:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication—continuation and maintenance phase.						
Objective 5.2:	Reduce use of multiple concurrent antipsychotics in children and adolescents.**						
Objective 5.3:	Reduce behavioral health-related hospital readmissions within 30 days of discharge. (One of MCOs' PIPs. Improvement TBD by MCO PIP goals.)						
Objective 5.4:	Increase follow-up after hospitalization for mental illness within 7 days of discharge.						
Objective 5.5:	Increase follow-up after hospitalization for mental illness within 30 days of discharge.						
Goal 6:	**Increase reporting of CMS quality measures**						
		AGP 2016	QISMC Goal	AGP 2017	HPN 2016	QISMC Goal	HPN 2017
Objective 6.1:	Increase number of CMS adult core measures reported to MACPro.						
Objective 6.2:	Increase number of CMS child core measures reported to MACPro.						

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

Nevada 2016–2017 Quality Strategy
Goals and Objectives for Nevada Check Up

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

Goal 1:	Improve the health and wellness of Nevada's Medicaid and Check Up population by increasing the use of preventive services.						
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For more information on the Nevada Comprehensive Care Waiver Quality Strategy, see the following Web site: http://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/NV2014-15_NCCW_Quality_Strategy_F1.pdf.

Nevada DHCFP Quality Strategy
Crosswalk to CMS Toolkit

The following table lists the required and recommended elements for State Quality Strategies, per 42 C.F.R. § 438.202(a) and corresponding sections in the DHCFP Quality Strategy and the DHCFP/MCO contract which address each required and recommended element.

SECTION I: INTRODUCTION

Regulatory Reference	Description	Corresponding Document and Page Reference or Comment
	Include a brief history of the state's Medicaid and CHIP managed care programs.	NV Quality Strategy—pgs. 1-1, 1-2
	Include an overview of the quality management structure that is in place at the state level. For example, how is the leadership team structured, are there any quality task forces, an MCO collaborative, Etc.?	NV Quality Strategy—pg. 1-8
	Include general information about the state's decision to contract with MCOs/PIHPs (e.g., to address issues of cost, quality, and/or access). Include the reasons why the state believes the use of a managed care system will positively impact the quality of care delivered in Medicaid and CHIP.	NV Quality Strategy—pg. 1-1
	Include a description of the goals and objectives of the state's managed care program. This description should include priorities, strategic partnerships, and quantifiable performance driven objectives. These objectives should reflect the state's priorities and areas of concern for the population covered by the MCO/PIHP contracts. For example, "the state will demonstrate a 10 percent improvement in childhood immunization rates over the next three years" or "through expansion of the primary care network, as evidenced by geographical reporting, the state will demonstrate a 5 percent improvement in enrollee access to primary care".	NV Quality Strategy—pgs. 1-10–14, B-2, B-3
	Include a description of the formal process used to develop the quality strategy.	NV Quality Strategy—pgs. 1-6–9

Regulatory Reference	Description	Corresponding Document and Page Reference or Comment
§438.202(b)	Include a description of how the state obtained the input of beneficiaries and other stakeholders in the development of the quality strategy.	NV Quality Strategy—pgs. 1-7, 1-8, 4-2; Contract Section 1.4.9
§438.202(b)	Include a description of how the state made (or plans to make) the quality strategy available for public comment before adopting it in final.	NV Quality Strategy—pgs. 1-7; 1-8, 4-2; Contract Section 1.4.9
§438.202(d)	Include a timeline for assessing the effectiveness of the quality strategy (e.g., monthly, quarterly, annually).	NV Quality Strategy—pgs. 1-7, 4-1, 4-2, 5-2, A-1
§438.202(d)	Include a timeline for modifying or updating the quality strategy. If this is based on an assessment of "significant changes", include the state's definition of "significant changes".	NV Quality Strategy—pgs. 1-8, 1-9, 4-1, 4-2, 5-2

SECTION II: ASSESSMENT
Quality and Appropriateness of Care

Regulatory Reference	Description	Corresponding Document and Page Reference or Comment
§438.204(b)(1)	Address procedures that assess the quality and appropriateness of care and services furnished to all Medicaid enrollees under the MCO and PIHP contracts, and to individuals with special health care needs.	NV Quality Strategy—pgs. 1-9, 1-10, 1-11, 1-12, 2-2, 2-3; Contract Sections 4.8.6, 4.8.6.5
§438.204(b)(1)	Include the state's definition of special health care needs.	NV Quality Strategy—pg. 2-2; Contract pg. 17
§438.204(b)(2)	Detail the methods or procedures the state uses to identify the race, ethnicity, and primary language spoken of each Medicaid enrollee. States must provide this information to the MCO and PIHP for each Medicaid enrollee at the time of enrollment.	NV Quality Strategy—pgs. 1-11, 2-1, 2-2; Contract Sections 4.2.1.16, 4.8.6.5.D, 4.8.18.5, 4.9.2.2
	Document any efforts or initiatives that the state or MCO/PIHP has engaged in to reduce disparities in health care.	NV Quality Strategy—pgs. 1-12, 1-13, 2-1, 2-2, 3-2, 5-1, 5-2, 6-5, 6-6; Contract Sections 4.8.6.5.D, 4.8.18.5, 4.9.2.2

National Performance Measures

Regulatory Reference	Description	Corresponding Document and Page Reference or Comment
§438.204(c)	Include a description of any required national performance measures and levels identified and developed by CMS.	NV Quality Strategy—pgs. 2-7, 2-8
	Indicate whether the state plans to voluntarily collect any of the CMS core performance measures for children and adults in Medicaid/CHIP. If so, identify state targets/goals for any of the core measures selected by the state for voluntary reporting.	NV Quality Strategy—pgs. 1-13, 2-7, 2-8

Monitoring and Compliance

Regulatory Reference	Description	Corresponding Document and Page Reference or Comment
§438.204(b)(3)	Detail procedures that account for the regular monitoring and evaluation of MCO and PIHP compliance with the standards of subpart D (access, structure and operations, and measurement and improvement standards). Some examples of mechanisms that may be used for monitoring include, but are not limited to: ◆ Member or provider surveys; ◆ HEDIS® results; ◆ Report Cards or profiles; ◆ Required MCO/PIHP reporting of performance measures; ◆ Required MCO/PIHP reporting on performance improvement projects; ◆ Grievance/Appeal logs, etc.	NV Quality Strategy—pgs. 1-16, 1-17, 2-4 thru 2-10; Contract Section 4.5.5, 4.8, 4.8.1, 4.8.6, 4.8.21, 4.9.2.3

External Quality Review (EQR)

Regulatory Reference	Description	Corresponding Document and Page Reference or Comment
§438.204(d)	Include a description of the state's arrangements for an annual, external independent quality review of the quality, access, and timeliness of the services covered under each MCO and PIHP contract. Identify what entity will perform the EQR and for what period of time.	NV Quality Strategy—pgs. 1-1, 1-2, 1-6, 2-4, 2-5, 2-9, 2-10; Contract Section 4.16.1
	Identify what, if any, optional EQR activities the state has contracted with its External Quality Review Organization (EQRO) to perform. The five optional activities include: 1. Validation of encounter data reported by an MCO or PIHP; 2. Administration or validation of consumer or provider surveys of quality of care; 3. Calculation of performance measures in addition to those reported by an MCO or PIHP and validated by an EQRO; 4. Conduct of performance improvement projects (PIPs) in addition to those conducted by an MCO or PIHP and validated by an EQRO; and 5. Conduct of studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time.	NV Quality Strategy—pgs. 1-1, 1-2, 2-4, 2-5, 2-6
§438.360(b)(4)	Identify the standards for which the EQR will use information from Medicare or private accreditation reviews. This must include an explanation of the rationale for why the standards are duplicative.	N/A: NV does not use results from Medicare or private accreditation reviews to determine EQR compliance.

SECTION III: STATE STANDARDS
Access Standards

Regulatory Reference	Description	Corresponding Document and Page Reference or Comment
§438.206	**Availability of Services**	
§438.206(b)(1)	Maintains and monitors a network of appropriate providers	NV Quality Strategy—pgs. 2-5, 2-6, 2-7, 2-8, 2-9; Contract Sections 4.2.1.7, 4.14.8
§438.206(b)(2)	Female enrollee direct access to a women's health specialist	NV Quality Strategy—pgs. 2-6, 2-7, 2-8, 2-9; Contract Section 4.2.1.9
§438.206(b)(3)	Provides for a second opinion from a qualified health care professional	NV Quality Strategy—pg. 2-6; Contract Section 4.2.1.11 and 4.2.1.12
§438.206(b)(4)	Adequately and timely coverage of services not available in network	NV Quality Strategy—pgs. 2-6, 2-7, 2-8, 2-9; Contract Section 4.2.1.10.A
§438.206(b)(5)	Out-of-network providers coordinate with the MCO or PIHP with respect to payment	NV Quality Strategy—pgs. 2-6, 2-7, 2-8, 2-9; Contract Sections 4.2.1.10, 4.2.1.12, 4.2.10.12.1
§438.206(b)(6)	Credential all providers as required by §438.214	NV Quality Strategy—pgs. 2-6, 2-7, 2-8, 2-9; 2-7 Contract Sections 4.5.10, 4.8.13
§438.206(c)(1)(i)	Providers meet state standards for timely access to care and services	NV Quality Strategy—pgs. 2-5, 2-7, 2-8, 2-9, 2-6; Contract Sections 4.2.1.14, 4.2.1.15, 4.5.2.3
§438.206(c)(1)(ii)	Network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service	NV Quality Strategy—pgs. 2-6, 2-7, 2-8, 2-9; Contract Sections 4.2.1.14, 4.5.2.4

Regulatory Reference	Description	Corresponding Document and Page Reference or Comment
§438.206(c)(1)(iii)	Services included in the contract available 24 hours a day, 7 days a week	NV Quality Strategy—pgs. 2-6, 2-7, 2-8, 2-9; Contract Sections 4.2.1.14, 4.2.1.15, 4.4.2.6, 4.5.2.5
§438.206(c)(1)(iv)-(vi)	Mechanisms to ensure compliance by providers	NV Quality Strategy—pgs. 2-6, 2-7, 2-8, 2-9; Contract Sections 4.2.1.14, 4.5.2.6, 4.5.5.2, 4.5.5.8
§438.206(c)(2)	Culturally competent services to all enrollees	NV Quality Strategy—pgs. 1-8, 1-9, 1-11, 2-1, 2-6, 2-7, 2-8, 2-9, 3-2, 5-1; A-1, B-3; Contract Sections 4.2.1.16, 4.5.2.9, 4.9.2.2
§ 438.207	**Assurances of Adequate Capacity and Services**	
§438.207(a)	Assurances and documentation of capacity to serve expected enrollment	NV Quality Strategy—pgs. 2-6, 2-7, 2-8, 2-9; Contract Sections 4.2.1.7, 4.5
§438.207(b)(1)	Offer an appropriate range of preventive, primary care, and specialty services	NV Quality Strategy—pgs. 2-6, 2-7, 2-8, 2-9; Contract Sections 4.2.1.7, 4.5
§438.207(b)(2)	Maintain network sufficient in number, mix, and geographic distribution	NV Quality Strategy—pgs. 2-6, 2-7, 2-8, 2-9, A-1; Contract Sections 4.2.1.7, 4.5
§ 438.208	**Coordination and Continuity of Care**	
§438.208(b)(1)	Each enrollee has an ongoing source of primary care appropriate to his or her needs	NV Quality Strategy—pgs. 2-6, 2-7, 2-8, 2-9, 5-2; Contract Section 4.4.3.1
§438.208(b)(2)	All services that the enrollee receives are coordinated with the services the enrollee receives from any other MCO/PIHP	NV Quality Strategy—pgs. 2-3, 2-6, 2-7, 2-8, 2-9, 5-2; Contract Section 4.2.12

Regulatory Reference	Description	Corresponding Document and Page Reference or Comment
§438.208(b)(3)	Share with other MCOs, PIHPs, and PAHPs serving the enrollee with special health care needs the results of its identification and assessment to prevent duplication of services	NV Quality Strategy—pgs. 2-6, 2-7, 2-8, 2-9; Contract Section 4.2.8, 4.2.12
§438.208(b)(4)	Protect enrollee privacy when coordinating care	NV Quality Strategy—pgs. 2-6, 2-7, 2-8, 2-9; Contract Section 4.2.12
§438.208(c)(1)	State mechanisms to identify persons with special health care needs	NV Quality Strategy—pgs. 2-2, 2-3, 2-6, 2-7, 2-8, 2-9
§438.208(c)(2)	Mechanisms to assess enrollees with special health care needs by appropriate health care professionals	NV Quality Strategy—pgs. 2-2, 2-3, 2-6, 2-7, 2-8, 2-9; Contract Section 4.2.8
§438.208(c)(3)	If applicable, treatment plans developed by the enrollee's primary care provider with enrollee participation, and in consultation with any specialists caring for the enrollee; approved in a timely manner; and in accord with state standards	NV Quality Strategy—pgs. 2-3, 2-6, 2-7, 2-8, 2-9; Contract Sections 4.2.8, 4.2.8.1, 4.2.8.2, 4.2.8.3
§438.208(c)(4)	Direct access to specialists for enrollees with special health care needs	NV Quality Strategy—pgs. 2-3, 2-6, 2-7, 2-8, 2-9; Contract Section 4.2.8.3
§ 438.210	**Coverage and Authorization of Services**	
§438.210(a)(1)	Identify, define, and specify the amount, duration, and scope of each service	NV Quality Strategy—pgs. 2-3, 2-6, 2-7, 2-8, 2-9; Contract Section 4.4.1.1.J
§438.210(a)(2)	Services are furnished in an amount, duration, and scope that is no less than the those furnished to beneficiaries under fee-for-service Medicaid	NV Quality Strategy—pgs. 2-6, 2-7, 2-8, 2-9; Contract Section 4.2.1
§438.210(a)(3)(i)	Services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished	NV Quality Strategy—pgs. 2-6, 2-7, 2-8, 2-9; Contract Section 4.2.1.1

Regulatory Reference	Description	Corresponding Document and Page Reference or Comment
§438.210(a)(3)(ii)	No arbitrary denial or reduction in service solely because of diagnosis, type of illness, or condition	NV Quality Strategy—pgs. 2-6, 2-7, 2-8, 2-9; Contract Section 4.2.1.2
§438.210(a)(3)(iii)	Each MCO/PIHP may place appropriate limits on a service, such as medical necessity	NV Quality Strategy—pgs. 2-6, 2-7, 2-8, 2-9; Contract Section 4.2.1.3
§438.210(a)(4)	Specify what constitutes "medically necessary services"	NV Quality Strategy—pgs. 2-6, 2-7, 2-8, 2-9 Contract Section 4.2.1.4
§438.210(b)(1)	Each MCO/PIHP and its subcontractors must have written policies and procedures for authorization of services	NV Quality Strategy—pgs. 2-6, 2-7, 2-8, 2-9; Contract Section 4.5.8.1.J; 4.8.17.3.D
§438.210(b)(2)	Each MCO/PIHP must have mechanisms to ensure consistent application of review criteria for authorization decisions	NV Quality Strategy—pgs. 2-6, 2-7, 2-8, 2-9; Contract Section 4.2.1.6, 4.5.2.2
§438.210(b)(3)	Any decision to deny or reduce services is made by an appropriate health care professional	NV Quality Strategy—pgs. 2-6, 2-7, 2-8, 2-9; Contract Section 4.2.1.6
§438.210(c)	Each MCO/PIHP must notify the requesting provider, and give the enrollee written notice of any decision to deny or reduce a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested	NV Quality Strategy—pgs. 2-6, 2-7, 2-8, 2-9; Contract Sections 4.11.3
§438.210(d)	Provide for the authorization decisions and notices as set forth in §438.210(d)	NV Quality Strategy—pgs. 2-6, 2-7, 2-8, 2-9; Contract Section 4.11.2, 4.11.3
§438.210(e)	Compensation does not provide incentives to deny, limit, or discontinue medically necessary services	NV Quality Strategy—pgs. 2-6, 2-7, 2-8, 2-9; Contract Section 4.5.4.7

Structure and Operations Standards

Regulatory Reference	Description	Corresponding Document and Page Reference or Comment
§438.206	**Provider Selection**	
§438.214(a)	Written policies and procedures for selection and retention of providers	NV Quality Strategy—pg. 2-7; Contract Sections 4.5.10, 4.8.13
§438.214(b)(1)	Uniform credentialing and recredentialing policy that each MCO/PIHP must follow	NV Quality Strategy—pgs. 2-7, 2-9; Contract Sections 4.5.10, 4.8.13
§438.214(b)(2)	Documented processes for credentialing and recredentialing that each MCO/PIHP must follow	NV Quality Strategy—pgs. 2-7, 2-9; Contract Sections 4.5.10, 4.8.13
§438.214(c)	Provider selection policies and procedures do not discriminate against providers serving high-risk populations or specialize in conditions that require costly treatment	Contract Section 4.5.2.9
§438.214(d)	MCOs/PIHPs may not employ or contract with providers excluded from Federal health care programs	NV Quality Strategy—pg. 2-7; Contract Section 4.5.10
§438.214(e)	Comply with any additional requirements established by the state	Contract Section 4.5
§438.218	**Enrollee Information**	
§438.218	Incorporate requirements of §438.10	
§438.224	**Confidentiality**	
§438.224	Individually identifiable health information is disclosed in accordance with Federal privacy requirements	NV Quality Strategy—pg. 2-7; Contract Sections 4.2.12, 4.3.10.3, 4.12.2, 4.15.4, 4.15.5
§438.226	**Enrollment and Disenrollment**	
§438.226	Each MCO/PIHP contract complies with the enrollment and disenrollment requirements and limitations set forth in §438.56	NV Quality Strategy—pgs. 2-7, 2-7, A-1; Contract Sections 4.3, 4.3.5, 4.3.5.1, 4.3.5.2, 4.3.5.3, 4.3.5.4, 4.3.6

Regulatory Reference	Description	Corresponding Document and Page Reference or Comment
§438.228	**Grievance Systems**	
§438.228(a)	Grievance systems meet the requirements of Part 438, subpart F	NV Quality Strategy—pgs. 1-10, 2-6, 2-7, 2-9, 4-1, A-1; Contract Section 4.8.14.5
§438.228(b)	If applicable, random state reviews of notice of action delegation to ensure notification of enrollees in a timely manner	N/A
§438.228	**Subcontractual Relationships and Delegation**	
§438.228(a)	Each MCO/PIHP must oversee and be accountable for any delegated functions and responsibilities	NV Quality Strategy—pgs. 2-6, 2-7, 2-8, 2-9; Contract Section 4.13.3.2
§438.228(b)(1)	Before any delegation, each MCO/PIHP must evaluate prospective subcontractor's ability to perform	NV Quality Strategy—pgs. 2-6, 2-7, 2-8, 2-9; Contract Section 4.13.3.2
§438.228(b)(2)	Written agreement that specifies the activities and report responsibilities delegated to the subcontractor; and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.	NV Quality Strategy—pgs. 2-6, 2-7, 2-8, 2-9; Contract Section 4.13.3.7
§438.228(b)(3)	Monitoring of subcontractor performance on an ongoing basis	NV Quality Strategy—pgs. 2-6, 2-7, 2-8, 2-9; Contract Section 4.13.3.8
§438.228(b)(4)	Corrective action for identified deficiencies or areas for improvement	NV Quality Strategy—pgs. 2-6, 2-7, 2-8, 2-9; Contract Section 4.13.3.8

Measurement and Improvement Standards

Regulatory Reference	Description	Corresponding Document and Page Reference or Comment
§ 438.236	**Practice Guidelines**	
§438.236(b)	Practice guidelines are: 1) based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field; 2) consider the needs of enrollees; 3) are adopted in consultation with contracting health care professionals; and 4) are reviewed and updated periodically, as appropriate.	NV Quality Strategy—pg. 2-7; Contract Sections 4.5.1, 4.5.1.1, 4.5.1.2, 4.5.1.3, 4.5.1.4
§438.236(c)	Dissemination of practice guidelines to all providers, and upon request, to enrollees	NV Quality Strategy—pg. 2-7; Contract Sections 4.5.2.1
§ 438.240	**Quality Assessment and Performance Improvement Program**	
§438.240(a)	Each MCO and PIHP must have an ongoing quality assessment and performance improvement program	NV Quality Strategy—pgs. 1-7, 2-4, 2-6, 2-7, 2-8; Contract Section 4.8
§438.240(b)(1)	Each MCO and PIHP must conduct PIPs List out PIPs in the quality strategy	NV Quality Strategy—pgs. 2-4, 2-6, 2-7, 2-8, 5-1; Contract Sections 4.8.1, 4.8.6.2.C
§438.240(b)(2)	Each MCO and PIHP must submit performance measurement data as specified by the state	NV Quality Strategy—pgs. 2-5, 2-6, 2-7, A-1; Contract Section 4.8.21
	List out performance measures in the quality strategy	
§438.240(b)(3)	Each MCO and PIHP must have mechanisms to detect both underutilization and overutilization of services	NV Quality Strategy—pg. 2-6; Contract Section 4.8.6.3.D
§438.240(b)(4)	Each MCO and PIHP must have mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs	NV Quality Strategy—pgs. 2-2, 2-3, 2-7; Contract Section 4.8.6.5.B
§438.240(e)	Annual review by the state of each quality assessment and performance improvement program. If the state requires that an MCO or PIHP have in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program, indicate this in the quality strategy.	NV Quality Strategy—pgs. 2-7, 5-2, A-1; Contract Section 4.8

Regulatory Reference	Description	Corresponding Document and Page Reference or Comment
§ 438.242	**Health Information Systems**	
§438.242(a)	Each MCO and PIHP must maintain a health information system that can collect, analyze, integrate, and report data	NV Quality Strategy—pg. 2-7; Contract Section 4.8.4
§438.242(b)(1)	Each MCO and PIHP must collect data on enrollee and provider characteristics and on services furnished to enrollees	NV Quality Strategy—pgs. 2-1, 2-7; Contract Section 4.8.4.1
§438.242(b)(2)	Each MCO and PIHP must ensure data received is accurate and complete	NV Quality Strategy—pgs. 1-10, 2-7; Contract Section 4.8.4.2

SECTION IV: IMPROVEMENT and INTERVENTIONS

Regulatory Reference	Description	Corresponding Document and Page Reference or Comment
	Describe, based on the results of assessment activities, how the state will attempt to improve the quality of care delivered by MCOs and PIHPs through interventions such as, but not limited to: ◆ Cross-state agency collaborative; ◆ Pay-for-performance or value-Based purchasing initiatives; ◆ Accreditation requirements; ◆ Grants; ◆ Disease management programs; ◆ Changes in benefits for enrollees; ◆ Provider network expansion, etc.	NV Quality Strategy—pgs. 3-2, 2-2, 2-3, 2-6; Sections 5 and 6; Contract Section 4.8.6.2.C.4 (PIPs); and 2.2.3.4, 4.8.18.5 (Disease/Case Management)
	Describe how the state's planned interventions tie to each specific goal and objective of the quality strategy.	NV Quality Strategy Sections 2, 3, 4, 6, 7

Intermediate Sanctions

Regulatory Reference	Description	Corresponding Document and Page Reference or Comment
§438.204(e)	For MCOs, detail how the state will appropriately use intermediate sanctions that meet the requirements of 42 C.F.R. Part 438, subpart I.	NV Quality Strategy—pgs. 1-11, 1-12; Contract Section 4.9.2.7
	Specify the state's methodology for using intermediate sanctions as a vehicle for addressing identified quality of care problems.	NV Quality Strategy—pgs. 1-11, 1-12; Contract Section 4.9.2.7

Health Information Technology

Regulatory Reference	Description	Corresponding Document and Page Reference or Comment
§438.204(f)	Detail how the state's information system supports initial and ongoing operation and review of the state's quality strategy.	NV Quality Strategy—pg. 2-10; Contract Section 4.9.2.6
	Include any health information technology (HIT) initiatives that will support the objectives of the state's quality strategy.	NV Quality Strategy—pg. 2-10, Section 7

SECTION V: DELIVERY SYSTEM REFORMS

Regulatory Reference	Description	Corresponding Document and Page Reference or Comment
	Describe the reasons for incorporating this population/service into managed care. Include a definition of this population and methods of identifying enrollees in this population.	N/A Managed care population includes acute care only.
	List any performance measures applicable to this population/service, as well as the reasons for collecting these performance measures.	N/A

Regulatory Reference	Description	Corresponding Document and Page Reference or Comment
	List any performance improvement projects that are tailored to this population/service. This should include a description of the interventions associated with the performance improvement projects.	N/A
	Address any assurances required in the state's Special Terms and Conditions (STCs), if applicable.	N/A

SECTION VI: CONCLUSIONS and OPPORTUNITIES

Regulatory Reference	Description	Corresponding Document and Page Reference or Comment
	Identify any successes that the state considers to be best or promising practices.	NV Quality Strategy—Section 6
	Include a discussion of the ongoing challenges the state faces in improving the quality of care for beneficiaries.	NV Quality Strategy—Section 7
	Include a discussion of challenges or opportunities with data collection systems, such as registries, claims or enrollment reporting systems, pay-for-performance tracking or profiling systems, electronic health record (EHR) information exchange, regional health information technology collaborative, telemedicine initiatives, grants that support state HIT/EHR development or enhancement, etc.	NV Quality Strategy—Section 7
	Include recommendations that the state has for ongoing Medicaid and CHIP quality improvement activities in the state. Highlight any grants received that support improvement of the quality of care received by managed care enrollees, if applicable.	NV Quality Strategy—Section 5 and Annual EQR Technical Report