State of Nevada

Division of Health Care Financing and Policy

2013–2014 External Quality Review Technical Report

for

Managed Care Organizations (MCOs)

October 2014

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Overview of the FY 2013–2014 External Quality Review

The Balanced Budget Act of 1997 (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' managed care organizations (MCOs). The data come from activities conducted in accordance with the Code of Federal Regulations (CFR) at 42 CFR 438.358. To meet these requirements, the State of Nevada, Department of Health and Human Services, Division of Health Care Financing and Policy (the DHCFP), contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO). HSAG has served as the EQRO for the DHCFP since 2000.

The goal of the managed care program is to maintain a successful partnership with quality health plans to provide care to recipients while focusing on continual quality improvement. The Nevada-enrolled recipient population encompasses the Family Medical Coverage (FMC), Temporary Assistance for Needy Families (TANF), and Child Health Assurance Program (CHAP) assistance groups as well as the Children's Health Insurance Program (CHIP) population, which is referred to as Nevada Check Up.

The Nevada Medicaid MCOs included in the FY 2013–2014 external quality review (EQR) were **Amerigroup Nevada, Inc.** (**Amerigroup**), and **Health Plan of Nevada** (**HPN**), which operate in both Clark and Washoe counties.

The FY 2013–2014 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, CHIP, also known as Nevada Check Up. In addition, the report focuses on the three federally-mandated EQR activities. As described in 42 CFR 438.358, these mandatory activities are:

- Compliance monitoring evaluation.
- Validation of performance measures.
- Validation of performance improvement projects (PIPs).

In accordance with 42 CFR 438.364, this report includes the following information for each mandatory activity conducted:

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

The report also includes an assessment of the MCOs' strengths and weaknesses, as well as recommendations for improvement. This 2013–2014 EQR Technical Report also includes a comparison of the two health plans that operate in the Nevada Medicaid managed care program.

Findings, Conclusions, and Recommendations About the Quality and Timeliness of, and Access to, Care

Overall, both **Amerigroup** and **HPN** have demonstrated strengths and opportunities for improvement related to access, timeliness, and quality of care provided to Nevada Medicaid and Check Up populations. HSAG encourages the continued use of collaborative meetings between the DHCFP and the MCOs to continually assess MCO performance and the Medicaid and Check Up programs' achievement of the goals and objectives identified in the State's Quality Strategy.

Internal Quality Assurance Program Review of Compliance

The BBA requires that a state or its EQRO 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. To meet this requirement, HSAG performed a comprehensive internal quality assurance program (IQAP) on-site compliance review of **HPN** and **Amerigroup** in FY 2011–2012, which was the first year of the three-year review cycle. The findings and recommendations that resulted from these reviews were included in the 2011–2012 EQR Technical Report.

HSAG's review of corrective action plans submitted by each MCO for the 2012–2013 EQR Technical Report demonstrated that the MCOs addressed each of the areas cited as an opportunity for improvement. During FY 2014–2015, HSAG will complete another comprehensive review of compliance with standards for both MCOs.

Validation of Performance Measures—NCQA HEDIS[1-1] Compliance Audits

HSAG conducted a HEDIS compliance audit to assess the performance of **HPN** and **Amerigroup** with respect to the HEDIS 2014 Technical Specifications and to review the MCOs' performance on the HEDIS measures. In HEDIS 2014, the MCOs were required to report 11 performance measures with a total of 38 rates for the Medicaid population and eight performance measures with a total of 22 rates for the Check Up population. HSAG validated all measures reported by the MCOs. Measures with a denominator less than 30 are shown as N/A.

Medicaid Findings

The HEDIS audit demonstrated that both MCOs had strong policies and procedures in place for collecting, processing, and reporting HEDIS data, and both MCOs were in full compliance with the HEDIS 2014 Technical Specifications. The claims and encounter data systems employed by the MCOs used sophisticated scanning processes and advanced software to ensure accurate data

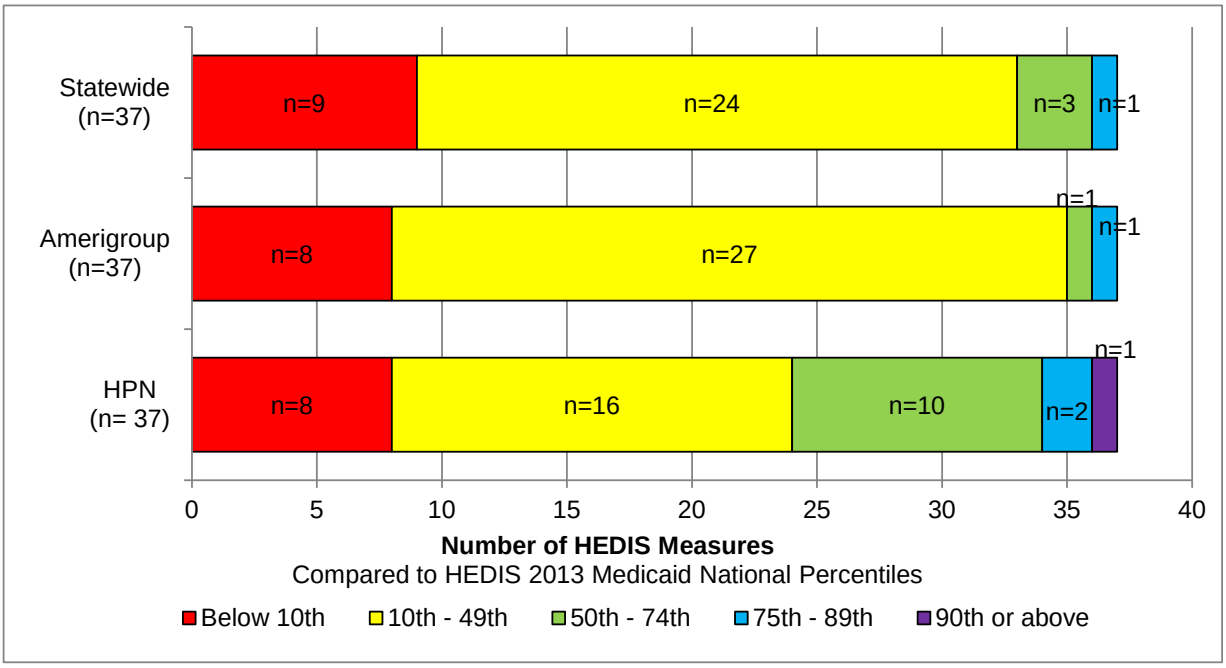
[1-1] The NCQA Audit Means and Percentiles data that are composed of HEDIS Means and Percentiles for Reporting and the NCQA CAHPS National Averages are the proprietary intellectual property of NCQA. The reports are to be used only for internal analysis and may not be displayed publicly. NCQA does not allow the public sharing of the actual NCQA Audit Means and Percentiles data and CAHPS National Averages. In previous years, the DHCFP has published the full EQR Technical Report on its Web site. Given the new instruction by NCQA, however, HSAG has omitted NCQA Audit Means and Percentiles and CAHPS National Averages from this publicly displayed report.

processing. Both MCOs used certified HEDIS software for reporting the HEDIS rates, which ensured accurate programming and reporting of the rates.

In terms of quality, access, and timeliness, both MCOs demonstrated mixed performance. Overall, the Nevada Medicaid rates have continued to improve, but opportunities for additional improvement remain.

Figure 1-1 below shows the MCOs' performance on the Medicaid measures compared to the national HEDIS percentiles. The graph shows the performance for **Amerigroup**, **HPN**, as well as the Statewide (**Amerigroup** and **HPN** combined) performance on the measures.

Figure 1-1—Comparison of Nevada MCO Medicaid Performance Measures to HEDIS Medicaid National Percentiles



None of the Nevada statewide Medicaid rates ranked above the 2013 HEDIS 90th percentile. Four Nevada Medicaid rates ranked above the 50th percentiles. Nine rates were below the 10th percentile, six of which were child-related measures.

Table 1-1 below shows each MCO's rates for each Medicaid measure and the corresponding percentile ranking for each MCO's rates.

Table 1 1 Nevada MCO Medicaid Performance Measure Rates and HEDIS 2013 Percentile Ranking

HEDIS Measure	HPN Rate	HEDIS Ranking*	AGP Rate	HEDIS Ranking*
Childhood Immunization Status—Combination 2	72.99%	10th to 49th percentile	61.34%	< 10th percentile
Childhood Immunization Status—Combination 3	67.88%	10th to 49th percentile	55.32%	< 10th percentile
Childhood Immunization Status—Combination 4	66.42%	50th to 74th percentile	54.63%	10th to 49th percentile

Table 1 1 Nevada MCO Medicaid Performance Measure Rates and HEDIS 2013 Percentile Ranking				
HEDIS Measure	**HPN Rate**	**HEDIS Ranking***	**AGP Rate**	**HEDIS Ranking***
Childhood Immunization Status—Combination 5	57.42%	50th to 74th percentile	45.37%	10th to 49th percentile
Childhood Immunization Status—Combination 6	40.15%	10th to 49th percentile	29.86%	10th to 49th percentile
Childhood Immunization Status—Combination 7	56.69%	50th to 74th percentile	44.91%	10th to 49th percentile
Childhood Immunization Status—Combination 8	39.90%	50th to 74th percentile	29.63%	10th to 49th percentile
Childhood Immunization Status—Combination 9	36.50%	50th to 74th percentile	25.93%	10th to 49th percentile
Childhood Immunization Status—Combination 10	36.25%	50th to 74th percentile	25.69%	10th to 49th percentile
Lead Screening in Children	37.23%	10th to 49th percentile	34.26%	< 10th percentile
Well-Child Visits in the First 15 Months of Life (6 or More Visits)	54.50%	10th to 49th percentile	53.47%	10th to 49th percentile
Well-Child Visits 3–6 Years of Life	54.74%	< 10th percentile	63.08%	10th to 49th percentile
Adolescent Well-Care Visits	42.09%	10th to 49th percentile	37.96%	10th to 49th percentile
Children's Access to Primary Care Practitioners (12–24 Months)	91.73%	< 10th percentile	93.58%	10th to 49th percentile
Children's Access to Primary Care Practitioners (25 Months–6 Years)	78.58%	< 10th percentile	83.40%	10th to 49th percentile
Children's Access to Primary Care Practitioners (7–11 Years)	82.35%	< 10th percentile	84.96%	10th to 49th percentile
Children's Access to Primary Care Practitioners (12–19 Years)	78.37%	< 10th percentile	80.97%	< 10th percentile
Annual Dental Visit—Combined Rate	53.32%	50th to 74th percentile	44.99%	10th to 49th percentile
Use of Appropriate Medications for People With Asthma (5–11 Years)	90.45%	50th to 74th percentile	84.16%	10th to 49th percentile
Use of Appropriate Medications for People With Asthma (12–18 Years)	86.82%	50th to 74th percentile	77.86%	< 10th percentile
Use of Appropriate Medications for People With Asthma (19–50 Years)	58.57%	< 10th percentile	60.23%	< 10th percentile
Use of Appropriate Medications for People With Asthma (51–64 Years)	NA	N/A	NA	N/A
Use of Appropriate Medications for People With Asthma (Combined)	84.54%	10th to 49th percentile	78.82%	10th to 49th percentile
Comprehensive Diabetes Care—HbA1c Testing	69.59%	< 10th percentile	73.99%	< 10th percentile
Comprehensive Diabetes Care—HbA1c Poor Control (>9.0)**	54.50%	10th to 49th percentile	54.16%	10th to 49th percentile
Comprehensive Diabetes Care—HbA1c Good Control (<8.0)	37.47%	10th to 49th percentile	38.34%	10th to 49th percentile
Comprehensive Diabetes Care—Eye Exam	44.04%	10th to 49th percentile	53.62%	10th to 49th percentile
Comprehensive Diabetes Care—LDL-C Screening	63.75%	< 10th percentile	68.10%	10th to 49th percentile
Comprehensive Diabetes Care—LDL-C Level < 100 mg/dL	27.49%	10th to 49th percentile	31.10%	10th to 49th percentile
Comprehensive Diabetes Care—Attention for Medical Nephropathy	72.75%	10th to 49th percentile	67.29%	< 10th percentile

Table 1 1 Nevada MCO Medicaid Performance Measure Rates and HEDIS 2013 Percentile Ranking				
HEDIS Measure	HPN Rate	HEDIS Ranking*	AGP Rate	HEDIS Ranking*
Comprehensive Diabetes Care—Blood Pressure <140/80	40.15%	50th to 74th percentile	34.05%	10th to 49th percentile
Comprehensive Diabetes Care—Blood Pressure <140/90	69.10%	75th to 89th percentile	58.45%	10th to 49th percentile
Frequency of Ongoing Prenatal Care (<21% of Visits)**	18.00%	10th to 49th percentile	9.47%	10th to 49th percentile
Frequency of Ongoing Prenatal Care (81–100% Visits)	59.37%	10th to 49th percentile	63.83%	10th to 49th percentile
Timeliness of Prenatal Care	74.94%	10th to 49th percentile	83.98%	10th to 49th percentile
Postpartum Care	57.66%	10th to 49th percentile	59.22%	10th to 49th percentile
Follow-up After Hospitalization for Mental Illness—7 Days	68.83%	90th percentile or >	62.13%	75th to 89th percentile
Follow-up After Hospitalization for Mental Illness—30 Days	81.82%	75th to 89th percentile	68.64%	50th to 74th percentile

* National Medicaid HEDIS 2013 Percentile Ranking.
** Lower rates are better for this measure. The national Medicaid HEDIS 2013 percentiles were reversed to have the same performance level alignment as the other measures (i.e., the value associated with the 90th percentile suggested better performance).
N/A denotes denominators less than 30.

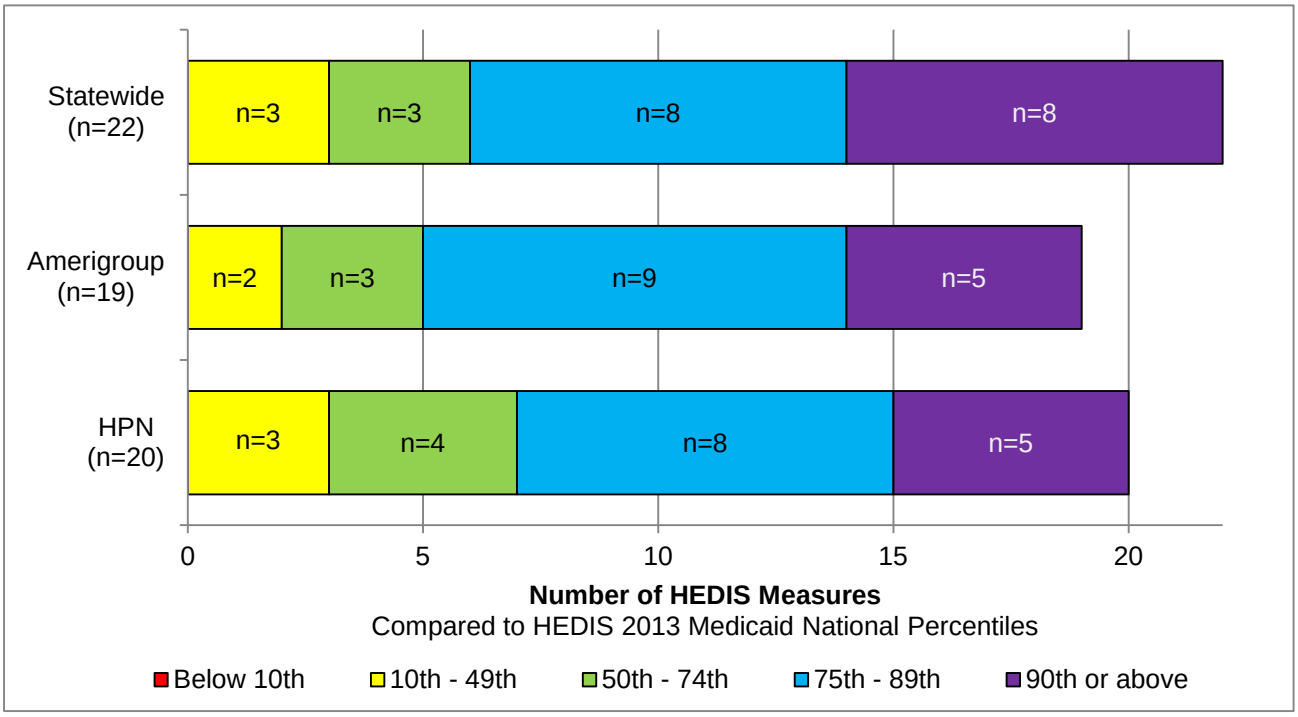
Overall, **HPN** performed better than **Amerigroup** for HEDIS 2014. Twenty-one of **HPN**'s rates exceeded **Amerigroup**'s rates. Twelve of **HPN's** rates were above the 50th percentile and one was above the 90th percentile. Eight rates were below the 10th percentile. Although **Amerigroup** has shown improvement over the last several years, only two measures are above the 50th percentile. **HPN** generally performed better than **Amerigroup** in *Childhood Immunization Status*, *Annual Dental Visit*, the asthma-related measures, and *Follow-up After Hospitalization for Mental Illness*.

Although 16 **Amerigroup** rates exceeded **HPN** rates, **Amerigroup** had only two rates above the 50th percentile and none above the 90th percentile. **Amerigroup** had the same number of rates (eight) ranked below the 10th percentile. **Amerigroup** generally performed better than **HPN** in *Children's and Adolescents' Access to PCPs*, maternity-related measures, and the *Comprehensive Diabetes Care* measure.

Nevada Check Up Findings

Figure 1-2 below shows the MCOs' performance on the Nevada Check Up measures compared to the national HEDIS percentiles. The graph shows the performance for **Amerigroup**, **HPN**, as well as the Statewide (**Amerigroup** and **HPN** combined) performance on the measures. National HEDIS percentiles are not available for CHIP (Nevada Check Up) populations; therefore, caution should be used when comparing Nevada Check Up rates to Medicaid HEDIS percentiles.

Figure 1-2—Comparison of MCO Nevada Check Up Performance Measures to HEDIS Medicaid National Percentiles



In general, Nevada Check Up continues to report better rates than Medicaid. Eight of the statewide Nevada Check Up rates were above the HEDIS 2013 90th percentile, and another 11 rates were above the 50th percentile. None of the rates fell below the 10th percentile.

Table 1-2 below shows MCO rates for each Nevada Check Up measure and the corresponding percentile ranking for each MCO's rates.

Table 1 2 Nevada MCO Check Up Performance Measure Rates and HEDIS 2013 Percentile Ranking

HEDIS Measure	HPN Rate	HEDIS Ranking*	AGP Rate	HEDIS Ranking*
Childhood Immunization Status—Combination 2	85.21%	75th to 89th	76.99%	50th to 74th percentile
Childhood Immunization Status—Combination 3	83.10%	75th to 89th	76.11%	50th to 74th percentile
Childhood Immunization Status—Combination 4	83.10%	90th percentile or above	74.34%	75th to 89th
Childhood Immunization Status—Combination 5	72.54%	90th percentile or above	68.14%	75th to 89th
Childhood Immunization Status—Combination 6	48.59%	50th to 74th percentile	51.33%	75th to 89th
Childhood Immunization Status—Combination 7	72.54%	90th percentile or above	67.26%	90th percentile or above
Childhood Immunization Status—Combination 8	48.59%	75th to 89th	49.56%	75th to 89th
Childhood Immunization Status—Combination 9	42.96%	75th to 89th	46.90%	75th to 89th
Childhood Immunization Status—Combination 10	42.96%	75th to 89th	46.02%	90th percentile or above
Lead Screening in Children	55.24%	10th to 49th percentile	50.44%	10th to 49th percentile
Well-Child Visits in the First 15 Months of Life (6 or More Visits)	63.01%	10th to 49th percentile	54.05%	10th to 49th percentile
Well-Child Visits 3–6 Years of Life	73.72%	50th to 74th percentile	78.74%	75th to 89th

Table 1 2 Nevada MCO Check Up Performance Measure Rates and HEDIS 2013 Percentile Ranking				
HEDIS Measure	HPN Rate	HEDIS Ranking*	AGP Rate	HEDIS Ranking*
Adolescent Well-Care Visits	54.26%	50th to 74th percentile	58.22%	75th to 89th
Children's Access to Primary Care Practitioners (12–24 Months)	95.08%	10th to 49th percentile	98.85%	90th percentile or above
Children's Access to Primary Care Practitioners (25 Months–6 Years)	91.39%	75th to 89th	94.11%	90th percentile or above
Children's Access to Primary Care Practitioners (7–11 Years)	94.88%	75th to 89th	97.25%	90th percentile or above
Children's Access to Primary Care Practitioners (12–19 Years)	91.49%	50th to 74th percentile	93.69%	75th to 89th
Annual Dental Visit—Combined Rate	77.21%	90th percentile or above	67.67%	75th to 89th
Use of Appropriate Medications for People With Asthma (5–11 Years)	97.00%	90th percentile or above	92.50%	50th to 74th percentile
Use of Appropriate Medications for People With Asthma (12–18 Years)	91.94%	75th to 89th	NA	N/A
Follow-up After Hospitalization for Mental Illness—7 Days	NA	N/A	NA	N/A
Follow-up After Hospitalization for Mental Illness—30 Days	NA	N/A	NA	N/A
* National Medicaid HEDIS 2013 Percentile Ranking. N/A denotes denominators less than 30.				

The two MCOs' performance was similar. Both had five Check Up rates above the 90th percentile, 12 rates above the 50th percentile, and no rates below the 10th percentile. **HPN** had nine rates that exceeded **Amerigroup**'s rates, and **Amerigroup** had 10 rates that exceeded **HPN**'s rates. The highest rate **HPN** reported was for the *Use of Appropriate Medications for People With Asthma—5–11 Years* measure (97.0 percent), and the highest rate **Amerigroup** reported was for the *Children's and Adolescents' Access to PCPs—12–24 Months* measure (98.85 percent).

Conclusions and Recommendations

The following recommendations are based on the audit findings and final reported rates:

- **HPN** has showed improvement in the Medicaid rate for *Lead Screening in Children* measure, and the rate is now higher than **Amerigroup**'s rate. The *Lead Screening in Children* rate for **Amerigroup** has not shown much improvement over the last three years. Both MCO Medicaid rates were significantly lower than the rates reported for Nevada Check Up. HSAG recommends that **HPN** continue its current interventions, which appear to be improving the lead screening rates for both Medicaid and Nevada Check Up. HSAG also recommends that **Amerigroup** increase its efforts to improve these rates. Lead screening may need more targeted intervention for Medicaid. Providers should be reminded that lead screening should be completed as part of a well-child visit or when immunizations are given.
- For **HPN**, the measures related to access to care have continued to decline each year. **HPN** should conduct a root cause analysis to determine if these results are due to member noncompliance, issues with network adequacy, or other potential barriers preventing members from accessing timely care.
- For **Amerigroup**, the maternity-related measures have shown little or no improvement since HEDIS 2011, with all four trended rates changing less than 1.5 percentage points. Since these

rates are still well below the 90th percentiles, **Amerigroup** should explore the potential barriers that are preventing early prenatal care, and postpartum care.

- All of the Medicaid rates for the *Use of Appropriate Medications for People With Asthma* measure for **Amerigroup** have also continued to decline since HEDIS 2011. These rates are also well below the National Medicaid 90th percentiles. Since the numerator specifications state that only one asthma medication is required, it does not appear likely that the rate for this measure is low due to member noncompliance or to providers not prescribing the appropriate medication. **Amerigroup** should conduct a root cause analysis to determine the reason for the low rates for this measure, such as potentially including individuals in the denominator who do not have asthma due to provider coding practices.
- For comprehensive diabetes care, both MCOs continued to report rates that were well below the 90th percentiles. HSAG has made recommendations for this measure for the past several years and continues to make the following recommendations:
  - The MCOs should conduct outreach to members with diabetes through PCPs, lab technicians, pharmacists, and other health care practitioners who are involved in disease management efforts.
  - The MCOs should encourage providers who provide diabetes-related screenings (e.g., lipid screenings and HbA1c testing) or who distribute medications to educate and provide information to members on the importance of taking a comprehensive approach to managing diabetes.
- Since HEDIS 2011 HSAG has made recommendations to improve the rates for *Follow-up After Hospitalization for Mental Illness*, and the trend over time has improved for both MCOs. However, this year the **HPN** rates for both 7-day and 30-day follow-up declined again, and the 30-day fell below the National Medicaid 90th percentile. Although the rates for **Amerigroup** have improved from 2011 and over last year, both rates are well below **HPN**'s rates and the National Medicaid 90th percentiles. HSAG recommends that both MCOs continue to identify additional areas that impede follow-up and apply interventions that can overcome barriers and improve performance for the measure.

Validation of Performance Improvement Projects (PIPs)

Amerigroup and **HPN** each conducted the required PIPs and submitted documentation to HSAG for validation. As reported in the FY 2012–2013 EQR Technical Report, the FY 2014 PIP validation process included heightened scrutiny on the following:

- Barrier analyses performed by the MCOs
- Intervention planning documented by the MCOs as a result of the barrier analyses performed
- Evaluation of mechanisms put in place by the MCOs to track and assess the effectiveness of each intervention implemented by the MCOs

In the previous report, HSAG recommended that, for any intervention implemented, the MCOs should ensure that the results of each intervention's evaluation are included in the PIP documentation sent to HSAG. If the MCO determined that interventions were not having the desired effect, the MCO should have discussed how it addressed these deficiencies and what

changes were made to its improvement strategies. Further, HSAG evaluated the PIP outcomes (i.e., rates) for each study indicator. The MCO must also achieve statistically significant improvement over the baseline rate and must sustain that improvement for a subsequent measurement period. HSAG critically evaluated each of these areas; thus, the findings that resulted from this outcome-focused evaluation are reflected in the validation scoring for the Study Implementation and Study Outcomes stages of each PIP.

HPN PIP Findings

HPN submitted two PIPs to HSAG for validation. **HPN** submitted baseline data for the ***Children and Adolescents' Access to Primary Care Practitioners*** PIP and Remeasurement 2 data for the ***Reducing Avoidable Emergency Room Visits*** PIP.

For the ***Children and Adolescents' Access to Primary Care Practitioners*** PIP, **HPN** reported baseline data for all study indicators. The MCO's goal is to increase the rates to the NCQA 10th percentile for the first remeasurement; however, it is recommended that the health plan choose a more aggressive goal given the longevity of the health plan in the managed care program. **Table 1-3** shows **HPN**'s baseline rates for all for study indicators.

Table 1 3 HPN Baseline Rates for Children and Adolescent's Access to Primary Care Practitioners PIP

PIP Study Indicator	Baseline CY 2013
1. The percentage of children 25 months to six years of age that had one or more visits with a PCP during the measurement year.	78.6%
2. The percentage of children seven to 11 years of age that had one or more visits with a PCP during the measurement year.	82.4%
3. The percentage of children 12 to 19 years of age that had one or more visits with a PCP during the measurement year.	78.3%
4. The percentage of children 12 to 24 months of age (Nevada Check Up) that had one or more visits with a PCP during the measurement year.	95.1%

Overall, 100 percent of the evaluation elements across the **HPN *Children and Adolescents' Access to Primary Care Practitioners*** PIP received a score of *Met*. **HPN**'s strong performance in the Design and Implementation stages indicated this PIP was designed appropriately to measure outcomes and improvement. The ***Children and Adolescents' Access to Primary Care Practitioners*** PIP received an overall validation status of *Met*.

For the ***Reducing Avoidable Emergency Room Visits*** PIP, the study indicators are inverse indicators; therefore, a decline in the rate represents improved outcomes. **HPN** achieved statistically significant improvement for both study indicators at Remeasurement 1; however, both indicators demonstrated statistically significant declines in performance at Remeasurement 2—with rates higher than the baseline. Table 1-4 shows **HPN**'s PIP outcomes for both study indicators.

Table 1 4 HPN Outcomes for *Reducing Avoidable Emergency Room Visits* PIP				
PIP Study Indicator	**Baseline CY 2011**	**Remeasurement 1 CY 2012**	**Remeasurement 2 CY 2013**	**Sustained Improvement^**
1. The percentage of avoidable ER visits for the Nevada Check Up population. ¤	39.0%	35.7%↓*	41.7%	No
2. The percentage of avoidable ER visits for the Medicaid population. ¤	42.0%	37.8%↓*	42.9%	No

¤ The study indicators are inverse indicators; therefore, a decline in the rate represents an improvement in the outcomes.
↓* Designates statistically significant improvement over the baseline (*p* value < 0.05).
CY Calendar year

Overall, 85 percent of the evaluation elements across the **HPN *Reducing Avoidable Emergency Room Visits*** PIP received a score of *Met*. While **HPN**'s strong performance in the Design stage indicated that the PIP was designed appropriately, the MCO was less successful in implementing improvement strategies that resulted in the desired outcomes for both study indicators. Due to the lack of statistically significant improvement achieved for all indicators for the ***Reducing Avoidable Emergency Room Visits*** PIP, the overall validation status was *Not Met*.

Amerigroup PIP Findings

HSAG reviewed two PIPs for the period of July 1, 2013, through June 30, 2014—***Diabetes Management*** and ***Reducing Avoidable Emergency Room Visits***. For the ***Diabetes Management*** PIP, **Amerigroup** progressed to reporting Remeasurement 4 data. All three study indicators have demonstrated improvement over the baseline; however, this improvement was not statistically significant. All three rates are below the NCQA 50th percentile. Table 1-5 shows **Amerigroup**'s PIP outcomes for all three study indicators.

Table 1 5 Amerigroup Outcomes for *Diabetes Management* PIP						
PIP Study Indicator	**Baseline CY 2009**	**Remeasurement 1 CY 2010**	**Remeasurement 2 CY 2011**	**Remeasurement 3 CY 2013**	**Remeasurement 4 CY 2013**	**Sustained Improvement**
1. The percentage of Medicaid-eligible members 18–75 years of age with a diagnosis of diabetes who had an HbA1C test performed during the measurement year.	70.1%	73.6%	71.6%	68.8%	73.9%	NA
2. The percentage of Medicaid-eligible members 18–75 years of age with a diagnosis of diabetes who had an LDL-C screening performed during the measurement year.	64.2%	67.5%	64.4%	65.2%	68.1%	NA
3. The percentage of Medicaid-eligible members 18–75 years of age with a diagnosis of diabetes who had a nephropathy screening test performed during the measurement year.	60.6%	66.5%	69.1%	64.0%	67.3%	NA

Overall, 95 percent of the evaluation elements across the **Amerigroup *Diabetes Management*** PIP received a score of *Met*. While **Amerigroup**'s strong performance in the Design and Implementation stages indicated that each PIP was designed appropriately to measure outcomes and improvement, the MCO was less successful in achieving the desired outcomes. The **Amerigroup *Diabetes Management*** PIP received an overall *Not Met* validation status due to the PIP not achieving the desired outcomes (i.e., statistically significant improvement over baseline.)

The ***Reducing Avoidable Emergency Room Visits*** PIP progressed to reporting Remeasurement 2 data. The study indicators for the ***Reducing Avoidable Emergency Room Visits*** PIP are inverse indicators; therefore, a decline in the rate represents an improvement in the outcomes. Study Indicator 1 has demonstrated consistent improvement over the baseline rate; however, none of this improvement has been statistically significant. Study Indicator 2 achieved statistically significant improvement over baseline at Remeasurement 1 and has sustained the improvement with a subsequent measurement period; however, all study indicators must achieve statistically significant improvement before the PIP can be assessed for sustained improvement. Table 1-6 shows **Amerigroup**'s PIP outcomes for both study indicators.

Table 1 6 Amerigroup Outcomes for *Reducing Avoidable Emergency Room Visits* PIP

PIP Study Indicator	Baseline CY 2011	Remeasurement 1 CY 2012	Remeasurement 2 CY 2013	Sustained Improvement
1. The percentage of avoidable ER visits for the Check Up (CHIP) population. ¤	39.7%	39.1%	37.5%	NA
2. The percentage of avoidable ER visits for the Medicaid population. ¤	42.6%	41.4%↓*	39.1%	NA

¤ The study indicators are inverse indicators; therefore, a decline in the rate represents an improvement in the outcomes.
↓* Designates statistically significant improvement over the baseline (p value < 0.05).
NA Sustained improvement cannot be determined until statistically significant improvement has been achieved across **all** study indicators followed by a subsequent measurement period.
CY Calendar year

Overall, 92 percent of the evaluation elements across the **Amerigroup *Reducing Avoidable Emergency Room Visits*** PIP received a score of *Met*. While **Amerigroup**'s strong performance in the Design stage indicated that each PIP was designed appropriately, the MCO was less successful in implementing improvement strategies that resulted in the desired outcomes for both study indicators. Overall, the **Amerigroup *Reducing Avoidable Emergency Room Visits*** PIP received a *Partially Met* validation status.

Recommendations

Overall, HSAG recommends that the MCOs:

- Conduct an annual causal/barrier and drill-down analyses more frequently than annually and incorporate quality improvement science such as the Plan-Do-Study-Act (PDSA) into its improvement strategies and action plans.
- Design small-scale tests coupled with analysis of results to determine the success of the intervention. If after reviewing the results of the test data, it is determined that the intervention has not been successful, the MCOs should determine: (1) if the true root cause was identified—if not, the MCOs should conduct another causal/barrier analysis to isolate the true root cause or

issue that is impacting improvement; and (2) if the interventions need to be revised because a new root cause was identified, or the intervention was unsuccessful. In evaluating the results of intervention testing, the MCOs may find that the results of the test yield more information that directs the MCOs to modify an existing intervention to yield a greater result. If the existing intervention is modified, the MCOs should develop another test to evaluate the modified intervention's effectiveness if the current test is obsolete. Prioritize barriers and focus efforts and resources on the top three-to-five barriers. When identifying barriers, the MCOs should be able to specifically define the problem within the barrier. For instance, when the MCO identifies "lack of provider education" as a barrier, the MCO should drill down even further to isolate the specific piece of education the provider is lacking, such as how to properly code for services, when preventive screenings and tests should occur, or which standards of practice should be followed. By pinpointing the specific cause for the barrier, the MCO will increase its chances of identifying a more appropriate intervention that will overcome the barrier.

- **Amerigroup** should consider using other types of QI tools such as a key driver diagram and a Failure Modes and Effects Analysis (FMEA) to identify process weaknesses.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Surveys

Three populations were surveyed for **HPN** and **Amerigroup**: adult Medicaid, child Medicaid, and Nevada Check Up. Two NCQA-certified vendors—the Center for the Study of Services (CSS) and Morpace—administered the 2014 CAHPS surveys for **HPN** and **Amerigroup**, respectively.

For each of the four global ratings, the percentage of respondents who chose the top satisfaction ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. This percentage is referred to as a question summary rate (or top-box response).

HPN Findings

In 2014, a total of 1,890 members were surveyed and 364 completed a survey. After ineligible members were excluded, the response rate was 19.8 percent. In 2013, the average NCQA response rate for the adult Medicaid population was 28.4 percent, which was higher than **HPN**'s response rate.[1-2]

HPN's adult Medicaid CAHPS scores were below the adult Medicaid national averages for all six reportable composite and global measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*. **HPN**'s response rate for the adult Medicaid population was lower than the 2013 NCQA adult Medicaid average response rate by 8.6 percentage points.

HPN's child Medicaid CAHPS scores were below the child Medicaid national averages for four reportable composite measures (*Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*) and one reportable global rating (*Rating of All Health Care*). **HPN**'s response rate for the child Medicaid population was 1.5 percentage points lower than the 2013 NCQA child Medicaid average response rate.

[1-2] 2014 NCQA national response rate information was not available at the time this report was produced.

HPN's 2014 Nevada Check Up CAHPS scores exceeded the 2013 Nevada Check Up CAHPS scores for four measures: *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often*.

Amerigroup Findings

In 2014, a total of 2,430 members were surveyed and 285 completed a survey. After ineligible members were excluded, the response rate was 12.0 percent. In 2013, the average NCQA response rate for the adult Medicaid population was 28.4 percent, which was higher than **Amerigroup**'s response rate.[1-3]

Amerigroup's adult Medicaid CAHPS scores were below the adult Medicaid national averages for seven composite and global measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*. **Amerigroup**'s response rate for the adult Medicaid population was lower than the 2013 NCQA adult Medicaid average response rate by 16.4 percentage points.

Amerigroup's child Medicaid CAHPS scores were below the child Medicaid national averages for all four composite measures (*Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service)* and one of the global measures (*Rating of All Health Care).* **Amerigroup**'s response rate for the child Medicaid population was 10.7 percentage points lower than the 2013 NCQA child Medicaid average response rate.

Amerigroup's 2014 Nevada Check Up CAHPS scores exceeded the 2013 Nevada Check Up CAHPS scores for five measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Shared Decision Making*, and *Rating of Health Plan*. Since NCQA does not publish separate rates for the CHIP program, national comparisons could not be made.

Recommendations

Overall, HSAG recommends the following:

- Each MCO should continue to work with its CAHPS vendor to ensure a sufficient number of completed surveys are obtained to enable reporting of all CAHPS measures. NCQA recommends targeting 411 completed surveys per survey administration. Neither **HPN** nor **Amerigroup** met this target for the adult Medicaid population. In the absence of sufficient responses, MCOs lack information that can be critical to designing and implementing targeted interventions, which can improve access to, and the quality and timeliness of, care.
- **HPN** should focus quality improvement initiatives on enhancing members' experiences with *Rating of All Health Care* for the adult Medicaid population, since the 2014 rate was lower than the 2013 adult CAHPS result and fell below the adult Medicaid national average. For the child Medicaid population, **HPN** should focus its efforts on improving *How Well Doctors Communicate*, since the 2014 rate was lower than the 2013 rate, and the rate fell below the child Medicaid national average. For the Nevada Check Up population, while no measures showed a

[1-3] Ibid.

substantial decrease from 2013 to 2014, HSAG recommends that quality improvement efforts focus on improving *Shared Decision Making* which overall had the lowest rate.

- For the adult population, **Amerigroup** should focus quality improvement initiatives on enhancing members' experiences with *Rating of Personal Doctor* and *Rating of Health Plan*, since these rates were lower than the 2013 adult CAHPS results and fell below NCQA's 2013 CAHPS adult Medicaid national averages. For the child Medicaid population, **Amerigroup** should focus its efforts on improving *Getting Care Quickly* and *Customer Service*, since these rates were lower than the 2013 child CAHPS results and fell below NCQA's 2013 CAHPS child Medicaid national averages.
- **Amerigroup** had reportable rates for all nine measures for the Nevada Check Up population in 2014, to compare with nine reportable measures from 2013. **Amerigroup**'s quality improvement efforts should focus on *Rating of Specialist Seen Most Often* as the 2014 rate was below the 2013 Nevada Check Up top-box rate—nearly a 5 percent decrease. **Amerigroup** should also survey the child Medicaid and Nevada Check Up populations as two unique populations (i.e., sample the populations separately) or continue to conduct an oversample of the Nevada Check Up population similar to the oversample conducted for 2014. This will enable the continued reporting of CAHPS results for both populations.

2. Overview of Nevada Managed Care Program

History of Nevada State Managed Care Program

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

In April 1992, Nevada Medicaid initiated a limited enrollment primary care case management (PCCM) program, the first managed care program in Nevada. The State implemented the PCCM program voluntarily. 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 with several vendors. Nevada contracted with **HPN** and **Amil International** (**Amil**) to provide services in Clark County, and with **Hometown Health Plan** to provide services in Washoe County. Voluntary managed care for most recipients was discontinued in December 1998; however, these health plans continued to provide services to Nevada recipients when the Nevada Legislature passed Senate Bill 559, requiring that Nevada Medicaid develop a mandatory managed care program. Mandatory managed care Medicaid contracts remained in effect, with several renewals, through 2001.

In 2002, contracts were procured again with **Nevada Health Solutions** and **HPN** in both Clark and Washoe counties. **Anthem** and **HPN** won the contracts when Medicaid procured them again in November 2006. **Anthem** left the Nevada market in January 2009 and was replaced by **Amerigroup**. In 2012, the DHCFP reprocured the managed care contracts, with services to begin on July 1, 2013. Both **HPN** and **Amerigroup** were selected to serve as the managed care organizations (MCOs) in Clark and Washoe counties and remain as the current MCOs for the State.

The State of Nevada managed care program requires the enrollment of recipients found eligible for Medicaid coverage under the following Medicaid eligibility categories when there are two or more MCOs in the geographic service area:

- Family Medical Category (FMC)/Temporary Assistance for Needy Families (TANF)
- FMC/Two-parent TANF
- FMC/TANF—Related medical only
- FMC/TANF—Post-medical (pursuant to Section 1925 of the Social Security Act)
- FMC/TANF—Transitional medical (under Section 1925 of the Act)
- FMC/TANF-Related (Sneede vs. Kizer)
- FMC/Child Health Assurance Program (CHAP)
- Children's Health Insurance Program (CHIP)

- Aged-out (AO) foster care (young adults in foster care who no longer qualify due to their age)

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 or 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).
- TANF and CHAP adults diagnosed as seriously mentally ill (SMI).
- TANF and CHAP children diagnosed as severely emotionally disturbed (SED).

Effective January 1, 2014, Nevada expanded its Medicaid program to allow persons with incomes up to 138 percent of the federal poverty level to enroll in the Medicaid program. Since the majority of the newly eligible population reside in managed care catchment areas, persons eligible as a result of Medicaid expansion have enrolled with one of the two MCOs offered in the Nevada Medicaid managed care program.

Demographics of Nevada State Managed Care Program

The Division of Welfare and Supportive Services (DWSS) carries out the eligibility and aid code determination functions for the Medicaid and Nevada Check Up applicant and eligible population. Table 2-1 presents the gender and age bands of Nevada Medicaid and CHIP enrolled recipients in fiscal year (FY) 2013−2014. The majority of members for both Medicaid and CHIP were children between 3 and 14 years of age.

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 (ACA). 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, by June 2014 both MCOs experienced significant increases in enrollment compared to June 2013.

Table 2 1 Nevada Medicaid and CHIP Managed Care Demographics

Gender/Age Band	June 2013 Members	June 2014 Members	Difference between 2014 and 2013
Medicaid			
Males and Females <1 Year of Age	13,566	15,108	1,542
Males and Females 1–2 Years of Age	19,511	25,313	5,802
Males and Females 3–14 Years of Age	90,232	122,533	32,301
Females 15–18 Years of Age	8,948	12,772	3,824
Males 15–18 Years of Age	8,277	12,253	3,976
Females 19–34 Years of Age	18,584	44,476	25,892
Males 19–34 Years of Age	4,489	21,610	17,121
Females 35+ Years of Age	7,928	37,960	30,032
Males 35+ Years of Age	3,407	28,250	24,843
Gender Not Yet Recorded	0	726	726
Total Medicaid	**174,932**	**321,001**	**146,069**
Males and Females <1 Year of Age	227	155	-72
Males and Females 1–2 Years of Age	1,534	1,532	-2
Males and Females 3–14 Years of Age	13,827	15,163	1,336
Females 15–18 Years of Age	1,423	1,913	490
Males 15–18 Years of Age	1,512	1,933	421
Females 19–34 Years of Age	0	40	40
Males 19–34 Years of Age	0	38	38
Total CHIP	**18,523**	**20,774**	**2,251**
Total Medicaid and CHIP	**193,455**	**341,775**	**148,320**

Table 2-2 presents enrollment of Medicaid recipients by MCO and county for June 2014.

Table 2 2 June 2014 Nevada MCO Medicaid Recipients		
MCO	Total Eligible Clark County	Total Eligible Washoe County
Health Plan of Nevada	145,429	31,100
Amerigroup	122,762	21,710
Total	**268,191**	**52,810**

Table 2-3 presents enrollment of CHIP recipients in the Nevada Check Up program by MCO and county for June 2014.

Table 2 3 June 2014 Nevada MCO CHIP (Nevada Check Up) Recipients		
MCO	Total Eligible Clark County	Total Eligible Washoe County
Health Plan of Nevada	10,012	2,503
Amerigroup	6,761	1,498
Total	**16,773**	**4,001**

Table 2-4 presents the ethnic composition of Nevada MCO Medicaid recipients in June 2014.

Table 2 4 June 2013 Nevada MCO Medicaid Ethnic Composition		
Ethnicity	Total Eligible Clark County	Total Eligible Washoe County
Asian or Pacific Islander Non-Hispanic	10,338	1,453
Black Non-Hispanic	60,814	2,499
Hispanic	56	26
Am Indian/Alaskan Non-Hispanic	966	587
Am Indian/Alaskan and White	326	150
Asian and White	1,042	219
Black African Am and White	2,783	456
Am Indian/Alaskan and Black	974	109
Other Non-Hispanic	17,346	2,522
Asian/Pacific Islander Hispanic	770	162
Black Hispanic	712	44
Am Indian/Alaskan Hispanic	161	37
White Hispanic	100,458	18,086
White Non-Hispanic	71,642	26,263
Total	**268,388**	**52,613**

Table 2-5 presents the ethnic composition of CHIP recipients in the Nevada Check Up program for June 2014.

Table 2 5 June 2014 Nevada MCO CHIP (Nevada Check Up) Ethnic Composition		
Ethnicity	Total Enrolled Clark County	Total Enrolled Washoe County
Asian or Pacific Islander Non-Hispanic	634	94
Black Non-Hispanic	1,137	47
Hispanic	0	3
Am Indian/Alaskan Non-Hispanic	40	31
Am Indian/Alaskan and White	13	1
Asian and White	96	7
Black African Am and White	94	40
Am Indian/Alaskan and Black	46	4
Other Non-Hispanic	912	166
Asian/Pacific Islander Hispanic	68	10
Black Hispanic	35	2
Am Indian/Alaskan Hispanic	2	3
White Hispanic	11,080	2,639
White Non-Hispanic	2,629	941
Total	**16,786**	**3,988**

Network Capacity Analysis

At the request of the DHCFP, HSAG conducted an evaluation of the adequacy of resources to serve the newly eligible population after the State of Nevada expands its Medicaid coverage according to the ACA. The purpose of this analysis was to estimate the provider network capacity of the MCOs' and fee-for-service (FFS) networks based on population expansion estimates.

As expected, the increased population served by Medicaid that will result from Medicaid expansion will increase provider ratios for both the FFS and managed care programs. The findings from the analysis suggest, however, that although the provider-to-member ratios will increase, the newly eligible membership will not saturate the programs to the point that reasonable industry-standard, provider-to-member ratios cannot be maintained. For the FFS program, the provider network will be more than adequate to accommodate the expanded Medicaid population. With the exception of a few specialty provider types, provider-to-member ratios for managed care networks will also remain less than industry-standard ratios based on estimated enrollment projections for June 2015. For those specialty types where provider-to-member ratios would fail with increased enrollment in the MCOs, provider outreach to engage and contract with additional providers in those specialty types is an option the MCOs can consider to ensure that provider-to-member ratios remain less than the standards. Further, results of the distance analysis suggest that provider access will not be affected by Medicaid expansion, assuming that the geographic distribution of new Medicaid enrollees mirrors that of the current membership for both the FFS and managed care programs.

Year One Impact of Medicaid Expansion

By the end of FY 2013−2014, the MCOs saw significant increases in enrollment in their managed care programs, as shown in Table 2-1 on page 2-3. Due to a 90-day claims lag, which is both expected and allowable for managed care claims and encounters to be received from providers, it is somewhat premature for the MCOs to determine the full effect that the Medicaid expansion population has had on service utilization. By August 2014, however, the MCOs have experienced expected and unexpected challenges in managing the care of a population whose health care previously went unchecked. Some of the initial experiences reported by the MCOs are presented below.

HPN

HPN reported a sharp increase in the number of persons who present with significant chronic medical diseases, such as diabetes, osteomyelitis, renal failure, non-healing wounds, as well as mental illness and substance abuse. **HPN** has also experienced an increase in physician services and inpatient and outpatient services. Dental service pre-determination requests have increased sharply as well as acute readmissions to inpatient facilities. **HPN** has also seen an increase in monthly member pharmacy-related costs. Although the health plan has seen an increase in service requests and utilization, **HPN** reports that significant challenges also exist with homeless members who need a skilled level of care for ongoing wound care. Currently, homeless members who require ongoing medical care needs remain in acute hospitals at a skilled level of care. The DHCFP is working with **HPN** to find appropriate placement for aftercare for homeless persons who need ongoing medical care.

Amerigroup

Similar to **HPN** , **Amerigroup** reported an increase in the number of persons with multiple chronic medical and behavioral health conditions. **Amerigroup** reported that inpatient census has doubled since the addition of the Medicaid expansion population. **Amerigroup** also reported that many newly eligible persons have advanced conditions of illnesses such as heart disease, lung disease, kidney disease, and diabetes; many have chronic wounds and advanced cancer. According to **Amerigroup** staff, outpatient behavioral health services, therapy requests, pain management and spinal injections, and prescription medications have sharply increased. **Amerigroup** also reported that additional concurrent review nurses and case managers have been added to the health plan's staff, and the need for additional social workers has increased due to the homeless populations.

Nevada State Quality Strategy

The U.S. Department of Health and Human Services (HHS) Centers for Medicare & Medicaid Services (CMS) Medicaid managed care regulations at 42 CFR 438.200 and 438.202, which implement Section 1932(c)(1) of the Social Security Act, define certain Medicaid state agency responsibilities. The regulations require Medicaid state agencies that operate Medicaid managed care programs to develop and implement a written Quality Assessment and Performance Improvement Strategy (herein referred to as "Quality Strategy") to assess and improve the quality of health care services offered to their members. The written strategy must describe the standards that the state and its contracted MCOs and prepaid inpatient health plans (PIHPs) must meet. The Medicaid state agency must, in part:

- Conduct periodic reviews to examine the scope and content of its Quality Strategy and evaluate its effectiveness.
- Ensure compliance with standards established by the state that are consistent with federal Medicaid managed care regulations.
- Update the strategy periodically, as needed.
- Submit to CMS a copy of its initial strategy, a copy of the revised strategy whenever significant changes have occurred in the program, and regular reports describing the implementation and effectiveness of the strategy.

An evaluation of the DHCFP's progress in meeting the goals and objectives detailed in the Quality Strategy for FY 2013–2014 is provided later in this report.

Quality Strategy Goals and Objectives

The DHCFP's mission is to purchase and ensure the provision of quality health care services, including Medicaid services, to low-income Nevadans in the most efficient manner. Furthermore, 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 determine the potential to maximize federal revenue opportunities. Consistent with this mission, the purpose of the DHCFP's Quality Strategy is to:

- Establish a comprehensive quality improvement system that is consistent with the Triple Aim adopted by CMS to achieve better care for patients, better health for communities, and lower costs through improvement in the health care system.
- Provide a framework for the DHCFP to design and implement a coordinated and comprehensive system to proactively drive quality throughout the Nevada Medicaid and 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 status of the enrolled population and improve health and wellness through preventive care services, chronic disease and special needs management, and health promotion.

- Identify opportunities to improve quality of care and quality of service, and implement improvement strategies to ensure Nevada Medicaid and Check Up recipients have access to high quality and culturally appropriate care.
- Improve recipient satisfaction with care and services.

Consistent with the proposed goals identified in Healthy People 2020 and the National Quality Strategy, the DHCFP established the following quality goals for the 2014−2015 Quality Strategy to improve the health and wellness of Nevada Medicaid and Check Up members and ensure they have access to high-quality and culturally appropriate care:

Goal 1: Improve the health and wellness of Nevada's Medicaid and Check Up population by increasing the use of preventive services, thereby modifying health care use patterns for the population.

Objective 1.1: Increase children's and adolescents' access to PCPs by 10 percent.[1-1]

Objective 1.2: Increase well-child visits (0–15 months) by 10 percent.

Objective 1.3: Increase well-child visits (3–6 years) by 10 percent.

Objective 1.4: Increase the prevalence of blood lead testing for children 1–2 years of age by 10 percent.

Objective 1.5: Decrease avoidable emergency room visits by 10 percent.

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

Objective 2.1: Increase rate of HbA1c testing for members with diabetes by 10 percent.

Objective 2.2: Increase rate of monitoring nephropathy for members with diabetes by 10 percent.

Objective 2.3: Increase LDL-C screening for members with diabetes by 10 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, which detail the health plans' goals, objectives, and processes for reducing and/or eliminating racial or ethnic disparities that negatively impact the quality and timeliness of, and access to, health care.

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 Check Up population.

[1-1] The goal for all measures to increase performance by 10 percent refers to the hybrid Quality Improvement System for Managed Care (QISMC) methodology for reducing the gap between the performance measure rate and 100 percent by 10 percent.

Objective 3.3: Ensure that the MCOs submit an annual evaluation of their cultural competency program to the DHCFP. The MCOs must receive a 100 percent *Met* compliance score for all of the 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 by 10 percent.

To view the State's most recent version of the Quality Strategy, please see https://dhcfp.nv.gov/ManagedCare/EQRO.htm. Stakeholders may provide input into the Quality Strategy at this location.

Annual Quality Strategy Evaluation

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 three goals and the objectives used to measure achievement of the goals. The DHCFP and HSAG update the Quality Strategy Tracking Table annually. In addition to sharing the revised table with the MCOs, the Medicaid and Check Up administration, and other stakeholders, HSAG has included the table in Appendix B. Table 2-7 lists the Quality Strategy goals, objectives, and indicators used to measure achievement, as well as the 2013–2014 status of the evaluation. The DHCFP modifies the performance targets for each of the objectives every two years, thereby raising the bar of performance for the MCOs. For the 2014–2015 Quality Strategy revision, the DHCFP increased the QISMC goal for each of the objectives based on the prior year's performance. The new QISMC performance targets will remain the same through FY 2015. During FY 2016, the DHCFP will consider adopting new QISMC performance targets for the MCOs.

Table 2-6 shows the MCOs' achievement of goals and objectives in FY 2013–2014.

Table 2 6 2013 2014 Quality Strategy Goals and Objectives Summary of Achievement by MCO*

Metric	HPN	Amerigroup
Number of Comparable Rates (Year 1 to Year 2)	20	20
Number of Rates That Improved	5/20 (25%)	9/20 (45%)
Number of Rates That Stayed the Same	0	0
Number of Rates That Achieved New QISMC Goal	1/20 (5%)	1/20 (5%)
Number of Rates That Declined	15/20 (75%)	11/20 (55%)

**Note: This table denotes changes in rates from FY 2013 to FY 2014 only and does not indicate that any changes are statistically significant.*

Table 2 7 2013 2014 Quality Strategy Goals and Objectives			
	Objective		
Goal 1: Improve the health and wellness of Nevada's Medicaid and Check Up population by increasing the use of preventive services, thereby modifying health care use patterns for the population.	**1.1** Increase children's and adolescents' access to PCPs by 10 percent.	*Children's and Adolescents' Access to PCPs* (12–24 months; 25 months–6 years; 7–11 years; 12–19 years).	This was a new objective for the 2014–2015 Quality Strategy. Neither Amerigroup nor HPN achieved the QISMC goal for these measures.
	1.2 Increase well-child visits (0–15 months) by 10 percent.	*Well-Child Visits* in the *First 15 Months of Life*.	Neither Amerigroup nor HPN achieved the newly set QISMC goal for these measures.
	1.3 Increase well-child visits (3–6 years) by 10 percent.	*Well-Child Visits* in the *Third, Fourth, Fifth, and Sixth Years of Life*.	Neither Amerigroup nor HPN achieved the newly set QISMC goal for these measures.
	1.4 Increase the prevalence of blood lead testing for children 1–2 years of age by 10 percent.	*Lead Screening in Children.*	Neither Amerigroup nor HPN achieved the newly set QISMC goal for these measures.
	1.5 Decrease avoidable emergency room visits by 10 percent.	*Avoidable Emergency Room Visit* PIP.	Neither Amerigroup nor HPN achieved the newly set QISMC goal for these measures.
Goal 2: Increase use of evidence-based preventive and treatment practices for members with chronic conditions.	**2.1** Increase rate of HbA1c testing for members with diabetes by 10 percent.	*Comprehensive Diabetes Care—HbA1c Testing*	This is a Medicaid-only measure and is a new objective for the 2014–2015 Quality Strategy. HPN did not achieve the QISMC goal for this measure. Amerigroup, however, did achieve the QISMC goal for this measure.
	2.2 Increase rate of monitoring for nephropathy for members with diabetes by 10 percent.	*Comprehensive Diabetes Care—Medical Attention for Nephropathy*	This is a Medicaid-only measure and is a new objective for the 2014–2015 Quality Strategy. Neither Amerigroup nor HPN achieved the QISMC goal for this measure.
	2.3 Increase LDL-C screening for members with diabetes by 10 percent.	*Comprehensive Diabetes Care—LDL-C Screening*	This is a Medicaid-only measure and is a new objective for the 2014–2015 Quality Strategy. Neither Amerigroup

Table 2 7 2013 2014 Quality Strategy Goals and Objectives			
	Objective		
			nor HPN achieved the QISMC goal for this measure.
Goal 3: Reduce and/or eliminate health care disparities for Medicaid and Nevada Check Up recipients.	**3.1** Ensure that the MCOs develop, submit for review, and annually revise cultural competency plans that detail the health plans' goals, objectives, and processes for reducing and/or eliminating racial or ethnic disparities that negatively impact the quality and timeliness of, and access to, health care.	Cultural Competency Plan (CCP) submission.	Both MCOs submitted the annual CCP and CCP evaluation to the DHCFP for review.
	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 Check Up populations.	Submission of avoidable emergency room utilization data stratified by race and ethnicity, by the MCOs.	Both MCOs stratified data for performance measures and for avoidable emergency room utilization by race and ethnicity and submitted the stratification to the DHCFP and HSAG.
	3.3 Ensure that the MCOs submit an annual evaluation of their cultural competency program to the DHCFP. The MCOs must receive a *Met* compliance score for all of the criteria listed in the MCO contract for cultural competency program development, maintenance, and evaluation.	MCO CCP annual evaluation submission	Both MCOs submitted their CCP annual evaluation to the DHCFP. Both MCOs received *Met* compliance for all requirements of the CCP 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.	**4.1** Increase the rate of postpartum visits by 10 percent.	*Postpartum Care*	Neither Amerigroup nor HPN achieved the newly set QISMC goal for these measures.

Quality Initiatives and Emerging Practices

Emerging practices can be achieved by incorporating evidence-based guidelines into operational structures, policies, and procedures. Emerging practices are born out of continuous quality improvement efforts to improve a particular service, health outcome, systems process, or operational procedure. The goal of these efforts is to improve the quality of and access to services. Only through continuous measurement and analyses to determine the efficacy of an intervention can an emerging practice be identified. Therefore, DHCPF encourages the MCOs to continually track and monitor the efficacy of quality improvement initiatives and interventions to determine if the benefit of the intervention outweighs the 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, the MCOs have the ability to determine which initiatives yield the greatest improvement. Listed below are some of the quality initiatives employed by the health plans to improve performance measure rates and PIP outcomes.

Health Plan of Nevada (HPN)

HPN implemented or maintained the following quality improvement initiatives:

- Provided educational materials and newsletter articles to members about the importance of going to urgent care centers for health issues that require prompt attention. These materials include an explanation of the efficiencies and time savings that result from using urgent care centers versus emergency rooms.
- Encouraged health plan members to access care at urgent care centers within Las Vegas and in northern Nevada. These options gave health plan members the ability to have their urgent care issues addressed outside of normal business hours.
- Maintained chart advisories as a priority quality improvement project led by the Behavioral Healthcare Options (BHO) Care Coordination Task Force.
- Created a new educational brochure on postpartum depression (PPD) to be sent to women scoring at risk for PPD but declining services. This brochure was also offered in Spanish.
- Emphasized the importance of lead screenings by including lead testing reminders in birthday cards sent to members and including articles about lead testing in the member newsletter.
- Expanded the Medicaid physician network.

- Developed a pediatric discharge instruction sheet about asthma. This information, available in English and Spanish, was distributed to parents of children who were discharged from urgent care or the emergency room.
- Provided welcome kits to all pregnant members highlighting the importance of receiving timely prenatal and postpartum care.
- Provided ongoing reminders (e.g., birthday cards, reminder postcards, outreach calls, and immunization schedules in new mother packets) from the health plan to parents/guardians about timely immunizations.
- Expanded multifaceted quality improvement initiatives to improve the rates for children's and adolescents' access to primary physicians including educational materials in the member handbook concerning timely and appropriate PCP visits and call outreach for scheduling primary care appointments.
- Used an automated telephone call outreach intervention to remind members about necessary tests and exams.
- Worked with the BHO to implement initiatives to help health plan members and providers better manage behavioral health issues.
- Enabled the BHO to work with Complex Case Management to educate RN Health Coaches on how to better identify members in these programs who may suffer from depression but have not been formally identified as such.
- Focused education to health plan members about the availability of urgent care services and the 24-hour Telephone Advice Nurse Line continued during 2013.
- Enhanced electronic medical record systems templates for age-specific well-child visits to better track and capture completed well-child visits and immunizations.
- Participated in a Medicaid disparities workgroup to assess the need for focused education on specific health topics for members and providers in various languages and/or to meet specific cultural needs and preferences.
- Developed a program involving two RN health coaches who are certified diabetes educators (CDEs) to work closely with providers' endocrinology staff to increase access to and improve the continuity of care for diabetic members.
- Redesigned the Health Management Program to better meet the needs of members in 2013. Preliminary indicators show that the program was effective in reducing both costly inpatient utilization and improving process outcomes (e.g., higher percentages of members getting appropriate tests—LDL, HbA1c, and retinal eye exams) and outcome measures (e.g., better control of LDL and HbA1c). Members in the Health Management population had 27.7 percent fewer inpatient days per thousand when compared to a similar risk-stratified peer group not participating in the program.

Amerigroup

Amerigroup implemented or maintained the following quality improvement initiatives:

- Initiated meetings between the medical director and individual provider group directors to increase awareness of quality measurements, health plan goals, and provider opportunities and best practices.

- Maintained a program where every associate in the health plan participated in initiatives to increase HEDIS quality scores, which included: identification and implementation of best practices, inclusion of barrier analysis, and ongoing monitoring and evaluation of outcomes.
- Implemented, in partnership with the State, a two-year study/grant "Medicaid Incentives for the Prevention of Chronic Disease" (MIPCD) to incentivize members to obtain diabetic screenings and promote education in improving diabetes care. The study included access to a vision vendor, and provided incentives to members who completed screenings.
- Collaborated with vision and dental vendors to improve HEDIS measure rates.
- Coordinated community-based events and partnered with the Mexican Consulate and community-based organizations to provide member education and outreach in English and Spanish via radio and telephone.
- Targeted members identified as having high emergency department (ED) utilization and implemented multiple interventions including outreach calls, reports to PCPs, and member educational mailings.
- Rewarded providers for achieving quality indicators.
- Provided a suite of reports to patient-centered medical home (PCMH) practices which include daily and weekly reports about member emergency department utilization, inpatient stays, and potential missed care opportunities.
- Improved 2013 Adult CAHPS satisfaction ratings for Specialist and Customer Service to achieve the 75th percentile for Rating of Personal Doctor. The 2013 Child CAHPS rating for Personal Doctor and Specialist met the 50th percentile.
- Continued a project plan developed in 2012 to educate, refine, and streamline the behavioral health network, with a goal to improve behavioral health outpatient services, with the member receiving the right care at the right time.
- Improved the management of Mental Health Rehabilitation services by using the call center and an MD psychiatrist to offer peer-to-peer review.
- Successfully implemented case management redesign which enhanced the ability to identify the most complex members for targeted interventions.
- Used bilingual staff to expand the number of outreach calls to members. These staff members provided education and assistance with over 2,000 appointments.
- Completed a provider satisfaction evaluation using results from the annual Provider Satisfaction Survey coupled with provider complaints to define improvement opportunities and initiate improvement plans.
- Added two data analysts in 2013 to further the analysis of health care and cultural disparities, barriers to treatment, and gaps in care. The analysts' findings guided development of action plans and methods to monitor and evaluate the effectiveness of interventions to improve care and services.
- Used regulatory reports, HEDIS measurements, and provider chart reviews of the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program to develop performance improvement interventions including member and provider education.
- Assessed the effectiveness of disease management and case management programs to ensure the programs demonstrate appropriate clinical outcomes and member and provider satisfaction with services, and acted on opportunities for improvement.

Collaborative Quality Initiatives

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 has enabled the DHCFP to track progress toward meeting the goals and objectives identified in the DHCFP's Quality Strategy. Some of the collaborative activities are described below.

- **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**—During summer 2014, the DHCFP began working with CMS and its subcontractor in support of the nationwide survey of access to care and experiences of care among adult Medicaid enrollees. The survey will be conducted in fall 2014. The DHCFP plans to use results from the CMS nationwide survey to determine the types of quality improvement activities that should be incorporated into its next Quality Strategy revision to improve adult Medicaid members' experiences with health care.
- **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 will enable the MCOs to produce rates that are comparable to the previous year (i.e., without Medicaid expansion) and also establish a "baseline" from which future comparisons could be made for the With Medicaid Expansion Population Included population.
- ***Lead Screening in Children* Collaborative PIP (Lead Screening PIP)**—Since FY 2009–2010, the MCOs have stratified lead screening rates by race and ethnicity to identify any potential disparities in rates of screening among populations. Additionally, the DHCFP has invited other stakeholders, such as staff members from the Nevada Division of Public and Behavioral Health, to the collaborative group sessions to (1) learn about the interventions put in place by the MCOs to increase lead screening rates, and (2) provide additional education to the MCOs' leaders on

the prevalence of lead and its harmful effects in Nevada communities. During FY 2013 and FY 2014, both MCOs encouraged more provider offices to use filter papers to collect blood samples from children. This service enables children to be screened for lead poisoning in provider offices, rather than having parents go to a laboratory to have their child tested. Additionally, MCOs implemented interventions that targeted children under 2 years of age and their parents to obtain lead screenings. For example, **HPN** offered a turtle backpack to members who received a lead screening and childhood immunizations by their second birthday. As a result of these efforts, HEDIS 2014 lead screening rates increased; **HPN** demonstrated an improvement in rates for both Medicaid and Check Up populations, and **Amerigroup** demonstrated improvement in rates for the Nevada Check Up population. The MCOs continue to stratify and evaluate lead screening rates by race and ethnicity to develop effective interventions to continue improvement in overall lead screening rates.

- **Reducing Avoidable Emergency Room (ER) Visits Work Group**—Over the last three years, the DHCFP and MCOs have worked to examine avoidable emergency room (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 were nonemergent, using the New York University (NYU) algorithm for classifying emergency department claims into categories based on primary diagnosis. As part of the collaborative performance improvement project (PIP) activities, HSAG facilitated monthly 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 usage 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 primary care physician (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 that frequented the ER, the MCOs hosted focus groups with members that 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 5:00 p.m. The MCO's staff also made telephone inquiries to members who returned to the ER within 7 to 10 days of an initial visit. Many members reported that 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 that 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 2014 was the second remeasurement year for the *Avoidable Emergency Room Visit* PIP. Health Plan of Nevada reported declines in avoidable ER visits for both the Medicaid and Nevada Check Up populations compared to the baseline measurement. **Amerigroup** reported statistically significant improvement in avoidable ER visits for the Medicaid population over baseline and non-statistically significant improvement over baseline for the Nevada Check Up population. Additional detail about the results for both MCOs' *Avoidable Emergency Room Visit* PIPs may be found in Section 6 of this report.

- **Cultural Competency Program (CCP)**—The MCOs are required to maintain a CCP that encourages 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 a foreign language. The DHCFP has determined that the most prevalent non-English language is Spanish; therefore, both MCOs are required to provide member education materials in Spanish and have Spanish-speaking nurses available to speak with members who call the MCOs' nurse help lines. Additionally, both MCOs are required to contract with Spanish-speaking providers to provide medical services to members. Each MCO submits to the DHCFP its CCP evaluation annually, which includes an evaluation of the cultural competency objectives identified in the DHCFP Quality Strategy and a plan for the following year's cultural competency activities. The DHCFP reviews the CCP evaluations from each MCO and provides feedback to incorporate any required changes for the following fiscal year.
- **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 Check Up quality measures, which are detailed in the DHCFP Quality Strategy. 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 to target interventions to reduce and/or eliminate disparities for members and increase performance measure rates overall. For FY 2013–2014, 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.

Health Information Technology

The primary objective of the Nevada Office of Health Information Technology (OHIT) is to administer the State's ARRA[2-2] Health Information Exchange (HIE) Cooperative Agreement,

[2-2] The American Recovery and Reinvestment Act (ARRA) of 2009.

facilitate the core infrastructure and capacity to enable the statewide HIE, and coordinate related HIT initiatives in Nevada. The infrastructure built as a result of OHIT initiatives facilitates better exchange of health information that can be collected and used to analyze data for continuous quality improvement. Nevada will incorporate both private sector health information technology businesses and additional trained work force personnel to implement, service, and maintain the hardware and software for the electronic health record (EHR) and HIE systems. For example, during the 2012–2013 contract year, the DHCFP established data-sharing agreements with the University of Nevada, Reno's (UNR's) Public Health Program to provide EPSDT, smoking cessation, and dental data to assist UNR with the reporting of Healthy People 2020 goals and objectives. Further, the DHCFP established a data-sharing agreement with the Office of Public Health Informatics and Epidemiology to create an interface between Medicaid's warehouse and the DHHS Division of Health's database to facilitate real-time sharing of vital statistics, immunizations, and other health data.

Additionally, the DHCFP implemented the Nevada Incentive Payment Program for Electronic Records. This program is part of the CMS Electronic Health Records Incentive Program. The program provides incentive payments to eligible professionals (EPs), eligible hospitals (EHs), and critical access hospitals (CAHs) as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology. As of August 1, 2014, a total of 352 providers and 27 hospitals have received over $34.5 million in payments from the Nevada Medicaid EHR Incentive Payment Program.

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 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, HSAG monitors compliance with requirements during the comprehensive compliance review.

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 State's 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 quarterly meeting wherein a member of the Reno Sparks Tribal Health Center (RSTHC) presented information about the barriers that exist for Native Americans in accessing services coordinated by the MCOs. The DHCFP, MCOs, and the RSTHC 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. This ongoing dialogue will occur throughout FY 2014, and the group will continually discuss and evaluate strategies to reduce barriers and improve collaboration.

3. Description of EQR Activities

Mandatory Activities

In accordance with 42 CFR 438.356, the DHCFP contracted with HSAG as the EQRO for the State of Nevada to conduct the mandatory EQR activities as set forth in 42 CFR 438.358. In FY 2013–2014, HSAG conducted the following mandatory EQR activities for the Nevada Medicaid and Check Up programs:

- **Compliance monitoring evaluation:**
  - HSAG performed a comprehensive evaluation of the case management programs operated by the MCOs. The evaluation included an on-site review of case management files to assess the methods used by the MCOs to identify persons for case management services, assess the needs of persons for case management, develop care management treatment plans, and provide case management services for persons enrolled in case management.
  - HSAG performed a comprehensive review of compliance with State and federal standards for both health plans in FY 2011–2012, which initiated a new three-year review cycle of Internal Quality Assurance Program (IQAP) On-Site Review of Compliance. The next IQAP compliance review will occur in FY 2014–2015.
- **Validation of performance measures:** HSAG validated each of the performance measures identified by the State to evaluate their accuracy as reported by, or on behalf of, the MCOs.
- **Validation of PIPs:** HSAG validated the MCOs' PIPs to determine if they were designed to achieve, through ongoing measurement and intervention, significant and sustained improvement in clinical and nonclinical care. HSAG also evaluated if the PIPs would have a favorable effect on health outcomes and enrollee satisfaction.

Optional Activities

HSAG provided technical assistance, upon request, to the DHCFP and the MCOs in areas related to performance measures, PIPs, and quality improvement. In addition, HSAG performed the following activities at the request of the DHCFP:

- Evaluated the State's quality strategy and the managed care program's achievement of the goals and objectives identified in the strategy. HSAG's evaluation of the activities that occurred in support of the State's quality strategy is presented in Section 2.
- Provided an analysis of the results of CAHPS activities conducted by the MCOs, which is presented in Section 7.
- Provided technical assistance to the DHCFP with activities related to the Nevada Comprehensive Care Waiver (NCCW) program. Those activities included:
  - Developing the NCCW Quality Strategy in response to the requirements included in the 1115 Research and Demonstration Waiver.
  - Drafting the NCCW 1115 Demonstration Evaluation Design Plan.

  - Performing a readiness review of the NCCW program vendor to assess the readiness of the vendor to commence operations and provide care management and care coordination services to program enrollees.
  - Performing source code review of the programming code used to calculate NCCW performance measures, which will be calculated by the DHCFP's actuary.
- Conducted an evaluation of the adequacy of resources to serve the newly eligible population after the State of Nevada expanded its Medicaid coverage per the Affordable Care Act (ACA). The analysis estimated the provider network capacity of the MCOs' and fee-for-service (FFS) networks based on population expansion estimates and showed the comparison among current provider ratios by provider type for both MCOs and the FFS program given anticipated enrollment growth projected by the DHCFP following Medicaid expansion. The analysis also showed the distance analysis between members and providers for each provider type for each of these entities.

The DHCFP's EQR contract with HSAG did not require HSAG to conduct or analyze and report results, conclusions, or recommendations from any other CMS-defined optional activities.

4. Internal Quality Assurance Program (IQAP) Review—FY 2013–2014

Overview

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 federal standards and 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. To meet this requirement, the DHCFP contracted with HSAG to perform a comprehensive review of compliance with State and federal standards for **Amerigroup** and **HPN** in FY 2011–2012, which initiated a new three-year cycle of Internal Quality Assurance Program (IQAP) On-Site Review of Compliance. The results of that review are described in the FY 2011–2012 Nevada External Quality Review Technical Report. The next IQAP compliance review is scheduled for FY 2014–2015.

For FY 2013–2014, the DHCFP contracted with HSAG to conduct a comprehensive review of **Amerigroup**'s and **HPN**'s care management programs. HSAG and the DHCFP staff reviewed case management files against contract requirements and standards from the American Case Management Association (ACMA) to determine how each MCO applied the requirements of the contract and which ACMA standards MCOs used in their case management programs. The reviews enabled the DHCFP to determine what, if any, contract changes were needed to strengthen DHCFP's case management requirements of the MCOs. The DHCFP later determined that no contract changes were required.

5. Validation of Performance Measures—HEDIS Compliance Audit—FY 2013–2014

The DHCFP requires the MCOs to submit performance measurement data as part of their quality assessment and performance improvement programs. Validating the MCOs' performance measures is one of the three mandatory BBA external quality review (EQRO) activities described in 42 CFR 438.358(b)(2). To comply with this requirement, the DHCFP contracted with HSAG to validate the performance measures through HEDIS compliance audits. These audits focused on the ability of the MCOs to accurately process claims and encounter data, pharmacy data, laboratory (lab) data, enrollment (or membership) data, and provider data. As part of the HEDIS compliance audits, HSAG also explored the issue of completeness of claims and encounter data to improve rates for the performance measures.

The following section provides summary information from the HEDIS compliance audits conducted by HSAG for **HPN** and **Amerigroup**. Further details regarding the results from the 2014 HEDIS compliance audits may be found in the July 2014 HEDIS Compliance Audit Final Report of Findings.

Objectives

The objectives of the HEDIS compliance audit were to assess the performance of the MCOs with respect to the HEDIS 2014 Technical Specifications and to review their performance on the HEDIS measures. The audits incorporated two main components:

- A detailed assessment of the health plan's information system (IS) capabilities for collecting, analyzing, and reporting HEDIS information.
- A review of the specific reporting methods used for HEDIS measures, including computer programming and the query logic used to access and manipulate data and to calculate measures; databases and files used to store HEDIS information; medical record abstraction tools and abstraction procedures used; and any manual processes employed in HEDIS 2014 data production and reporting. The audit included any data collection and reporting processes supplied by vendors, contractors, or third parties, as well as the MCOs' oversight of these outsourced functions.

The HEDIS performance review evaluated the strengths and weaknesses of the MCOs in achieving compliance with HEDIS measures.

In HEDIS 2014, the MCOs were required to report 11 performance measures with a total of 38 rates for the Medicaid population and eight performance measures with a total of 22 rates for the Check Up population. Table 5-1 lists the required HEDIS 2014 measures for these two populations.

Table 5 1 Required HEDIS 2014 Measures		
Measures	**Medicaid Population**	**Check Up Population**
Children-Related Measures		
Childhood Immunization Status (Combo 2 – Combo 10)	√	√
Lead Screening in Children	√	√
Children's and Adolescents' Access to PCPs	√	√
Well-Child Visits First 15 Months of Life (Six or More Visits)	√	√
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	√	√
Adolescent Well-Care Visits	√	√
Annual Dental Visits—Combined Rate	√	√
Maternity-Related Measures		
Prenatal and Postpartum Care (Timeliness of Prenatal Care and *Postpartum Care)*	√	
Frequency of Ongoing Prenatal Care (<21% Visits and *81–100% Visits)*	√	
Condition-Specific Measures		
Comprehensive Diabetes Care	√	
Use of Appropriate Medications for People With Asthma	√	√*
Follow-up After Hospitalization for Mental Illness	√	√
Utilization and Relative Resource Use Measures		
*Ambulatory Care (Emergency Department Visits**)*	√	√

*The MCOs were required to report NV Check Up HEDIS 2014 rates for the 5–11 and 12–18 age groups only.
**MCOs were also required to report the Emergency Department Visits rate for the *Ambulatory Care* measure as part of the performance improvement project (PIP), *Reducing Avoidable Emergency Department Visits*.

Plan-Specific Findings—Health Plan of Nevada

A detailed review of the 2014 performance reports submitted by **HPN** determined that the reports were prepared according to the HEDIS 2014 Technical Specifications for all of the audited measures, which are listed in Appendix A. Audits of IS capabilities for accurate HEDIS reporting found that **HPN** was compliant with the standards assessed, as follows:

- **HPN** was fully compliant with the IS Standard 1.0 reporting requirements for data capture, transfer, and entry related to claims and encounter data processing. **HPN** used the FACETS system for claims processing. Data entry processes were effective and efficient and assured timely, accurate entry into the system. **HPN** had appropriate procedures and processes in place to receive and monitor electronic submissions. **HPN** staff routinely monitored and trended volume. **HPN** had appropriate processes in place for oversight of vendors, which included review of submitted data and monitoring contract standards.
- **HPN** was fully compliant with the IS Standard 2.0 reporting requirements for enrollment data processing. This process remained the same as the previous year. Membership data were received by **HPN** from the State's vendor and were fully reconciled. **HPN** had adequate processes in place to assure timely and accurate loading of membership data. **HPN** tracked members using the system-issued unique member identification number. This allowed linkage of data if a member lost and regained eligibility. **HPN** also had the ability to link members who switched product lines. Newborns were identified by the mother's ID until they received their own Medicaid ID. There appeared to be no issues with linking the appropriate claims back to the newborn's record using the State-assigned temporary ID.
- **HPN** was fully compliant with the IS Standard 3.0 reporting requirements for provider data processing. All required, provider-related data elements for the HEDIS measures reported for the Medicaid product line were captured and verified within the systems. **HPN** was able to distinguish provider types and specialties as required for HEDIS reporting. Since the Board Certification measures were not reported by the health plan, credentialing and recredentialing verification were not included in the scope of the audit.
- **HPN** was fully compliant with the IS Standard 4.0 reporting requirements for medical record review process. **HPN** staff conducted medical record review. Medical record data were collected into the Verisk hybrid tools. HSAG reviewed the Verisk hybrid tools and instructions and provided feedback to **HPN.** Reviewer qualifications, training, and oversight were appropriate. **HPN** added two new reviewers and subsequently conducted over-read of 100 percent of their records. A convenience sample was not required, and no issues were noted. **HPN** passed the medical record review validation (MRRV) process for the following measure groups:
  - **Group A:** Postpartum Care
  - **Group B:** Well-Child Visits in the First 15 Months of Life
  - **Group C:** Comprehensive Diabetes Care—HbA1c Control (<8.0%)
  - **Group D:** Comprehensive Diabetes Care–Eye Exam (Retinal Performed)
  - **Group F:** No exclusions
- **HPN** was fully compliant with the IS Standard 5.0 reporting requirements for supplemental data. **HPN** received lab data from QUEST and the immunization registry data from the State.

Both of these databases were considered standard supplemental data. This year, **HPN** also included a nonstandard database for chlamydia screening. **HPN** had adequate processes for data receipt, processing, and loading into the HEDIS vendor's software. **HPN** provided all the required supporting documentation for both the standard and nonstandard databases. The nonstandard database only contained only five cases, so all five cases were reviewed for proof-of-service documentation, as required. No issues were identified during primary source verification, and all of these data sources were approved for HEDIS 2014 reporting.

- IS 6.0 was not applicable to the scope of the audit as **HPN** was not required to report the call center measures for Nevada Medicaid and Check Up.
- **HPN** was fully compliant with the IS Standard 7.0 reporting requirements for data integration. The data integration process followed the same method as the prior year. **HPN** used Verisk software, certified for rate calculation. Data were loaded from FACETS into the data warehouse repository. These data were then loaded into Verisk. Reports were generated during each load process to ensure that accurate and complete data were captured. This high-level reporting system helped to ensure the appropriateness of the data and the accuracy of the data transfers. No issues were discovered during primary source verification.

Medicaid Results

The Medicaid HEDIS rates for 2011 through 2014 for **HPN** are presented in Table 5-2, along with the 2013 HEDIS 90th percentile for each measure. Trended results are also provided, comparing the HEDIS 2014 rates with the earliest HEDIS results available in the table. For the two measures with lower rates suggesting better performance (i.e., *Frequency of Ongoing Prenatal Care <21% Visits* and *Comprehensive Diabetes Care—Poor HbA1c Control*), their national Medicaid 10th percentiles are displayed in the 90th percentile column. Rates *below* these percentiles suggest that the MCOs performed above the 90th percentiles.

Table 5 2 Medicaid HEDIS Results for HPN

HEDIS Measure	Medicaid HEDIS Results for HPN[1]				2013 Medicaid HEDIS 90th Percentile	Trended Results
	2011	2012	2013	2014		
Childhood Immunization Status—Combo 2	69.3	73.5	70.32	72.99	***	3.69
Childhood Immunization Status—Combo 3	65.2	67.6	66.42	67.88	***	2.68
Childhood Immunization Status—Combo 4	36.0	40.6	66.18	66.42	***	30.42
Childhood Immunization Status—Combo 5	46.7	50.6	51.34	57.42	***	10.72
Childhood Immunization Status—Combo 6	30.2	28.5	36.74	40.15	***	9.95
Childhood Immunization Status—Combo 7	27.3	32.6	51.09	56.69	***	29.39
Childhood Immunization Status—Combo 8	20.0	19.5	36.74	39.90	***	19.90
Childhood Immunization Status—Combo 9	24.3	23.8	30.41	36.50	***	12.20
Childhood Immunization Status—Combo 10	16.3	16.3	30.41	36.25	***	19.95
Lead Screening in Children	26.3	29.4	32.36	37.23	***	10.93
Children's and Adolescents' Access to PCPs (12–24 Months)	92.9	92.7	93.00	91.73	***	-1.17
Children's and Adolescents' Access to PCPs (25 Months–6 Years)	83.5	82.4	80.49	78.58	***	-4.92
Children's and Adolescents' Access to PCPs (7–11 Years)	85.2	84.1	82.99	82.35	***	-2.85
Children's and Adolescents' Access to PCPs (12–19 Years)	83.2	82.2	78.82	78.37	***	-4.83
Well-Child Visits First 15 Months (Six or More Visits)	52.6	49.4	51.34	54.50	***	1.90
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	56.9	63.0	57.42	54.74	***	-2.16
Adolescent Well-Care Visits	38.9	37.0	33.09	42.09	***	3.19
Annual Dental Visit—Combined Rate	58.1	59.4	54.71	53.32	***	-4.78
Timeliness of Prenatal Care	87.1	81.3	85.89	74.94	***	-12.16
Postpartum Care	60.8	67.2	64.96	57.66	***	-3.14
Frequency of Ongoing Prenatal Care (< 21% Visits)*	7.8	3.9	8.03	18.00	***	10.20
Frequency of Ongoing Prenatal Care (81–100% Visits)	68.6	73.0	68.13	59.37	***	-9.23
Comprehensive Diabetes Care—HbA1c Testing	74.0	72.8	69.98	69.59	***	-4.41
Comprehensive Diabetes Care—Poor HbA1c Control*	53.8	52.8	55.07	54.50	***	0.70
Comprehensive Diabetes Care—Good HbA1c Control (< 8%)	37.8	38.2	36.14	37.47	***	-0.33
Comprehensive Diabetes Care—Eye Exams	40.9	49.6	44.55	44.04	***	3.14
Comprehensive Diabetes Care—LDL-C Screening	66.4	67.4	67.88	63.75	***	-2.65
Comprehensive Diabetes Care—LDL-C Level <100	26.9	32.6	29.45	27.49	***	0.59

Table 5 2 Medicaid HEDIS Results for HPN						
HEDIS Measure	Medicaid HEDIS Results for HPN[1]				2013 Medicaid HEDIS 90th Percentile	Trended Results
	2011	2012	2013	2014		
Comprehensive Diabetes Care—Blood Pressure <140/90	57.1	60.8	65.39	69.10	***	12.00
Comprehensive Diabetes Care—Blood Pressure <140/80	32.8	36.7	37.48	40.15	***	7.35
Comprehensive Diabetes Care—Monitoring for Nephropathy	74.8	67.4	72.47	72.75	***	-2.05
Use of Appropriate Medications for People With Asthma (5–11 Years)	95.0	92.7	89.38	90.45	***	-4.55
Use of Appropriate Medications for People With Asthma (12–18 Years)	NA	84.0	83.15	86.82	***	2.82
Use of Appropriate Medications for People With Asthma (19–50 Years)	NA	58.3	60.91	58.57	***	0.27
Use of Appropriate Medications for People With Asthma (51–64 Years)	-	NA	NA	NA	***	-
Use of Appropriate Medications for People With Asthma (Combined)	88.3	85.6	84.42	84.54	***	-3.76
Follow-up After Hospitalization for Mental Illness—7 Days	49.5	59.6	77.08	68.83	***	19.33
Follow-up After Hospitalization for Mental Illness—30 Days	67.0	70.2	86.46	81.82	***	14.82

* Lower rates are better for this measure, so the 2013 National Medicaid HEDIS 10th percentile is used for percentile comparison. Additionally, positive values shown in the Trended Results column for this measure should be interpreted as declines in performance.
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NA is shown when the health plan followed HEDIS specifications but the denominator was too small (n<30) to report a valid rate.
[1] Rates are displayed to two decimal places to be consistently compared against the Medicaid HEDIS 2013 percentiles. For consistency, the HEDIS 2011 and 2012 rates are displayed to one decimal place as in previous technical reports.

All of **HPN**'s rates were reportable for HEDIS 2014, though *Use of Appropriate Medications for People With Asthma* (51–64 years) had less than 30 eligible cases and is displayed as NA. The rate for *Follow-up After Hospitalization for Mental Illness—7 Days* was above the Medicaid HEDIS 2013 90th percentile. Overall, 20 rates showed performance improvement over last year, and 17 rates declined.

Twelve of the 18 children-related measures reported a rate increase from HEDIS 2013 ranging from an improvement of 0.24 percentage points for *Childhood Immunization Status (Combo 4)* to 9.0 percentage points for *Adolescent Well-Care Visits.* All four rates for *Children's and Adolescent's Access to PCPs*, along with the *Annual Dental Visit* rate continued to show a decline. These measures are related to the HEDIS domain of access to care.

All four maternity-related measures showed a decline from HEDIS 2013, ranging from 7.3 percentage points to 10.95 percentage points. These maternity-related measures tend to be related to both timeliness and access.

In regard to the condition-specific measures, five *Comprehensive Diabetes Care* rates showed small improvements from HEDIS 2013. Three rates of the *Use of Appropriate Medications for People With Asthma* measure showed an increase from the previous year. Both indicators under *Follow-Up After Hospitalization for Mental Illness* reported rate decreased from HEDIS 2013. However, the trend shows a 19.33 and 14.82 percentage point gain since HEDIS 2011, for the 7-day and 30-day rates, respectively. In addition, the 7-day indicator for this year still ranked above the National Medicaid HEDIS 2013 90th percentile.

In terms of quality and access, **HPN** appeared to provide appropriate services to its members. Twenty of the 37 measures with baseline rates in either 2011 or 2012 showed performance improvement over time, with 12 demonstrating a rate increase of at least 7 percentage points. Most of the measures indicating improvement were the *Childhood Immunization Status* measures, the *Comprehensive Diabetes Care* blood pressure measures, and the *Follow-up After Hospitalization for Mental Illness* measure. Over time, 17 measures reported performance decline ranging from 0.33 percentage points to 12.16 percentage points. Of these measures, *Timeliness of Prenatal Care* had the largest decline in performance since HEDIS 2011 (12.16 percentage points).

Nevada Check Up Results

The Nevada Check Up HEDIS rates for 2011 through 2014 for **HPN** are presented in Table 5-3, along with the 2013 HEDIS 90th percentile and the trended results. Since HEDIS percentiles are not available for the Children's Health Insurance Program (CHIP) population, the Nevada Check Up rates are compared to the HEDIS Medicaid percentiles; therefore, caution should be exercised when comparing the rates.

Table 5 3 Nevada Check Up Results for HPN HPN

HEDIS Measure	Nevada Check Up HEDIS Results for HPN[1]				2013 Medicaid HEDIS 90th Percentile*	Trended Results
	2011	2012	2013	2014		
Childhood Immunization Status—Combo 2	85.1	86.4	90.96	85.21	***	0.11
Childhood Immunization Status—Combo 3	80.7	82.2	85.64	83.10	***	2.40
Childhood Immunization Status—Combo 4	56.6	57.1	84.57	83.10	***	26.50
Childhood Immunization Status—Combo 5	63.2	67.5	72.34	72.54	***	9.34
Childhood Immunization Status—Combo 6	38.6	36.1	47.87	48.59	***	9.99
Childhood Immunization Status—Combo 7	44.7	48.2	71.81	72.54	***	27.84
Childhood Immunization Status—Combo 8	28.1	29.8	47.87	48.59	***	20.49
Childhood Immunization Status—Combo 9	33.3	31.4	43.62	42.96	***	9.66
Childhood Immunization Status—Combo 10	25.4	25.7	43.62	42.96	***	17.56
Lead Screening in Children	45.2	50.8	50.53	55.24	***	10.04
Annual Dental Visit—Combined Rate	75.7	78.1	76.09	77.21	***	1.51
Children's and Adolescents' Access to PCPs (12–24 Months)	96.9	97.6	96.95	95.08	***	-1.82
Children's and Adolescents' Access to PCPs (25 Months–6 Years)	93.0	93.1	92.85	91.39	***	-1.61
Children's and Adolescents' Access to PCPs (7–11 Years)	95.0	94.2	94.95	94.88	***	-0.12
Children's and Adolescents' Access to PCPs (12–19 Years)	93.2	93.0	90.91	91.49	***	-1.71
Well-Child Visits First 15 Months (Six or More Visits)	56.9	56.6	65.00	63.01	***	6.11
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.0	74.2	69.34	73.72	***	0.72
Adolescent Well-Care Visits	50.1	50.9	49.64	54.26	***	4.16
Use of Appropriate Medications for People With Asthma (5–11 Years)	98.5	98.4	93.51	97.00	***	-1.50
Use of Appropriate Medications for People With Asthma (12–18 Years)	NA	95.8	86.89	91.94	***	-3.86
Follow-up After Hospitalization for Mental Illness—7 Days	55.6	57.5	NA	NA	***	-
Follow-up After Hospitalization for Mental Illness—30 Days	75.0	67.5	NA	NA	***	-

*Because national HEDIS 2013 Medicaid percentiles are not available for the CHIP population, rate comparison against the HEDIS 2013 Medicaid percentiles should be interpreted with caution.
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NA is shown when the health plan followed HEDIS specifications but the denominator was too small (<30) to report a valid rate.
[1] Rates are displayed to two decimal places to be consistently compared against the Medicaid HEDIS 2013 percentiles. For consistency, the HEDIS 2011 and 2012 rates are displayed to one decimal place as in previous technical reports.

All of **HPN**'s rates were reportable for HEDIS 2014, though *Follow-up After Hospitalization for Mental Illness* had less than 30 eligible cases for both rates and is displayed as NA. Five rates were above the National Medicaid HEDIS 90th percentile; three of these were *Childhood Immunization Status* measure rates.

Compared to HEDIS 2013, 11 rates showed an increase ranging from 0.20 percentage points for *Childhood Immunization Status (Combo 5)* to 5.05 percentage points for *Use of Appropriate Medications for People With Asthma (12–18 Years)*. Nine rates reported a decline ranging from 0.07 percentage points to 5.75 percentage points (for *Childhood Immunization Status–Combo 2*).

In terms of quality, **HPN** continued to improve the delivery of services to enrolled members. Fourteen measures with baseline rates in either 2011 or 2012 demonstrated performance improvement, with nine reporting a rate increase of at least 5 percentage points. The greatest improvement was seen in the *Childhood Immunization Status* measure (*Combo 4*: 26.50 percentage points; *Combo 7*: 27.84 percentage points; and *Combo 8*: 20.49 percentage points). Six rates (all four *Children's and Adolescents' Access to PCPs* rates and both *Use of Appropriate Medications for People With Asthma* rates) reporting a decline over time, but no declines were greater than 5 percentage points.

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, 5, 6, 7, 8, 9,* and *10*
- *Lead Screening in Children*
- *Comprehensive Diabetes Care—Blood Pressure <140/90* and *Blood Pressure <140/80*
- *Follow-up After Hospitalization for Mental Illness—7–Day* and *30–Day*

All HEDIS 2014 Check Up rates were higher than the corresponding Medicaid reported rates. The following Nevada Check Up performance measures were identified as strengths for **HPN** based rate improvements greater than 5 percentage points over time.

- *Childhood Immunization Status—Combinations 4,5,6, 7, 8, 9,* and *10*
- *Lead Screening in Children*
- *Well-Child Visits First 15 Months (Six or More Visits)*

Summary of HPN Opportunities for Improvement

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

- *Timeliness of Prenatal Care*
- *Frequency of Ongoing Prenatal Care— <21%Visits* and *81–100% Visits*

In addition, measures related to access to care have continued to decline each year. **HPN** should conduct an analysis to determine if these results are due to member noncompliance, issues with network adequacy, or other potential barriers preventing members from accessing timely care.

None of the Nevada Check Up performance measures showed a decline of greater than 5 percentage points. The greatest decline was noted for the *Use of Appropriate Medications for People With Asthma (12–18 Years)* indicator (3.86 percentage points) and was an identified opportunity for improvement.

Data Completeness

Table 5-4 provides an estimate of data completeness for the hybrid performance measures for both Medicaid and Nevada Check Up for **HPN**. These measures use administrative data (i.e., claims and encounter data) and supplement the results with medical record data. The table displays the HEDIS 2014 final rate and the percentage determined solely through administrative data for both populations, respectively. For example, a rate of 100 percent in the last two columns indicates that administrative data were complete for that HEDIS measure (i.e., no additional numerator compliance was determined via medical record review).

Table 5 4 Estimated Data Completeness for HPN Hybrid Measures

HEDIS Hybrid Measures	2014 HEDIS Rate		Percent From Administrative Data	
	Medicaid	Nevada Check Up	Medicaid	Nevada Check Up
Childhood Immunization Status—Combo 2	72.99	85.21	76.67	68.60
Childhood Immunization Status—Combo 3	67.88	83.10	46.24	22.88
Lead Screening in Children	37.23	55.24	98.69	100.00
Well-Child Visits—First 15 Months (Six or More Visits)	54.50	63.01	87.95	78.26
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	54.74	73.72	92.44	93.40
Adolescent Well-Care Visits	42.09	54.26	94.22	96.86
Medicaid-Only HEDIS Measures				
Timeliness of Prenatal Care	74.94		44.81	
Postpartum Care	57.66		32.49	
Frequency of Ongoing Prenatal Care (81–100% Visits)	59.37		16.39	
Comprehensive Diabetes Care—HbA1c Testing	69.59		94.41	
Comprehensive Diabetes Care—Good HbA1c Control (<8%)	37.47		86.36	
Comprehensive Diabetes Care—Eye Exams	44.04		76.24	
Comprehensive Diabetes Care—LDL-C Screening	63.75		95.04	
Comprehensive Diabetes Care—LDL-C Level <100	27.49		80.53	
Comprehensive Diabetes Care—Monitoring for Nephropathy	72.75		98.33	

Rates in **green** indicate that more than 90 percent of the final rate was derived from administrative data.
Rates in **red** indicate that 50 percent or less of the final rate was derived from administrative data.
The data completeness for *Childhood Immunization Status Combos 4–10* must be the same or lower as the Combo 3 data completeness rate.

Table 5-4 shows that for both Medicaid and Nevada Check Up populations, **HPN** had over 90 percent of the final rate derived from administrative data (highlighted in green) for *Lead Screening in Children*; *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*; and *Adolescent Well-Care Visits* measures. These rates indicate that the administrative data are mostly complete. *Childhood Immunization Status–Combo 3* is the only measure for which less than half of the final rate was derived from administrative data for both populations, indicating that **HPN** relied heavily on medical record data for the childhood immunization measure.

For Medicaid-only measures, three rates from the *Comprehensive Diabetes Care* measure (*HbA1c Testing*, *LDL-C Screening*, and *Monitoring for Nephropathy*) had over 90 percent of the final rate deriving from administrative data. All three maternity-related measures had less than 50 percent of the final rate derived from administrative data.

These findings suggest that, in general, **HPN** displayed good data completeness. However, **HPN** continued to have difficulty in obtaining complete encounter data for childhood immunizations for both Medicaid and Nevada Check Up populations and maternity care (for Medicaid reporting only). The difficulty of administrative data collection for childhood immunization may be attributed to immunizations often being provided at locations other than the provider's office (e.g., health fairs, schools). In these cases, **HPN** would generally not receive a claim for the immunization. The maternity-related administrative data completeness issue appears to be associated with global billing. However, providers should still submit encounter data for maternity care. **HPN** should focus on this area for the next audit year. Since medical record abstraction was performed for these measures, final rates were not impacted.

Plan-Specific Findings—Amerigroup

A detailed review of the 2014 performance reports submitted by **Amerigroup** determined that the reports were prepared according to the HEDIS 2014 Technical Specifications for all of the audited measures. Audits of IS capabilities for accurate HEDIS reporting found that **Amerigroup** was compliant with the standards assessed, as follows:

- **Amerigroup** was fully compliant with the IS Standard 1.0 reporting requirements for claims and encounter data processing. There were no major changes in the systems or processes used for receiving and managing medical claims. **Amerigroup** received paper and electronic claims daily. As in prior years, **Amerigroup** continued to use FACETS as its claims processing system. Paper claims were received by the Document Management Group, scanned, and sent to two local vendors for keying. Using a standard Health Insurance Portability and Accountability Act (HIPAA) 837 format, all files were transmitted back to **Amerigroup**. Electronic claims were received from three clearinghouses (Emdeon, Capario, and Availity) or via the provider Web portal where providers could key in the claims directly. All claims were loaded into a central repository where edit checks were applied. Claims that passed the edit checks were loaded into FACETS nightly for adjudication. Sufficient controls and vendor oversight were in place to ensure claims were accurately and completely received and transmitted into FACETS. **Amerigroup** conducted different types of claims audits, including a weekly market-specific audit to ensure financial and payment accuracy of claims processing. Vision claims and pharmacy claims were contracted out to vendors and monitored by the National Account Department. These claims were loaded into **Amerigroup**'s data warehouse (ODW), and data were checked before being included for HEDIS reporting. No major deficiencies were noted during the measurement year.

  During the measurement year, vision data were received from DentaQuest, dental data were received from Scion, and pharmacy data were received from CareMark. These ancillary vendors submitted data monthly. These data were loaded into the warehouse after passing a series of compliance checks to ensure accuracy. HSAG had no concerns with any of the sources of vendor data or claims and encounters received by **Amerigroup**.
- **Amerigroup** was fully compliant with the IS Standard 2.0 reporting requirements for enrollment data processing. Similar to last year, monthly files with HIPAA 834 format from the State were received and assessed via compliance checks and business rules before loading into FACETS. Enrollment analysts used the Membership Eligibility Editing Tool (MEET) to identify and correct any data discrepancy or anomaly. Enrollment data were processed in a timely manner. Every month **Amerigroup** reconciled the enrollment data in FACETS with the State's data. No major concerns with enrollment data processing were identified. Since newborns have their own **Amerigroup** member ID number, there were no concerns in identifying all claims associated with newborns.
- **Amerigroup** was fully compliant with the IS Standard 3.0 reporting requirements for provider data processing. Credentialing information was maintained in CACTUS and practitioner specialty information in FACETS. There were no major concerns with practitioner data processing.
- **Amerigroup** was fully compliant with the IS Standard 4.0 reporting requirements for the medical record review process. The MCO contracted with Inovalon, Inc., (Inovalon) as its

NCQA-certified software vendor and for medical record pursuit and abstraction. Medical record data were collected into the Inovalon hybrid tools. HSAG reviewed Inovalon's hybrid tools and corresponding instructions and found no concerns. Reviewer qualifications, training, and oversight were appropriate. **Amerigroup**'s oversight of the vendor was appropriate. Due to abstraction errors noted during the 2014 MRRV, a convenience sample was required for the *Well-Child Visits in the First 15 Months of Life (6+ Visits)* measure and subsequently passed.

Amerigroup passed the MRRV process for the following measure groups:

- Group A: Timeliness of Prenatal Care
- Group B: Adolescent Well-Care Visits
- Group B: Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
- Group C: Comprehensive Diabetes Care—HbA1c Control (<8.0%)
- Group D: Comprehensive Diabetes Care—Eye Exam (Retinal) Performed
- Group F: No exclusions

Upon validation of the *Adolescent Well-Care Visits* (AWC) measure, one abstraction error was found. Since there were no further cases to review, HSAG extrapolated the findings to the *Well-Child Visits in the First 15 Months of Life* (W15) measure. Upon validation of the W15 measure, three abstraction errors were noted. HSAG validated the remaining 14 cases and did not detect any further abstraction errors. **Amerigroup** removed cases that involved abstraction errors from the numerator category.

- **Amerigroup** was fully compliant with the IS Standard 5.0 reporting requirements for supplemental data**. Amerigroup** utilized multiple standard databases and one nonstandard database. Standard databases used by **Amerigroup** included immunization registry data, WebIZ, and lab results from Quest and LabCorp. One nonstandard database, a medical record database, was used for HEDIS 2014. Primary source verification was conducted on the nonstandard database and approved for use during HEDIS 2014.
- IS 6.0 was not applicable to the scope of the audit as **Amerigroup** was not required to report the call center measures for Nevada Medicaid and Check Up.
- **Amerigroup** was fully compliant with the IS Standard 7.0 reporting requirements for data integration. **Amerigroup** contracted with the same calculation vendor (Inovalon) as the previous year and used its Quality Spectrum Insight (QSI) software to generate HEDIS measures in-house on a monthly basis. All applicable data were first loaded to the HEDIS data warehouse from its respective sources (i.e., FACETS, ODW, and other data warehouses) before being loaded to the QSI server. At each data transfer/transmission point, **Amerigroup** evaluated the completeness and accuracy of data. **Amerigroup** had thorough and detailed processes in place to ensure no data were lost during the integration process. **Amerigroup** used a comprehensive tracking spreadsheet to monitor all volumes of HEDIS data. This process was extremely well-developed and should be considered a best practice. Preliminary rates were reviewed informally on-site with no major concerns. Primary source verification was conducted on-site, and no issues were identified through this review.

Medicaid Results

The Medicaid HEDIS 2014 rates for **Amerigroup** are presented in Table 5-5, along with the 2013 HEDIS 90th percentile and the trended results, when applicable.

Table 5 5 Medicaid HEDIS Results for Amerigroup

HEDIS Measure	Medicaid HEDIS Results for Amerigroup[1]				2013 Medicaid HEDIS 90th Percentile	Trended Results
	2011	2012	2013	2014		
Childhood Immunization Status—Combo 2	65.5	69.0	70.60	61.34	***	-4.16
Childhood Immunization Status—Combo 3	59.4	64.1	66.20	55.32	***	-4.08
Childhood Immunization Status—Combo 4	31.0	41.4	64.58	54.63	***	23.63
Childhood Immunization Status—Combo 5	44.1	45.4	50.93	45.37	***	1.27
Childhood Immunization Status—Combo 6	23.3	29.4	37.04	29.86	***	6.56
Childhood Immunization Status—Combo 7	22.6	31.7	50.23	44.91	***	22.31
Childhood Immunization Status—Combo 8	15.2	21.8	36.81	29.63	***	14.43
Childhood Immunization Status—Combo 9	18.4	20.6	29.40	25.93	***	7.53
Childhood Immunization Status—Combo 10	11.4	16.7	29.40	25.69	***	14.29
Lead Screening in Children	28.7	33.3	34.49	34.26	***	5.56
Children's and Adolescents' Access to PCPs (12–24 Months)	94.7	95.0	94.84	93.58	***	-1.12
Children's and Adolescents' Access to PCPs (25 Months–6 Years)	85.8	85.4	84.62	83.40	***	-2.4
Children's and Adolescents' Access to PCPs (7–11 Years)	84.4	84.7	84.65	84.96	***	0.56
Children's and Adolescents' Access to PCPs (12–19 Years)	80.7	80.5	81.41	80.97	***	0.27
Well-Child Visits First 15 Months (Six or More Visits)	51.4	57.6	55.79	53.47	***	2.07
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	66.4	66.1	65.38	63.08	***	-3.32
Adolescent Well-Care Visits	37.6	35.7	37.27	37.96	***	0.36
Annual Dental Visit—Combined Rate	49.6	53.2	51.02	44.99	***	-4.61
Timeliness of Prenatal Care	83.8	82.3	88.84	83.98	***	0.18
Postpartum Care	59.6	58.8	61.76	59.22	***	-0.38
Frequency of Ongoing Prenatal Care (<21% Visits)*	10.4	11.3	4.51	9.47	***	-0.93
Frequency of Ongoing Prenatal Care (81–100% Visits)	65.3	66.0	75.30	63.83	***	-1.47
Comprehensive Diabetes Care—HbA1c Testing	73.6	71.6	68.75	73.99	***	0.39
Comprehensive Diabetes Care—Poor HbA1c Control*	53.8	54.3	52.98	54.16	***	0.36
Comprehensive Diabetes Care—Good HbA1c Control (<8%)	39.2	38.6	41.37	38.34	***	-0.86
Comprehensive Diabetes Care—Eye Exams	48.6	42.8	53.57	53.62	***	5.02
Comprehensive Diabetes Care—LDL-C Screening	67.5	64.4	65.18	68.10	***	0.60
Comprehensive Diabetes Care—LDL-C Level <100	28.3	29.7	31.25	31.10	***	2.8
Comprehensive Diabetes Care—Blood Pressure <140/90	60.8	62.4	61.61	58.45	***	-2.35
Comprehensive Diabetes Care—Blood Pressure <140/80	39.6	36.3	36.61	34.05	***	-5.55
Comprehensive Diabetes Care—Monitoring for Nephropathy	66.5	69.0	63.99	67.29	***	0.79
Use of Appropriate Medications for People With Asthma (5–11 Years)	96.3	87.2	86.43	84.16	***	-12.14
Use of Appropriate Medications for People With Asthma (12–18 Years)	NA	88.0	82.73	77.86	***	-10.14

Table 5 5 Medicaid HEDIS Results for Amerigroup						
HEDIS Measure	Medicaid HEDIS Results for Amerigroup[1]				2013 Medicaid HEDIS 90th Percentile	Trended Results
	2011	2012	2013	2014		
Use of Appropriate Medications for People With Asthma (19–50 Years)	NA	74.6	73.08	60.23	***	-14.37
Use of Appropriate Medications for People With Asthma (51–64 Years)**	NA	NA	NA	NA	***	--
Use of Appropriate Medications for People With Asthma (Combined)	91.9	85.5	83.48	78.82	***	-13.08
Follow-up After Hospitalization for Mental Illness—7 Days	45.1	59.2	54.49	62.13	***	17.03
Follow-up After Hospitalization for Mental Illness—30 Days	60.9	68.4	67.31	68.64	***	7.74

* Lower rates are better for this measure, so it uses the 2013 National Medicaid HEDIS 10th percentile for comparison. Additionally, positive values shown in the Trended Results column for this measure should be interpreted as declines in performance.
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NA is shown when the health plan followed HEDIS specifications but the denominator was too small (n<30) to report a valid rate.
[1] Rates are displayed to two decimal places to be consistently compared against the Medicaid HEDIS 2013 percentiles. For consistency purposes, the HEDIS 2011 and 2012 rates are displayed to one decimal place as in previous technical reports.

All of **Amerigroup**'s rates were reportable for HEDIS 2014, though *Use of Appropriate Medications for People with Asthma (51–64 years)* had less than 30 eligible cases and is displayed as NA. None of the rates for **Amerigroup** were above the 2013 National Medicaid HEDIS 90th percentile this year. Overall, eight rates had a performance improvement, ranging from 0.05 percentage points for *Comprehensive Diabetes Care (Eye Exams)* to 7.64 percentage points for *Follow-up After Hospitalization for Mental Illness–7 Days*. Twenty-nine rates reported a decline from HEDIS 2013, ranging from 0.15 percentage points or the *Comprehensive Diabetes Care—LDL-C Level <100* indicator to 12.85 percentage points for the *Use of Appropriate Medications for People With Asthma—19–50 Years* indicator.

Only two of the 18 children-related measures (*Adolescent Well-Care Visits* and *Children's and Adolescents' Access to PCPs—7–11 Years)* showed a rate increase from 2013, and both of the increases were less than 1 percentage point. The remaining measures showed a decline in rates ranging from 0.60 percentage points to 10.88 percentage points.

All four maternity-related measures showed a decline from HEDIS 2013 ranging from 2.54 percentage points to 11.47 percentage points. These maternity-related measures tend to be related to both timeliness and access.

Regarding the condition-specific measures, four Comprehensive Diabetes Care indicator rates and both *Follow-up After Hospitalization for Mental Illness* indicator rates showed improvement from HEDIS 2013. The increases ranged from 0.05 percentage points to 7.64 percentage points. All of the *Use of Appropriate Medications for People With Asthma* rates continued to decline.

In terms of quality and access, **Amerigroup** appeared to provide appropriate services to its members. Twenty-one of the 37 measures with baseline rates either in 2011 or 2012 showed performance improvement over time, with 10 demonstrating an improvement of at least 5

percentage points. Conversely, 16 measures showed a performance decline, ranging from 0.36 percentage points to 14.37 percentage points. Rates with declines greater than 5.0 percentage points were all condition-specific measures.

Nevada Check Up Results

The Nevada Check Up HEDIS 2014 rates for **Amerigroup** are presented in Table 5-6 along with the 2013 HEDIS 90th percentile and trended results from earliest available rates in the table, when applicable. Since HEDIS percentiles are not available for the CHIP population, the Nevada Check Up rates are compared to the HEDIS Medicaid percentiles; therefore, caution should be exercised when comparing the rates.

Table 5 6 Nevada Check Up HEDIS Results for Amerigroup

HEDIS Measure	Nevada Check Up HEDIS Results for Amerigroup[1]				2013 Medicaid HEDIS 90th Percentile*	Trended Results
	2011	2012	2013	2014		
Childhood Immunization Status—Combo 2	84.8	84.2	84.47	76.99	***	-7.81
Childhood Immunization Status—Combo 3	79.5	81.6	76.70	76.11	***	-3.39
Childhood Immunization Status—Combo 4	50.0	59.7	76.70	74.34	***	24.34
Childhood Immunization Status—Combo 5	62.5	70.2	66.99	68.14	***	5.64
Childhood Immunization Status—Combo 6	41.1	42.1	53.40	51.33	***	10.23
Childhood Immunization Status—Combo 7	38.4	52.6	66.99	67.26	***	28.86
Childhood Immunization Status—Combo 8	32.1	33.3	53.40	49.56	***	17.46
Childhood Immunization Status—Combo 9	31.3	40.4	48.54	46.90	***	15.60
Childhood Immunization Status—Combo 10	25.9	31.6	48.54	46.02	***	20.12
Lead Screening in Children	39.3	44.7	49.51	50.44	***	11.14
Annual Dental Visit—Combined Rate	68.9	72.4	74.31	67.67	***	-1.23
Children's and Adolescents' Access to PCPs (12–24 Months)	98.9	99.0	100	98.85	***	-0.05
Children's and Adolescents' Access to PCPs (25 Months–6 Years)	95.1	95.5	95.07	94.11	***	-0.99
Children's and Adolescents' Access to PCPs (7–11 Years)	93.9	95.1	97.06	97.25	***	3.35
Children's and Adolescents' Access to PCPs (12–19 Years)	87.2	91.0	93.30	93.69	***	6.49
Well-Child Visits First 15 Months (Six or More Visits)	55.9	51.5	51.28	54.05	***	-1.85
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	82.6	76.4	78.82	78.74	***	-3.86
Adolescent Well-Care Visits	48.4	54.4	56.71	58.22	***	9.82
Use of Appropriate Medications for People With Asthma (5–11 Years)	NA	96.0	90.74	92.50	***	-3.50
Use of Appropriate Medications for People With Asthma (12–18 Years)	NA	NA	73.08	NA	***	-
Follow-up After Hospitalization for Mental Illness—7 Days	NA	NA	NA	NA	***	-
Follow-up After Hospitalization for Mental Illness—30 Days	NA	NA	NA	NA	***	-

*Because national HEDIS 2013 Medicaid percentiles are not available for the CHIP population, rate comparison against the HEDIS 2013 Medicaid percentiles should be interpreted with caution.

*** The NCQA Audit Means and Percentiles data that are composed of HEDIS Means and Percentiles for Reporting are the proprietary intellectual property of NCQA. The reports are to be used only for internal analysis and may not be displayed publicly. NCQA does not allow the public sharing of the actual NCQA Audit Means and Percentiles data.

NA is shown when the health plan followed HEDIS specifications but the denominator was too small (<30) to report a valid rate.

[1] Rates are displayed to two decimal places to be consistently compared against the Medicaid HEDIS 2013 percentiles. For consistency purposes, the HEDIS 2011 and 2012 rates are displayed to one decimal place as in previous technical reports.

All of **Amerigroup's** rates were reportable for HEDIS 2014, though *Follow-up After Hospitalization for Mental Illness* and *Use of Appropriate Medications for People With Asthma*

(12–18 years) had less than 30 eligible cases and are displayed as NA. Overall, five rates ranked above the National Medicaid 90th percentile, with two from the *Childhood Immunization Status* measure and the other three from the *Children's and Adolescents' Access to PCPs* measure. Compared to HEDIS 2013, eight rates showed an increase, ranging from 0.19 for *Children's and Adolescents' Access to PCPs (7–11 Years)* to 2.77 percentage points for *Well-Child Visits First 15 Months (Six or More Visits).*

Eleven rates reported a decline from HEDIS 2013, ranging from 0.08 to 7.48 percentage points, with the largest decline found in the *Childhood Immunization Status—Combo 2* indicator.

In terms of quality and access, **Amerigroup** continued to provide appropriate services and improved the delivery of services to members. Eleven of the 19 measures with baseline rates in either 2011 or 2012 improved over time, and 10 of those rates improved by at least 5 percentage points.

Summary of Amerigroup Strengths

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

- *Childhood Immunization Status—Combinations 4, 6, 7, 8, 9,* and *10*
- *Lead Screening in Children*
- *Comprehensive Diabetes Care—Eye Exams*
- *Follow-up After Hospitalization for Mental Illness—7 Days* and *30 Days*

All 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, 5, 6, 7, 8, 9,* and *10*
- *Lead Screening in Children*
- *Children's and Adolescents' Access to PCPs—12–19 Years*
- *Adolescent Well-Care Visits*

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.

- *Comprehensive Diabetes Care—Blood Pressure <140/80*
- *Use of Appropriate Medications for People With Asthma* (all indicators)

In addition, the maternity-related measures for **Amerigroup** have shown little or no improvement since HEDIS 2011, with all four trended rates changing less than 1.5 percentage points. Since these rates are

still well below the 90th percentiles, **Amerigroup** should explore the potential barriers to preventing early prenatal care and postpartum care.

The following Nevada Check Up performance measure was identified as an opportunity for improvement for **Amerigroup** based on a decline in performance of greater than 5 percentage points over time.

- *Childhood Immunization Status—Combo 2*

Data Completeness

Table 5-7 provides an estimate of data completeness for **Amerigroup**'s hybrid performance measures for both Medicaid and Nevada Check Up. These hybrid measures use administrative data (i.e., claims and encounter data) and supplement the results with medical record data. The table displays the HEDIS 2014 final rate and the percentage determined solely through administrative data for both populations, respectively. For example, a rate of 100 percent in the last two columns indicates that administrative data were complete for that HEDIS measure (i.e., no additional numerator compliance was determined via medical record review).

Table 5 7 Estimated Data Completeness for Amerigroup Hybrid Measures

HEDIS Hybrid Measures	2014 HEDIS Rate		Percent From Administrative Data	
	Medicaid	Nevada Check Up	Medicaid	Nevada Check Up
Childhood Immunization Status—Combo 2	61.34	76.99	55.48	26.44
Childhood Immunization Status—Combo 3	55.32	76.11	51.05	25.58
Lead Screening in Children	34.26	50.44	97.97	100.00
Well-Child Visits—First 15 Months (Six or More Visits)	53.47	54.05	90.48	90.00
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	63.08	78.74	99.19	99.58
Adolescent Well-Care Visits	37.96	58.22	96.34	97.98
Medicaid-Only HEDIS Measures				
Timeliness of Prenatal Care	83.98		59.83	
Postpartum Care	59.22		54.51	
Frequency of Ongoing Prenatal Care (81–100% Visits)	63.83		32.70	
Comprehensive Diabetes Care—HbA1c Testing	73.99		98.55	
Comprehensive Diabetes Care—Good HbA1c Control (<8%)	38.34		77.62	
Comprehensive Diabetes Care—Eye Exams	53.62		91.00	
Comprehensive Diabetes Care—LDL-C Screening	68.10		97.24	
Comprehensive Diabetes Care—LDL-C Level <100	31.10		75.86	
Comprehensive Diabetes Care—Monitoring for Nephropathy	67.29		94.42	

Rates in **green** indicate that more than 90 percent of the final rate was derived from administrative data.
Rates in **red** indicate that 50 percent or less of the final rate was derived from administrative data.
The data completeness for *Childhood Immunization Status Combos 4–10* must be the same or lower as the Combo 3 data completeness rate.

Table 5-7 shows that **Amerigroup** had over 90 percent of the final rate derived from administrative data (highlighted in green) for *Lead Screening in Children* and all measures related to well-child visits. However, at least 40 percent of the *Childhood Immunization Status—Combo 2* and *Combo 3* rates still relied on medical record data for both Medicaid and Check Up populations.

Four Medicaid-only measures derived at least 90 percent of their final rates from administrative data. These measures appeared to be related to lab data and indicate **Amerigroup** has fairly complete administrative lab data. Only one measure (*Frequency of Ongoing Prenatal Care—81–100% Visits*) derived less than 50 percent of its rate from administrative data. In general, these results suggest that **Amerigroup** demonstrated good data completeness.

Capturing maternity-related visits has declined since last year, and **Amerigroup** should make an effort to improve the obtaining of this data. For maternity care, **Amerigroup** continues to reimburse providers using global billing, which can result in capturing fewer visits than required for the HEDIS measures, since the provider is not required to include all prenatal care visits on the claim or global billing form. Since medical record abstraction was performed for these measures, final rates were not impacted.

Plan Comparison

The HEDIS 2014 Nevada Medicaid and Nevada Check Up rates for the MCOs are shown in Table 5-8 and Table 5-10, respectively. These rates are calculated by adding the numerators and denominators for both MCOs. Rates above the 2013 HEDIS 50th percentile are highlighted in yellow, those above the 90th percentile are highlighted in green, and rates below the 10th percentile are highlighted in red.

Medicaid Results

Table 5-8 presents the MCO-specific rates and the Nevada Medicaid rates along with the national Medicaid HEDIS 2013 percentiles. For *Frequency of Ongoing Prenatal Care (<21 Percent of Visits)* and *Comprehensive Diabetes Care—Poor HbA1c Control*, lower rates indicated better performance; therefore, the 10th percentiles were displayed in the 90th percentile column.

Table 5 8 HEDIS 2014 Results for Medicaid

HEDIS Measure	HPN	AGP	NV Medicaid	2013 HEDIS Percentiles	
				50th	90th
Childhood Immunization Status—Combo 2	72.99	61.34	67.02	***	***
Childhood Immunization Status—Combo 3	67.88	55.32	61.45	***	***
Childhood Immunization Status—Combo 4	66.42	54.63	60.38	***	***
Childhood Immunization Status—Combo 5	57.42	45.37	51.25	***	***
Childhood Immunization Status—Combo 6	40.15	29.86	34.88	***	***
Childhood Immunization Status—Combo 7	56.69	44.91	50.65	***	***
Childhood Immunization Status—Combo 8	39.90	29.63	34.64	***	***
Childhood Immunization Status—Combo 9	36.50	25.93	31.08	***	***
Childhood Immunization Status—Combo 10	36.25	25.69	30.84	***	***
Lead Screening in Children	37.23	34.26	35.71	***	***
Children's and Adolescents' Access to PCPs (12–24 Months)	91.73	93.58	92.68	***	***
Children's and Adolescents' Access to PCPs (25 Months–6 Years)	78.58	83.40	80.90	***	***
Children's and Adolescents' Access to PCPs (7–11 Years)	82.35	84.96	83.35	***	***
Children's and Adolescents' Access to PCPs (12–19 Years)	78.37	80.97	79.37	***	***
Well-Child Visits First 15 Months (Six or More Visits)	54.50	53.47	53.97	***	***
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	54.74	63.08	58.80	***	***
Adolescent Well-Care Visits	42.09	37.96	39.98	***	***
Annual Dental Visit—Combined Rate	53.32	44.99	49.70	***	***
Timeliness of Prenatal Care	74.94	83.98	79.47	***	***
Postpartum Care	57.66	59.22	58.44	***	***
Frequency of Ongoing Prenatal Care (<21% Visits)*	18.00	9.47	13.73	***	***
Frequency of Ongoing Prenatal Care (81–100% Visits)	59.37	63.83	61.60	***	***
Comprehensive Diabetes Care—HbA1c Testing	69.59	73.99	71.68	***	***
Comprehensive Diabetes Care—Poor HbA1c Control*	54.50	54.16	54.34	***	***
Comprehensive Diabetes Care—Good HbA1c Control (<8%)	37.47	38.34	37.88	***	***

Table 5 8 HEDIS 2014 Results for Medicaid					
HEDIS Measure	HPN	AGP	NV Medicaid	2013 HEDIS Percentiles	
				50th	90th
Comprehensive Diabetes Care—Eye Exams	44.04	53.62	48.60	***	***
Comprehensive Diabetes Care—LDL-C Screening	63.75	68.10	65.82	***	***
Comprehensive Diabetes Care—LDL-C Level <100	27.49	31.10	29.21	***	***
Comprehensive Diabetes Care—Blood Pressure <140/90	69.10	58.45	64.03	***	***
Comprehensive Diabetes Care—Blood Pressure <140/80	40.15	34.05	37.24	***	***
Comprehensive Diabetes Care—Monitoring for Nephropathy	72.75	67.29	70.15	***	***
Use of Appropriate Medications for People With Asthma (5–11 Years)	90.45	84.16	88.02	***	***
Use of Appropriate Medications for People With Asthma (12–18 Years)	86.82	77.86	84.07	***	***
Use of Appropriate Medications for People With Asthma (19–50 Years)	58.57	60.23	59.21	***	***
Use of Appropriate Medications for People With Asthma (51–64 Years)	NA	NA	NA	***	***
Use of Appropriate Medications for People With Asthma (Combined)	84.54	78.82	82.46	***	***
Follow-up After Hospitalization for Mental Illness—7 Days	68.83	62.13	64.23	***	***
Follow-up After Hospitalization for Mental Illness—30 Days	81.82	68.64	72.76	***	***

* Lower rates are better for this measure, so this measure uses the 2013 National Medicaid HEDIS 10th percentile for comparison.
HEDIS 2014 rates shaded in yellow are at or above the 50th percentile, rates shaded in green are at or above the 90th percentile, and rates shaded in red are at or below the 10th percentile.
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NA is shown when the health plan followed HEDIS specifications but the denominator was too small (<30) to report a valid rate.

One of the Nevada Medicaid rates, *Follow-up After Hospitalization for Mental Illness—7 Days*, ranked above the 2013 HEDIS 90th percentile. Four Nevada Medicaid rates ranked above the 50th percentiles. Nine rates were below the 10th percentile, six of which were child-related measures.

Overall, **HPN** performed better than **Amerigroup** for HEDIS 2014. Twenty-one of **HPN**'s rates exceeded **Amerigroup**'s rates. Thirteen of **HPN's** rates were above the 50th percentile, of which one was above the 90th percentile. Eight rates were below the 10th percentile. **HPN** generally performed better than **Amerigroup** in *Childhood Immunization Status, Annual Dental Visit,* the asthma-related measures, and *Follow-up After Hospitalization for Mental Illness.*

Although 16 **Amerigroup** rates exceeded **HPN** rates, **Amerigroup** had only two rates above the 50th percentile and none above the 90th percentile. **Amerigroup** had the same number of rates (eight) ranked below the 10th percentile. **Amerigroup** generally performed better than **HPN** in *Children's and Adolescents' Access to PCPs,* maternity-related measures, and the *Comprehensive Diabetes Care* measure.

Data Completeness

Table 5-9 provides an estimate of data completeness for the hybrid performance measures. These measures use administrative data (i.e., claims and encounter data) and supplement the results with medical record data. Measures using only administrative data are not included. The table displays the HEDIS 2014 final rate and the percentage that was determined solely through administrative data for both populations, respectively. For example, a rate of 100 percent in the last two columns indicates that administrative data were complete for that HEDIS measure. Rates in red had a 50 percent or less data completion factor.

Table 5 9 Estimated Data Completeness for Medicaid Hybrid Measures

Performance Measures	Final HEDIS Rate		Percent From Administrative Data	
		AGP		AGP
Childhood Immunization Status—Combo 2	72.99	61.34	76.67	55.48
Childhood Immunization Status—Combo 3	67.88	55.32	46.24	51.05
Lead Screening in Children	37.23	34.26	98.69	97.97
Well-Child Visits First 15 Months (Six or More Visits)	54.50	53.47	87.95	90.48
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	54.74	63.08	92.44	99.19
Adolescent Well-Care Visits	42.09	37.96	94.22	96.34
Timeliness of Prenatal Care	74.94	83.98	44.81	59.83
Postpartum Care	57.66	59.22	32.49	54.51
Frequency of Ongoing Prenatal Care (81–100% Visits)	59.37	63.83	16.39	32.70
Comprehensive Diabetes Care—HbA1c Testing	69.59	73.99	94.41	98.55
Comprehensive Diabetes Care—Good HbA1c Control (<8%)	37.47	38.34	86.36	77.62
Comprehensive Diabetes Care—Eye Exams	44.04	53.62	76.24	91.00
Comprehensive Diabetes Care—LDL-C Screening	63.75	68.10	95.04	97.24
Comprehensive Diabetes Care—LDL-C Level <100	27.49	31.10	80.53	75.86
Comprehensive Diabetes Care—Monitoring for Nephropathy	72.75	67.29	98.33	94.42

Rates in green indicate that more than 90 percent of the final rate was derived from administrative data.
Rates in red indicate that 50 percent or less of the final rate was derived from administrative data.
The data completeness for *Childhood Immunization Status Combos 4–10* must be the same or lower as the Combo 3 data completeness rate.

Overall, **Amerigroup** had more measures (10 of 15) with higher administrative data completeness than **HPN**. **Amerigroup** also had more measures that derived at least 90 percent of their final rates from administrative data than **HPN** (eight measures versus six measures). Achievement of higher administrative data completeness was most likely due to the fee-for-service compensation structure **Amerigroup** uses for most of its providers, which tends to improve data submission. This was particularly apparent when reviewing **Amerigroup**'s administrative data completion for the maternity-related measures. Since **Amerigroup** uses global billing, the maternity-related measures had lower administrative data completeness. Lower administrative data completeness that resulted from global billing for maternity-related measures also applied to **HPN**.

Both MCOs demonstrate fair administrative data completeness in *Lead Screening in Children*, the well-child visits measures, and the *Comprehensive Diabetes Care* measure. As noted in previous years, the MCOs should continue to research methods for capturing administrative data for individual prenatal care visits and postpartum care visits.

Nevada Check Up Results

Table 5-10 presents the MCO-specific rates and the Nevada Check Up rates along with the national Medicaid HEDIS 2013 percentiles. Since HEDIS percentiles are not available for the CHIP population, the Nevada Check Up rates are compared to the HEDIS Medicaid percentiles; therefore, caution should be exercised when comparing the rates.

Table 5 10 HEDIS 2014 Results for Nevada Check Up

HEDIS Measure	HPN	AGP	NV Check UP	2013 HEDIS Percentiles*	
				50th	90th
Childhood Immunization Status—Combo 2	85.21	76.99	81.57	***	***
Childhood Immunization Status—Combo 3	83.10	76.11	80.00	***	***
Childhood Immunization Status—Combo 4	83.10	74.34	79.22	***	***
Childhood Immunization Status—Combo 5	72.54	68.14	70.59	***	***
Childhood Immunization Status—Combo 6	48.59	51.33	49.80	***	***
Childhood Immunization Status—Combo 7	72.54	67.26	70.20	***	***
Childhood Immunization Status—Combo 8	48.59	49.56	49.02	***	***
Childhood Immunization Status—Combo 9	42.96	46.90	44.71	***	***
Childhood Immunization Status—Combo 10	42.96	46.02	44.31	***	***
Lead Screening in Children	55.24	50.44	53.13	***	***
Annual Dental Visit— Combined Rate	77.21	67.67	74.02	***	***
Children's and Adolescents' Access to PCPs (12–24 Months)	95.08	98.85	96.65	***	***
Children's and Adolescents' Access to PCPs (25 Months–6 Years)	91.39	94.11	92.50	***	***
Children's and Adolescents' Access to PCPs (7–11 Years)	94.88	97.25	95.58	***	***
Children's and Adolescents' Access to PCPs (12–19 Years)	91.49	93.69	92.10	***	***
Well-Child Visits First 15 Months (Six or More Visits)	63.01	54.05	60.00	***	***
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.72	78.74	75.84	***	***
Adolescent Well-Care Visits	54.26	58.22	56.27	***	***
Use of Appropriate Medications for People With Asthma (5–11 Years)	97.00	92.50	95.71	***	***
Use of Appropriate Medications for People With Asthma (12–18 Years)	91.94	NA	89.41	***	***
Follow-up After Hospitalization for Mental Illness—7 Days	NA	NA	75.61	***	***
Follow-up After Hospitalization for Mental Illness—30 Days	NA	NA	87.80	***	***

HEDIS 2014 rates shaded in yellow are at or above the 50th percentile, rates shaded in green are at or above the 90th percentile.
*Because national HEDIS 2013 Medicaid percentiles are not available for the Children's Health Insurance Program (CHIP) population, comparison of Nevada's Check Up to HEDIS 2013 Medicaid percentiles should be interpreted with caution.
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NA is shown when the health plan followed HEDIS specifications but the denominator was too small (<30) to report a valid rate.

In general, Nevada Check Up continues to report better rates than Medicaid. Eight of the Nevada Check Up rates were above the HEDIS 2013 90th percentile, and another 11 rates were above the 50th percentile. None of the rates fell below the 10th percentile.

The two MCOs' performance was similar. Both had five Check Up rates above the 90th percentile, 12 rates above the 50th percentile, and no rates below the 10th percentile. **HPN** had nine rates that exceeded **Amerigroup**'s rates, and **Amerigroup** had 10 rates that exceeded **HPN**'s rates. The highest rate **HPN** reported was for the *Use of Appropriate Medications for People With Asthma—5–11 Years* measure (97 percent), and the highest rate reported by **Amerigroup** was for the *Children's and Adolescents' Access to PCPs—12–24 Months* measure (98.85 percent).

Data Completeness

Table 5-11 provides an estimate of data completeness for the hybrid performance measures. These measures use administrative data (i.e., claims and encounter data) and supplement the results with medical record data. Measures using only administrative data are not included. The table displays the HEDIS 2014 final rate and the percentage determined solely through administrative data for both populations, respectively. For example, a rate of 100 percent in the last two columns indicates that administrative data were complete for that HEDIS measure. Rates in red had a 50 percent or less data completion factor.

Table 5 11 Estimated Data Completeness for NV Check Up Hybrid Measures

Performance Measures	Final HEDIS Rate		Percent From Administrative Data	
	HPN	AGP	HPN	AGP
Childhood Immunization Status—Combo 2	85.21	76.99	68.60	26.44
Childhood Immunization Status—Combo 3	83.10	76.11	22.88	25.58
Lead Screening in Children	55.24	50.44	100.00	100.00
Well-Child Visits First 15 months (Six or More Visits)	63.01	54.05	78.26	90.00
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.72	78.74	93.40	99.58
Adolescent Well-Care Visits	54.26	58.22	96.86	97.98

Rates in **green** indicate that more than 90 percent of the final rate was derived from administrative data.
Rates in **red** indicate that 50 percent or less of the final rate was derived from administrative data.
The data completeness for *Childhood Immunization Status Combos 4–10* must be the same or lower as the Combo 3 data completeness rate.

Table 5-11 shows that both MCOs demonstrated exceptionally complete encounter data for *Lead Screening in Children; Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life;* and *Adolescent Well-Care Visits*. However, both plans continued to experience difficulty in obtaining complete encounter data for the *Childhood Immunization Status* measure.

Conclusions

The HEDIS audit demonstrated that both MCOs had adequate policies and procedures in place for collecting, preparing, processing, and reporting HEDIS data and were in full compliance with each of the seven NCQA-specified Information System standards. Both MCOs used the FACETS claims processing system. Data entry processes were efficient with the assurance of timely and accurate entry into the system. Only standard codes were accepted, and the standard HIPAA 837 file format was used. Both MCOs applied several validation checks to ensure accurate information processing.

Nevada Check Up rates continued to outperform the Nevada Medicaid rates for every measure. Four of the 38 Medicaid measures were above the 50th percentiles, with no rate reaching the 90th percentile and nine rates falling below the 10th percentile. Conversely, 11 of the 22 Check Up measures had rates ranked above the 50th percentile, and an additional eight exceeding the 90th percentile. None of the Nevada Check Up measures had rates below the 10th percentile.

Both MCOs continued to demonstrate mixed performance in the Medicaid and Nevada Check Up populations. For the Medicaid population, **HPN** reported more measures ranking above the national 50th percentile than **Amerigroup**; 21 **HPN** rates exceeded **Amerigroup** rates, and 16 **Amerigroup** rates exceeded **HPN** rates. For the Nevada Check Up population, For the Nevada Check Up population, both MCOs had five Check Up rates above the 90th percentile, 12 rates above the 50th percentile, and no rates below the 10th percentile. Ten **HPN** rates exceeded **Amerigroup** rates, and nine **Amerigroup** rates exceeded **HPN** rates.

In terms of administrative data completeness, both MCOs had fairly complete encounter data for most of the Medicaid and Check Up measures. Nonetheless, each MCO had its own unique challenges in obtaining complete administrative data for specific measures. **HPN** continued to experience some difficulty obtaining complete encounter data for maternity-related care, possibly due to global billing practices. **Amerigroup** had some difficulty obtaining complete encounter data for childhood immunizations. Since the MCOs supplemented their administrative data for these measures with medical record review, no bias was observed in any of these rates.

Recommendations

The following recommendations are based on the audit findings and final reported rates:

HPN has showed improvement in the Medicaid rate for *Lead Screening in Children* measure, and the rate is now higher than **Amerigroup**'s rate. The *Lead Screening in Children* rate for **Amerigroup** has not shown much improvement over the last three years. Both MCO Medicaid rates were significantly lower than the rates reported for Nevada Check Up. HSAG recommends that **HPN** continue its current interventions, which appear to be improving the lead screening rates for both Medicaid and Nevada Check Up. HSAG also recommends that **Amerigroup** increase its efforts to improve these rates. Lead screening may need more targeted intervention for Medicaid. Providers should be reminded that lead screening should be completed as part of a well-child visit or when immunizations are given.

For **HPN**, the measures related to access to care have continued to decline each year. **HPN** should conduct an analysis to determine if these results are due to member noncompliance, issues with network adequacy, or other potential barriers preventing members from accessing timely care.

For **Amerigroup**, the maternity-related measures have shown little or no improvement since HEDIS 2011, with all four trended rates changing less than 1.5 percentage points. Since these rates are still well below the 90th percentiles, **Amerigroup** should explore the potential barriers that are preventing early prenatal care and postpartum care.

All of the Medicaid rates for the *Use of Appropriate Medications for People With Asthma* measure for **Amerigroup** have also continued to decline since HEDIS 2011. These rates are also well below the National Medicaid 90th percentiles. Since the numerator specifications identify only one asthma medication needed, it does not appear likely that the rate for this measure is low due to member noncompliance or to providers not prescribing the appropriate medication. **Amerigroup** should conduct a root cause analysis to determine the reason for the low rates for this measure, such as

potentially including individuals in the denominator who do not have asthma due to provider coding practices.

For comprehensive diabetes care, both MCOs continued to report rates that were well below the 90th percentiles. HSAG has made recommendations for this measure for the past several years and continues to make the following recommendations:

- The MCOs should conduct outreach to members with diabetes through PCPs, lab technicians, pharmacists, and other health care practitioners who are involved in disease management efforts.
- The MCOs should encourage providers who provide diabetes-related screenings (e.g., lipid screenings and HbA1c testing) or who distribute medications to educate and provide information to members on the importance of taking a comprehensive approach to managing diabetes.

Finally, since HEDIS 2011, HSAG has made recommendations to improve the rates for *Follow-up After Hospitalization for Mental Illness,* and the trend over time has improved for both MCOs. However, this year the **HPN** rates for both 7-day and 30-day follow-up declined again and the 30-day rate fell below the National Medicaid 90th percentile. Although the rates for **Amerigroup** have improved from 2011 and over last year, both rates are well below **HPN**'s rates and the National Medicaid 90th percentiles. HSAG recommends that both MCOs continue to identify additional areas that impede follow-up and apply interventions that can overcome barriers and improve performance for the measure.

6. Validation of Performance Improvement Projects—FY 2013–2014

As described in 42 CFR 438.240(b)(1), the DHCFP requires MCOs to conduct performance improvement projects (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.

One of the mandatory EQR activities under the BBA requires the DHCFP to validate PIPs. To meet this validation requirement, the DHCFP contracted with HSAG as the EQRO. The BBA requires HSAG to assess each MCO's "strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid recipients" (42 CFR 438.364 [a] [2]).

Objectives

PIPs provide a structured method to assess and improve processes, and thereby outcomes, of care for the population that an MCO serves. This structure facilitates the documentation and evaluation of improvements in care or services. MCOs conduct PIPs to assess and improve the quality of clinical and nonclinical health care and services received by recipients.

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 system interventions to achieve improvement in quality.
- Evaluation of the effectiveness of interventions.
- Planning and initiation of activities to increase or sustain improvement.

As described in both **Amerigroup**'s and **HPN**'s FY 2012–2013 PIP reports and in Nevada's *2012–2013 External Quality Review Technical Report for Managed Care Organizations (MCOs),* the FY 2013–2014 PIP validation process included heightened scrutiny on:

- Barrier analyses performed by the MCO.
- Interventions planned by the MCOs as a result of barrier analyses.
- Mechanisms put in place by the MCO to track interventions and evaluate the effectiveness of the interventions to improve rates.

HSAG critically evaluated each of these areas. The findings that resulted from the outcome-focused evaluation are reflected in the validation scoring for the Study Implementation and Study Outcomes stages of each PIP. Once a PIP has achieved statistically significant improvement over baseline, it is necessary to sustain that improvement in the following year to receive a *Met* validation status for the PIP. Refer to Appendix A for the technical methods of data collection and analysis for performance improvement projects.

Plan-Specific Findings—Health Plan of Nevada (HPN)

For **HPN**, HSAG reviewed two PIPs for the period of July 1, 2013, through June 30, 2014: ***Children and Adolescents' Access to Primary Care Practitioners*** and ***Reducing Avoidable Emergency Room Visits***. HSAG PIP reviewers validated each PIP twice—once when the PIP was originally submitted and then again when the PIP was resubmitted. Of the two originally-submitted **HPN** PIPs, one received a *Partially Met* overall validation status, and one received a *Not Met* overall validation status. The MCO did not seek technical assistance prior to resubmission. **HPN** had the opportunity to incorporate HSAG's recommendations and resubmit both PIPs. The overall percentage of evaluation elements *Met* improved for both PIPs, and the validation status improved for the ***Children and Adolescents' Access to Primary Care Practitioners*** PIP; however, due to the lack of statistically significant improvement achieved for all indicators for the ***Reducing Avoidable Emergency Room Visits*** PIP, the overall validation status remained *Not Met*. Table 6-1 below shows the validation status of each PIP for each of the two submissions.

Table 6-1––Performance Improvement Project Validation Activity for Health Plan of Nevada, Inc. July 1, 2013, through June 30, 2014

Name of Project/Study	Type of Annual Review [1]	Percentage Score of Evaluation Elements *Met* [2]	Percentage Score of Critical Elements *Met* [3]	Overall Validation Status [4]
Children and Adolescents' Access to Primary Care Practitioners	Submission	75%	56%	*Partially Met*
	Resubmission	100%	100%	*Met*
Reducing Avoidable Emergency Room Visits	Submission	73%	88%	*Not Met*
	Resubmission	85%	89%	*Not Met*

[1] **Type of Annual Review**—Designates the PIP reviewed as an annual submission, or resubmission. A resubmission means the MCO had the opportunity to resubmit the PIP with updated documentation because it did not meet 100 percent of the validation elements.
[2] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total applicable elements of all categories (*Met*, *Partially Met*, and *Not Met*).
[3] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the applicable critical elements *Met*, *Partially Met*, and *Not Met*.
[4] **Overall Validation Status**—The overall validity and reliability of the PIP, which is based on the PIP Validation Tool results.

On the pages that follow, Table 6-2 shows the validation results for the **HPN** *Children and Adolescents' Access to Primary Care Practitioners* PIP, and Table 6-3 shows the validation results for the **HPN** *Reducing Avoidable Emergency Room Visits* PIP evaluated during FY 2014. These tables illustrate the plan's overall application of the PIP process and achieved success with implementing the studies. Each activity is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements that received a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 6-2 and Table 6-3 show the percentage of applicable evaluation elements that received each score by activity. Additionally, HSAG calculated a score for each study stage and an overall score across all activities.

Table 6-2––Performance Improvement Project Validation Results for HPN's *Children and Adolescents' Access to Primary Care Practitioners* PIP (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	Clearly Defined Study Indicator(s)	100% (1/1)	0% (0/1)	0% (0/1)
	Valid Sampling Techniques (if sampling was used)	*Not Applicable*		
	Accurate/Complete Data Collection	100% (3/3)	0% (0/3)	0% (0/3)
Design Total		**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Implementation	Accurate Data Analysis and Interpretation of Results	100% (3/3)	0% (0/3)	0% (0/3)
	Appropriate Improvement Strategies	100% (5/5)	0% (05)	0% (0/5)
Implementation Total		**100% (8/8)**	**0% (0/8)**	**0% (0/8)**
Outcomes	Real Improvement Achieved	*Not Assessed*		
	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total		*Not Assessed*		
Percentage Score of Applicable Evaluation Elements *Met*		**100% (16/16)**		

Overall, 100 percent of the evaluation elements across the **HPN *Children and Adolescents' Access to Primary Care Practitioners*** PIP received a score of *Met*. **HPN**'s strong performance in the Design and Implementation stages indicated this PIP was designed appropriately to measure outcomes and improvement. The ***Children and Adolescents' Access to Primary Care Practitioners*** PIP received an overall validation status of *Met*.

Table 6-3––Performance Improvement Project Validation Results for HPN's *Reducing Avoidable Emergency Room Visits* PIP (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	Clearly Defined Study Indicator(s)	100% (2/2)	0% (0/2)	0% (0/2)
	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	Valid Sampling Techniques (if sampling was used)	*Not Applicable*		
	Accurate/Complete Data Collection	100% (4/4)	0% (0/4)	0% (0/4)
Design Total		**100% (10/10)**	**0% (0/10)**	**0% (0/10)**
Implementation	Accurate Data Analysis and Interpretation of Results	100% (8/8)	0% (0/8)	0% (0/8)
	Appropriate Improvement Strategies	75% (3/4)	25% (1/4)	0% (0/4)
Implementation Total		**92% (11/12)**	**8% (1/12)**	**0% (0/12)**
Outcomes	Real Improvement Achieved	50% (2/4)	0% (0/4)	50% (2/4)
	Sustained Improvement Achieved	0% (0/1)	0% (0/1)	100% (1/1)
Outcomes Total		**40% (2/5)**	**0% (0/5)**	**60% (3/5)**
Percentage Score of Applicable Evaluation Elements *Met*		**85% (23/27)**		

Overall, 85 percent of the evaluation elements across the **HPN *Reducing Avoidable Emergency Room Visits*** PIP received a score of *Met*. While **HPN**'s strong performance in the Design stage indicated that the PIP was designed appropriately, the MCO was less successful in implementing improvement strategies that resulted in the desired outcomes for both study indicators. Due to the lack of statistically significant improvement achieved for all indicators for the ***Reducing Avoidable Emergency Room Visits*** PIP, the overall validation status was *Not Met*.

The following subsections highlight HSAG's validation findings associated with each of the three PIP stages.

PIP-Specific Results

The purpose of a PIP is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas. Therefore, in addition to the validation results, the study indicator results for each MCO are compared to the results from the prior measurement period in terms of whether improvement and/or sustained improvement were attained.

Table 6-4 displays outcome data for **HPN**'s two PIPs. The MCO submitted baseline data for the ***Children and Adolescents' Access to Primary Care Practitioners*** PIP and Remeasurement 2 data for the ***Reducing Avoidable Emergency Room Visits*** PIP. Statistically significant improvement is the standard for assessing real improvement and supports the conclusion that the noted improvement is not due to chance.

Table 6-4––HEDIS-based Performance Improvement Project Outcomes for HPN

PIP #1 *Children and Adolescents' Access to Primary Care Practitioners*	
PIP Study Indicator	**Baseline CY 2013**
1. The percentage of children 25 months to six years of age that had one or more visits with a PCP during the measurement year.	78.6%
2. The percentage of children seven to 11 years of age that had one or more visits with a PCP during the measurement year.	82.4%
3. The percentage of children 12 to 19 years of age that had one or more visits with a PCP during the measurement year.	78.3%
4. The percentage of children 12 to 24 months of age (Nevada Check Up) that had one or more visits with a PCP during the measurement year.	95.1%

PIP #2 *Reducing Avoidable Emergency Room Visits*				
PIP Study Indicator	**Baseline CY 2011**	**Remeasurement 1 CY 2012**	**Remeasurement 2 CY 2013**	**Sustained Improvement^**
1. The percentage of avoidable ER visits for the Nevada Check Up population. ¤	39.0%	35.7%↓*	41.7%	No
2. The percentage of avoidable ER visits for the Medicaid population. ¤	42.0%	37.8%↓*	42.9%	No

¤ The study indicators are inverse indicators; therefore, a decline in the rate represents an improvement in the outcomes.
↓* Designates statistically significant improvement over the baseline (p value < 0.05).
CY Calendar year

For the ***Children and Adolescents' Access to Primary Care Practitioners*** PIP, **HPN** reported baseline data for all study indicators. The MCO's goal is to increase the rates to the NCQA 10th percentile for the first remeasurement; however, HSAG recommends that the health plan choose a more aggressive goal given the longevity of the health plan in the managed care program.

For the ***Reducing Avoidable Emergency Room Visits*** PIP, the study indicators are inverse indicators; therefore, a decline in the rate represents improved outcomes. **HPN** achieved statistically significant improvement for both study indicators at Remeasurement 1; however, both indicators demonstrated statistically significant declines in performance at Remeasurement 2—with rates higher than the baseline.

Barriers/Interventions

The identification of barriers through barrier analysis and the subsequent selection of appropriate interventions to address these barriers are necessary steps to improve outcomes. The MCO's choice of interventions, the combination of intervention types, and the sequence of implementing the interventions are essential to the performance improvement project's overall success.

For the ***Children and Adolescents' Access to Primary Care*** PIP, **HPN** documented that its HEDIS validation team met weekly to review data and that this team conducted the initial barrier analysis using an affinity diagram and brainstorming to isolate the barriers and develop interventions. The barriers identified and determined to be high-priority barriers were lack of provider engagement, population increases, and lack of clinic and primary care provider (PCP) access/availability in areas with highest Medicaid concentration. To address these barriers, the MCO initiated the following interventions:

- HEDIS Office Visit Template—Education provided to the providers on using the HEDIS office visit template, which aligns with HEDIS measures. **HPN's** documentation noted that addressing multiple measures during an office visit will decrease the number of visits needed by a recipient, therefore allowing improved access for other recipients.
- Provider education—A nurse provides in-office education to providers and/or office staff about appropriate coding and proper medical record documentation for sports physicals and minor ambulatory or preventive care visits.
- Blinded Study Report—Compares provider groups' HEDIS measure performance with peers' performance.
- Gaps in Care Report—Composed of the provider's empaneled recipients' outstanding tests and exams based on medical history, these reports are distributed and reviewed with the provider and/or staff during the initial HEDIS nurse visit.

In addition to the provider-focused interventions listed above, **HPN** also conducted recipient call outreach. Recipients were contacted by the Call Outreach Team to assist with scheduling annual appointments. The MCO reported having methods in place to evaluate the effectiveness of the implemented interventions.

For the ***Reducing Avoidable Emergency Room Visits*** PIP, **HPN**'s HEDIS Validation Team conducted causal/barrier and drill-down analyses using a variety of quality improvement (QI) tools. Using these tools, the MCO identified the following barriers: urgent care facility closure, follow-up appointments with PCPs not completed in a timely manner, lack of recipient education about urgent care services and locations, poor location of urgent care facilities, recipients preferring to use the ER, recipients not having an assigned PCP, and invalid recipient contact information. To address these barriers, the following interventions were implemented:

- Call outreach—A member of the quality improvement (QI) team called recipients who accessed the ER and were discharged with an avoidable ER visit code. Once the QI team member reached the recipient, the date of the ER visit was confirmed and education was provided about use of urgent care centers and the 24 Hour Nurse Helpline as well as assistance with selecting a PCP or scheduling an appointment, if applicable.
- Recipient newsletter—Mailed to recipients, this newsletter contained information on how and when to use an urgent care center and what constituted an appropriate ER visit. The newsletter also contained information about the 24 Hour Nurse Helpline.
- Provider newsletter—Distributed to providers, this newsletter urged providers to educate recipients about using urgent care centers for avoidable ER diagnoses.
- Southwest Medical Associates (SMA) Convenience Care Clinics—SMA opened convenience care clinics in Wal-Mart stores. These clinics allow MCO recipients to access care for minor illnesses.
- Urgent Care Cling Sheets—**HPN** created easy-to-use and easy-to-remove 3x6 sheets that cling to most surfaces. The sheets listed all contracted urgent care facilities in southern Nevada (14 locations) with the facilities' telephone numbers. The cling sheets also included the telephone number for the 24 Hour Nurse Helpline. The cling sheets were mailed to all recipients who accessed the emergency room.
- Web site update—In 2013, **HPN**'s Web site underwent major changes. The PIP documentation noted that the updated Web site is more user-friendly. Using the Web site, recipients may update contact information, access information on when to seek emergency versus urgent care services, obtain 24-hour nurse advice line information, and use the Symptom Checker 24/7 (available in both English and Spanish).

HPN had processes in place to evaluate most interventions and continues to address the problem of invalid recipient contact information.

Plan-Specific Findings—Amerigroup

HSAG reviewed two PIPs for the period of July 1, 2013, through June 30, 2014—***Diabetes Management*** and ***Reducing Avoidable Emergency Room Visits***. HSAG PIP reviewers validated each PIP twice—once when the PIP was originally submitted and then again when the PIP was resubmitted. Of the two originally-submitted **Amerigroup** PIPs, one received a *Partially Met* overall validation status, and one received a *Not Met* overall validation status. HSAG provided technical assistance to **Amerigroup** staff to address all noted deficiencies in the initial validation. After technical assistance was provided, **Amerigroup** had the opportunity to incorporate HSAG's recommendations and resubmit both PIPs. The overall percentage of evaluation elements *Met* improved for both PIPs; however, due to the lack of statistically significant improvement achieved for all indicators, neither PIP improved the overall validation status. Table 6-5 displays the percent of evaluation elements scored as *Met* and the overall PIP validation status for both of the **Amerigroup** PIPs.

Table 6-5—Performance Improvement Project Validation Activity for Amerigroup July 1, 2013, through June 30, 2014

Name of Project/Study	Type of Annual Review[1]	Percentage Score of Evaluation Elements *Met* [2]	Percentage Score of Critical Elements *Met* [3]	Overall Validation Status [4]
Diabetes Management	Submission	93%	92%	*Not Met*
	Resubmission	95%	92%	*Not Met*
Reducing Avoidable Emergency Room Visits	Submission	77%	75%	*Partially Met*
	Resubmission	92%	88%	*Partially Met*

[1] **Type of Annual Review**—Designates the PIP reviewed as an annual submission, or resubmission. A resubmission means the MCO had the opportunity to resubmit the PIP with updated documentation because it did not meet 100 percent of the validation elements.

[2] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total applicable elements of all categories (*Met*, *Partially Met*, and *Not Met*).

[3] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the applicable critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Overall Validation Status**—The overall validity and reliability of the PIP, which is based on the PIP Validation Tool results.

Table 6-6 displays the validation results for **Amerigroup**'s ***Diabetes Management*** PIP, evaluated during FY 2014. This table illustrates the MCO's overall application of the PIP process and achieved success in implementing the studies. Each activity is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 6-6 show the percentage of applicable evaluation elements that received each score by activity. Additionally, HSAG calculated a score for each stage and an overall score across all activities.

Table 6-6—Performance Improvement Project Validation Results for Amerigroup's *Diabetes Management* PIP (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	Appropriate Study Topic	100% (6/6)	0% (0/6)	0% (0/6)
	Clearly Defined, Answerable Study Question(s)	100% (2/2)	0% (0/2)	0% (0/2)
	Clearly Defined Study Indicator(s)	100% (6/6)	0% (0/6)	0% (0/6)
	Correctly Identified Study Population	100% (3/3)	0% (0/3)	0% (0/3)
	Valid Sampling Techniques (if sampling was used)	*Not Applicable*		
	Accurate/Complete Data Collection	100% (11/11)	0% (0/11)	0% (0/11)
Design Total		**100% (28/28)**	**0% (0/28)**	**0% (0/28)**
Implementation	Accurate Data Analysis and Interpretation of Results	100% (8/8)	0% (0/8)	0% (0/8)
	Appropriate Improvement Strategies	100% (3/3)	0% (0/3)	0% (0/3)
Implementation Total		**100% (11/11)**	**0% (0/11)**	**0% (0/11)**
Outcomes	Real Improvement Achieved	50% (2/4)	0% (0/4)	50% (2/4)
	Sustained Improvement Achieved‡	*Not Assessed*		
Outcomes Total		**50% (2/4)**	**0% (0/4)**	**50% (2/4)**
Percentage Score of Applicable Evaluation Elements *Met*		**95% (41/43)**		

‡ The PIP was not assessed for sustained improvement. Sustained improvement can be assessed once all study indicator(s) have demonstrated statistically significant improvement over the baseline and reported a subsequent measurement period.

Overall, 95 percent of the evaluation elements across the **Amerigroup *Diabetes Management*** PIP received a score of *Met*. While **Amerigroup**'s strong performance in the Design and Implementation stages indicated that each PIP was designed appropriately to measure outcomes and improvement, the MCO was less successful in achieving the desired outcomes.

Table 6-7 displays the validation results for **Amerigroup**'s ***Reducing Avoidable Emergency Room Visits*** PIP, evaluated during FY 2014. This table illustrates the MCO's overall application of the PIP process and achieved success in implementing the studies. Each activity is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 6-7 show the percentage of applicable evaluation elements that received each score by activity. Additionally, HSAG calculated a score for each stage and an overall score across all activities.

Table 6-7—Performance Improvement Project Validation Results for Amerigroup's *Reducing Avoidable Emergency Room Visits* PIP (N=1 PIP)

Stage	Activity	Percentage of Applicable Elements		
		Met	*Partially Met*	*Not Met*
Design	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	Clearly Defined Study Indicator(s)	100% (2/2)	0% (0/2)	0% (0/2)
	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	Valid Sampling Techniques (if sampling was used)	*Not Applicable*		
	Accurate/Complete Data Collection	100% (4/4)	0% (0/4)	0% (0/4)
Design Total		**100% (10/10)**	**0% (0/10)**	**0% (0/10)**
Implementation	Accurate Data Analysis and Interpretation of Results	100% (8/8)	0% (0/8)	0% (0/8)
	Appropriate Improvement Strategies	100% (4/4)	0% (0/4)	0% (0/4)
Implementation Total		**100% (12/12)**	**0% (0/12)**	**0% (0/12)**
Outcomes	Real Improvement Achieved	50% (2/4)	50% (2/4)	0% (0/4)
	Sustained Improvement Achieved‡	*Not Assessed*		
Outcomes Total		**50% (2/4)**	**50% (2/4)**	**0% (0/4)**
Percentage Score of Applicable Evaluation Elements *Met*		**92% (24/26)**		

‡ The PIP was not assessed for sustained improvement. Sustained improvement can be assessed once all study indicator(s) have demonstrated statistically significant improvement over the baseline and reported a subsequent measurement period.

Overall, 92 percent of the evaluation elements across the **Amerigroup *Reducing Avoidable Emergency Room Visits*** PIP received a score of *Met*. While **Amerigroup**'s strong performance in the Design stage indicated that each PIP was designed appropriately, the MCO was less successful in implementing improvement strategies that resulted in the desired outcomes for both study indicators.

PIP-Specific Results

The purpose of a PIP is to achieve through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas. Therefore, in addition to the validation results, the study indicator results are compared to the baseline to determine if real and sustained improvement were attained.

Table 6-8—Performance Improvement Project Outcomes for Amerigroup

PIP #1 *Diabetes Management*						
PIP Study Indicator	**Baseline CY 2009**	**Remeasurement 1 CY 2010**	**Remeasurement 2 CY 2011**	**Remeasurement 3 CY 2013**	**Remeasurement 4 CY 2013**	**Sustained Improvement**
1. The percentage of Medicaid-eligible members 18–75 years of age with a diagnosis of diabetes who had an HbA1C test performed during the measurement year.	70.1%	73.6%	71.6%	68.8%	73.9%	NA
2. The percentage of Medicaid-eligible members 18–75 years of age with a diagnosis of diabetes who had an LDL-C screening performed during the measurement year.	64.2%	67.5%	64.4%	65.2%	68.1%	NA
3. The percentage of Medicaid-eligible members 18–75 years of age with a diagnosis of diabetes who had a nephropathy screening test performed during the measurement year.	60.6%	66.5%	69.1%	64.0%	67.3%	NA

PIP #2 *Reducing Avoidable Emergency Room Visits*				
PIP Study Indicator	**Baseline CY 2011**	**Remeasurement 1 CY 2012**	**Remeasurement 2 CY 2013**	**Sustained Improvement**
1. The percentage of avoidable ER visits for the Check Up (CHIP) population. ¤	39.7%	39.1%	37.5%	NA
2. The percentage of avoidable ER visits for the Medicaid population. ¤	42.6%	41.4%↓*	39.1%	NA

¤ The study indicators are inverse indicators; therefore, a decline in the rate represents an improvement in the outcomes.
↓* Designates statistically significant improvement over the baseline (p value < 0.05).
NA Sustained improvement cannot be determined until statistically significant improvement has been achieved across **all** study indicators followed by a subsequent measurement period.
CY Calendar year

For the ***Diabetes Management*** PIP, **Amerigroup** progressed to reporting Remeasurement 4 data. All three study indicators have demonstrated improvement over the baseline; however, this improvement was not statistically significant. All three rates are below the NCQA 50th percentile.

The ***Reducing Avoidable Emergency Room Visits*** PIP progressed to reporting Remeasurement 2 data. The study indicators for the ***Reducing Avoidable Emergency Room Visits*** PIP are inverse indicators; therefore, a decline in the rate represents an improvement in the outcomes. Study Indicator 1 has demonstrated consistent improvement over the baseline rate; however, none of this

improvement has been statistically significant. Study Indicator 2 achieved statistically significant improvement over baseline at Remeasurement 1 and has sustained the improvement with a subsequent measurement period; however, all study indicators must achieve statistically significant improvement before the PIP can be assessed for sustained improvement. Study Indicator 1 has demonstrated consistent improvement since baseline; however, the improvement has not been statistically significant.

Barriers/Interventions

The identification of barriers through barrier analysis and the subsequent selection of appropriate interventions to address these barriers are necessary steps to improve outcomes. The MCO's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the MCO's overall success in improving PIP rates.

For the ***Diabetes Management*** PIP, **Amerigroup** implemented a "whole health plan" approach to improving HEDIS outcomes. Senior management led each cross functional team in bi-weekly meetings to brainstorm and identify barriers, develop interventions, and discuss action plans. The MCO identified and prioritized recipient-focused, provider-focused, and system-focused barriers. These barriers were continued lack of knowledge, providers' inadequate follow-up, lack of knowledge regarding performance scores, and the MCO's inadequate data sources. To address these barriers, **Amerigroup** increased development of educational materials in community locations and in the media. Nevada Healthy Choices was implemented with initial mailings sent to all recipients 18 to 75 years of age with a diagnosis of diabetes, and mailing was repeated two months later. The MCO also developed a "Missed Opportunity List" for the Provider Quality Incentive Program (PQIP) providers. This list allows providers to identify recipients who have missed HEDIS measure tests or screenings. The following are **Amerigroup**'s additional interventions:

- Recipient mailings—These mailings were sent to all new recipients and monthly educational mailings were sent to existing recipients.
- Disease management telephone outreach—Disease management staff members called recipients with diabetes to discuss required tests and screenings and appropriate diet and exercise and to assist diabetic recipients with whatever needs they may have.
- Provider education—Providers received education about required HEDIS screening criteria and were provided a list of noncompliant recipients empaneled with the provider.
- Medical record review in providers' offices—Chart audits were conducted to determine providers' compliance with appropriate diabetic screenings.
- Eliza (computer-generated reminder calls)—These calls encouraged recipients to see their provider for necessary diabetic screenings.
- Telephone outreach—Diabetic recipients who had not had a diabetic vision screening were contacted through the telephone outreach program administered by the MCO's vision vendor.
- Provider Scorecards—Letters were mailed to providers to inform them of their HEDIS scores and reinforce clinical practice guidelines.
- Diabetes and Obesity Committee—**Amerigroup** partnered with the community-based iDo (Improving Diabetes & Obesity Outcomes) Coalition to promote diabetic screenings. The iDo

Coalition developed fact sheets about diabetes that were distributed to recipients and providers. The fact sheets were approved for distribution at recipient health fairs and outreach events.

- Recipient incentive—When the recipient obtained all required services, a $25 gift certificate was mailed to him or her.

The MCO also initiated a home health pilot intervention; however, only one recipient participated. The intervention established a collaboration with a local home health agency to provide home health visits to recipients with diabetes within 24 hours of a hospital discharge. In addition to the home visit, the recipient received follow-up telephone calls both one week after the initial home visit and after one month to ensure compliance with the PCP's and/or the specialist's follow-up visit. This intervention will continue and, when data are available, analysis of the effectiveness of this piloted intervention will be conducted. If found to be effective, the intervention will be expanded to additional eligible recipients.

For the ***Reducing Avoidable Emergency Room Visits*** PIP, **Amerigroup**'s multidisciplinary quality committee conducted a causal/barrier analysis using a fishbone diagram and determined that the barriers were unchanged from the previous year. The prioritized, recipient-focused barriers addressed from Remeasurement 1 to Remeasurement 2 were lack of understanding for nonemergent care that can be performed at the PCP's office, lack of knowledge regarding resources for medical advice, and cultural comfort of proximity of emergency room opposed to PCP location. The prioritized, provider-focused barrier was that providers are unaware of paneled recipients frequenting the emergency room. Interventions implemented to address these barriers are listed below:

- Quality Management Outreach: A registered nurse (RN) made outreach calls to the top 10 PCPs with greatest number of avoidable ER visits. The purpose of the call was to notify providers that they have recipients with high avoidable ER use and to provide education on directing these recipients to urgent care facilities and other means to address nonurgent medical needs.
- Increased provider awareness: MCO staff provided education to providers about alternatives for recipients by distributing "Ameritips," which included listings of local urgent care centers' availability, and providers who offer after-hours care.
- Revised provider orientation: During provider forums, greater emphasis was placed on directing recipients to urgent care centers and encouraging use of the 24 Hour Nurse Helpline.
- Real-Time ER Reports—These reports allow **Amerigroup** and providers to see which recipients are frequenting the ER and from what facility.
- Recipient Outreach: A recipient advocate contacted recipients who had an avoidable ER visit. The recipient advocate provided assistance with scheduling PCP visits and addressed other concerns and barriers identified during the call.
- 24 Hour Nurse Helpline refrigerator magnet—This reminder was included in all new member welcome packets.
- "Right Care, Right Place" brochure: The MCO modified the "Right Care, Right Place" brochure. The brochure now contains a listing of urgent care centers and is included in new member welcome packets, which were sent to recipients who had three or more avoidable ER visits.

The MCO also conducted a drill-down analysis. The MCO found that Clark County recipients had a higher rate of ER utilization for avoidable diagnoses, and that recipients younger than nine years of age had a higher percentage of avoidable ER visits. To overcome these identified barriers, the MCO implemented daily ER utilization reports, which are sent, along with recipients' telephone numbers, to University Medical Center (UMC) in Clark County. A recipient advocate contacts the recipient to determine why he or she went to the ER, arranges an appointment with the PCP, and provides help with any other identified needs. The advocate outreach call is also conducted for recipients nine years of age and younger. In addition, **Amerigroup** documented that, by developing and implementing additional interventions, it will continue to address identified ethnicity issues.

Plan Comparison

Both MCOs received a *Met* validation score for 100 percent of the elements in the Design and Implementation stages. The strong performance in these activities suggests both a thorough application of designing methodologically sound study designs and linking interventions to barriers. Opportunities for improvement exist in the Outcomes stage, however, for both of **Amerigroup**'s PIPs, ***Diabetes Management*** and ***Reducing Avoidable Emergency Room Visits*** and **HPN**'s PIP, ***Reducing Avoidable Emergency Room Visits***. **Amerigroup**'s PIPs received a *Not Met* and *Partially Met* validation status, respectively, and **HPN**'s PIP received a *Not Met* validation status. **HPN**'s PIP, ***Children and Adolescents' Access to Primary Care Practitioners***, reported baseline data only and will not progress to the Outcomes stage until FY 2015 when Remeasurement 1 data are available. This PIP received an overall validation status of *Met*.

Table 6-9—Performance Improvement Project Validation Status for Nevada Managed Care Organizations July 1, 2013, through June 30, 2014

Health Plan	Name of Project/Study	Percentage Score of Evaluation Elements *Met* [1]	Percentage Score of Critical Elements *Met* [2]	Overall Validation Status [3]
Amerigroup	*Diabetes Management*	95%	92%	*Not Met*
Amerigroup	*Reducing Avoidable Emergency Room Visits*	92%	88%	*Partially Met*
HPN		85%	89%	*Not Met*
HPN	*Children and Adolescents' Access to Primary Care Practitioners*	100%	100%	*Met*

[1] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total applicable elements of all categories (*Met*, *Partially Met*, and *Not Met*).

[2] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the applicable critical elements *Met*, *Partially Met*, and *Not Met*.

[3] **Overall Validation Status**—The overall validity and reliability of the PIP, which is based on the PIP Validation Tool results.

For **HPN**'s ***Reducing Avoidable Emergency Room Visits*** PIP, the PIP did not demonstrate statistically significant improvement for all indicators; therefore, the PIP received a *Not Met* validation status.

Amerigroup's ***Diabetes Management*** PIP received a *Not Met* validation status due to lack of statistically significant improvement achieved for all three study indicators. The ***Reducing Avoidable Emergency Room Visits*** PIP also has opportunities for improvement. Only Study Indicator 2, avoidable ER visits for the TANF/CHAP (Medicaid) population, demonstrated statistically significant improvement over baseline, leaving opportunities for improvement for the Nevada Check Up population.

Overall Recommendations

Overall, HSAG recommends that the MCOs:

- Conduct an annual causal/barrier and drill-down analyses more frequently than annually and incorporate quality improvement science such as the Plan-Do-Study-Act (PDSA) process into its improvement strategies and action plans.
- Design small-scale tests coupled with analysis of results to determine the success of the intervention. If after reviewing the results of the test data, it is determined that the intervention has not been successful, the MCOs should determine: (1) if the true root cause was identified—if not, the MCOs should conduct another causal/barrier analysis to isolate the true root cause or issue that is impacting improvement; and (2) if the interventions need to be revised because a new root cause was identified, or the intervention was unsuccessful. In evaluating the results of intervention testing, the MCOs may find that the results of the test yield more information that directs the MCOs to modify an existing intervention to yield a greater result. If the existing intervention is modified, the MCOs should develop another test to evaluate the modified intervention's effectiveness if the current test is obsolete.

- Prioritize barriers and focus efforts and resources on the top three-to-five barriers. When identifying barriers, the MCOs should be able to specifically define the problem within the barrier. For instance, when the MCO identifies "lack of provider education" as a barrier, the MCO should drill down even further to isolate the specific piece of education the provider is lacking, such as how to properly code for services, when preventive screenings and tests should occur, or which standards of practice should be followed. By pinpointing the specific cause for the barrier, the MCO will increase its chances of identifying a more appropriate intervention that will overcome the barrier.
- **Amerigroup** should consider using other types of QI tools such as a key driver diagram and a Failure Modes and Effects Analysis (FMEA) to identify process weaknesses.

The CAHPS surveys ask members to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers, such as the communication skills of providers and the accessibility of services. **HPN** and **Amerigroup** were responsible for obtaining a CAHPS vendor to administer the CAHPS surveys on their behalf.

Objectives

The primary objective of the CAHPS surveys was to effectively and efficiently obtain information on the level of satisfaction that patients have with their health care experiences.

Technical Methods of Data Collection and Analysis

Three populations were surveyed for **HPN** and **Amerigroup**: adult Medicaid, child Medicaid, and Nevada Check Up. Two NCQA-certified vendors—the Center for the Study of Services (CSS) and Morpace—administered the 2014 CAHPS surveys for **HPN** and **Amerigroup**, respectively.

The technical method of data collection was through administration of the CAHPS 5.0H Adult Medicaid Health Plan Survey to the adult population, and the CAHPS 5.0H Child Medicaid Health Plan Survey to the child Medicaid and Nevada Check Up populations. **HPN** and **Amerigroup** used a mixed-mode methodology for data collection (i.e., mailed surveys followed by telephone interviews of non-respondents to the mailed surveys).

The survey questions were categorized into nine measures of satisfaction. These measures included four global ratings and five composite scores. The global ratings reflected patients' overall satisfaction with their personal doctor, specialist, health plan, and all health care. The composite scores were derived from sets of questions to address different aspects of care (e.g., getting needed care and how well doctors communicate). When a minimum of 100 responses for a measure was not achieved, the result of the measure was denoted as Not Applicable (NA).

For each of the four global ratings, the percentage of respondents who chose the top satisfaction ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. This percentage is referred to as a question summary rate (or top-box response).

For each of the five composite scores, the percentage of respondents who chose a positive response was calculated. CAHPS composite question response choices fell into one of three categories: (1) "Never," "Sometimes," "Usually," or "Always;" (2) "Not at all," "A little," "Some," or "A lot;" or (3) "No" or "Yes." A positive or top-box response for the composites was defined as a response of "Usually/Always" or "A lot/Yes." The percentage of top-box responses is referred to as a global proportion for the composite scores. A substantial increase or decrease is denoted by a change of 5 percentage points or more.

It is important to note that as a result of the transition from the CAHPS 4.0H to the CAHPS 5.0H Adult and Child Medicaid Health Plan Surveys and changes to the Shared Decision Making composite measure, 2013 NCQA CAHPS national averages were not available for this composite measure. This was denoted with a dash (—).

Plan-Specific Findings—Health Plan of Nevada

Table 7-1 shows **HPN**'s 2013 and 2014 adult Medicaid CAHPS top-box rates along with NCQA's 2013 CAHPS adult Medicaid national averages.[7-1] In 2014, a total of 1,890 members were surveyed and 364 completed a survey. After ineligible members were excluded, the response rate was 19.8 percent. In 2013, the average NCQA response rate for the adult Medicaid population was 28.4 percent, which was higher than **HPN**'s response rate.[7-2]

Table 7 1 HPN Adult Medicaid CAHPS Results

	2013 Top Box Rates	2014 Top Box Rates	2013 NCQA CAHPS Adult Medicaid National Averages**
Composite Measures			
Getting Needed Care	76.9%	75.8%	**
Getting Care Quickly	79.5%	76.7%	**
How Well Doctors Communicate	87.7%	87.4%	**
Customer Service	NA	NA	**
Shared Decision Making	NA	NA	—
Global Ratings			
Rating of All Health Care	49.4%	46.0%	**
Rating of Personal Doctor	60.0%	62.4%	**
Rating of Specialist Seen Most Often	NA	NA	**
Rating of Health Plan	53.3%	45.0%	**

A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as Not Applicable (NA). Measures for which NCQA national averages are not available are denoted with a dash (—).

**The NCQA CAHPS National Averages are the proprietary intellectual property of NCQA. The NCQA CAHPS National Averages are to be used only for internal analysis and may not be displayed publicly. NCQA does not allow the public sharing of the actual NCQA CAHPS National Averages. In previous years, the DHCFP has published the full EQR Technical Report on its Web site. Given the new instruction by NCQA, however, HSAG has omitted the CAHPS National Averages from this publicly displayed report.

HPN's rate increased between 2013 and 2014 for one of the reportable measures: *Rating of Personal Doctor*. **HPN**'s rates decreased between 2013 and 2014 for the remaining reportable measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, and *Rating of Health Plan*. Further, one measure showed a substantial decrease of more than 5 percentage points: *Rating of Health Plan*.

HPN's 2014 top-box rates for the adult Medicaid population were lower than the 2013 NCQA adult Medicaid national averages for all six reportable measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*.

[7-1] As previously noted, due to changes to the *Shared Decision Making* composite measure, 2013 NCQA national average data were not available for this composite measure.

[7-2] 2014 NCQA national response rate information was not available at the time this report was produced.

Table 7-2 shows **HPN**'s 2013 and 2014 child Medicaid CAHPS top-box rates along with NCQA's 2013 CAHPS child Medicaid national averages.[7-3] In 2014, a total of 2,390 members were surveyed and 620 completed a survey. After ineligible members were excluded, the response rate was 27.2 percent. In 2013, the average NCQA response rate for the child Medicaid population was 28.7 percent, which was higher than **HPN**'s 2014 response rate.[7-4]

Table 7 2 HPN Child Medicaid CAHPS Results

	2013 Top Box Rates	2014 Top Box Rates	2013 NCQA CAHPS Child Medicaid National Averages**
Composite Measures			
Getting Needed Care	86.9%	84.3%	**
Getting Care Quickly	87.6%	86.5%	**
How Well Doctors Communicate	91.3%	91.0%	**
Customer Service	87.1%	87.5%	**
Shared Decision Making	NA	NA	—
Global Ratings			
Rating of All Health Care	62.8%	63.6%	**
Rating of Personal Doctor	70.1%	73.7%	**
Rating of Specialist Seen Most Often	NA	NA	**
Rating of Health Plan	64.6%	71.4%	**

A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as Not Applicable (NA). Measures for which NCQA national averages are not available are denoted with a dash (—).

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HPN's rates decreased between 2013 and 2014 for three of the seven reportable measures: *Getting Needed Care*, *Getting Care Quickly*, and *How Well Doctors Communicate*. **HPN**'s rates increased between 2013 and 2014 for four measures: *Customer Service*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*. Additionally, one measure, *Rating of Health Plan*, showed a substantial increase of more than 5 percentage points.

HPN's 2014 top-box rates for the child Medicaid population were lower than the 2013 NCQA child Medicaid national averages for five measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, and *Rating of All Health Care*. Two of **HPN**'s 2014 top-box rates for the child Medicaid population were higher than the 2013 NCQA child Medicaid national average: *Rating of Personal Doctor* and *Rating of Health Plan.*

[7-3] Due to changes to the *Shared Decision Making* composite measure, 2013 NCQA national average data were not available for this composite measure.
[7-4] 2014 NCQA national response rate information was not available at the time this report was produced.

Table 7-3 displays **HPN**'s 2013 and 2014 Nevada Check Up CAHPS top-box rates. Since NCQA does not publish separate rates for the Children's Health Insurance Program (CHIP) population, national comparisons could not be performed. In 2014, a total of 2,310 members were surveyed and 1,135 completed a survey. After ineligible members were excluded, the response rate was 49.7 percent.

Table 7 3 HPN Nevada Check Up CAHPS Results

	2013 Top Box Rates	2014 Top Box Rates
Composite Measures		
Getting Needed Care	82.8%	81.9%
Getting Care Quickly	86.2%	85.8%
How Well Doctors Communicate	91.5%	91.7%
Customer Service	89.9%	89.2%
Shared Decision Making	51.4%	50.9%
Global Ratings		
Rating of All Health Care	62.2%	62.3%
Rating of Personal Doctor	72.1%	74.6%
Rating of Specialist Seen Most Often	70.7%	73.1%
Rating of Health Plan	78.0%	76.6%

HPN's rates increased between 2013 and 2014 for four measures: *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often*. For the remaining five measures, **HPN**'s rates decreased between 2013 and 2014: *Getting Needed Care*, *Getting Care Quickly*, *Customer Service*, *Shared Decision Making*, and *Rating of Health Plan*. No measures showed a substantial increase or decrease between 2013 and 2014.

Plan-Specific Findings—Amerigroup

Table 7-4 shows **Amerigroup**'s 2013 and 2014 adult Medicaid CAHPS top-box rates along with NCQA's 2013 CAHPS adult Medicaid national averages.[7-5,7-6] In 2014, a total of 2,430 members were surveyed and 285 completed a survey. After ineligible members were excluded, the response rate was 12.0 percent. In 2013, the average NCQA response rate for the adult Medicaid population was 28.4 percent, which was higher than **Amerigroup**'s response rate.[7-7]

Table 7 4 Amerigroup Adult Medicaid CAHPS Results

	2013 Top Box Rates	2014 Top Box Rates	2013 NCQA CAHPS Adult Medicaid National Averages**
Composite Measures			
Getting Needed Care	75.5%	75.0%	**
Getting Care Quickly	72.4%	74.0%	**
How Well Doctors Communicate	87.5%	87.0%	**
Customer Service	89.6%	89.0%	**
Shared Decision Making	NA	44.0%	—
Global Ratings			
Rating of All Health Care	48.1%	45.3%	**
Rating of Personal Doctor	64.6%	56.0%	**
Rating of Specialist Seen Most Often	NA	57.6%	**
Rating of Health Plan	50.8%	46.4%	**

A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as Not Applicable (NA). Measures for which NCQA national averages are not available are denoted with a dash (—).

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Amerigroup's rates decreased between 2013 and 2014 for six measures: *Getting Needed Care*, *How Well Doctors Communicate*, *Customer Service*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan.* Further, one measure showed a substantial decrease of more than 5 percentage points: *Rating of Personal Doctor*. **Amerigroup**'s rates increased between 2013 and 2014 for one measure: *Getting Care Quickly*.

[7-5] **Amerigroup**'s 2014 top-box rates for all adult composite measures were rounded to the nearest whole percent, while the composite measure top-box rates provided for **HPN** and **Amerigroup**'s child population were rounded to the tenth decimal place. Given this variability, caution should be exercised when interpreting the comparisons of **Amerigroup**'s 2014 adult Medicaid CAHPS results to previous year's rates and NCQA national averages for all composite measures.

[7-6] As previously noted, due to changes to the *Shared Decision Making* composite measure, 2013 NCQA national average data were not available for this composite measure.

[7-7] 2014 NCQA national response rate information was not available at the time this report was produced.

Amerigroup's 2014 top-box rates for the adult Medicaid population were lower than the 2013 NCQA adult Medicaid national averages for seven measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*. One of **Amerigroup**'s 2014 top-box rates for the adult Medicaid population was higher than the 2013 NCQA adult Medicaid national average: *Customer Service.*

Table 7-5 shows **Amerigroup**'s 2013 and 2014 child Medicaid CAHPS top-box rates along with NCQA's 2013 CAHPS child Medicaid national averages.[7-8] In 2014, a total of 3,778 members were surveyed and 660 completed a survey. After ineligible members were excluded, the response rate was 18.0 percent. In 2013, the average NCQA response rate for the child Medicaid population was 28.7 percent, which was higher than **Amerigroup**'s response rate.[7-9]

Table 7 5 Amerigroup Child Medicaid CAHPS Results

	2013 Top Box Rates	2014 Top Box Rates	2013 NCQA CAHPS Child Medicaid National Averages**
Composite Measures			
Getting Needed Care	77.1%	78.2%	**
Getting Care Quickly	84.4%	83.4%	**
How Well Doctors Communicate	89.4%	88.2%	**
Customer Service	86.4%	84.7%	**
Shared Decision Making	55.6%	47.6%	—
Global Ratings			
Rating of All Health Care	60.8%	60.8%	**
Rating of Personal Doctor	74.5%	73.7%	**
Rating of Specialist Seen Most Often	70.2%	72.2%	**
Rating of Health Plan	67.3%	70.0%	**

A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as Not Applicable (NA). Measures for which NCQA national averages are not available are denoted with a dash (—).
**The NCQA CAHPS National Averages are the proprietary intellectual property of NCQA. The NCQA CAHPS National Averages are to be used only for internal analysis and may not be displayed publicly. NCQA does not allow the public sharing of the actual NCQA CAHPS National Averages. In previous years, the DHCFP has published the full EQR Technical Report on its Web site. Given the new instruction by NCQA, however, HSAG has omitted the CAHPS National Averages from this publicly displayed report.

Amerigroup's rates increased between 2013 and 2014 for three measures: *Getting Needed Care*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*. **Amerigroup**'s rates decreased between 2013 and 2014 for five measures: *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, *Shared Decision Making*, and *Rating of Personal Doctor*. Of these, *Shared*

[7-8] Due to changes to the *Shared Decision Making* composite measure, 2013 NCQA national average data were not available for this composite measure.
[7-9] 2014 NCQA national response rate information was not available at the time this report was produced.

Decision Making showed a substantial decrease of more than 5 percentage points. The rate for one measure, *Rating of All Health Care*, did not change between 2013 and 2014.

Amerigroup's 2014 top-box rates for the child Medicaid population were lower than the 2013 NCQA child Medicaid national average for five measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, and *Rating of All Health Care.* Three of **Amerigroup**'s 2014 top-box rates for the child Medicaid population were higher than the 2013 NCQA child Medicaid national average: *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*.

Table 7-6 shows **Amerigroup**'s 2013 and 2014 Nevada Check Up CAHPS top-box rates. Since NCQA does not publish separate rates for the CHIP program, national comparisons could not be made. In 2014, a total of 1,865 members were surveyed and 543 completed a survey. After ineligible members were excluded, the response rate was 32.6 percent.

Table 7 6 Amerigroup Nevada Check Up CAHPS Results

	2013 Top Box Rates	2014 Top Box Rates
Composite Measures		
Getting Needed Care	77.4%	79.3%
Getting Care Quickly	79.8%	81.8%
How Well Doctors Communicate	87.1%	89.2%
Customer Service	85.0%	80.9%
Shared Decision Making	48.0%	50.3%
Global Ratings		
Rating of All Health Care	62.9%	61.8%
Rating of Personal Doctor	75.5%	75.5%
Rating of Specialist Seen Most Often	70.2%	65.6%
Rating of Health Plan	74.5%	76.5%

Amerigroup's rate decreased between 2013 and 2014 for three measures: *Customer Service*, *Rating of All Health Care*, and *Rating of Specialist Seen Most Often*. Five measures increased between 2013 and 2014: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Shared Decision Making*, and *Rating of Health Plan.* One measure's rate, *Rating of Personal Doctor*, remained the same between 2013 and 2014.

Plan Comparison

HPN's adult Medicaid CAHPS scores were below the adult Medicaid national averages for all six reportable composite and global measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*. **HPN**'s response rate for the adult Medicaid population was lower than the 2013 NCQA adult Medicaid average response rate by 8.6 percentage points. **Amerigroup**'s adult Medicaid CAHPS scores were below the adult Medicaid national averages for seven composite and global measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*. **Amerigroup**'s response rate for the adult Medicaid population was lower than the 2013 NCQA adult Medicaid average response rate by 16.4 percentage points.

HPN's child Medicaid CAHPS scores were below the child Medicaid national averages for four reportable composite measures (*Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*) and for one reportable global rating (*Rating of All Health Care)*. **HPN**'s response rate for the child Medicaid population was 1.5 percentage points lower than the 2013 NCQA child Medicaid average response rate. **Amerigroup**'s child Medicaid CAHPS scores were below the child Medicaid national averages for all four composite measures (*Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*) and for one of the global measures (*Rating of All Health Care*). **Amerigroup**'s response rate for the child Medicaid population was 10.7 percentage points lower than the 2013 NCQA child Medicaid average response rate.

HPN's 2014 Nevada Check Up CAHPS scores were above the 2013 Nevada Check Up CAHPS scores for four measures: *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often*. **Amerigroup**'s 2014 Nevada Check Up CAHPS scores were above the 2013 Nevada Check Up CAHPS scores for five measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Shared Decision Making*, and *Rating of Health Plan*. Since NCQA does not publish separate rates for the CHIP program, national comparisons could not be made.

Overall Recommendations

HSAG recommends that each MCO continue to work with its CAHPS vendor to ensure a sufficient number of completed surveys are obtained to enable reporting of all CAHPS measures. NCQA recommends targeting 411 completed surveys per survey administration. Neither **HPN** nor **Amerigroup** met this target for the adult Medicaid population. Without sufficient responses, MCOs lack information that can be critical to designing and implementing targeted interventions which can improve access to, and the quality and timeliness of, care.

HSAG recommends that **HPN** focus quality improvement initiatives on enhancing members' experiences with *Rating of All Health Care* for the adult Medicaid population, since the 2014 rate was lower than the 2013 adult CAHPS result and fell below the adult Medicaid national average. For the child Medicaid population, **HPN** should focus its efforts on improving *How Well Doctors*

Communicate, since the 2014 rate was lower than the 2013 rate, and the rate fell below the child Medicaid national average. For the Nevada Check Up population, while no measures showed a substantial decrease from 2013 to 2014, HSAG recommends that quality improvement efforts focus on improving *Shared Decision Making* which overall had the lowest rate.

For the adult population, HSAG recommends that **Amerigroup** focus quality improvement initiatives on enhancing members' experiences with *Rating of Personal Doctor* and *Rating of Health Plan*, since these rates were lower than the 2013 adult CAHPS results and fell below NCQA's 2013 CAHPS adult Medicaid national averages. For the child Medicaid population, **Amerigroup** should focus its efforts on improving *Getting Care Quickly* and *Customer Service*, since these rates were lower than the 2013 child CAHPS results and fell below NCQA's 2013 CAHPS child Medicaid national averages.

Amerigroup had reportable rates for all nine measures for the Nevada Check Up population in 2014, to compare with nine reportable measures from 2013. HSAG recommends that quality improvement efforts focus on *Rating of Specialist Seen Most Often* as the 2014 rate was below the 2013 Nevada Check Up top-box rate—nearly a 5 percent decrease. HSAG also recommends that **Amerigroup** survey the child Medicaid and Nevada Check Up populations as two unique populations (i.e., sample the populations separately) or continue to conduct an oversample of the Nevada Check Up population similar to the oversample conducted for 2014. This will enable the continued reporting of CAHPS results for both populations.

Appendix A. Technical Methods of Data Collection and Analysis

The Balanced Budget Act of 1997 (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' managed care organizations (MCOs). The data come from activities conducted in accordance with the Code of Federal Regulations (CFR) at 42 CFR 438.358. To meet these requirements, the State of Nevada, Department of Health and Human Resources, Division of Health Care Financing and Policy (the DHCFP), contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO). HSAG has served as the EQRO for the DHCFP since 2000.

From all of the data collected, HSAG summarizes each MCO's strengths and weaknesses and provides an overall assessment and evaluation of the quality, timeliness of, and access to, care and services that each MCO provided. The evaluations are based on the following definitions of quality, access, and timeliness:

- ***Quality***—CMS defines quality in the final rule at 42 CFR §438.320 as follows: "Quality, as it pertains to external quality review, means the degree to which an MCO or PIHP increases the likelihood of desired health outcomes of its beneficiaries through its structural and operational characteristics and through provision of health services that are consistent with current professional knowledge."[A-1]
- ***Timeliness***—NCQA defines timeliness relative to utilization decisions as follows: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[A-2] It further discusses the intent of this standard to minimize any disruption in the provision of health care. HSAG extends this definition of timeliness to include other managed care provisions that impact services to enrollees and that require a timely response from the MCO (e.g., processing expedited member appeals and providing timely follow-up care).
- ***Access***—In the preamble to the BBA Rules and Regulations, CMS discusses access and availability of services to Medicaid enrollees as "the degree to which MCOs/PIHPs implement the standards set forth by the state to ensure that all covered services are available to enrollees. Access includes the availability of an adequate and qualified provider network that considers the needs and characteristics of the enrollees served by the MCO or PIHP."[A-3]

This appendix describes the technical methods for data collection and analysis for each of the following activities: performance measure validation, validation of performance improvement projects, and CAHPS surveys. The objectives for each of these activities are described in the respective sections of this report.

[A-1] Federal Register. *Code of Federal Regulations, Title 42, Volume 3*, October 1, 2005. Available at: http://www.gpo.gov/fdsys/pkg/CFR-2012-title42-vol4/xml/CFR-2012-title42-vol4-sec438-320.xml. Accessed on: September 15, 2014.

[A-2] NCQA. *2014 Standards and Guidelines for the Accreditation of Health Plans.* Available at: https://iss.ncqa.org/RDSat/ATMain.asp?ProductType=License&ProductID=313&activityID=54453. Accessed on: September 15, 2014.

[A-3] Federal Register. *Code of Federal Regulations. Vol. 67, No. 115*, June 14, 2002.

Validation of Performance Improvement Projects (PIPs)

The DHCFP requires its MCOs to conduct PIPs annually. The topics for the 2013–2014 PIP validation cycle were:

- Improving children's and adolescents' access to primary care practitioners (**HPN** only).
- Improving diabetes screening and control (**Amerigroup** only).
- Reducing avoidable emergency room visits (both MCOs).

Amerigroup and **HPN** conducted each required PIP and submitted documentation to HSAG for validation.

Validation Overview

The primary objective of PIP validation was to determine each MCO's compliance with the requirements of 42 CFR 438.240(b)(1), including:

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

HSAG used the CMS publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012, in evaluating and validating the PIPs.[7-4]

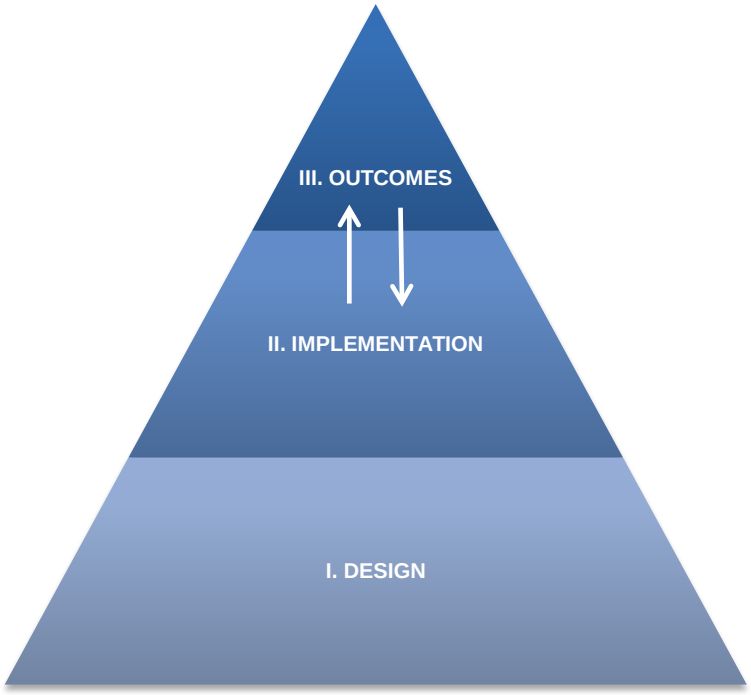
HSAG obtained the data needed to conduct the PIP validation from the MCO's PIP Summary Forms. These forms provided detailed information about each MCO's PIPs related to completed activities HSAG evaluated for the FY 2013–2014 validation cycle.

Stages of a PIP

Figure A–1 illustrates the three stages of the PIP process—i.e., Study Design, Study Implementation, and Study Outcomes. Each sequential stage provides the foundation for the next stage. The Study Design stage establishes the methodological foundation for the PIP. The activities in this section include development of the study topic, question, indicators, and population. To implement successful improvement strategies, a strong study design is necessary.

[7-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): 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.

Figure A–1—PIP Stages



Once an MCO establishes its study design, the PIP process moves into the Study Implementation stage. This stage includes data analysis and interventions. During this stage, the MCO analyzes data, identifies barriers to performance, and develops interventions targeted to overcome barriers and improve outcomes. Implementing effective improvement strategies is necessary to improve PIP outcomes.

The final stage is Study Outcomes, which involves the evaluation of real and sustained improvement based on reported results and statistical testing. Sustained improvement is achieved when outcomes exhibit statistical improvement over time and multiple measurements. This stage is the culmination of the previous two stages. The MCO should regularly evaluate interventions to ensure they are having the desired effect. A concurrent review of the data is encouraged. If the MCO's evaluation of the interventions, and/or review of the data, indicate that the interventions are not having the desired effect, the MCO should revisit its causal/barrier analysis process; verify the proper barriers are being addressed; and discontinue, revise, or implement new interventions as needed. This cyclical process should be used throughout the duration of the PIP and revisited as often as needed.

The purpose of a PIP is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas. Therefore, in addition to the validation results, the study indicator results for each MCO are compared to the results from the prior measurement period in terms of whether improvement and/or sustained improvement were attained.

HSAG PIP Validation Scoring

Each required activity was evaluated on one or more elements that form a valid PIP. The HSAG PIP Review Team scored each evaluation element within a given activity as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed*. HSAG designated some of the evaluation elements that are pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all of the critical elements had to be *Met*. Given the importance of critical elements to the scoring methodology, any critical element that received a *Not Met* score resulted in an overall validation rating for the PIP of *Not Met*. An MCO would be given a *Partially Met* score if 60 to 79 percent of all evaluation elements were *Met* or one or more critical elements were *Partially Met*. HSAG provided a *Point of Clarification* when enhanced documentation would have demonstrated a stronger application of the PIP activities and evaluation elements.

In addition to the validation status (e.g., *Met*) HSAG gave each PIP an overall percentage score for all evaluation elements (including critical elements). HSAG calculated the overall percentage score by dividing the total number of elements scored as *Met* by the total number of elements scored as *Met*, *Partially Met*, and *Not Met*. HSAG also calculated a critical element percentage score by dividing the total number of critical elements scored as *Met* by the sum of the critical elements scored as *Met*, *Partially Met*, and *Not Met*.

Performance Measure Validation

HSAG performed an audit of the MCOs' HEDIS reporting for their Medicaid and Nevada Check Up programs. Methods and information sources used by HSAG to conduct the audits included:

- Teleconferences with the MCOs' personnel and vendor representatives as necessary.
- Detailed review of the MCOs' completed responses to the NCQA Roadmap.
- On-site meetings, including the following:
  - Staff interviews
  - Live system and procedure demonstration
  - Documentation review and requests for additional information
  - Primary HEDIS data source verification
  - Programming logic review and inspection of dated job logs
  - Computer database and file structure review
  - Discussion and feedback sessions
- Detailed evaluation of computer programming used to access administrative data sets, manipulate medical record review data, and calculate HEDIS measures.
- Detailed evaluation of encounter data completeness.
- Re-abstraction of sample medical records selected by the auditors, with a comparison of results to each MCO's review determinations for the same records, if the hybrid method was used.
- Requests for corrective actions and modifications related to HEDIS data collection and reporting processes and data samples, as necessary, and verification that actions were taken.
- Accuracy checks of the final HEDIS rates completed by the MCOs.
- Interviews with a variety of individuals whose department or responsibilities played a role in the production of HEDIS data. Representatives of vendors that provided or processed HEDIS 2014 (and earlier historical) data may also have been interviewed and asked to provide documentation of their work.

In addition, activities conducted prior to on-site meetings with representatives of **HPN** and **Amerigroup** included written and e-mail correspondence explaining the scope of the audit, methods used, and time frames for major audit activities; a compilation of a standardized set of comprehensive working papers for the audit; a determination of the number of sites and locations for conducting on-site meetings, demonstrations, and interviews with critical personnel; the preparation of an on-site agenda; a review of source code, computer programming, and query language; and a detailed review of a select set of HEDIS measures required for reporting by the DHCFP.

The IS capabilities assessment consisted of the auditor's findings on IS capabilities, compliance with each IS standard, and any impact on HEDIS reporting. Assessment details included facts on claims and encounter data, enrollment, provider data, medical record review processes, data integration, data control, and measure calculation processes.

To validate the medical record review portion of the audit, NCQA policies and procedures require auditors to perform two steps. First, the audit team reviews medical record review processes employed by the MCOs, which include review of staff qualifications, training, data collection instruments and tools, interrater reliability (IRR) testing, and the method used to combine medical record review data with administrative data. The second step is a reabstraction of selected medical records and a comparison of the audit team's results to abstraction results for medical records used in the hybrid data source measures.

The analysis of the validation of performance measures involved tracking and reporting rates for the measures required for reporting by the DHCFP for Medicaid and Nevada Check Up. The audited measures (and the programs to which they apply) are presented in Table A-1.

Table A 1 Audited 2014 HEDIS Measures

Required HEDIS Measures	Medicaid	Check-Up
*Ambulatory Care (Emergency Department Visits)**		
Childhood Immunization Status—Combos 2–10	X	X
Lead Screening in Children	X	X
Children's and Adolescents' Access to Primary Care Practitioners	X	X
Well-Child Visits in the First 15 Months of Life	X	X
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	X	X
Adolescent Well-Care Visits	X	X
Annual Dental Visit	X	X
Use of Appropriate Medications for People With Asthma	X	X
Follow-Up After Hospitalization for Mental Illness	X	X
Comprehensive Diabetes Care	X	
Weeks of Pregnancy at the Time of Enrollment	X	
Timeliness of Prenatal Care	X	
Postpartum Care	X	
Frequency of Ongoing Prenatal Care	X	

*Performance Improvement Project (PIP) measure

CAHPS Surveys

Three populations were surveyed for **HPN** and **Amerigroup**: adult Medicaid, child Medicaid, and Nevada Check Up. Two NCQA-certified vendors—the Center for the Study of Services (CSS) and Morpace—administered the 2014 CAHPS surveys for **HPN** and **Amerigroup**, respectively.

The technical method of data collection was through administration of the CAHPS 5.0H Adult Medicaid Health Plan Survey to the adult population, and the CAHPS 5.0H Child Medicaid Health Plan Survey to the child Medicaid and Nevada Check Up populations. **HPN** and **Amerigroup** used a mixed-mode methodology for data collection (i.e., mailed surveys followed by telephone interviews of non-respondents to mailed surveys).

The survey questions were categorized into nine measures of satisfaction. These measures included four global ratings and five composite scores. The global ratings reflected patients' overall satisfaction with their personal doctor, specialist, health plan, and all health care. The composite scores were derived from sets of questions to address different aspects of care (e.g., getting needed care and how well doctors communicate). When a minimum of 100 responses for a measure was not achieved, the result of the measure was denoted as Not Applicable (NA).

For each of the four global ratings, the percentage of respondents who chose the top satisfaction ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. This percentage is referred to as a question summary rate (or top-box response).

For each of the five composite scores, the percentage of respondents who chose a positive response was calculated. CAHPS composite question response choices fell into one of three categories: (1) "Never," "Sometimes," "Usually," or "Always;" (2) "Not at all," "A little," "Some," or "A lot;" or (3) "No" or "Yes." A positive or top-box response for the composites was defined as a response of "Usually/Always" or "A lot/Yes." The percentage of top-box responses is referred to as a global proportion for the composite scores. A substantial increase or decrease is denoted by a change of 5 percentage points or more.

It is important to note that as a result of the transition from the CAHPS 4.0H to the CAHPS 5.0H Adult and Child Medicaid Health Plan Surveys and changes to the Shared Decision Making composite measure, 2013 NCQA CAHPS national averages were not available for this composite measure. This was denoted with a dash (—).

Appendix B. Quality Strategy Goals and Objectives Table

Appendix B, which follows this page, contains the Quality Strategy Goals and Objectives Table.

State of Nevada

Division of Health Care Financing and Policy

Quality Assessment and Performance Improvement Strategy (Quality Strategy)

Goals and Objectives Results for FY 2013-2014

Goal 1:	**Improve the health and wellness of Nevada children by increasing the use of preventive services, thereby modifying health care use patterns for the population.**					
Objective 1.1:	Increase children's and adolescents' access to PCPs by 10 percent.					
	HPN 2013	QISMC Goal	**HPN 2014**	AGP 2013	QISMC Goal	**AMG 2014**
Medicaid:						
Children's Access to PCP (12-24 months)	93.00%	93.70%	**91.73%**	94.84%	95.36%	**93.58%**
Children's Access to PCP (25 months - 6 years)	80.49%	82.44%	**78.58%**	84.62%	86.16%	**83.40%**
Children's Access to PCP (7-11 years)	82.99%	84.69%	**82.35%**	84.65%	86.19%	**84.96%**
Adolescent's Access to PCP (12-19 years)	78.82%	80.94%	**78.37%**	81.41%	83.27%	**80.97%**
Nevada Check-Up:						
Children's Access to PCP (12-24 months)	96.95%	97.26%	**95.08%**	100%	100%	**98.85%**
Children's Access to PCP (25 months - 6 years)	92.85%	93.57%	**91.39%**	95.07%	95.56%	**94.11%**
Children's Access to PCP (7-11 years)	94.95%	95.46%	**94.88%**	97.06%	97.35%	**97.25%**
Adolescent's Access to PCP (12-19 years)	90.91%	91.82%	**91.49%**	93.30%	93.97%	**93.69%**
Objective 1.2:	Increase well-child visits (0 - 15 Months) by 10 percent.					
	HPN 2013	QISMC Goal	**HPN 2014**	AGP 2013	QISMC Goal	**AMG 2014**
Medicaid:						
Well-Child Visits 0 - 15 Months of Life	57.42%	61.68%	**54.50%**	65.38%	68.84%	**53.47%**
Nevada Check-Up:						
Well-Child Visits 0 - 15 Months of Life	69.34%	72.41%	**63.01%**	78.82%	80.94%	**54.05%**
Objective 1.3:	Increase well-child visits (3-6 Years) by 10 percent.					
	HPN 2013	QISMC Goal	**HPN 2014**	AGP 2013	QISMC Goal	**AMG 2014**
Medicaid:						
Well-Child Visits 3 - 6 Years of Life	57.42%	61.68%	**54.74%**	65.38%	68.84%	**63.08%**
Nevada Check-Up:						
Well-Child Visits 3 - 6 Years of Life	69.34%	72.41%	**73.72%**	78.82%	80.94%	**78.74%**
Objective 1.4:	Increase the prevalence of blood lead testing for children 1-2 years of age by 10 percent.					
	HPN 2013	QISMC Goal	**HPN 2014**	AGP 2013	QISMC Goal	**AMG 2014**
Medicaid:						
Lead Screening in Children	32.36%	39.12%	**37.23%**	34.49%	41.04%	**34.26%**
Nevada Check-Up:						
Lead Screening in Children	50.53%	55.48%	**55.24%**	49.51%	54.56%	**50.44%**
Objective 1.5:	Decrease avoidable emergency room visits by 10 percent.*					
	HPN 2013	QISMC Goal	**HPN 2014**	AGP 2013	QISMC Goal	**AMG 2014**
Medicaid:						
Avoidable Emergency Room Visit Rate	37.80%	34.02%	**42.90%**	41.40%	37.26%	**39.10%**
Nevada Check-Up:						
Avoidable Emergency Room Visit Rate	35.70%	32.13%	**41.70%**	39.10%	35.19%	**37.50%**
*Lower rates are indicative of better performance for this measure.						

State of Nevada

Division of Health Care Financing and Policy

Quality Assessment and Performance Improvement Strategy (Quality Strategy)

Goals and Objectives Results for FY 2013-2014

Goal 2:	**Increase use of evidence-based preventive treatment practices for Medicaid members with chronic conditions.**					
Objective 2.1:	Incrase rate of HbA1c testing for members with diabetes by 10 percent.					
	HPN 2013	QISMC Goal	**HPN 2014**	AGP 2013	QISMC Goal	**AMG 2014**
Diabetes Care - HbA1c Testing	69.98%	72.98%	**69.59%**	68.75%	71.88%	**73.99%**
Objective 2.2:	Increase rate of monitoring for nephropathy for members with diabetes by 10 percent.					
	HPN 2013	QISMC Goal	**HPN 2014**	AGP 2013	QISMC Goal	**AMG 2014**
Diabetes Care - Nephropathy	72.47%	75.22%	**72.75%**	63.99%	67.59%	**67.29%**
Objective 2.3:	Increase LDL-C screening for members with diabetes by 10 percent.					
	HPN 2013	QISMC Goal	**HPN 2014**	AGP 2013	QISMC Goal	**AMG 2014**
Diabetes Care - LDL-C Screening	67.88%	71.09%	**63.75%**	65.18%	68.66%	**68.10%**

Goal 3:	**Reduce and/or eliminate health care disparities for Medicaid and Nevada Check Up recipients.**			
Objective 3.1:	Ensure that health plans develop a cultural competency plan, which details the health plans' goals, objectives and processes for reducing and/or eliminating racial or ethnic disparities that negatively impact health care.			
	HPN 2013	**HPN 2014**	**AMG 2013**	**AMG 2014**
Plan Developed?	Yes	Yes	Yes	Yes
Objective 3.2:	Stratify data for performance measures and avoidable emergency room utilization by race and ethnicity to determine where disparities exist.			
	HPN 2013	**HPN 2014**	**AMG 2013**	**AMG 2014**
Medicaid: Stratified by Race and Ethnicity				
Performance Measures	Yes	Yes	Yes	Yes
Avoidable Emergency Room Visits	Yes	Yes	Yes	Yes
Nevada Check-Up: Stratified by Race & Ethnicity				
Performance Measures	Yes	Yes	Yes	Yes
Avoidable Emergency Room Visits	Yes	Yes	Yes	Yes
Objective 3.3:	Ensure that health plans submit an annual evaluation of the cultural competency program (CCP) to DHCFP. Health plans must receive 100 percent *Met* compliance score for all of the criteria listed in the MCO contract for CCP development, maintenance, and evaluation.			
	HPN 2013	**HPN 2014**	**AMG 2013**	**AMG 2014**
CCP Evaluation Submitted?	Yes	Yes	Yes	Yes
MCO Fully Compliant with all CCP Provisions?	Yes	Yes	Yes	Yes

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 by 10 percent.					
	HPN 2013	QISMC Goal	**HPN 2014**	AGP 2013	QISMC Goal	**AMG 2014**
Medicaid:						
Postpartum Care	65.00%	68.50%	**57.66%**	61.80%	65.62%	**59.22%**

HPN - Health Plan of Nevada

AMG - Amerigroup Community Care

Rates in **green** have met or exceeded the QISMC goal.