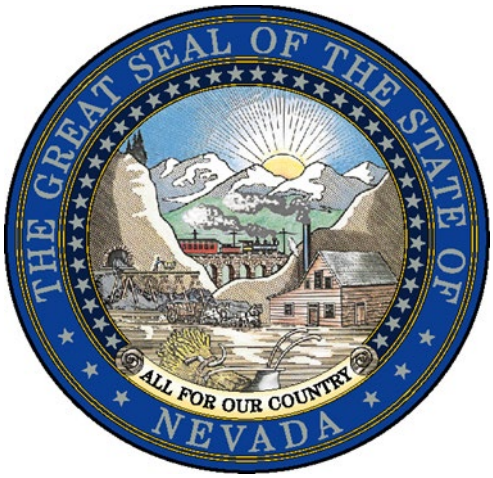

Division of Health Care Financing and Policy
Nevada Managed Care Program

State Fiscal Year 2024 External Quality Review Technical Report

February 2025

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Purpose and Overview of Report

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

DHCFP administers and oversees the Nevada Managed Care Program, which provides Medicaid and Children's Health Insurance Program (CHIP, also referred to as Nevada Check Up in Nevada) benefits to members residing in Clark and Washoe counties. The Nevada Managed Care Program's MCEs include four managed care organizations (MCOs) contracted with DHCFP to provide physical health and behavioral health services to Medicaid and Nevada Check Up members. DHCFP also contracted with one prepaid ambulatory health plan (PAHP), also known as the dental benefits administrator (DBA), to provide dental benefits for Medicaid and Nevada Check Up members. The MCOs and PAHP contracted with DHCFP during state fiscal year (SFY) 2024 are displayed in Table 1-1.

Table 1-1—MCEs in Nevada

MCO Name	MCO Short Name
Anthem Blue Cross and Blue Shield Healthcare Solutions	Anthem
Molina Healthcare of Nevada, Inc.	Molina
SilverSummit Healthplan, Inc.	SilverSummit
UnitedHealthcare Health Plan of Nevada Medicaid	UHC HPN
PAHP Name	**PAHP Short Name**
LIBERTY Dental Plan of Nevada, Inc.	LIBERTY

Scope of External Quality Review Activities

To conduct the annual assessment, HSAG used the results of mandatory and optional external quality review (EQR) activities, as described in 42 CFR §438.358. The EQR activities included as part of this assessment were conducted consistent with the associated EQR protocols developed by the Centers for Medicare & Medicaid Services (CMS) (referred to as the CMS EQR Protocols).[1] The purpose of the

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

EQR activities, in general, is to improve states' ability to oversee and manage MCEs they contract with for services, and help MCEs improve their performance with respect to the quality, timeliness, and accessibility of care. Effective implementation of the EQR-related activities will facilitate State efforts to purchase high-value care and to achieve higher performing healthcare delivery systems for their Medicaid and CHIP members. For the SFY 2024 assessment, no MCEs were exempt from the EQR conducted by HSAG. HSAG used findings from the mandatory and optional EQR activities displayed in Table 1-2 that were performed during the preceding 12 months to derive conclusions and make recommendations about the quality, timeliness, and accessibility of care and services provided by each MCE. Detailed information about each activity methodology is provided in Appendix A of this report.

Table 1-2—EQR Activities

Activity	Description	CMS Protocol
Validation of Performance Improvement Projects (PIPs)	This activity verifies whether a PIP conducted by an MCE used sound methodology in its design, implementation, analysis, and reporting.	Protocol 1. Validation of Performance Improvement Projects
Performance Measure Validation (PMV)	This activity assesses whether the performance measures calculated by an MCE are accurate based on the measure specifications and State reporting requirements.	Protocol 2. Validation of Performance Measures
Compliance Review	This activity determines the extent to which a Medicaid and CHIP MCE is in compliance with federal standards and associated state-specific requirements, when applicable.	Protocol 3. Review of Compliance with Medicaid and CHIP Managed Care Regulations
Network Adequacy Validation (NAV)	This activity assesses the accuracy of network adequacy indicators reported by an MCE and the extent to which an MCE has met the quantitative network adequacy standards defined by the State.	Protocol 4. Validation of Network Adequacy
Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[2] Analysis	This activity assesses member experience with an MCE and its providers and the quality of care members receive.	Protocol 6. Administration or Validation of Quality of Care Surveys

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

Nevada Managed Care Program Conclusions and Recommendations

HSAG used its analyses and evaluations of EQR activity findings from the SFY 2024 activities to comprehensively assess the MCEs' performance in providing quality, timely, and accessible healthcare services to Medicaid and CHIP members. For each MCE reviewed, HSAG provides a summary of its overall key findings, conclusions, and recommendations based on the MCE's performance, which can be found in Section 3 (MCOs) and Section 4 (PAHP) of this report. The overall findings and conclusions for all MCEs were also compared and analyzed to develop overarching conclusions and recommendations for the Nevada Managed Care Program. Table 1-3 highlights substantive conclusions and actionable state-specific recommendations, when applicable, for DHCFP to drive progress toward achieving the goals of the Nevada Quality Strategy and support improvement in the quality and timeliness of, and access to, healthcare services furnished to Medicaid managed care members.

Table 1-3—Programwide Conclusions and Recommendations

	Performance Impact on Goals and Objectives[3]	Performance Domain
Goal 1—Improve the health and wellness of Nevada's Medicaid population by increasing the use of preventive services by December 31, 2024		
✓	The MCOs' *Child and Adolescent Well Care Visit (WCV)* PIP positively impacted achieving Objectives 1.2(a) through 1.2(c) as all four MCOs achieved statistically significant improvement in the associated performance indicators.	☒ Quality ☒ Timeliness ☒ Access
✓	The Nevada Managed Care Program met Objectives 1.2(b) *Increase child and adolescent well-care visits (WCV)—12-17 years* for the Medicaid population and 1.8(a) *Increase chlamydia screening in women (CHL)—16-20 years* for the Medicaid and Nevada Check Up population. Additionally, rates for 11 of 18 objectives for Medicaid and rates for 10 of 14 objectives for Nevada Check Up demonstrated an increase in performance from the prior year.	
✓	All four MCOs in the Nevada Managed Care Program exceeded DHCFP's network adequacy requirements for provider-to-member-ratios for primary care providers (PCPs).	
✓	Although no MCO met the 100 percent threshold for the *Primary Care, Adults* and *Pediatrician* time or distance standards for Clark County, all four MCOs performed at or above 99.9 percent. Additionally, although no MCO met the 100 percent threshold for the *Primary Care, Adults* and *Pediatrician* time or distance standards for Washoe County, all four MCOs performed at or above 99.6 percent.	

[3] All EQR activities were included in HSAG's analysis, as applicable, if the activity results substantially impacted the Quality Strategy goals and objectives. However, only the Quality Strategy objectives with an established minimum performance standard (MPS) and reportable aggregate rates are included in HSAG's analysis for Table 8-1. HSAG's analysis did not include all performance measures validated through the PMV and performance measures without an established MPS or a reportable aggregate rate were excluded.

	Performance Impact on Goals and Objectives[3]	Performance Domain
✗	The MCOs' *Adults' Access to Preventive/Ambulatory Health Services (AAP)* PIP had limited impact on achieving Objectives 1.7(a) and 1.7(b) as three of the four MCOs did not achieve statistically significant improvement in the associated performance indicators.	
✗	The Nevada Managed Care Program did not meet the minimum performance standards (MPS) for 16 of 18 objectives for the Medicaid and 13 of 14 objectives for the Nevada Check Up population. Additionally, rates for seven of 18 objectives for the Medicaid population and rates for four of 14 objectives for the Nevada Check Up population demonstrated a decrease in performance from the prior year.	
–	No trends were identified through the compliance review and CAHPS activities that substantially impacted Goal 1.	
Goal 2—Increase use of evidence-based practices for members with chronic conditions by December 31, 2024		
✓	The Nevada Managed Care Program met Objectives 2.3 *Increase rate of controlling high blood pressure* and 2.5 *Decrease the rate of adult acute inpatient stays that were followed by an unplanned readmission for any diagnosis within 30 days after discharge (PCR)–Observed readmissions* for the Medicaid population. Additionally, rates for five of seven objectives for Medicaid demonstrated an increase in performance from the prior year.	☒ Quality ☒ Timeliness ☒ Access
✓	All four MCOs within the Nevada Managed Care Program exceeded DHCFP's network adequacy requirements for provider-to-member-ratios for specialty providers.	
m	The MCOs' *Plan All-Cause Readmissions (PCR)* PIP minimally impacted Objective 2.5 as only two of the four MCOs achieved statistically significant improvement in the associated performance indicators.	
✗	The Nevada Managed Care Program did not meet the MPS for five of seven objectives for the Medicaid and zero of one objective for the Nevada Check Up population. Additionally, rates for two of seven objectives for the Medicaid population demonstrated a decrease in performance from the prior year.	
–	No trends were identified through the compliance review and CAHPS activities that substantially impacted Goal 2.	
Goal 3—Reduce misuse of opioids by December 31, 2024		
✓	The Nevada Managed Care Program met Objective 3.1 *Reduce use of opioids at high dosage (HDO)* for the Medicaid population. Additionally, rates for two of four objectives for Medicaid demonstrated a slight increase in performance from the prior year.	☒ Quality ☐ Timeliness ☐ Access
✗	The Nevada Managed Care Program did not meet the MPS for one of four objectives for the Medicaid population. Additionally, rates for two of four objectives for the Medicaid population demonstrated a decrease in performance from the prior year.	
–	No trends were identified through the compliance review and CAHPS activities that substantially impacted Goal 3.	

	Performance Impact on Goals and Objectives[3]	Performance Domain
Goal 4—Improve the health and wellness of pregnant women and infants by December 31, 2024		
✓	The MCOs' *Prenatal and Postpartum Care (PPC)* PIP positively impacted achieving Objectives 4.1(a) and 4.1(b) as all four MCOs achieved statistically significant improvement in the associated performance indicators.	☒ Quality ☒ Timeliness ☒ Access
✓	Rates for four of five objectives for the Medicaid population demonstrated a slight increase in performance from the prior year.	
✓	Although no MCO met the 100 percent threshold for the *OB/GYN (Adult Females)* time or distance standards for Clark County, all four MCOs performed at or above 99.6 percent.	
✗	The Nevada Managed Care Program did not meet the MPS for all five objectives for the Medicaid population. Additionally, rates for one of five objectives for the Medicaid population demonstrated a slight decrease in performance from the prior year.	
✗	No MCO met the 100 percent threshold for the *OB/GYN (Adult Females)* time or distance standard for both Washoe and Clark Counties. Additionally, two MCOs in Washoe County only met a threshold of 96.2 percent and 96.8 percent.	
–	No trends were identified through the compliance review and CAHPS activities that substantially impacted Goal 4.	
Goal 5—Increase use of evidence-based practices for members with behavioral health conditions by December 31, 2024		
✓	The Nevada Managed Care Program met Objectives 5.4 *Increase diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications (SSD)* and 5.11(a) *Increase the rate of inpatient, residential treatment and detoxification visits or discharges for a diagnosis of substance use disorder (SUD) among patients 13 years of age and older that resulted in follow-up care for a diagnosis of SUD within 7 days (FUI)* for the Medicaid population. For the Nevada Check Up population, the Nevada Managed Care Program met four objectives: 5.3(a) and 5.3(b) *Increase follow-up after hospitalization for mental illness (FUM)—7-day* and *30-day* and 5.6(a) and 5.6(b) *Increase follow-up after ED visit for mental illness (FUM)—7-day* and *30-day.* Additionally, rates for 15 of 21 objectives for Medicaid and six of 10 objectives for Nevada Check Up demonstrated an increase in performance from the prior year.	☒ Quality ☒ Timeliness ☒ Access
✓	For all outpatient behavioral health related provider categories under the time or distance standards (*Psychologist; Psychologist*, *Pediatric*; *Psychiatrist*; *Board Certified Child and Adolescent Psychiatrist*; *Qualified Mental Health Professional (QMHP)*; and *QMHP, Pediatric*), all four MCOs performed at or above 99.9 percent threshold.	
m	The MCOs' *Follow-Up After Emergency Department Visit for Mental Illness (FUM)* PIP minimally impacted Objective 5.6(a) and 5.6(b) as only one of the four MCOs achieved statistically significant improvement in the associated performance indicators.	

	Performance Impact on Goals and Objectives[3]	Performance Domain
✗	The MCOs' *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)* PIP had limited impact on achieving Objectives 5.7(a) and 5.7(b) as none of the MCOs achieved statistically significant improvement in the associated performance indicators.	
✗	The Nevada Managed Care Program did not meet the MPS for 19 of 21 objectives for the Medicaid population and six of 10 objectives for the Nevada Check Up population. Additionally, rates for six of 21 objectives for the Medicaid population and four of 10 objectives for the Nevada Check Up population demonstrated a decrease in performance from the prior year.	
–	No trends were identified through the compliance review and CAHPS activities that substantially impacted Goal 5.	
Goal 6—Increase utilization of dental services by December 31, 2024		
✓	The PAHP's *Increase Preventive Services for Children* PIP positively impacted achieving Objectives 6.1, 6.2, 6.3(a) and 6.3(b) as the PAHP achieved a *High Confidence* rating in its PIP design.	☒ Quality ☒ Timeliness ☒ Access
✓	Rates for all four objectives for the Medicaid population and rates for two of four objectives for the Nevada Check Up population demonstrated a slight increase in performance from the prior year.	
✓	The Nevada Managed Care Program exceeded DHCFP's network adequacy requirements for provider-to-member-ratios for dental PCPs.	
✗	The Nevada Managed Care Program did not meet the MPS for all four objectives for the Medicaid population and all four objectives for the Nevada Check Up population. Additionally, although there were no rate decreases for the Medicaid population, rates for two of four objectives for the Nevada Check Up population demonstrated a decrease in performance from the prior year.	
–	No trends were identified through the compliance review and CAHPS activities that substantially impacted Goal 6.	
Goal 7—Reduce and/or eliminate health care disparities for Medicaid members by December 31, 2024		
✓	All MCEs met their contract obligations related to cultural competency programs and stratification of member data as required.	☒ Quality ☒ Timeliness ☒ Access
✓	DHCFP required the data for the *Prenatal and Postpartum Care (PPC)* PIP to be stratified by race and ethnicity to help identify health disparities for the African American population. All MCOs stratified data for this PIP as required.	
–	No trends were identified through the compliance review and CAHPS activities that substantially impacted Goal 7.	

Recommendations

Based on findings identified through the EQR activities that impacted the goals and objectives in DHCFP's Quality Strategy, HSAG identified the following recommendations to support improvement in the quality, timeliness, and access to healthcare services furnished to Nevada Managed Care Program members:

- To comply with the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F), DHCFP should update the contracts with its MCEs as follows within the required effective dates for each specific requirement:
  - Require the MCEs to respond to prior authorization requests for covered items and services within seven calendar days for standard requests to improve patient care outcomes and ensure members have more timely access to services.
  - Require the MCEs to publicly report prior authorization data for members and providers to better understand the types of items and services which require prior authorization and how each MCE performed over time for approvals and denials. This requirement is to assure transparency and accountability in the healthcare system and allow for the efficiency of prior authorization practices of each MCE, and enables the MCEs to assess trends, identify areas for improvement, and work toward continuous process improvement while maintaining necessary checks for quality and appropriateness of care.
- To comply with the Medicaid and CHIP Managed Care Access, Finance, and Quality Final Rule (CMS–2439–F), DHCFP should implement the following within the required effective dates for each specific requirement:
  - Review the maximum appointment wait times standards (e.g., 10 business days for outpatient mental health and SUD appointments) and update its contracts with its MCEs, as applicable.
  - Contract with an independent vendor to perform secret shopper surveys of MCE compliance with appointment wait times and accuracy of provider directories and require directory inaccuracies to be sent to DHCFP within three days of discovery. Results from the secret shopper survey will provide assurances to DHCFP that the MCEs' networks have the capacity to serve the expected enrollment in their service area and that they offer appropriate access to preventive and primary care services for their members.
  - Although DHCFP currently requires its MCEs to contract with a CAHPS survey vendor, the new rule requires an annual member experience survey to be conducted by DHCFP, or its contracted vendor, to ensure consistency in administration within its managed care program. Because the member experience survey results will provide direct and candid input from members, DHCFP and its MCEs can use the results to determine whether their networks offer an appropriate range of services and access as well as whether they provide a sufficient number, mix, and geographic distribution of providers to meet their members' needs. DHCFP will be required to post the results of the survey on its website annually in accordance with 42 CFR §438.10(c)(3).
- To ensure accurate and consistent reporting of MCE network adequacy standards, DHCFP should evaluate its expectations for how the MCEs must calculate the time and distance standards and provide written guidance to its MCEs (e.g., contract amendment, reporting template instructions) to confirm they have a clear understanding of DHCFP's specifications for calculating network adequacy (e.g., should MCEs report network adequacy standards and indicators by time *and* distance or by time *or* distance). DHCFP should also update its required network adequacy reporting template to align with DHCFP's network adequacy standards and indicators outlined in the contract (e.g., reporting on adult and pediatric populations separately). Updates to the contracts and reporting template should improve DHCFP's and the MCEs' ability to monitor for any gaps in network adequacy that may be a contributing barrier to members accessing timely care and services.

2. Overview of the Nevada Managed Care Program

Managed Care in Nevada

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

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

Table 2-1—Nevada Medicaid and Nevada Check Up Managed Care Demographics[4]

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

[4] The Medicaid dataset for males and females <1 year of age include members with unidentified gender. Totals for Table 2-1 reflect the whole Medicaid managed care population using the current county of residence at the time of the data pull on July 15, 2024. Table 2-2 and Table 2-3 reflect only Medicaid managed care members in Clark and Washoe counties. Enrollment data for 2024 are preliminary and subject to change.

Gender/Age Band	Member Enrollment
Females 15–19 Years of Age	1,075
Males 15–19 Years of Age	1,082
Total Nevada Check Up	**28,737**
Total Nevada Medicaid and Nevada Check Up	**578,886**

Overview of Managed Care Entities

During the SFY 2024 review period, DHCFP contracted with four MCOs and one PAHP. These MCEs are responsible for the provision of services to Nevada Managed Care Program members. Table 2-2 and Table 2-3 provide a profile for each MCO. As Nevada has only one PAHP, the eligible population is inclusive of all Medicaid and Nevada Check Up members and therefore the PAHP, **LIBERTY**, is not displayed in the tables below.

Table 2-2—Nevada MCO Medicaid Managed Care Members[4]

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

Table 2-3—Nevada MCO Nevada Check Up Managed Care Members[4]

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

Quality Strategy

In accordance with 42 CFR §438.340 and 42 CFR §457.1240(e), DHCFP implemented a written quality strategy for assessing and improving the quality of healthcare and services furnished by the MCEs to Nevada Medicaid and Nevada Check Up members under the Nevada Managed Care Program.

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

- Establish a comprehensive quality improvement system that is consistent with the CMS National Quality Strategy[5].
- Provide a framework for DHCFP to design and implement a coordinated and comprehensive system to proactively drive quality throughout the Nevada Medicaid and Nevada Check Up system. The Quality Strategy promotes the identification of creative initiatives to continually monitor; assess; and improve access to care, clinical quality of care, and health outcomes of the population served.
- Identify opportunities to improve the health status of the enrolled population and improve health and wellness through preventive care services, chronic disease and special needs management, and health promotion.
- Identify opportunities to improve quality of care and quality of service and implement improvement strategies to ensure Nevada Medicaid and Nevada Check Up members have access to high-quality and culturally appropriate care.
- Identify creative and efficient models of care delivery that are steeped in best practice and make healthcare more affordable for individuals, families, and the State government.
- Improve member satisfaction with care and services.

Quality Strategy Goals

In alignment with the purpose of the Quality Strategy, DHCFP established quality goals that are supported by specific objectives to continuously improve the health and wellness of Nevada Medicaid and Nevada Check Up members. The goals and supporting objectives are measurable and take into consideration the health status of all populations served by the Nevada Managed Care Program. The

[5] CMS National Quality Strategy. Available at: https://www.cms.gov/medicare/quality/meaningful-measures-initiative/cms-quality-strategy. Accessed on: Dec 12, 2024.

overarching Quality Strategy goals in place for the time period of 2022–2024 and the applicable program(s) are displayed in Table 2-4. Refer to Appendix B for a detailed description of the objectives and performance measures used to support each goal.

Table 2-4—Quality Strategy Goals and Applicable Program

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

Payment Initiative Programs

Certified Community Behavioral Health Centers

The Certified Community Behavioral Health Centers (CCBHCs) provide outpatient behavioral health services and primary care screenings and monitoring to individuals in Nevada for mental illness and SUD regardless of their ability to pay, including Nevada Medicaid and Nevada Check Up members. The Quality Incentive Payment (QIP) program for CCBHCs uses clinic-led and state-led quality measures, listed in Table 2-5, to determine quality payments that will be granted to each CCBHC based on performance year over year. DHCFP establishes the minimum patient volume in each performance measure denominator necessary for the performance measure to be valid. The QIP is composed of two payments—a payment for reporting and a payment for performance. In the first two years, the QIP only includes the payment for reporting. The QIP amount given to a CCBHC is based on multiplying the total facility-specific bundled rate payments made to the CCBHC in the performance period by a statewide percentage for reporting requirements in the first two years and by both a statewide percentage for performance requirements and a statewide percentage for reporting requirements in subsequent years. QIPs are made to CCBHCs meeting established criteria, within one year following the end of the relevant measurement year (July 1 to June 30), and after all final data needed to calculate the QIP are received. Of note, performance measure data are monitored and maintained by DHCFP and not reported through the EQR technical report.

Table 2-5—CCBHC Performance Measures

Performance Measure	Clinic/State-Led	Source	Target Goal
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	Clinic-led	Mathematica Policy Research (MPR)	90%
Adult MDD: Suicide Risk Assessment	Clinic-led	MPR	90%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	State-led	CMS	60.1%
Follow-Up After Hospitalization for Mental Illness, Ages 21+	State-led	NCQA*	7 days–43.9% 30 days–63%
Follow-Up After Hospitalization for Mental Illness, Ages 6–21	State-led	NCQA	7 days–43.9% 30 days–63%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	State-led	NCQA	Initiation–38.3% Engagement–11.3%
Plan All-Cause Readmission Rate	State-led	NCQA	15.2%
State Directed Crisis Measure	State-led	Public Health Supportive Services (PH-SS)	25%

*NCQA: National Committee for Quality Assurance

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

State-Directed Payment Initiative

In SFY 2023, DHCFP received CMS approval for a renewal of its delivery system and provider payment initiative in accordance with 42 CFR §438.6(c) for public hospital systems in Nevada in counties where the population is 700,000 or more, the licensed professionals working in those public hospital systems, and/or the licensed professionals affiliated with accredited public medical schools in those large populated counties. DHCFP implemented the payment initiative to help ensure the financial viability of these hospitals and licensed professionals, and to support them in maintaining and enhancing the high quality of care they provide to Medicaid members in Nevada. To evaluate the effectiveness of the state-directed payment initiative related to inpatient services, DHCFP added a performance measure in SFY 2021 to the Quality Strategy under Goal 2 to *decrease rate of adult acute inpatient stays that were followed by an unplanned readmission for any diagnosis within 30 days after discharge*. For

outpatient services, effectiveness of the payment initiative aligns with Quality Strategy Goal 1—*Improve the health and wellness of Nevada's Medicaid population by increasing the use of preventive services by December 31, 2024,* and Goal 2—*Increase use of evidence-based practices for members with chronic conditions by December 31, 2024*. The MCOs are annually required to calculate the performance of the providers eligible for the payment increase based on the utilization and delivery of services to Medicaid managed care members, using state-directed payment measure specifications and HEDIS data results.

Three providers were eligible for the state-directed payment initiative in SFY 2024: University Medical Center (UMC), a public hospital; the University of Nevada, Reno School of Medicine (UNR), a public medical school; and University of Nevada Las Vegas School of Medicine (UNLV), a public medical school. DHCFP's expectation is that each provider's rates for each measure included in the initiative will improve over a five-year period. After the baseline year, which is calendar year (CY) 2020 for UMC, CY 2021 for UNR, and CY 2023 for UNLV, DHCFP expects to see, at minimum, an increase of 2 percent per calendar year. Performance is evaluated by DHCFP annually, and results of the evaluation, including progress on meeting the associated Quality Strategy goals, are included as part of the EQR technical report.

Table 2-6 and Table 2-7 identify the Quality Strategy objectives identified in the CMS-approved Section 438.6(c) Preprint to evaluate performance of the state-directed payment initiative and the baseline rates, CY 2023[6] (measurement year [MY] 2023) rates, and the CY 2023 targets for UMC for Nevada Medicaid and Nevada Check Up. Rates listed in **green** font indicate that UMC met the target for CY 2023. Rates listed in **red** font indicate that UMC did not meet the target for CY 2023. UMC met the targets for CY 2023 for two of the 10 Nevada Medicaid/Nevada Check Up measures: *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Counseling for Physical Activity* for Medicaid and *Controlling High Blood Pressure (CBP)*. Based on these results, the payment initiative did not support that significant progress was made toward achieving the related Quality Strategy goals, and continued efforts should be implemented to support improvement in the eight measures which did not meet the target rate.

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

Measure	Objective Alignment	UMC Baseline[1]	UMC CY 2023 Rate	UMC CY 2023 Target[2]
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—BMI Percentile	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—BMI percentile	40.29%	**25.00%**	42.74%

[6] The rates were individually calculated by each MCO and submitted to DHCFP to provide to HSAG for inclusion in the EQR technical report. These rates were not validated by HSAG. HSAG used the denominators and numerators provided by DHCFP for each MCO to aggregate the CY 2023 rate for each measure.

Measure	Objective Alignment	UMC Baseline[1]	UMC CY 2023 Rate	UMC CY 2023 Target[2]
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Counseling for Nutrition	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—counseling for nutrition	31.31%	**25.00%**	33.21%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Counseling for Physical Activity	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—counseling for physical activity	28.18%	**37.50%**	29.90%
Comprehensive Diabetes Care (CDC)[∞]—Hemoglobin A1c (HbA1c) Testing	Increase rate of HbA1c testing for members with diabetes (CDC)	40.78%	**41.55%**	43.26%
Comprehensive Diabetes Care (CDC)[∞]—HbA1c Poor Control (>9.0%)[3]	Decrease rate of HbA1c poor control (>9.0%) for members with diabetes (CDC)	21.97%	**38.29%**	20.67%
Controlling High Blood Pressure (CBP)	Increase rate of controlling high blood pressure (CBP)	11.95%	**46.98%**	12.67%
Plan All-Cause Readmissions (PCR)—Observed Readmissions[3]	Decrease rate of adult acute inpatient stays that were followed by an unplanned readmission for any diagnosis within 30 days after discharge (PCR)—Observed readmissions	11.81%	**15.50%**	11.57%

BMI: body mass index

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

∞ NCQA retired the CDC measure in CY 2022 and replaced the measure with *Hemoglobin A1c Control for Patients With Diabetes (HBD).*

[1] The baseline year for UMC was CY 2020.

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

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

Green font indicates UMC met the target for CY 2023.

Red font indicates UMC did not meet the target for CY 2023.

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

Measure	Objective Alignment	UMC Baseline[1]	UMC CY 2023 Rate	UMC CY 2023 Target[2]
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—BMI Percentile	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—BMI percentile	49.68%	**0.00%**	52.70%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Counseling for Nutrition	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—counseling for nutrition	38.92%	**0.00%**	41.29%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Counseling for Physical Activity	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—counseling for physical activity	35.76%	**0.00%**	37.93%
Comprehensive Diabetes Care (CDC) ∞—Hemoglobin A1c (HbA1c) Testing	Increase rate of HbA1c testing for members with diabetes (CDC)	NA	NA	NA
Comprehensive Diabetes Care (CDC) ∞—HbA1c Poor Control (>9.0%)[3]	Decrease rate of HbA1c poor control (>9.0%) for members with diabetes (CDC)	NA	NA	NA
Controlling High Blood Pressure (CBP)	Increase rate of controlling high blood pressure (CBP)	NA	NA	NA
Plan All-Cause Readmissions (PCR)—Observed Readmissions[3]	Decrease rate of adult acute inpatient stays that were followed by an unplanned readmission for any diagnosis within 30 days after discharge (PCR)—Observed readmissions	NA	NA	NA

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

∞ NCQA retired the CDC measure in CY 2022 and replaced the measure with *Hemoglobin A1c Control for Patients With Diabetes (HBD).*

[1] The baseline year for UMC was CY 2020.

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

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

[4] The denominator for the WCC measure during CY 2023 was 2.

NA (Not Applicable) indicates the performance measure is not applicable to the Nevada Check Up population.

Green font indicates UMC met the target for CY 2023.

Red font indicates UMC did not meet the target for CY 2023.

Table 2-8 and Table 2-9 identify the Quality Strategy objectives identified in the CMS-approved Section 438.6(c) Preprint to evaluate performance of the state-directed payment initiative and the baseline rate,

CY 2023[7] rate, and the CY 2023 target for UNR for Medicaid and Nevada Check Up. Rates listed in **green** font indicate that UNR met the target for CY 2023. Rates listed in **red** font indicate that UNR did not meet the target for CY 2023. UNR met the targets for CY 2023 for seven of the nine applicable measures. Based on these results, the payment initiative supported that significant progress was made toward achieving the related Quality Strategy goals. Continued efforts should be implemented to support improvement in the two measures which did not meet the target rate.

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

Measure	Objective Alignment	UNR Baseline[1]	UNR CY 2023 Rate	UNR CY 2023 Target[2]
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—BMI Percentile	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—BMI percentile	10.44%	**51.16%**	10.86%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Counseling for Nutrition	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—counseling for nutrition	10.88%	**40.92%**	11.32%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Counseling for Physical Activity	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—counseling for physical activity	11.99%	**36.13%**	12.47%
Comprehensive Diabetes Care (CDC) ∞*—Hemoglobin A1c (HbA1c) Testing*	Increase rate of HbA1c testing for members with diabetes (CDC)	53.49%	**17.37%**	55.65%
Comprehensive Diabetes Care (CDC) ∞*—HbA1c Poor Control (>9.0%)*[3]	Decrease rate of HbA1c poor control (>9.0%) for members with diabetes (CDC)	53.49%	**59.91%**	51.37%
Controlling High Blood Pressure (CBP)	Increase rate of controlling high blood pressure (CBP)	2.36%	**44.88%**	2.46%

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

∞ NCQA retired the CDC measure in CY 2022 and replaced the measure with *Hemoglobin A1c Control for Patients With Diabetes (HBD).*

1 The baseline year for UNR was CY 2021.

7 The rates were individually calculated by each MCO and submitted to DHCFP to provide to HSAG for inclusion in the EQR technical report. These rates were not validated by HSAG. HSAG used the denominators and numerators provided by DHCFP for each MCO to aggregate the CY 2023 rate for each measure.

[2] Year-over-year targets were set at 2 percent improvement over the baseline year. Overall targets for the full five-year period of state-directed payment initiative is 10 percent.
[3] A lower rate indicates better performance for this measure.
Green font indicates UNR met the target for CY 2023.
Red font indicates UNR did not meet the target for CY 2023.

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

Measure	Objective Alignment	UNR Baseline[1]	UNR CY 2023 Rate	UNR CY 2023 Target[2]
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—BMI Percentile	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—BMI percentile	17.65%	**55.69%**	18.36%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Counseling for Nutrition	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—counseling for nutrition	14.71%	**45.48%**	15.30%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Counseling for Physical Activity	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—counseling for physical activity	14.71%	**40.52%**	15.30%
Comprehensive Diabetes Care (CDC)[∞]—Hemoglobin A1c (HbA1c) Testing	Increase rate of HbA1c testing for members with diabetes (CDC)	NA	NA	NA
Comprehensive Diabetes Care (CDC)[∞]—HbA1c Poor Control (>9.0%)[3]	Decrease rate of HbA1c poor control (>9.0%) for members with diabetes (CDC)	NA	NA	NA
Controlling High Blood Pressure (CBP)	Increase rate of controlling high blood pressure (CBP)	NA	NA	NA

* Rates in this table were derived from validated HEDIS measure rates; however, these rates were a subset of the validated measures that were calculated by the MCOs and were not validated through the HEDIS audit process.
[∞] NCQA retired the CDC measure in CY 2022 and replaced the measure with *Hemoglobin A1c Control for Patients With Diabetes (HBD).*
[1] The baseline year for UNR was CY 2021.
[2] Year-over-year targets were set at 2 percent improvement over the baseline year. The overall target for the full five-year period of each state-directed payment initiative is 10 percent.
[3] A lower rate indicates better performance for this measure.
NA (Not Applicable) indicates the performance measure is not applicable to the Nevada Check Up population.
Green font indicates UNR met the target for CY 2023.
Red font indicates UNR did not meet the target for CY 2023.

Table 2-10 and Table 2-11 identify the Quality Strategy objectives identified in the CMS-approved Section 438.6(c) Preprint to evaluate performance of the state-directed payment initiative and the CY 2024 target for UNLV. UNLV's performance will be evaluated in the SFY 2025 EQR technical report.

Table 2-10—State-Directed Payment Initiative Nevada Medicaid Performance Measures—UNLV*

Measure	Objective Alignment	UNLV Baseline[1]	UNLV Target[2]
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—BMI Percentile	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—BMI percentile	12.10%	12.34%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Counseling for Nutrition	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—counseling for nutrition	4.09%	4.17%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Counseling for Physical Activity	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—counseling for physical activity	3.74%	3.81%
Comprehensive Diabetes Care (CDC) [∞]*—Hemoglobin A1c (HbA1c) Testing*	Increase rate of HbA1c testing for members with diabetes (CDC)	32.30%	32.95%
Comprehensive Diabetes Care (CDC) [∞]*—HbA1c Poor Control (>9.0%)*[3]	Decrease rate of HbA1c poor control (>9.0%) for members with diabetes (CDC)	41.11%	41.93%
Controlling High Blood Pressure (CBP)	Increase rate of controlling high blood pressure (CBP)	23.91%	24.39%

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

[∞] NCQA retired the CDC measure in CY 2022 and replaced the measure with *Hemoglobin A1c Control for Patients With Diabetes (HBD).*

[1] The baseline year for UNLV is CY 2023.

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

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

Table 2-11—State-Directed Payment Initiative Nevada Check Up Performance Measures—UNLV*

Measure	Objective Alignment	UNLV Baseline[1]	UNLV Target[2]
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—BMI Percentile	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—BMI percentile	12.96%	13.22%

Measure	Objective Alignment	UNLV Baseline[1]	UNLV Target[2]
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Counseling for Nutrition	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—counseling for nutrition	5.07%	5.17%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Counseling for Physical Activity	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—counseling for physical activity	2.82%	2.88%
Comprehensive Diabetes Care (CDC) ∞—Hemoglobin A1c (HbA1c) Testing	Increase rate of HbA1c testing for members with diabetes (CDC)	NA	NA
Comprehensive Diabetes Care (CDC) ∞—HbA1c Poor Control (>9.0%)[3]	Decrease rate of HbA1c poor control (>9.0%) for members with diabetes (CDC)	NA	NA
Controlling High Blood Pressure (CBP)	Increase rate of controlling high blood pressure (CBP)	NA	NA

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

∞ NCQA retired the CDC measure in CY 2022 and replaced the measure with *Hemoglobin A1c Control for Patients With Diabetes (HBD).*

[1] The baseline year for UNLV was CY 2023.

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

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

NA (Not Applicable) indicates the performance measure is not applicable to the Nevada Check Up population.

Private Hospital Tax

In SFY 2023 and SFY 2024, DHCFP received approval from CMS for its delivery system and provider payment initiative in accordance with 42 CFR §438.6(c) for an enhanced rate of reimbursement for all private hospitals eligible for the directed payment based on the provider class as defined in the Medicaid State plan. The classes are: Acute, Psychiatric, Long Term Acute Care, Rehabilitation, and Critical Access Hospitals. All private hospital providers in a class will receive a uniform add-on reimbursement per inpatient day and per outpatient encounter. DHCFP implemented a provider tax to manage the add-on reimbursement. This payment arrangement will ensure that Nevada hospitals will continue to be able to maintain access to health services and continue to provide high quality, culturally sensitive care. To evaluate the effectiveness of the state-directed payment initiative, DHCFP will aim to advance Goal 2 to *increase use of evidence-based practices for members with chronic conditions*; Goal 3 to *reduce misuse of opioids*; Goal 4 to *improve the health and wellness of pregnant women and infants*; and Goal 5 to *increase use of evidence-based practices for members with behavioral health conditions*.

As part of the Private Hospital Tax state-directed payment, DHCFP is conducting a Nevada Hospital Quality Collaborative to communicate processes for fostering value-based payment at Nevada hospitals; provide helpful information to inform decisions about the future of the payment arrangements; and provide

opportunities for each hospital class to focus on value-based payment efforts. The Nevada Hospital Quality Collaborative goals are to improve the value of Nevada's health system through aligning incentives via alternative payment models; incorporate a population health approach to improve outcomes in maternal, behavioral, and primary care; and identify and address health inequities among populations.

Table 2-12 identifies the Quality Strategy objectives identified in the CMS-approved Section 438.6(c) Preprint to evaluate performance of the state-directed payment initiative. Of note, Goal 8 and the objectives in Table 2-12 were added to the 2025–2027 Quality Strategy and performance will be monitored and maintained by DHCFP.

Table 2-12—State-Directed Payment Initiative Nevada Medicaid Performance Measures and Objectives

Measure	Objective Alignment
Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function	Objective 8.2: Improve percent of LTCH patients with an admission and discharge functional assessment and a care plan that addresses function.
Discharge to Community-Post Acute Care Measure for Inpatient Rehabilitation Facilities	Objective 8.3: Assess discharges to the community following a post-acute stay (post-acute care measure for inpatient rehabilitation facilities)
PC-06: Unexpected Complications in Term Newborns	Objective 4.7: Reduce unexpected complications in term newborns (PC-06)
Safe Use of Opioids—Concurrent Prescribing	Objective 3.5: Improve safe use of opioids—Concurrent prescribing
Hospital-Based Inpatient Psychiatric (HBIPS)-2: Hours of Physical Restraint Use	Objective 5.15: Track the hours of physical restraint use (HBIPS-2)
HBIPS-3: Hours of Seclusion Use	Objective 5.16: Track the hours of seclusion use (HBIPS-3)

Nursing Facilities

In CY 2023, with a revision in CY 2024, DHCFP submitted a Section 438.6(c) Preprint application to CMS for its delivery system and provider payment initiative in support of payment arrangements to nursing facilities based on the facilities' number of bed days in a given quarter, acuity of patients at the facilities, a set of quality metrics, and the accuracy of the MDS. Hospital-based facilities and Nevada State Veteran Homes are excluded. The state-directed payment will provide supplemental payment for nursing facility residents covered under the Nevada Medicaid Managed Care Program. The directed payments are designed to incentivize and support the eligible nursing facilities to work toward improvement of quality of care for the Medicaid population. The program targets a main domain of nursing home improvement through avoidance of negative care events. To evaluate the effectiveness of the state-directed payment initiative, DHCFP added a performance measure to the 2025–2027 Quality Strategy under newly developed Goal 8 to *reduce the percentage of long stay nursing facility residents with high-risk/unstageable pressure ulcers*. The MCOs are annually required to calculate the performance of the providers eligible for the payment increase based on the delivery of services to Medicaid managed care members, using state-directed payment measure specifications and the related

performance measure data results. The performance target is to reduce the baseline rate of 2 percent by 0.5 percent using the Quality Improvement System for Managed Care (QISMC) methodology published by CMS in 1998. Table 2-13 identifies the Quality Strategy objective identified in the CMS-approved Section 438.6(c) Preprint to evaluate performance of the state-directed payment initiative.

Table 2-13—State-Directed Payment Initiative Nevada Medicaid Performance Measure and Objective

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

Table 2-14 includes the CY 2023[8] Nevada Medicaid Pressure Ulcer results for skilled nursing stays for the expansion and nonexpansion populations in the Las Vegas and Reno regions.

Table 2-14—Nevada Medicaid Pressure Ulcer Results for Skilled Nursing Stays

		Stays with Pressure Ulcer Diagnosis						Total Stays and Percents		
Region	Type	Un-Stageable	Stage 2	Stage 3	Stage 4	Pressure Induced Deep Tissue Damage	Unspecified	Stay Count	All Pressure Induced Ulcer Percent*	II-IV and Un-Stageable Percent*
Las Vegas	Expansion	9	1	19	36	1	16	1,030	7.96%	6.31%
	Non-Expansion	8	3	8	6	10	9	579	7.60%	4.32%
	Las Vegas Total	17	4	27	42	11	25	1,609	7.83%	5.59%

[8] The results were individually calculated by each MCO and submitted to DHCFP to provide to HSAG for inclusion in the EQR technical report. These rates were not validated by HSAG. HSAG used the denominators and numerators provided by DHCFP for each MCO to aggregate the CY 2023 rate for each indicator.

		Stays with Pressure Ulcer Diagnosis						Total Stays and Percents		
Region	Type	Un-Stageable	Stage 2	Stage 3	Stage 4	Pressure Induced Deep Tissue Damage	Unspecified	Stay Count	All Pressure Induced Ulcer Percent*	II-IV and Un-Stageable Percent*
Reno	Expansion	3	0	0	2	1	0	80	7.50%	6.25%
	Non-Expansion	0	0	3	0	1	0	59	6.78%	5.08%
	Reno Total	3	0	3	2	2	0	139	7.19%	5.76%
Grand Total		20	4	30	44	13	25	1,748	7.78%	5.61%

* A lower rate indicates better performance for this measure or indicator.
Pressure Ulcer and Stages determined using the highest acuity L89 diagnosis code for the duration of the stay.
Diagnosis codes do not provide if the condition was present at admission or obtained during the stay.

Table 2-15 demonstrates the baseline, CY 2023 performance target, and grand total percentage for all pressure-induced ulcers for Nevada Medicaid. Nevada Medicaid did not meet the performance target of 1.8 percent.

Table 2-15—Nevada Medicaid Pressure Induced Ulcer Percentage

Baseline (CY 2022)	CY 2023 Performance Target*	CY 2023 All Pressure Induced Ulcer Percentage—Grand Total
2%	1.8%	**7.78%**

* A lower rate indicates better performance for this measure or indicator.
Red font indicates Nevada Medicaid did not meet the target for CY 2023.

Bonus Incentive Payments

In CY 2024, DHCFP implemented three Bonus Incentive Payments (BIPs) to increase the MCOs' investment in, and members' access to, primary care; foster the expansion of value-based payment design; improve members' access to family planning counseling and long-acting reversible contraceptives (LARCs); and increase screening, testing, and treatment of syphilis among pregnant women and infants. Through the Primary Care, Value Based Purchasing, and Maternal and Infant Health Promotion BIPs, the MCOs are eligible to receive bonus payments up to a DHCFP-disclosed percentage for each BIP, based on the total approved capitated payments if the MCOs are able to meet the defined

performance goals outlined by DCHFP in an annual Bonus Incentive Payments for Medicaid Managed Care Contract memo. DHCFP will continue to monitor and expand the BIPs, and implement new BIPs as appropriate, based on the priorities of the State each SFY, as funding is available.

Evaluation of Quality Strategy Effectiveness

To continually track the progress of achieving the goals and objectives outlined in the Quality Strategy, HSAG developed the Goals and Objectives Tracking Table, as shown in Appendix B. The Goals and Objectives Tracking Table lists each of the seven goals in the 2022–2024 Quality Strategy and the objectives used to measure achievement of those goals.

Table 2-16 and Table 2-17 show the number of rates reported by the MCO or PAHP and the number and percentage of reported rates that achieved the DHCFP-established MPS. Of note, Goal 7—*Reduce and/or eliminate health care disparities for Medicaid members by December 31, 2024* is not evaluated through a performance measure rate and overall performance is determined as either a *Met* or *Not Met* score based on DHCFP's assessment. Therefore, this information is not included in the following tables. For additional details, please see Appendix B of this report.

Table 2-16—SFY 2024 Quality Strategy Goals and Objectives: Summary of Performance by the MCOs

	Anthem Medicaid	Molina Medicaid	SilverSummit Medicaid	UHC HPN Medicaid	Anthem Check Up	Molina Check Up	SilverSummit Check Up	UHC HPN Check Up
Number of Objectives With an Established MPS	55	55	55	55	25	25	25	25
Number of Objectives With an Established MPS and Reported Rates	55	53	55	55	18	16	17	21
Rates Achieving the MPS	**9**	**5**	**4**	**13**	**0**	**2**	**1**	**9**
Percentage of Rates Achieving the MPS	**16%**	**9%**	**7%**	**24%**	**0%**	**13%**	**6%**	**43%**

Table 2-17—SFY 2024 Quality Strategy Goals and Objectives: Summary of Performance by the PAHP

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

At the conclusion of SFY 2024, DHCFP, in collaboration with HSAG, evaluated the quality of the managed care services offered to Nevada Managed Care Program members and, subsequently, the overall effectiveness of the Quality Strategy goals through EQR-related performance results and year-over-year trending of performance measure data, when a comparison of data was appropriate. Table 2-18 presents a summary of the Nevada Managed Care Program's progress on meeting the Quality Strategy goals and objectives. The performance impact—positive (✓) or negative (✗)—is presented by aggregated Medicaid and Nevada Check Up MY 2023 rates. Overall conclusions and future Quality Strategy updates for each goal are also presented in Table 2-18.

Table 2-18—SFY 2024 Quality Strategy Goals and Objectives Summary of Performance

	Quality Strategy Goals	Performance Impact on Goals and Objectives
1	Improve the health and wellness of Nevada's Medicaid population by increasing the use of preventive services by December 31, 2024	✓ 2/18 Medicaid rates met the MPS
		✗ 16/18 Medicaid rates did not meet the MPS
		✓ 11/18 Medicaid rates improved in performance from the prior year
		✗ 7/18 Medicaid rates declined in performance from the prior year
		✓ 1/14 applicable Nevada Check Up rates met the MPS
		✗ 13/14 applicable Nevada Check Up rates did not meet the MPS
		✓ 10/14 Nevada Check Up rates improved in performance from the prior year
		✗ 4/14 Nevada Check Up rates declined in performance from the prior year
	Conclusion:	The Nevada Managed Care Program made ***minimal progress*** in meeting the objectives under Goal 1 for Medicaid and Nevada Check Up. While 21 measure rates improved in performance from the prior year, only three measure rates met DHCFP's established MPS, and 11 measure rates declined in performance, indicating many opportunities for improvement.
	Quality Strategy Updates for SFY 2025:	For the 2025–2027 Quality Strategy, DHCFP added objectives to Goal 1 to include the following mandatory Child Core Set measures: • *Developmental Screening in the First Three Years of Life (DEV-CH)* • *Lead Screening in Children (LSC)* HSAG has no additional Quality Strategy update recommendations related to Goal 1 for SFY 2025. DHCFP should continue to monitor its contracted MCOs' performance for all objectives under Goal 1 and update the Quality Strategy as appropriate to address any new priorities of the State related to preventive services.

	Quality Strategy Goals	Performance Impact on Goals and Objectives
2	Increase use of evidence-based practices for members with chronic conditions by December 31, 2024	✓ 2/7 Medicaid rates met the MPS
		× 5/7 Medicaid rates did not meet the MPS
		✓ 5/7 Medicaid rates improved in performance from the prior year
		× 2/7 Medicaid rates declined in performance from the prior year
		× 0/1 applicable Nevada Check Up rates met the MPS
		× 1/1 applicable Nevada Check Up rates declined in performance from the prior year.
	Conclusion:	The Nevada Managed Care Program made ***minimal progress*** in meeting the objectives under Goal 2 for Medicaid and Nevada Check Up. Two measure rates met DHCFP's established MPS and five measure rates improved in performance from the prior year; however, six measure rates did not meet DHCFP's established MPS indicating continued opportunities for improvement.
	Quality Strategy Updates for SFY 2025:	HSAG has no Quality Strategy update recommendations related to Goal 2 for SFY 2025. DHCFP should continue to monitor its contracted MCOs' performance for all objectives under Goal 2 and update the Quality Strategy as appropriate to address any new priorities of the State related to chronic conditions.
3	Reduce misuse of opioids by December 31, 2024	✓ 1/4 Medicaid rates met the MPS
		× 3/4 Medicaid rates did not meet the MPS
		✓ 2/4 Medicaid rates improved in performance from the prior year
		× 2/4 rates declined in performance from the prior year
	Conclusion:	The Nevada Managed Care Program made ***minimal progress*** in meeting the objectives under Goal 3 for Medicaid, as one measure rate met the MPS for the Medicaid program and two measure rates improved from the prior year. However, the three remaining measure rates did not meet the DHCFP-established MPS, and two measure rates declined in performance from the prior year.
	Quality Strategy Updates for SFY 2025:	For the 2025–2027 Quality Strategy, DHCFP updated the name of Goal 3 to include other prescribed medications and added two objectives for the following mandatory Child Core Set measure: • *Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)* HSAG has no additional Quality Strategy update recommendations related to Goal 3 for SFY 2025. DHCFP should continue to monitor its contracted MCOs' performance for all objectives under Goal 3 and update the Quality Strategy as appropriate to address any new priorities of the State related to misuse of opioids and other prescribed medications.

	Quality Strategy Goals	Performance Impact on Goals and Objectives
4	Improve the health and wellness of pregnant women and infants by December 31, 2024	✗ 0/5 applicable Medicaid rates met the MPS
		✓ 4/5 applicable Medicaid rates improved in performance from the prior year
		✗ 1/5 applicable Medicaid rates declined in performance from the prior year
	Conclusion:	The Nevada Managed Care Program made ***minimal progress*** in meeting the objectives under Goal 4 for Medicaid. While four measure rates improved in performance from the prior year, no rates met DHCFP's established MPS and one applicable rate declined slightly in performance.
	Quality Strategy Updates for SFY 2025:	For the 2025–2027 Quality Strategy, DHCFP added objectives to Goal 4 for the following mandatory Child Core Set measures: • *Contraceptive Care—All Women Ages 15–20 (CCW-CH)* • *Contraceptive Care—Postpartum Women Ages 15–20 (CCP-CH)* HSAG has no additional Quality Strategy update recommendations related to Goal 4 for SFY 2025. DHCFP should continue to monitor its contracted MCOs' performance for all objectives under Goal 4 and update the Quality Strategy as appropriate to address any new priorities of the State related to the health and wellness of pregnant women and infants.
5	Increase use of evidence-based practices for members with behavioral health conditions by December 31, 2024	✓ 2/21 applicable Medicaid rates met the MPS
		✗ 19/21 applicable Medicaid rates did not meet the MPS
		✓ 15/21 applicable Medicaid rates improved in performance from the prior year
		✗ 6/21 applicable Medicaid rates declined in performance from the prior year
		✓ 4/10 applicable Nevada Check Up rates met the MPS
		✗ 6/10 applicable Nevada Check Up rates did not meet the MPS
		✓ 6/10 applicable Nevada Check rates improved in performance from the prior year
		✗ 4/10 applicable Nevada Check Up rates declined in performance from the prior year
	Conclusion:	The Nevada Managed Care Program made ***minimal progress*** in meeting the objectives under Goal 5 for Medicaid. Although six measure rates met DHCFP's established MPS and 21 of the measure rates improved in performance from the prior year, 25 measure rates did not meet the DHCFP-established MPS, and 10 applicable rates declined in performance.
	Quality Strategy Updates for SFY 2025:	For the 2025–2027 Quality Strategy, DHCFP revised the age stratifications related to objective 5.13, *Increase the rate of screening for depression and follow-up plan for members (CDF)*, to align with the Behavioral Health Adult Core Set measure. DHCFP also added an objective to Goal 5 for the following mandatory Behavioral Health Adult Core Set measure: • *Diabetes Care for People With Serious Mental Illness: HbA1c Poor Control (>9.0%) (HPCMI-AD)* HSAG has no additional Quality Strategy update recommendations related to Goal 5 for SFY 2025. DHCFP should continue to monitor its contracted MCOs' performance for all objectives under Goal 5 and update the Quality Strategy as appropriate to address any new priorities of the State related to use of evidence-based practices for members with behavioral health conditions.

	Quality Strategy Goals	Performance Impact on Goals and Objectives
6	Increase utilization of dental services by December 31, 2024	✗ 0/4 Medicaid rates met the MPS
		✓ 4/4 Medicaid rates improved in performance from the prior year
		✗ 0/4 Nevada Check Up rates met the MPS
		✓ 2/4 Nevada Check Up rates improved in performance from the prior year
		✗ 2/4 Nevada Check Up rates declined in performance from the prior year
	Conclusion:	The Nevada Managed Care Program made ***minimal progress*** in meeting the objectives under Goal 6 for Medicaid and Nevada Check Up. While four Medicaid rates and two Nevada Check Up rates improved in performance from the prior year, no Medicaid or Nevada Check Up rates met the DHCFP-established MPS.
	Quality Strategy Updates for SFY 2025:	HSAG has no Quality Strategy update recommendations related to Goal 6 for SFY 2025. DHCFP should continue to monitor its contracted PAHP's performance for all objectives under Goal 6 and update the Quality Strategy as appropriate to address any new priorities of the State related to dental services.
7	Reduce and/or eliminate health care disparities for Medicaid members by December 31, 2024	✓ 3/3 objectives received a *Met* designation
	Conclusion:	The Nevada Managed Care Program ***met*** the objectives under Goal 7, as DHCFP determined that the MCEs met the following requirements: • Ensure that health plans maintain, submit for review, and annually revise cultural competency plans. • Stratify data for performance measures by race and ethnicity to determine where disparities exist. Continually identify, organize, and target interventions to reduce disparities and improve access to appropriate services for the Medicaid and Nevada Check Up population. • Ensure that each MCO submits an annual evaluation of its cultural competency programs to the DHCFP. The MCOs must receive a 100 percent *Met* compliance score for all criteria listed in the MCO contract for cultural competency program development, maintenance, and evaluation.
	Quality Strategy Updates for SFY 2025:	HSAG has no Quality Strategy update recommendations related to Goal 7 for SFY 2025. DHCFP should continue to monitor its contracted MCEs' performance for all objectives under Goal 7 and update the Quality Strategy as appropriate to address any new priorities of the State related to reducing and eliminating healthcare disparities.

3. Assessment of Managed Care Organization Performance

HSAG used findings across mandatory and optional EQR activities conducted during the SFY 2024 review period to evaluate the performance of the MCOs on providing quality, timely, and accessible healthcare services to Nevada Managed Care Program members. Quality, as it pertains to EQR, means the degree to which the MCOs increased the likelihood of members' desired health outcomes through structural and operational characteristics; the provision of services that were consistent with current professional, evidenced-based knowledge; and interventions for performance improvement. Timeliness refers to the elements defined under §438.68 (adherence to DHCFP's network adequacy standards) and §438.206 (adherence to DHCFP's standards for timely access to care and services). Access relates to members' timely use of services to achieve optimal health outcomes, as evidenced by how effective the MCOs were at successfully demonstrating and reporting on outcomes for the availability and timeliness of services.

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

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

Objectives of External Quality Review Activities

This section of the report provides the objectives and a brief overview of each EQR activity conducted in SFY 2024 to provide context for the resulting findings of each EQR activity. For more details about each EQR activity's objectives and the comprehensive methodology, including the technical methods for data collection and analysis, a description of the data obtained and the related time period, and the process for drawing conclusions from the data, refer to Appendix A. Table 3-1 provides HSAG's timeline for conducting each of the EQR activities.

Table 3-1—Timeline for EQR Activities

Activity	EQR Activity Start Date	EQR Activity End Date
PIPs	May 1, 2024	December 20, 2024
PMV	November 16, 2023	July 15, 2024

Activity	EQR Activity Start Date	EQR Activity End Date
Compliance Review	January 8, 2024	July 3, 2024
NAV	May 13, 2024	November 22, 2024
CAHPS	July 15, 2024	November 8, 2024

Validation of Performance Improvement Projects

For SFY 2024, the four MCOs continued the six DHCFP-mandated clinical and nonclinical PIP topics: *Improving the Rates for Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)*, *Adults' Access to Preventive/Ambulatory Health Services (AAP), Child and Adolescent Well Care Visit (WCV), Follow-Up After Emergency Department Visit for Mental Illness (FUM), Prenatal and Postpartum Care (PPC)* and *Plan All-Cause Readmissions (PCR)*. DHCFP required the data for the *Prenatal and Postpartum Care (PPC)* PIP to be stratified by race and ethnicity to help identify health disparities for the African American population. Further, DHCFP required interventions to be aimed at improving timeliness of prenatal care and access to postpartum care in addition to using data to identify opportunities to reduce health disparities.

HSAG's validation activities included an evaluation of the MCOs' documentation submitted to support all phases of the PIP process, called the Design, Implementation and Outcomes stages (Steps 1 through 9), to determine the overall validity of each state-mandated PIP's methodological framework. HSAG's validation of the design of each PIP included a review of the PIP topic, Aim statement, target population, sampling methods, performance indicators, and data collection methods to ensure they were based on sound methodological principles and will support reliable reporting of measure outcomes. For the SFY 2023 validations, which were completed in December 2023[9], HSAG assigned a validation rating of *Met*, *Partially Met*, or *Not Met* to each applicable evaluation element within the Design and Implementation stages of each PIP, and an overall validation rating of *Met*, *Partially Met*, or *Not Met*. For the SFY 2024 validations, which were completed in December 2024, HSAG assigned an overall confidence level of *High Confidence, Moderate Confidence, Low Confidence, or No Confidence* for the two required confidence levels. Level of confidence assignment methodology is defined in Appendix A.

Table 3-2 outlines the state-mandated PIP topics and the Aim statements defined by the MCOs for each PIP topic. The Aim statement helps the MCOs maintain the focus of the PIPs and sets the framework for data collection, analysis, and interpretation of the results.

[9] Due to the timing of the SFY 2023 EQR Technical Report (i.e., January 2024 submission to DHCFP), data from the SFY 2023 PIP activity are being included in the SFY 2024 EQR Technical Report along with the most current PIP data from the SFY 2024 PIP activity.

Table 3-2—PIP Topics and Aim Statements

Plan Name	State-Mandated PIP Topic	MCO-Defined PIP Aim Statement
Anthem	*Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)*	Do targeted interventions increase the percentage of SUD episodes for members 13 years of age and older who had initiation of treatment within 14 days and treatment engagement within 34 days of initiation?
	Adults' Access to Preventive/Ambulatory Health Services (AAP)	Do targeted interventions increase the percentage of ambulatory or preventive care visits during the measurement year for members 20 years of age and older?
	Child and Adolescent Well-Care Visit (WCV)	Do targeted interventions increase the percentage of Members 3-21 years of age who had at least one comprehensive well care visit with a PCP [primary care provider] or OB/GYN [obstetrics and gynecology] practitioner during the measurement year?
	Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Do targeted interventions increase the percentage of follow-Up After Emergency Department Visit for Mental Illness (FUM) for members 6 years of age and older that received follow-up visit within 7 days (8 total days) and 30 days (31 total days)?
	Prenatal and Postpartum Care (PPC)	Do targeted interventions increase the percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization? Do targeted interventions increase the percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery?
	Plan All-Cause Readmissions (PCR)	Do targeted interventions decrease the percentage of acute inpatient or observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days for members 18 to 64 years of age?

Plan Name	State-Mandated PIP Topic	MCO-Defined PIP Aim Statement
Molina	*Initiation and Engagement of Substance Use Disorder Treatment (IET)*	Does implementing targeted strategies increase initiation of treatment within 14 days of a new SUD episode for Molina Medicaid members age 13 and older? Does implementing targeted strategies increase treatment engagement within 34 days of initiation of a new SUD episode for Molina Medicaid members age 13 and older?
	Adults' Access to Preventive/Ambulatory Health Services (AAP)	Do targeted interventions result in an increased number of adults receiving at least one annual preventative care visit for Molina Medicaid members 20 years and older?
	Child and Adolescent Well-Care Visit (WCV)	Do targeted interventions increase the number of Molina Medicaid children ages 3 to 21 years of age who receive a well-care visit?
	Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Does deploying interventions increase the number of follow-Up visits that occur within 7 days for Medicaid members 6 years old or older who were seen in an ED setting for behavioral health/intentional self-harm diagnoses in the measurement period? Does deploying interventions increase the number of follow-up visits that occur within 30 days for Medicaid members 6 years old or older who were seen in an ED setting for behavioral health/intentional self-harm diagnoses in the measurement period?
	Prenatal and Postpartum Care (PPC)	Do targeted interventions increase the percentage of deliveries that had prenatal care within the required timeframe (on or before the enrollment start date or within 42 days of enrollment in the organization)? Do targeted interventions increase the percentage of deliveries that had postpartum care between 7 and 84 days after delivery?
	Plan All-Cause Readmissions (PCR)	Do targeted interventions decrease the percentage of acute inpatient or observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days for members 18 to 64 years of age?

Plan Name	State-Mandated PIP Topic	MCO-Defined PIP Aim Statement
SilverSummit	*Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)*	Do targeted interventions increase the percentage of SUD episodes for members 13 years of age and older who had initiation of treatment within 14 days and treatment engagement within 34 days of initiation?
	Adults' Access to Preventive/Ambulatory Health Services (AAP)	Does the targeted interventions increase the number of Medicaid members ages 20 and above who have had an ambulatory or preventative care visit during the measurement year? Plan will achieve statistical significance from baseline year to resubmission years to evaluate effectiveness of interventions.
	Child and Adolescent Well-Care Visit (WCV)	Does the targeted interventions increase the number of children and adolescents ages 3-21 years of age who receive a well care visit with a primary care practitioner or an OB/GYN practitioner annually? Plan will achieve statistical significance from baseline year to resubmission years to evaluate effectiveness of interventions.
	Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Does the targeted intervention increase rates of follow up after emergency department (ED) visits with diagnosis of mental illness for adults and children 6 years of age and older within 7 days and/or within 30 days of visit? Plan will achieve statistical significance from baseline year to resubmission years to evaluate effectiveness of interventions.
	Prenatal and Postpartum Care (PPC)	Do targeted interventions increase the percentage of deliveries that had prenatal care within the required timeframe (on or before the enrollment start date or within 42 days of enrollment in the organization)? Do targeted interventions increase the percentage of deliveries that had postpartum care between 7 and 84 days after delivery?
	Plan All-Cause Readmissions (PCR)	Do targeted interventions decrease the percentage of acute inpatient or observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days for members 18 to 64 years of age?

Plan Name	State-Mandated PIP Topic	MCO-Defined PIP Aim Statement
UHC HPN	*Initiation and Engagement of Substance Use Disorder Treatment (IET)*	Do targeted interventions increase the percentage of SUD episodes for members 13 years of age and older who had initiation of treatment within 14 days and treatment engagement within 34 days of initiation?
	Adults' Access to Preventive/Ambulatory Health Services (AAP)	Do targeted interventions increase the percentage of members 20 years of age and older that had an ambulatory or preventive care visit during the measurement year?
	Child and Adolescent Well-Care Visit (WCV)	Do targeted interventions increase the percentage of members 3 to 21 years of age that had at least one comprehensive well-care visit with a primary care physician (PCP) or an OB/GYN practitioner during the measurement year?
	Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Do targeted interventions increase the percentage of ED visits with a principal diagnosis of mental illness or intentional self-harm for which the member 6 years of age and older had a follow-up visit with any practitioner within 7 and 30 days?
	Prenatal and Postpartum Care (PPC)	Do targeted interventions increase the percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment? Do targeted interventions increase the percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery?
	Plan All-Cause Readmissions (PCR)	Do targeted interventions decrease the percentage of acute inpatient or observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days for members 18 to 64 years of age?

Performance Measure Validation

For SFY 2024, DHCFP contracted with HSAG to conduct independent audits of its four contracted MCOs in alignment with NCQA's *HEDIS Compliance* Audit™,[10] *Standards, Policies and Procedures, Volume 5*, which outlines the accepted approach for auditors to use when conducting an Information

[10] HEDIS Compliance Audit™ is a trademark of NCQA.

Systems Capabilities Assessment and an evaluation of compliance with performance measure specifications. All HSAG lead auditors are certified HEDIS compliance auditors (CHCAs). The PMV activity included a comprehensive evaluation of the MCOs' information systems (IS) capabilities and processes used to collect and report data for the performance measures selected by DHCFP for validation.

Table 3-3 lists the performance measures selected by DHCFP for MY 2023 reporting of the Medicaid and Nevada Check Up populations for the SFY 2024 PMV activity, which included a combination of HEDIS, CMS Child Core Set, and CMS Adult Core Set measures. The reported measures are divided into performance domains of care as demonstrated in the following table.

Table 3-3—SFY 2024 Performance Measures

Performance Measure	Measure Type		Populations	
	HEDIS	Core Set	Medicaid	Nevada Check Up
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services (AAP)	✓		✓	
Children's Preventive Care				
Child and Adolescent Well-Care Visits (WCV)	✓	✓	✓	✓
Childhood Immunization Status (CIS)	✓	✓	✓	✓
Developmental Screening in the First Three Years of Life (DEV-CH)		✓	✓	✓
Immunizations for Adolescents (IMA)	✓	✓	✓	✓
Lead Screening in Children (LSC)	✓	✓	✓	✓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	✓	✓	✓	✓
Well-Child Visits in the First 30 Months of Life (W30)	✓	✓	✓	✓
Women's Health and Maternity Care				
Breast Cancer Screening (BCS-E)	✓		✓	
Chlamydia Screening in Women (CHL)	✓	✓	✓	✓
Contraceptive Care —All Women Ages 15—20 (CCW-CH)		✓	✓	✓
Contraceptive Care—Postpartum Women Ages 15—20 (CCP-CH)		✓	✓	✓
Postpartum Depression Screening and Follow-Up (PDS-E)	✓		✓	
Prenatal and Postpartum Care (PPC)	✓	✓	✓	✓
Prenatal and Postpartum Care— Prenatal and Postpartum Care: Under Age 21 (PPC2-CH)		✓	✓	✓
Prenatal Depression Screening and Follow-Up (PND-E)	✓		✓	

Performance Measure	Measure Type		Populations	
	HEDIS	Core Set	Medicaid	Nevada Check Up
Prenatal Immunization Status (PRS-E)	✓		✓	
Care for Chronic Conditions				
Asthma Medication Ratio (AMR)	✓	✓	✓	✓
Blood Pressure Control for Patients With Diabetes (BPD)	✓		✓	
Controlling High Blood Pressure (CBP)	✓		✓	
Hemoglobin A1c Control for Patients With Diabetes (HBD)	✓		✓	
Behavioral Health				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	✓	✓	✓	
Antidepressant Medication Management (AMM)	✓	✓	✓	
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	✓	✓	✓	
Diabetes Care for People With Serious Mental Illness: HbA1c Poor Control (>9.0%) (HPCMI-AD)		✓	✓	
*Follow-Up After ED Visit for Substance Use (FUA)**	✓	✓	✓	✓
*Follow-Up After ED Visit for Mental Illness (FUM)**	✓	✓	✓	✓
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)	✓		✓	✓
Follow-Up After Hospitalization for Mental Illness (FUH)	✓	✓	✓	✓
*Follow-Up Care for Children Prescribed ADHD Medication (ADD)**	✓	✓	✓	✓
Initiation and Engagement of Substance Use Disorder Treatment (IET)	✓	✓	✓	✓
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	✓	✓	✓	✓
Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)		✓	✓	✓
Screening for Depression and Follow-Up Plan (CDF-CH/CDF-AD)		✓	✓	✓
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	✓	✓	✓	✓
Utilization				
Ambulatory Care—Total (Per 1,000 Member Years) (AMB)	✓	✓	✓	✓
Plan All-Cause Readmissions (PCR)	✓	✓	✓	
Overuse/Appropriateness				
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	✓	✓	✓	✓

Performance Measure	Measure Type		Populations	
	HEDIS	Core Set	Medicaid	Nevada Check Up
Risk of Continued Opioid Use (COU)	✓		✓	
Use of Opioids at High Dosage (HDO)	✓		✓	
Use of Opioids From Multiple Providers (UOP)	✓		✓	

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

Compliance Review

DHCFP requires its MCEs to undergo periodic compliance reviews to ensure that an assessment is conducted to meet mandatory EQR requirements. The compliance reviews focus on standards identified in 42 CFR §438.358(b)(1)(iii) and applicable state-specific contract requirements. The current three-year compliance review cycle was initiated in SFY 2024 and comprises 14 program areas referred to as standards. At DHCFP's direction, HSAG conducted a review of the first seven federally required standards and requirements in Year One (SFY 2024) and a review of the remaining federally required seven standards and requirements will be reviewed in Year Two (SFY 2025) of the three-year compliance review cycle. In SFY 2026 (Year Three), the compliance review activity will consist of a re-review of the standards that were not fully compliant during the SFY 2024 (Year One) and SFY 2025 (Year Two) compliance review activities, as indicated by elements (i.e., requirements) that received *Not Met* scores and required corrective action plans (CAPs) to remediate the noted deficiencies. Table 3-4 outlines the standards that will be reviewed over the three-year review cycle.

Table 3-4—Nevada Three-Year Cycle of Compliance Reviews

Standards	Associated Federal Citation[1]		Year One (SFY 2024)	Year Two (SFY 2025)	Year Three (SFY 2026)
	Medicaid	CHIP			
Standard I—Disenrollment: Requirements and Limitations	§438.56	§457.1212	✓		Review of the MCE's Year One and Year Two CAPs
Standard II—Member Rights and Member Information	§438.10 §438.100	§457.1207 §457.1220	✓		
Standard III—Emergency and Poststabilization Services	§438.114	§457.1228	✓		
Standard IV—Availability of Services	§438.206	§457.1230(a)	✓		
Standard V—Assurances of Adequate Capacity and Services	§438.207	§457.1230(b) §457.1218	✓		
Standard VI—Coordination and Continuity of Care	§438.208	§457.1230(c)	✓		
Standard VII—Coverage and Authorization of Services	§438.210	§457.1230(d)	✓		

Standards	Associated Federal Citation[1]		Year One (SFY 2024)	Year Two (SFY 2025)	Year Three (SFY 2026)
	Medicaid	CHIP			
Standard VIII—Provider Selection	§438.214	§457.1233(a)		✓	
Standard IX—Confidentiality	§438.224	§457.1233(e)		✓	
Standard X—Grievance and Appeal Systems	§438.228	§457.1260		✓	
Standard XI—Subcontractual Relationships and Delegation	§438.230	§457.1233(b)		✓	
Standard XII—Practice Guidelines	§438.236	§457.1233(c)		✓	
Standard XIII—Health Information Systems[2]	§438.242	§457.1233(d)		✓	
Standard XIV—Quality Assessment and Performance Improvement Program	§438.330	§457.1240		✓	

[1] The compliance review standards comprise a review of all requirements, known as elements, under the associated federal citation, including all requirements that are cross-referenced within each federal standard, as applicable (e.g., Standard X—Grievance and Appeal Systems includes a review of §438.228 and all requirements under Subpart F of 42 CFR Part 438).

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

Network Adequacy Validation

The NAV activity for SFY 2024 included validation of network capacity and geographic standards and indicators set forth by DHCFP. HSAG assessed the accuracy of DHCFP-defined network adequacy indicators reported by the MCEs and evaluated the MCEs' collection of provider data, the reliability and validity of network adequacy data, the methods used to assess network adequacy, and the systems and processes used. Based on the findings from these assessments and evaluations, HSAG then determined an overall validation rating, which provides HSAG's overall confidence that acceptable methodology was used for all phases of the design, data collection, analysis, and interpretation of the network adequacy indicators defined by DHCFP. Table 3-5 and Table 3-6 define the provider categories and provider standards and indicators that were validated by HSAG.

Table 3-5—MCO Network Adequacy Ratio Indicators Validated

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

* If the PCP practices in conjunction with a healthcare professional (i.e., nurse practitioner or physician's assistant), the ratio is increased to one FTE PCP for every 1,800 members. DHCFP's 402 network adequacy reporting template did not break out PCP practices in conjunction with a healthcare professional.

Table 3-6—MCO Network Adequacy Time or Distance Indicators Validated

Provider Category	Member Criteria	Time or Distance Access Standard to the Nearest Provider
Primary Care Providers		
Primary Care, Adults	Adults	15 minutes or 10 miles
OB/GYN	Adult Females	15 minutes or 10 miles
Pediatrician	Children	15 minutes or 10 miles
Physician Specialists		
Endocrinologist	Adults	60 minutes or 40 miles
Endocrinologist, Pediatric	Children	60 minutes or 40 miles
Infectious Disease	Adults	60 minutes or 40 miles
Infectious Disease, Pediatric	Children	60 minutes or 40 miles
Rheumatologist	Adults	60 minutes or 40 miles
Rheumatologist, Pediatric	Children	60 minutes or 40 miles
Oncologist—Medical/Surgical	Adults	45 minutes or 30 miles
Oncologist—Medical/Surgical, Pediatric	Children	45 minutes or 30 miles
Oncologist/Radiologist	Adults	60 minutes or 40 miles
Behavioral Health Providers		
Psychologist	Adults	45 minutes or 30 miles
Psychologist, Pediatric	Children	45 minutes or 30 miles
Psychiatrist	Adults	45 minutes or 30 miles
Board Certified Child and Adolescent Psychiatrist	Children	45 minutes or 30 miles
Qualified Mental Health Professional (QMHP)	Adults	45 minutes or 30 miles
QMHP, Pediatric	Children	45 minutes or 30 miles
Facility-Level Providers		
Hospital, All	Adults	45 minutes or 30 miles
Psychiatric Inpatient Hospital	Adults	45 minutes or 30 miles
Dialysis/End Stage Renal Disease (ESRD) Facility	Adults	45 minutes or 30 miles
Pharmacy	All	15 minutes or 10 miles

Consumer Assessment of Healthcare Providers and Systems Analysis

The primary objective of the CAHPS surveys was to effectively and efficiently obtain information on experiences of adult members and parents/caretakers of child members with the healthcare they/their child received through their/their child's MCO. These surveys cover topics that are important to members, such as the communication skills of providers and the accessibility of services. The MCOs were responsible for obtaining a CAHPS vendor to administer the CAHPS surveys on their behalf and were required to submit CAHPS data and a completed methodology form to HSAG by July 15, 2024, for the EQR assessment. HSAG presents top-box scores, which indicate the percentage of respondents who reported positive experiences in a particular aspect of their/their child's healthcare.

Table 3-7 displays the various measures of member experience.

Table 3-7—CAHPS Measures of Member Experience

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

External Quality Review Activity Results

Anthem Blue Cross and Blue Shield Healthcare Solutions

Validation of Performance Improvement Projects

Performance Results

Table 3-8 displays the overall validation status for the Design and Implementation stages of each PIP topic for the SFY 2023 PIP activity, which concluded in December 2023.

Table 3-8—2023 Overall Validation Ratings* for Anthem

Name of Project	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Overall Validation Status[3]
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	100%	100%	*Met*
Adults' Access to Preventive/Ambulatory Health Services (AAP)	100%	100%	*Met*
Child and Adolescent Well-Care Visit (WCV)	100%	100%	*Met*
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	100%	100%	*Met*
Prenatal and Postpartum Care (PPC)	100%	100%	*Met*
Plan All-Cause Readmissions (PCR)	100%	100%	*Met*

*The PIP activities for SFY 2023 were initiated prior to release of the 2023 CMS EQR Protocols; therefore, HSAG adhered to the guidance published in the 2019 CMS EQR Protocols. With the release of the new protocols, HSAG updated its PIP worksheets for the SFY 2024 activity to include the two validation ratings (i.e., overall confidence that the PIP adhered to an acceptable methodology for all phases of design and data collection, and the MCO conducted accurate data analysis and interpretation of PIP results; overall confidence that PIP produced significant evidence of improvement.)

[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 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 critical elements *Met*, *Partially Met*, and *Not Met*.

[3] **Overall Validation Status**—Populated from the PIP Validation Tool and based on the percentage scores.

Table 3-9 displays the overall validation scores and confidence level ratings for all three stages of the PIP process of each PIP topic for the SFY 2024 PIP activity, which concluded in December 2024.

Table 3-9—2024 Overall Validation Ratings for Anthem

PIP Topic	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	100%	100%	*High Confidence*	33%	100%	*Low Confidence*
Adults' Access to Preventive/Ambulatory Health Services (AAP)	100%	100%	*High Confidence*	33%	100%	*No Confidence*
Child and Adolescent Well-Care Visit (WCV)	100%	100%	*High Confidence*	100%	100%	*High Confidence*
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	100%	100%	*High Confidence*	67%	100%	*Moderate Confidence*
Prenatal and Postpartum Care (PPC)	100%	100%	*High Confidence*	100%	100%	*High Confidence*
Plan All-Cause Readmissions (PCR)	100%	100%	*High Confidence*	100%	100%	*High Confidence*

[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 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 critical elements *Met*, *Partially Met*, and *Not Met*.

[3] **Confidence Level**— Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

Table 3-10 includes the performance indicators that will be used to track performance or improvement over the life of the PIP.

Table 3-10—Performance Indicator Results for Anthem

PIP Topic	Performance Indicator	Performance Indicator Results		
		Baseline (01/01/2022–12/31/2022)	R1 (01/01/2023–12/31/2023)	R2 (01/01/2024–12/31/2024)
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	The percentage of SUD episodes that resulted in initiation of treatment with 14 days.	45.9%	46.4%	—
	The percentage of SUD episodes that resulted in treatment engagement within 34 days of initiation.	17.4%	16.9%	—
Adults' Access to Preventive/Ambulatory Health Services (AAP)	The percentage of adults 20 years of age and older that had at least one preventive or ambulatory care visit during the measurement year.	66.4%	64.8%	—
Child and Adolescent Well Care Visit (WCV)	The percentage of members 3 to 21 years of age that had at least one well-care visit with a PCP or OB/GYN practitioner during the measurement year.	45.5%	46.7%	—
Follow-up After Emergency Department Visit for Mental Illness (FUM)	The percentage of mental illness ED visits for which members 6 years of age and older had a follow-up visit within 7 days after the ED visit.	50.5%	53.3%	—
	The percentage of mental illness ED visits for which the member 6 years of age and older had a follow-up visit within 30 days after the ED visit.	40.2%	43.0%	—
Prenatal and Postpartum Care (PPC)	The percentage of deliveries for which received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.	62.9%	67.1%	—
	The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.	53.6%	59.6%	—

PIP Topic	Performance Indicator	Performance Indicator Results		
		Baseline (01/01/2022–12/31/2022)	R1 (01/01/2023–12/31/2023)	R2 (01/01/2024–12/31/2024)
Plan All-Cause Readmissions (PCR)	The percentage of acute readmissions for any diagnosis within 30 days of the index discharge date.	12.8%	10.9%	—

— The PIP had not progressed to including Remeasurement 2 results during SFY 2024. R=Remeasurement
HSAG rounded percentages to the first decimal place.

Interventions

Table 3-11 displays the barriers and interventions as documented by **Anthem** for each PIP.

Table 3-11—Interventions Implemented/Planned

Barriers	Interventions
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	
Timely engagement of members with a principal diagnosis of SUD, or any diagnosis of drug overdose for treatment initiation within 14 days, and treatment engagement within 34 days of an ED event.	The Plan will engage with WellCare Health and Human Behavior Institute to outreach to the members immediately following an ED visit for SUD and initiate treatment.
Adults' Access to Preventive/Ambulatory Health Services (AAP)	
Value-based payment programs do not include AAP as an incentivized quality metric.	Add AAP to the incentivized quality metrics in value-based care contracts.
Not all PCPs participate in value-based payment programs.	Implement a provider incentive program for providers not in a value-based care contract.
Challenges scheduling appointments.	Implement Experian, a digital scheduling platform.
Lack of member annual provider visit education/awareness assistance.	Add live agent telephonic outreach.
Social determinants of health (SDOH) barriers, specifically, housing instability, lead to increased usage of the ED and limited engagement for preventative care visits with PCP.	Complete preventative health visit for members who are provided with temporary housing as they are experiencing homelessness and have a presented Behavioral Health need and aid in their transition to permanent housing and connection to healthcare and other essential social services to support improved whole-health outcomes.

Barriers	Interventions
Child and Adolescent Well-Care Visit (WCV)	
Staff constraints prevent outreach or inaccurate contact information.	Implement a provider co-branded Immunization Schedule Program outreach mailer, focusing on members ages 3–21 to help increase Child and Adolescent Well-Care Visit (WCV) rates with PCPs participating in the outreach program.
Poor patient engagement, high no-show rates, lack of understanding about the importance of preventative care visits, and limited access to preventive care	WCV as an incentivized quality metrics in value-based care contracts, within both the Pediatric and Family Practice cohorts.
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	
Timely engagement of members.	The health plan engaged WC Health in late October 2022 to outreach to the members immediately following the MCAT to complete the *FUM* Assessment or to schedule an appointment within seven days following discharge from the ED. Incentivized quality metrics in PCP value-based care contracts (PQIP and PQIP Essentials), within both the Pediatric and Family Practice cohorts.
Prenatal and Postpartum Care (PPC)	
Not all providers participate in value-based payment programs.	Implement a provider incentive program for *PPC* to PCPs and OB/GYNs not in a non-value-based care contract.
Member contact and enrollment challenges.	Implement a doula program among all eligible population members to provide support to pregnant members for *PPC*.
Plan All-Cause Readmissions (PCR)	
Appointment scheduling challenges.	Implement Experian, a digital appointment scheduling platform.
Enhanced post-index discharge date support needed	ED Diversion program with contracted Mobile Crisis providers

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: The performance on all PIPs suggests a thorough application of the PIP Design. A sound design, which consists of collecting data and implementing interventions that have the potential to impact performance indicator results, created the foundation for **Anthem** to progress to subsequent PIP stages and measure the desired outcomes for the project. **[Quality, Timeliness,** and **Access]**

Strength #2: Anthem achieved statistically significant improvement at the first remeasurement for three of six PIPs: *Child and Adolescent Well Care Visit (WCV), Prenatal and Postpartum Care (PPC),* and *Plan All-Cause Readmissions (PCR)*. **[Quality, Timeliness,** and **Access]**

Weaknesses and Recommendations

Weakness #1: Anthem did not achieve statistically significant improvement for the *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET), Adults' Access to Preventive/Ambulatory Health Services (AAP)*, and *Follow-up After Emergency Department Visit for Mental Illness (FUM)* PIPs. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: The interventions initiated by **Anthem** did not have the desired impact.

Recommendation: For the PIPs that did not achieve the desired outcome of statistically significant improvement across all performance indicators, **Anthem** should revisit its causal/barrier analysis processes and current interventions to determine the possible causes for the lack of significant improvement or the decline in performance. **Anthem** should use the findings from this analysis to develop new active engaging interventions or to revise current strategies to address the barriers to achieving improvement.

Performance Measure Validation

Performance Results

Table 3-12 and Table 3-13 display **Anthem**'s Medicaid and Nevada Check Up HEDIS and CMS Child and Adult Core Set performance measure results for MY 2021, MY 2022, and MY 2023, along with MY 2022 to MY 2023 rate comparisons and performance target ratings.

Performance for MY 2023 (SFY 2024) is indicated by symbols and color coding; **bolded** rates indicate the rate met or exceeded the DHCFP-established minimum performance standard (MPS)[11]; ↑ indicates the rate was above the national Medicaid 50th percentile benchmark, ↓ indicates the rate was below the national 50th percentile benchmark, **green** shading indicates that the rate improved by 5 percentage points from the prior year, and **red** shading indicates that the rate declined by 5 percentage points from the prior year.

[11] Refer to *Appendix B. Goals and Objectives Tracking* for measures with an established MPS. Not all measure rates reported by the MCO have a DHCFP-established MPS.

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

Table 3-12—Medicaid SFY 2024 Performance Measure Results and Trending for Anthem

HEDIS Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	MY 2022–MY 2023 Rate Comparison
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services (AAP)				
(20–44 Years)	62.89%	63.95%	62.61%↓	-1.34
(45–64 Years)	70.45%	72.30%	70.24%↓	-2.06
(65+ Years)	68.99%	68.56%	57.43%↓	-11.13
(Total)	65.03%	66.40%	64.84%↓	-1.56
Children's Preventive Care				
Child and Adolescent Well-Care Visits (WCV)				
(3–11 Years)	50.14%	50.84%	51.08%↓	0.24
(12–17 Years)	45.39%	45.59%	**46.76%**↓	1.17
(18–21 Years)	20.53%	20.40%	23.08%↓	2.68
Total	44.67%	45.07%	46.19%↓	1.12
Childhood Immunization Status (CIS)				
Combination 3	57.42%	57.11%	58.15%↓	1.04
Combination 7	49.15%	51.48%	49.88%↓	-1.60
Combination 10	25.55%	24.26%	22.63%↓	-1.63
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	81.27%	83.16%	82.28%↑	-0.88
Combination 2 (Meningococcal, Tdap, HPV)	30.17%	32.21%	33.12%↓	0.91
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile Documentation (Total)	80.05%	81.02%	83.45%↑	2.43
Counseling for Nutrition (Total)	74.94%	72.99%	73.97%↑	0.98
Counseling for Physical Activity (Total)	72.26%	68.13%	71.05%↑	2.92

HEDIS Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	MY 2022–MY 2023 Rate Comparison
Well-Child Visits in the First 30 Months of Life (W30)				
(First 15 Months)	58.50%	58.26%	58.10%↓	-0.16
(15 Months–30 Months)	60.39%	60.70%	63.15%↓	2.45
Developmental Screening in the First Three Years of Life (DEV-CH)				
(1 Year)	—	—	23.36%	NC
(2 Years)	—	—	35.77%	NC
(3 Years)	—	—	39.42%	NC
(Total)	—	—	32.85%	NC
Lead Screening in Children (LSC)				
Lead Screening in Children	—	—	26.76%↓	NC
Women's Health and Maternity Care				
Breast Cancer Screening (BCS-E)				
Breast Cancer Screening	39.50%	40.50%	39.51%↓	-0.99
Chlamydia Screening in Women (CHL)				
(16–20 Years)	48.04%	49.03%	47.40%↓	-1.63
(21–24 Years)	61.22%	60.24%	59.85%↓	-0.39
(Total)	55.65%	55.45%	54.31%↓	-1.14
Postpartum Depression Screening and Follow-Up (PDS-E)				
Depression Screening	NA	0.00%	0.03%↓	0.03
Follow–Up on Positive Screen	NA	NA	NA	NC
Prenatal and Postpartum Care (PPC)				
Timeliness of Prenatal Care	81.75%	83.33%	78.83%↓	-4.50
Postpartum Care	71.29%	74.27%	73.72%↓	-0.55
Prenatal and Postpartum Care (PPC2-CH)				
Timeliness of Prenatal Care—Under 21 Years	—	—	74.85%	NC
Postpartum Care—Under 21 Years	—	—	65.20%	NC
Prenatal Depression Screening and Follow-Up (PND-E)				
Depression Screening	—	0.00%	0.00%↓	0.00
Follow–Up on Positive Screen	—	NA	NA	NC

HEDIS Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	MY 2022–MY 2023 Rate Comparison
Prenatal Immunization Status (PRS-E)				
Influenza	—	9.62%	9.33%↓	-0.29
Tdap	—	19.61%	19.83%↓	0.22
Combination	—	5.64%	5.72%↓	0.08
Contraceptive Care—Postpartum Women (CCP-CH)				
Most or Moderately Effective Contraception—3 Days—(15–20 Years)	—	—	1.08%	NC
Most or Moderately Effective Contraception—90 Days—(15–20 Years)	—	—	36.02%	NC
Long-Acting Reversible Contraception—3 Days—(15–20 Years)	—	—	0.00%	NC
Long-Acting Reversible Contraception—90 Days—(15–20 Years)	—	—	11.83%	NC
Contraceptive Care—All Women (CCW-CH)				
Most or Moderately Effective Contraception—(15–20 Years)	—	—	12.66%	NC
Long-Acting Reversible Contraception—(15–20 Years)	—	—	2.05%	NC
Care for Chronic Conditions				
Asthma Medication Ratio (AMR)				
(5–11 Years)	81.70%	79.08%	69.64%↓	-9.44
(12–18 Years)	68.08%	69.74%	51.63%↓	-18.11
(5-18 years) Child Core Set	—	75.09%	61.82%	-13.28
(19–50 Years)	55.37%	53.22%	48.65%↓	-4.57
(51–64 Years)	54.71%	56.10%	49.57%↓	-6.53
(19-64 years) Adult Core Set	—	54.03%	48.93%	-5.10
(Total)	63.28%	62.05%	54.06%↓	-7.99
Blood Pressure Control for Patients With Diabetes (BPD)				
Blood Pressure Control for Patients With Diabetes	51.82%	60.34%	58.15%↓	-2.19
Controlling High Blood Pressure (CBP)				
Controlling High Blood Pressure	53.04%	54.50%	56.45%↓	1.95

HEDIS Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	MY 2022–MY 2023 Rate Comparison
Hemoglobin A1c Control for Patients With Diabetes (HBD)				
*HbA1c Control (>9.0%)**	47.45%	39.90%	**39.66%↓**	-0.24
HbA1c Control (<8%)	45.74%	51.82%	**52.80%↑**	0.98
Behavioral Health				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	34.31%	38.83%	37.59%↓	-1.24
Antidepressant Medication Management (AMM)				
Effective Acute Phase Treatment	52.06%	52.81%	53.30%↓	0.49
Effective Continuation Phase Treatment	35.05%	36.17%	36.75%↓	0.58
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	76.68%	76.48%	**79.35%↑**	2.87
Follow-Up After Emergency Department Visit for Substance Use (FUA)				
7 days (Total)	—	20.41%	18.57%↓	-1.84
30 days (Total)	—	29.46%	**29.10%↓**	-0.36
Follow-Up After Emergency Department Visit for Mental Illness (FUM)				
7 days (Total)	35.58%	39.96%	42.34%↑	2.38
30 days (Total)	46.93%	50.22%	52.81%↓	2.59
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)				
7 Days (Total)	—	29.75%	32.11%↑	2.36
30 days (Total)	—	50.44%	49.45%↓	-0.99
Follow-Up After Hospitalization for Mental Illness (FUH)				
7 days (Total)	28.87%	30.55%	33.57%↓	3.02
30 days (Total)	46.60%	48.00%	50.68%↓	2.68
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
Initiation Phase	49.38%	45.07%	48.95%↑	3.88
Continuation and Maintenance Phase	60.81%	60.38%	68.29%↑	7.91

HEDIS Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	MY 2022–MY 2023 Rate Comparison
Initiation and Engagement of Substance Use Disorder Treatment (IET)				
Initiation of SUD Treatment—Total (Total)	—	45.88%	46.46%↑	0.58
Engagement of SUD Treatment—Total (Total)	—	17.10%	16.86%↑	-0.24
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)				
Blood Glucose and Cholesterol Testing (Total)	31.58%	32.01%	35.69%↑	3.68
Screening for Depression and Follow-Up Plan (CDF-CH/CDF-AD) ∞				
(12–17 Years)	—	0.38%	0.44%	0.06
(18–64 Years)	—	1.85%	2.62%	0.77
(65+ Years)	—	1.79%	2.37%	0.58
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)				
(1–11 Years)	53.19%	62.50%	68.33%↑	5.83
(12–17 Years)	63.41%	65.12%	63.30%↑	-1.82
(Total)	59.69%	64.08%	**65.09%**↑	1.01
Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)				
Rate 1: Total	—	53.34%	56.87%	3.53
Rate 2: Buprenorphine	—	29.08%	31.30%	2.22
Rate 3: Oral Naltrexone	—	4.78%	4.72%	-0.06
Rate 4: Long-Acting, Injectable Naltrexone	—	1.79%	1.83%	0.04
Rate 5: Methadone	—	23.46%	24.58%	1.12
Diabetes Care for People With Serious Mental Illness: Hemoglobin A1c Poor Control (>9.0%) (HPCMI-AD)*				
(18–64 Years)	—	—	46.83%	NC
(65–75 Years)	—	—	NA	NC
Utilization				
Ambulatory Care—Total (per 1,000 Member Years) (AMB)*				
*ED Visits—Total**	551.08	642.32	618.63	-23.69
Outpatient Visits—Total	3,017.10	3,265.66	3,294.95	NC
Plan All-Cause Readmissions (PCR)				
*Observed Readmissions Total—(18–64 Years)**	13.23%	12.82%	**10.94%**	-1.88

HEDIS Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	MY 2022–MY 2023 Rate Comparison
Expected Readmissions Total—(18–64 Years)	9.51%	9.65%	9.09%	-0.56
Observed/Expected (O/E) Ratio Total—(18–64 Years)	1.3912	1.3282	1.2030	-0.1252
Outliers Total—(18–64 Years)	72.32	72.12	81.91	9.79
Overuse/Appropriateness of Care				
Risk of Continued Opioid Use (COU)*				
>=15 Days (Total)	—	7.44%	7.57%↓	0.13
>=31 Days (Total)	—	5.85%	5.85%↓	0.00
Use of Opioids at High Dosage (HDO)*				
Use of Opioids at High Dosage	8.15%	7.63%	**7.80%↓**	0.17
Use of Opioids From Multiple Providers (UOP)*				
Multiple Prescribers	20.68%	19.36%	**20.60%↓**	1.24
Multiple Pharmacies	0.52%	0.56%	0.99%↑	0.43
Multiple Prescribers and Multiple Pharmacies	0.30%	0.34%	0.64%↑	0.30
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)				
(3 Months–17 Years)	—	—	72.02%↓	NC
(18–64 Years)	—	—	52.88%↑	NC
(65+ Years)	—	—	NA	NC
(Total)	—	—	65.26%↑	NC

↑ Indicates the MY 2023 rate was above NCQA's Quality Compass 2023 Medicaid HMO 50th percentile benchmark.
↓ Indicates the MY 2023 rate was below NCQA's Quality Compass 2023 Medicaid HMO 50th percentile benchmark.
* A lower rate indicates better performance for this measure or indicator.
** Beginning MY 2022, this rate was reported per 1,000 member years instead of per 1,000 member months; the rates for MY 2021 were converted to member years for comparison.
— Indicates that the MCO was not previously required to report this measure or that the rate is not appropriate to display due to changes in the technical specifications resulting in a break in trending.
∞ MCOs reported *CDF—18—64 years* and *CDF—65 years and older* to align with the CMS Adult Core Set FFY 2024 technical specifications. HSAG will assess each indicator separately to determine if the MCOs met or exceeded DHCFP's QISMC goal for *CDF—18 years and older.*
NC indicates the MY 2022–MY 2023 Rate Comparison could not be calculated because data are not available for both years.
NA indicates that the MCO followed the specifications, but the denominator was too small (i.e., <30) to report a valid rate.
Bolded rates indicate that the MY 2023 performance measure rate met or exceeded the DHCFP-established MPS.

Indicates that the MY 2023 rate declined by 5 percentage points or more from MY 2022.

Indicates that the MY 2023 rate improved by 5 percentage points or more from MY 2022.

Table 3-13—Nevada Check Up SFY 2024 Performance Measure Results and Trending for Anthem

HEDIS Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	MY 2022–MY 2023 Rate Comparison
Children's Preventive Care				
Child and Adolescent Well-Care Visits (WCV)				
(3–11 Years)	56.17%	53.19%	53.48%↓	0.29
(12–17 Years)	53.97%	52.64%	51.42%↑	-1.22
(18–21 Years)	33.52%	36.95%	37.97%↑	1.02
Total	53.95%	51.80%	51.74%↑	-0.06
Childhood Immunization Status (CIS)				
Combination 3	71.33%	65.00%	67.23%↑	2.23
Combination 7	66.67%	61.25%	61.34%↑	0.09
Combination 10	35.33%	37.50%	21.01%↓	-16.49
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	91.48%	90.97%	90.03%↑	-0.94
Combination 2 (Meningococcal, Tdap, HPV)	44.28%	44.48%	41.88%↑	-2.60
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile Documentation (Total)	83.94%	80.05%	82.24%↑	2.19
Counseling for Nutrition (Total)	76.64%	73.97%	73.97%↑	0.00
Counseling for Physical Activity (Total)	73.24%	69.59%	72.26%↑	2.67
Well-Child Visits in the First 30 Months of Life (W30)				
(First 15 Months)	66.29%	67.61%	67.35%↑	-0.26
(15 Months–30 Months)	72.19%	68.97%	64.00%↓	-4.97
Developmental Screening in the First Three Years of Life (DEV-CH)				
(1 Year)	—	—	25.55%	NC
(2 Years)	—	—	41.61%	NC
(3 Years)	—	—	37.23%	NC
(Total)	—	—	34.79%	NC
Lead Screening in Children (LSC)				
Lead Screening in Children	—	—	26.05%↓	NC

HEDIS Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	MY 2022–MY 2023 Rate Comparison
Women's Health and Maternity Care				
Chlamydia Screening in Women (CHL)				
(16–20 Years)	39.58%	45.87%	39.62%↓	-6.25
(21–24 Years)	NA	NA	NA	NC
(Total)	39.58%	45.87%	39.62%↓	-6.25
Prenatal and Postpartum Care (PPC)				
Timeliness of Prenatal Care	NA	NA	NA	NC
Postpartum Care	NA	NA	NA	NC
Prenatal and Postpartum Care (PPC2-CH)				
Timeliness of Prenatal Care—Under 21 Years	—	—	NA	NC
Postpartum Care—Under 21 Years	—	—	NA	NC
Contraceptive Care—Postpartum Women (CCP-CH)				
Most or Moderately Effective Contraception—3 Days—(15–20 Years)	—	—	NA	NC
Most or Moderately Effective Contraception—90 Days—(15–20 Years)	—	—	NA	NC
Long-Acting Reversible Contraception—3 Days—(15–20 Years)	—	—	NA	NC
Long-Acting Reversible Contraception—90 Days—(15–20 Years)	—	—	NA	NC
Contraceptive Care—All Women (CCW-CH)				
Most or Moderately Effective Contraception—(15–20 Years)	—	—	9.35%	NC
Long-Acting Reversible Contraception—(15–20 Years)	—	—	0.66%	NC
Care for Chronic Conditions				
Asthma Medication Ratio (AMR)				
(5–11 Years)	77.14%	84.38%	61.22%↓	-23.16
(12–18 Years)	64.71%	NA	63.64%↓	NC
(5–18 years) Child Core Set	—	81.82%	62.20%	-19.62
(19–50 Years)	NA	NA	NA	NC
(51–64 Years)	NA	NA	NA	NC

HEDIS Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	MY 2022–MY 2023 Rate Comparison
(19–64 years) Adult Core Set	—	NA	NA	NC
(Total)	71.01%	82.14%	62.20%↓	-19.94
Behavioral Health				
Follow-Up After Emergency Department Visit for Substance Use (FUA)				
7 days (Total)	—	NA	NA	NC
30 days (Total)	—	NA	NA	NC
Follow-Up After Emergency Department Visit for Mental Illness (FUM)				
7 days (Total)	NA	NA	NA	NC
30 days (Total)	NA	NA	NA	NC
Follow-Up After Hospitalization for Mental Illness (FUH)				
7 days (Total)	35.48%	NA	NA	NC
30 days (Total)	61.29%	NA	NA	NC
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
Initiation Phase	50.00%	45.16%	NA	NC
Continuation and Maintenance Phase	NA	NA	NA	NC
Initiation and Engagement of Substance Use Disorder Treatment (IET)				
Initiation of SUD Treatment—Total (Total)	—	NA	NA	NC
Engagement of SUD Treatment—Total (Total)	—	NA	NA	NC
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)				
Blood Glucose and Cholesterol Testing (Total)	NA	NA	38.10%↑	NC
Screening for Depression and Follow-Up Plan (CDF-CH/CDF-AD)				
(12–17 Years)	—	0.20%	0.31%	0.11
(18–64 Years)	—	0.47%	0.91%	0.44
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)				
(1–11 Years)	—	NA	NA	NC
(12–17 Years)	—	NA	NA	NC
(Total)	—	NA	NA	NC

HEDIS Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	MY 2022–MY 2023 Rate Comparison
Utilization				
Ambulatory Care—Total (per 1,000 Member Years) (AMB) **				
*ED Visits—Total**	191.34	309.40	302.92	-6.48
Outpatient Visits—Total	2,308.41	2,589.87	2,501.21	NC
Overuse/Appropriateness of Care				
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)				
(3 Months–17 Years)	—	—	70.00%↓	NC
(18–64 Years)	—	—	NA	NC
(Total)	—	—	70.42%↑	NC

↑ Indicates the MY 2023 rate was above NCQA's Quality Compass 2023 Medicaid HMO 50th percentile benchmark.
↓ Indicates the MY 2023 rate was below NCQA's Quality Compass 2023 Medicaid HMO 50th percentile benchmark.
* A lower rate indicates better performance for this measure or indicator.
** Beginning MY 2022, this rate was reported per 1,000 member years instead of per 1,000 member months; the rates for MY 2021 were converted to member years for comparison.
— Indicates that the MCO was not previously required to report this measure or that the rate is not appropriate to display due to changes in the technical specifications resulting in a break in trending.NC indicates the MY 2022–MY 2023 Rate Comparison could not be calculated because data are not available for both years.
NA indicates that the MCO followed the specifications, but the denominator was too small (i.e., <30) to report a valid rate.
Bolded rates indicate that the MY 2023 performance measure rate met or exceeded the DHCFP-established MPS.
Indicates that the MY 2023 rate declined by 5 percentage points or more from MY 2022.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Within the Care for Chronic Conditions domain, **Anthem**'s Medicaid rates for *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%) and HbA1c Poor Control (>9.0%)* measure indicators met the State's established MPS. This performance suggests **Anthem**'s Medicaid population is receiving adequate blood sugar management, which can reduce the risk of serious health conditions and complications. [**Quality** and **Access**]

Strength #2: Within the Behavioral Health domain, **Anthem**'s Medicaid rates for *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*, *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total*, and *Follow-Up After Emergency Department Visit for Substance Use—30 Day Follow-Up*, met the State's established MPS. This performance suggests members with SUD received timely, coordinated care post-ED discharge and that **Anthem** ensured behavioral health medications were prescribed after appropriate screening occurred and are managed correctly, while the members' co-existing diagnoses were taken into consideration. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Within the Children's Preventive Care and Women's Health and Maternity Care domains for **Anthem**'s Nevada Check Up population, no measure indicator rates with a QISMC goal met the State's established MPS. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Although **Anthem**'s Medicaid members appear to have access to PCPs for preventive and ambulatory services, as well as children's and women's preventive services, these members were not consistently utilizing these services, which can significantly reduce nonurgent ED visits and potentially prevent more serious health and development issues from occurring, reducing healthcare costs. The low performance in these domains could also be due to disparities within **Anthem**'s populations that could impact access to care, such as language barriers, access to transportation, geographic location, and socioeconomic status.

Recommendation: **Anthem** self-reported strategies to address the domains of Children's Preventive Care and Women's Health and Maternity Care, including continuing to educate its contracted providers, furnish them with member-level detail data, and encourage them to conduct outreach and reduce member gaps in care. HSAG recommends that **Anthem** continue these initiatives and where possible, identify and measure effectiveness of interventions by establishing baseline and remeasurement metrics. Regarding *Childhood Immunization Status—Combination 10*, HSAG recommends that **Anthem** provide education to providers and members about the importance of vaccination for disease prevention and encourage vaccination at every opportunity, including mild illness visits.[12] Reminder/recall systems can be effective for members/families and providers. Standing orders for immunizations and provider-specific reports identifying providers with lower immunization rates can assist in plan follow up.[13] Regarding *Chlamydia Screening in Women—16-20 years*, HSAG recommends that **Anthem** perform provider outreach and education, and member education and outreach; track chlamydia screening rates and report results to physicians and large practices; and require providers to use Logical Observation Identifiers Names and Codes (LOINC3),

[12] Anderson, Edwin L. "Recommended solutions to the barriers to immunization in children and adults." *Missouri Medicine* vol. 111,4 (2014): 344-8.

[13] Anderson, Edwin L. "Recommended solutions to the barriers to immunization in children and adults." Missouri Medicine vol. 111,4 (2014): 344-8.

which creates an electronic record of the screening test.[14] HSAG recommends that labs report tests directly to the MCO, in addition to the usual reports sent to providers.

Weakness #2: Within the Care for Chronic Conditions domain, no measure indicator rates with a QISMC goal met the State's established MPS except for *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)* and *HbA1c Poor Control (>9.0%)*. [**Quality, Timeliness,** and **Access**]

Why the weakness exists: Declines in the *Asthma Medication Ratio* rates indicate children and adolescents with persistent asthma are not consistently receiving appropriate monitoring of their medications, which could be due to barriers to care. Appropriate medication management for patients with asthma could reduce the need for rescue medication, as well as costs associated with ED visits, inpatient admissions, and missed days of work or school.

Recommendation: **Anthem** self-reported strategies to address the Care for Chronic Conditions domain, including continuing to educate its contracted providers, furnish them with member-level detail data, and encourage them to conduct outreach and reduce member gaps in care. **Anthem** reported offering assistance in scheduling patient appointments and is piloting a vendor service that provides an electronic health record (EHR) overlay activated when a medical record is open. **Anthem** has leveraged Anthem Intelligence to evaluate barriers to care (e.g., SDOH). HSAG recommends that **Anthem** continue these initiatives and where possible, identify and measure the effectiveness of interventions by establishing baseline and remeasurement metrics. Regarding *Asthma Medication Ratio*, HSAG recommends that **Anthem** provide education to providers about establishing an asthma action plan with members.[15] HSAG also recommends that **Anthem** use pharmacy data to identify members outside the asthma medication ratio and prioritize case management services to these members. HSAG further recommends that **Anthem** provide member education about medication adherence.

Compliance Review

Performance Results

Table 3-14 presents an overview of the results of the standards reviewed during the SFY 2024 compliance review for **Anthem**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Appendix A. If a requirement was not applicable to **Anthem** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all seven standards.

[14] NCQA. Improving Chlamydia Screening. Available at: https://www.ncqa.org/wp-content/uploads/2018/08/20071200_HEDIS_Improving_Chlamydia_Screening.pdf. Accessed on Dec 19, 2024.

[15] Asthma and Allergy Foundation of America. "Asthma Action Plan." Available at: https://aafa.org/asthma/asthma-treatment/asthma-treatment-action-plan. Accessed on Dec 19, 2024.

Table 3-14—Summary of Standard Compliance Scores

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Disenrollment: Requirements and Limitations	6	6	5	1	0	**83%**
Standard II—Member Rights and Member Information	24	23	19	4	1	**83%**
Standard III—Emergency and Poststabilization Services	13	13	13	0	0	**100%**
Standard IV—Availability of Services	12	12	10	2	0	**83%**
Standard V—Assurances of Adequate Capacity and Services	5	5	4	1	0	**80%**
Standard VI—Coordination and Continuity of Care	28	28	23	5	0	**82%**
Standard VII—Coverage and Authorization of Services	27	27	22	5	0	**81%**
Total	**115**	**114**	**96**	**18**	**1**	**84%**

M = Met*; *NM = Not Met*; *NA = Not Applicable

Total Elements: The total number of elements within each standard.

Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

Based on the findings from the SFY 2024 compliance review activity, **Anthem** was required to develop and submit a CAP for each element assigned a score of *Not Met*. The CAP was reviewed by DHCFP and HSAG for sufficiency, and **Anthem** was responsible for implementing each action plan in a timely manner.

Strengths, Weaknesses, and Recommendations

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

Strengths

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

Weaknesses and Recommendations

Weakness #1: Anthem had four elements in the Member Rights and Member Information program area that received a score of *Not Met*, indicating that members may not be notified of or receive required member materials and information timely. [**Timeliness** and **Access**]

Why the weakness exists: Anthem did not demonstrate the MCO ensured that member materials adhered to State and federal requirements, that members were notified of the time frame for receiving a member handbook upon member's request, and that the member handbook included all required components under federal and State regulations.

Recommendation: While **Anthem** was required to develop a CAP to address the deficiencies identified, HSAG recommends that the MCO conduct a comprehensive review of its member-facing materials and its processes and procedures related to member information to identify whether additional opportunities for improvement in this program area exist and take remedial action, as necessary.

Weakness #2: Anthem had five elements in the Coordination and Continuity of Care program area that received a score of *Not Met*, indicating members' care may not be effectively coordinated through the care management program. **[Quality**, **Timeliness**, and **Access]**

Why the weakness exists: Anthem did not consistently complete the comprehensive assessment timely and the comprehensive assessment was not consistently or adequately assessing members for all required assessment areas. **Anthem** also did not consistently provide information to members' PCPs regarding member eligibility for and/or enrollment into care management; provide members' PCPs with members' care plans; or demonstrate that the MCO's member services staff has access to members' case management notes, including recent inpatient or ED utilization if member services staff was contacted by the member.

Recommendation: While **Anthem** was required to develop a CAP to address the deficiencies identified, HSAG recommends that the MCO continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to care coordination and care management of members.

Weakness #3: Anthem had five elements in the Coverage and Authorization of Services program area that received a score of *Not Met*, indicating members may not consistently receive timely and adequate notice of prior authorization decisions, including decisions that result in an adverse benefit determination (ABD) notice to the member. **[Quality** and **Timeliness]**

Why the weakness exists: Anthem did not consistently adhere to requirements related to the timing of authorization decisions (i.e., expedited, standard) and the timing and content of notices of adverse benefit determination.

Recommendation: While **Anthem** was required to develop a CAP to address the deficiencies identified, HSAG recommends that the MCO continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to coverage and authorization of services.

Network Adequacy Validation

Performance Results

HSAG determined that the providers per 1,500 members in Clark and Washoe counties exceeded DHCFP's requirements. Table 3-15 presents results by the number of providers per 1,500 members in Clark and Washoe counties and by the DHCFP-required provider types.

Table 3-15 presents **Anthem**'s network adequacy results for Provider-to-Member Ratios.

Table 3-15—Anthem Provider-to-Member Ratios by Provider Type by County

Provider Type	Indicators	Providers per 1,500 Members (Clark County)	Providers per 1,500 Members (Washoe County)
PCP not practicing in conjunction with healthcare professional*	1:1,500	13.66	46.55
Specialists	1:1,500	137.81	296.56

* If the PCP practices in conjunction with a healthcare professional (i.e., nurse practitioner or physician's assistant), the ratio is increased to one FTE PCP for every 1,800 members. DHCFP's 402 network adequacy reporting template did not break out PCP practices in conjunction with a healthcare professional.

DHCFP established a 100 percent threshold when determining compliance with time or distance standards. HSAG determined that indicators that fell below the 100 percent threshold achieved greater than or equal to 99.6 percent compliance with access standards. Table 3-16 presents results by percentage of members with access across Clark and Washoe counties and by the DHCFP-established provider categories. Results that achieved the 100 percent access threshold are shaded **green**.

Table 3-16 presents **Anthem**'s network adequacy results for Time or Distance:

Table 3-16—Anthem Percentage of Members with Access by Provider Category by County

Provider Category	Time or Distance Indicator	Percentage of Members With Access (Clark County)	Percentage of Members With Access (Washoe County)
Primary Care, Adults	10 miles or 15 minutes	99.9%	99.7%
OB/GYN (Adult Females)	10 miles or 15 minutes	99.6%	99.7%
Pediatrician	10 miles or 15 minutes	99.9%	99.7%
Endocrinologist	40 miles or 60 minutes	99.9%	100%

Provider Category	Time or Distance Indicator	Percentage of Members With Access (Clark County)	Percentage of Members With Access (Washoe County)
Endocrinologist, Pediatric	40 miles or 60 minutes	99.9%	100%
Infectious Disease	40 miles or 60 minutes	99.9%	100%
Infectious Disease, Pediatric	40 miles or 60 minutes	99.9%	100%
Rheumatologist	40 miles or 60 minutes	99.9%	100%
Rheumatologist, Pediatric	40 miles or 60 minutes	99.9%	100%
Oncologist/Radiologist	40 miles or 60 minutes	100%	100%
Oncologist/Radiologist, Pediatric	40 miles or 60 minutes	100%	100%
Oncologist—Medical/Surgical	30 miles or 45 minutes	99.9%	100%
Oncologist—Medical/Surgical, Pediatric	30 miles or 45 minutes	99.9%	100%
Psychologist	30 miles or 45 minutes	99.9%	100%
Psychologist, Pediatric	30 miles or 45 minutes	99.9%	100%
Psychiatrist	30 miles or 45 minutes	99.9%	100%
Board Certified Child and Adolescent Psychiatrist	30 miles or 45 minutes	99.9%	100%
Qualified Mental Health Professional (QMHP)	30 miles or 45 minutes	100%	100%
QMHP, Pediatric	30 miles or 45 minutes	100%	100%
Hospital, All	30 miles or 45 minutes	100%	100%
Psychiatric Inpatient Hospital	30 miles or 45 minutes	99.9%	100%
Dialysis/End Stage Renal Disease (ESRD) Facility	30 miles or 45 minutes	99.9%	100%

Provider Category	Time or Distance Indicator	Percentage of Members With Access (Clark County)	Percentage of Members With Access (Washoe County)
Pharmacy	10 miles or 15 minutes	99.9%	99.7%

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Anthem had strong oversight and validation processes in place to ensure completeness and accuracy in member enrollment and eligibility data processing. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: HSAG observed **Anthem** excluding members who had invalid addresses or ZIP Codes from network adequacy calculation and reporting. [**Quality** and **Access**]

Why the weakness exists: Anthem reported there were invalid addresses and ZIP Codes in the DHCFP 834 file, resulting in those members being excluded.

Recommendation: HSAG recommends **Anthem** seek additional guidance from DHCFP on any requirements related to the exclusion of members where an invalid address and/or ZIP Code is identified when calculating network adequacy results.

Weakness #2: Although **Anthem** was able to apply the necessary corrections for final reporting, HSAG observed that **Anthem** was not applying the correct parameters when calculating and determining compliance with the GeoAccess standards. **Anthem** was applying "and" versus "or" to its network adequacy calculation methodology. [**Quality** and **Access**]

Why the weakness exists: DHCFP's contract with the MCOs includes a table labeled, "Maximum Time and Distance Standards"; however, HSAG confirmed with DHCFP that the time and distance standards are to be "or" versus "and." **Anthem** was applying the "and" methodology based on language within the contract and unclear guidance in the network adequacy reporting template required by DHCFP to be used by the MCO when reporting network adequacy compliance.

Recommendation: HSAG recommends that **Anthem** conduct a quarterly review of DHCFP reporting requirements and/or consult with DHCFP to ensure accurate understanding of DHCFP's required methodology for calculating network adequacy. Additionally, HSAG recommends that **Anthem** build in additional layers of validation to ensure logic and parameters used to inform calculations are in alignment with DHCFP's network adequacy calculation requirements. Finally,

HSAG recommends that **Anthem** ensure internal process flows are documented to reflect changes year over year.

Weakness #3: Although **Anthem** was able to apply the necessary corrections for final reporting, HSAG observed **Anthem** was not separating the adult and pediatric populations for a subset of provider categories, as well as not reporting inpatient psychiatric hospitals separately as required by DHCFP. [**Quality** and **Access**]

Why the weakness exists: DHCFP's network adequacy reporting template was not structured to allow for MCO reporting of both adult and pediatric populations for DHCFP-specified provider categories. The network adequacy reporting template also did not include a place for **Anthem** to report inpatient psychiatric hospitals.

Recommendation: HSAG recommends that **Anthem** work with DHCFP on future template updates to ensure all DHCFP reporting requirements are captured on the reporting template, including the necessary population stratifications.

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results

Table 3-17 presents the 2024 CAHPS top-box scores for **Anthem**'s adult Medicaid, general child Medicaid, CCC Medicaid, Nevada Check Up general child, and Nevada Check Up CCC populations. Arrows (↓ or ↑) indicate 2024 scores that were statistically significantly higher or lower than the 2023 national average.[16]

Table 3-17—Summary of 2024 CAHPS Top-Box Scores for Anthem

	Adult Medicaid	General Child Medicaid	CCC Medicaid	Nevada Check Up General Child	Nevada Check Up CCC
Composite Measures					
Getting Needed Care	NA	NA	NA	NA	NA
Getting Care Quickly	NA	NA	NA	NA	NA
How Well Doctors Communicate	NA	NA	NA	89.64% ↓	NA
Customer Service	NA	NA	NA	NA	NA
Global Ratings					
Rating of All Health Care	NA	NA	NA	71.13%	NA
Rating of Personal Doctor	62.50%	NA	NA	74.62%	NA
Rating of Specialist Seen Most Often	NA	NA	NA	NA	NA
Rating of Health Plan	66.00%	NA	NA	78.40% ↑	NA

[16] 2024 national average results were not available at the time this report was produced.

	Adult Medicaid	General Child Medicaid	CCC Medicaid	Nevada Check Up General Child	Nevada Check Up CCC
Medical Assistance with Smoking and Tobacco Use Cessation Measure Items*					
Advising Smokers and Tobacco Users to Quit	NA	—	—	—	—
Discussing Cessation Medications	NA	—	—	—	—
Discussing Cessation Strategies	NA	—	—	—	—
CCC Composite Measures/Items					
Access to Specialized Services	—	—	NA	—	NA
FCC: Personal Doctor Who Knows Child	—	—	NA	—	NA
Coordination of Care for Children With Chronic Conditions	—	—	NA	—	NA
Access to Prescription Medicines	—	—	NA	—	NA
FCC: Getting Needed Information	—	—	NA	—	NA

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

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

↑ Indicates the 2024 score is statistically significantly higher than the 2023 national average.

↓ Indicates the 2024 score is statistically significantly lower than the 2023 national average.

— Indicates the measure does not apply to the population.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Parents/caretakers of Nevada Check Up general child members had positive overall experiences with their child's health plan since the score for this measure was statistically significantly higher than the 2023 NCQA Medicaid national average. **[Quality]**

Weaknesses and Recommendations

Weakness #1: Parents/caretakers of Nevada Check Up general child members had less positive overall experiences with how well their child's personal doctor communicated with them since the score for this measure was statistically significantly lower than the 2023 NCQA Medicaid national average. **[Quality]**

Why the weakness exists: Parents/caretakers may not receive patient-centered communication from their child's providers, which impacts their patient experience.

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

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

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

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

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

HSAG performed a comprehensive assessment of **Anthem**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **Anthem** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **Anthem**'s overall performance contributed to the Nevada Managed Care Program's progress in achieving the Nevada Quality Strategy goals and objectives. Table 3-18 displays each Nevada Quality Strategy goal and EQR activity results that indicate whether the MCO positively (✓) or negatively (✗) impacted the Nevada Managed Care Program's progress toward achieving the applicable goals and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **Anthem**'s Medicaid members.

Table 3-18—Overall Performance Impact to Nevada Quality Strategy and Quality, Timeliness, and Access

	Quality Strategy Goals	Performance Impact on Goals and Objectives	
1	Improve the health and wellness of Nevada's Medicaid population by increasing the use of preventive services by December 31, 2024	✓	1/18 Medicaid rates met the MPS
		✗	17/18 Medicaid rates did not meet MPS
		✗	0/14 applicable Nevada Check Up rates met the MPS
2	Increase use of evidence-based practices for members with chronic conditions by December 31, 2024	✓	3/7 Medicaid rates met the MPS
		✗	4/7 Medicaid rates did not meet MPS
		✗	0/1 applicable Nevada Check Up rates met the MPS
3	Reduce misuse of opioids by December 31, 2024	✓	2/4 Medicaid rates met the MPS
		✗	2/4 Medicaid rates did not meet MPS
4	Improve the health and wellness of pregnant women and infants by December 31, 2024	✗	0/5 applicable Medicaid rates did not meet the MPS
5	Increase use of evidence-based practices for members with behavioral health conditions by December 31, 2024	✓	3/21 Medicaid rates met the MPS
		✗	18/21 Medicaid rates did not meet the MPS
		✗	0/3 applicable Nevada Check Up rates met the MPS
6	Increase utilization of dental services by December 31, 2024	Not applicable to the MCO	
7	Reduce and/or eliminate health care disparities for Medicaid members by December 31, 2024	✓	3/3 objectives received a *Met* designation

Molina Healthcare of Nevada, Inc.

Validation of Performance Improvement Projects

Performance Results

Table 3-19 displays the overall validation status for the Design and Implementation stages of each PIP topic for the SFY 2023 PIP activity, which concluded in December 2023.

Table 3-19—2023 Overall Validation Ratings* for Molina

Name of Project	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Overall Validation Status[3]
Initiation and Engagement of Substance Use Disorder Treatment (IET)	100%	100%	*Met*
Adults' Access to Preventive/Ambulatory Health Services (AAP)	100%	100%	*Met*
Child and Adolescent Well-Care Visit (WCV)	100%	100%	*Met*
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	100%	100%	*Met*
Timeliness of Prenatal and Postpartum Care (PPC)	100%	100%	*Met*
Plan All-Cause Readmissions (PCR)	100%	100%	*Met*

*The PIP activities for SFY 2023 were initiated prior to release of the 2023 CMS EQR Protocols; therefore, HSAG adhered to the guidance published in the 2019 CMS EQR Protocols. With the release of the new protocols, HSAG updated its PIP worksheets for the SFY 2024 activity to include the two validation ratings (i.e., overall confidence that the PIP adhered to an acceptable methodology for all phases of design and data collection, and the MCO conducted accurate data analysis and interpretation of PIP results; overall confidence that PIP produced significant evidence of improvement.)

[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 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 critical elements *Met*, *Partially Met*, and *Not Met*.

[3] **Overall Validation Status**—Populated from the PIP Validation Tool and based on the percentage scores.

Table 3-20 displays the overall validation scores and confidence level ratings for all three stages of the PIP process of each PIP topic for the SFY 2024 PIP activity, which concluded in December 2024.

Table 3-20—2024 Overall Validation Ratings for Molina

PIP Topic	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
Initiation and Engagement of Substance Use Disorder (IET)	100%	100%	*High Confidence*	33%	100%	*Moderate Confidence*
Adults' Access to Preventive/Ambulatory Health Services (AAP)	100%	100%	*High Confidence*	100%	100%	*High Confidence*
Child and Adolescent Well-Care Visit (WCV)	100%	100%	*High Confidence*	100%	100%	*High Confidence*
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	100%	100%	*High Confidence*	33%	100%	*Low Confidence*
Prenatal and Postpartum Care (PPC)	100%	100%	*High Confidence*	100%	100%	*High Confidence*
Plan All-Cause Readmissions (PCR)	100%	100%	*High Confidence*	100%	100%	*High Confidence*

[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 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 critical elements *Met*, *Partially Met*, and *Not Met*.

[3] **Confidence Level**— Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

Table 3-21 includes the performance indicators that will be used to track performance or improvement over the life of the PIP.

Table 3-21—Performance Indicator Results for Molina

PIP Topic	Performance Indicator	Performance Indicator Results		
		Baseline (01/01/2022–12/31/2022)	R1 (01/01/2023–12/31/2023)	R2 (01/01/2024–12/31/2024)
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit, or medication treatment within 14 days.	49.8%	47.8%	—
	The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.	31.2%	16.1%	—
Adults' Access to Preventive/Ambulatory Health Services (AAP)	The percentage of members 20 years of age and older who had an ambulatory or preventive care visit.	52.7%	56.3%	—
Child and Adolescent Well Care Visit (WCV)	The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	38.8%	43.4%	—
Follow-up After Emergency Department Visit for Mental Illness (FUM)	The percentage of ED visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness within 7 days of the ED visit.	50.8%	51.1%	—
	The percentage of ED visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness within 30 days of the ED visit.	58.0%	57.0%	—

PIP Topic	Performance Indicator	Performance Indicator Results		
		Baseline (01/01/2022–12/31/2022)	R1 (01/01/2023–12/31/2023)	R2 (01/01/2024–12/31/2024)
Prenatal and Postpartum Care (PPC)	The percentage of deliveries for which the member received a prenatal care visit in the first trimester or within 42 days of enrollment in the organization.	52.8%	59.7%	—
	The percentage of members with a delivery that had a postpartum visit on or between 7 and 84 days after delivery.	37.8%	46.4%	—
Plan All-Cause Readmissions (PCR)	For members 18 years of age and older, the percentage of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.	20.6%	10.3%	—

— The PIP had not progressed to including Remeasurement 2 results during SFY 2024. R=Remeasurement
HSAG rounded percentages to the first decimal place.

Interventions

Table 3-22 displays the barriers and interventions as documented by **Molina** for each PIP.

Table 3-22—Interventions Implemented/Planned

Barriers	Interventions
Initiation and Engagement of Substance Use Disorder Treatment (IET)	
Basic life needs are not met such as food and housing.	Referral process to SDOH team who can assist with housing, treatment enrollment, transportation, food, etc. **Revision:** Social Health Equity Navigators (replaced SDOH team in 2023) connect members with programs to reduce SDOH, working closely with our Community Engagement team and partner with providers, embedding themselves in primary care and Comprehensive Therapy Centers (CTC) offices.

Barriers	Interventions
Coexisting mental illness, ability to address both to ensure success of initiation and engagement of treatment.	Grow relationship and expand scope of Quality Partners to address SUD in addition to mental illness when they coexist.
Adults' Access to Preventive/Ambulatory Health Services (AAP)	
Provider groups unaware of assigned members, contact information, and open gaps.	Data sharing through Practice Transformation team creates and shares summary and member-level performance data.
Lack of provider incentives discouraged providers from using their manpower for additional outreach activities.	Quarter 4 Pay for Quality (P4Q) incentive program, incentivized providers to close gaps in care.
Population understanding the importance of preventive care.	Designed and implemented **Molina** Clinic Day events, Relay Health campaigns, informational mailers to educate members on the importance of preventive care, and promote member incentives.
Establishing with PCP, members unfamiliar with PCP, providers unable to contact members to schedule an appointment with newly assigned members.	Coordinate **Molina** Day events. Dedicated day(s) for **Molina** members to see PCP and receive incentives, swag, and educational materials. **Molina** resources contact members to invite them to the **Molina** Day event at the PCP's office, driving the connection between the PCP and member.
Lack of member year-over-year trends.	In an established health plan, year-over-year measure trends can assist in identifying seasonal trends and opportunities. **Molina** having launched in 2022 resulted in limited claims history to create reporting, trends, or reference "where we were this point last year." Productive HEDIS data runs began in March 2022 with dashboards and reporting insights leveraged to establish in-year trends. The insights and projection tools will continue to build accuracy until there are 3+ years' claims history available for reliable projections.
Child and Adolescent Well-Care Visit (WCV)	
Basic life needs are not met such as food and housing.	Referral process to Social Determinants of Health (SDOH) team who can assist with housing, treatment enrollment, transportation, food, etc. **Revision:** Social Health Equity Navigators (replaced SDOH team in 2023) connect members with programs to reduce SDOH, working closely with our Community Engagement team and partner with providers, embedding themselves in primary care and CTC offices.

Barriers	Interventions
Coexisting mental illness, ability to address both to ensure success of initiation and engagement of treatment.	Grow relationship and expand scope of Quality Partners to address SUD in addition to mental illness when they coexist.
Basic life needs are not met such as food and housing.	Referral process to SDOH team who can assist with housing, treatment enrollment, transportation, food, etc. **Revision:** Social Health Equity Navigators (replaced SDOH team in 2023) connect members with programs to reduce SDOH, working closely with our Community Engagement team and partner with providers, embedding themselves in primary care and CTC offices.
Coexisting mental illness, ability to address both to ensure success of initiation and engagement of treatment.	Grow relationship and expand scope of Quality Partners to address SUD in addition to mental illness when they coexist.
Provider groups unaware of assigned members, contact information, and open gaps.	Data sharing through Practice Transformation team creates and shares summary and member-level performance data.
Lack of provider incentives discouraged providers from using their manpower for additional outreach activities.	Quarter 4 Pay for Quality (P4Q) incentive program, incentivized providers to close gaps in care.
Population understanding the importance of preventive care.	Designed and implemented **Molina** Clinic Day events, Relay Health campaigns, informational mailers to educate members on the importance of preventive care and promote member incentives.
Establishing with PCP, members unfamiliar with PCP, providers unable to contact members to schedule an appointment with newly assigned members.	Coordinate **Molina** Day events. Dedicated day(s) for **Molina** members to see PCP and receive incentives, swag, and educational materials. **Molina** resources contact members to invite them to the **Molina** Day event at the PCP's office, driving the connection between the PCP and member.
Lack of member year-over-year trends.	In an established health plan, year-over-year measure trends can assist in identifying seasonal trends and opportunities. **Molina** having launched in 2022 resulted in limited claims history to create reporting, trends, or reference "where we were this point last year." Productive HEDIS data runs began in March 2022 with dashboards and reporting insights leveraged to establish in-year trends. The insights and projection tools will continue to build accuracy until there are 3+ years' claims history available for reliable projections.
Provider groups unaware of assigned members, contact information, and open gaps.	Data sharing through Practice Transformation team creates and shares summary and member-level performance data.

Barriers	Interventions
Lack of provider incentives discouraged providers from using their manpower for additional outreach activities.	Quarter 4 Pay for Quality (P4Q) incentive program, incentivized providers to close gaps in care.
Population understanding the importance of preventive care.	Designed and implemented **Molina** Clinic Day events, Relay Health campaigns, informational mailers to educate members on the importance of preventive care and promote member incentives.
Establishing with PCP, members unfamiliar with PCP, providers unable to contact members to schedule an appointment with newly assigned members.	Coordinate **Molina** Day events. Dedicated day(s) for **Molina** members to see PCP and receive incentives, swag, and educational materials. **Molina** resources contact members to invite them to the **Molina** Day event at the PCP's office, driving the connection between the PCP and member.
Lack of member year-over-year trends.	In an established health plan, year-over-year measure trends can assist in identifying seasonal trends and opportunities. **Molina** having launched in 2022 resulted in limited claims history to create reporting, trends, or reference "where we were this point last year." Productive HEDIS data runs began in March 2022 with dashboards and reporting insights leveraged to establish in-year trends. The insights and projection tools will continue to build accuracy until there are 3+ years' claims history available for reliable projections.
Financial disincentive due to salary loss experienced by members, parents, and caregivers when taking themselves or their well children for preventive care.	Offered a Healthy Rewards, Value Added Benefit (VAB), gift card for members who completed their annual well-child visit. The VAB was intended to provide financial incentive to encourage healthy behaviors and support transportation or salary loss due to the well visit. Upon a completed visit, the member would call to request VAB, **Molina** would confirm a claim for a qualifying visit, and a gift card would be mailed. During 2022, $25 VABs for well-child visits had low utilization indicating promotion, fulfillment, and incentive opportunities.
Provider disengagement due to a lack of value-based contracts (VBCs).	Implemented value-based contracts with our providers with a concentration of **Molina** members in their practices. These pay-for-performance contracts financially incentivize providers to make a concerted effort to schedule and see WCV patients prior to the end of each calendar year. The VBC methodology incentivized the provider with a dollar amount per gap closed for dates of service after 10/01/2022.

Barriers	Interventions
Lack of transportation and/or childcare financial disincentives.	Care Connections is a program that brings the medical practitioner to the member. Members targeted are in multi-child homes. Utilizes telemedicine and face-to-face encounters to increase member convenience.
As **Molina** launched, providers had limited visibility to their member panels, population trends, and/or member gaps in care; providers communicated limited ability to conduct their outreach efforts and visit opportunities.	**Molina**'s Practice Transformation (PT) team visits up to 70 of our network's medical practices each month. Practices visited have the highest number of **Molina** members compared to our other network providers and represent over 80 percent of our membership. During these meetings, PT shares reports showing a provider's monthly performance, member-specific performance, best practices, and identifies intervention opportunities.
Lack of member initiative to schedule and of health education opportunities; change in healthcare habits: Industry trends indicate members are not returning to previous healthcare practices since the public health emergency	Member Outreach and Health Education Opportunities—Parents and caregivers reminded of their children's well-care needs. Text campaign reminds parents and caregivers that their child needs to be taken in for a well-care visit. Keeps children's preventive care top of mind with parents and caregivers. The text message has been revised to generate the month preceding a child's birthday month and include the Healthy Rewards dollar amount as an additional incentive.
Lack of member initiative to schedule and of health education opportunities; new members were unfamiliar with **Molina**'s benefits and services.	Member Outreach and Health Education Opportunities—Welcome calls: Call outreach was conducted to welcome new members to the health plan, conduct health risk assessments, and assist with scheduling PCP appointments for well visits.
Lack of member initiative to schedule and of health education opportunities; not all members are able to be contacted by phone.	Member Outreach and Health Education: Social media campaigns—communicating with members who are seeking more information on **Molina** benefits. WCV Facebook Campaign on the NV account communicating the importance of child well visits and questions to ask at a child's next visit. WCV Website Banner, located on **Molina** NV website, communicating the importance of child well visits and questions to ask at a child's next visit.
As a newly launched plan, **Molina** lacked year-over-year member trends. Not having historic member/population trends limited **Molina**'s ability to determine its rates were on/off track. It also limited visibility to member patterns that help identify the most appropriate intervention strategies.	In an established health plan, year-over-year measure trends can assist in identifying seasonal trends and opportunities. **Molina** having launched in 2022 resulted in limited claims history to create reporting, trends, or reference "where we were this point last year." Production HEDIS data runs began in 03/2022 with dashboards and reporting insights leveraged to establish in-year trends. The insights and projection tools will continue to build

Barriers	Interventions
	accuracy until there are 3+ years' claims history available for reliable projections.
Financial disincentive due to salary loss experienced by members, parents, and caregivers when taking themselves or their well children for preventive care.	Offered a Healthy Rewards, Value Added Benefit (VAB), gift card for members who completed their annual well-child visit. The VAB was intended to provide financial incentive to encourage healthy behaviors and support transportation or salary loss due to the well visit. Upon a completed visit, the member would call to request VAB, **Molina** would confirm a claim for a qualifying visit, and a gift card would be mailed. During 2022, $25 VABs for well-child visits had low utilization indicating promotion, fulfillment, and incentive opportunities.
Provider disengagement due to a lack of value-based contracts (VBCs).	Implemented value-based contracts with our providers with a concentration of **Molina** members in their practices. These pay-for-performance contracts financially incentivize providers to make a concerted effort to schedule and see WCV patients prior to the end of each calendar year. The VBC methodology incentivized the provider with a dollar amount per gap closed for dates of service after 10/01/2022.
Lack of transportation and/or childcare financial disincentives.	Care Connections is a program that brings the medical practitioner to the member. Members targeted are in multi-child homes. Utilizes telemedicine and face-to-face encounters to increase member convenience.
As **Molina** launched, providers had limited visibility to their member panels, population trends, and/or member gaps in care; providers communicated limited ability to conduct their outreach efforts and visit opportunities.	**Molina**'s Practice Transformation (PT) team visits up to 70 of our network's medical practices each month. Practices visited have the highest number of **Molina** members compared to our other network providers and represent over 80 percent of our membership. During these meetings, PT shares reports showing a provider's monthly performance, member-specific performance, best practices, and identifies intervention opportunities.
Lack of member initiative to schedule and of health education opportunities; change in healthcare habits: Industry trends indicate members are not returning to previous healthcare practices since the public health emergency	Member Outreach and Health Education Opportunities—Parents and caregivers reminded of their children's well-care needs. Text campaign reminds parents and caregivers that their child needs to be taken in for a well-care visit. Keeps children's preventive care top of mind with parents and caregivers. The text message has been revised to generate the month preceding a child's birthday month and include the Healthy Rewards dollar amount as an additional incentive.

Barriers	Interventions
Lack of member initiative to schedule and of health education opportunities; new members were unfamiliar with **Molina**'s benefits and services.	Member Outreach and Health Education Opportunities—Welcome calls: Call outreach was conducted to welcome new members to the health plan, conduct health risk assessments, and assist with scheduling PCP appointments for well visits.
Lack of member initiative to schedule and of health education opportunities; not all members are able to be contacted by phone.	Member Outreach and Health Education: Social media campaigns—communicating with members who are seeking more information on **Molina** benefits. WCV Facebook Campaign on the NV account communicating the importance of child well visits and questions to ask at a child's next visit. WCV Website Banner, located on **Molina** NV website, communicating the importance of child well visits and questions to ask at a child's next visit.
As a newly launched plan, **Molina** lacked year-over-year member trends. Not having historic member/population trends limited **Molina**'s ability to determine its rates were on/off track. It also limited visibility to member patterns that help identify the most appropriate intervention strategies.	In an established health plan, year-over-year measure trends can assist in identifying seasonal trends and opportunities. **Molina** having launched in 2022 resulted in limited claims history to create reporting, trends, or reference "where we were this point last year." Production HEDIS data runs began in 03/2022 with dashboards and reporting insights leveraged to establish in-year trends. The insights and projection tools will continue to build accuracy until there are 3+ years' claims history available for reliable projections.
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	
Number of tasks to schedule a follow-up after ED visit. Steps can include a call to the health plan to find a PCP, calling the PCP to schedule an appointment (discussion regarding purpose and transportation options). Possible call for transportation and/or medication which can be overwhelming after a mental health crisis.	Have Quality Partners meet the member at the ED room for triage/discharge planning, assistance with follow-up visit, and transportation to appointment reducing the number of steps the member has to take to receive follow-up care.
Lack of engagement with PCP.	Practice Transformation Specialist provides a panel and care gap report to PCPs so offices can establish care with members.
Timeliness of Prenatal and Postpartum Care (PPC)	
Delays in identifying **Molina**'s pregnant population resulted in prenatal care occurring outside of the recommended time frame.	Socialize sources for providers to notify **Molina** of pregnant members. The Notice of Pregnancy form allows the PCP to communicate pregnancy and kicks off health plan interventions like scheduling assistance and risk assessments in a timelier manner.

Barriers	Interventions
Members disengage/unfamiliar with navigating healthcare system.	Conduct multimodal member education via social media, call outreach, and mailers communicating recommended preventive care and covered services. Promote VABs which incentivize members who successfully completed their screenings.
Molina's initiatives were focused on high-risk members. Opportunity to add initiatives to support at-risk populations like the Black/African American population. The Black/African American expectant mother may present as low risk at screening but experience change over the course of the pregnancy. Low-risk and at-risk member engagement was a missing component in the strategy. Reducing the opportunity to identify a member's change in risk over the course of her pregnancy.	Interdepartmental collaboration and vendor evaluation to increase member outreach, provider collaborations, and screenings over the course of the pregnancy. Supporting the member's access to care and changes in risk during her pregnancy.
Feedback from industry experts, doulas, and member committees indicated members' hesitation to participate in healthcare. In particular, Black/African American and Hispanic/Latina populations demonstrated reliance on recommendations from their family/community over healthcare practices.	Pregnant **Molina** members and their families joined **Molina** for a quarterly Baby Shower with games, health education information, and incentives. Invitations were prioritized toward noncompliant trends like Black/African American expectant mothers. Intent was to create community, conduct health education, and reduce a distrust in healthcare.
Providers are disengaged to participate in *PPC* interventions due to limited bandwidth and poor member contact information.	Engaged a white-glove, concierge-like clinical resource that works with members to provide prenatal and postpartum care within requisite time parameters (Ouma). Although this is a full service OB provider, the services they deliver are not intended to replace PCPs or OB/GYNs, but rather to deliver specific services and then redirect members back to their PCPs or OB/GYNs for continued care.
Plan All-Cause Readmissions (PCR)	
Black/African Americans are more likely to have a readmit than any other race.	SDOH Team assisted at-risk populations by connecting them with community-based organizations that can assist with transportation, health literacy, and any other SDOH. The SDOH team will also assess need and connect the member to case management if appropriate.
Members do not seek primary care which leads to exacerbated existing conditions or unidentified and/or untreated physical and mental health conditions.	Practice Transformation quality scorecard that allows providers to track members with open care gaps that include controlling high blood pressure, uncontrolled HbA1c, and access to ambulatory and preventive care.
Providers unaware that member has had inpatient stay, discharged, or is at risk for readmission	Case management team initiates and assists with discharge planning and collaborates with the facility and PCP, based on admission, discharge, and transfer (ADT) data they

Barriers	Interventions
	receive. Ensuring providers that are assigned members with high probability of readmit are notified of the inpatient discharge.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: The performance on all PIPs suggests a thorough application of the PIP Design. A sound design, which consists of collecting data and implementing interventions that have the potential to impact performance indicator results, created the foundation for **Molina** to progress to subsequent PIP stages and measure the desired outcomes for the project. **[Quality, Timeliness,** and **Access]**

Strength #2: Molina achieved statistically significant improvement at the first remeasurement for four of six PIPs: *Adults' Access to Preventive/Ambulatory Health Services (AAP), Child and Adolescent Well Care Visit (WCV), Prenatal and Postpartum Care (PPC),* and *Plan All-Cause Readmissions (PCR)*. **[Quality, Timeliness,** and **Access]**

Weaknesses and Recommendations

Weakness #1: Molina did not achieve statistically significant improvement for the *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)* and *Follow-up After Emergency Department Visit for Mental Illness (FUM)* PIPs. **[Quality, Timeliness,** and **Access]**

Why the weakness exists: The interventions initiated by **Molina** did not have the desired impact.

Recommendation: For the PIPs that did not achieve the desired outcome of statistically significant improvement across all performance indicators, **Molina** should revisit its causal/barrier analysis processes and current interventions to determine the possible causes for the lack of significant improvement or the decline in performance. **Molina** should use the findings from this analysis to develop new active engaging interventions or to revise current strategies to address the barriers to achieving improvement.

Performance Measure Validation

Performance Results

Table 3-23 and Table 3-24 show **Molina**'s Medicaid and Nevada Check Up HEDIS and CMS Child and Adult Core Set performance measure results for MY 2022 and MY2023, along with MY 2022 to MY 2023 rate comparisons and performance target ratings. **Molina** began accepting Medicaid members on January 1, 2022; therefore, no performance measure results are displayed for MY 2021.

Performance for MY 2023 (SFY 2024) is indicated by symbols and font style; **bolded** rates indicate the rate met or exceeded the DHCFP-established MPS[17], ↑ indicates the rate was above the national Medicaid 50th percentile benchmark, and ↓ indicates the rate was below the national 50th percentile benchmark, **green** shading indicates that the rate improved by 5 percentage points from the prior year, and **red** shading indicates that the rate declined by 5 percentage points from the prior year.

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

Table 3-23—Medicaid SFY 2024 Performance Measure Results for Molina

HEDIS Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	MY 2022–MY 2023 Rate Comparison
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services (AAP)				
(20–44 Years)	—	51.45%	55.02%↓	3.57
(45–64 Years)	—	55.74%	59.51%↓	3.77
(65+ Years)	—	50.27%	46.99%↓	-3.28
(Total)	—	52.66%	56.27%↓	3.61
Children's Preventive Care				
Child and Adolescent Well-Care Visits (WCV)				
(3–11 Years)	—	44.09%	48.58%↓	4.49
(12–17 Years)	—	39.84%	43.84%↓	4.00
(18–21 Years)	—	17.00%	21.99%↓	4.99

[17] Refer to *Appendix B. Goals and Objectives Tracking* for measures with an established MPS. Not all measure rates reported by the MCO have a DHCFP-established MPS.

HEDIS Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	MY 2022–MY 2023 Rate Comparison
Total	—	38.84%	43.38%↓	4.54
Childhood Immunization Status (CIS)				
Combination 3	—	47.60%	45.50%↓	-2.10
Combination 7	—	43.67%	39.17%↓	-4.50
Combination 10	—	14.85%	15.09%↓	0.24
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	—	74.49%	80.92%↑	6.43
Combination 2 (Meningococcal, Tdap, HPV)	—	28.34%	28.52%↓	0.18
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile Documentation (Total)	—	72.26%	82.48%↑	10.22
Counseling for Nutrition (Total)	—	66.91%	74.45%↑	7.54
Counseling for Physical Activity (Total)	—	64.23%	72.75%↑	8.52
Well-Child Visits in the First 30 Months of Life (W30)				
(First 15 Months)	—	NA	45.23%↓	NC
(15 Months–30 Months)	—	NA	54.05%↓	NC
Developmental Screening in the First Three Years of Life (DEV-CH)				
(1 Year)	—	—	20.60%	NC
(2 Years)	—	—	38.61%	NC
(3 Years)	—	—	31.89%	NC
(Total)	—	—	30.58%	NC
Lead Screening in Children (LSC)				
Lead Screening in Children	—	—	24.09%↓	NC
Women's Health and Maternity Care				
Breast Cancer Screening (BCS-E)				
Breast Cancer Screening	—	NA	NA	NC
Chlamydia Screening in Women (CHL)				
(16–20 Years)	—	47.81%	50.34%↓	2.53
(21–24 Years)	—	61.21%	62.62%↑	1.41
(Total)	—	55.33%	57.06%↑	1.73

HEDIS Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	MY 2022–MY 2023 Rate Comparison
Postpartum Depression Screening and Follow-Up (PDS-E)				
Depression Screening	—	0.00%	0.12%↑	0.12
Follow–Up on Positive Screen	—	NA	NA	NC
Prenatal and Postpartum Care (PPC)				
Timeliness of Prenatal Care	—	64.96%	75.43%↓	10.47
Postpartum Care	—	49.88%	57.91%↓	8.03
Prenatal and Postpartum Care (PPC2-CH)				
Timeliness of Prenatal Care—Under 21 Years	—	—	54.73%	NC
Postpartum Care—Under 21 Years	—	—	45.27%	NC
Prenatal Depression Screening and Follow-Up (PND-E)				
Depression Screening	—	0.00%	1.48%↑	1.48
Follow–Up on Positive Screen	—	NA	NA	NC
Prenatal Immunization Status (PRS-E)				
Influenza	—	5.04%	9.77%↓	4.73
Tdap	—	13.55%	21.98%↓	8.43
Combination	—	3.30%	6.81%↓	3.51
Contraceptive Care—Postpartum Women (CCP-CH)				
Most or Moderately Effective Contraception—3 Days—(15–20 Years)	—	—	0.00%	NC
Most or Moderately Effective Contraception—90 Days—(15–20 Years)	—	—	33.96%	NC
Long-Acting Reversible Contraception—3 Days—(15–20 Years)	—	—	0.00%	NC
Long-Acting Reversible Contraception—90 Days—(15–20 Years)	—	—	13.21%	NC
Contraceptive Care—All Women (CCW-CH)				
Most or Moderately Effective Contraception—(15–20 Years)	—	—	10.68%	NC
Long-Acting Reversible Contraception—(15–20 Years)	—	—	1.23%	NC

HEDIS Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	MY 2022–MY 2023 Rate Comparison
Care for Chronic Conditions				
Asthma Medication Ratio (AMR)				
(5–11 Years)	—	NA	67.44%↓	NC
(12–18 Years)	—	NA	52.78%↓	NC
(5-18 years) Child Core Set	—	NA	60.76%	NC
(19–50 Years)	—	NA	44.50%↓	NC
(51–64 Years)	—	NA	43.66%↓	NC
(19–64 years) Adult Core Set	—	NA	44.29%	NC
(Total)	—	NA	50.11%↓	NC
Blood Pressure Control for Patients With Diabetes (BPD)				
Blood Pressure Control for Patients With Diabetes	—	44.77%	48.18%↓	3.41
Controlling High Blood Pressure (CBP)				
Controlling High Blood Pressure	—	44.04%	45.01%↓	0.97
Hemoglobin A1c Control for Patients With Diabetes (HBD)				
*HbA1c Control (>9.0%)**	—	62.29%	53.04%↓	-9.25
HbA1c Control (<8%)	—	31.14%	42.34%↓	11.20
Behavioral Health				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	—	44.50%	38.90%↓	-5.60
Antidepressant Medication Management (AMM)				
Effective Acute Phase Treatment	—	48.41%	51.83%↓	3.42
Effective Continuation Phase Treatment	—	31.21%	34.41%↓	3.20
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	73.58%	75.90%↓	2.32
Follow-Up After Emergency Department Visit for Substance Use (FUA)				
7 days (Total)	—	19.89%	17.78%↓	-2.11

HEDIS Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	MY 2022–MY 2023 Rate Comparison
30 days (Total)	—	27.45%	26.53%↓	-0.92
Follow-Up After Emergency Department Visit for Mental Illness (FUM)				
7 days (Total)	—	50.78%	**51.13%**↑	0.35
30 days (Total)	—	58.01%	**56.98%**↑	-1.03
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)				
7 Days (Total)	—	27.84%	19.81%↓	-8.03
30 days (Total)	—	42.66%	33.96%↓	-8.70
Follow-Up After Hospitalization for Mental Illness (FUH)				
7 days (Total)	—	25.29%	30.12%↓	4.83
30 days (Total)	—	41.30%	47.85%↓	6.55
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
Initiation Phase	—	NA	47.01%↑	NC
Continuation and Maintenance Phase	—	NA	NA	NC
Initiation and Engagement of Substance Use Disorder Treatment (IET)				
Initiation of SUD Treatment—Total (Total)	—	49.79%	**47.82%**↑	-1.97
Engagement of SUD Treatment—Total (Total)	—	13.20%	16.07%↑	2.87
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)				
Blood Glucose and Cholesterol Testing (Total)	—	37.88%	32.00%↓	-5.88
Screening for Depression and Follow-Up Plan (CDF-CH/CDF-AD) ∞				
(12–17 Years)	—	0.92%	1.87%	0.95
(18–64 Years)	—	2.10%	7.67%	5.57
(65+ Years)	—	2.00%	9.09%	7.09
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)				
(1–11 Years)	—	NA	NA	NC
(12–17 Years)	—	59.38%	58.82%↓	-0.56
(Total)	—	64.44%	50.88%↓	-13.56
Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)				
Rate 1: Total	—	57.58%	57.94%	0.36
Rate 2: Buprenorphine	—	25.00%	28.41%	3.41

HEDIS Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	MY 2022–MY 2023 Rate Comparison
Rate 3: Oral Naltrexone	—	3.28%	3.36%	0.08
Rate 4: Long-Acting, Injectable Naltrexone	—	1.02%	1.34%	0.32
Rate 5: Methadone	—	33.81%	30.43%	-3.38
Diabetes Care for People With Serious Mental Illness: Hemoglobin A1c Poor Control (>9.0%) (HPCMI-AD)*				
(18–64 Years)	—	—	64.07%	NC
(65–75 Years)	—	—	NA	NC
Utilization				
Ambulatory Care—Total (per 1,000 Member Years) (AMB)				
*ED Visits—Total**	—	593.41	579.93	-13.48
Outpatient Visits—Total	—	2,175.17	2,461.55	NC
Plan All-Cause Readmissions (PCR)				
*Observed Readmissions Total—(18–64 Years)**	—	20.55%	**10.29%**	-10.26
Expected Readmissions—(18–64 Years)	—	10.32%	9.23%	-1.09
O/E Ratio Total—(18–64 Years)	—	1.992	1.1144	-0.8776
Outliers Total—(18–64 Years)	—	0.00	63.06	63.06
Overuse/Appropriateness of Care				
Risk of Continued Opioid Use (COU)*				
>=15 Days (Total)	—	8.06%	8.06%↓	0.00
>=31 Days (Total)	—	6.19%	6.35%↓	0.16
Use of Opioids at High Dosage (HDO)*				
Use of Opioids at High Dosage	—	11.50%	10.73%↓	-0.77
Use of Opioids From Multiple Providers (UOP)*				
Multiple Prescribers	—	20.99%	**21.56%**↓	0.57
Multiple Pharmacies	—	1.52%	1.01%↑	-0.51
Multiple Prescribers and Multiple Pharmacies	—	0.72%	0.28%↑	-0.44
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)				
(3 Months–17 Years)	—	NA	71.28%↓	NC
(18–64 Years)	—	NA	51.85%↑	NC

HEDIS Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	MY 2022–MY 2023 Rate Comparison
(65+ Years)	—	NA	NA	NC
(Total)	—	NA	64.49%↑	NC

↑ Indicates the MY 2023 rate was above NCQA's Quality Compass 2023 Medicaid HMO 50th percentile benchmark.
↓ Indicates the MY 2023 rate was below NCQA's Quality Compass 2023 Medicaid HMO 50th percentile benchmark.
* A lower rate indicates better performance for this measure or indicator.
** Beginning MY 2022, this rate was reported per 1,000 member years instead of per 1,000 member months; the rates for MY 2021 were converted to member years for comparison.
— Indicates that the MCO was not previously required to report this measure or that the rate is not appropriate to display due to changes in the technical specifications resulting in a break in trending.
∞ MCOs reported *CDF—18—64 years* and *CDF—65 years and older* to align with the CMS Adult Core Set FFY 2024 technical specifications. HSAG will assess each indicator separately to determine if the MCOs met or exceeded DHCFP's QISMC goal for *CDF—18 years and older.*
NC indicates the MY 2022–MY 2023 Rate Comparison could not be calculated because data are not available for both years.
NA indicates that the MCO followed the specifications, but the denominator was too small (i.e., <30) to report a valid rate.
Bolded rates indicate that the MY 2023 performance measure rate met or exceeded the DHCFP-established MPS.

Indicates that the MY 2023 rate declined by 5 percentage points or more from MY 2022.

Indicates that the MY 2023 rate improved by 5 percentage points or more from MY 2022.

Table 3-24—Nevada Check Up SFY 2024 Performance Measure Results for Molina

HEDIS Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	MY 2022–MY 2023 Rate Comparison
Children's Preventive Care				
Child and Adolescent Well-Care Visits (WCV)				
(3–11 Years)	—	44.36%	49.33%↓	4.97
(12–17 Years)	—	46.40%	46.81%↓	0.41
(18–21 Years)	—	32.52%	33.20%↑	0.68
Total	—	44.33%	46.96%↓	2.63
Childhood Immunization Status (CIS)				
Combination 3	—	NA	76.79%↑	NC
Combination 7	—	NA	**76.79%**↑	NC
Combination 10	—	NA	33.93%↑	NC

HEDIS Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	MY 2022–MY 2023 Rate Comparison
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	—	NA	88.69%↑	NC
Combination 2 (Meningococcal, Tdap, HPV)	—	NA	36.31%↑	NC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile Documentation (Total)	—	78.35%	80.05%↑	1.7
Counseling for Nutrition (Total)	—	69.34%	68.37%↓	-0.97
Counseling for Physical Activity (Total)	—	66.18%	64.96%↓	-1.22
Well-Child Visits in the First 30 Months of Life (W30)				
(First 15 Months)	—	NA	40.00%↓	NC
(15 Months–30 Months)	—	NA	62.22%↓	NC
Developmental Screening in the First Three Years of Life (DEV-CH)				
(1 Year)	—	—	NA	NC
(2 Years)	—	—	53.57%	NC
(3 Years)	—	—	33.33%	NC
(Total)	—	—	41.13%	NC
Lead Screening in Children (LSC)				
Lead Screening in Children	—	—	42.86%↓	NC
Women's Health and Maternity Care				
Chlamydia Screening in Women (CHL)				
(16–20 Years)	—	26.87%	**49.30%↓**	22.43
(21–24 Years)	—	NA	NA	NC
(Total)	—	26.87%	49.30%↓	22.43
Prenatal and Postpartum Care (PPC)				
Timeliness of Prenatal Care	—	—	NA	NC
Postpartum Care	—	—	NA	NC
Prenatal and Postpartum Care (PPC2-CH)				
Timeliness of Prenatal Care—Under 21 Years	—	—	NA	NC
Postpartum Care—Under 21 Years	—	—	NA	NC

HEDIS Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	MY 2022–MY 2023 Rate Comparison
Contraceptive Care—Postpartum Women (CCP-CH)				
Most or Moderately Effective Contraception—3 Days—(15–20 Years)	—	—	NA	NC
Most or Moderately Effective Contraception—90 Days—(15–20 Years)	—	—	NA	NC
Long-Acting Reversible Contraception—3 Days—(15–20 Years)	—	—	NA	NC
Long-Acting Reversible Contraception—90 Days—(15–20 Years)	—	—	NA	NC
Contraceptive Care—All Women (CCW-CH)				
Most or Moderately Effective Contraception—(15–20 Years)	—	—	6.85%	NC
Long-Acting Reversible Contraception—(15–20 Years)	—	—	0.81%	NC
Care for Chronic Conditions				
Asthma Medication Ratio (AMR)				
(5–11 Years)	—	NA	NA	NC
(12–18 Years)	—	NA	NA	NC
(5–18 years) Child Core Set	—	NA	NA	NC
(19–50 Years)	—	NA	NA	NC
(51–64 Years)	—	NA	NA	NC
(19–64 years) Adult Core Set	—	NA	NA	NC
(Total)	—	NA	NA	NC
Behavioral Health				
Follow-Up After Emergency Department Visit for Substance Use (FUA)				
7 days (Total)	—	NA	NA	NC
30 days (Total)	—	NA	NA	NC
Follow-Up After Emergency Department Visit for Mental Illness (FUM)				
7 days (Total)	—	NA	NA	NC
30 days (Total)	—	NA	NA	NC
Follow-Up After Hospitalization for Mental Illness (FUH)				
7 days (Total)	—	NA	NA	NC

HEDIS Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	MY 2022–MY 2023 Rate Comparison
30 days (Total)	—	NA	NA	NC
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
Initiation Phase	—	NA	NA	NC
Continuation and Maintenance Phase	—	NA	NA	NC
Initiation and Engagement of Substance Use Disorder Treatment (IET)				
Initiation of SUD Treatment—Total (Total)	—	NA	NA	NC
Engagement of SUD Treatment—Total (Total)	—	NA	NA	NC
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)				
Blood Glucose and Cholesterol Testing (Total)	—	NA	NA	NC
Screening for Depression and Follow-Up Plan (CDF-CH/CDF-AD)				
(12–17 Years)	—	0.60%	1.23%	0.63
(18–64 Years)	—	0.46%	4.41%	3.95
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)				
(1–11 Years)	—	NA	NA	NC
(12–17 Years)	—	NA	NA	NC
(Total)	—	NA	NA	NC
Utilization				
Ambulatory Care—Total (per 1,000 Member Years) (AMB)*				
*ED Visits—Total**	—	279.64	272.41	-7.23
Outpatient Visits—Total	—	1,973.16	2,011.34	NC
Overuse/Appropriateness of Care				
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)				
(3 Months–17 Years)	—	—	NA	NC
(18–64 Years)	—	—	NA	NC
(Total)	—	—	NA	NC

↑ Indicates the MY 2023 rate was above NCQA's Quality Compass 2023 Medicaid HMO 50th percentile benchmark.
↓ Indicates the MY 2023 rate was below NCQA's Quality Compass 2023 Medicaid HMO 50th percentile benchmark.
* A lower rate indicates better performance for this measure or indicator.
** Beginning MY 2022, this rate was reported per 1,000 member years instead of per 1,000 member months; the rates for MY 2021 r were converted to member years for comparison.

— Indicates that the MCO was not previously required to report this measure or that the rate is not appropriate to display due to changes in the technical specifications resulting in a break in trending.
NC indicates the MY 2022–MY 2023 Rate Comparison could not be calculated because data are not available for both years.
NA indicates that the MCO followed the specifications, but the denominator was too small (i.e., <30) to report a valid rate.
Bolded rates indicate that the MY 2023 performance measure rate met or exceeded the DHCFP-established MPS.
Indicates that the MY 2023 rate improved by 5 percentage points or more from MY 2022.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Within the Behavioral Health domain for **Molina**'s Medicaid population, the *Follow-Up After Emergency Department Visit for Mental Illness* measure indicators and *Initiation and Engagement of Substance Use Disorder Treatment—Initiation of SUD Treatment—Total* measure indicator, which are all tied to QISMC goals, met the state established MPS. This performance suggests **Molina** continues ensuring that its Medicaid members with behavioral health and SUDs receive appropriate care, which potentially leads to reduced costs resulting from ED visits and inpatient stays. **[Quality, Timeliness,** and **Access]**

Strength #2: Within the Utilization domain, **Molina**'s Medicaid rate for the *Plan All-Cause Readmissions—Observed Readmissions* measure indicator, which is tied to a QISMC goal, met the State's established MPS. This performance suggests **Molina**'s adequate quality of care in the hospital as well as appropriate post-discharge planning and care coordination. Additionally, by decreasing use of the ED for nonurgent conditions and increased use of outpatient visits, **Molina** demonstrates reduced risk of excessive healthcare spending, reduced risk of unnecessary testing and treatment, and enhancement of stronger patient-primary care provider relationships. **[Quality, Timeliness,** and **Access]**

Weaknesses and Recommendations

Weakness #1: Within the Access to Care, Children's Preventive Care, and Women's Health and Maternity Care domains for **Molina**'s Medicaid population, no measure indicator rates with a QISMC goal met the State's established MPS. Further, within the Children's Preventive Care and Women's Health and Maternity Care domains for **Molina**'s Nevada Check Up population, no measure indicator rates with a QISMC goal except for the *Childhood Immunization Status—Combination 7* and *Chlamydia Screening in Women—16-20 years* measure indicators met the State's established MPS. **[Quality, Timeliness,** and **Access]**

Why the weakness exists: Although **Molina**'s Medicaid and Nevada Check Up members appear to have access to PCPs for preventive and ambulatory services, as well as children's and women's

preventive services, these members were not consistently utilizing these services, which can significantly reduce nonurgent ED visits and potentially prevent more serious health and development issues from occurring, reducing healthcare costs. The low performance in these domains could also be due to disparities in **Molina**'s populations that could impact access to care, such as language barriers, access to transportation, geographic location, and socioeconomic status.

Recommendation: Molina self-reported several improvement strategies based on race/ethnicity, age group, and ZIP Code analyses, including a focus on Prenatal and Postpartum Care to black/African American members. **Molina** launched a telehealth maternal fetal medicine group and referred 100 percent of Molina's black/African American identified pregnancies for telehealth care. In addition, **Molina** focused on Children's Preventive Care by launching the Regional Transportation Commission (RTC) bus shelter poster in 2024. **Molina** identified four ZIP Codes with disparate populations and placed bus shelter posters in the transit lines of these ZIP Codes. **Molina** reported raising awareness, connecting members to care, and reminding members about available member incentives. HSAG recommends that **Molina** continue these initiatives and where possible, identify and measure effectiveness of interventions by establishing baseline and remeasurement metrics. HSAG recommends that **Molina** develop additional improvement strategies to target performance measures in the Access to Care and Children's Preventive Care domains.

Weakness #2: Within the Care for Chronic Conditions domain, no measure indicator rates with a QISMC goal met the State's established MPS for **Molina**'s Medicaid or Nevada Check Up populations. **[Quality, Timeliness,** and **Access]**

Why the weakness exists: Low performance could be due to disparities within its populations that could impact access to care, such as language barriers, access to transportation, geographic location, and socioeconomic status. Declines in the *Asthma Medication Ratio* rates indicate children and adolescents with persistent asthma are not consistently receiving appropriate monitoring of their medications, which could be due to barriers to care. Appropriate medication management for patients with asthma could reduce the need for rescue medication, as well as costs associated with ED visits, inpatient admissions, and missed days of work or school.

Recommendation: Molina self-reported several improvement strategies based on race/ethnicity, age group, and ZIP Code analyses. HSAG recommends that **Molina** continue these initiatives and where possible, identify and measure effectiveness of interventions by establishing baseline and remeasurement metrics. Regarding *Asthma Medication Ratio*, HSAG recommends that **Molina** provide education to providers about establishing an asthma action plan with members.[18] HSAG also recommends that **Molina** use pharmacy data to identify members outside the asthma medication ratio and prioritize case management services to these members. Further, HSAG recommends that **Molina** provide member education about medication adherence.

[18] Asthma and Allergy Foundation of America. "Asthma Action Plan." Available at: https://aafa.org/asthma/asthma-treatment/asthma-treatment-action-plan/. Accessed on Oct 23, 2024.

Compliance Review

Performance Results

Table 3-25 presents an overview of the results of the standards reviewed during the SFY 2024 compliance review for **Molina**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Appendix A. If a requirement was not applicable to **Molina** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all seven standards.

Table 3-25—Summary of Standard Compliance Scores

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Disenrollment: Requirements and Limitations	6	6	6	0	0	**100%**
Standard II—Member Rights and Member Information	24	23	18	5	1	**78%**
Standard III—Emergency and Poststabilization Services	13	13	13	0	0	**100%**
Standard IV—Availability of Services	12	12	10	2	0	**83%**
Standard V—Assurances of Adequate Capacity and Services	5	5	5	0	0	**100%**
Standard VI—Coordination and Continuity of Care	28	28	26	2	0	**93%**
Standard VII—Coverage and Authorization of Services	27	27	23	4	0	**85%**
Total	**115**	**114**	**101**	**13**	**1**	**89%**

M = Met*; *NM = Not Met*; *NA = Not Applicable

Total Elements: The total number of elements within each standard.

Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

Based on the findings from the SFY 2024 compliance review activity, **Molina** was required to develop and submit a CAP for each element assigned a score of *Not Met*. The CAP was reviewed by DHCFP and HSAG for sufficiency, and **Molina** was responsible for implementing each action plan in a timely manner.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Molina achieved full compliance for the Disenrollment: Requirements and Limitations program area, demonstrating that the MCO had appropriate processes and procedures in place related to member and MCO requests for disenrollment. **[Quality]**

Strength #2: Molina achieved full compliance for the Emergency and Poststabilization Services program area, demonstrating that the MCO had adequate processes in place to ensure appropriate coverage of and payment for emergency and poststabilization care services. [**Timeliness** and **Access**]

Strength #3: Molina achieved full compliance for the Assurances of Adequate Capacity and Services program area, demonstrating that the MCO had policies and processes in place to maintain and monitor an adequate provider network to provide adequate access to all services (e.g., primary care, specialty care, hospital and emergency services, behavioral health, and prenatal care) for its membership. **[Timeliness** and **Access]**

Weaknesses and Recommendations

Weakness #1: Molina had five elements in the Member Rights and Member Information program area that received a score of *Not Met*, indicating that members may not be notified of or receive required member materials and information timely. [**Timeliness** and **Access**]

Why the weakness exists: Molina did not demonstrate that all member materials adhered to State and federal requirements, that members were notified of the time frame for receiving a member handbook upon member's request, or that it had a documented process for timely notification to members of a significant change to the member handbook.

Recommendation: While **Molina** was required to develop a CAP to address the deficiencies identified, HSAG recommends that the MCO conduct a comprehensive review of its member-facing materials and its processes and procedures related to member information to identify whether additional opportunities for improvement in this program area exist and take remedial action as necessary.

Weakness #2: Molina had four elements in the Coverage and Authorization of Services program area that received a score of *Not Met*, indicating members may not consistently receive timely and adequate notice of authorization decisions, including decisions that result in an adverse benefit determination to the member. **[Quality** and **Timeliness]**

Why the weakness exists: **Molina** did not consistently adhere to requirements related to the timing of authorization decisions (i.e., expedited, advance notice) and the timing and content of notices of adverse benefit determination.

Recommendation: While **Molina** was required to develop a CAP to address the deficiencies identified, HSAG recommends that the MCO continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to coverage and authorization of services.

Network Adequacy Validation

Performance Results

HSAG determined that the providers per 1,500 members in Clark and Washoe counties exceeded DHCFP's requirements. Table 3-26 presents results by the number of providers per 1,500 members in Clark and Washoe counties and by the DHCFP-required provider types.

Table 3-26 presents **Molina**'s network adequacy results for Provider-to-Member Ratios.

Table 3-26—Molina Provider-to-Member Ratios by Provider Type by County

Provider Type	Indicator	Providers per 1,500 Members (Clark County)	Providers per 1,500 Members (Washoe County)
PCP not practicing in conjunction with healthcare professional*	1:1,500	7.73	13.37
Specialists	1:1,500	39.47	81.55

* If the PCP practices in conjunction with a healthcare professional (i.e., nurse practitioner or physician's assistant), the ratio is increased to one FTE PCP for every 1,800 members. DHCFP's 402 network adequacy reporting template did not break out PCP practices in conjunction with a healthcare professional.

DHCFP established a 100 percent threshold when determining compliance with time or distance standards. HSAG determined that indicators that fell below the 100 percent threshold achieved greater than or equal to 96.2 percent compliance with access standards. Table 3-27 presents results by percentage of members with access across Clark and Washoe counties and by the DHCFP-established provider categories. Results that achieved the 100 percent access threshold are shaded **green**.

Table 3-27 presents **Molina**'s network adequacy results for Time or Distance.

Table 3-27—Molina Percentage of Members With Access by Provider Category by County

Provider Category	Time or Distance Indicator	Percentage of Members With Access (Clark County)	Percentage of Members With Access (Washoe County)
Primary Care, Adults	10 miles or 15 minutes	99.9%	99.6%

Provider Category	Time or Distance Indicator	Percentage of Members With Access (Clark County)	Percentage of Members With Access (Washoe County)
OB/GYN (Adult Females)	10 miles or 15 minutes	99.6%	96.2%
Pediatrician	10 miles or 15 minutes	99.9%	99.7%
Endocrinologist	40 miles or 60 minutes	99.9%	100%
Endocrinologist, Pediatric	40 miles or 60 minutes	100%	100%
Infectious Disease	40 miles or 60 minutes	99.9%	100%
Infectious Disease, Pediatric	40 miles or 60 minutes	100%	100%
Rheumatologist	40 miles or 60 minutes	99.9%	100%
Rheumatologist, Pediatric	40 miles or 60 minutes	100%	100%
Oncologist/Radiologist	40 miles or 60 minutes	99.9%	100%
Oncologist/Radiologist, Pediatric	30 miles or 45 minutes	100%	100%
Oncologist—Medical/Surgical	30 miles or 45 minutes	99.9%	99.9%
Oncologist—Medical/Surgical, Pediatric	30 miles or 45 minutes	100%	99.9%
Psychologist	30 miles or 45 minutes	100%	99.9%
Psychologist, Pediatric	30 miles or 45 minutes	100%	99.9%
Psychiatrist	30 miles or 45 minutes	99.9%	99.9%
Board Certified Child and Adolescent Psychiatrist	30 miles or 45 minutes	100%	99.9%
Qualified Mental Health Professional (QMHP)	30 miles or 45 minutes	99.9%	100%
QMHP, Pediatric	30 miles or 45 minutes	100%	100%
Hospital, All	30 miles or 45 minutes	99.9%	100%
Psychiatric Inpatient Hospital	30 miles or 45 minutes	99.9%	99.9%

Provider Category	Time or Distance Indicator	Percentage of Members With Access (Clark County)	Percentage of Members With Access (Washoe County)
Dialysis/End Stage Renal Disease (ESRD) Facility	30 miles or 45 minutes	99.9%	99.9%
Pharmacy	10 miles or 15 minutes	99.9%	99.7%

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Molina established robust processes to mitigate missing or incomplete data from the 834 eligibility and enrollment files by generating fallout or exceptions reports, which were manually reviewed and resolved within two business days following receipt. Manually edited member enrollment records were audited through random sampling logic to ensure ongoing accuracy and completeness of data. **[Quality** and **Access]**

Weaknesses and Recommendations

Weakness #1: Although **Molina** was able to apply the necessary corrections for final reporting, HSAG observed that **Molina** was not applying the correct parameters when calculating and determining compliance with the GeoAccess standards. Molina was applying "and" versus "or" to its network adequacy calculation methodology. **[Quality** and **Access]**

Why the weakness exists: DHCFP's contract with the MCOs includes a table labeled, "Maximum Time *and* Distance Standards"; however, HSAG confirmed with DHCFP that the time and distance standards are to be "or" versus "and." **Molina** was applying the "and" methodology based on language in the contract and unclear guidance in the network adequacy reporting template required by DHCFP to be used by the MCO when reporting network adequacy compliance.

Recommendation: HSAG recommends that **Molina** conduct a quarterly review of DHCFP reporting requirements and/or consult with DHCFP to ensure accurate understanding of DHCFP's required methodology for calculating network adequacy. Additionally, HSAG recommends that **Molina** build in additional layers of validation to ensure logic and parameters used to inform calculations are in alignment with DHCFP's network adequacy calculation requirements. Finally, HSAG recommends that **Molina** ensure internal process flows are documented to reflect changes year over year.

Weakness #2: Although Molina was able to apply the necessary corrections for final reporting, HSAG observed **Molina** was not separating the adult and pediatric populations for a subset of provider categories as well as not reporting inpatient psychiatric hospitals separately as required by DHCFP. **[Quality** and **Access]**

Why the weakness exists: DHCFP's network adequacy reporting template was not structured to allow for MCO reporting of both adult and pediatric populations for DHCFP-specified provider categories. The network adequacy reporting template also did not include a place for **Molina** to report inpatient psychiatric hospitals.

Recommendation: HSAG recommends that **Molina** work with DHCFP on future template updates to ensure all DHCFP reporting requirements are captured on the reporting template, including the necessary population stratifications.

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results

Table 3-28 presents the 2024 CAHPS top-box scores for **Molina**'s adult Medicaid, general child Medicaid, CCC Medicaid, Nevada Check Up general child, and Nevada Check Up CCC populations. Arrows (↓ or ↑) indicate 2024 scores that were statistically significantly higher or lower than the 2023 national average.[19]

Table 3-28—Summary of 2024 CAHPS Top-Box Scores for Molina

	Adult Medicaid	General Child Medicaid	CCC Medicaid	Nevada Check Up General Child	Nevada Check Up CCC
Composite Measures					
Getting Needed Care	NA	NA	NA	NA	NA
Getting Care Quickly	NA	NA	NA	NA	NA
How Well Doctors Communicate	NA	NA	NA	NA	NA
Customer Service	NA	NA	NA	NA	NA
Global Ratings					
Rating of All Health Care	NA	NA	NA	NA	NA
Rating of Personal Doctor	NA	69.00%	NA	NA	NA
Rating of Specialist Seen Most Often	NA	NA	NA	NA	NA
Rating of Health Plan	51.46% ↓	56.69% ↓	NA	NA	NA

[19] 2024 national average results were not available at the time this report was produced.

	Adult Medicaid	General Child Medicaid	CCC Medicaid	Nevada Check Up General Child	Nevada Check Up CCC
Medical Assistance with Smoking and Tobacco Use Cessation Measure Items*					
Advising Smokers and Tobacco Users to Quit	NA	—	—	—	—
Discussing Cessation Medications	NA	—	—	—	—
Discussing Cessation Strategies	NA	—	—	—	—
CCC Composite Measures/Items					
Access to Specialized Services	—	—	NA	—	NA
Family Centered Care (FCC): Personal Doctor Who Knows Child	—	—	NA	—	NA
Coordination of Care for Children With Chronic Conditions	—	—	NA	—	NA
Access to Prescription Medicines	—	—	NA	—	NA
FCC: Getting Needed Information	—	—	NA	—	NA

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

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

↑ Indicates the 2024 score is statistically significantly higher than the 2023 national average.

↓ Indicates the 2024 score is statistically significantly lower than the 2023 national average.

— Indicates the measure does not apply to the population.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: HSAG did not identify any strengths for **Molina** for the CAHPS surveys as no scores were statistically significantly higher than the 2023 NCQA Medicaid national average. **[Quality, Timeliness,** and **Access]**

Weaknesses and Recommendations

Weakness #1: Adult members and parents/caretakers of general child Medicaid members had less positive overall experiences with their child's health plan since the scores for this measure were statistically significantly lower than the 2023 NCQA Medicaid national averages. **[Quality]**

Why the weakness exists: Adult members and parents/caretakers of child members may have a difficult time getting an appointment with their child's provider or may have to talk to more than one provider, and **Molina**'s providers may not be aware of all the needs of their members; as a result, they may not be providing the consultative care required. Additionally, providers may not be spending enough quality time with adult members/child members or the parents/caretakers, or not satisfactorily addressing their needs, and adult members and parents/caretakers of child members may experience barriers to receiving timely care that could contribute to their overall perception of their child's health plan.

Recommendation: HSAG recommends that **Molina** include reminders about the importance of improving communication with patients from different cultures, handling challenging patient encounters, and emphasizing patient-centered communication for members. Patient-centered communication could have a positive impact on patient experience, adherence to treatments, and self-management of conditions. Indicators of good physician communication skills include providing clear explanations, listening carefully, checking for understanding, and being considerate of members' perspectives. Additionally, **Molina** could consider any barriers to receiving timely care from specialists that may result in lower levels of experience. **Molina** also could consider obtaining feedback from patients on their recent office visit, such as a follow-up call or email, to gather more specific information concerning areas for improvement and implement strategies of quality improvement to address these concerns.

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

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

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

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

HSAG performed a comprehensive assessment of **Molina**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **Molina** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **Molina**'s overall performance contributed to the Nevada Managed Care Program's progress in achieving the Nevada Quality Strategy goals and objectives. Table 3-29 displays each Nevada Quality Strategy goal and EQR activity results that indicate whether the MCO positively (✓) or negatively (✗) impacted the Nevada Managed Care Program's progress toward achieving the applicable goals and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **Molina**'s Medicaid members.

Table 3-29—Overall Performance Impact to Nevada Quality Strategy and Quality, Timeliness, and Access

	Quality Strategy Goals	Performance Impact on Goals and Objectives	
1	Improve the health and wellness of Nevada's Medicaid population by increasing the use of preventive services by December 31, 2024	✗	0/17 applicable Medicaid rates met the MPS
		✓	2/14 applicable Nevada Check Up rates met the MPS
		✗	12/14 applicable Nevada Check Up rates did not meet the MPS
2	Increase use of evidence-based practices for members with chronic conditions by December 31, 2024	✓	1/7 Medicaid rates met the MPS
		✗	6/7 Medicaid rates did not meet MPS
		✗	0/1 applicable Nevada Check Up rate did not meet the MPS
3	Reduce misuse of opioids by December 31, 2024	✓	1/4 Medicaid rates met the MPS
		✗	3/4 Medicaid rates did not meet MPS
4	Improve the health and wellness of pregnant women and infants by December 31, 2024	✗	0/5 applicable Medicaid rates did not meet the MPS
5	Increase use of evidence-based practices for members with behavioral health conditions by December 31, 2024	✓	3/20 applicable Medicaid rates met the MPS
		✗	17/20 applicable Medicaid rates did not meet the MPS
		✗	0/2 applicable Nevada Check Up rates met the MPS
6	Increase utilization of dental services by December 31, 2024	Not applicable to the MCO	
7	Reduce and/or eliminate health care disparities for Medicaid members by December 31, 2024	✓	3/3 objectives received a *Met* designation

SilverSummit Healthplan, Inc.

Validation of Performance Improvement Projects

Performance Results

Table 3-30 displays the overall validation status for the Design and Implementation stages of each PIP topic for the SFY 2023 PIP activity, which concluded in December 2023.

Table 3-30—2023 Overall Validation Ratings* for SilverSummit

Name of Project	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Overall Validation Status[3]
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	93%	100%	*Met*
Adults' Access to Preventive/Ambulatory Health Services (AAP)	93%	100%	*Met*
Child and Adolescent Well-Care Visit (WCV)	93%	100%	*Met*
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	93%	100%	*Met*
Prenatal and Postpartum Care (PPC)	93%	100%	*Met*
Plan All-Cause Readmissions (PCR)	100%	100%	*Met*

*The PIP activities for SFY 2023 were initiated prior to release of the 2023 CMS EQR Protocols; therefore, HSAG adhered to the guidance published in the 2019 CMS EQR Protocols. With the release of the new protocols, HSAG updated its PIP worksheets for the SFY 2024 activity to include the two validation ratings (i.e., overall confidence that the PIP adhered to an acceptable methodology for all phases of design and data collection, and the MCO conducted accurate data analysis and interpretation of PIP results; overall confidence that PIP produced significant evidence of improvement.)

[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 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 critical elements *Met*, *Partially Met*, and *Not Met*.

[3] **Overall Validation Status**—Populated from the PIP Validation Tool and based on the percentage scores.

Table 3-31 displays the overall validation scores and confidence level ratings for all three stages of the PIP process of each PIP topic for the SFY 2024 PIP activity, which concluded in December 2024.

Table 3-31—2024 Overall Validation Ratings for SilverSummit

PIP Topic	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	100%	100%	*High Confidence*	67%	100%	*Moderate Confidence*
Adults' Access to Preventive/Ambulatory Health Services (AAP)	100%	100%	*High Confidence*	33%	100%	*No Confidence*
Child and Adolescent Well-Care Visit (WCV)	100%	100%	*High Confidence*	100%	100%	*High Confidence*
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	100%	100%	*High Confidence*	33%	100%	*No Confidence*
Prenatal and Postpartum Care (PPC)	100%	100%	*High Confidence*	100%	100%	*High Confidence*
Plan All-Cause Readmissions (PCR)	100%	100%	*High Confidence*	33%	100%	*No Confidence*

[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 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 critical elements *Met*, *Partially Met*, and *Not Met*.

[3] **Confidence Level**— Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

Table 3-32 includes the performance indicators that will be used to track performance or improvement over the life of the PIP.

Table 3-32—Performance Indicator Results for SilverSummit

PIP Topic	Performance Indicator	Performance Indicator Results		
		Baseline (01/01/2022–12/31/2022)	R1 (01/01/2023–12/31/2023)	R2 (01/01/2024–12/31/2024)
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit, or medication treatment within 14 days.	43.6%	46.8%	—
	The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.	13.4%	13.6%	—
Adults' Access to Preventive/Ambulatory Health Services (AAP)	The percentage of members 20 years of age and older who had an ambulatory or preventive care visit during the measurement year.	55.7%	55.5%	—
Child and Adolescent Well Care Visit (WCV)	The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	36.6%	41.0%	—
Follow-up After Emergency Department Visit for Mental Illness (FUM)	The percentage of ED visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness within 7 days of the ED visit.	48.5%	44.4%	—
	The percentage of ED visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness within 30 days of the ED visit.	57.1%	52.4%	—

PIP Topic	Performance Indicator	Performance Indicator Results		
		Baseline (01/01/2022–12/31/2022)	R1 (01/01/2023–12/31/2023)	R2 (01/01/2024–12/31/2024)
Prenatal and Postpartum Care (PPC)	The percentage of deliveries for which the member received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.	49.2%	52.4%	—
	The percentage of deliveries for which the member had a postpartum visit on or between 7 and 84 days after delivery.	45.8%	51.1%	—
Plan All-Cause Readmissions (PCR)	For members 18 years of age and older, the percentage of acute inpatient and observation stays during the measure year that were followed by an unplanned acute readmission for any diagnosis within 30 days.	11.2%	11.6%	—

— The PIP had not progressed to including Remeasurement 2 results during SFY 2024. R=Remeasurement
HSAG rounded percentages to the first decimal place.

Table 3-33 displays the barriers and interventions as documented by **SilverSummit** for each PIP.

Table 3-33—Interventions Implemented/Planned

Barriers	Interventions
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	
Educate members on their new diagnosis.	Collaborating with a provider partner for additional member outreach and education and improve coordination of access to care by expansion of telehealth services.
Social determinants of health (SDOH).	Collaborating with behavioral health partner to outreach, assess, and refer members to community resource centers to address SDOH.
Provider understanding of measure specifications and care coordination.	Increased provider educational material and resources. Whole health approach to coordination and engagement of care with provider partner.
Enable Strategic Partner (SP) to engage network in performance improvement.	Attribution report that details global analysis of BH [behavioral health] utilization to better create HEDIS

Barriers	Interventions
	scorecards for BH members to drive provider engagement.
Adults' Access to Preventive/Ambulatory Health Services (AAP)	
Lack of incentives for PCPs to target Medicaid population.	Revision of the provider Pay for Performance (P4P) incentive program for the Medicaid population.
Competing priorities for members and not prioritizing their health.	Promoting/education of available telehealth services to increase utilization that will fit within a member's availability to access care.
Providers do not have enough staff to outreach to members.	Increased provider partnerships for both Medicaid counties.
Lack of engagement with members, plan conducting limited outreach to members.	Increasing telephonic member outreach from SilverSummit QI [Quality Improvement]Team.
Members understating the importance of preventative health.	Member outreach and coordination from Community Health Workers; members selected through disparity analysis with targeted ZIP Codes.
Child and Adolescent Well-Care Visit (WCV)	
Medicaid members not a priority, lack of incentives for PCPs to make outreach and schedule appointments.	Revise provider incentive program and increase payout amount.
Lack of engagement with members, Plan conducting limited outreach to members.	Increasing telephonic member outreach from QI Team.
Providers have limited staff and availability to outreach and schedule wellness visits.	Increased provider partnerships for both Medicaid counties.
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	
Provider incentives and knowing that measure does not require behavioral health professional.	Revised provider incentives. Increased engagement with providers and rolling out measure-specific resources.
Data lag; case management data are not "real time."	Revision of data process for ED utilization to improve timeliness of engagement.
Appointment availability (near housing).	Provider partnership coordination and expansion of telehealth services.
Members' perception and not understanding the need for follow-up appointments.	Whole health approach to coordination and engagement of care with provider partner.
Provider scorecard only has one address and phone field for outreach.	Attribution report that details global analysis of BH utilization. To better create HEDIS scorecards for BH members to drive provider engagement.
Do not receive reminders; forget to schedule appointments.	Certified BH CHWs [community health workers] embedded in support centers to facilitate additional member engagement and coordination.

Barriers	Interventions
Prenatal and Postpartum Care (PPC)	
No incentive for our providers for this measure/population.	Rolling out the CPT II (Current Procedural Terminology II) code incentive for OB [obstetrics] specialty and other value-based agreements.
Providers' frustration of SilverSummit Notification of Pregnancy (NOP) form and process.	Improving NOP form to increase provider participation. Expanding ways providers can report NOPs to health plans thru strategic partners and case management. Including education and disparities data inclusive of African American population; focused effort to increase NOPs submitted for this population.
Members not enrolled in Start Smart for Baby (SSFB) program	Reviewing daily ED report to identify members that are pregnant timely, data will be stratified by race/ethnicity to ensure highest disparate populations are targeted for SSFB enrollment including our African American women.
Appointment availability and accessibility for OB-GYN care.	Members participating in Project Guardian (remote patient monitoring) program at **SilverSummit**.
Plan All-Cause Readmissions (PCR)	
Members with behavioral health needs not engaging with their PCP, using the hospital as a form of primary care.	Monthly review of high utilizers to leverage PCP services and resource centers and promoting telehealth services.
Members lacking strong relationship with acute care staff, resulting in communication gaps with discharge planning.	Building out Transition of Care Program at **SilverSummit** to improve staffing of discharge planners.
Members do not understand importance of post-discharge follow-up; lack of understanding discharge paperwork.	Review of Daily ED/Discharge report by Case Management to outreach, coordinate (ED/Urgent Care steering) and educate (comprehensive assessment) members.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: The performance on all PIPs suggests a thorough application of the PIP Design. A sound design, which consists of collecting data and implementing interventions that have the potential to impact performance indicator results, created the foundation for **SilverSummit** to

progress to subsequent PIP stages and measure the desired outcomes for the project. **[Quality**, **Timeliness**, and **Access]**

Strength #2: SilverSummit achieved statistically significant improvement at the first remeasurement for two of six PIPs: *Child and Adolescent Well-Care Visit (WCV)* and *Prenatal and Postpartum Care (PPC).* **[Timeliness** and **Access]**

Weaknesses and Recommendations

Weakness #1: SilverSummit did not achieve statistically significant improvement for the *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET), Adults' Access to Preventive/Ambulatory Health Services (AAP*), *Follow-up After Emergency Department Visit for Mental Illness (FUM),* and *Plan All-Cause Readmissions (PCR)* PIPs. **[Quality**, **Timeliness**, and **Access]**

Why the weakness exists: The interventions initiated by **SilverSummit** did not have the desired impact.

Recommendation: For the PIPs that did not achieve the desired outcome of statistically significant improvement across all performance indicators, **SilverSummit** should revisit its causal/barrier analysis processes and current interventions to determine the possible causes for the lack of significant improvement or the decline in performance. **SilverSummit** should use the findings from this analysis to develop new active engaging interventions or to revise current strategies to address the barriers to achieving improvement.

Performance Measure Validation

Performance Results

Table 3-34 and Table 3-35 show **SilverSummit**'s Medicaid and Nevada Check Up HEDIS and CMS Child and Adult Core Set performance measure results for MY 2021, MY 2022, and MY 2023, along with MY 2022 to MY 2023 rate comparisons and performance target ratings.

Performance for MY 2023 (SFY 2024) is indicated by symbols and color coding; **bolded** rates indicate the rate met or exceeded the DHCFP-established MPS[20], ↑ indicates the rate was above the national Medicaid 50th percentile benchmark, ↓ indicates the rate was below the national 50th percentile benchmark, **green** shading indicates that the rate improved by 5 percentage points from the prior year, and **red** shading indicates that the rate declined by 5 percentage points from the prior year.

Measures in the Utilization domain are designed to capture the frequency of services provided by the MCO. With the exception of *Ambulatory Care—Total (per 1,000 Member Years)—ED Visits—Total*,

[20] Refer to *Appendix B. Goals and Objectives Tracking* for measures with an established MPS. Not all measure rates reported by the MCO have a DHCFP-established MPS.

higher or lower rates in this domain do not necessarily indicate better or worse performance. Therefore, these rates are provided for information only.

Table 3-34—Medicaid SFY 2024 Performance Measure Results and Trending for SilverSummit

HEDIS Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	MY 2022–MY 2023 Rate Comparison
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services (AAP)				
(20–44 Years)	55.38%	53.16%	53.09%↓	-0.07
(45–64 Years)	66.42%	61.75%	61.43%↓	-0.32
(65+ Years)	59.23%	54.51%	46.61%↓	-7.90
(Total)	58.64%	55.66%	55.54%↓	-0.12
Children's Preventive Care				
Child and Adolescent Well-Care Visits (WCV)				
(3–11 Years)	43.66%	43.05%	47.63%↓	4.58
(12–17 Years)	35.55%	36.36%	40.06%↓	3.70
(18–21 Years)	16.80%	15.99%	18.58%↓	2.59
Total	36.57%	36.70%	41.07%↓	4.37
Childhood Immunization Status (CIS)				
Combination 3	57.42%	54.26%	53.28%↓	-0.98
Combination 7	51.58%	46.96%	47.45%↓	0.49
Combination 10	27.49%	21.90%	17.76%↓	-4.14
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	76.64%	77.86%	76.64%↓	-1.22
Combination 2 (Meningococcal, Tdap, HPV)	27.74%	28.71%	23.60%↓	-5.11
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile Documentation (Total)	73.24%	75.18%	81.02%↑	5.84
Counseling for Nutrition (Total)	66.91%	70.07%	72.02%↑	1.95
Counseling for Physical Activity (Total)	61.07%	63.75%	68.13%↑	4.38
Well-Child Visits in the First 30 Months of Life (W30)				
(First 15 Months)	56.31%	52.88%	51.66%↓	-1.22

HEDIS Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	MY 2022–MY 2023 Rate Comparison
(15 Months–30 Months)	60.53%	57.27%	56.82%↓	-0.45
Developmental Screening in the First Three Years of Life (DEV-CH)				
(1 Year)	—	—	16.12%	NC
(2 Years)	—	—	29.58%	NC
(3 Years)	—	—	25.08%	NC
(Total)	—	—	24.07%	NC
Lead Screening in Children (LSC)				
Lead Screening in Children	—	—	27.74%↓	NC
Women's Health and Maternity Care				
Breast Cancer Screening (BCS-E)				
Breast Cancer Screening	40.99%	41.49%	39.49%↓	-2.00
Chlamydia Screening in Women (CHL)				
(16–20 Years)	46.84%	46.74%	48.25%↓	1.51
(21–24 Years)	56.73%	59.67%	62.21%↑	2.54
(Total)	53.07%	54.57%	56.70%↑	2.13
Postpartum Depression Screening and Follow-Up (PDS-E)				
Depression Screening	NA	0.00%	0.09%↓	0.09
Follow–Up on Positive Screen	NA	NA	NA	NC
Prenatal and Postpartum Care (PPC)				
Timeliness of Prenatal Care	73.24%	66.42%	69.10%↓	2.68
Postpartum Care	62.77%	61.07%	67.15%↓	6.08
Prenatal and Postpartum Care (PPC2-CH)				
Timeliness of Prenatal Care—Under 21 Years	—	—	53.55%	NC
Postpartum Care—Under 21 Years	—	—	52.83%	NC
Prenatal Depression Screening and Follow-Up (PND-E)				
Depression Screening	—	0.00%	0.11%↓	0.11
Follow–Up on Positive Screen	—	NA	NA	NC
Prenatal Immunization Status (PRS-E)				
Influenza	—	4.48%	11.13%↓	6.65

HEDIS Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	MY 2022–MY 2023 Rate Comparison
Tdap	—	10.57%	21.84%↓	11.27
Combination	—	2.81%	7.70%↓	4.89
Contraceptive Care—Postpartum Women (CCP-CH)				
Most or Moderately Effective Contraception—3 Days—(15–20 Years)	—	—	5.93%	NC
Most or Moderately Effective Contraception—90 Days—(15–20 Years)	—	—	37.29%	NC
Long-Acting Reversible Contraception—3 Days—(15–20 Years)	—	—	2.54%	NC
Long-Acting Reversible Contraception—90 Days—(15–20 Years)	—	—	11.86%	NC
Contraceptive Care—All Women (CCW-CH)				
Most or Moderately Effective Contraception—(15–20 Years)	—	—	11.68%	NC
Long-Acting Reversible Contraception—(15–20 Years)	—	—	1.53%	NC
Care for Chronic Conditions				
Asthma Medication Ratio (AMR)				
(5–11 Years)	72.58%	62.86%	49.68%↓	-13.18
(12–18 Years)	53.19%	42.25%	40.83%↓	-1.42
(5–18 years) Child Core Set	—	52.48%	45.85%	-6.63
(19–50 Years)	34.09%	36.00%	37.45%↓	1.45
(51–64 Years)	37.66%	48.67%	38.37%↓	-10.30
(19–64 years) Adult Core Set	—	39.27%	37.69%	-1.58
(Total)	42.00%	42.49%	40.08%↓	-2.41
Blood Pressure Control for Patients With Diabetes (BPD)				
Blood Pressure Control for Patients With Diabetes	44.28%	49.15%	58.15%↓	9.00
Controlling High Blood Pressure (CBP)				
Controlling High Blood Pressure	40.88%	53.04%	**59.12%↓**	6.08
Hemoglobin A1c Control for Patients With Diabetes (HBD)				
*HbA1c Control (>9.0%)**	52.07%	49.88%	49.15%↓	-0.73
HbA1c Control (<8%)	42.82%	44.04%	43.55%↓	-0.49

HEDIS Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	MY 2022–MY 2023 Rate Comparison
Behavioral Health				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	41.14%	41.30%	35.16%↓	-6.14
Antidepressant Medication Management (AMM)				
Effective Acute Phase Treatment	54.56%	52.64%	53.03%↓	0.39
Effective Continuation Phase Treatment	39.57%	34.42%	34.92%↓	0.50
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	71.56%	70.78%	76.17%↓	5.39
Follow-Up After Emergency Department Visit for Substance Use (FUA)				
7 days (Total)	—	20.56%	18.06%↓	-2.50
30 days (Total)	—	29.41%	27.09%↓	-2.32
Follow-Up After Emergency Department Visit for Mental Illness (FUM)				
7 days (Total)	38.68%	48.49%	44.40%↑	-4.09
30 days (Total)	48.43%	57.10%	52.43%↓	-4.67
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)				
7 Days (Total)	—	16.60%	18.97%↓	2.37
30 days (Total)	—	30.71%	34.45%↓	3.74
Follow-Up After Hospitalization for Mental Illness (FUH)				
7 days (Total)	31.07%	28.87%	32.47%↓	3.60
30 days (Total)	45.99%	45.17%	49.37%↓	4.20
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
Initiation Phase	49.02%	47.79%	47.49%↑	-0.30
Continuation and Maintenance Phase	NA	NA	54.05%↓	NC
Initiation and Engagement of Substance Use Disorder Treatment (IET)				
Initiation of SUD Treatment—Total (Total)	—	43.57%	46.78%↑	3.21
Engagement of SUD Treatment—Total (Total)	—	13.70%	13.58%↓	-0.12

HEDIS Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	MY 2022–MY 2023 Rate Comparison
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)				
Blood Glucose and Cholesterol Testing (Total)	34.17%	29.39%	36.62%↑	7.23
Screening for Depression and Follow-Up Plan (CDF-CH/CDF-AD) ∞				
(12–17 Years)	—	NA	0.66%	NC
(18–64 Years)	—	1.72%	2.37%	0.65
(65+ Years)	—	3.42%	1.93%	-1.49
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)				
(1–11 Years)	NA	45.24%	31.43%↓	-13.81
(12–17 Years)	51.61%	42.65%	50.94%↓	8.29
(Total)	53.06%	43.64%	43.18%↓	-0.46
Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)				
Rate 1: Total	—	54.72%	56.59%	1.87
Rate 2: Buprenorphine	—	28.53%	32.26%	3.73
Rate 3: Oral Naltrexone	—	3.22%	2.98%	-0.24
Rate 4: Long-Acting, Injectable Naltrexone	—	0.66%	1.18%	0.52
Rate 5: Methadone	—	25.82%	24.10%	-1.72
Diabetes Care for People With Serious Mental Illness: Hemoglobin A1c Poor Control (>9.0%) (HPCMI-AD)*				
(18–64 Years)	—	—	53.85%	NC
(65–75 Years)	—	—	NA	NC
Utilization				
Ambulatory Care—Total (per 1,000 Member Years) (AMB)*				
*ED Visits—Total**	549.11	575.18	560.19	-14.99
Outpatient Visits—Total	2,851.48	2,472.90	2,604.61	NC
Plan All-Cause Readmissions (PCR)				
*Observed Readmissions Total—(18–64 Years)**	12.58%	11.18%	11.56%	0.38
Expected Readmissions Total—(18–64 Years)	9.59%	9.63%	9.53%	-0.10
O/E Ratio Total—(18–64 Years)	1.3118	1.1608	1.2131	0.0523
Outliers Total—(18–64 Years)	42.07	48.53	67.39	18.86

HEDIS Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	MY 2022–MY 2023 Rate Comparison
Overuse/Appropriateness of Care				
Risk of Continued Opioid Use (COU)*				
>=15 Days (Total)	—	7.87%	**5.99%↓**	-1.88
>=31 Days (Total)	—	5.88%	**4.54%↓**	-1.34
Use of Opioids at High Dosage (HDO)*				
Use of Opioids at High Dosage	4.14%	4.88%	**4.59%↓**	-0.29
Use of Opioids From Multiple Providers (UOP)*				
Multiple Prescribers	17.52%	21.43%	27.09%↓	5.66
Multiple Pharmacies	0.39%	0.24%	0.86%↑	0.62
Multiple Prescribers and Multiple Pharmacies	0.08%	0.10%	0.55%↑	0.45
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)				
(3 Months–17 Years)	—	—	71.30%↓	NC
(18–64 Years)	—	—	50.16%↑	NC
(65+ Years)	—	—	NA	NC
(Total)	—	—	63.00%↑	NC

↑ Indicates the MY 2023 rate was above NCQA's Quality Compass 2023 Medicaid HMO 50th percentile benchmark.
↓ Indicates the MY 2023 rate was below NCQA's Quality Compass 2023 Medicaid HMO 50th percentile benchmark.
* A lower rate indicates better performance for this measure or indicator.
** Beginning MY 2022, this rate was reported per 1,000 member years instead of per 1,000 member months; the rates for MY 2021 were converted to member years for comparison.
— Indicates that the MCO was not previously required to report this measure or that the rate is not appropriate to display due to changes in the technical specifications resulting in a break in trending.
∞ MCOs reported *CDF—18—64 years* and *CDF—65 years and older* to align with the CMS Adult Core Set FFY 2024 technical specifications. HSAG will assess each indicator separately to determine if the MCOs met or exceeded DHCFP's QISMC goal for *CDF—18 years and older.*
NC indicates the MY 2022–MY 2023 Rate Comparison could not be calculated because data are not available for both years.
NA indicates that the MCO followed the specifications, but the denominator was too small (i.e., <30) to report a valid rate.
Bolded rates indicate that the MY 2023 performance measure rate met or exceeded the DHCFP-established MPS.

Indicates that the MY 2023 rate declined by 5 percentage points or more from MY 2022.

Indicates that the MY 2023 rate improved by 5 percentage points or more from MY 2022.

Table 3-35—Nevada Check Up SFY 2024 Performance Measure Results and Trending for SilverSummit

HEDIS Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	MY 2022–MY 2023 Rate Comparison
Children's Preventive Care				
Child and Adolescent Well-Care Visits (WCV)				
(3–11 Years)	43.39%	43.02%	48.87%↓	5.85
(12–17 Years)	39.79%	38.44%	43.54%↓	5.10
(18–21 Years)	29.91%	23.17%	22.79%↓	-0.38
Total	40.95%	39.43%	44.76%↓	5.33
Childhood Immunization Status (CIS)				
Combination 3	75.51%	53.33%	66.23%↑	12.90
Combination 7	69.39%	48.89%	62.34%↑	13.45
Combination 10	42.86%	24.44%	32.47%↑	8.03
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	86.02%	80.53%	86.26%↑	5.73
Combination 2 (Meningococcal, Tdap, HPV)	26.88%	32.74%	35.55%↑	2.81
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile Documentation (Total)	75.43%	46.13%	81.02%↑	34.89
Counseling for Nutrition (Total)	65.45%	38.25%	74.70%↑	36.45
Counseling for Physical Activity (Total)	62.04%	33.91%	71.53%↑	37.62
Well-Child Visits in the First 30 Months of Life (W30)				
(First 15 Months)	NA	NA	68.33%↑	NC
(15 Months–30 Months)	69.77%	51.16%	62.77%↓	11.61
Developmental Screening in the First Three Years of Life (DEV-CH)				
(1 Year)	—	—	13.33%	NC
(2 Years)	—	—	24.36%	NC
(3 Years)	—	—	30.43%	NC
(Total)	—	—	25.21%	NC
Lead Screening in Children (LSC)				
Lead Screening in Children	—	—	32.05%↓	NC

HEDIS Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	MY 2022–MY 2023 Rate Comparison
Women's Health and Maternity Care				
Chlamydia Screening in Women (CHL)				
(16–20 Years)	34.15%	27.27%	**46.53%↓**	19.26
(21–24 Years)	NA	NA	NA	NC
(Total)	34.15%	27.27%	46.53%↓	19.26
Prenatal and Postpartum Care (PPC)				
Timeliness of Prenatal Care	—	—	NA	NC
Postpartum Care	—	—	NA	NC
Prenatal and Postpartum Care (PPC2-CH)				
Timeliness of Prenatal Care—Under 21 Years	—	—	NA	NC
Postpartum Care—Under 21 Years	—	—	NA	NC
Contraceptive Care—Postpartum Women (CCP-CH)				
Most or Moderately Effective Contraception—3 Days—(15–20 Years)	—	—	NA	NC
Most or Moderately Effective Contraception—90 Days—(15–20 Years)	—	—	NA	NC
Long-Acting Reversible Contraception—3 Days—(15–20 Years)	—	—	NA	NC
Long-Acting Reversible Contraception—90 Days—(15–20 Years)	—	—	NA	NC
Contraceptive Care—All Women (CCW-CH)				
Most or Moderately Effective Contraception—(15–20 Years)	—	—	8.47%	NC
Long-Acting Reversible Contraception—(15–20 Years)	—	—	1.13%	NC
Care for Chronic Conditions				
Asthma Medication Ratio (AMR)				
(5–11 Years)	NA	NA	NA	NC
(12–18 Years)	NA	NA	NA	NC
(5–18 years) Child Core Set	—	NA	53.85%	NC
(19–50 Years)	NA	NA	NA	NC
(51–64 Years)	NA	NA	NA	NC

HEDIS Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	MY 2022–MY 2023 Rate Comparison
(19–64 years) Adult Core Set	—	NA	NA	NC
(Total)	NA	NA	55.00%↓	NC
Behavioral Health				
Follow-Up After Emergency Department Visit for Substance Use (FUA)				
7 days (Total)	—	NA	NA	NC
30 days (Total)	—	NA	NA	NC
Follow-Up After Emergency Department Visit for Mental Illness (FUM)				
7 days (Total)	NA	NA	NA	NC
30 days (Total)	NA	NA	NA	NC
Follow-Up After Hospitalization for Mental Illness (FUH)				
7 days (Total)	NA	NA	NA	NC
30 days (Total)	NA	NA	NA	NC
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
Initiation Phase	NA	NA	NA	NC
Continuation and Maintenance Phase	NA	NA	NA	NC
Initiation and Engagement of Substance Use Disorder Treatment (IET)				
Initiation of SUD Treatment—Total (Total)	—	NA	NA	NC
Engagement of SUD Treatment—Total (Total)	—	NA	NA	NC
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)				
Blood Glucose and Cholesterol Testing (Total)	NA	NA	NA	NC
Screening for Depression and Follow-Up Plan (CDF-CH/CDF-AD)				
(12–17 Years)	—	NA	0.80%	NC
(18–64 Years)	—	0.00%	2.13%	2.13
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)				
(1–11 Years)	—	NA	NA	NC
(12–17 Years)	—	NA	NA	NC
(Total)	—	NA	NA	NC

HEDIS Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	MY 2022–MY 2023 Rate Comparison
Utilization				
Ambulatory Care—Total (per 1,000 Member Years) (AMB) **				
*ED Visits—Total**	216.27	256.66	305.07	48.41
Outpatient Visits—Total	1,906.61	1,873.91	2,031.95	NC
Overuse/Appropriateness of Care				
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)				
(3 Months–17 Years)	—	—	51.32%↓	NC
(18–64 Years)	—	—	NA	NC
(Total)	—	—	51.32%↓	NC

↑ Indicates the MY 2023 rate was above NCQA's Quality Compass 2023 Medicaid HMO 50th percentile benchmark.
↓ Indicates the MY 2023 rate was below NCQA's Quality Compass 2023 Medicaid HMO 50th percentile benchmark.
* A lower rate indicates better performance for this measure or indicator.
** Beginning MY 2022, this rate was reported per 1,000 member years instead of per 1,000 member months; the rates for MY 2021 were converted to member years for comparison.
— Indicates that the MCO was not previously required to report this measure or that the rate is not appropriate to display due to changes in the technical specifications resulting in a break in trending.
NC indicates the MY 2022–MY 2023 Rate Comparison could not be calculated because data are not available for both years.
NA indicates that the MCO followed the specifications, but the denominator was too small (i.e., <30) to report a valid rate.
Bolded rates indicate that the MY 2023 performance measure rate met or exceeded the DHCFP-established MPS.
Indicates that the MY 2023 rate improved by 5 percentage points or more from MY 2022.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Within the Women's Health and Maternity Care domain, **SilverSummit**'s Nevada Check Up population rate for the *Chlamydia Screening in Women—16–20 years* measure indicator demonstrated an increase in performance of more than 5 percentage points from the prior measurement year and met the State's established MPS associated with a QISMC goal. This performance suggests **SilverSummit**'s Medicaid and Nevada Check Up members continue to receive appropriate and timely screenings and immunizations, which can reduce the risk of

developing more serious conditions and potentially reduce healthcare costs. **[Quality, Timeliness,** and **Access]**

Strength #2: Within the Overuse and Appropriateness of Care domain, **SilverSummit**'s Medicaid population rates for *Risk of Continued Opioid Use* and *Use of Opioids at High Dosage*, which are tied to QISMC goals, met the State's established MPS. Further, **SilverSummit**'s Medicaid population rates for *Use of Opioids from Multiple Providers—Multiple Pharmacies* and *Use of Opioids from Multiple Providers—Multiple Prescribers and Multiple Pharmacies* measure indicators met the State's established MPS. This performance suggests **SilverSummit** ensures its adult Medicaid members receiving opioid prescriptions are not being prescribed opioids for 15 days or more during the measurement year from multiple prescribers, which can reduce the risk of opioid overuse and misuse, and potentially reduce the risk of overdose. **[Quality, Timeliness,** and **Access]**

Weaknesses and Recommendations

Weakness #1: Within the Access to Care, Children's Preventive Care, and Women's Health and Maternity Care domains for **SilverSummit**'s Medicaid population, no measure indicator rates with a QISMC goal met the State's established MPS. Further, within the Children's Preventive Care and Women's Health and Maternity Care domains for **SilverSummit**'s Nevada Check Up populations, no measure indicator rates with a QISMC goal, except *Chlamydia Screening in Women—16-20 years,* met the State's established MPS. **[Quality, Timeliness,** and **Access]**

Why the weakness exists: Immunization declines may be due to disparities within **SilverSummit**'s Medicaid population that could impact access to care, such as language barriers, access to transportation, geographic location, and socioeconomic status. Although **SilverSummit**'s Medicaid and Nevada Check Up members appear to have access to PCPs, members were not consistently utilizing these services, which can significantly reduce nonurgent ED visits and potentially prevent more serious health issues from occurring, reducing healthcare costs.

Recommendation: **SilverSummit** self-reported several interventions to address these domains, such as provider incentives, member outreach, utilization of community partners and advancing technological resources and data mapping. **SilverSummit** has a health equity team that assessed measure performance by race, ethnicity, and ZIP Codes to identify data trends and areas of need for targeted interventions. **SilverSummit** utilizes Plan-Do-Study-Act (PDSA) methodology to track and monitor specific intervention progress and works with various departments to revise and update interventions to better fit member needs when necessary. **SilverSummit** reviews measure performance and initiative progress, updates, and barriers in meetings of the Performance Improvement Team (PIT) and quarterly in meetings of the Quality Improvement Committee (QIC). Regarding the *Adults' Access to Preventive/Ambulatory Health Services—65 Years and Older* measure indicator, HSAG recommends that **SilverSummit** consider a first-visit incentive to members who see a doctor for the first time. HSAG recommends that **SilverSummit** consider offering to schedule the appointment and addressing barriers as needed (e.g., transportation, SDOH). Additionally, HSAG recommends that **SilverSummit** ensure provider availability is within required

time frames and consider increasing appointment hours.[21] Regarding *Immunizations for Adolescents—Combination 2,* HSAG recommends that **SilverSummit** implement strategies such as holding vaccine clinics at convenient hours for families such as evenings and Saturdays, developing reports based on vaccinations due and disseminating to providers, doing all recommended vaccinations at every visit, and ensuring vaccination records are accurate.[22] Reminder/recall systems can be effective for members/families and providers as well.

Weakness #2: Within the Behavioral Health domain for **SilverSummit**'s Medicaid and Nevada Check Up populations, no measure indicator rates with a QISMC goal met the State's established MPS. **[Quality, Timeliness,** and **Access]**

Why the weakness exists: Low performance within the Behavioral Health domain may potentially be due to disparities within Medicaid and Nevada Check Up populations that could impact access to care, such as language barriers, access to transportation, geographic location, and socioeconomic status. Additionally, performance may be low due to low appointment availability for qualified mental health professionals to meet the demand, lack of transportation, or perceived social stigma related to seeking mental health services.

Recommendation: SilverSummit self-reported several interventions to address this domain, such as provider incentives, member outreach, utilization of community partners, and advancing technological resources and data mapping. **SilverSummit** has a health equity team that assessed measure performance by race, ethnicity, and ZIP Codes to identify data trends and areas of need for targeted interventions. **SilverSummit** utilizes PDSA methodology to track and monitor specific intervention progress and works with various departments to revise and update interventions to better fit member needs when necessary. **SilverSummit** reviews measure performance and initiative progress, updates, and barriers in the PIT meetings and quarterly in the QIC meetings. HSAG recommends that **SilverSummit** continue these initiatives and where possible, identify and measure effectiveness of interventions by establishing baseline and remeasurement metrics. Regarding *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*, HSAG recommends that **SilverSummit** consider effective interventions highlighted in a systematic review of studies focusing on adherence to medications for people with schizophrenia, which include motivational interviewing, daily texts to individuals with schizophrenia, and other medication reminders. Other effective interventions include pharmacy-based interventions, a psychoeducational program (FSPP), and an individualized occupational therapy (IOT) program.[23] Regarding *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—1-11 years*, HSAG recommends that **SilverSummit** educate providers on ensuring children have had a psychosocial evaluation and document psychotherapy, including telehealth, music, and art therapy. HSAG

[21] AAP—Adults' Access to Preventive/Ambulatory Health Services. Available at: Adults' Access to Preventive/Ambulatory Health Services (hopkinsmedicine.org). Accessed on Dec 19, 2024.

[22] Immunization Strategies and Resources for Health Care Professionals from the American Academy of Pediatrics (AAP). Available at: Immunization Strategies and Resources | Red Book Online | American Academy of Pediatrics Accessed on Dec 19, 2024.

[23] Cahaya, Noor et al. "Interventions to Improve Medication Adherence in People with Schizophrenia: A Systematic Review." Patient preference and adherence vol. 16 2431-2449. 1 Sep. 2022, doi:10.2147/PPA.S378951

recommends that **SilverSummit** analyze measure results by provider to identify provider-specific trends.

Compliance Review

Performance Results

Table 3-36 presents an overview of the results of the standards reviewed during the SFY 2024 compliance review for **SilverSummit**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Appendix A. If a requirement was not applicable to **SilverSummit** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all seven standards.

Table 3-36—Summary of Standard Compliance Scores

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Disenrollment: Requirements and Limitations	6	6	5	1	0	**83%**
Standard II—Member Rights and Member Information	24	23	17	6	1	**74%**
Standard III—Emergency and Poststabilization Services	13	13	13	0	0	**100%**
Standard IV—Availability of Services	12	12	10	2	0	**83%**
Standard V—Assurances of Adequate Capacity and Services	5	5	1	4	0	**20%**
Standard VI—Coordination and Continuity of Care	28	28	25	3	0	**89%**
Standard VII—Coverage and Authorization of Services	27	27	23	4	0	**85%**
Total	**115**	**114**	**94**	**20**	**1**	**82%**

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

Based on the findings from the SFY 2024 compliance review activity, **SilverSummit** was required to develop and submit a CAP for each element assigned a score of *Not Met*. The CAP was reviewed by DHCFP and HSAG for sufficiency, and **SilverSummit** was responsible for implementing each action plan in a timely manner.

Strengths, Weaknesses, and Recommendations

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

Strengths

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

Weaknesses and Recommendations

Weakness #1: SilverSummit had six elements in the Member Rights and Member Information program area that received a score of *Not Met*, indicating that members may not be notified of or receive required member materials and information timely. [**Timeliness** and **Access**]

Why the weakness exists: SilverSummit did not demonstrate that member materials adhered to State and federal requirements, that members were notified of the time frame for receiving a member handbook upon member's request, or that the member handbook included all required elements.

Recommendation: While **SilverSummit** was required to develop a CAP to address the deficiencies identified, HSAG recommends that the MCO conduct a comprehensive review of its member facing materials and its processes and procedures related to member information to identify whether additional opportunities for improvement exist in this program area and take remedial action, as necessary.

Weakness #2: SilverSummit had four elements within the Assurances of Adequate Capacity and Services program area that received a score of *Not Met*, indicating that members may experience barriers to accessing all services (e.g., primary care, specialty care, hospital and emergency services, behavioral health). [**Access**]

Why the weakness exists: SilverSummit did not demonstrate that the capacity of its PCP network met the Full Time Equivalent (FTE) staffing requirements for accepting eligible members per service area, including that this ratio did not exceed the FTE requirement. Additionally, the MCO's PCP member ratios included in provider materials were not consistent. Further, the MCO's policies did not outline all requirements regarding notification to DHCFP, including for significant changes in the MCO's network, requesting an exception from DHCFP when the MCO does not meet the required time and distance standards, and if an exception is accepted, the process for additional reporting in the MCO's quarterly network adequacy reporting.

Recommendation: While **SilverSummit** was required to submit a CAP to address the deficiencies identified, HSAG recommends that the MCO conduct a comprehensive review of its network

adequacy policies and procedures to identify whether additional opportunities for improvement exist to ensure adherence to all State and federal network adequacy requirements and take remedial action, as necessary.

Weakness #3: SilverSummit had three elements in the Coordination and Continuity of Care program area that received a score of *Not Met*, indicating members' care may not be effectively coordinated through the care management program. **[Quality**, **Timeliness**, and **Access]**

Why the weakness exists: SilverSummit did not demonstrate that its care management department was consistently or adequately assessing members for all required assessment areas. Additionally, the MCO did not demonstrate that it consistently provided information to the member's PCP regarding member eligibility for and/or enrollment into care management or that this information was provided to the member's PCP timely. Further, the MCO did not demonstrate that care managers consistently adhered to the check-in schedule to monitor member's progress.

Recommendation: While **SilverSummit** was required to develop a CAP to address the deficiencies identified, HSAG recommends that the MCO continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to care coordination and care management of members.

Weakness #4: SilverSummit had four elements within the Coverage and Authorization of Services program area that received a score of *Not Met*, indicating members may not consistently receive timely and adequate notice of authorization decisions, including decisions that result in an adverse benefit determination to the member. **[Quality** and **Timeliness]**

Why the weakness exists: SilverSummit did not consistently adhere to requirements related to the timing of authorization decisions (i.e., expedited) and the timing and content of notices of adverse benefit determination.

Recommendation: While **SilverSummit** was required to develop a CAP to address the deficiencies identified, HSAG recommends that the MCO continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to coverage and authorization of services.

Network Adequacy Validation

Performance Results

HSAG determined that the providers per 1,500 members in Clark and Washoe counties exceeded DHCFP's requirements. Table 3-37 presents results by the number of providers per 1,500 members in Clark and Washoe counties and by the DHCFP-required provider types.

Table 3-37 presents **SilverSummit**'s network adequacy results for Provider-to-Member Ratios.

Table 3-37—SilverSummit Provider-to-Member Ratios by Provider Type by County

Provider Type	Indicator	Providers per 1,500 Members (Clark County)	Providers per 1,500 Members (Washoe County)
PCP not practicing in conjunction with healthcare professional*	1:1,500	17.65	33.40
Specialists	1:1,500	97.89	263.03

* If the PCP practices in conjunction with a healthcare professional (i.e., nurse practitioner or physician's assistant), the ratio is increased to one FTE PCP for every 1,800 members. DHCFP's 402 network adequacy reporting template did not break out PCP practices in conjunction with a healthcare professional.

DHCFP established a 100 percent threshold when determining compliance with time or distance standards. HSAG determined that indicators that fell below the 100 percent threshold achieved greater than or equal to 99.5 percent compliance with access standards. Table 3-38 presents results by percentage of members with access across Clark and Washoe counties and by the DHCFP-established provider categories. Results that achieved the 100 percent access threshold are shaded **green**.

Table 3-38 presents **SilverSummit**'s network adequacy results for Time or Distance.

Table 3-38—SilverSummit Percentage of Members With Access by Provider Category by County

Provider Category	Time or Distance Indicator	Percentage of Members With Access (Clark County)	Percentage of Members With Access (Washoe County)
Primary Care, Adults	10 miles or 15 minutes	99.9%	99.6%
OB/GYN (Adult Females)	10 miles or 15 minutes	99.9%	99.5%
Pediatrician	10 miles or 15 minutes	99.9%	99.7%
Endocrinologist	40 miles or 60 minutes	99.9%	100%
Endocrinologist, Pediatric	40 miles or 60 minutes	99.9%	100%
Infectious Disease	40 miles or 60 minutes	99.9%	100%
Infectious Disease, Pediatric	40 miles or 60 minutes	100%	100%
Rheumatologist	40 miles or 60 minutes	99.9%	100%
Rheumatologist, Pediatric	40 miles or 60 minutes	99.9%	100%

Provider Category	Time or Distance Indicator	Percentage of Members With Access (Clark County)	Percentage of Members With Access (Washoe County)
Oncologist/Radiologist	40 miles or 60 minutes	100%	100%
Oncologist/Radiologist, Pediatric	40 miles or 60 minutes	100%	100%
Oncologist—Medical/Surgical	30 miles or 45 minutes	100%	99.9%
Oncologist—Medical/Surgical, Pediatric	30 miles or 45 minutes	99.9%	100%
Psychologist	30 miles or 45 minutes	99.9%	100%
Psychologist, Pediatric	30 miles or 45 minutes	99.9%	100%
Psychiatrist	30 miles or 45 minutes	100%	99.9%
Board Certified Child and Adolescent Psychiatrist	45 minutes or 30 miles	99.9%	100%
Qualified Mental Health Professional (QMHP)	30 miles or 45 minutes	100%	100%
QMHP, Pediatric	30 miles or 45 minutes	100%	100%
Hospital, All	30 miles or 45 minutes	100%	100%
Psychiatric Inpatient Hospital	30 miles or 45 minutes	99.9%	99.9%
Dialysis/End Stage Renal Disease (ESRD) Facility	30 miles or 45 minutes	100%	100%
Pharmacy	10 miles or 15 minutes	99.9%	99.7%

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: SilverSummit established robust processes to mitigate missing or incomplete data from the 834 eligibility and enrollment files by running two types of error reports prior to the member data being incorporated into its management information systems. One hundred percent of all errors were manually reviewed and corrected. [**Quality** and **Access**]

Strength #2: SilverSummit's Provider Data Management Team audited 100 percent of provider data entries that were uploaded from the provider database system, Portico, to its claims system, Amisys. [**Quality** and **Access**]

Weaknesses and Recommendations

Weakness #1: HSAG observed **SilverSummit** excluded members listed as homeless or with an invalid or missing ZIP Code in the DHCFP 834 file from the time or distance calculations and reporting. **[Quality** and **Access]**

Why the weakness exists: SilverSummit indicated that when a member's address could not be geocoded exactly, the member could not be accurately assessed for compliance with required time or distance from the member address to a provider.

Recommendation: HSAG recommends **SilverSummit** seek additional DHCFP guidance on ways to improve capturing valid addresses on the 834 files, as this resulted in approximately 7 percent of the Medicaid population being excluded from these calculations and reporting.

Weakness #2: Although **SilverSummit** was able to apply the necessary corrections for final reporting, HSAG observed that **SilverSummit** was not applying the correct parameters when calculating and determining compliance with the GeoAccess standards. **SilverSummit** was applying "and" versus "or" to its network adequacy calculation methodology. [**Quality** and **Access**]

Why the weakness exists: DHCFP's contract with the MCOs includes a table labeled, "Maximum Time and Distance Standards"; however, HSAG confirmed with DHCFP that the time and distance standards are to be "or" versus "and." **SilverSummit** was applying the "and" methodology based on language in the contract and unclear guidance in the network adequacy reporting template required by DHCFP to be used by the MCO when reporting network adequacy compliance.

Recommendation: HSAG recommends that **SilverSummit** conduct a quarterly review of DHCFP reporting requirements and/or consult with DHCFP to ensure accurate understanding of DHCFP's required methodology for calculating network adequacy. Additionally, HSAG recommends that **SilverSummit** build in additional layers of validation to ensure logic and parameters used to inform calculations are in alignment with DHCFP's network adequacy calculation requirements. Finally, HSAG recommends that **SilverSummit** ensure internal process flows are documented to reflect changes year over year.

Weakness #3: Although **SilverSummit** was able to apply the necessary corrections for final reporting, HSAG observed **SilverSummit** was not separating the adult and pediatric populations for a subset of DHCFP-defined provider categories as well as not reporting inpatient psychiatric hospitals separately as required by DHCFP.

Why the weakness exists: DHCFP's network adequacy reporting template was not structured to allow for MCO reporting of both adult and pediatric populations for DHCFP-specified provider categories. The network adequacy reporting template also did not include a place for **SilverSummit** to report inpatient psychiatric hospitals.

Recommendation: HSAG recommends that **SilverSummit** work with DHCFP on future template updates to ensure all DHCFP reporting requirements are captured on the reporting template, including the necessary population stratifications.

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results

Table 3-39 presents the 2024 CAHPS top-box scores for **SilverSummit**'s adult Medicaid, general child Medicaid, CCC Medicaid, Nevada Check Up general child, and Nevada Check Up CCC populations. Arrows (↓ or ↑) indicate 2024 scores that were statistically significantly higher or lower than the 2023 national average.[24]

Table 3-39—Summary of 2024 CAHPS Top-Box Scores for SilverSummit

	Adult Medicaid	General Child Medicaid	CCC Medicaid	Nevada Check Up General Child	Nevada Check Up CCC
Composite Measures					
Getting Needed Care	78.36%	NA	NA	NA	NA
Getting Care Quickly	NA	NA	NA	NA	NA
How Well Doctors Communicate	89.46%	NA	NA	NA	NA
Customer Service	NA	NA	NA	NA	NA
Global Ratings					
Rating of All Health Care	55.28%	72.00%	NA	NA	NA
Rating of Personal Doctor	65.65%	69.92%	64.15% ↓	80.20%	NA
Rating of Specialist Seen Most Often	NA	NA	NA	NA	NA
Rating of Health Plan	57.92%	78.11% ↑	68.07%	76.19%	NA
Medical Assistance with Smoking and Tobacco Use Cessation Measure Items*					
Advising Smokers and Tobacco Users to Quit	NA	—	—	—	—
Discussing Cessation Medications	NA	—	—	—	—
Discussing Cessation Strategies	NA	—	—	—	—

[24] 2024 national average results were not available at the time this report was produced.

	Adult Medicaid	General Child Medicaid	CCC Medicaid	Nevada Check Up General Child	Nevada Check Up CCC
CCC Composite Measures/Items					
Access to Specialized Services	—	—	NA	—	NA
Family Centered Care (FCC): Personal Doctor Who Knows Child	—	—	NA	—	NA
Coordination of Care for Children With Chronic Conditions	—	—	NA	—	NA
Access to Prescription Medicines	—	—	NA	—	NA
FCC: Getting Needed Information	—	—	NA	—	NA

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

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

↑ Indicates the 2024 score is statistically significantly higher than the 2023 national average.

↓ Indicates the 2024 score is statistically significantly lower than the 2023 national average.

— Indicates the measure does not apply to the population.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Parents/caretakers of general child Medicaid members had positive overall experiences with their child's health plan since the score for this measure was statistically significantly higher than the 2023 NCQA Medicaid national average. **[Quality]**

Weaknesses and Recommendations

Weakness #1: Parents/caretakers of CCC Medicaid members had less positive overall experiences with their child's personal doctor since the score for this measure was statistically significantly lower than the 2023 NCQA Medicaid national average. **[Quality]**

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

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

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

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

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

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

HSAG performed a comprehensive assessment of **SilverSummit**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **SilverSummit** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **SilverSummit**'s overall performance contributed to the Nevada Managed Care Program's progress in achieving the Nevada Quality Strategy goals and objectives. Table 3-40 displays each Nevada Quality Strategy goal and EQR activity results that indicate whether the MCO positively (✓) or negatively (✗) impacted the Nevada Managed Care Program's progress toward achieving the applicable goals and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **SilverSummit**'s Medicaid members.

Table 3-40—Overall Performance Impact to Nevada Quality Strategy and Quality, Timeliness, and Access

	Quality Strategy Goals	Performance Impact on Goals and Objectives	
1	Improve the health and wellness of Nevada's Medicaid population by increasing the use of preventive services by December 31, 2024	✗	0/18 applicable Medicaid rates met the MPS
		✓	1/14 applicable Nevada Check Up rates met the MPS
		✗	13/14 applicable Nevada Check Up rates did not meet the MPS
2	Increase use of evidence-based practices for members with chronic conditions by December 31, 2024	✓	1 /7 Medicaid rates met the MPS
		✗	6 /7 Medicaid rates did not meet MPS
		✗	0/1 applicable Nevada Check Up rate met the MPS
3	Reduce misuse of opioids by December 31, 2024	✓	3/4 Medicaid rates met the MPS
		✗	1/4 Medicaid rates did not meet MPS
4	Improve the health and wellness of pregnant women and infants by December 31, 2024	✗	0/5 applicable Medicaid rates met the MPS
5	Increase use of evidence-based practices for members with behavioral health conditions by December 31, 2024	✗	0/21 Medicaid rates met the MPS
		✗	0/2 applicable Nevada Check Up rates met the MPS
6	Increase utilization of dental services by December 31, 2024	Not applicable to the MCO	
7	Reduce and/or eliminate health care disparities for Medicaid members by December 31, 2024	✓	3/3 objectives received a *Met* designation

UnitedHealthcare Health Plan of Nevada

Validation of Performance Improvement Projects

Performance Results

Table 3-41 displays the overall validation status for the Design and Implementation stages of each PIP topic for the SFY 2023 PIP activity, which concluded in December 2023.

Table 3-41—2023 Overall Validation Ratings* for UHC HPN

Name of Project	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Overall Validation Status[3]
Initiation and Engagement of Substance Use Disorder Treatment (IET)	100%	100%	*Met*
Adults' Access to Preventive/Ambulatory Health Services (AAP)	100%	100%	*Met*
Child and Adolescent Well-Care Visit (WCV)	100%	100%	*Met*
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	100%	100%	*Met*
Timeliness of Prenatal and Postpartum Care (PPC)	100%	100%	*Met*
Plan All-Cause Readmissions (PCR)	100%	100%	*Met*

*The PIP activities for SFY 2023 were initiated prior to release of the 2023 CMS EQR Protocols; therefore, HSAG adhered to the guidance published in the 2019 CMS EQR Protocols. With the release of the new protocols, HSAG updated its PIP worksheets for the SFY 2024 activity to include the two validation ratings (i.e., overall confidence that the PIP adhered to an acceptable methodology for all phases of design and data collection, and the MCO conducted accurate data analysis and interpretation of PIP results; overall confidence that PIP produced significant evidence of improvement.)

[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 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 critical elements *Met*, *Partially Met*, and *Not Met*.

[3] **Overall Validation Status**—Populated from the PIP Validation Tool and based on the percentage scores.

Table 3-42 displays the overall validation scores and confidence level ratings for all three stages of the PIP process of each PIP topic for the SFY 2024 PIP activity, which concluded in December 2024.

Table 3-42—2024 Overall Validation Ratings for UHC HPN

PIP Topic	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
Initiation and Engagement of Substance Use Disorder Treatment (IET)	100%	100%	*High Confidence*	67%	100%	*Moderate Confidence*
Adults' Access to Preventive/Ambulatory Health Services (AAP)	100%	100%	*High Confidence*	33%	100%	*No Confidence*
Child and Adolescent Well-Care Visit (WCV)	100%	100%	*High Confidence*	100%	100%	*High Confidence*
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	100%	100%	*High Confidence*	100%	100%	*High Confidence*
Timeliness of Prenatal and Postpartum Care (PPC)	100%	100%	*High Confidence*	100%	100%	*High Confidence*
Plan All-Cause Readmissions	100%	100%	*High Confidence*	33%	100%	*No Confidence*

[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 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 critical elements *Met*, *Partially Met*, and *Not Met*.

[3] **Confidence Level**— Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

Table 3-43 includes the performance indicators that will be used to track performance or improvement over the life of the PIP.

Table 3-43—Performance Indicator Results for UHC HPN

PIP Topic	Performance Indicator	Performance Indicator Results		
		Baseline (01/01/2022–12/31/2022)	R1 (01/01/2023–12/31/2023)	R2 (01/01/2024–12/31/2024)
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit, or medication treatment within 14 days.	44.8%	45.0%	—
	The engagement portion of IET measures the percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.	13.8%	14.6%	—
Adults' Access to Preventive/Ambulatory Health Services (AAP)	The percentage of adults 20 years of age and older that had at least one preventive or ambulatory care visit during the measurement year.	70.7%	69.1%	—
Child and Adolescent Well Care Visit (WCV)	The percentage of members ages 3–21 years who had one or more well-child visits with a PCP or OB/GYN during the measurement year.	46.4%	48.3%	—
Follow-up After Emergency Department Visit for Mental Illness (FUM)	The percentage of mental illness ED visits for which the member 6 years of age and older had a follow-up visit within 7 days after the ED visit.	47.2%	53.1%	—
	The percentage of mental illness ED visits for which the member 6 years of age and older had a follow-up visit within 30 days after the ED visit.	54.6%	61.6%	—
Prenatal and Postpartum Care (PPC)	The percentage of deliveries as defined by the eligible population that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization	68.6%	75.7%	—

PIP Topic	Performance Indicator	Performance Indicator Results		
		Baseline (01/01/2022–12/31/2022)	R1 (01/01/2023–12/31/2023)	R2 (01/01/2024–12/31/2024)
	The percentage of Medicaid members as defined by the eligible population that completed a postpartum visit on or between 7 and 84 days after delivery.	65.4%	71.9%	—
Plan All-Cause Readmissions (PCR)	The percentage of acute readmissions for any diagnosis within 30 days of the index discharge date.	10.4%	10.6%	—

— The PIP had not progressed to including Remeasurement 2 results during SFY 2024. R=Remeasurement
HSAG rounded percentages to the first decimal place.

Interventions

Table 3-44 displays the barriers and interventions as documented by **UHC HPN** for each PIP.

Table 3-44—Interventions Implemented/Planned

Barriers	Interventions
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	
Low levels of engagement among members with SUD. **Update 2024 submission**: Some members are unable to access the member perks website to complete the attestation. The incentive dollar amount is low when compared to other member incentive programs.	A member-targeted incentive to influence initiation and engagement in AOD [alcohol and other drug] treatment services. Members who initiate treatment within 14 days of a new SUD episode will be rewarded a $15 gift card. Members who have treatment engagement within 34 days of initiation will be rewarded a $30 gift card. **Update 2024 submission:** The plan will consider an increase in the incentive amount in the hopes it may increase members' motivation.
There is a statewide shortage of providers which is a barrier for members seeking substance abuse treatment, especially those living in rural areas. This shortage affects the **UHC HPN** provider network for SUD providers.	Partner with SUD treatment provider/vendor to improve timely initiation and engagement in treatment. This SUD treatment provider is a digital SUD addiction treatment program that works from an app on a smartphone. Counseling and medication management appointments are conducted over a secure video conference via the app which eliminates the need for cellular service and/or minutes. The digital platform allows for all members to access timely treatment from anywhere.

Barriers	Interventions
	Update 2024 submission: Engagement between the digital provider and members continued all through 2023.
Limited prescriber knowledge of the PA [prior authorization] process is a barrier to prescribing MAT [medication assisted treatment]. **Update 2024 submission:** Providers reported having a previously established relationship with another specialty pharmacy, so they were not interested in transferring patient prescriptions. Limited provider space to store medications.	Modify MAT PA [medication assisted treatment prior authorization] process. Move to a provider attestation to assist provider and patient with gaining access to MAT medication when clinically appropriate. PA will be waived, and an attestation will be accepted for providers using one of three identified Nevada pharmacies. **Update 2024 submission:** All plans were completed: The PA process was terminated and replaced with provider attestation for providers who utilized the 3 select pharmacies. Education about the new process was completed.
Adults' Access to Preventive/Ambulatory Health Services (AAP)	
Members do not know about the benefits and importance of completing their annual preventive appointment.	Educate and incentivize members for completing their annual visit by adding the *AAP* measure to the VAB [Value Added Benefit]/Member Rewards program. **Update 2024 submission:** As stated in the PDSA form, this intervention will be adapted to educate and encourage members for completing their annual visit by adding an external vendor to conduct outbound calls to increase member engagement and change their behavior when accessing preventative health services.
Providers are not focused on closing gaps in the *AAP* measure for members who are empaneled to them.	Incentivize providers for completing adult annual wellness visits by adding *AAP* to the Primary Care Provider Incentive (PCPi) program. **Update 2024 submission:** As stated in the PDSA form, **UHC HPN** will continue to incentivize providers for preventive visits by continuing to include the *AAP* measure in the Primary Care Provider Incentive (PCPi) program.
Members cannot get *AAP* appointments during convenient hours or have other barriers that prevent an in-office visit such as transportation or childcare.	Conduct in-person appointments via mobile medical vendor to the noncompliant population with specific barriers to ensure that their annual preventive care visit is completed. **Update 2024 submission:** As stated in the PDSA form, **UHC HPN** will continue to conduct in person appointments via mobile medical vendor to the non-

Barriers	Interventions
	compliant population with specific barriers to ensure that their annual preventive care visit is completed.
Child and Adolescent Well-Care Visit (WCV)	
Members' parent(s) or guardian(s) overlook scheduling well-child visit appointments.	Vendor to conduct live outbound calls to educate members of the importance of well-child visits and assist with scheduling an appointment with their empaneled provider. **Update 2024 submission:** The **UHC HPN** PIP team will continue to test for sustained improvement over time.
Members' parent(s) or guardian(s) do not know about the importance of taking their child to complete their WCV appointment.	**UHC HPN** Clinical Operations team to conduct local live outbound calls to educate members of the importance of well-child visits and schedule an appointment directly in the provider scheduling software. **Update 2024 submission:** The **UHC HPN** PIP team will continue to test for sustained improvement over time.
Providers are neglecting to code for well-child visits. Providers do not conduct well-child visits during scheduled sick visits. Providers do not bill well-child visits when Medicaid is secondary payer.	Incentivize and educate three underperforming providers for completing well-child visits by adding an additional *WCV* bonus program. **Update 2024 submission:** **UHC HPN** will adopt this intervention and expand the increased incentives to all primary care providers participating in the PCPI program. PIP team will continue to test for sustained improvement over time.
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	
Delay in notification of ED visits. Primary care groups and integrated medical/behavioral practices do not receive timely notification of ED visits for members who are assigned to a PCP within their group. A delay in notification can impact timely follow-up. **Update 2024 submission:** Behavioral health CPCs [clinical practice consultants] are challenged with securing meetings with medical and medical/behavioral health integrated groups. In person meetings have shown improved engagement from the providers.	Develop data exchange for behavioral health-related ED visits. Notify select primary care groups and integrated medical/behavioral practices of behavioral health-related ED visits for members who are assigned to a PCP within their group. **Update 2024 submission:** Provider offices who agreed to participate in the intervention are receiving reports as planned. A new intervention is now in process to address the lack of understanding by the provider offices of mental health resources and services.

Barriers	Interventions
Provider groups have expressed challenges with addressing mental health needs with patients due to their limited knowledge of existing mental health services.	
Limited appointment availability for members with a recent ED visit. **Update 2024 submission:** Although appointment access is improved, an additional barrier was identified. Incomplete and outdated contact information for members reduces the number of patients that can be reached once discharged from the ED. Additionally, while members may be empaneled to a particular provider group, the patient may not have established care so is unknown to the group.	Provider incentive for select primary care groups and integrated medical/behavioral practices for completing follow-up appointments within 7 days and 30 days of an ED visit and using appropriate documentation and coding. **Update 2024 submission:** The incentive is in place with higher payouts for the 7-day versus the 30-day compliance. Contact information for Medicaid members is always a challenge due to changing phone numbers and short-term addresses. The plan is working hard to collect email addresses and there may be some opportunity to communicate with our members in this preferred and immediate manner for follow-up appointments.
SDOH may serve as a barrier to completing follow-up appointments. Members can be difficult to engage in follow-up treatment. **Update 2024 submission:** The inability to connect with members once they are discharged from the hospital remains a barrier.	**UHC HPN**'s post-discharge team should outreach to members immediately following discharge from the ED. Educate members on the importance of follow-up appointments and assist with scheduling or rescheduling of the appointments. Identify and address any SDOH (transportation, unsecure housing, etc.) which may serve as a barrier to completing a follow-up visit after an ED visit. **Update 2024 submission:** In October 2023, the Post Discharge team expanded to include **UHC HPN** NowClinic® licensed therapists. The addition of licensed therapists allowed members to speak with a mental health therapist in real time. This innovative therapist-led intervention helped to increase follow-up care.
Prenatal and Postpartum Care (PPC)	
Delayed notification of pregnancy.	Provider education on coding CPT II [Current Procedural Terminology II] code 0500F to identify the population early during pregnancy for early outreach and impactable reduction in SDOH barriers to accessing prenatal care. **Update 2024 submission:** Intervention was successful with measured improvement. **UHC HPN** will test this for another cycle and compare sustainable outcomes.

Barriers	Interventions
Members' lack of access to nutritional foods/desserts is a SDOH nonmedical factor that influences health outcomes.	Member outreach and value-added benefit reward to schedule postpartum appointments for women of color. Member will receive a Healthy Food Box with 5–6 plant-based meals delivered to the home by a **UHC HPN** vendor for completion of a postpartum visit. **Update 2024 submission:** Intervention was successful with measured improvement. **UHC HPN** will test this for another cycle and compare sustainable outcomes.
Lack of gap closure through claims and encounters.	Provider education and reporting tools to identify missed opportunities for closing gaps in care for postpartum visits with CPT II coding 0503F. **Update 2024 submission:** Intervention was successful with measured improvement. **UHC HPN** will test this for another cycle and compare sustainable outcomes.
Members' lack of social support is a SDOH nonmedical factor that influences health outcomes like completing a postpartum care visit.	Member education, resources, and support. Monthly in-person support group for African-American population. Education is provided with structured planned topics regarding resiliency, healthy boundaries, balance, and alternatives to talk therapy. The OB [obstetric] CHW [community health worker] provides education and resources for transportation, breastfeeding, and postpartum support. **Update 2024 submission:** Intervention testing cycle 1 was successful. Qualitative success stories have proven peer support improves postpartum care.
Plan All-Cause Readmissions (PCR)	
Members experience barriers to accessing and following up with their PCP such as transportation and appointment reminders.	Screen members upon admission for barriers that would prevent them from attending their PCP appointment. **Update 2024 submission:** To make a larger impact on the plan's overall readmit rate, **UHC HPN** will implement changes aimed to ensure the intervention screening is conducted correctly and to increase the rate at which the intervention is done.
Inadequate provider, staff, and member engagement.	Change in referral process to increase member engagement, conversion rates, and referral volume. **Update 2024 submission:** To make a larger impact on the plan's overall readmit rate, **UHC HPN** will reeducate inpatient case management staff of the importance of the Dispatch Health visits following discharge to increase the rate at which the intervention is done.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: The performance on all PIPs suggests a thorough application of the PIP Design. A sound design, which consists of collecting data and implementing interventions that have the potential to impact performance indicator results, created the foundation for **UHC HPN** to progress to subsequent PIP stages and measure the desired outcomes for the project. **[Quality, Timeliness,** and **Access]**

Strength #2: UHC HPN achieved statistically significant improvement at the first remeasurement for three of six PIPs: *Child and Adolescent Well Care Visit (WCV), Follow-Up After Emergency Department Visit for Mental Illness (FUM),* and *Timeliness of Prenatal and Postpartum Care (PPC)*. **[Timeliness,** and **Access]**

Weaknesses and Recommendations

Weakness #1: UHC HPN did not achieve statistically significant improvement for the *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)*, *Adults' Access to Preventive/Ambulatory Health Services (AAP)*, and *Plan All-Cause Readmissions (PCR)* PIPs. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: The interventions initiated by **UHC HPN** did not have the desired impact.

Recommendation: For the PIPs that did not achieve the desired outcome of statistically significant improvement across all performance indicators, **UHC HPN** should revisit its causal/barrier analysis processes and current interventions to determine the possible causes for the lack of significant improvement or the decline in performance. **UHC HPN** should use the findings from this analysis to develop new active engaging interventions or to revise current strategies to address the barriers to achieving improvement.

Performance Measure Validation

Performance Results

Table 3-45 and Table 3-46 show **UHC HPN**'s Medicaid and Nevada Check Up HEDIS and CMS Child and Adult Core Set performance measure results for MY 2021, MY 2022, and MY 2023, along with MY 2022 to MY 2023 rate comparisons and performance target ratings.

Performance for MY 2023 (SFY 2024) is indicated by symbols and color coding; **bolded** rates indicate the rate met or exceeded the DHCFP-established MPS[25]; ↑ indicates the rate was above the national Medicaid 50th percentile benchmark, ↓ indicates the rate was below the national 50th percentile benchmark, **green** shading indicates that the rate improved by 5 percentage points from the prior year, and **red** shading indicates that the rate declined by 5 percentage points from the prior year.

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

Table 3-45—Medicaid SFY 2024 Performance Measure Results and Trending for UHC HPN

HEDIS Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	MY 2022–MY 2023 Rate Comparison
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services (AAP)				
(20–44 Years)	66.38%	67.63%	66.11%↓	-1.52
(45–64 Years)	74.57%	76.95%	75.23%↓	-1.72
(65+ Years)	71.43%	71.03%	62.17%↓	-8.86
(Total)	68.93%	70.70%	69.07%↓	-1.63
Children's Preventive Care				
Child and Adolescent Well-Care Visits (WCV)				
(3–11 Years)	50.75%	52.63%	**54.85%**↓	2.22
(12–17 Years)	46.03%	47.96%	**48.98%**↓	1.02
(18–21 Years)	20.86%	23.14%	24.64%↑	1.5
Total	44.66%	46.43%	48.26%↑	1.83
Childhood Immunization Status (CIS)				
Combination 3	60.58%	60.34%	55.14%↓	-5.20
Combination 7	52.80%	53.77%	49.35%↓	-4.42
Combination 10	27.25%	25.79%	18.82%↓	-6.97

[25] Refer to *Appendix B. Goals and Objectives Tracking* for measures with an established MPS. Not all measure rates reported by the MCO have a DHCFP-established MPS.

HEDIS Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	MY 2022–MY 2023 Rate Comparison
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	83.21%	86.62%	85.16%↑	-1.46
Combination 2 (Meningococcal, Tdap, HPV)	37.96%	39.66%	36.74%↑	-2.92
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile Documentation (Total)	86.58%	82.99%	84.76%↑	1.77
Counseling for Nutrition (Total)	76.68%	76.42%	76.83%↑	0.41
Counseling for Physical Activity (Total)	72.84%	73.13%	71.34%↑	-1.79
Well-Child Visits in the First 30 Months of Life (W30)				
(First 15 Months)	57.43%	62.03%	**63.09%**↑	1.06
(15 Months–30 Months)	59.91%	62.38%	64.88%↓	2.5
Developmental Screening in the First Three Years of Life (DEV-CH)				
(1 Year)	—	—	12.30%	NC
(2 Years)	—	—	32.87%	NC
(3 Years)	—	—	30.47%	NC
(Total)	—	—	25.10%	NC
Lead Screening in Children (LSC)				
Lead Screening in Children	NA	NA	22.97%↓	NC
Women's Health and Maternity Care				
Breast Cancer Screening (BCS-E)				
Breast Cancer Screening	51.07%	54.90%	51.72%↓	NC
Chlamydia Screening in Women (CHL)				
(16–20 Years)	57.86%	58.15%	**60.87%**↑	2.72
(21–24 Years)	62.11%	62.44%	62.32%↑	-0.12
(Total)	60.02%	60.30%	61.62%↑	1.32
Postpartum Depression Screening and Follow-Up (PDS-E)				
Depression Screening	NA	0.00%	0.00%↓	0.00
Follow–Up on Positive Screen	NA	NA	NA	NC
Prenatal and Postpartum Care (PPC)				
Timeliness of Prenatal Care	86.37%	88.08%	**89.29%**↑	1.21

HEDIS Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	MY 2022–MY 2023 Rate Comparison
Postpartum Care	74.21%	80.29%	**81.27%↑**	0.98
Prenatal and Postpartum Care (PPC2-CH)				
Timeliness of Prenatal Care—Under 21 Years	—	—	84.62%	NC
Postpartum Care—Under 21 Years	—	—	82.69%	NC
Prenatal Depression Screening and Follow-Up (PND-E)				
Depression Screening	—	0.00%	0.00%↓	0.00
Follow–Up on Positive Screen	—	NA	NA	NC
Prenatal Immunization Status (PRS-E)				
Influenza	—	12.26%	11.13%↓	-1.13
Tdap	—	26.50%	28.70%↓	2.20
Combination	—	8.00%	8.03%↓	0.03
Contraceptive Care—Postpartum Women (CCP-CH)				
Most or Moderately Effective Contraception—3 Days—(15–20 Years)	—	—	4.76%	NC
Most or Moderately Effective Contraception—90 Days—(15–20 Years)	—	—	39.68%	NC
Long-Acting Reversible Contraception—3 Days—(15–20 Years)	—	—	0.40%	NC
Long-Acting Reversible Contraception—90 Days—(15–20 Years)	—	—	8.73%	NC
Contraceptive Care—All Women (CCW-CH)				
Most or Moderately Effective Contraception—(15–20 Years)	—	—	12.61%	NC
Long-Acting Reversible Contraception—(15–20 Years)	—	—	1.60%	NC
Care for Chronic Conditions				
Asthma Medication Ratio (AMR)				
(5–11 Years)	77.84%	72.17%	67.71%↓	-4.46
(12–18 Years)	67.40%	65.87%	54.89%↓	-10.98
(5–18 years) Child Core Set	—	69.20%	61.91%	-7.29
(19–50 Years)	50.58%	53.09%	48.20%↓	-4.89
(51–64 Years)	52.41%	54.01%	52.07%↓	-1.94

HEDIS Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	MY 2022–MY 2023 Rate Comparison
(19–64 years) Adult Core Set	—	53.36%	49.34%	-4.02
(Total)	58.78%	59.14%	54.12%↓	-5.02
Blood Pressure Control for Patients With Diabetes (BPD)				
Blood Pressure Control for Patients With Diabetes	68.37%	67.64%	**65.21%**↑	-2.43
Controlling High Blood Pressure (CBP)				
Controlling High Blood Pressure	65.69%	64.36%	**66.32%**↑	NC
Hemoglobin A1c Control for Patients With Diabetes (HBD)				
*HbA1c Control (>9.0%)**	37.71%	45.26%	40.63%↓	-4.63
HbA1c Control (<8%)	51.58%	46.23%	50.61%↓	4.38
Behavioral Health				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	43.18%	47.96%	42.41%↓	-5.55
Antidepressant Medication Management (AMM)				
Effective Acute Phase Treatment	54.22%	53.48%	**58.05%**↓	4.57
Effective Continuation Phase Treatment	36.61%	35.81%	40.04%↓	4.23
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	72.69%	72.60%	76.68%↓	4.08
Follow-Up After Emergency Department Visit for Substance Use (FUA)				
7 days (Total)	—	19.47%	14.95%↓	-4.52
30 days (Total)	—	29.78%	25.77%↓	-4.01
Follow-Up After Emergency Department Visit for Mental Illness (FUM)				
7 days (Total)	44.07%	47.19%	**53.08%**↑	5.89
30 days (Total)	53.79%	54.55%	**61.61%**↑	7.06
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)				
7 Days (Total)	NA	28.28%	31.10%↑	2.82
30 days (Total)	NA	43.72%	50.06%↓	6.34

HEDIS Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	MY 2022–MY 2023 Rate Comparison
Follow-Up After Hospitalization for Mental Illness (FUH)				
7 days (Total)	35.73%	35.88%	33.07%↓	-2.81
30 days (Total)	51.96%	53.75%	49.04%↓	-4.71
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
Initiation Phase	54.56%	49.89%	54.69%↑	4.80
Continuation and Maintenance Phase	72.15%	68.00%	63.96%↑	-4.04
Initiation and Engagement of Substance Use Disorder Treatment (IET)				
Initiation of SUD Treatment—Total (Total)	—	44.75%	45.04%↑	0.29
Engagement of SUD Treatment—Total (Total)	—	13.78%	14.63%↑	0.85
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)				
Blood Glucose and Cholesterol Testing (Total)	29.86%	32.02%	**39.68%↑**	7.66
Screening for Depression and Follow-Up Plan (CDF-CH/CDF-AD) ∞				
(12–17 Years)	—	0.31%	0.28%	-0.03
(18–64 Years)	—	1.25%	1.64%	0.39
(65+ Years)	—	3.94%	0.75%	-3.19
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)				
(1–11 Years)	56.63%	50.00%	52.83%↓	2.83
(12–17 Years)	54.70%	65.63%	50.42%↓	-15.21
(Total)	55.50%	60.75%	51.16%↓	-9.59
Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)				
Rate 1: Total	—	51.01%	43.15%	-7.86
Rate 2: Buprenorphine	—	39.60%	30.80%	-8.8
Rate 3: Oral Naltrexone	—	6.71%	3.15%	-3.56
Rate 4: Long-Acting, Injectable Naltrexone	—	3.36%	0.41%	-2.95
Rate 5: Methadone	—	4.70%	10.72%	6.02
Diabetes Care for People With Serious Mental Illness: Hemoglobin A1c Poor Control (>9.0%) (HPCMI-AD)*				
(18–64 Years)	—	—	44.44%	NC
(65–75 Years)	—	—	NA	NC

HEDIS Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	MY 2022–MY 2023 Rate Comparison
Utilization				
Ambulatory Care—Total (per 1,000 Member Years) (AMB) **				
*ED Visits—Total**	515.38	576.62	542.57	-34.05
Outpatient Visits—Total	3,228.10	3,611.76	3,499.54	NC
Plan All-Cause Readmissions (PCR)				
*Observed Readmissions Total—(18–64 Years)**	9.99%	10.41%	**10.62%**	0.21
Expected Readmissions Total—(18–64 Years)	8.85%	9.05%	9.12%	0.07
O/E Ratio Total—(18–64 Years)	1.1294	1.1499	1.1648	0.0149
Outliers Total—(18–64 Years)	60.09	67.04	68.38	1.34
Overuse/Appropriateness of Care				
Risk of Continued Opioid Use (COU)*				
>=15 Days (Total)	NA	7.77%	8.45%↓	0.68
>=31 Days (Total)	NA	6.36%	6.72%↓	0.36
Use of Opioids at High Dosage (HDO)*				
Use of Opioids at High Dosage	8.83%	8.68%	8.92%↓	0.24
Use of Opioids From Multiple Providers (UOP)*				
Multiple Prescribers	21.57%	21.04%	22.73%↓	1.69
Multiple Pharmacies	1.08%	1.19%	1.04%↑	-0.15
Multiple Prescribers and Multiple Pharmacies	0.69%	0.54%	0.50%↑	-0.04
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)				
(3 Months–17 Years)	NA	NA	71.76%↓	NC
(18–64 Years)	NA	NA	49.19%↑	NC
(65+ Years)	NA	NA	NA	NC
(Total)	NA	NA	63.54%↑	NC

↑ Indicates the MY 2023 rate was above NCQA's Quality Compass 2023 Medicaid HMO 50th percentile benchmark.
↓ Indicates the MY 2023 rate was below NCQA's Quality Compass 2023 Medicaid HMO 50th percentile benchmark.
* A lower rate indicates better performance for this measure or indicator.
** Beginning MY 2022, this rate was reported per 1,000 member years instead of per 1,000 member months; the rates for MY 2021 were converted to member years for comparison.
— Indicates that the MCO was not previously required to report this measure or that the rate is not appropriate to display due to changes in the technical specifications resulting in a break in trending.

∞ MCOs reported *CDF—18—64 years* and *CDF—65 years and older* to align with the CMS Adult Core Set FFY 2024 technical specifications. HSAG will assess each indicator separately to determine if the MCOs met or exceeded DHCFP's QISMC goal for *CDF—18 years and older*.
NC indicates the MY 2022–MY 2023 Rate Comparison could not be calculated because data are not available for both years.
NA indicates that the MCO followed the specifications, but the denominator was too small (i.e., <30) to report a valid rate.
Bolded rates indicate that the MY 2023 performance measure rate met or exceeded the DHCFP-established MPS.

Indicates that the MY 2023 rate declined by 5 percentage points or more from MY 2022.

Indicates that the MY 2023 rate improved by 5 percentage points or more from MY 2022.

Table 3-46—Nevada Check Up SFY 2024 Performance Measure Results and Trending for UHC HPN

HEDIS Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	MY 2022–MY 2023 Rate Comparison
Children's Preventive Care				
Child and Adolescent Well-Care Visits (WCV)				
(3–11 Years)	52.35%	54.82%	59.20%↑	4.38
(12–17 Years)	52.87%	55.26%	**54.98%**↑	-0.28
(18–21 Years)	28.69%	39.92%	34.95%↑	-4.97
Total	50.72%	53.69%	55.40%↑	1.71
Childhood Immunization Status (CIS)				
Combination 3	75.78%	74.12%	71.67%↑	-2.45
Combination 7	68.61%	70.59%	68.33%↑	-2.26
Combination 10	43.05%	37.65%	26.67%↓	-10.98
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	89.05%	92.82%	94.16%↑	1.34
Combination 2 (Meningococcal, Tdap, HPV)	47.93%	47.95%	47.69%↑	-0.26
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile Documentation (Total)	85.07%	81.49%	**85.67%**↑	4.18
Counseling for Nutrition (Total)	76.12%	75.22%	**77.13%**↑	1.91
Counseling for Physical Activity (Total)	72.84%	73.43%	**75.30%**↑	1.87
Well-Child Visits in the First 30 Months of Life (W30)				
(First 15 Months)	63.03%	75.00%	**76.15%**↑	1.15
(15 Months–30 Months)	73.96%	68.49%	68.10%↑	-0.39

HEDIS Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	MY 2022–MY 2023 Rate Comparison
Developmental Screening in the First Three Years of Life (DEV-CH)				
(1 Year)	—	—	12.44%	NC
(2 Years)	—	—	39.47%	NC
(3 Years)	—	—	32.43%	NC
(Total)	—	—	29.80%	NC
Lead Screening in Children (LSC)				
Lead Screening in Children	—	—	28.10%↓	NC
Women's Health and Maternity Care				
Chlamydia Screening in Women (CHL)				
(16–20 Years)	59.62%	51.76%	**61.36%↑**	9.60
(21–24 Years)	NA	NA	NA	NC
(Total)	59.62%	51.76%	61.36%↑	9.60
Prenatal and Postpartum Care (PPC)				
Timeliness of Prenatal Care	—	—	NA	NC
Postpartum Care	—	—	NA	NC
Prenatal and Postpartum Care (PPC2-CH)				
Timeliness of Prenatal Care—Under 21 Years	—	—	NA	NC
Postpartum Care—Under 21 Years	—	—	NA	NC
Contraceptive Care—Postpartum Women (CCP-CH)				
Most or Moderately Effective Contraception—3 Days—(15–20 Years)	—	—	NA	NC
Most or Moderately Effective Contraception—90 Days—(15–20 Years)	—	—	NA	NC
Long-Acting Reversible Contraception—3 Days—(15–20 Years)	—	—	NA	NC
Long-Acting Reversible Contraception—90 Days—(15–20 Years)	—	—	NA	NC
Contraceptive Care—All Women (CCW-CH)				
Most or Moderately Effective Contraception—(15–20 Years)	—	—	9.91%	NC
Long-Acting Reversible Contraception—(15–20 Years)	—	—	1.14%	NC

HEDIS Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	MY 2022–MY 2023 Rate Comparison
Care for Chronic Conditions				
Asthma Medication Ratio (AMR)				
(5–11 Years)	83.02%	NA	76.00%↑	NC
(12–18 Years)	69.70%	63.04%	66.00%↓	2.96
(5–18 years) Child Core Set	—	67.61%	71.00%	3.39
(19–50 Years)	NA	NA	NA	NC
(51–64 Years)	NA	NA	NA	NC
(19–64 years) Adult Core Set	—	NA	NA	NC
(Total)	75.63%	67.61%	71.29%↑	3.68
Behavioral Health				
Follow-Up After Emergency Department Visit for Substance Use (FUA)				
7 days (Total)	—	NA	NA	NC
30 days (Total)	—	NA	NA	NC
Follow-Up After Emergency Department Visit for Mental Illness (FUM)				
7 days (Total)	NA	NA	NA	NC
30 days (Total)	NA	NA	NA	NC
Follow-Up After Hospitalization for Mental Illness (FUH)				
7 days (Total)	57.89%	NA	**63.64%**↑	NC
30 days (Total)	81.58%	NA	**84.85%**↑	NC
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
Initiation Phase	50.85%	34.00%	**54.29%**↑	20.29
Continuation and Maintenance Phase	NA	NA	NA	NC
Initiation and Engagement of Substance Use Disorder Treatment (IET)				
Initiation of SUD Treatment—Total (Total)	—	NA	NA	NC
Engagement of SUD Treatment—Total (Total)	—	NA	NA	NC
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)				
Blood Glucose and Cholesterol Testing (Total)	43.90%	42.86%	35.14%↑	-7.72

HEDIS Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	MY 2022–MY 2023 Rate Comparison
Screening for Depression and Follow-Up Plan (CDF-CH/CDF-AD)				
(12–17 Years)	—	0.25%	0.29%	0.04
(18–64 Years)	—	1.32%	1.83%	0.51
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)				
(1–11 Years)	—	NA	NA	NC
(12–17 Years)	—	NA	NA	NC
(Total)	—	NA	NA	NC
Utilization				
Ambulatory Care—Total (per 1,000 Member Years) (AMB)**				
*ED Visits—Total**	192.71	282.16	277.78	-4.38
Outpatient Visits—Total	2,292.59	2,666.78	2,495.27	NC
Overuse/Appropriateness of Care				
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)				
(3 Months–17 Years)	—	—	55.05%↓	NC
(18–64 Years)	—	—	NA	NC
(Total)	—	—	55.36%↓	NC

↑ Indicates the MY 2023 rate was above NCQA's Quality Compass 2023 Medicaid HMO 50th percentile benchmark.
↓ Indicates the MY 2023 rate was below NCQA's Quality Compass 20232 Medicaid HMO 50th percentile benchmark.
* A lower rate indicates better performance for this measure or indicator.
** Beginning MY 2022, this rate was reported per 1,000 member years instead of per 1,000 member months; the rates for MY 2021 were converted to member years for comparison.
— Indicates that the MCO was not previously required to report this measure or that the rate is not appropriate to display due to changes in the technical specifications resulting in a break in trending.
NC indicates the MY 2022–MY 2023 Rate Comparison could not be calculated because data are not available for both years.
NA indicates that the MCO followed the specifications, but the denominator was too small (i.e., <30) to report a valid rate.
Bolded rates indicate that the MY 2023 performance measure rate met or exceeded the DHCFP-established MPS.

Indicates that the MY 2023 rate declined by 5 percentage points or more from MY 2022.

Indicates that the MY 2023 rate improved by 5 percentage points or more from MY 2022.

Strengths, Weaknesses, and Recommendations

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

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

Strengths

Strength #1: Within the Children's Preventive Care domain, **UHC HPN**'s Medicaid population met the State's established MPS for the *Child and Adolescent Well-Care Visits —3–11 Years* and *12–17 Years,* and *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months* measure indicators, which are all associated with QISMC goals. In addition, **UHC HPN**'s Nevada Check Up population met the State's established MPS for the *Child and Adolescent Well-Care Visits—12–17 Years, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI percentile documentation, Counseling for Nutrition,* and *Counseling for Physical Activity,* as well as *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure indicators, which are also all associated with QISMC goals. This performance indicates that **UHC HPN**'s child and adolescent Medicaid and Nevada Check Up members received the appropriate well-care visits, which allowed health care providers the opportunity to influence health and development, as well as assist in early detection of health problems through screening, which could lead to decreased healthcare costs. **[Quality, Timeliness,** and **Access]**

Strength #2: Within the Behavioral Health domain, **UHC HPN**'s Medicaid population met the State's established MPS for the *Antidepressant Medication Management—Effective Acute Phase Treatment*, *Follow-Up After Emergency Department Visit for Mental Illness*, and *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total*, which are all tied to a QISMC goal. Additionally, **UHC HPN**'s Nevada Check Up population met the State's established MPS for *Follow-Up After Hospitalization for Mental Illness* and *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*, which are both associated with a QISMC goal. This performance suggests **UHC HPN** is ensuring its Medicaid and Nevada Check Up members with mental health needs and SUDs receive appropriate care, which potentially leads to reduced costs resulting from ED visits and inpatient stays, as well as reducing risks associated with medications by ensuring appropriate management of children and adolescents on psychiatric medications. **[Quality, Timeliness,** and **Access]**

Weaknesses and Recommendations

Weakness #1: Within the Access to Care domain, **UHC HPN**'s Medicaid rate for *Adults' Access to Preventive/Ambulatory Health Services—20-44 years* and *Adults' Access to Preventive/Ambulatory Health Services—45-64 years* measure indicators associated with QISMC goals did not meet the state-established MPS. **[Timeliness** and **Access]**

Why the weakness exists: Although **UHC HPN**'s Medicaid members appear to have access to PCPs for preventive and ambulatory services, these members were not consistently utilizing these services, which can significantly reduce nonurgent ED visits and potentially prevent more serious health and development issues from occurring, reducing healthcare costs. The low performance in these measure indicators could also be due to disparities in **UHC HPN**'s populations that could

impact access to care, such as language barriers, access to transportation, geographic location, and socioeconomic status.

Recommendation: HSAG recommends that **UHC HPN** identify trends and stratify data based on race/ethnicity, age, ZIP Code, and other factors as needed on the indicators. HSAG recommends that **UHC HPN** also consider a first-visit incentive to members who see a doctor for the first time. Further, HSAG recommends that **UHC HPN** consider offering to schedule the appointment and addressing barriers as needed (e.g. transportation, SDOH). Finally, HSAG recommends that **UHC HPN** ensure provider availability is within required time frames and consider increasing appointment hours.[26]

Weakness #2: Within the Care for Chronic Conditions domain, no measure indicator rates with a QISMC goal met the State's established MPS except for *Blood Pressure Control for Patients With Diabetes* and *Controlling High Blood Pressure.* **[Quality** and **Access]**

Why the weakness exists: Low performance could be due to disparities in its populations that could impact access to care, such as language barriers, access to transportation, geographic location, and socioeconomic status. Declines in the *Asthma Medication Ratio* rates indicate children and adolescents with persistent asthma are not consistently receiving appropriate monitoring of their medications, which could be due to barriers to care. Appropriate medication management for patients with asthma could reduce the need for rescue medication, as well as costs associated with ED visits, inpatient admissions, and missed days of work or school.

Recommendation: UHC HPN has self-reported interventions to address rates for *Asthma Medication Ratio,* including provider education on prescribing patterns for controller medications and encouraging providers to refer members to the health plan asthma disease management program. **UHC HPN** has focused care management outreach efforts to members who have been admitted to the hospital for persistent asthma, members who were noncompliant with the measure in the year prior, and members still noncompliant in the current year. **UHC HPN** created a new educational resource for families on how to manage pediatric asthma that was designed with pictures and a step-by-step guide that is easy for children to follow and launched a new video chat medication management program for children with persistent asthma. **UHC HPN** has indicated measures are monitored monthly. HSAG recommends that **UHC HPN** continue these initiatives, and where possible, identify and measure effectiveness of interventions by establishing baseline and remeasurement metrics. For instance, **UHC HPN** might identify how often the new video chat medication program is utilized and its effectiveness in closing care gaps. HSAG recommends that **UHC HPN** include establishing an asthma action plan with members in its provider education.[27]

[26] AAP—Adults' Access to Preventive/Ambulatory Health Services. Available at: Adults' Access to Preventive/Ambulatory Health Services (hopkinsmedicine.org). Accessed on Dec 19, 2024.

[27] Asthma and Allergy Foundation of America. "Asthma Action Plan." Available at: https://aafa.org/asthma/asthma-treatment/asthma-treatment-action-plan/. Accessed on Dec 19, 2024.

Compliance Review

Performance Results

Table 3-47 presents an overview of the results of the standards reviewed during the SFY 2024 compliance review for **UHC HPN**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Appendix A. If a requirement was not applicable to **UHC HPN** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all seven standards.

Table 3-47—Summary of Standard Compliance Scores

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Disenrollment: Requirements and Limitations	6	6	6	0	0	**100%**
Standard II—Member Rights and Member Information	24	23	20	3	1	**87%**
Standard III—Emergency and Poststabilization Services	13	13	13	0	0	**100%**
Standard IV—Availability of Services	12	12	10	2	0	**83%**
Standard V—Assurances of Adequate Capacity and Services	5	5	5	0	0	**100%**
Standard VI—Coordination and Continuity of Care	28	28	26	2	0	**93%**
Standard VII—Coverage and Authorization of Services	27	27	25	2	0	**93%**
Total	**115**	**114**	**105**	**9**	**1**	**92%**

M = Met*; *NM = Not Met*; *NA = Not Applicable

Total Elements: The total number of elements within each standard.

Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

Based on the findings from the SFY 2024 compliance review activity, **UHC HPN** was required to develop and submit a CAP for each element assigned a score of *Not Met*. The CAP was reviewed by DHCFP and HSAG for sufficiency, and **UHC HPN** was responsible for implementing each action plan in a timely manner.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: UHC HPN achieved full compliance for the Disenrollment: Requirements and Limitations program area, demonstrating that the MCO had appropriate processes and procedures in place related to member and MCO requests for disenrollment. **[Quality]**

Strength #2: UHC HPN achieved full compliance for the Emergency and Poststabilization Services program area, demonstrating that the MCO had adequate processes in place to ensure appropriate coverage of and payment for emergency and poststabilization care services. [**Timeliness** and **Access**]

Strength #3: UHC HPN achieved full compliance for the Assurances of Adequate Capacity and Services program area, demonstrating that the MCO had policies and processes in place to maintain and monitor an adequate provider network to provide adequate access to all services (e.g., primary care, specialty care, hospital and emergency services, behavioral health, and prenatal care) for its membership. [**Timeliness** and **Access**]

Weaknesses and Recommendations

Weakness #1: UHC HPN had three elements in the Member Rights and Member Information program area that received a score of *Not Met*, indicating that members may not be notified of or receive required member materials and information timely. [**Timeliness** and **Access**]

Why the weakness exists: UHC HPN did not demonstrate that the MCO ensured member materials adhered to State and federal requirements, that members were notified of the time frame for receiving a member handbook upon member's request, and there were inconsistencies between information included in the online and paper provider directories.

Recommendation: While **UHC HPN** was required to develop a CAP to address the deficiencies identified, HSAG recommends that the MCO conduct a comprehensive review of its member-facing materials and its processes and procedures related to member information to identify whether additional opportunities for improvement in this program area exist and take remedial action as necessary.

Network Adequacy Validation

Performance Results

HSAG determined that the providers per 1,500 members in Clark and Washoe counties exceeded DHCFP's requirements. Table 3-48 presents results by the number of providers per 1,500 members in Clark and Washoe counties and by the DHCFP-required provider types.

Table 3-48 presents **UHC HPN**'s network adequacy results for Provider-to-Member Ratios.

Table 3-48—United Healthcare Health Plan Provider-to-Member Ratios by Provider Type by County

Provider Type	Indicator	Providers per 1,500 Members (Clark County)	Providers per 1,500 Members (Washoe County)
PCP not practicing in conjunction with healthcare professional*	1:1,500	2.42	6.81
Specialists	1:1,500	2.65	10.98

* If the PCP practices in conjunction with a healthcare professional (i.e., nurse practitioner or physician's assistant), the ratio is increased to one FTE PCP for every 1,800 members. DHCFP's 402 network adequacy reporting template did not break out PCP practices in conjunction with a healthcare professional.

DHCFP established a 100 percent threshold when determining compliance with time or distance standards. HSAG determined that indicators that fell below the 100 percent threshold achieved greater than or equal to 96.8 percent compliance with access standards. Table 3-49 presents results by percentage of members with access across Clark and Washoe counties and by the DHCFP-established provider categories. Results that achieved the 100 percent access threshold are shaded **green**.

Table 3-49 presents **UHC HPN**'s network adequacy results for Time or Distance.

Table 3-49—United Healthcare Health Plan Percentage of Members With Access by Provider Category by County

Provider Category	Time or Distance Indicator	Percentage of Members With Access (Clark County)	Percentage of Members With Access (Washoe County)
Primary Care, Adults	10 miles or 15 minutes	99.9%	99.9%
OB/GYN (Adult Females)	10 miles or 15 minutes	99.9%	96.8%
Pediatrician	10 miles or 15 minutes	99.9%	99.6%
Endocrinologist	40 miles or 60 minutes	100%	100%

Provider Category	Time or Distance Indicator	Percentage of Members With Access (Clark County)	Percentage of Members With Access (Washoe County)
Endocrinologist, Pediatric	40 miles or 60 minutes	100%	100%
Infectious Disease	40 miles or 60 minutes	100%	100%
Infectious Disease, Pediatric	40 miles or 60 minutes	100%	100%
Rheumatologist	40 miles or 60 minutes	100%	100%
Rheumatologist, Pediatric	40 miles or 60 minutes	100%	100%
Oncologist/Radiologist	40 miles or 60 minutes	100%	100%
Oncologist/Radiologist, Pediatric	40 miles or 60 minutes	100%	100%
Oncologist—Medical/Surgical	30 miles or 45 minutes	100%	100%
Oncologist—Medical/Surgical, Pediatric	30 miles or 45 minutes	100%	100%
Psychologist	30 miles or 45 minutes	100%	100%
Psychologist, Pediatric	30 miles or 45 minutes	99.9%	100%
Psychiatrist	30 miles or 45 minutes	100%	100%
Board Certified Child and Adolescent Psychiatrist	45 minutes or 30 miles	100%	100%
Qualified Mental Health Professional (QMHP)	30 miles or 45 minutes	100%	100%
QMHP, Pediatric	30 miles or 45 minutes	100%	100%
Hospital, All	30 miles or 45 minutes	100%	100%
Psychiatric Inpatient Hospital	30 miles or 45 minutes	99.9%	99.9%
Dialysis/End Stage Renal Disease (ESRD) Facility	30 miles or 45 minutes	99.9%	100%

Provider Category	Time or Distance Indicator	Percentage of Members With Access (Clark County)	Percentage of Members With Access (Washoe County)
Pharmacy	10 miles or 15 minutes	99.9%	99.8%

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: UHC HPN had established robust processes to mitigate missing or incomplete provider information through its comprehensive contracting and credentialing processes. Additionally, **UHC HPN** has several methods of maintaining and updating provider demographic information ensuring members have access to accurate and current provider information for use in selecting providers and making appointments. **[Quality** and **Access]**

Weaknesses and Recommendations

Weakness #1: Provider network information is manually loaded from the eVIPS provider network management database system to the Facets claims system by system analysts. **[Quality** and **Access]**

Why the weakness exists: UHC HPN may have potential gaps in its system capabilities to automate data integration that can contribute to a greater possibility of data errors.

Recommendation: Although **UHC HPN** had quality assurance checks and validations in place, HSAG recommends **UHC HPN** explore options to have the data automatically or systemically uploaded from one system to another to mitigate the potential for human data entry error.

Weakness #2: UHC HPN adjusted its calculation methodology for provider-to-member ratio reporting based on its interpretation of DHCFP contract language. **[Quality** and **Access]**

Why the weakness exists: UHC HPN advised that it interpreted DHCFP's contract language to mean that **UHC HPN** should adjust the FTE calculations to take into consideration the provider's availability to see **UHC HPN**'s Medicaid members and that a provider may have other health plan contracts and see members across commercial, exchange, Medicare, and Medicaid lines of business. Therefore, a calculation was used that accounted for only a portion of the provider's time as being available for **UHC HPN**'s members as it was interpreted by **UHC HPN** that if it had used a full FTE calculation, it would have overinflated the ratio and the access to the provider's members.

Recommendation: HSAG recommends **UHC HPN** reach out to DHCFP to confirm **UHC HPN** is following the DHCFP-required methodology to calculate these network adequacy indicators.

Weakness #3: Although **UHC HPN** was able to apply the necessary corrections for final reporting, HSAG observed **UHC HPN** was not separating the adult and pediatric populations for a subset of provider categories as well as not reporting inpatient psychiatric hospitals separately as required by DHCFP. **[Quality** and **Access]**

Why the weakness exists: DHCFP's network adequacy reporting template was not structured to allow for MCO reporting of both adult and pediatric populations for DHCFP-specified provider categories. The network adequacy reporting template also did not include a place for **UHC HPN** to report inpatient psychiatric hospitals.

Recommendation: HSAG recommends that **UHC HPN** work with DHCFP on future template updates to ensure all DHCFP reporting requirements are captured on the reporting template, including the necessary population stratifications.

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results

Table 3-50 presents the 2024 CAHPS top-box scores for **UHC HPN**'s adult Medicaid, general child Medicaid, CCC Medicaid, Nevada Check Up general child, and Nevada Check Up CCC populations. Arrows (↓ or ↑) indicate 2024 scores that were statistically significantly higher or lower than the 2023 national average.[28]

Table 3-50—Summary of 2024 CAHPS Top-Box Scores for UHC HPN

	Adult Medicaid	General Child Medicaid	CCC Medicaid	Nevada Check Up General Child	Nevada Check Up CCC
Composite Measures					
Getting Needed Care	NA	NA	NA	NA	NA
Getting Care Quickly	NA	NA	NA	NA	NA
How Well Doctors Communicate	NA	NA	NA	94.04%	NA
Customer Service	NA	NA	NA	NA	NA
Global Ratings					
Rating of All Health Care	NA	NA	NA	76.00% ↑	NA
Rating of Personal Doctor	NA	73.91%	NA	82.50% ↑	NA
Rating of Specialist Seen Most Often	NA	NA	NA	NA	NA

[28] 2024 national average results were not available at the time this report was produced.

	Adult Medicaid	General Child Medicaid	CCC Medicaid	Nevada Check Up General Child	Nevada Check Up CCC
Rating of Health Plan	63.96%	76.92%	76.64% ↑	78.06% ↑	NA
Medical Assistance with Smoking and Tobacco Use Cessation Measure Items*					
Advising Smokers and Tobacco Users to Quit	NA	—	—	—	—
Discussing Cessation Medications	NA	—	—	—	—
Discussing Cessation Strategies	NA	—	—	—	—
CCC Composite Measures/Items					
Access to Specialized Services	—	—	NA	—	NA
Family Centered Care (FCC): Personal Doctor Who Knows Child	—	—	NA	—	NA
Coordination of Care for Children With Chronic Conditions	—	—	NA	—	NA
Access to Prescription Medicines	—	—	NA	—	NA
FCC: Getting Needed Information	—	—	NA	—	NA

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

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

↑ Indicates the 2024 score is statistically significantly higher than the 2023 national average.

↓ Indicates the 2024 score is statistically significantly lower than the 2023 national average.

— Indicates the measure does not apply to the population.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Parents/caretakers of CCC Medicaid members had positive overall experiences with their child's health plan since the score for this measure was statistically significantly higher than the 2023 NCQA Medicaid national average. **[Quality]**

Strength #2: Parents/caretakers of Nevada Check Up general child members had positive overall experiences with their child's health care, personal doctor, and health plan since the scores for these measures were statistically significantly higher than the 2023 NCQA Medicaid national averages. **[Quality]**

Weaknesses and Recommendations

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

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

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

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

HSAG performed a comprehensive assessment of **UHC HPN**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **UHC HPN** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **UHC HPN**'s overall performance contributed to the Nevada Managed Care Program's progress in achieving the Nevada Quality Strategy goals and objectives. Table 3-51 displays each Nevada Quality Strategy goal and EQR activity results that indicate whether the MCO positively (✓) or negatively (✗) impacted the Nevada Managed Care Program's progress toward achieving the applicable goals and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **UHC HPN**'s Medicaid members.

Table 3-51—Overall Performance Impact to Nevada Quality Strategy and Quality, Timeliness, and Access

	Quality Strategy Goals		Performance Impact on Goals and Objectives
1	Improve the health and wellness of Nevada's Medicaid population by increasing the use of preventive services by December 31, 2024	✓	4/18 Medicaid rates met the MPS
		✗	14/18 Medicaid rates did not meet MPS
		✓	6/14 applicable Nevada Check Up rates met the MPS
		✗	8/14 applicable Nevada Check Up rates met the MPS

	Quality Strategy Goals		Performance Impact on Goals and Objectives
2	Increase use of evidence-based practices for members with chronic conditions by December 31, 2024	✓	3/7 Medicaid rates met the MPS
		✗	4/7 Medicaid rates did not meet MPS
		✗	0/1 applicable Nevada Check Up rates met the MPS
3	Reduce misuse of opioids by December 31, 2024	✗	0/4 Medicaid rates met the MPS
4	Improve the health and wellness of pregnant women and infants by December 31, 2024	✓	2/5 applicable Medicaid rates met the MPS
		✗	3/5 applicable Medicaid rates did not meet the MPS
5	Increase use of evidence-based practices for members with behavioral health conditions by December 31, 2024	✓	4/21 Medicaid rates met the MPS
		✗	17/21 Medicaid rates did not meet the MPS
		✓	3/6 applicable Nevada Check Up rates met the MPS
		✗	3/6 applicable Nevada Check Up rates met the MPS
6	Increase utilization of dental services by December 31, 2024	Not applicable to the MCO	
7	Reduce and/or eliminate health care disparities for Medicaid members by December 31, 2024	✓	3/3 objectives received a *Met* designation

4. Assessment of Prepaid Ambulatory Health Plan Performance

HSAG used findings across mandatory EQR activities conducted during the SFY 2024 review period to evaluate the performance of the PAHP on providing quality, timely, and accessible healthcare services to Nevada Managed Care Program members. Quality, as it pertains to EQR, means the degree to which the PAHPs increased the likelihood of members' desired outcomes through structural and operational characteristics; the provision of services that were consistent with current professional, evidenced-based knowledge; and interventions for performance improvement. Timeliness refers to the elements defined under §438.68 (adherence to DHCFP's network adequacy standards) and §438.206 (adherence to DHCFP's standards for timely access to care and services). Access relates to members' timely use of services to achieve optimal outcomes, as evidenced by how effective the PAHP was at successfully demonstrating and reporting on outcomes for the availability and timeliness of services.

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

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

Objectives of External Quality Review Activities

This section of the report provides the objectives and a brief overview of each EQR activity conducted in SFY 2024 to provide context for the resulting findings of each EQR activity. For more details about each EQR activity's objectives and the comprehensive methodology, including the technical methods for data collection and analysis, a description of the data obtained and the related time period, and the process for drawing conclusions from the data, refer to Appendix A. Table 4-2 provides HSAG's timeline for conducting each of the EQR activities.

Table 4-1—Timeline for EQR Activities

Activity	EQR Activity Start Date	EQR Activity End Date
PIPs	May 1, 2024	July 22, 2024
PMV	November 16, 2023	July 15, 2024
Compliance Review	January 8, 2024	July 3, 2024

Activity	EQR Activity Start Date	EQR Activity End Date
NAV	May 13, 2024	November 22, 2024
CAHPS	July 15, 2024	November 8, 2024

Validation of Performance Improvement Projects

For SFY 2024, **LIBERTY** submitted its selected PIP topics: a clinical PIP, *Increase Preventive Services for Children,* and a nonclinical PIP, *Coordination of Transportation Services*.

HSAG's validation activities included an evaluation of the PAHP's documentation submitted to support the first eight phases of the PIP process, called the Design and Implementation stages, to determine the overall validity of each PIP's methodological framework. HSAG's validation of the design of each PIP included a review of the PIP topic, Aim statement, target population, sampling methods, performance indicators, and data collection methods to ensure they were based on sound methodological principles and will support reliable reporting of measure outcomes. HSAG assigned a validation rating of *Met*, *Partially Met*, or *Not Met* to each applicable evaluation element within the Design and Implementation stages of each PIP, and an overall validation rating of *High Confidence, Moderate Confidence, Low Confidence,* or *No Confidence* using the level of confidence assignments methodology defined in Appendix A.

Table 4-2 outlines the PIP topics and the Aim statements defined by the PAHP for each PIP topic. The Aim statement helps the PAHP maintain the focus of the PIPs and sets the framework for data collection, analysis, and interpretation of the results.

Table 4-2—PIP Topics and Aim Statements

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

Performance Measure Validation

The SFY 2024 (MY 2023) PMV activity included a comprehensive evaluation of the processes used by **LIBERTY** to collect and report data for three CMS Child Core Set performance measures selected by DHCFP for **LIBERTY**'s Medicaid and Nevada Check Up populations. Table 4-3 lists the performance measures that were validated by HSAG and the measure specifications **LIBERTY** was required to use for calculating the performance measure results.

Table 4-3—SFY 2024 Performance Measures for LIBERTY

Performance Measures	Measure Specifications*
Oral Evaluation, Dental Services (OEV-CH)	FFY 2024 Child Core Set
Sealant Receipt on Permanent First Molars (SFM-CH)	FFY 2024 Child Core Set
Topical Fluoride for Children (TFL-CH)	FFY 2024 Child Core Set

*FFY = federal fiscal year

Compliance Review

DHCFP requires its MCEs to undergo periodic compliance reviews to ensure that an assessment is conducted to meet mandatory EQR requirements. The compliance reviews focus on standards identified in 42 CFR §438.358(b)(1)(iii) and applicable state-specific contract requirements. The current three-year compliance review cycle was initiated in SFY 2024 and comprises 14 program areas referred to as standards. However, DHCFP determined that one standard, Disenrollment: Requirements and Limitations, is not applicable to the PAHP. At DHCFP's direction, HSAG conducted a review of the first six applicable federally required standards and requirements in Year One (SFY 2024) and a review of the remaining federally required seven standards and requirements will be reviewed in Year Two (SFY 2025) of the three-year compliance review cycle. In SFY 2026 (Year Three), the compliance review activity will consist of a re-review of the standards that were not fully compliant during the SFY 2024 (Year One) and SFY 2025 (Year Two) compliance review activities, as indicated by elements (i.e., requirements) that received *Not Met* scores and required CAPs to remediate the noted deficiencies.

Table 4-4 outlines the standards that will be reviewed over the three-year review cycle.

Table 4-4—Nevada Three-Year Cycle of Compliance Reviews

Standards	Associated Federal Citation[1]		Year One (SFY 2024)	Year Two (SFY 2025)	Year Three (SFY 2026)
	Medicaid	CHIP			
Standard I—Disenrollment: Requirements and Limitations	§438.56	§457.1212	Not Applicable[2]		Review of the MCE's Year One and Year Two CAPs
Standard II—Member Rights and Member Information	§438.10 §438.100	§457.1207 §457.1220	✓		

Standards	Associated Federal Citation[1]		Year One (SFY 2024)	Year Two (SFY 2025)	Year Three (SFY 2026)
	Medicaid	CHIP			
Standard III—Emergency and Poststabilization Services	§438.114	§457.1228	✓		
Standard IV—Availability of Services	§438.206	§457.1230(a)	✓		
Standard V—Assurances of Adequate Capacity and Services	§438.207	§457.1230(b) §457.1218	✓		
Standard VI—Coordination and Continuity of Care	§438.208	§457.1230(c)	✓		
Standard VII—Coverage and Authorization of Services	§438.210	§457.1230(d)	✓		
Standard VIII—Provider Selection	§438.214	§457.1233(a)		✓	
Standard IX—Confidentiality	§438.224	§457.1233(e)		✓	
Standard X—Grievance and Appeal Systems	§438.228	§457.1260		✓	
Standard XI—Subcontractual Relationships and Delegation	§438.230	§457.1233(b)		✓	
Standard XII—Practice Guidelines	§438.236	§457.1233(c)		✓	
Standard XIII—Health Information Systems[3]	§438.242	§457.1233(d)		✓	
Standard XIV—Quality Assessment and Performance Improvement Program	§438.330	§457.1240		✓	

[1] The compliance review standards comprise a review of all requirements, known as elements, under the associated federal citation, including all requirements that are cross-referenced within each federal standard, as applicable (e.g., Standard X—Grievance and Appeal Systems includes a review of §438.228 and all requirements under Subpart F of 42 CFR Part 438).

[2] DHCFP determined that the requirements under Standard I—Disenrollment: Requirements and Limitations were not applicable to LIBERTY.

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

Network Adequacy Validation

The NAV activity for SFY 2024 included validation of network capacity and geographic standards and indicators set forth by DHCFP. HSAG assessed the accuracy of DHCFP-defined network adequacy indicators reported by the PAHP and evaluated the PAHP's collection of provider data, the reliability and validity of network adequacy data, the methods used to assess network adequacy, the systems and processes used. Based on the findings from these assessments and evaluations, HSAG then determined an overall validation rating, which provides HSAG's overall confidence that acceptable methodology was used for all phases of the design, data collection, analysis, and interpretation of the network adequacy indicators defined by DHCFP. Table 4-5 and Table 4-6 define the provider categories and provider standards and indicators that were validated by HSAG.

Table 4-5—PAHP Network Adequacy Ratio Indicators Validated

Provider Type	Indicator
Dental PCP	1:1,500

Table 4-6—PAHP Network Adequacy Time or Distance Indicators Validated

Provider Category	Time or Distance Indicator
General Dentist	20 miles or 30 minutes
Dentist, Pediatric	20 miles or 30 minutes
Endodontist	40 miles or 60 minutes
Periodontist	40 miles or 60 minutes
Prosthodontist	40 miles or 60 minutes
Oral Surgeon	40 miles or 60 minutes
Dental Hygienist	40 miles or 60 minutes
Dental Therapist*	40 miles or 60 minutes

Dental Satisfaction Survey

The primary objective of the dental satisfaction survey was to obtain information, effectively and efficiently, on adult members and parents'/caretakers' of child members experiences with the dental care their child received through the PAHP. This survey covers topics that are important to members, such as the communication skills of dental providers and the accessibility of services. The PAHP was responsible for obtaining a CAHPS vendor to administer the dental satisfaction survey on its behalf and was required to submit survey data and a completed methodology form to HSAG by July 15, 2024, for the EQR assessment. HSAG presents top-box scores, which indicate the percentage of respondents who reported positive experiences in a particular aspect of their child's dental care.

Table 4-7 displays the various measures of member experience.

Table 4-7—Dental Satisfaction Survey Measures of Member Experience

CAHPS Measures
Global Ratings
Rating of Regular Dentist
Rating of All Dental Care
Rating of Finding a Dentist
Rating of Dental Plan

CAHPS Measures
Composite Measures
Care from Dentists and Staff
Access to Dental Care
Dental Plan Services
Individual Item Measures
Care from Regular Dentist
Would Recommend Regular Dentist
Would Recommend Dental Plan

External Quality Review Activity Results

LIBERTY Dental Plan of Nevada, Inc.

Validation of Performance Improvement Projects

Performance Results

Table 4-8 displays the overall validation scores and confidence level ratings for the Design and Implementation stages of the PIP process of each PIP topic.

Table 4-8—Overall Validation Ratings for LIBERTY

PIP Topic	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
Increase Preventive Services for Children	100%	100%	*High Confidence*	*Not Assessed*[4]		
Coordination of Transportation Services	100%	100%	*High Confidence*	*Not Assessed*[4]		

[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 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 critical elements *Met*, *Partially Met*, and *Not Met*.
[3] **Confidence Level**— Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.
[4] **Not Assessed**—HSAG did not assess Step 9 as the PAHP only reported baseline data.

Table 4-9 includes the performance indicators that will be used to track performance or improvement over the life of the PIP.

Table 4-9—Performance Indicator Results for LIBERTY

PIP Topic	Performance Indicator	Performance Indicator Results		
		Baseline (01/01/2023–12/31/2023)	R1 (01/01/2024–12/31/2024)	R2 (01/01/2025–12/31/2025)
Increase Preventive Services for Children	The percentage of children who received a topical fluoride application and/or sealants within the reporting year.	38.0%	—	—
Coordination of Transportation Services	The percentage of requests for transportation to and/or from covered oral health services LIBERTY referred to and/or scheduled with the plan's transportation vendor.	100%	—	—
	The percentage of requests for transportation to and/or from covered oral health services that LIBERTY referred to and/or scheduled with and/or the plan's transportation vendor AND where LIBERTY contacted the enrollee to ensure that the transportation was scheduled, and the enrollee had been notified.	45.8%		

— The PIP had not progressed to including Remeasurement 1 and 2 results during SFY 2024. R=Remeasurement
HSAG rounded percentages to the first decimal place.

Interventions

Table 4-10 displays the barriers and interventions as documented by **LIBERTY** for each PIP.

Table 4-10—Interventions Implemented/Planned

Barriers	Interventions
Increase Preventive Services for Children	
LIBERTY believes that various factors all contribute to utilization barriers encountered by the Parents & Guardians of/Members. These factors, such as outdated or incorrect addresses, not understanding dental benefits, and not enough personal time to make appointments, as well as social determinants of health barriers can all lead to utilization barriers.	Multiphase monthly Text Message Outreach campaign that targets non-utilizers of preventive care with a goal of increasing utilization of preventive dental services focusing on the study indicator population group. Additional campaigns will commence focusing on provider identification, appointment assistance, and detailed benefit guidance.
Lack of initiative and incentive from dental providers on prioritizing NV Medicaid members and preventive procedures.	Monitor ongoing "pay for performance" initiatives that reimburse primary care physicians for certain treatment. **Potential Bonus #1**: 18-Month Utilization Provider Bonus. Incentive for serving eligible member who has not been seen in 24 months or more. This incentive encourages and rewards providers for bringing in a member that has not been seen in 24 months or more, which helps members use their preventive services. **Potential Bonus #2**: Provider Initiative Nevada, ongoing. Incentive for completing OHRA/CRA on an eligible *new* child member or pregnant member. **Potential Bonus #3**: Utilization Provider Bonus. Incentive for providers to conduct proactive calls and schedule appointments with specific, assigned Nevada Medicaid children. The purpose is to get the "Outreach Eligible" population scheduled for an appointment.
Coordination of Transportation Services	
Enrollee lack of awareness or understanding of transportation benefits and procedure for contacting **LIBERTY** to schedule appointments.	LIBERTY's Member Services Representatives (MSR) and Case Management (CM) teams conduct continued outreach to non-utilizing enrollees to inform them of transportation availability as well as appointment coordination. Additionally, MSR and CM teams can also follow up about transportation inquiries, previously scheduled appointments, or any access-related barriers that may have been previously identified.
A portion of enrollees are unable to be contacted via telephonic outreach and remain unaware of **LIBERTY**'s transportation services and assistance.	Conduct monthly outreach campaigns, including text message outreach to non-utilizers offering information and assistance with transportation services.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: The performance on **LIBERTY**'s two PIP topics suggests a thorough application of the PIP Design (Steps 1 through 6). A sound design created the foundation for **LIBERTY** to progress to subsequent PIP stages—collecting data and implementing interventions that have the potential to impact performance indicator results and the desired outcomes for the project. **[Quality**, **Timeliness**, and **Access]**

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any weaknesses for **LIBERTY** as both PIPs received a *High Confidence* level under Validation Rating 1. **[Quality**, **Timeliness**, and **Access]**

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

Recommendation: Although no significant weaknesses were identified during the SFY 2024 PIP activities, as **LIBERTY** progresses to the Outcomes stage of the PIP, HSAG recommends that **LIBERTY** review its strategies (i.e., interventions), and update as necessary, to successfully improve member outcomes.

Performance Measure Validation

Performance Results

Table 4-11 through Table 4-12 display **LIBERTY**'s Medicaid and Nevada Check Up CMS Child Core Set performance measure results for MY 2023. The measures selected by DHCFP are CMS Child Core Set measures; therefore, performance was not assessed against NCQA Quality Compass benchmarks. Additionally, SFY 2024 (MY 2023) is the second year **LIBERTY** reported these measures; therefore, trending is displayed for MY 2022 and MY 2023. DHCFP determined MPSs for the QISMC goals related to these measures, using the baseline rates from MY 2022. Performance for MY 2023 (SFY 2024) is indicated by symbols and color coding as applicable; **bolded** rates indicate the rate met or exceeded the DHCFP-established MPS[29], **green** shading indicates that the rate improved by 5 percentage points from the prior year, and **red** shading indicates that the rate declined by 5 percentage points from the prior year.

[29] Refer to *Appendix B. Goals and Objectives Tracking* for measures with an established MPS. Not all measure rates reported by the PAHP have a DHCFP-established MPS.

Table 4-11—Medicaid SFY 2024 Performance Measure Results for LIBERTY

HEDIS Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	MY 2022–MY 2023 Rate Comparison
Dental			
Oral Evaluation (OEV)			
Ages <1	1.12%	1.49%	0.37
Ages 1–2	19.44%	20.73%	1.29
Ages 3–5	40.54%	41.19%	0.65
Ages 6–7	50.41%	50.25%	-0.16
Ages 8–9	51.95%	51.24%	-0.71
Ages 10–11	50.25%	50.43%	0.18
Ages 12–14	46.80%	46.47%	-0.33
Ages 15–18	38.08%	38.19%	0.11
Ages 19–20	22.35%	22.41%	0.06
Total (Ages <1–20)	39.64%	39.75%	0.11
Sealant Receipt on Permanent First Molars (SFM)			
Rate 1—At Least One Sealant	55.26%	56.69%	1.43
Rate 2—All Four Molars	38.18%	38.30%	0.12
Topical Fluoride for Children (TFL)			
Rate 1—Dental or Oral Health Services—Ages 1–2	5.74%	5.96%	0.22
Rate 1—Dental or Oral Health Services—Ages 3–5	16.94%	18.44%	1.50
Rate 1—Dental or Oral Health Services—Ages 6–7	22.68%	23.36%	0.68
Rate 1—Dental or Oral Health Services—Ages 8–9	23.27%	24.38%	1.11
Rate 1—Dental or Oral Health Services- Ages 10–11	22.16%	23.71%	1.55
Rate 1—Dental or Oral Health Services—Ages 12–14	18.79%	19.93%	1.14
Rate 1—Dental or Oral Health Services—Ages 15–18	12.86%	13.69%	0.83
Rate 1—Dental or Oral Health Services—Ages 19–20	4.95%	4.99%	0.04
Rate 1—Dental or Oral Health Services—Total (Ages <1–20)	16.25%	17.30%	1.05
Rate 2—Dental Services—Ages 1–2	5.74%	5.95%	0.21
Rate 2—Dental Services—Ages 3–5	16.94%	18.28%	1.34
Rate 2—Dental Services—Ages 6–7	22.68%	22.66%	-0.02

HEDIS Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	MY 2022–MY 2023 Rate Comparison
Rate 2—Dental Services—Ages 8–9	23.27%	23.76%	0.49
Rate 2—Dental Services—Ages 10–11	22.16%	23.31%	1.15
Rate 2—Dental Services—Ages 12–14	18.79%	19.88%	1.09
Rate 2—Dental Services—Ages 15–18	12.86%	13.68%	0.82
Rate 2—Dental Services—Ages 19–20	4.95%	4.99%	0.04
Rate 2—Dental Services—Total (Ages <1–20)	16.25%	17.08%	0.83
Rate 3—Oral Health Services—Ages 1–2	0.00%	0.00%	0.00
Rate 3—Oral Health Services—Ages 3–5	0.00%	0.02%	0.02
Rate 3—Oral Health Services—Ages 6–7	0.00%	0.06%	0.06
Rate 3—Oral Health Services—Ages 8–9	0.00%	0.08%	0.08
Rate 3—Oral Health Services—Ages 10–11	0.00%	0.04%	0.04
Rate 3—Oral Health Services—Ages 12–14	0.00%	0.00%	0.00
Rate 3—Oral Health Services—Ages 15–18	0.00%	0.00%	0.00
Rate 3—Oral Health Services—Ages 19–20	0.00%	0.00%	0.00
Rate 3—Oral Health Services—Total (Ages <1–20)	0.00%	0.02%	0.02

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

Table 4-12—Nevada Check Up SFY 2024 Performance Measure Results for LIBERTY

HEDIS Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	MY 2022–MY 2023 Rate Comparison
Dental			
Oral Evaluation (OEV)			
Ages <1	2.82%	2.38%	-0.44
Ages 1–2	21.04%	24.81%	3.77
Ages 3–5	46.13%	48.89%	2.76
Ages 6–7	57.21%	59.53%	2.31

HEDIS Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	MY 2022–MY 2023 Rate Comparison
Ages 8–9	59.42%	59.39%	-0.03
Ages 10–11	57.01%	59.07%	2.06
Ages 12–14	54.00%	54.88%	0.88
Ages 15–18	45.46%	45.81%	0.34
Ages 19–20	24.84%	25.22%	0.38
Total (Ages <1–20)	50.15%	51.30%	1.15
Sealant Receipt on Permanent First Molars (SFM)			
Rate 1—At Least One Sealant	62.78%	60.64%	-2.14
Rate 2—All Four Molars	43.46%	40.75%	-2.70
Topical Fluoride for Children (TFL)			
Rate 1—Dental or Oral Health Services—Ages 1–2	8.17%	9.04%	0.88
Rate 1—Dental or Oral Health Services—Ages 3–5	22.61%	24.49%	1.87
Rate 1—Dental or Oral Health Services—Ages 6–7	30.25%	31.41%	1.16
Rate 1—Dental or Oral Health Services—Ages 8–9	30.49%	33.05%	2.56
Rate 1—Dental or Oral Health Services—Ages 10–11	29.67%	32.43%	2.75
Rate 1- Dental or Oral Health Services—Ages 12–14	26.16%	26.96%	0.80
Rate 1—Dental or Oral Health Services—Ages 15–18	17.70%	19.87%	2.17
Rate 1—Dental or Oral Health Services—Ages 19–20	7.94%	4.84%	-3.10
Rate 1—Dental or Oral Health Services—Total (Ages <1–20)	24.14%	25.88%	1.74
Rate 2—Dental Services—Ages 1–2	8.17%	9.04%	0.88
Rate 2—Dental Services—Ages 3–5	22.61%	24.22%	1.61
Rate 2—Dental Services—Ages 6–7	30.25%	30.90%	0.66
Rate 2—Dental Services—Ages 8–9	30.49%	32.30%	1.80
Rate 2—Dental Services—Ages 10–11	29.67%	32.10%	2.42
Rate 2—Dental Services—Ages 12–14	26.16%	26.94%	0.78
Rate 2—Dental Services—Ages 15–18	17.70%	19.87%	2.17
Rate 2—Dental Services—Ages 19–20	7.94%	4.84%	-3.10
Rate 2—Dental Services—Total (Ages <1–20)	24.14%	25.64%	1.50
Rate 3—Oral Health Services—Ages 1–2	0.00%	0.00%	0.00

HEDIS Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	MY 2022–MY 2023 Rate Comparison
Rate 3—Oral Health Services—Ages 3–5	0.00%	0.04%	0.04
Rate 3—Oral Health Services—Ages 6–7	0.00%	0.03%	0.03
Rate 3—Oral Health Services—Ages 8–9	0.00%	0.09%	0.09
Rate 3—Oral Health Services—Ages 10–11	0.00%	0.00%	0.00
Rate 3—Oral Health Services—Ages 12–14	0.00%	0.00%	0.00
Rate 3—Oral Health Services—Ages 15–18	0.00%	0.00%	0.00
Rate 3—Oral Health Services—Ages 19–20	0.00%	0.00%	0.00
Rate 3—Oral Health Services—Total (Ages <1–20)	0.00%	0.02%	0.02

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: LIBERTY noted during the virtual review that it uses quality improvement activities to improve performance on the measures in the scope of the validation. For example, through its Community Smiles Outreach Team, **LIBERTY** noted that it supported 596 community engagements in 2023, facilitating 943 dental screenings and fluoride varnish applications in partnership with dental providers. **[Quality**, **Timeliness**, and **Access]**

Weaknesses and Recommendations

Weakness #1: During primary source verification (PSV), a few cases were reviewed in which dental hygienists rendered the dental service. While the measure specifications for *OEV-CH* and *TFL-CH* allow dental hygienists to be a rendering provider for a dental service, the specifications require that the hygienist must be working under the supervision of a dentist. Upon further review, **LIBERTY** determined that the dental hygienists who provided the services for the members reviewed were not practicing under the supervision of a dentist because they were credentialed as independent network providers. **[Quality**, **Timeliness**, and **Access]**

Why the weakness exists: LIBERTY credentialed dental hygienists as independent network providers to offer mobile clinics to help close care gaps for members who had barriers to accessing dental and oral health services. **LIBERTY** reported that the taxonomy code for dental hygienists

was included in the measure specifications, but did not notice the footnote in the specifications that hygienists were required to be working under the supervision of a dentist when performing dental services. **LIBERTY** also indicated that its source code for the *OEV-CH* and *TFL-CH* measures included members whose rendering provider's taxonomy code was assigned to dental hygienists but did not check to ensure they were practicing under supervision of a dentist. During the virtual review, **LIBERTY** indicated that it would update its source code and its rates to exclude any dental hygienists who performed dental services and were practicing independently.

Recommendation: HSAG recommends that **LIBERTY** conduct a thorough review of its source code for the three measures against the measure specifications annually, at a minimum, as part of the reporting process, as well as when the specifications are updated by the measure steward (American Dental Association). Additionally, HSAG recommends that **LIBERTY** involve multiple business owners (including the quality team due to its role in designing member interventions) in the annual review of source code against measure specifications to ensure agreement in interpretation of the specifications.

Weakness #2: No measure indicator rates with a QISMC goal met the State's established MPS for **LIBERTY**'s Medicaid population. Further, for **LIBERTY**'s Nevada Check Up populations, no measure indicator rates with a QISMC goal met the State's established MPS. **[Quality, Timeliness,** and **Access]**

Why the weakness exists: Immunization declines may be due to disparities in **LIBERTY**'s Medicaid population that could impact access to care, such as language barriers, access to transportation, geographic location, and socioeconomic status. Although **LIBERTY**'s Medicaid and Nevada Check Up members appear to have access to dental providers, members were not consistently utilizing these services, which can significantly reduce nonurgent ED visits and potentially prevent more serious health issues from occurring, reducing healthcare costs.

Recommendation: **LIBERTY** self-reported that it conducts ongoing, monthly monitoring of all Nevada Medicaid and Nevada Check Up performance measures by utilizing internal software such as Microsoft Power BI. The Quality Improvement (QI) team monitors these dashboards to ensure that each rate is within the state-established MPS. HSAG recommends that **LIBERTY** consider a first-visit incentive to members who see a dentist for the first time. HSAG also recommends that **LIBERTY** consider offering to schedule the appointment and addressing barriers as needed (e.g., transportation, SDOH). Additionally, HSAG recommends that **LIBERTY** ensure provider availability is within required time frames and consider increasing appointment hours. Reminder calls and text messages can be effective for members/families and providers as well.

Compliance Review

Performance Results

Table 4-13 presents an overview of the results of the standards reviewed during the SFY 2024 compliance review for **LIBERTY**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Appendix A. If a requirement was not applicable to **LIBERTY** during the period covered by the review, HSAG used a *Not Applicable*

(*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all seven standards.

Table 4-13—Summary of Standard Compliance Scores

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Disenrollment: Requirements and Limitations	NA	NA	NA	NA	NA	**NA**
Standard II—Member Rights and Member Information	21	20	14	6	1	**70%**
Standard III—Emergency and Poststabilization Services	14	8	8	0	6	**100%**
Standard IV—Availability of Services	10	10	8	2	0	**80%**
Standard V—Assurances of Adequate Capacity and Services	5	5	4	1	0	**80%**
Standard VI—Coordination and Continuity of Care	18	18	14	4	0	**78%**
Standard VII—Coverage and Authorization of Services	25	24	20	4	1	**83%**
Total	**93**	**85**	**68**	**17**	**8**	**80%**

M = Met*; *NM = Not Met*; *NA = Not Applicable

Total Elements: The total number of elements within each standard.

Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.

Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

Based on the findings from the SFY 2024 compliance review activity, **LIBERTY** was required to develop and submit a CAP for each element assigned a score of *Not Met*. The CAP was reviewed by DHCFP and HSAG for sufficiency, and **LIBERTY** was responsible for implementing each action plan in a timely manner.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: LIBERTY achieved full compliance in the Emergency and Postabilization Services program area, demonstrating the PAHP had adequate processes in place to ensure appropriate coverage of and payment for emergency and poststabilization care services. [**Access**]

Weaknesses and Recommendations

Weakness #1: LIBERTY had six elements within the Member Rights and Member Information program area that received a score of *Not Met*, indicating that members may not be notified of or receive required member materials and information timely. [**Timeliness** and **Access**]

Why the weakness exists: LIBERTY did not demonstrate that member materials adhered to State and federal requirements, that members were notified of the time frame for receiving a member handbook upon member's request, or that the member handbook and provider directory included all required elements.

Recommendation: While **LIBERTY** was required to develop a CAP to address the deficiencies identified, HSAG recommends that the PAHP conduct a comprehensive review of its member facing materials and its processes and procedures related to member information to identify whether additional opportunities for improvement in this program area exist and take remedial action, as necessary.

Weakness #2: LIBERTY had four elements within the Coordination and Continuity of Care program area, indicating members' dental care may not be effectively assessed or coordinated through the PAHP's care management program. [**Timeliness** and **Access**]

Why the weakness exists: LIBERTY's oral health needs assessment template did not include all required elements. Additionally, the PAHP did not demonstrate that oversight and monitoring processes were in place to ensure members were offered assistance in scheduling an initial appointment with a primary dental provider or that the assessment was conducted timely. The PAHP did not demonstrate that within 30 calendar days of enrollment it consistently requested members to authorize release of the provider's member records to the new primary dental provider or other appropriate provider, or that the PAHP assisted in requesting those records from the member's previous provider(s). Lastly, the care managers did not consistently adhere to the outreach protocol based on members' risk stratification level.

Recommendation: While **LIBERTY** was required to develop a CAP to address the deficiencies identified, HSAG recommends that the PAHP continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to coordination of care and care management processes.

Weakness #3: LIBERTY had four elements within Coverage and Authorization of Services program area, indicating opportunities for improvement related to the PAHP's prior authorization decision time frames and the notices of adverse benefit determination sent to members. [**Quality** and **Timeliness**]

Why the weakness exists: **LIBERTY** did not have adequate notice templates for informing members of an extension of the authorization time frames and policies and procedures did not include all advance notice requirements.

Recommendation: While **LIBERTY** was required to develop a CAP to address the deficiencies identified, HSAG recommends that the PAHP continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to coverage and authorization of services.

Network Adequacy Validation

Performance Results

HSAG assessed **LIBERTY**'s provider-to-member ratios and determined that it exceeded DHCFP's requirements. Table 4-14 presents results for **LIBERTY** by the number of providers per 1,500 members in Clark and Washoe counties and by the DHCFP required provider category.

Table 4-14 presents **LIBERTY**'s network adequacy results for Provider-to-Member Ratios.

Table 4-14—LIBERTY Provider-to-Member Ratio by Provider Category and County

Provider Category	Indicator	Providers per 1,500 Members (Clark County)	Providers per 1,500 Members (Washoe County)
Dental PCP	1:1,500	1.16	1.43

HSAG assessed **LIBERTY**'s submitted time or distance reports and found that **LIBERTY** fell below the 100 percent threshold by county for all provider categories except for Endodontist in Washoe County, which met the 100 percent threshold, and is shaded in **green**.

Table 4-15 presents **LIBERTY**'s network adequacy results for Time or Distance by the DHCFP-established provider category and by county.

Table 4-15—LIBERTY Percentage of Members With Access by Provider Category and by County

Provider Category	Time or Distance Indicator	Percentage of Members With Access (Clark County)	Percentage of Members With Access (Washoe County)
General Dentist	20 miles or 30 minutes	99.9%	99.9%
Dentist, Pediatric	20 miles or 30 minutes	99.9%	99.9%
Endodontist	40 miles or 60 minutes	99.9%	100%

Provider Category	Time or Distance Indicator	Percentage of Members With Access (Clark County)	Percentage of Members With Access (Washoe County)
Periodontist	40 miles or 60 minutes	99.9%	0%
Prosthodontist	40 miles or 60 minutes	99.9%	0%
Oral Surgeon	40 miles or 60 minutes	99.9%	99.9%
Dental Hygienist	40 miles or 60 minutes	99.9%	99.9%
Dental Therapist*	40 miles or 60 minutes	NA	NA

*NA: DHCFP granted an exception for reporting the Dental Therapist provider type due to no known dental therapists servicing the area.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: LIBERTY has established robust processes to keep provider data up to date and accurate through its quarterly provider directory validation, credentialing process, and monthly monitoring of the multiple sanction/exclusion lists. **[Quality** and **Access]**

Weaknesses and Recommendations

Weakness #1: Although **LIBERTY** was able to apply the necessary corrections for final reporting, HSAG observed **LIBERTY** was not reporting Dental Hygienist providers on the 407 GeoAccess reports, as required by DHCFP. **[Quality** and **Access]**

Why the weakness exists: LIBERTY indicated there was an understanding with DHCFP that it had a requirement for at least one Dental Hygienist per geographical area, for which **LIBERTY** was compliant, and that the time and distance standard was not applicable for the Dental Hygienist provider type.

Recommendation: HSAG recommends that **LIBERTY** perform a quarterly review of DHCFP reporting requirements and build in additional layers of validation to ensure logic and parameters used to inform calculations are in alignment with DHCFP expectations. In addition, HSAG recommends that **LIBERTY** ensure internal process flows are documented to reflect changes year over year.

Dental Satisfaction Survey

Performance Results

Table 4-16 presents the 2024 dental satisfaction survey top-box scores for **LIBERTY**'s adult Medicaid, child Medicaid, and Nevada Check Up populations.[30]

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

	Adult Medicaid	Child Medicaid	Nevada Check Up
Global Ratings			
Rating of Regular Dentist	NA	70.97%	79.12%
Rating of All Dental Care	35.00%	70.90%	76.56%
Rating of Finding a Dentist	NA	NA	NA
Rating of Dental Plan	28.71%	69.92%	78.13%
Composite Measures			
Care from Dentists and Staff	NA	92.49%	94.72%
Access to Dental Care	NA	NA	73.68%
Dental Plan Services	NA	NA	NA
Individual Items			
Care from Regular Dentist	—	90.24%	92.86%
Would Recommend Regular Dentist	—	91.06%	92.18%
Would Recommend Dental Plan	NA	70.45%	81.28%

A minimum of 100 respondents is required for a measure to be reported as a dental satisfaction survey result. Measures that do not meet the minimum number of respondents are denoted as NA (Not Applicable).
— Indicates the measure does not apply to the population.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: HSAG did not identify any strengths for **LIBERTY** for the dental satisfaction survey as there are no national comparisons for the dental satisfaction survey. Additionally, there were no

[30] HSAG did not weight the dental CAHPS results by county; therefore, the results in this technical report may not align with results presented in reports prepared by **LIBERTY**'s survey vendor.

reportable scores for the Child Medicaid and Nevada Check Up results from the SFY 2023 dental satisfaction survey and the SFY 2024 dental satisfaction survey included the adult population; therefore, HSAG could not display year-over-year performance results. **[Quality, Timeliness,** and **Access]**

Weaknesses and Recommendations

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

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

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

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

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

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

	Quality Strategy Goals	Performance Impact on Goals and Objectives	
1	Improve the health and wellness of Nevada's Medicaid population by increasing the use of preventive services by December 31, 2024	Not applicable to the PAHP	
2	Increase use of evidence-based practices for members with chronic conditions by December 31, 2024	Not applicable to the PAHP	
3	Reduce misuse of opioids by December 31, 2024	Not applicable to the PAHP	
4	Improve the health and wellness of pregnant women and infants by December 31, 2024	Not applicable to the PAHP	
5	Increase use of evidence-based practices for members with behavioral health conditions by December 31, 2024	Not applicable to the PAHP	
6	Increase utilization of dental services by December 31, 2024	✗ ✓	0/4 applicable Medicaid rates did not meet the MPS 2/4 applicable Nevada Check Up rates met the MPS
7	Reduce and/or eliminate health care disparities for Medicaid members by December 31, 2024	✓	3/3 objectives received a *Met* designation

5. Follow-Up on Prior EQR Recommendations for MCOs

From the findings of each MCO's performance for the SFY 2023 EQR activities, HSAG made recommendations for improving the quality of healthcare services furnished to members enrolled in the Nevada Managed Care Program. The recommendations provided to each MCO for the EQR activities in the *State Fiscal Year 2023 External Quality Review Technical Report* are summarized in Table 5-1, Table 5-2, Table 5-3, and Table 5-4. The MCO's summary of the activities that were either completed, or were implemented and still underway, to improve the finding that resulted in the recommendation, and as applicable, identified performance improvement, and/or barriers identified are also provided in Table 5-1, Table 5-2, Table 5-3, and Table 5-4.

Anthem Blue Cross and Blue Shield Healthcare Solutions

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

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • HSAG did not identify any weaknesses for **Anthem**. Although no significant weaknesses were identified during the SFY 2023 PIP activities, as **Anthem** progresses to the Implementation stage of the PIP, HSAG recommends that **Anthem** develop effective improvement strategies (i.e., interventions) that are designed to target the designated PIP population(s) and age group(s) to successfully improve member outcomes.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • One of the main initiatives implemented is Anthem's Whole Health approach, designed to improve Health Outcomes and advance Health Equity. This includes aligning strategies and goals across teams, focusing on improving quality of care, and implementing strategies for improving population health outcomes. • Anthem's Urgent Stabilization Housing program has been implemented for members experiencing homelessness with co-occurring mental illnesses and substance use disorders. This involves linking these members to safe short-term housing, medical/behavioral health services, and case management focused on transitioning to stable, permanent housing. • The program addresses two key PIP HEDIS measures: the Follow-Up After Emergency Department Visit for Mental Illness (FUM) measure and Adult Access to Preventive/Ambulatory Health Services (AAP) measure. These measures aim to improve the health outcomes of the program's targeted population by increasing access to primary care and behavioral health services. • Metrics for measuring the success of interventions include compliance rates for the aforementioned HEDIS measures among members touched by the program. • Anthem Health Intelligence is regularly utilized to develop and assess quality strategies at individual, community, and county/state levels.

- Risk attribution methodology is used to identify disparate populations by matching members' demographic information with geocodes or addresses to determine social risk.
- Regular outreach optimization is implemented to proactively anticipate and fulfill member healthcare needs, improving engagement and allowing for timely interventions.
- SDOH metrics are employed to identify members at risk, with a particular focus on housing conditions, education, digital and food access, and transportation.

- Anthem's Urgent Stabilization Housing program is currently ongoing and aims to reduce health care disparities, particularly among homeless populations.

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

- For CY2023:
  - 643 members participated in the program.
  - Members served in the housing intervention achieved a compliance rate of 97.5% and 100% for AAP and FUM, respectively.
  - 66% of members obtained stable housing at exit from the short-term housing program, effectively ending their episode of homelessness.

c. Identify any barriers to implementing initiatives:

- The scale of homelessness in Nevada presents a significant challenge in fully executing these initiatives as the number of available beds for the Urgent Stabilization Housing program is often at full capacity.

HSAG Assessment: HSAG has determined that **Anthem** addressed the prior year's recommendations for some but not all PIPs. Effective intervention strategies resulted in statistically significant improvement achieved for the applicable performance indicators for three of the six PIPs. For these PIPs, **Anthem** developed effective improvement strategies (i.e., interventions) that were designed to target the designated PIP population(s) and age group(s) to successfully improve member outcomes. For the remaining PIPs, the MCO should review recommendations provided under the *External Quality Review Activity Results* section.

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

HSAG recommended the following:

- Within the Access to Care, Children's Preventive Care, and Women's Health and Maternity Care domains for **Anthem**'s Medicaid population, although there were no significant increases or decreases (+/- 5 percentage points) from the prior MY, no measure indicator rates associated with a QISMC goal except *Prenatal and Postpartum Care—Postpartum Care* met the State's established MPS. **Anthem** self-reported several interventions it put in place during MY 2023, some of which include adding *Adults Access to Preventive/Ambulatory Health Services* as a quality metric to its value-based payment program, as well as implementing an incentive program for providers not participating in a value-based payment program. **Anthem** also reported it conducts telephonic outreach to providers with messages to focus on ADHD medications and to ensure follow-up appointments are discussed with caregivers and are scheduled. Additionally, **Anthem** reported that it conducts root cause analyses to determine why child members are not receiving all recommended well-care visits and vaccines, and that it considers disparities within its populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Further, **Anthem** reported that it continues to advertise telehealth services in provider newsletters and provider education materials, and that it shares member-level detail data with contracted providers to conduct outreach and reduce member gaps in care. HSAG recommends that **Anthem** continue to educate its contracted providers, furnish them with member-level detail data, and encourage them to conduct outreach and reduce member gaps in care. **Anthem** should also continue the various interventions put in place during MY 2023, to conduct root cause analyses, and to consider disparities within its Medicaid population that

may be contributing to lower performance in the *Access to Care*, *Children's Preventive Care*, and *Women's Health and Maternity Care* domains.

- Excluding the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total* measure indicator in the Behavioral Health domain for Medicaid, no measures with a QISMC goal met the State's established MPS. **Anthem** self-reported that it has continued with interventions and programs to address low performance in the Behavioral Health domain, implemented a post-ED discharge visit in partnership with two provider groups to improve the timeliness of follow-up visits for members with a mental health diagnosis, and expanded its member incentive program to include a member incentive for completing a follow-up visit within seven days of ED discharge or within 30 days of a mental health inpatient discharge. HSAG recommends that **Anthem** continue these efforts and also continue to consider additional interventions based on its root cause analyses to improve performance in this domain.
- Within the Children's Preventive Care domain, **Anthem**'s Nevada Check Up performance for the *Childhood Immunization Status—Combination 3* and *Combination 7* measure indicators showed a decline in performance of more than 5 percentage points from the prior MY. **Anthem** self-reported that it has implemented several interventions in a continued effort to ensure child members are receiving the recommended immunizations. Some of the interventions reported include offering member incentives for completing immunizations, piloting an after-hours clinic with one provider group to improve access to child and adolescent immunizations, as well as a value-based program that incentivizes PCPs to close gaps in care for priority HEDIS metrics, including *Childhood Immunization Status*. **Anthem** should continue its efforts to ensure child members in the Nevada Check Up population are receiving the recommended vaccines and continue to monitor and conduct root cause analyses to determine why these members are not receiving all recommended vaccines. **Anthem** should also consider disparities within this population that may have contributed to lower performance in a particular race or ethnicity, age group, ZIP Code, etc.

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

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

- In addition to Anthem continuing to educate its contracted providers, furnish them with member-level detail data, and encourage them to conduct outreach and reduce member gaps in care, Anthem is exploring or has implemented the following to drive increased improvement across is quality metrics:
  - QM participates in recurring monthly meetings between contracted providers and our Provider Success team, reviewing current HEDIS performance rates among the provider group's attributed membership, providing further HEDIS education, barriers to care, and opportunities for the QM team to support the group through collaborative partnerships.
  - Anthem offers its contracted provider with assistance in scheduling their patients for appointments through its Experian Scheduling platform. Outreach is conducted towards members with open gaps, and an appointment is scheduled on behalf of the member when Anthem's Live Agent team is able to successfully contact an Anthem member.
  - In partnership with a local Las Vegas practice, Anthem is piloting a vendor service that provides an electronic medical record (EMR) overlay that activates when a member's medical record is opened. The overlay software will immediately notify the provider (during the visit)

of existing gaps that can be either immediately addressed or completed after the appointment, if required.

- Leveraging Anthem Intelligence, Anthem is proactively developing programs to address Access to Care, Children's Preventive Care, and Women's Health and Maternity Care. Anthem has begun reviewing the interrelationship of social risk factors and medical history, and how the combination of such factors influence compliance. For Prenatal and Postpartum Care, Anthem has proactively evaluated barriers to care/compliance, and has subsequently developed programs that are implemented with the intention of reducing or eliminated SDOH barriers. Ongoing programs supporting the Maternal & Child populations include:
  - OB Lyft Program – Lyft vouchers offered to pregnant members to attend prenatal and post-partum visits.
  - Anthem Wellness Center Events – Focused on supporting the health and wellness of the members they serve, by hosting different events, baby showers, parenting classes, SNAP, food, utility assistance.
  - New Baby New Life – Program for expecting and new moms by providing resources different services including childbirth education, breastfeeding guidance, prenatal and postnatal care, mental health support for postpartum depression, and more.
- Anthem Health Intelligence is regularly utilized to develop and assess quality strategies at individual, community, and county/state levels.
  - Risk attribution methodology is used to identify disparate populations by matching members' demographic information with geocodes or addresses to determine social risk.
  - Regular outreach optimization is implemented to proactively anticipate and fulfill member healthcare needs, improving engagement and allowing for timely interventions.
  - SDOH metrics are employed to identify members at risk, with a particular focus on housing conditions, education, digital and food access, and transportation.

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

- Anthem's administrative performance rates for both prenatal and postpartum care saw a +4.21% and +5.99% YoY increase (MY2023 vs. MY2022), respectively. The increased administrative performance rate for both measures was considered statistically significant.

c. Identify any barriers to implementing initiatives:

- Social risk factors (housing instability, food insecurity, transportation, etc.)
- Vaccine Hesitancy (Influenza and HPV)

HSAG Assessment: HSAG has determined that **Anthem** addressed the prior year's recommendations based on the MCO's reported initiatives. Although **Anthem** developed improvement strategies based on the prior year recommendations (i.e., interventions) that are designed to target the population(s) and age group(s) to successfully improve member outcomes, there is additional room for improvement with measures that declined in performance or did not meet the MPS.

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

HSAG recommended the following:

- **Anthem** did not remediate three of the 10 elements for the Grievance and Appeal Systems standard, indicating continued gaps in the MCO's processes for acknowledgment of appeals and in providing oral notice to members when an expedited appeal request has been denied and for expedited and standard appeal resolutions. Providing proper acknowledgement of appeals and prompt oral notice to members as required ensures that members are properly informed of the status and resolution of their appeal in a timely manner.

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

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

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

- Anthem revised the NV Grievance and Appeals Verbal Notification Requirements desktop procedure to include all scenarios in which a Grievance and Appeals associate would be required to make a telephonic attempt to notify the member/authorized representative and/or provider about case information. The desktop procedure includes the process Grievance and Appeals associates must follow to ensure members are receiving verbal notification, within 24 hours, when their expedited review request is denied and downgraded to standard. In addition, the desktop procedure also includes the process Grievance and Appeals associates must follow to ensure members are receiving verbal notification, within 24 hours, when their expedited review request is approved.
- To ensure adherence to these procedures, our internal Quality Auditing team conducts a monthly audit of five random cases from each appeal associate. The results of these audits are shared with the Grievance and Appeals manager. Based on these findings, the manager provides targeted education or reinforcements regarding the importance of following the processes outlined in our policies and procedures, as needed.

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

[The MCO did not complete this section.]

c. Identify any barriers to implementing initiatives:

[The MCO did not complete this section.]

HSAG Assessment: HSAG has determined that **Anthem** partially addressed the prior year's recommendations based on the MCO's reported interventions. The MCO revised its desktop procedure to provide oral notice to members when an expedited appeal request has been denied and for when an expedited review request is approved. However, **Anthem** did not specifically address whether changes were made to **Anthem**'s processes for acknowledgment of appeals, including whether staff members were trained on requirements regarding the provision of oral notice and revisions to the appeal process to ensure members receive one acknowledgement letter for a denied request for an expedited appeal resolution, or prompt oral notice for expedited and standard appeal resolutions. As such, HSAG recommends that **Anthem** prioritize its review of these prior recommendations to ensure all are addressed and that its processes comply with federal rules.

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

HSAG recommended the following:

- **Anthem** did not meet the time-distance contract standards for OB/GYNs, indicating members may experience challenges accessing this provider type within an adequate time or distance from their residence. HSAG recommends that **Anthem** collaborate with DHCFP to determine whether Medicaid

reimbursement rates can be increased to improve the number of OB/GYN providers willing to contract with the MCOs to provide Medicaid-covered services.

- **Anthem** did not meet the time-distance contract standards for Pediatric Rheumatologists in Washoe County, indicating members may experience challenges accessing this provider type within an adequate time or distance from their residence. HSAG recommends that **Anthem** consider collaborating with DHCFP and the other MCOs to determine whether community reinvestment funds can be used to incentivize pediatric rheumatologists to join a rheumatology clinic in Washoe County.

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

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

- OBGYN

  Our 2023 4th Quarter submission identified 10 Clark County zip codes and 11 Washoe County zip codes with one or more time and distance gap(s). Our research has identified that 8 of the 11 zip codes in Clark County and 9 of the 10 zip codes in Washoe County do not have a certified Medicaid provider to close these gaps. As a result, only 19 member gaps can be closed through recruitment efforts by the MCO. Anthem has identified these provider targets, and the Network team is working diligently to recruit.

- Rheumatology

  Our 2023 4th Quarter submission identified 4 Clark County zip codes and 2 Washoe County zip codes with one or more time and distance gap(s). Our research has identified that all of the zip codes identified do not have a certified Medicaid provider to close these gaps.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
[The MCO did not complete this section.]

c. Identify any barriers to implementing initiatives:

- Today Clark and Washoe counties have one set time and distance standard for the entire geography. We would encourage the state to review the standards for the outlier zip codes for potential update. For instance, 89002 between Henderson and Boulder City has 25 members identified as outside the 15 min drive time for OBGYN, however the 25 members all meet the 10 mile drive distance standard. At this time there is no identified Medicaid provider that can close this gap.

HSAG Assessment: HSAG has determined that **Anthem** addressed the prior year's recommendations based on the MCO's reported initiatives. **Anthem** also provided an explanation about the barriers (i.e., lack of providers available to close gaps) that contributed to the MCO not meeting all state-established network adequacy standards. Because the SFY 2024 NAV activity methodology was conducted as a new scope of work in alignment with the 2023 release of CMS EQR Protocol 4, and therefore the methodology for conducting the NAV audit activities and the subsequent results were not comparable to the SFY 2023 NAV activity, HSAG has provided additional recommendations to **Anthem** in the *External Quality Review Activity Results* section, as necessary, based on findings from the SFY 2024 NAV audit.

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

HSAG recommended the following:

- Parents/caretakers of Nevada Check Up general child members had less positive overall experiences with their child's personal doctor since the score for this measure was statistically significantly lower than the 2022 NCQA Medicaid national average. HSAG recommends that **Anthem** prioritize improving parents'/caretakers' overall experiences with their child's personal doctor and determine a root cause for

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

- There were less than 100 respondents for every measure for the adult Medicaid, CCC Medicaid, and Nevada Check Up CCC populations and most measures for the general child Medicaid and Nevada Check Up general child populations; therefore, results could not be reported for the applicable measures and strengths and weaknesses could not be identified for the associated populations. HSAG recommends that **Anthem**, in collaboration with its CAHPS vendor, focus on increasing response rates to the CAHPS survey for all populations so there are greater than 100 respondents for each measure by continuing to educate and engage all employees to increase their knowledge of CAHPS, applying effective customer service techniques, increasing the percentage of oversampling, using innovative outreach strategies to follow up with the non-respondents, and continuing to provide awareness to members and providers during the survey period. Additionally, **Anthem**'s care management and/or other member-facing teams, such as the customer service team, could consider asking members if they know about the CAHPS survey and, if they received the survey, what barriers may prevent them from responding to the survey. These questions can be asked during routine contacts with members or when members outreach to **Anthem**. The information provided by these members could be shared with **Anthem**'s CAHPS vendor so that **Anthem** and the vendor can identify solutions to address low response rates.

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

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

- Anthem has implemented the following activities over the past 12 months to CAHPS:
  - Revamp of Provider Education material and resources, including the Anthem Provider Training Academy (an online resource for Nevada providers that offers online learnings and access to additional Anthem-branded patient experience resources).
  - Addition of CAHPS module within Provider Pathways – an on-demand digital eLearning that gives providers flexibility when scheduling training for themselves and their staff.
  - Launch Carelon Health After Hours program; program provides access to after-hours appointments Monday through Thursday 5-7 PM, in addition to appointment availability every other Saturday.
  - Care Consultants from the Provider Success team will disseminate and review educational CAHPS collateral with the Plan's network of value-based contracted providers.

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

- For MY2022 Child CAHPS:
  - Coordination of Care (87.80%) and Rating of All Health Care (72.90%) outperformed target goals of 86.51% and 70.69%, respectively.
  - Four questions demonstrated YOY improvement - Coordination of Care (+1.29%), Getting Needed Care Composite (+2.47%), How Well Doctors Communicate Composite (+3.15%), and Rating of All Health Care (+2.79%).

c. Identify any barriers to implementing initiatives: • Due to time constraints, providers and staff may be busy and might not have enough time to go through the new training materials or take part in eLearning sessions. • Staffing Adjustments for After Hours Program
HSAG Assessment: HSAG has determined that **Anthem** addressed the prior year's recommendations based on the MCO's reported initiatives; however, results from the current EQR indicate that the initiatives were ineffective in supporting improved positive experiences reported by parents/caretakers or in increasing the number of respondents. Parents/caretakers of Nevada Check Up general child members had less positive overall experiences with how well their child's personal doctor communicates. The score for this measure (89.64 percent) was statistically significantly lower than the 2023 NCQA Medicaid national average; therefore, HSAG recommends that **Anthem** identify additional interventions to increase this measure score. Additionally, there were less than 100 respondents for every measure for the general child Medicaid, CCC Medicaid, and Nevada Check Up CCC populations and for most measures for the adult Medicaid population whereby results could not be reported for the applicable measures. HSAG also recommends that **Anthem** continue to evaluate and revise interventions to increase response rates to the CAHPS survey for all populations.

Molina Healthcare of Nevada, Inc.

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

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • HSAG did not identify any weaknesses for **Molina**. Although no significant weaknesses were identified during the SFY 2023 PIP activities, as **Molina** progresses to the Implementation state of the PIP, HSAG recommends that **Molina** develop effective improvement strategies (i.e., interventions) that are designed to target the designated population(s) and age group(s) to successfully improve member outcomes.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Molina Healthcare of NV (MHNV) evaluated HSAG recommendations and implemented multiple improvement strategies. The improvement strategies were designed to target stratified populations and age groups between Performance Improvement Project (PIP) baseline (representing MY 2022), and PIP remeasurement period 1 (representing MY2023). • For each measure in a PIP, MHNV assessed population trends for disparate and/or high-risk populations by evaluating age bands, race/ethnicity, ZIP Code, Primary Care Provider (PCP) data, and population utilization/diagnoses patterns. • Several efforts completed including build out of measure specific dashboards and analytics, refinement of PCP member assignment logic, and distribution of provider facing collateral. • Examples of efforts that continue/were refined include Social Health Equity Navigators (SHEN) initiatives, initiatives with integrated behavioral health and primary care systems, interactive text messaging to disparate populations, and culturally appropriate member facing collateral. • New through late 2023-2024 were the inclusion of a new telehealth provider to increase access to prenatal and postpartum care, monthly engagements with hospital systems, bus shelter posters promoting Medicaid benefits, and clinical engagements with high utilized hospital systems.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • All PIPs demonstrated statistically significant improvement in rates with the exception of Initiation of Substance Use Disorder Treatment (IET-Int) and Follow-Up After Emergency Department Visit for Mental Illness (FUM).
c. Identify any barriers to implementing initiatives: • Common barriers to implementing initiatives were speed to launch. Establishing telehealth providers, development of collateral, etc. are multidepartment efforts with various levels of approval delaying anticipated launch times.
HSAG Assessment: HSAG has determined that **Molina** addressed the prior year's recommendations for some but not all PIPs. Effective intervention strategies resulted in statistically significant improvement achieved for the applicable performance indicators for four of the six PIPs. For these PIPs, **Molina** developed effective improvement strategies (i.e., interventions) that were designed to target the designated PIP population(s) and

age group(s) to successfully improve member outcomes. For the remaining PIPs, the MCO should review recommendations provided under the *External Quality Review Activity Results* section.

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

HSAG recommended the following:

- No rates within the Access to Care, Children's Preventive Care, Women's Health and Maternity Care, Care for Chronic Conditions, and Utilization domains for **Molina**'s Medicaid population and no rates within all domains for **Molina**'s Nevada Check Up populations met the State's established MPS. HSAG recommends that **Molina** conduct root cause analyses and consider disparities within its Medicaid and Nevada Check Up populations that may be contributing to low performance in a particular race or ethnicity, age group, ZIP Code, etc. Based on root cause analyses, **Molina** should implement interventions to increase Medicaid and Nevada Check Up performance across all domains of care.

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

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

- Molina Healthcare of NV (MHNV) evaluated HSAG recommendations and has implemented multiple improvement strategies based on race/ethnicity, age group, and zip code analyses.
- Through 2024, MHNV implemented two large scale initiatives based on HSAG recommendation.
- Initiative #1 is intended to support all domains with a focus on Children's Preventive Care. The Regional Transportation Commission (RTC) bus shelter poster was launched in 2024. Zip code and race/ethnicity analyses identified 4 zip codes with disparate population. Bus shelter posters were placed in the transit lines of these zip codes, raising awareness, connecting members to care, and reminding of available member incentives.
- Initiative #2 is intended to support all domains with a focus on Prenatal and Postpartum Care to black/African American members. This initiative is based on national and state findings. It included the launch of a telehealth maternal fetal medicine group and referring 100% of Molina's black/African American identified pregnancies for telehealth care.

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

- Initiative #1: Launched August 2024 with improved performance yet to be demonstrated.
- Initiative #2: Launched October 2023 with 2024 in-year improvements being noted. Final reporting will be available June 2025.

c. Identify any barriers to implementing initiatives:

- Common barriers to implementing initiatives were speed to launch. Establishing telehealth providers, development of collateral, etc. are multidepartment efforts with various levels of approval delaying anticipated launch times.

HSAG Assessment: HSAG has determined that **Molina** addressed the prior year's recommendations based on the initiatives reported. Although **Molina** developed improvement strategies based on the prior year recommendations (i.e., interventions) that are designed to target the population(s) and age group(s) to successfully improve member outcomes, there is additional room for improvement with measures that declined in performance or did not meet the MPS.

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

HSAG recommended the following:

- **Molina** received a score of 77 percent in the Member Rights and Member Information program area, indicating members may not receive timely and adequate access to information that can assist them in accessing care and services. HSAG required **Molina** to submit an action plan to address the deficiencies and provide assurances indicating:
  - Taglines included in member materials meet the requirement for conspicuously visible font and are fully translated in the prevalent non-English language in the State.
  - All written materials for potential and current members use a font size no smaller than 12-point.
  - The member handbook includes required information related to fraud and abuse; disenrollment; Early and Periodic Screening, Diagnostic, and Treatment (EPSDT); and procedures for members to recommend changes to policies and services.
  - A process is in place to obtain required information from **Molina**'s provider network to be included in the provider directory (e.g., provider photos, proof of cultural compliance training, age bands of members seen, accessibility and building features, and board certifications).
  - The machine-readable drug list/formulary is posted on the MCO's website.

  In addition to ensuring all action plans are implemented in a timely manner, HSAG recommends that the MCO continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to member rights and member information.
- **Molina** received a score of 67 percent in the Assurances of Adequate Capacity and Services program area, demonstrating that the MCO was not sufficiently monitoring its provider network to ensure adequate access to all services for its membership. HSAG required that **Molina** submit an action plan to address the deficiencies and provide assurances that QMHPs are included in network time and distance calculations. HSAG also recommends that the MCO continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to network adequacy requirements.
- **Molina** received a score of 53 percent for the Coordination and Continuity of Care program area, indicating members' care may not be effectively coordinated through the care management program. HSAG required **Molina** to submit a CAP to address the deficiencies and provide assurances that **Molina** will implement processes to conduct the initial screening of members' needs in the required time frames; notify a member's PCP when the member is identified as meeting the criteria for care management and subsequently enrolled into care management services; consistently document the collaboration with the member, the member's designated formal and informal supports, and the member's PCP and treatment team in developing the care plan; incorporate the member's self-reported health concerns into the goals and interventions and any identified gaps and coordination with State and county agencies in the care plan; reevaluate the member's care plan and level of care management services within the established time frames and adjust the care plan accordingly; and document ongoing communication with a member's PCP or designee and revise the clinical portion of the care plan as necessary in consultation with the PCP. Additionally, HSAG recommends that **Molina** implement methods to continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to the coordination and continuity of care for its members.
- **Molina** did not remediate one of the two SFY 2022 CAP elements for the Provider Selection standard, indicating continued gaps in the MCO's recredentialing processes. HSAG required **Molina** to submit an action plan to address these findings and provide assurances that **Molina** identifies the appeal data to be

considered when making recredentialing decisions, and that documentation in the recredentialing file includes a review of appeal data as part of the recredentialing decision. Additionally, HSAG recommends that the MCO continue to monitor implementation of its CAP to ensure timely, effective remediation of the deficiencies.

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

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

- Taglines for materials have been fully translated into Spanish and will be added to all future/revised materials. After the edits were completed, they were submitted to the state and approved. Taglines were fully translated and replaced in the 6/27/23 version of the Member Handbook. The fully translated, state approved version of the taglines are being added to materials as they are revised or created. All required contract language related to fraud and abuse; disenrollment; Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) has been added to the 6/27/23 version of the handbook.
- Molina worked with CVS to have a JSON file (standard machine-readable file) posted on our website since May 10, 2023.
- The Online Provider Directory has been updated to ensure inclusion of provider photos, proof of cultural competency training, age bands, accessibility and links to board certification. This process runs each night to pick up any new information in our data management system.
- QHMPs are now be included in network Time and Distance calculations. A full list of QHMPs is pulled on a monthly basis and shared with the internal Quest Analytics team. This team will upload the list to the Quest Analytics tool, which compares our network to the time and distance standards for the state. The first report was reviewed on 7/14/23. Once this report set up was approved, it was moved into the production file that is supplied to the Quest Analytics team on a monthly basis. The reporting then autoruns based on the files uploaded.
- Molina established service level agreements internally with the Outbound Call Center for initial screening of member's needs in required timeframes. In addition, member letters were updated and configured to address notification of the PCP when a member is identified for care management and enrolled into care management services. Internal workflows and processes were updated to include collaboration in the members plan of care – PCP, specialists, formal and informal supports, and external agencies, including state and county. Workflows and processes were updated to incorporate self-reported health concerns and identified gaps.
- For Provider Selection, we completed validation audits of recredentialing files in December 2023, April 2024, and July 2024. 25 total files were reviewed across the 3 audits, and all files showed that appeal outcome information was included as required.

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

- The member materials workflow has been revised to include a mandatory annual review of all materials. All internal departments that request materials will be required to participate in the annual review. The materials from the HSAG audit that were out of compliance have been revised to include compliant taglines and font size. Materials are tracked through and internal log and through the Government Contracts tracking log.

- Molina created reporting to track the oversight of the outbound call center and care management activities. Compliance is monitored through these reports and improvement was noted in the 2024 audit of Coordination and Continuity of Care, which Molina received a score of 93%.
- Machine-readable file is not expected to provide performance improvement

c. Identify any barriers to implementing initiatives:

- No barriers.

HSAG Assessment: HSAG has determined that **Molina** has addressed the prior recommendations based on the initiatives reported; however, since similar findings were determined in SFY 2024, the MCO should continue its current processes and initiatives focused on ensuring taglines in Spanish are in conspicuously visible font and included in all critical member materials, including pharmacy denial letters. Additionally, the MCO should continue to implement initiatives that ensure all required elements are included in the provider directory (i.e., provider's board certification status, whether providers have completed cultural competency training).

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

HSAG recommended the following:

- **Molina** did not meet the time-distance contract standards for OB/GYNs, indicating members may experience challenges accessing these provider types within an adequate time or distance from their residence. HSAG recommends that **Molina** continue to review the DHCFP Monthly Active Provider Report to identify newly added OB/GYNs and conduct outreach to confirm the OB/GYN providers' willingness to contract with **Molina**.
- **Molina** did not meet the time-distance contract standards for the Pediatrician, Pediatric Rheumatologist, and Pediatric Psychologist provider types in Washoe County, indicating members may experience challenges accessing these provider types within an adequate time or distance from their residence. HSAG recommends that **Molina** review DHCFP's monthly enrolled provider list to determine whether new Pediatrician providers are available in Washoe County for contracting. **Molina** should also continue its contracting efforts with Pediatric Psychologist providers in Washoe County to mitigate any access to care barriers for members needing care from this provider type. Finally, **Molina** should consider collaborating with DHCFP and the other MCOs to determine whether community reinvestment funds can be used to incentivize pediatric rheumatologists to join a rheumatology clinic in Washoe County.

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

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

- Reviewing network data, Molina has been at over 98% for Time and Distance for OB/GYNs in Clark County since the beginning of 2022 and a minimum of 93% in Washoe County in Washoe County since 2022.
- Molina is at 96% for T&D for Pediatricians in Washoe county. In reviewing targeting data from Quest Analytics, there is only one additional pediatric practice available, that would take us to 97% adequacy. Contracting efforts with that group have been under way for over a year. Additionally, community reinvestment funds have been offered for recruitment and salary for a pediatric rheumatologist, however no groups have agreed to this funding.

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

- [The MCO did not complete this section.]

c. Identify any barriers to implementing initiatives:
   - No barriers.

HSAG Assessment: HSAG has determined that **Molina** addressed the prior year's recommendations based on the MCO's reported initiatives. **Molina** also provided an explanation about the challenges (i.e., lack of providers available for contracting, prolonged contracting efforts with a provider group, providers not agreeing to funding) that contributed to the MCO not meeting all state-established network adequacy standards. Because the SFY 2024 NAV activity methodology was conducted as a new scope of work in alignment with the 2023 release of CMS EQR Protocol 4, and therefore the methodology for conducting the NAV audit activities and the subsequent results were not comparable to the SFY 2023 NAV activity, HSAG has provided additional recommendations to **Molina** within the *External Quality Review Activity Results* section, as necessary, based on the findings from the SFY 2024 NAV audit.

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

HSAG recommended the following:

- There were less than 100 respondents for every measure across all adult and child populations; therefore, results could not be reported and strengths and weaknesses could not be identified. HSAG recommends that **Molina** focus on increasing response rates to the CAHPS survey for all populations so there are greater than 100 respondents for each measure by educating and engaging all employees to increase their knowledge of CAHPS, applying effective customer service techniques, increasing the percentage of oversampling, using innovative outreach strategies to follow up with non-respondents, and providing awareness to members and providers during the survey period. Additionally, **Molina**'s care management and/or other member-facing teams, such as the customer service team, could consider asking members if they know about the CAHPS survey and, if they received the survey, what barriers may prevent them from responding to the survey. These questions can be asked during routine contacts with members or when members outreach to **Molina**. The information provided by these members could be shared with **Molina**'s CAHPS vendor so that **Molina** and the vendor can identify solutions to address low response rates.

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

a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:
   - Molina Healthcare of NV (MHNV) evaluated HSAG recommendations and has implemented multiple improvement strategies with intent to improve CAHPS member response rates.
   - Initiative #1: In 2024, MHNV increased efforts to socialize upcoming CAHPS survey with primary care providers (PCPs) sharing intent, timing, and Frequently Asked Questions (FAQ)
   - Initiative #2: Developed and launched the "Every Member Counts campaign". An internal employee education program aimed at raising awareness of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey and how the results are impactful. This education is mandatory for customer contact associates for them to communicate the importance of responding to the survey for members. The campaign includes a pre-CAHPS and post-CAHPS iLearn to determine associate engagement and retention of the information.
   - Initiative #3: Developed and launched a "Did You Know" primer campaign for members, including phone calls, emails, relay texts and mailings aimed at increasing awareness and knowledge of the CAHPS survey.

• Initiative #4: MHNV continues to oversample CAHPS survey recipients in an attempt to increase response rates. Molina oversampled both the Adult and Child populations by 100% in 2023 and 2024 to try and increase response rates.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Response rates on some CAHPS questions increased to reportable status.
c. Identify any barriers to implementing initiatives: • Medicaid's volume of Unable to Contact/nonresponding members remains a challenge across multiple health plan initiatives. • The anonymity of the survey limits detailed barriers analyses.
HSAG Assessment: HSAG has determined that **Molina** addressed the prior year's recommendations based on the MCO's reported initiatives; however, results from the current EQR indicate that the initiatives were ineffective as every measure for the CCC Medicaid, Nevada Check Up general child, and Nevada Check Up CCC populations had less than 100 respondents and for most measures for the adult and general child Medicaid populations whereby results could not be reported for the applicable measures. HSAG recommends that **Molina** continue to evaluate and revise interventions to increase response rates to the CAHPS survey for all populations.

SilverSummit Healthplan, Inc.

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

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • HSAG did not identify any weaknesses for **SilverSummit**. Although no significant weaknesses were identified during the SFY 2023 PIP activities, as **SilverSummit** progresses to the Implementation stage of the PIP, HSAG recommends that **SilverSummit** develop effective improvement strategies (i.e., interventions) that are designed to target the designated population(s) and age group(s) to successfully improve member outcomes.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • SilverSummit developed initiatives to target areas of focus selected by DHCFP to drive performance in Adult Access to Preventative/Ambulatory Health Services, Prenatal and Postpartum Care, Follow-Up After Emergency Department Visits for Mental Illness, Well-Child Visits, Initiation and Engagement of Substance Use Disorder and Plan All-Cause Readmissions. • SilverSummit's initiatives included provider incentives, member outreach, utilization of community partners and advancing technological resources and data mapping. The health equity team also assessed measure performance by race, ethnicity, and zip codes to identify data trends and areas of need for targeted interventions. • SilverSummit's Performance Improvement (PI) Team utilizes PDSA methodology to track and monitor specific intervention progress. The PI team works with various departments to revise/update interventions to better fit member needs when necessary. Measure performance and initiative progress/updates/barriers are reviewed monthly in the Performance Improvement Team (PIT) and quarterly in the Quality Improvement Committee (QIC).
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • SilverSummit had 5 indicators that increased in performance from Baseline MY22 to Remeasurement Year 1 MY23 PIP submission. – 1 measure improved by >5% in only one year of measurement. – 4 noted statistical significance in only one year of measurement. • SilverSummit continues to monitor initiative successes and outcomes to drive measure performance for next the PIP cycle.
c. Identify any barriers to implementing initiatives: • SilverSummit has multiple interventions addressing the same population at once, therefore, it is difficult to pinpoint which activity is creating the most change or impact to measure performance. • SilverSummit and Providers face barriers with successful member outreach (incorrect member contact information, unresponsive to outreach, member moved, etc.), but continue to find alternative opportunities to connect with members.

- SilverSummit noted that some interventions did not yield desired outcomes only within the first year of implementation and were revised and/or discontinued for the following measurement period.

HSAG Assessment: HSAG has determined that **SilverSummit** addressed the prior year's recommendations for some but not all PIPs. Effective intervention strategies resulted in statistically significant improvement achieved for the applicable performance indicators for two of the six PIPs. For these PIPs, **SilverSummit** developed effective improvement strategies (i.e., interventions) that were designed to target the designated PIP population(s) and age group(s) to successfully improve member outcomes. For the remaining PIPs, the MCO should review recommendations provided under the *External Quality Review Activity Results* section.

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

HSAG recommended the following:

- Within the Children's Preventive Care domain, **SilverSummit**'s Medicaid rate for the *Childhood Immunization Status—Combination 10* measure indicator decreased more than 5 percentage points from the prior MY, suggesting that not all members 2 years of age are receiving the appropriate immunizations, which are essential for disease prevention and are a critical aspect of preventable care for children. **SilverSummit** self-reported that it has conducted root cause analyses and investigated interventions to ensure improved performance and member engagement across all domains of care, some of which include revising member and provider incentive models, developing educational materials, and a general increase in engagement practices. HSAG recommends that **SilverSummit** continue these interventions and as part of its implementation process, **SilverSummit** should conduct a timely evaluation to determine whether the member and provider rewards are resulting in increased and timely immunizations. **SilverSummit** should consider disparities within this population that may contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc.
- Overall performance was low within the Children's Preventive Care domain for **SilverSummit**'s Nevada Check Up population. **SilverSummit**'s rates for the *Childhood Immunization Status*, *Immunizations for Adolescents—Combination 1*, *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*, *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits*, and *Child and Adolescent Well-Care Visits—18–21 Years* measure indicator rates decreased more than 5 percentage points from the prior MY. Of note, rates for the *Childhood Immunization Status—Combination 3* and *Combination 7* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure indicators decreased more than 20 percentage points from the prior MY. This performance suggests that not all of **SilverSummit**'s Nevada Check Up child and adolescent members are receiving the recommended immunizations and well-care visits, which are important for avoiding vaccine-preventable diseases, as well as providing screening and counseling, which are important at every stage of life. **SilverSummit** self-reported that it has conducted root cause analyses and investigated interventions to ensure improved performance and member engagement across all domains of care for its populations, some of which include revising member and provider incentive models, developing educational materials, and a general increase in engagement practices. HSAG recommends that **SilverSummit** continue these interventions and as part of its implementation process, **SilverSummit** should conduct a timely evaluation to determine whether the member and provider rewards are resulting in increased member well-child visits and timely immunizations. **SilverSummit** should consider disparities within this population that may contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc.
- **SilverSummit** did not meet the MPS for any performance measure rates in its Nevada Check Up population. Furthermore, **SilverSummit** did not meet the MPS for any performance measure rates for its Medicaid population other than the *Follow-Up After Emergency Department Visit for Mental Illness, Plan*

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

- Within the Women's Health and Maternity Care domain, **SilverSummit**'s Medicaid rate for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure indicator decreased more than 5 percentage points from the prior MY, indicating not all Medicaid women members are receiving timely prenatal care, which can set the stage for the long-term health of new mothers and their infants, as well as potentially prevent pregnancy-related deaths. In addition, **SilverSummit**'s Nevada Check Up rate for *Chlamydia Screening in Women—16–20 Years* decreased more than 5 percentage points from the prior MY, suggesting that not all Nevada Check Up women ages 16–20 years of age who are sexually active received at least one test for chlamydia during the MY. Untreated chlamydia infections may lead to serious, irreversible complications. **SilverSummit** should conduct root cause analyses to determine why its Medicaid women members are not receiving timely prenatal care visits and why its Nevada Check Up women members who are sexually active are not receiving appropriate screening for chlamydia. **SilverSummit** should consider disparities within these populations that may be contributing to low performance for these measures.

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

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

- SilverSummit expanded resources within the Quality Team to add additional PI staff to focus on continuing and implementing member and provider focused initiatives geared towards improving children preventive care and women's health. The PI team monitors intervention successes through the PDSA model and revises/updates interventions to better fit member needs when necessary.
- SilverSummit enhanced the quality of care and critical incident process to better collaborate with grievances and appeals department to identify additional barriers for members accessing or receiving care, these data points are discussed in the PIT and QIC.
- SilverSummit's health equity team monitors disparities for targeted outreach from both a Quality perspective but also shared departmentally and within the Provider Network. There is regular review and assessment of disparities that are incorporated into SilverSummit's interventions.

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

- 58% of Medicaid Measures reported by SilverSummit increased from MY22 to MY23.
  - 7 unique measures increased by >5% from MY22 to MY23.
- Statistically Significant improvement was made to PPC and WCC performance.

c. Identify any barriers to implementing initiatives:

- SilverSummit and Providers face barriers with successful member outreach (incorrect member contact information, unresponsive to outreach, member moved, etc.), but continue to find alternative opportunities to connect with members.

- Some interventions did not yield desired outcomes only within the first year of implementation (MY23) and had to be adjusted/revised for MY24.

HSAG Assessment: HSAG has determined that **SilverSummit** addressed the prior year's recommendations based on the initiatives reported. Although **SilverSummit** developed improvement strategies based on the prior year recommendations (i.e., interventions) that are designed to target the population(s) and age group(s) to successfully improve member outcomes, there is additional room for improvement with measures that declined in performance or did not meet the MPS.

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

HSAG recommended the following:

- **SilverSummit** did not remediate one of the five elements for the Member Rights and Member Information standard, indicating continued gaps in the MCO's processes that ensured all member materials critical to obtaining services included taglines in conspicuously visible font. HSAG required **SilverSummit** to submit an action plan to address the deficiencies and provide assurances that all critical member materials include taglines in a conspicuously visible font. Additionally, HSAG recommends that **SilverSummit** conduct ongoing formal staff training on requirements pertaining to the development of member informational materials and audit materials regularly to confirm they continue to meet the requirements under 42 CFR §438.10.

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

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

- We updated our Taglines to ensure a conspicuously visible font and communicated the updates to staff. We also placed the most current tagline version in a resource section on our internal SharePoint site where all staff have access. In addition, we added a tagline review to our annual audit and monitoring plan, completing the review in quarter four of 2023.

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

- All materials found to contain outdated taglines were identified and corrected as a result of the review.

c. Identify any barriers to implementing initiatives:

- Identifying all relevant materials from various departments for review proved challenging. An annual request for all departments to review their taglines will also be implemented to supplement the annual audit and monitoring review.

HSAG Assessment: HSAG has determined that **SilverSummit** has addressed the prior recommendations based on the initiatives reported; however, since similar findings were determined in SFY 2024, the MCO should continue its current processes and initiatives focused on ensuring taglines in Spanish are in conspicuously visible font and included in all critical member materials.

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation
HSAG recommended the following: • **SilverSummit** did not meet the time-distance contract standards for Pediatric Rheumatologists, indicating members may experience challenges accessing these provider types within an adequate time or distance from their residence. HSAG recommends that **SilverSummit** consider collaborating with DHCFP and the other MCOs to determine whether community reinvestment funds can be used to incentivize pediatric rheumatologists to join a rheumatology clinic in Washoe County. • **SilverSummit** did not meet the time-distance contract standard for OB/GYN and Pediatrician provider types, indicating members may experience challenges accessing those provider types within an adequate time or distance from their residence. HSAG recommends that **SilverSummit** continue to review DHCFP's monthly enrolled provider list to determine whether new providers are available for contracting.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • SilverSummit is working with our current provider network to identify how we could work collaboratively to bring in Pediatric Rheumatology to Washoe County as currently and per the Medicaid State File, there are no providers enrolled with NV Medicaid under this specialty for Washoe County. SilverSummit has previously collaborated with other limited specialist groups and donated community reinvestment funds to successfully recruit providers. SilverSummit will work with UNLV and UNR to determine if there are any potential providers actively enrolled or if there is an opportunity to help fund and develop a fellowship program to encourage Pediatric Rheumatology Providers to Washoe County. SilverSummit is also actively working with Out of State Providers that are enrolled with NV Medicaid under Pediatric Rheumatology to determine if a contract is feasible. During this time however, SilverSummit continues to work with providers whether in-state or out of state on Single Case Agreements to ensure members are receiving timely and quality care. • Although there is not a Pediatric provider type in Boulder City listed on the state file, SilverSummit has confirmed that there is an NP and PA-C within the time/distance standard that treats pediatrics through adult (0-120 yrs.). SilverSummit also confirmed Boulder City Primary Care refers OB patients to the closest OB/GYN available. • SilverSummit will continue to work with Pediatric and OB/GYN groups in the surrounding area for opportunities to bring on additional providers. • SilverSummit will continue to review DHCFP's monthly enrolled provider list to determine whether new providers are available for contracting.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • As a result of our outreach and efforts, we expect Renown will be adding one Pediatric Rheumatologist within the next 6 months.
c. Identify any barriers to implementing initiatives: • Clark and Washoe county have historically been limited in pediatric specialists. • There are no licensed OB/GYN or Pediatrician provider types practicing in Boulder City, NV. The nearest OB/GYN is 18 miles/25 min and the nearest Pediatrician is 16 miles/19 min.

HSAG Assessment: HSAG has determined that **SilverSummit** addressed the prior year's recommendations based on the MCO's reported initiatives. **SilverSummit** also provided an explanation about the barriers (i.e., lack of providers available for contracting) that contributed to the MCO not meeting all state-established network adequacy standards. Because the SFY 2024 NAV activity methodology was conducted as a new scope of work in alignment with the 2023 release of CMS EQR Protocol 4, and therefore the methodology for conducting the NAV audit activities and the subsequent results were not comparable to the SFY 2023 NAV activity, HSAG has provided additional recommendations to **SilverSummit** in the *External Quality Review Activity Results* section, as necessary, based on the findings from the SFY 2024 NAV audit.

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

HSAG recommended the following:

- There were less than 100 respondents for every measure for the child populations and most measures for the adult population; therefore, results could not be reported for the applicable measures and strengths and weaknesses could not be identified for the associated populations. HSAG recommends that **SilverSummit** focus on increasing response rates to the CAHPS survey for all populations so there are greater than 100 respondents for each measure by educating and engaging all employees to increase their knowledge of CAHPS, using customer service techniques, oversampling, using innovative outreach strategies to follow up with non-respondents, and continuing to provide awareness to members and providers during the survey period.

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

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

- SilverSummit oversampled the Adult and Child Population to increase response rates for MY 2023. Additional initiatives include:
- Increased options of modality to include internet (URL Link, QR Code and standard email) for members.
- Survey responses were available in both English and Spanish.
- SilverSummit Quality Department expanded to include a dedicated member experience team to monitor all survey outcomes, identify member barriers to effectively create and implement targeted interventions and areas of focus.

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

- MY 2023 showed a significant increase in response rates for both the Child populations. Child with CCC increased 3% and Child with CCC CHIP increased 4.4%.
- Adult population response rate increased by .1%.
- Adult age range of 45-54 increased 8.5% and Hispanic/Latino respondents increased 2.8% over MY 2022.
- Child with CCC had a significant increase in the Hispanic/Latino population of 18.8% over MY2022.
- Child with CCC respondents in the age range of 25-34 increased 11.6% over MY2022.
- Child with CCC/CHIP had a significant increase in the Hispanic/Latino population of 22.8% over MY2022.

c. Identify any barriers to implementing initiatives: • Inaccurate member demographic information. • Large homeless population without ability to complete/respond to survey.
HSAG Assessment: HSAG has determined that **SilverSummit** addressed the prior year's recommendations based on the MCO's reported interventions. However, results from the SFY 2024 CAHPS activity indicate that **SilverSummit** should continue to focus its efforts on improving response rates and positive responses.

UnitedHealthcare Health Plan of Nevada

Table 5-4—Prior Year Recommendations and Responses for UHC HPN

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • HSAG did not identify any weaknesses for **UHC HPN**. Although no significant weaknesses were identified during the SFY 2023 PIP activities, as **UHC HPN** progresses to the Implementation stage of the PIP, HSAG recommends that **UHC HPN** develop effective improvement strategies (i.e., interventions) that are designed to target the designated population(s) and age group(s) to successfully improve member outcomes.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • UnitedHealthcare Health Plan of Nevada (UHPN) has been working on the state mandated performance improvement projects (PIP) and has developed new tools to stratify data to identify population trends based on age, gender, race/ethnicity, and geographical area. UHPN has selected two measures (Child and Adolescent Well Care Visits (WCV) and Adult Access to Preventive/Ambulatory Health Services (AAP)) to focus interventions based on health disparities. To increase compliance amongst these populations, we have developed the following strategies to increase engagement and preventative care services. • For the WCV PIP, the 18–21-year-old population has been identified as having the lowest compliance rate within the sub-measure age groups. UnitedHealthcare Health Plan of Nevada has introduced new member and provider incentive programs focusing on this subgroup. We have identified opportunities to transition this age group to an age-appropriate primary care provider (PCP) as they age out of their current pediatrician's scope of practice. We also understand the GenZ population has been exposed to mobile systems saturated by technology, leading us to find new ways to bring them healthcare in the home and develop age-appropriate educational resources tailored to the transition to adulthood (TAY) 18–21-year-old population. These resources will be available to provider groups and members through our online webpages, member center, and provider center. • For the AAP PIP, the health plan has identified the unhoused population, the male population ages 45-64, and the African American male population ages 20 + as not effectively utilizing preventive healthcare. The plan has implemented strategies focused on these populations to address this issue. For our unhoused population within this measure, we are deploying our Community Health Worker (CHW) team to locate these members to help them establish a primary care medical home. Additionally, the male population (ages 45-64) has been identified as not completing their preventive health care screenings, with disparities amongst African American males. To improve health equity for the African American male population, we have formed collaborative partnerships with men's fraternities and community-based organizations serving the African American communities to host a men's health event offering on-site barbershop haircuts, and wellness checkups by our mobile units. Understanding that the male population is less likely to seek preventive care services, live outbound telephonic calls are being made to schedule a mobile in-home care assessment, bringing care to the home within this demographic. • For the FUM PIP, activities included a data exchange with select groups, a provider incentive and a post discharge call outreach. These activities were applied to members who were empaneled to select groups.

- For the IET PIP, activities included a member incentive, a new relationship with a virtual SUD provider and a modification to the prior authorization process. These activities applied to all members.

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

- The WCV measure, 18–21-year-old age group population demonstrated a 4.8% percentage point increase in performance over the last three months in the current MY 2024. We also measured improvement from MY 2022 to MY 2023 of 1.4% percentage points, indicating the interventions (transition to adulthood (TAY) member resources, and consistent call outreach and scheduling campaigns) have been successful and incorporated into normal practice.
- The overall AAP measure demonstrated an increase in performance of 8.5% over the last three months in the current MY 2024. The African American male aged 20+ showed an increase over the last three months of 7.6% in the current MY 2024. The AAP rate for the male ages 45-64 population increased 8.0% over the past three months in current MY 2024. The narrowed focused interventions (CHW engagement with the unhoused population, African American Male focus events, mobile healthcare units and consistent call outreach and scheduling campaigns) for disparate populations are having a positive impact on improvement. UnitedHealthcare Health Plan of Nevada continues to collaborate to prepare innovative ideas to increase the overall AAP compliance rate.
- The FUM measure saw statistically significant improvement in both the 7- and 30-day indicators of 5.89 and 7.06 percentage points respectively.
- The IET measure (both indicators) saw a modest improvement, however neither was statistically significant. Improvements were 0.29 and 0.85 percentage points for the initiation and engagement indicators respectively.

c. Identify any barriers to implementing initiatives:

- WCV: UHPN continues to evaluate barriers identified while implementing initiatives focused on the WCV transition-age youth population (18–21-year-olds). These include but are not limited to, the following: limited access/contact information to the young adult instead of their parents, the misconception that they don't need to visit the doctor if they are healthy, and the handoff from the pediatrician to a primary care provider.
- AAP: UHPN continues to evaluate barriers identified that do not contribute to the success of the AAP measure. Some of these barriers are lack of member availability, no-show for appointments, incorrect phone numbers, transient and unstable housing making it challenging to engage and communicate.
- No barriers were identified for the FUM measure
- The IET measure interventions encountered various barriers including low member engagement for the IET incentive and a reluctance for providers to adopt the simplified prior authorization process for SUD treatment.

HSAG Assessment: HSAG has determined that **UHC HPN** addressed the prior year's recommendations for some but not all PIPs. Effective intervention strategies resulted in statistically significant improvement achieved for applicable performance indicators for three of the six PIPs. For these PIPs, **UHC HPN** developed effective improvement strategies (i.e., interventions) that were designed to target the designated PIP population(s) and age group(s) to successfully improve member outcomes. For the remaining PIPs, the MCO should review recommendations provided under the *External Quality Review Activity Results* section.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures
HSAG recommended the following: • Within the Care for Chronic Conditions domain, **UHC HPN**'s Medicaid performance for the *Asthma Medication Ratio—5–11 Years*, *Hemoglobin A1c Control for Patients With Diabetes*, and *Kidney Health Evaluation for Patients With Diabetes—65–74 Years* measure indicators demonstrated a decrease of more than 5 percentage points from the prior MY, suggesting opportunities for improving asthma medication management for children ages 5–11 years and opportunities to ensure its members with diabetes are receiving timely and appropriate care, reducing the risk of developing complicated conditions. In addition, **UHC HPN**'s Nevada Check Up performance for *the Asthma Medication Ratio* measure indicators showed an overall decline of more than 5 percentage points from the prior MY, suggesting **UHC HPN**'s Nevada Check Up members with asthma are not receiving appropriate medication management. **UHC HPN** should conduct root cause analyses to determine why its diabetic members are not receiving appropriate diabetes management and should monitor the *Hemoglobin A1c Control for Patients With Diabetes and Kidney Health Evaluation for Patients With Diabetes* rates. **UHC HPN** should also conduct root cause analyses of members with persistent asthma to determine why their asthma medications are not consistently being managed. **UHC HPN** should also consider whether there are disparities within its population that contribute to low performance in a particular race or ethnicity, age group, ZIP Code, etc. Based on the results of its root cause analyses for these measures, **UHC HPN** should implement interventions to improve the performance for these measures. • Within the Behavioral Health domain, **UHC HPN**'s Medicaid rate for the *Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—1–11 Years* measure indicator declined more than 5 percentage points from the prior MY, indicating children in this age group are not receiving psychosocial interventions as first-line treatment, which may result in being prescribed antipsychotic medications for nonpsychotic conditions and unnecessarily incurring the risks associated with antipsychotic medications. In addition, **UHC HPN**'s Nevada Check Up rate for the *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase—Total* measure indicator decreased more than 15 percentage points from the prior MY, indicating its Nevada Check Up members with asthma are not receiving a follow-up visit with a pediatrician with prescribing authority within 30 days of their first prescription of ADHD medication. To ensure that medication is prescribed and managed correctly, it is important that children be monitored by a pediatrician with prescribing authority. **UHC HPN** should conduct root cause analyses to determine why its child Medicaid members who are prescribed antipsychotics are not receiving psychosocial care as first-line treatment and why its Nevada Check Up child members with persistent asthma are not receiving appropriate follow-up for medication management. Based on root cause analyses findings, **UHC HPN** should implement initiatives or interventions to help improve these rates.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • UHPN conducted a root cause analysis for the CHAP-TANF asthma medication ratio (AMR) measure age stratification 5-11 years old and the AMR Nevada Checkup populations 5-18 years old. o CHAP-TANF AMR 5-11 Key findings: The MY2022 5-11 AMR population fell short of MY2021 by a count of 25 (numerator) compliant members and 11% of the members were not on a controller medication. Although the rate decreased by over 5% points, the eligible population decreased significantly, indicating less members were identified during the HEDIS measurement year with

persistent asthma. We have also identified opportunities to educate the largest prescriber of dispensed reliever meds for members that did not have a controller medication.

- Nevada Check-up AMR Key findings: The MY2022 NV Check-up AMR population fell short of MY2021 by a count of 3 (numerator) compliant members and 21.74% of members were not on a controller medication. Although the rate decreased by over 5% points, the eligible population decreased significantly, indicating less members were identified during the HEDIS measurement year with persistent asthma. Overall, the population size is much smaller leading to more sensitive compliance variances. We have also identified opportunities to educate the largest prescriber of dispensed reliever meds for members that did not have a controller medication.
- AMR Initiatives: UHPN has implemented several initiatives including provider education on prescribing patterns for controller medications as well as encouraging providers to refer members to the health plans asthma disease management program. We have focused efforts to outreach members that have been admitted to hospital for persistent asthma and /or were noncompliant with the measure in the year prior and still non-compliant in the current year by our care management teams. A new educational resource for families on how to manage pediatric asthma has been designed with pictures step by step guide easy to follow for children. Finally, new for 2024 we have launched a new video chat medication management program for children with persistent asthma.

- UHPN conducted a root cause analysis for the HBD < 8% controlled population and the Kidney Health Evaluation (KED) age 65-74 years old.
  - HBD <8% Key Findings: There were significant changes in the HEDIS technical specifications for this measure from MY2021 to MY2022 as HBD was reported as a stand-alone measure and no longer a sub-measure under Comprehensive Diabetes Care (CDC). Also, new for MY2022, required exclusions were added, such as polycystic ovarian syndrome, gestational diabetes, and steroid-induced diabetes from the denominator. Although the MY2022 HBD <8% rate decreased by 5.35%, the eligible population decreased significantly, indicating fluctuations based on changes to the measure reporting from the prior year MY2021 to the current year MY2022.
  - KED 65–74-year-old Key Findings: The MY2022 KED 65–74-year-old fell short of MY2021 by a count of 6 (numerator) compliant members. Although the rate decreased by over 7.81% points, the eligible population (denominator) is small. A smaller denominator indicates that each member, compliant or not, is significant in determining the final compliance rate variances. It was also found that in MY2022, nine members in the eligible population had multiple provider visits in the measurement year related to diabetes and did not complete the KED testing.
  - HBD <8% and KED Initiatives: UHPN has taken several steps to address the decrease in Hemoglobin A1c Control and Kidney Health Evaluation (KED) for diabetic members with a focus on the new MY2022 race/ethnicity stratification and the KED population age 65–74-year-old including:
    - Forming a Diabetes Task Force to tackle diabetic disparities within the UHPN Medicaid population. The task force has implemented various initiatives, including a diabetes dashboard for providers, launched a new video chat medication management program to assist members with diabetes medication and annual KED screening, identified focused member outreach opportunities for members with poorly controlled diabetes and healthcare disparities amongst the American Asian Pacifica Islander (AAPI) population.
    - Provider education on how to refer patients to our diabetes disease management program and classes supporting diet, exercise, nutrition, weight and medication management.
    - Collaboration with provider groups to develop a diabetes lab panel that includes eGFR, uACR, and HbA1c on one order set.

- To improve member and provider engagement, we offer incentives/rewards when an annual Hemoglobin A1c screening is completed and/or when the member sees their PCP for an annual preventative wellness visit.

- For the behavioral health measures, education to both member and providers continued via written communications and face-to-face meetings between providers and our clinical practice consultants (CPCs). Measures are monitored on a monthly basis.

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

- UHPN has seen a 3.39% improvement in our Nevada check-up AMR population from MY2022 to MY 23023, indicating the focus on provider education, member outreach and engagement and new family resources has been successful. We have, however, not seen improvement in our CHAP-TANF age 5-11 population and will conduct a more thorough review for opportunities to close gaps in care for members that have medication ratios of 0.40-0.49 in quarter four.
- UHPN HBD controlled population <8% has demonstrated an average increase of 5.3% over the last three months, and 3.6% increase in our AAPI population over the last three months in the current MY2024. We also had measured improvement from MY2022 to MY2023 of 4.38% percentage points for the HBD measure and an increase of 15.3% from MY2022 to MY2023 in the sub-population AAPI indicating the interventions (diabetes task force, diabetes dashboard with provider performance reports, diabetes classes, member rewards, provider rewards, medication management video chat app and outreach to disparate population AAPI) have been successful and incorporated into normal practice.
- UHPN KED 65–74-year-old sub measure age group demonstrated an average 5.5% increase over the last three months in the current MY2024. We also had measured improvement from MY2022 to MY2023 of 9.4% percentage points, indicating the interventions (monthly gap in care reports, diabetes dashboard, diabetes task force, and diabetes classes) have been successful and have been incorporated into normal practice/ have been reevaluated with focused outreach for this population.
- For APP, the rate for 2023 was 52.83% which is an improvement of 2.83 percentage points over 2022. This updated rate is within the 5-percentage point threshold. For ADD, there was an improvement of 20.29 percentage points, indicating a data anomaly in 2022. The ADD rate for 2023 is 54.29%.

c. Identify any barriers to implementing initiatives:

- For the BH measures, the denominators are extremely small (58 for APP and 50 for ADD in 2022). This makes compliance more sensitive to variances and adds difficulty to drawing conclusions or measuring the impact of interventions. The APP measure, age 1-11, is further challenged by the number of pediatric BH providers who provide psychosocial care. more sensitive and difficult to draw conclusions or measure the impact of interventions.
- UHPN continues to evaluate member engagement rates and unable to contact information for our members. Engagement rates and inaccurate contact information continue to be barriers. Our data supports significant improvement in chronic disease management once a member is enrolled in one of the health plans, asthma or diabetes disease management programs, and begins to receive individual health coaching by our professionally trained and licensed staff. We are actively collaborating with providers to increase awareness of these programs and improve engagement rates. To improve contact information, we are working to increase awareness about selecting communication preferences through our online member center so that we have alternative communication options to communicate with members through text and email once they opt into those preferences.

HSAG Assessment: HSAG has determined that **UHC HPN** addressed the prior year's recommendations based on the MCO's reported initiatives. Although **UHC HPN** developed improvement strategies based on the prior year recommendations (i.e., interventions) that are designed to target the population(s) and age group(s) to

successfully improve member outcomes, there is additional room for improvement with measures that declined in performance or did not meet the MPS.

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

HSAG recommended the following:

- **UHC HPN** did not remediate one element for the Coverage and Authorization of Services standard, indicating continued gaps in the MCO's processes for providing members with adverse benefit determination (ABD) notices at the time claims are denied, in whole or in part. Notices related to claim payment denials provide transparency and important information to members regarding payment for their rendered services, including potential financial liability for payment in certain circumstances (e.g., services rendered by a non-Medicaid contracted provider without a prior authorization for services), appeal rights, and awareness of possible fraudulent provider billing practices. HSAG required **UHC HPN** to submit an action plan to address these findings and provide assurances that **UHC HPN** had implemented a documented process which included business requirements for mailing ABD notices when there is a partial or full denial of payment, and evidence that ABD notices for the denial of payment are being mailed at the time the decision to deny payment is made. Additionally, HSAG recommends that **UHC HPN** consider conducting case file reviews periodically to ensure that utilization management staff and/or claims staff are adhering to established policies and procedures for providing members with ABD notices at the time a claim payment is denied.

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

a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:
   - The Corrective Action for implementing the ABD notices is still ongoing. Once operational, the health plan will include a case file review to monitor adherence to established protocols.

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

c. Identify any barriers to implementing initiatives:
   - N/A

HSAG Assessment: HSAG has determined that **UHC HPN** partially addressed the prior year's recommendations based on the training initiatives reported by the MCO. While the MCO continues to operationalize its CAP related to the mailing of an ABD notice to a member at the time of a denial of payment, HSAG continues to recommend that the MCO prioritize its efforts to fully implement its action plans to ensure the deficiencies and gaps identified through the compliance review activity are fully remediated.

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

HSAG recommended the following:

- **UHC HPN** did not meet the time-distance contract standards for the OB/GYN provider type, indicating members may experience challenges accessing this provider type within an adequate time or distance from their residence. HSAG recommends that **UHC HPN** continue to review DHCFP's monthly enrolled provider list to determine if new providers are available for contracting and promote telehealth services as an option to accessing services when feasible and appropriate.

- **UHC HPN** did not meet the time-distance contract standards for Pediatric Rheumatologists in Washoe County, indicating that pediatric members may experience challenges accessing this provider type within an adequate time or distance from their residence. HSAG recommends that **UHC HPN** consider collaborating with DHCFP and the other MCOs to determine whether community reinvestment funds can be used to incentivize pediatric rheumatologists to join a rheumatology clinic in Washoe County.

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

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

- Contracting and Case Management staff have a long-established routine of reviewing DHCFP's monthly enrolled provider list to determine if new providers are available for contracting, including OB and Rheumatologist providers. In addition, where providers are able and willing, we promote telehealth services as an option to accessing services when feasible and appropriate.

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

- From 2023 to 2024, the health plan increased in-network OB providers from 266 to 329 (non-unique), which is a 24% increase.
- The health plan increased its Pediatric Rheumatologists from 1 to 2 in Clark County. The health plan continues to monitor all sources for new Pediatric Rheumatology providers in Washoe County.

c. Identify any barriers to implementing initiatives:

- Lack of providers in Washoe County and providers, when identified, lack the desire to enroll as a Medicaid provider.

HSAG Assessment: HSAG has determined that **UHC HPN** addressed the prior year's recommendations based on the MCO's reported initiatives. **UHC HPN** also provided an explanation about the barriers (i.e., lack of providers available for contracting) that contributed to the MCO not meeting all state-established network adequacy standards. Because the SFY 2024 NAV activity methodology was conducted as a new scope of work in alignment with the 2023 release of CMS EQR Protocol 4, therefore the methodology for conducting the NAV audit activities and the subsequent results were not comparable to the SFY 2023 NAV activity. HSAG has provided additional recommendations to **UHC HPN** in the *External Quality Review Activity Results* section, as necessary, based on the findings from the SFY 2024 NAV audit.

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

HSAG recommended the following:

- Parents/caretakers of CCC Medicaid child members had less positive overall experiences with all their child's healthcare since the score for this measure was statistically significantly lower than the 2022 NCQA Medicaid national average. HSAG recommends that **UHC HPN** focus on improving provider-patient communications by distributing provider bulletins or trainings that explain the importance of providing clear explanations, listening carefully, and being considerate of parents'/caretakers' perspectives. **UHC HPN** could consider exploring service recovery methods, which is a type of intervention used to identify and resolve dissatisfaction in customer or clinical service. Service recovery actions can range from simply listening to the upset parent/caretaker to providing solutions or making amends for problems that the parent/caretaker reported.
- There were less than 100 respondents for every measure for the Nevada Check Up CCC population and for most measures for the other adult and child populations; therefore, results could not be reported for the applicable measures, and strengths and weaknesses could not be identified for the associated populations.

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

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

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

- CAHPS workgroups were formed in early 2022. Activities included a letter to members to complete the survey, reminder text messages, member appreciation events, CAHPS articles in the member newsletter and website and the health plan intranet. Complaints were analyzed to discover whether there were any trends that could be acted upon. All these activities continue along with the Member Advisory Board, comparisons to NPS surveys completed by the national teams, review and discussion on verbatims received from member surveys and more. The Provider Services team initiated a "Service with a Smile" training for provider offices that includes member sensitivity and quality customer service.
- UHC HPN Medicaid continues to oversample these populations as recommended.

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

- There was an improvement in the response rate for the adult survey in 2023 (6.6 to 7.9). The child survey was stable at 8.4 versus 8.5 in 2022.

c. Identify any barriers to implementing initiatives:

- There are no barriers to implementing initiatives. The plan is committed to increasing the response rate.
- There are 88 questions on the child survey and 52 on the adult survey. The burden is evident when later questions on the survey are not filled out and incomplete (although valid) surveys are submitted. Interventions may encourage members to start the survey, but not necessarily complete it so some questions will have less than the 100 responses required to be reportable.
- The public is survey weary.

HSAG Assessment: HSAG has determined that **UHC HPN** addressed the prior year's recommendations based on the MCO's reported interventions. However, there were less than 100 respondents for every measure for the Nevada Check Up CCC populations and for most measures for the adult and child populations whereby results could not be reported for the applicable measures. HSAG recommends that **UHC HPN** continue to evaluate and revise interventions to increase response rates to the CAHPS survey for all populations.

6. Follow-Up on Prior EQR Recommendations for PAHP

From the findings of the PAHP performance for the SFY 2023 EQR activities, HSAG made recommendations for improving the quality of healthcare services furnished to members enrolled in the Nevada Managed Care Program. The recommendations provided to the PAHP for the EQR activities in the *State Fiscal Year 2023 External Quality Review Technical Report* are summarized in Table 6-1. The PAHP's summary of the activities that were either completed, or were implemented and still underway, to improve the finding that resulted in the recommendation, and as applicable, identified performance improvement, and/or barriers identified are also provided in Table 6-1.

LIBERTY Dental Plan of Nevada, Inc.

Table 6-1—Prior Year Recommendations and Responses for LIBERTY

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • HSAG did not identify any weaknesses for **LIBERTY**. Although no significant weaknesses were identified during the SFY 2023 PIP activities, as **LIBERTY** progresses to the Implementation stage of the PIP, HSAG recommends that **LIBERTY** develop effective strategies (i.e., interventions) that are designed to target the designated PIP populations(s) and age group(s) to successfully improve member outcomes.
MCE's Response: (Note—the narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Performance Improvement Project (PIP) / Quality Improvement Project (QIP) Data Stratification: When conducting PIP/QIP evaluations, LIBERTY's Quality Improvement (QI) team stratifies datasets by demographics such as ethnicity, primary language, gender, member zip code, and age. This data is analyzed to determine if disparities are present. The stratified data will be evaluated at each demographic level within the context of each PIP's overall AIM statement/goal. • If a disparity is identified, LIBERTY's QI team will facilitate workgroups with the applicable business areas to evaluate current interventions and determine if modifications are needed or if new interventions need to be developed. • All findings related to health equity are shared with our Quality Management Population Health Management (PHM) team for documentation and to take any additional actions.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • During SFY 2023, there were no disparities identified during the PIP evaluations, so no actions were deemed necessary. LIBERTY will continue to monitor for any potential disparities and will act accordingly.
c. Identify any barriers to implementing initiatives: • Not applicable, as there were no disparities identified during SFY 2023.

HSAG Assessment: HSAG has determined that **LIBERTY** addressed the prior year's recommendations based on the initiatives reported to improve the processes to the PIPs. **LIBERTY** developed effective improvement strategies (i.e., interventions) that are designed to target the designated PIP population(s) and to successfully improve member outcomes.

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

HSAG recommended the following:

- No weaknesses were identified as MY 2022 was the first year **LIBERTY** reported rates for the measures selected by the State; therefore, no trending is available and a state-established MPS has not been determined for each measure. Although no weaknesses were identified, HSAG recommends that **LIBERTY** monitor these rates regularly so that it can identify any potential barriers early in the reporting process.

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

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

- LIBERTY conducts ongoing, monthly monitoring of all Nevada Medicaid and Nevada Check Up performance measures by utilizing internal software such as Power BI. The Quality Improvement (QI) team monitors these dashboards to ensure that each rate is within the state-established Minimum Performance Standard (MPS). By continuously monitoring the data, LIBERTY can identify and implement timely corrective actions or performance improvement projects depending on the data results. This approach ensures issues are addressed early, maintaining optimal performance levels.

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

- Not applicable.

c. Identify any barriers to implementing initiatives:

- Not applicable.

HSAG Assessment: HSAG has determined that **LIBERTY** addressed the prior year's recommendations based on the PAHP's reported initiatives (i.e., interventions). However, as **LIBERTY** did not meet any DHCFP-established MPS, HSAG recommends that the PAHP continue to monitor these rates regularly and implement interventions, as necessary, to support improvement.

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

HSAG recommended the following:

- HSAG did not identify any substantial weaknesses for **LIBERTY** as all CAPs had been fully implemented and all requirements deemed compliant. While **LIBERTY** demonstrated that its CAPs were implemented and remediated the deficiencies identified, HSAG recommends that the PAHP continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to the Nevada Medicaid Managed Care Program. HSAG will evaluate adherence to the requirements during the next three-year compliance review cycle.

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

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

- LIBERTY maintains a documented New Requirements process to ensure compliance with all federal and State obligations that may impact the Nevada Medicaid Managed Care Program. Through this process, LIBERTY reviews new requirements to identify impact(s) and risk(s) and develops workplans and tasks, as appropriate, to implement any necessary changes. Implementation of new requirements is monitored, validated, and reported to LIBERTY's Regulatory Compliance Committee and senior leadership.

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

- Any performance improvements would be identified and reported to LIBERTY's Regulatory Compliance Committee and senior leadership.

c. Identify any barriers to implementing initiatives:

- No barriers have been identified at this time.

HSAG Assessment: HSAG has determined that **LIBERTY** addressed the prior year's recommendations based on the initiatives reported. However, HSAG recommends that in addition to reviewing new requirements that may impact the Nevada Managed Care Program, the PAHP also continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to the Nevada Managed Care Program.

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

HSAG recommended the following:

- **LIBERTY** did not meet the statewide provider ratio standard for Dental Primary Care Providers, after doing so in SFY 2022. This indicates that members outside Clark and Washoe counties may have limited access to preventive dental care. HSAG recommends that **LIBERTY** continue using DHCFP's monthly provider list to identify new dental providers and, subsequently, outreach and try to recruit them.
- **LIBERTY** did not meet the time-distance contract standards for Periodontists and Prosthodontists in Washoe County or statewide, indicating **LIBERTY** may not have a sufficient provider network for its members to access these services. From SFY 2022 to SFY 2023, the percentage of members with access to Periodontists statewide decreased more than 10 percentage points, from 99.4 percent with access to 88.4 percent with access. This result was driven by no members in Washoe County having access to a Periodontist within standards for SFY 2023. HSAG recommends that **LIBERTY** continue using DHCFP's monthly provider list to identify new specialty dental providers and, subsequently, outreach and try to recruit those specialists in Clark and Washoe counties.
- **LIBERTY** did not meet the time-distance contract standards for Public Health Endorsed Dental Hygienists in Washoe County or statewide, indicating members may experience challenges accessing these provider types within an adequate time or distance from their residence. HSAG recommends that **LIBERTY** continue to conduct an in-depth review of provider categories for which it did not meet the time-distance contract standards, with the goal of determining whether or not the failure of the PAHP to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area. **LIBERTY** should continue using DHCFP's monthly provider list to identify new specialty dental providers and, subsequently, outreach and try to recruit those specialists in Clark and Washoe counties.

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

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

- LIBERTY continues to utilize the DHCFP's active provider report received monthly.
- LIBERTY is over a 95% match to all active, contracted Dental Primary Care Providers. LIBERTY utilizes the report to identify newly enrolled providers for recruitment.
- LIBERTY is contracted with 7 of the 8 Periodontists with a Medicaid ID, the other one is in a catchment area. LIBERTY is contracted with 5 of 7 Prosthodontists with a Medicaid ID, the other two are in catchment areas.
- LIBERTY is contracted with 17 of the 18 Public Health Endorsed Hygienists with a Medicaid ID, the other one is in a catchment area.

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

- The DHCFP requires quarterly network adequacy reporting and the ratio of Members to Dental Primary Care Providers is 1:1,500. As of Q2 2024 reporting, LIBERTY is at 1:1,274.
- LIBERTY has active recruitment going on for Specialists. LIBERTY has reached out to the Nevada State Board of Dental Examiners to obtain a list of all providers who hold a Specialty license to identify and recruit new providers.
- LIBERTY contracted 1 Public Health Endorsed Hygienist in Northern Nevada since the Network Adequacy Validation activity. LIBERTY continues to outreach and recruit providers.

c. Identify any barriers to implementing initiatives:

- The barrier to contracting new Dental Primary Care Providers is the fees.
- The barriers to recruiting Specialists are the limited adult benefit, the no call percentage for the membership, and the fees.
- The barrier to contracting Public Health Endorsed Dental Hygienists is the limited number of dental hygienists who hold a public health endorsement.

HSAG Assessment: HSAG has determined that **LIBERTY** addressed the prior year's recommendations based on the DBA's reported initiatives. **LIBERTY** also provided an explanation about the barriers (e.g., fees, limited providers) that contributed to the PAHP not meeting all state-established network adequacy standards. Because the SFY 2024 NAV activity methodology was conducted as a new scope of work in alignment with the 2023 release of CMS EQR Protocol 4, and therefore the methodology for conducting the NAV audit activities and the subsequent results were not comparable to the SFY 2023 NAV activity, HSAG has provided additional recommendations to **LIBERTY** in the *External Quality Review Activity Results* section, as necessary, based on the findings from the SFY 2024 NAV audit.

5. Prior Year Recommendation from the EQR Technical Report for Member Satisfaction Survey

HSAG recommended the following:

- There were less than 100 respondents for every measure across both child populations; therefore, results could not be reported and strengths and weaknesses could not be identified. HSAG recommends that **LIBERTY** focus on increasing response rates to the dental satisfaction survey for both populations so there are greater than 100 respondents for each measure by educating and engaging all employees to increase their knowledge of dental satisfaction surveys, applying effective customer service techniques, increasing the percentage of oversampling, using innovative outreach strategies to follow up with non-respondents, and providing awareness to members and providers during the survey period. Additionally, **LIBERTY**'s

care management and/or other member-facing teams, such as the customer service team, could consider asking members if they know about the dental satisfaction survey and, if they received the survey, what barriers may prevent them from responding to the survey. These questions can be asked during routine contacts with members or when members outreach to **LIBERTY**. The information provided by these members could be shared with **LIBERTY**'s dental satisfaction survey vendor so that **LIBERTY** and the vendor can identify solutions to address low response rates.

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

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

- Staff Education: Our Subject Matter Experts (SMEs) have actively participated in a series of targeted webinars and educational courses aimed at enhancing our expertise in customer service techniques, survey methodology, and outreach strategies. This initiative has significantly strengthened our team's ability to engage with members effectively and address their needs more proficiently.
- Survey Implementation: We introduced an email-based survey methodology to increase response rates for both child and adult members. Additionally, we extended the survey timeline to optimize outreach efforts, giving members more opportunities to participate and ensuring their voices are heard. LIBERTY is also working with integrating market research tools and technology to improve the survey confidence level and reduce the margin of error rate by ensuring proper sample size is accounted for during our annual surveys.
- Member Feedback: The Member Advisory Committee (MAC) has been leveraged as a key workgroup to gain valuable insight to members' understanding and preferences regarding the satisfaction survey. LIBERTY will continue to utilize member feedback to refine our strategies and better serve our community.
- Member Engagement: To enhance member engagement, we have developed an outreach strategy that includes active social media interaction, closing call scripts, member newsletter announcements, and survey information during in-person engagement by outreach staff. We have shared survey results on LIBERTY website in efforts to foster transparency and encourage ongoing participation in our surveys.

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

- The response rate saw a significant increase, rising from 102 respondents to 108 adult respondents and 333 child respondents, culminating in 433 survey responses. This is a remarkable increase of more than 300% when compared to the previous survey year. We are committed to maintaining this upward trajectory, and response rates, along with survey results, will be continuously monitored as part of LIBERTY's ongoing process improvement efforts.

c. Identify any barriers to implementing initiatives:

- Member Information: Inaccurate member contact information, including invalid phone numbers, emails, and addresses, remains a significant barrier to effective outreach efforts and is directly linked to lower response rates.

HSAG Assessment: HSAG has determined that **LIBERTY** addressed the prior year's recommendations based on the MCO's reported initiatives. However, results from the SFY 2024 CAHPS activity indicate that **LIBERTY** should continue to focus its efforts on improving response rates and positive responses.

7. MCE Comparative Information

In addition to performing a comprehensive assessment of each MCE's performance, HSAG uses a step-by-step process methodology to compare the findings and conclusions established for each MCE to assess the Nevada Managed Care Program. Specifically, HSAG identifies any patterns and commonalities that exist across the five MCEs and the Nevada Managed Care Program, draws conclusions about the overall strengths and weaknesses of the program, and identifies areas in which DHCFP could leverage or modify its Quality Strategy to promote improvement.

EQR Activity Results

This section provides the summarized results for the mandatory and optional EQR activities across the MCEs, when the activity methodologies and resulting findings were comparable.

Validation of Performance Improvement Projects

For the SFY 2024 validation, the MCOs submitted all nine steps of the PIP process for six DHCFP-mandated PIP topics, and the PAHP submitted Steps 1 through 8 of the PIP process for the two PAHP-selected PIP topics.

Table 7-1 through Table 7-6 provides a comparison of the overall PIP performance indicator rates for all MCOs per PIP topic. All MCOs used the same comparative targeted age group for each PIP's performance indicators as defined by NCQA's HEDIS specifications. The PAHP's PIP performance indicator rates are not included in the following tables, as the PIP topics were not consistent with those of the MCOs.

Table 7-1—Comparison of PIP Performance Indicators for IET PIP

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)			
Plan Name	**Performance Indicator**	**Baseline Rate**	**R1 Rate**
Anthem	The percentage of SUD episodes that resulted in initiation of treatment with 14 days.	45.9%	46.4%
	The percentage of SUD episodes that resulted in treatment engagement within 34 days of initiation.	17.9%	16.9%
Molina	The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit, or medication treatment within 14 days.	49.8%	47.8%
	The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.	13.2%	16.1%

Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)			
Plan Name	**Performance Indicator**	**Baseline Rate**	**R1 Rate**
SilverSummit	The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit, or medication treatment within 14 days.	43.6%	46.8%
	The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.	13.4%	13.6%
UHC HPN	The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit, or medication treatment within 14 days.	44.8%	45.0%
	The engagement portion of IET measures the percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.	13.8%	14.6%

R=Remeasurement

For the *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)* PIP, two of the four MCOs demonstrated improvement at Remeasurement 1 for both performance indicators, **SilverSummit** and **UHC HPN**. **Anthem** and **Molina** demonstrated improvement at Remeasurement 1 for one of the two performance indicators.

Table 7-2—Comparison of PIP Performance Indicators for AAP PIP

Adults' Access to Preventive/Ambulatory Health Services (AAP)			
Plan Name	**Performance Indicator**	**Baseline Rate**	**R1 Rate**
Anthem	The percentage of adults 20 years of age and older that had at least one preventive or ambulatory care visit during the measurement year.	66.4%	64.8%
Molina	The percentage of members 20 years of age and older who had an ambulatory or preventive care visit.	52.7%	56.3%
SilverSummit	The percentage of members 20 years of age and older who had an ambulatory or preventive care visit during the measurement year.	55.7%	55.5%
UHC HPN	The percentage of adults 20 years of age and older that had at least one preventive or ambulatory care visit during the measurement year.	70.7%	69.1%

R=Remeasurement

For the *Adults' Access to Preventive/Ambulatory Health Services (AAP)* PIP, one of the four MCOs demonstrated improvement at Remeasurement 1, Molina. The other three MCOs had a decline in performance at Remeasurement 1.7

Table 7-3—Comparison of PIP Performance Indicators for WCV PIP

Child and Adolescent Well Care Visit (WCV)			
Plan Name	**Performance Indicator**	**Baseline Rate**	**R1 Rate**
Anthem	The percentage of members 3 to 21 years of age that had at least one well-care visit with a PCP or OB/GYN practitioner during the measurement year.	45.5%	46.7%
Molina	The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	38.8%	43.4%
SilverSummit	The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	36.6%	41.0%
UHC HPN	The percentage of members ages 3–21 years who had one or more well-child visits with a PCP or OB/GYN during the measurement year.	46.4%	48.3%

R=Remeasurement

For the *Child and Adolescent Well Care Visit (WCV)* PIP, all four MCOs demonstrated improvement at Remeasurement 1.

Table 7-4—Comparison of PIP Performance Indicators for FUM PIP

Follow-up After Emergency Department Visit for Mental Illness (FUM)			
Plan Name	**Performance Indicator**	**Baseline Rate**	**R1 Rate**
Anthem	The percentage of mental illness ED visits for which members 6 years of age and older had a follow-up visit within 7 days after the ED visit.	50.5%	53.3%
	The percentage of mental illness ED visits for which the member 6 years of age and older had a follow-up visit within 30 days after the ED visit.	40.2%	43.0%

Follow-up After Emergency Department Visit for Mental Illness (FUM)			
Plan Name	**Performance Indicator**	**Baseline Rate**	**R1 Rate**
Molina	The percentage of ED visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness within 7 days of the ED visit.	50.8%	51.1%
	The percentage of ED visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness within 30 days of the ED visit.	58.0%	57.0%
SilverSummit	The percentage of ED visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness within 7 days of the ED visit.	48.5%	44.4%
	The percentage of ED visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness within 30 days of the ED visit.	57.1%	52.4%
UHC HPN	The percentage of mental illness ED visits for which the member 6 years of age and older had a follow-up visit within 7 days after the ED visit.	47.2%	53.1%
	The percentage of mental illness ED visits for which the member 6 years of age and older had a follow-up visit within 30 days after the ED visit.	54.6%	61.6%

R=Remeasurement

For the *Follow-up After Emergency Department Visit for Mental Illness (FUM)* PIP, two of the four MCOs demonstrated improvement at Remeasurement 1 for both performance indicators, **Anthem** and **UHC HPN**. **Molina** and **SilverSummit** demonstrated improvement at Remeasurement 1 for one of the two performance indicators.

Table 7-5—Comparison of PIP Performance Indicators for PPC PIP

Prenatal and Postpartum Care (PPC)			
Plan Name	**Performance Indicator**	**Baseline Rate**	**R1 Rate**
Anthem	The percentage of deliveries for which received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.	62.9%	67.1%
	The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.	53.6%	59.6%

Prenatal and Postpartum Care (PPC)			
Plan Name	**Performance Indicator**	**Baseline Rate**	**R1 Rate**
Molina	The percentage of deliveries for which the member received a prenatal care visit in the first trimester or within 42 days of enrollment in the organization.	52.8%	59.7%
	The percentage of members with a delivery that had a postpartum visit on or between 7 and 84 days after delivery.	37.8%	46.4%
SilverSummit	The percentage of deliveries for which the member received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.	49.2%	52.4%
	The percentage of deliveries for which the member had a postpartum visit on or between 7 and 84 days after delivery.	45.8%	51.1%
UHC HPN	The percentage of deliveries as defined by the eligible population that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization	68.6%	75.7%
	The percentage of Medicaid members as defined by the eligible population that completed a postpartum visit on or between 7 and 84 days after delivery.	65.4%	71.9%

R=Remeasurement

For the *Prenatal and Postpartum Care (PPC)* PIP, all of the four MCOs demonstrated improvement at Remeasurement 1 for both performance indicators.

Table 7-6—Comparison of PIP Performance Indicators for PCR PIP

Plan All-Cause Readmissions (PCR)			
Plan Name	**Performance Indicator**	**Baseline Rate**	**R1 Rate**
Anthem	The percentage of acute readmissions for any diagnosis within 30 days of the index discharge date.	12.8%	10.9%
Molina	For members 18 years of age and older, the percentage of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.	20.6%	10.3%

Plan All-Cause Readmissions (PCR)			
Plan Name	**Performance Indicator**	**Baseline Rate**	**R1 Rate**
SilverSummit	For members 18 years of age and older, the percentage of acute inpatient and observation stays during the measure year that were followed by an unplanned acute readmission for any diagnosis within 30 days.	11.2%	11.6%
UHC HPN	The percentage of acute readmissions for any diagnosis within 30 days of the index discharge date.	10.4%	10.6%

R=Remeasurement

For the *Plan All-Cause Readmissions (PCR)* PIP, two of the four MCOs demonstrated improvement at Remeasurement 1, **Anthem** and **Molina**. **SilverSummit** and **UHC HPN** demonstrated decline in performance at Remeasurement 1.

Performance Measure Validation

Table 7-7 and Table 7-8 show the HEDIS and CMS Child and Adult Core Set MY 2023 Medicaid and Nevada Check Up performance measure results for **Anthem**, **UHC HPN**, **Molina**, and **SilverSummit**, along with the MPS for each performance measure and the Medicaid and Nevada Check Up aggregate, which represents the average of all four MCOs' performance measure rates weighted by the eligible population.

Performance for MY 2023 (SFY 2024) is indicated by symbols and color coding; **bolded** rates indicate the rate met or exceeded the DHCFP-established MPS[31]; ↑ indicates the rate was above the national Medicaid 50th percentile benchmark; ↓ indicates the rate was below the national 50th percentile benchmark; **green** shading indicates that the rate improved by 5 percentage points from the prior year; **red** shading indicates that the rate declined by 5 percentage points from the prior year; and **orange** shading indicates that the aggregate rate was at or above the MPS.

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

LIBERTY's performance measures were dental focused and not comparable to the MCOs' performance measures and resulting rates; therefore, **LIBERTY**'s results are not included in the following tables.

[31] Refer to *Appendix B. Goals and Objectives Tracking* for measures with an established MPS. Not all measures reported by the MCO have a DHCFP-established MPS.

Table 7-7—Medicaid SFY 2024 Performance Measure Results

HEDIS Measure	Anthem	Molina	SilverSummit	UHC HPN	MPS	MY 2023 Medicaid Aggregate†
Access to Care						
Adults' Access to Preventive/Ambulatory Health Services (AAP)						
(20–44 Years)	62.61%↓	55.02%↓	53.09%↓	66.11%↓	69.68%	60.57%
(45–64 Years)	70.24%↓	59.51%↓	61.43%↓	75.23%↓	76.59%	68.74%
(65+ Years)	57.43%↓	46.99%↓	46.61%↓	62.17%↓	MNA	54.74%
(Total)	64.84%↓	56.27%↓	55.54%↓	69.07%↓	MNA	63.04%
Children's Preventive Care						
Child and Adolescent Well-Care Visits (WCV)						
(3–11 Years)	51.08%↓	48.58%↓	47.63%↓	**54.85%**↓	52.50%	51.38%
(12–17 Years)	**46.76%**↓	43.84%↓	40.06%↓	**48.98%**↓	45.85%	46.00%
(18–21 Years)	23.08%↓	21.99%↓	18.58%↓	24.64%↑	29.68%	22.70%
Total	46.19%↓	43.38%↓	41.07%↓	48.26%↑	MNA	45.60%
Childhood Immunization Status (CIS)						
Combination 3	58.15%↓	45.50%↓	53.28%↓	55.14%↓	68.95%	54.41%
Combination 7	49.88%↓	39.17%↓	47.45%↓	49.35%↓	62.11%	47.71%
Combination 10	22.63%↓	15.09%↓	17.76%↓	18.82%↓	38.58%	19.34%
Immunizations for Adolescents (IMA)						
Combination 1 (Meningococcal, Tdap)	82.28%↑	80.92%↑	76.64%↓	85.16%↑	87.81%	82.07%
Combination 2 (Meningococcal, Tdap, HPV)	33.12%↓	28.52%↓	23.60%↓	36.74%↑	48.91%	31.98%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)						
BMI Percentile Documentation (Total)	83.45%↑	82.48%↑	81.02%↑	84.76%↑	85.76%	83.40%
Counseling for Nutrition (Total)	73.97%↑	74.45%↑	72.02%↑	76.83%↑	77.65%	74.78%
Counseling for Physical Activity (Total)	71.05%↑	72.75%↑	68.13%↑	71.34%↑	74.96%	70.92%
Well-Child Visits in the First 30 Months of Life (W30)						
(First 15 Months)	58.10%↓	45.23%↓	51.66%↓	**63.09%**↑	62.88%	57.11%
(15 Months–30 Months)	63.15%↓	54.05%↓	56.82%↓	64.88%↓	70.56%	61.24%
Developmental Screening in the First Three Years of Life (DEV-CH)						
(1 Year)	23.36%	20.60%	16.12%	12.30%	MNA	17.93%

HEDIS Measure	Anthem	Molina	SilverSummit	UHC HPN	MPS	MY 2023 Medicaid Aggregate†
(2 Years)	35.77%	38.61%	29.58%	32.87%	MNA	33.95%
(3 Years)	39.42%	31.89%	25.08%	30.47%	MNA	32.53%
(Total)	32.85%	30.58%	24.07%	25.10%	MNA	28.27%
Lead Screening in Children (LSC)						
Lead Screening in Children	26.76%↓	24.09%↓	27.74%↓	22.97%↓	MNA	25.39%
Women's Health and Maternity Care						
Breast Cancer Screening (BCS-E)						
Breast Cancer Screening	39.51%↓	NA	39.49%↓	51.72%↓	54.27%	45.49%
Chlamydia Screening in Women (CHL)						
(16–20 Years)	47.40%↓	50.34%↓	48.25%↓	**60.87%**↑	53.24%	53.57%
(21–24 Years)	59.85%↓	62.62%↑	62.21%↑	62.32%↑	65.10%	61.60%
(Total)	54.31%↓	57.06%↑	56.70%↑	61.62%↑	MNA	57.96%
Postpartum Depression Screening and Follow-Up (PDS-E)						
Depression Screening	0.03%↓	0.12%↑	0.09%↓	0.00%↓	10.00%	0.04%
Follow–Up on Positive Screen	NA	NA	NA	NA	MNA	NA
Prenatal and Postpartum Care (PPC)						
Timeliness of Prenatal Care	78.83%↓	75.43%↓	69.10%↓	**89.29%**↑	85.02%	79.98%
Postpartum Care	73.72%↓	57.91%↓	67.15%↓	**81.27%**↑	74.13%	72.75%
Prenatal and Postpartum Care (PPC2-CH)						
Timeliness of Prenatal Care—Under 21 Years	74.85%	54.73%	53.55%	84.62%	MNA	60.14%
Postpartum Care—Under 21 Years	65.20%	45.27%	52.83%	82.69%	MNA	57.68%
Prenatal Depression Screening and Follow-Up (PND-E)						
Depression Screening	0.00%↓	1.48%↑	0.11%↓	0.00%↓	10.00%	0.23%
Follow–Up on Positive Screen	NA	NA	NA	NA	MNA	NA
Prenatal Immunization Status (PRS-E)						
Influenza	9.33%↓	9.77%↓	11.13%↓	11.13%↓	MNA	10.34%
Tdap	19.83%↓	21.98%↓	21.84%↓	28.70%↓	MNA	23.48%
Combination	5.72%↓	6.81%↓	7.70%↓	8.03%↓	15.07%	7.03%

HEDIS Measure	Anthem	Molina	SilverSummit	UHC HPN	MPS	MY 2023 Medicaid Aggregate†
Contraceptive Care—Postpartum Women (CCP-CH)						
Most or Moderately Effective Contraception—3 Days—(15–20 Years)	1.08%	0.00%	5.93%	4.76%	MNA	3.17%
Most or Moderately Effective Contraception—90 Days—(15–20 Years)	36.02%	33.96%	37.29%	39.68%	MNA	37.31%
Long-Acting Reversible Contraception—3 Days—(15–20 Years)	0.00%	0.00%	2.54%	0.40%	MNA	0.60%
Long-Acting Reversible Contraception—90 Days—(15–20 Years)	11.83%	13.21%	11.86%	8.73%	MNA	10.88%
Contraceptive Care—All Women (CCW-CH)						
Most or Moderately Effective Contraception—(15–20 Years)	12.66%	10.68%	11.68%	12.61%	MNA	12.18%
Long-Acting Reversible Contraception—(15–20 Years)	2.05%	1.23%	1.53%	1.60%	MNA	1.67%
Care for Chronic Conditions						
Asthma Medication Ratio (AMR)						
(5–11 Years)	69.64%↓	67.44%↓	49.68%↓	67.71%↓	MNA	65.16%
(12–18 Years)	51.63%↓	52.78%↓	40.83%↓	54.89%↓	MNA	51.38%
(5–18 years) Child Core Set	61.82%	60.76%	45.85%	61.91%	75.97%	59.04%
(19–50 Years)	48.65%↓	44.50%↓	37.45%↓	48.20%↓	MNA	45.32%
(51–64 Years)	49.57%↓	43.66%↓	38.37%↓	52.07%↓	MNA	47.72%
(19–64 years) Adult Core Set	48.93%	44.29%	37.69%	49.34%	55.66%	46.00%
(Total)	54.06%↓	50.11%↓	40.08%↓	54.12%↓	MNA	50.75%
Blood Pressure Control for Patients With Diabetes (BPD)						
Blood Pressure Control for Patients With Diabetes	58.15%↓	48.18%↓	58.15%↓	**65.21%**↑	60.51%	59.69%
Controlling High Blood Pressure (CBP)						
Controlling High Blood Pressure	56.45%↓	45.01%↓	**59.12%**↓	**66.32%**↑	58.81%	59.63%
Hemoglobin A1c Control for Patients With Diabetes (HBD)						
*Poor HbA1c Control (>9.0%)**	**39.66%**↓	53.04%↓	49.15%↓	40.63%↓	40.52%	43.36%
HbA1c Control (<8%)	**52.80%**↑	42.34%↓	43.55%↓	50.61%↓	50.84%	49.02%

HEDIS Measure	Anthem	Molina	SilverSummit	UHC HPN	MPS	MY 2023 Medicaid Aggregate†
Behavioral Health						
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)						
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	37.59%↓	38.90%↓	35.16%↓	42.41%↓	45.22%	38.73%
Antidepressant Medication Management (AMM)						
Effective Acute Phase Treatment	53.30%↓	51.83%↓	53.03%↓	**58.05%**↓	56.85%	54.63%
Effective Continuation Phase Treatment	36.75%↓	34.41%↓	34.92%↓	40.04%↓	41.55%	37.19%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)						
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	**79.35%**↑	75.90%↓	76.17%↓	76.68%↓	77.29%	77.45%
Follow-Up After Emergency Department Visit for Substance Use (FUA)						
7 days (Total)	18.57%↓	17.78%↓	18.06%↓	14.95%↓	23.59%	17.40%
30 days (Total)	**29.10%**↓	26.53%↓	27.09%↓	25.77%↓	28.26%	27.36%
Follow-Up After Emergency Department Visit for Mental Illness (FUM)						
7 days (Total)	42.34%↑	**51.13%**↑	44.40%↑	**53.08%**↑	47.85%	47.02%
30 days (Total)	52.81%↓	**56.98%**↑	52.43%↓	**61.61%**↑	56.82%	55.67%
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)						
7 Days (Total)	32.11%↑	19.81%↓	18.97%↓	31.10%↑	34.67%	28.78%
30 days (Total)	49.45%↓	33.96%↓	34.45%↓	50.06%↓	50.37%	46.16%
Follow-Up After Hospitalization for Mental Illness (FUH)						
7 days (Total)	33.57%↓	30.12%↓	32.47%↓	33.07%↓	41.37%	32.70%
30 days (Total)	50.68%↓	47.85%↓	49.37%↓	49.04%↓	56.67%	49.56%
Follow-Up Care for Children Prescribed ADHD Medication (ADD)						
Initiation Phase	48.95%↑	47.01%↑	47.49%↑	54.69%↑	55.68%	50.76%
Continuation and Maintenance Phase	68.29%↑	NA	54.05%↓	63.96%↑	72.54%	64.80%
Initiation and Engagement of Substance Use Disorder Treatment (IET)						
Initiation of SUD Treatment—Total (Total)	46.46%↑	**47.82%**↑	46.78%↑	45.04%↑	47.63%	46.37%
Engagement of SUD Treatment—Total (Total)	16.86%↑	16.07%↑	13.58%↓	14.63%↑	21.54%	15.43%

HEDIS Measure	Anthem	Molina	SilverSummit	UHC HPN	MPS	MY 2023 Medicaid Aggregate†
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)						
Blood Glucose and Cholesterol Testing (Total)	35.69%↑	32.00%↓	36.62%↑	**39.68%**↑	38.41%	36.87%
Screening for Depression and Follow-Up Plan (CDF-CH/CDF-AD) ∞						
(12–17 Years)	0.44%	1.87%	0.66%	0.28%	10.41%	0.60%
(18–64 Years)	2.62%	7.67%	2.37%	1.64%	11.21%	2.81%
(65+ Years)	2.37%	9.09%	1.93%	0.75%	MNA	2.61%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)						
(1–11 Years)	68.33%↑	NA	31.43%↓	52.83%↓	MNA	52.05%
(12–17 Years)	63.30%↑	58.82%↓	50.94%↓	50.42%↓	MNA	55.87%
(Total)	**65.09%**↑	50.88%↓	43.18%↓	51.16%↓	63.72%	54.53%
Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)						
Rate 1: Total	56.87%	57.94%	56.59%	43.15%	59.25%	52.45%
Rate 2: Buprenorphine	31.30%	28.41%	32.26%	30.80%	MNA	30.95%
Rate 3: Oral Naltrexone	4.72%	3.36%	2.98%	3.15%	MNA	3.74%
Rate 4: Long-Acting, Injectable Naltrexone	1.83%	1.34%	1.18%	0.41%	MNA	1.19%
Rate 5: Methadone	24.58%	30.43%	24.10%	10.72%	MNA	20.65%
Diabetes Care for People With Serious Mental Illness: Hemoglobin A1c Poor Control (>9.0%) (HPCMI-AD)*						
(18–64 Years)	46.83%	64.07%	53.85%	44.44%	MNA	49.35%
(65–75 Years)	NA	NA	NA	NA	MNA	NA
Utilization						
Ambulatory Care—Total (per 1,000 Member Years) (AMB)*						
*ED Visits—Total**	618.63	579.93	560.19	542.57	MNA	575.51
Outpatient Visits—Total	3,294.95	2,461.55	2,604.61	3,499.54	MNA	3,104.26
Plan All-Cause Readmissions (PCR)						
*Observed Readmissions Total—(18–64 Years)**	**10.94%**	**10.29%**	11.56%	**10.62%**	11.28%	10.85%
Expected Readmissions—(18–64 Years)	9.09%	9.23%	9.53%	9.12%	MNA	9.20%
Observed/Expected (O/E) Ratio Total—(18–64 Years)	1.2030	1.1144	1.2131	1.1648	MNA	1.1788
Outliers Total—(18–64 Years)	81.91	63.06	67.39	68.38	MNA	71.93

HEDIS Measure	Anthem	Molina	SilverSummit	UHC HPN	MPS	MY 2023 Medicaid Aggregate†
Overuse/Appropriateness of Care						
Risk of Continued Opioid Use (COU)*						
>=15 Days (Total)	7.57%↓	8.06%↓	**5.99%**↓	8.45%↓	6.92%	7.65%
>=31 Days (Total)	5.85%↓	6.35%↓	**4.54%**↓	6.72%↓	5.47%	5.98%
Use of Opioids at High Dosage (HDO)*						
Use of Opioids at High Dosage	**7.80%**↓	10.73%↓	**4.59%**↓	8.92%↓	8.23%	8.11%
Use of Opioids From Multiple Providers (UOP)*						
Multiple Prescribers	**20.60%**↓	**21.56%**↓	27.09%↓	22.73%↓	22.14%	22.60%
Multiple Pharmacies	0.99%↑	1.01%↑	0.86%↑	1.04%↑	MNA	0.99%
Multiple Prescribers and Multiple Pharmacies	0.64%↑	0.28%↑	0.55%↑	0.50%↑	MNA	0.53%
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)						
(3 Months–17 Years)	72.02%↓	71.28%↓	71.30%↓	71.76%↓	MNA	71.70%
(18–64 Years)	52.88%↑	51.85%↑	50.16%↑	49.19%↑	MNA	50.83%
(65+ Years)	NA	NA	NA	NA	MNA	NA
(Total)	65.26%↑	64.49%↑	63.00%↑	63.54%↑	MNA	64.10%

† Represents performance under the Medicaid managed care program.

* A lower rate indicates better performance for this measure.

** Beginning MY 2022, this rate was reported per 1,000 member years instead of per 1,000 member months; the rates for MY 2021 were converted to member years for comparison.

∞ MCOs reported *CDF—18—64 years* and *CDF—65 years and older* to align with the CMS Adult Core Set FFY 2024 technical specifications. HSAG calculated the total of these two indicators to determine if the MCOs met or exceeded DHCFP's QISMC goal for *CDF—18 years and older.*

↑ Indicates the MY 2023 rate was above NCQA's Quality Compass 2023 Medicaid HMO 50th percentile benchmark.

↓ Indicates the MY 2023 rate was below NCQA's Quality Compass 2023 Medicaid HMO 50th percentile benchmark.

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

MNA indicates MY 2023 QISMC goals are unavailable for this measure or indicator.

Bolded rates indicate that the MY 2023 performance measure rate met or exceeded the DHCFP-established MPS.

Indicates that the MY 2023 rate declined by 5 percentage points or more from MY 2022.

Indicates that the MY 2023 rate improved by 5 percentage points or more from MY 2022.

Indicates that the Medicaid aggregate rate met or exceeded the DHCFP-established MPS.

Table 7-8—Nevada Check Up SFY 2024 Performance Measure Results

HEDIS Measure	Anthem	Molina	SilverSummit	UHC HPN	MPS	MY 2023 NV Check Up Aggregate†
Children's Preventive Care						
Child and Adolescent Well-Care Visits (WCV)						
(3–11 Years)	53.48%↓	49.33%↓	48.87%↓	59.20%↑	59.37%	54.29%
(12–17 Years)	51.42%↑	46.81%↓	43.54%↓	**54.98%**↑	54.57%	50.90%
(18–21 Years)	37.97%↑	33.20%↑	22.79%↓	34.95%↑	38.72%	33.39%
Total	51.74%↑	46.96%↓	44.76%↓	55.40%↑	MNA	51.35%
Childhood Immunization Status (CIS)						
Combination 3	67.23%↑	76.79%↑	66.23%↑	71.67%↑	82.36%	69.89%
Combination 7	61.34%↑	**76.79%**↑	62.34%↑	68.33%↑	76.15%	66.13%
Combination 10	21.01%↓	33.93%↑	32.47%↑	26.67%↓	48.22%	27.15%
Immunizations for Adolescents (IMA)						
Combination 1 (Meningococcal, Tdap)	90.03%↑	88.69%↑	86.26%↑	94.16%↑	94.17%	90.77%
Combination 2 (Meningococcal, Tdap, HPV)	41.88%↑	36.31%↑	35.55%↑	47.69%↑	57.30%	42.22%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)						
BMI Percentile Documentation (Total)	82.24%↑	80.05%↑	81.02%↑	**85.67%**↑	85.62%	83.18%
Counseling for Nutrition (Total)	73.97%↑	68.37%↓	74.70%↑	**77.13%**↑	77.08%	74.65%
Counseling for Physical Activity (Total)	72.26%↑	64.96%↓	71.53%↑	**75.30%**↑	74.09%	72.45%
Well-Child Visits in the First 30 Months of Life (W30)						
(First 15 Months)	67.35%↑	40.00%↓	68.33%↑	**76.15%**↑	73.00%	68.01%
(15 Months–30 Months)	64.00%↓	62.22%↓	62.77%↓	68.10%↑	82.95%	64.74%
Developmental Screening in the First Three Years of Life (DEV-CH)						
(1 Year)	25.55%	NA	13.33%	12.44%	MNA	18.66%
(2 Years)	41.61%	53.57%	24.36%	39.47%	MNA	39.74%
(3 Years)	37.23%	33.33%	30.43%	32.43%	MNA	33.93%
(Total)	34.79%	41.13%	25.21%	29.80%	MNA	31.96%
Lead Screening in Children (LSC)						
Lead Screening in Children	26.05%↓	42.86%↓	32.05%↓	28.10%↓	MNA	30.48%

HEDIS Measure	Anthem	Molina	SilverSummit	UHC HPN	MPS	MY 2023 NV Check Up Aggregate†
Women's Health and Maternity Care						
Chlamydia Screening in Women (CHL)						
(16–20 Years)	39.62%↓	**49.30%↓**	**46.53%↓**	**61.36%↑**	45.62%	52.69%
(21–24 Years)	NA	NA	NA	NA	MNA	NA
(Total)	39.62%↓	49.30%↓	46.53%↓	61.36%↑	MNA	52.69%
Prenatal and Postpartum Care (PPC)						
Timeliness of Prenatal Care	NA	NA	NA	NA	MNA	NA
Postpartum Care	NA	NA	NA	NA	MNA	NA
Prenatal and Postpartum Care (PPC2-CH)						
Timeliness of Prenatal Care—Under 21 Years	NA	NA	NA	NA	MNA	NA
Postpartum Care—Under 21 Years	NA	NA	NA	NA	MNA	NA
Contraceptive Care—Postpartum Women (CCP-CH)						
Most or Moderately Effective Contraception—3 Days—(15–20 Years)	NA	NA	NA	NA	MNA	NA
Most or Moderately Effective Contraception—90 Days—(15–20 Years)	NA	NA	NA	NA	MNA	NA
Long-Acting Reversible Contraception—3 Days—(15–20 Years)	NA	NA	NA	NA	MNA	NA
Long-Acting Reversible Contraception—90 Days—(15–20 Years)	NA	NA	NA	NA	MNA	NA
Contraceptive Care—All Women (CCW-CH)						
Most or Moderately Effective Contraception—(15–20 Years)	9.35%	6.85%	8.47%	9.91%	MNA	9.07%
Long-Acting Reversible Contraception—(15–20 Years)	0.66%	0.81%	1.13%	1.14%	MNA	0.96%
Care for Chronic Conditions						
Asthma Medication Ratio (AMR)						
(5–11 Years)	61.22%↓	NA	NA	76.00%↑	MNA	64.84%
(12–18 Years)	63.64%↓	NA	NA	66.00%↓	MNA	62.39%
(5–18 years) Child Core Set	62.20%	NA	53.85%	71.00%	76.68%	63.67%

HEDIS Measure	Anthem	Molina	SilverSummit	UHC HPN	MPS	MY 2023 NV Check Up Aggregate†
(19–50 Years)	NA	NA	NA	NA	MNA	NA
(51–64 Years)	NA	NA	NA	NA	MNA	NA
(19–64 years) Adult Core Set	NA	NA	NA	NA	MNA	NA
(Total)	62.20%↓	NA	55.00%↓	71.29%↑	MNA	63.97%
Behavioral Health						
Follow-Up After Emergency Department Visit for Substance Use (FUA)						
7 days (Total)	NA	NA	NA	NA	MNA	NA
30 days (Total)	NA	NA	NA	NA	MNA	NA
Follow-Up After Emergency Department Visit for Mental Illness (FUM) ♦						
7 days (Total)	NA	NA	NA	NA	77.50%	77.78%
30 days (Total)	NA	NA	NA	NA	77.50%	82.22%
Follow-Up After Hospitalization for Mental Illness (FUH)						
7 days (Total)	NA	NA	NA	**63.64%**↑	52.00%	55.91%
30 days (Total)	NA	NA	NA	**84.85%**↑	65.20%	78.49%
Follow-Up Care for Children Prescribed ADHD Medication (ADD) ♦						
Initiation Phase	NA	NA	NA	**54.29%**↑	50.75%	46.15%
Continuation and Maintenance Phase	NA	NA	NA	NA	MNA	NA
Initiation and Engagement of Substance Use Disorder Treatment (IET) ♦						
Initiation of SUD Treatment—Total (Total)	NA	NA	NA	NA	37.69%	32.31%
Engagement of SUD Treatment—Total (Total)	NA	NA	NA	NA	12.77%	12.31%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)						
Blood Glucose and Cholesterol Testing (Total)	38.10%↑	NA	NA	35.14%↑	45.36%	34.21%
Screening for Depression and Follow-Up Plan (CDF-CH/CDF-AD)						
(12–17 Years)	0.31%	1.23%	0.80%	0.29%	10.27%	0.46%
(18–64 Years)	0.91%	4.41%	2.13%	1.83%	10.71%	1.92%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP) ♦						
(1–11 Years)	NA	NA	NA	NA	MNA	NA
(12–17 Years)	NA	NA	NA	NA	MNA	NA

HEDIS Measure	Anthem	Molina	SilverSummit	UHC HPN	MPS	MY 2023 NV Check Up Aggregate†
(Total)	NA	NA	NA	NA	MNA	58.54%
Utilization						
Ambulatory Care—Total (per 1,000 Member Years) (AMB) **						
*ED Visits—Total**	302.92	272.41	305.07	277.78	MNA	289.42
Outpatient Visits—Total	2,501.21	2,011.34	2,031.95	2,495.27	MNA	2,332.13
Overuse/Appropriateness of Care						
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)						
(3 Months–17 Years)	70.00%↓	NA	51.32%↓	55.05%↓	MNA	56.63%
(18–64 Years)	NA	NA	NA	NA	MNA	NA
(Total)	70.42%↑	NA	51.32%↓	55.36%↓	MNA	56.69%

† Represents performance under the Medicaid managed care program.

* A lower rate indicates better performance for this measure.

** Beginning MY 2022, this rate was reported per 1,000 member years instead of per 1,000 member months; the rates for MY 2021 were converted to member years for comparison.

*♦ Individual MCO denominators for this measure or indicator were less than 30 resulting in an "NA" audit designation; however, when the MCO rates were combined to generate the statewide aggregate rate, the denominator was large enough to be reported and subsequently compared to the MPS.

↑ Indicates the MY 2023 rate was above NCQA's Quality Compass 2023 Medicaid HMO 50th percentile benchmark.

↓ Indicates the MY 2023 rate was below NCQA's Quality Compass 2023 Medicaid HMO 50th percentile benchmark.

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

MNA indicates MY 2023 QISMC goals are unavailable for this measure or indicator.

Bolded rates indicate that the MY 2023 performance measure rate met or exceeded the DHCFP-established MPS.

Indicates that the MY 2023 rate declined by 5 percentage points or more from MY 2022.

Indicates that the MY 2023 rate improved by 5 percentage points or more from MY 2022.

Indicates that the Medicaid aggregate rate met or exceeded the DHCFP-established MPS.

Three-Year Medicaid and Nevada Check Up Aggregate Rate Trending

Table 7-9 and Table 7-10 provide a three-year comparison (i.e., MY 2021, MY 2022, and MY 2023) of the Medicaid and Nevada Check Up aggregate rates and applicable MPS for each performance measure. The Medicaid and Nevada Check Up aggregate rates represent the average of all four MCOs' performance measure rates weighted by the eligible population.

Table 7-9—Medicaid Aggregate Three-Year Rate Trending

HEDIS Measure	MY 2021 Medicaid Aggregate†	MY 2021 MPS	MY 2022 Medicaid Aggregate†	MY 2022 MPS	MY 2023 Medicaid Aggregate†	MY 2023 MPS
Access to Care						
Adults' Access to Preventive/Ambulatory Health Services (AAP)						
(20–44 Years)	63.48%	69.68%	60.55%	69.68%	60.57%	69.68%
(45–64 Years)	71.92%	76.59%	69.16%	76.59%	68.74%	76.59%
(65+ Years)	68.46%	81.35%	62.35%	81.35%	54.74%	MNA
(Total)	65.99%	71.84%	63.15%	71.84%	63.04%	MNA
Children's Preventive Care						
Child and Adolescent Well-Care Visits (WCV)						
(3–11 Years)	49.81%	52.50%	48.72%	52.50%	51.38%	52.50%
(12–17 Years)	44.81%	45.85%	43.63%	45.85%	**46.00%**	45.85%
(18–21 Years)	20.27%	29.68%	19.90%	29.68%	22.70%	29.68%
Total	43.88%	47.37%	42.80%	47.37%	45.60%	MNA
Childhood Immunization Status (CIS)						
Combination 3	58.90%	68.95%	57.64%	68.95%	54.41%	68.95%
Combination 7	51.16%	62.11%	51.35%	62.11%	47.71%	62.11%
Combination 10	26.59%	38.58%	24.21%	38.58%	19.34%	38.58%
Immunizations for Adolescents (IMA)						
Combination 1 (Meningococcal, Tdap)	81.84%	87.81%	83.71%	87.81%	82.07%	87.81%
Combination 2 (Meningococcal, Tdap, HPV)	33.87%	48.91%	34.89%	48.91%	31.98%	48.91%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)						
BMI Percentile Documentation (Total)	82.70%	85.76%	79.38%	85.76%	83.40%	85.76%
Counseling for Nutrition (Total)	75.12%	77.65%	72.79%	77.65%	74.78%	77.65%
Counseling for Physical Activity (Total)	71.60%	74.96%	68.55%	74.96%	70.92%	74.96%
Well-Child Visits in the First 30 Months of Life (W30)						
(First 15 Months)	57.74%	62.88%	58.74%	62.88%	57.11%	62.88%
(15 Months–30 Months)	60.18%	70.56%	60.76%	70.56%	61.24%	70.56%
Developmental Screening in the First Three Years of Life (DEV-CH)						
(1 Year)	—	—	—	—	17.93%	MNA

HEDIS Measure	MY 2021 Medicaid Aggregate†	MY 2021 MPS	MY 2022 Medicaid Aggregate†	MY 2022 MPS	MY 2023 Medicaid Aggregate†	MY 2023 MPS
(2 Years)	—	—	—	—	33.95%	MNA
(3 Years)	—	—	—	—	32.53%	MNA
(Total)	—	—	—	—	28.27%	MNA
Lead Screening in Children (LCS)						
Lead Screening in Children	—	—	—	—	25.39%	MNA
Women's Health and Maternity Care						
Breast Cancer Screening (BCS-E)						
Breast Cancer Screening	46.13%	54.27%	47.93%	54.27%	45.49%	54.27%
Chlamydia Screening in Women (CHL)						
(16–20 Years)	53.43%	MNA	52.21%	MNA	**53.57%**	53.24%
(21–24 Years)	61.06%	MNA	60.98%	MNA	61.60%	65.10%
(Total)	57.61%	MNA	57.05%	MNA	57.96%	MNA
Postpartum Depression Screening and Follow-Up (PDS-E)						
Depression Screening	—	—	0.00%	MNA	0.04%	10.00%
Follow–Up on Positive Screen	—	—	NA	MNA	NA	MNA
Prenatal and Postpartum Care (PPC)						
Timeliness of Prenatal Care	82.78%	85.02%	80.61%	85.02%	79.98%	85.02%
Postpartum Care	71.56%	74.13%	72.25%	74.13%	72.75%	74.13%
Prenatal and Postpartum Care (PPC2-CH)						
Timeliness of Prenatal Care—Under 21 Years	—	—	—	—	60.14%	MNA
Postpartum Care—Under 21 Years	—	—	—	—	57.68%	MNA
Prenatal Depression Screening and Follow-Up (PND-E)						
Depression Screening	—	—	0.00%	MNA	0.23%	10.00%
Follow–Up on Positive Screen	—	—	NA	MNA	NA	MNA
Prenatal Immunization Status (PRS-E)						
Influenza	—	—	9.02%	MNA	10.34%	MNA
Tdap	—	—	19.52%	MNA	23.48%	MNA
Combination	—	—	5.63%	MNA	7.03%	15.07%

HEDIS Measure	MY 2021 Medicaid Aggregate†	MY 2021 MPS	MY 2022 Medicaid Aggregate†	MY 2022 MPS	MY 2023 Medicaid Aggregate†	MY 2023 MPS
Contraceptive Care—Postpartum Women (CCP-CH)						
Most or Moderately Effective Contraception—3 Days—(15–20 Years)	—	—	—	—	3.17%	MNA
Most or Moderately Effective Contraception—90 Days—(15–20 Years)	—	—	—	—	37.31%	MNA
Long-Acting Reversible Contraception—3 Days—(15–20 Years)	—	—	—	—	0.60%	MNA
Long-Acting Reversible Contraception—90 Days—(15–20 Years)	—	—	—	—	10.88%	MNA
Contraceptive Care—All Women (CCW-CH)						
Most or Moderately Effective Contraception—(15–20 Years)	—	—	—	—	12.18%	MNA
Long-Acting Reversible Contraception—(15–20 Years)	—	—	—	—	1.67%	MNA
Care for Chronic Conditions						
Asthma Medication Ratio (AMR)						
(5–11 Years)	79.07%	MNA	74.00%	MNA	65.16%	MNA
(12–18 Years)	66.86%	MNA	64.70%	MNA	51.38%	MNA
(5–18 years) Child Core Set	—	—	69.74%	MNA	59.04%	75.97%
(19–50 Years)	50.34%	MNA	50.26%	MNA	45.32%	MNA
(51–64 Years)	51.82%	MNA	53.90%	MNA	47.72%	MNA
(19–64 years) Adult Core Set	—	—	51.29%	MNA	46.00%	55.66%
(Total)	58.86%	MNA	57.81%	MNA	50.75%	MNA
Blood Pressure Control for Patients With Diabetes (BPD)						
Blood Pressure Control for Patients With Diabetes	59.10%	60.51%	59.16%	60.51%	59.69%	60.51%
Controlling High Blood Pressure (CBP)						
Controlling High Blood Pressure	57.94%	58.81%	57.65%	58.81%	**59.63%**	58.81%
Hemoglobin A1c Control for Patients With Diabetes (HBD)						
*HbA1c Control (>9.0%)**	43.19%	40.52%	46.43%	40.52%	43.36%	40.52%
HbA1c Control (<8%)	48.28%	50.84%	45.83%	50.84%	49.02%	50.84%

HEDIS Measure	MY 2021 Medicaid Aggregate†	MY 2021 MPS	MY 2022 Medicaid Aggregate†	MY 2022 MPS	MY 2023 Medicaid Aggregate†	MY 2023 MPS
Behavioral Health						
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)						
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	38.50%	45.22%	42.63%	45.22%	38.73%	45.22%
Antidepressant Medication Management (AMM)						
Effective Acute Phase Treatment	53.35%	MNA	52.95%	MNA	54.63%	56.85%
Effective Continuation Phase Treatment	36.33%	MNA	35.62%	MNA	37.19%	41.55%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)						
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	74.37%	77.29%	73.69%	77.29%	**77.45%**	77.29%
Follow-Up After Emergency Department Visit for Substance Use (FUA)						
7 days (Total)	—	—	20.12%	23.59%	17.40%	23.59%
30 days (Total)	—	—	**29.16%**	28.26%	27.36%	28.26%
Follow-Up After Emergency Department Visit for Mental Illness (FUM)						
7 days (Total)	39.65%	47.85%	45.81%	47.85%	47.02%	47.85%
30 days (Total)	49.87%	56.82%	54.40%	56.82%	55.67%	56.82%
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)						
7 Days (Total)	—	—	27.41%	MNA	28.78%	34.67%
30 days (Total)	—	—	44.85%	MNA	46.16%	50.37%
Follow-Up After Hospitalization for Mental Illness (FUH)						
7 days (Total)	31.55%	41.37%	30.65%	41.37%	32.70%	41.37%
30 days (Total)	48.34%	56.67%	47.71%	56.67%	49.56%	56.67%
Follow-Up Care for Children Prescribed ADHD Medication (ADD)						
Initiation Phase	51.88%	55.68%	47.83%	55.68%	50.76%	55.68%
Continuation and Maintenance Phase	65.90%	72.54%	63.06%	72.54%	64.80%	72.54%
Initiation and Engagement of Substance Use Disorder Treatment (IET)						
Initiation of SUD Treatment—Total (Total)	—	—	45.39%	MNA	46.37%	47.63%
Engagement of SUD Treatment—Total (Total)	—	—	14.89%	MNA	15.43%	21.54%

HEDIS Measure	MY 2021 Medicaid Aggregate†	MY 2021 MPS	MY 2022 Medicaid Aggregate†	MY 2022 MPS	MY 2023 Medicaid Aggregate†	MY 2023 MPS
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)						
Blood Glucose and Cholesterol Testing (Total)	31.11%	38.41%	32.18%	38.41%	36.87%	38.41%
Screening for Depression and Follow-Up Plan (CDF-CH/CDF-AD)∞						
(12–17 Years)	—	—	0.46%	MNA	0.60%	10.41%
(18–64 Years)	—	—	1.65%	MNA	2.81%	11.21%
(65+ Years)	—	—	2.66%	MNA	2.61%	MNA
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)						
(1–11 Years)	55.41%	MNA	55.03%	MNA	52.05%	MNA
(12–17 Years)	57.39%	MNA	59.87%	MNA	55.87%	MNA
(Total)	56.61%	MNA	58.18%	MNA	54.53%	63.72%
Use of Pharmacotherapy for Opioid Use Disorder (OUD)*						
Rate 1: Total	—	—	54.60%	MNA	52.45%	59.25%
Rate 2: Buprenorphine	—	—	28.38%	MNA	30.95%	MNA
Rate 3: Oral Naltrexone	—	—	4.04%	MNA	3.74%	MNA
Rate 4: Long-Acting, Injectable Naltrexone	—	—	1.33%	MNA	1.19%	MNA
Rate 5: Methadone	—	—	25.80%	MNA	20.65%	MNA
Diabetes Care for People With Serious Mental Illness: Hemoglobin A1c Poor Control (>9.0%) (HPCMI-AD)*						
(18–64 Years)	—	—	—	—	49.35%	MNA
(65–75 Years)	—	—	—	—	NA	MNA
Utilization						
Ambulatory Care—Total (per 1,000 Member Years) (AMB)*						
*ED Visits—Total**	534.09	MNA	598.44	MNA	575.51	MNA
Outpatient Visits—Total	3,095.29	MNA	3,023.10	MNA	3,104.26	MNA
Plan All-Cause Readmissions (PCR)						
*Observed Readmissions Total—(18–64 Years)**	11.51%	11.28%	11.56%	11.28%	**10.85%**	11.28%
Expected Readmissions Total—(18–64 Years)	9.18%	MNA	9.38%	MNA	9.20%	MNA
Observed/Expected (O/E) Ratio Total—(18–64 Years)	1.2537	MNA	1.2317	MNA	1.1788	MNA
Outliers Total—(18–64 Years)	62.76	MNA	64.92	MNA	71.93	MNA

HEDIS Measure	MY 2021 Medicaid Aggregate†	MY 2021 MPS	MY 2022 Medicaid Aggregate†	MY 2022 MPS	MY 2023 Medicaid Aggregate†	MY 2023 MPS
Overuse/Appropriateness of Care						
Risk of Continued Opioid Use (COU)*						
>=15 Days (Total)	—	—	7.69%	MNA	7.65%	6.92%
>=31 Days (Total)	—	—	6.08%	MNA	5.98%	5.47%
Use of Opioids at High Dosage (HDO)*						
Use of Opioids at High Dosage	**8.14%**	8.23%	**7.96%**	8.23%	**8.11%**	8.23%
Use of Opioids From Multiple Providers (UOP)*						
Multiple Prescribers	**20.87%**	22.14%	**20.60%**	22.14%	22.60%	22.14%
Multiple Pharmacies	0.82%	1.49%	0.88%	1.49%	0.99%	MNA
Multiple Prescribers and Multiple Pharmacies	0.50%	0.83%	0.42%	0.83%	0.53%	MNA
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)						
(3 Months–17 Years)	—	—	—	—	71.70%	MNA
(18–64 Years)	—	—	—	—	50.83%	MNA
(65+ Years)	—	—	—	—	NA	MNA
(Total)	—	—	—	—	64.10%	MNA

† Represents performance under the Medicaid managed care program.

* A lower rate indicates better performance for this measure.

** Beginning MY 2022, this rate was reported per 1,000 member years instead of per 1,000 member months; the rates for MY 2021 were converted to member years for comparison.

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

∞ MCOs reported *CDF—18—64 years* and *CDF—65 years and older* to align with the CMS Adult Core Set FFY 2024 technical specifications. HSAG calculated the total of these two indicators to determine if the MCOs met or exceeded DHCFP's QISMC goal for *CDF—18 years and older.*

MNA indicates QISMC goals are unavailable for this measure or indicator.

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

Bolded rates indicate that the Medicaid Aggregate performance measure rate met or exceeded the DHCFP-established MPS.

Table 7-10—Nevada Check Up Aggregate Three-Year Rate Trending

HEDIS Measure	MY 2021 NV Check UP Aggregate†	MY 2021 MPS	MY 2022 NV Check UP Aggregate†	MY 2022 MPS	MY 2023 NV Check UP Aggregate†	MY 2023 MPS
Children's Preventive Care						
Child and Adolescent Well-Care Visits (WCV)						
(3–11 Years)	53.00%	59.37%	50.13%	59.37%	54.29%	59.37%
(12–17 Years)	52.22%	54.57%	49.67%	54.57%	50.90%	54.57%
(18–21 Years)	30.28%	38.72%	34.63%	38.72%	33.39%	38.72%
Total	51.06%	56.06%	48.69%	56.06%	51.35%	MNA
Childhood Immunization Status (CIS)						
Combination 3	74.17%	82.36%	65.73%	82.36%	69.89%	82.36%
Combination 7	68.01%	76.15%	61.97%	76.15%	66.13%	76.15%
Combination 10	40.29%	48.22%	34.27%	48.22%	27.15%	48.22%
Immunizations for Adolescents (IMA)						
Combination 1 (Meningococcal, Tdap)	89.68%	94.17%	90.35%	94.17%	90.77%	94.17%
Combination 2 (Meningococcal, Tdap, HPV)	45.18%	57.30%	43.91%	57.30%	42.22%	57.30%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)						
BMI Percentile Documentation (Total)	83.88%	85.62%	74.49%	85.62%	83.18%	85.62%
Counseling for Nutrition (Total)	75.51%	77.08%	67.56%	77.08%	74.65%	77.08%
Counseling for Physical Activity (Total)	72.17%	74.09%	64.36%	74.09%	72.45%	74.09%
Well-Child Visits in the First 30 Months of Life (W30)						
(First 15 Months)	63.79%	73.00%	65.27%	73.00%	68.01%	73.00%
(15 Months–30 Months)	73.00%	82.95%	65.02%	82.95%	64.74%	82.95%
Developmental Screening in the First Three Years of Life (DEV-CH)						
(1 Year)	—	—	—	—	18.66%	MNA
(2 Years)	—	—	—	—	39.74%	MNA
(3 Years)	—	—	—	—	33.93%	MNA
(Total)	—	—	—	—	31.96%	MNA
Lead Screening in Children (LCS)						
Lead Screening in Children	NA	MNA	NA	MNA	30.48%	MNA

HEDIS Measure	MY 2021 NV Check UP Aggregate†	MY 2021 MPS	MY 2022 NV Check UP Aggregate†	MY 2022 MPS	MY 2023 NV Check UP Aggregate†	MY 2023 MPS
Women's Health and Maternity Care						
Chlamydia Screening in Women (CHL)						
(16–20 Years)	50.79%	MNA	42.48%	MNA	**52.69%**	45.62%
(21–24 Years)	NA	MNA	NA	MNA	NA	MNA
(Total)	50.79%	MNA	42.48%	MNA	52.69%	MNA
Prenatal and Postpartum Care (PPC)						
Timeliness of Prenatal Care	—	—	NA	MNA	NA	MNA
Postpartum Care	—	—	NA	MNA	NA	MNA
Prenatal and Postpartum Care (PPC2-CH)						
Timeliness of Prenatal Care—Under 21 Years	—	—	—	—	NA	MNA
Postpartum Care—Under 21 Years	—	—	—	—	NA	MNA
Contraceptive Care—Postpartum Women (CCP-CH)						
Most or Moderately Effective Contraception—3 Days—(15–20 Years)	—	—	—	—	NA	MNA
Most or Moderately Effective Contraception—90 Days—(15–20 Years)	—	—	—	—	NA	MNA
Long-Acting Reversible Contraception—3 Days—(15–20 Years)	—	—	—	—	NA	MNA
Long-Acting Reversible Contraception—90 Days—(15–20 Years)	—	—	—	—	NA	MNA
Contraceptive Care—All Women (CCW-CH)						
Most or Moderately Effective Contraception—(15–20 Years)	—	—	—	—	9.07%	MNA
Long-Acting Reversible Contraception—(15–20 Years)	—	—	—	—	0.96%	MNA
Care for Chronic Conditions						
Asthma Medication Ratio (AMR)						
(5–11 Years)	81.52%	MNA	78.69%	MNA	64.84%	MNA
(12–18 Years)	67.33%	MNA	66.67%	MNA	62.39%	MNA
(5–18 years) Child Core Set	—	—	72.06%	MNA	63.67%	76.68%
(19–50 Years)	NA	MNA	NA	MNA	NA	MNA

HEDIS Measure	MY 2021 NV Check UP Aggregate†	MY 2021 MPS	MY 2022 NV Check UP Aggregate†	MY 2022 MPS	MY 2023 NV Check UP Aggregate†	MY 2023 MPS
(51–64 Years)	NA	MNA	NA	MNA	NA	MNA
(19–64 years) Adult Core Set	—	—	NA	MNA	NA	MNA
(Total)	74.09%	MNA	72.26%	MNA	63.97%	MNA
Behavioral Health						
Follow-Up After Emergency Department Visit for Substance Use (FUA)						
7 days (Total)	—	—	NA	MNA	NA	MNA
30 days (Total)	—	—	NA	MNA	NA	MNA
Follow-Up After Emergency Department Visit for Mental Illness (FUM)						
7 days (Total)	**91.89%**	77.50%	**87.50%**	77.50%	**77.78%**	77.50%
30 days (Total)	**91.89%**	77.50%	**90.63%**	77.50%	**82.22%**	77.50%
Follow-Up After Hospitalization for Mental Illness (FUH)						
7 days (Total)	44.87%	52.00%	51.43%	52.00%	**55.91%**	52.00%
30 days (Total)	**69.23%**	65.20%	**74.29%**	65.20%	**78.49%**	65.20%
Follow-Up Care for Children Prescribed ADHD Medication (ADD)						
Initiation Phase	50.00%	50.75%	39.78%	50.75%	46.15%	50.75%
Continuation and Maintenance Phase	NA	MNA	NA	MNA	NA	MNA
Initiation and Engagement of Substance Use Disorder Treatment (IET)						
Initiation of SUD Treatment—Total (Total)	—	—	42.11%	MNA	32.31%	37.69%
Engagement of SUD Treatment—Total (Total)	—	—	23.68%	MNA	12.31%	12.77%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)						
Blood Glucose and Cholesterol Testing (Total)	35.71%	45.36%	38.24%	45.36%	34.21%	45.36%
Screening for Depression and Follow-Up Plan (CDF-CH/CDF-AD)						
(12–17 Years)	—	—	0.30%	MNA	0.46%	10.27%
(18–64 Years)	—	—	0.79%	MNA	1.92%	10.71%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)						
(1–11 Years)	NA	MNA	NA	MNA	NA	MNA
(12–17 Years)	NA	MNA	NA	MNA	NA	MNA
(Total)	67.57%	MNA	57.58%	MNA	58.54%	MNA

HEDIS Measure	MY 2021 NV Check UP Aggregate†	MY 2021 MPS	MY 2022 NV Check UP Aggregate†	MY 2022 MPS	MY 2023 NV Check UP Aggregate†	MY 2023 MPS
Utilization						
Ambulatory Care—Total (per 1,000 Member Years) (AMB)*						
*ED Visits—Total**	194.30	MNA	284.02	MNA	289.42	MNA
Outpatient Visits—Total	2,264.23	MNA	2,360.27	MNA	2,332.13	MNA
Overuse/Appropriateness of Care						
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)						
(3 Months–17 Years)	—	—	—	—	56.63%	MNA
(18–64 Years)	—	—	—	—	NA	MNA
(Total)	—	—	—	—	56.69%	MNA

† Represents performance under the Medicaid managed care program.
* A lower rate indicates better performance for this measure.
** Beginning MY 2022, this rate was reported per 1,000 member years instead of per 1,000 member months; the rates for MY 2021 were converted to member years for comparison.
— Indicates that the MCOs were not previously required to report this measure or that the rate is not appropriate to display due to changes in the technical specifications resulting in a break in trending.
MNA indicates QISMC goals are unavailable for this measure or indicator.
NA indicates that the MCOs followed the specifications, but the denominator was too small (i.e., <30) to report a valid rate.
Bolded rates indicate that the Medicaid Aggregate performance measure rate met or exceeded the DHCFP-established MPS.

Compliance Review

HSAG calculated the Nevada Managed Care Program's performance in each of the seven compliance review standards that were reviewed during the first year of the three-year compliance review cycle. Table 7-11 compares the MCEs' compliance scores and the Nevada Managed Care Program aggregated score in each of the seven compliance review standards.

Table 7-11—MCE and Nevada Managed Care Program Compliance Review Scores for SFY 2024

Standard	Anthem	Molina	SilverSummit	UHC HPN	LIBERTY	Nevada Managed Care Program
Standard I—Disenrollment: Requirements and Limitations	83%	100%	83%	100%	NA[1]	**92%**
Standard II—Member Rights and Member Information	83%	78%	74%	87%	70%	**79%**

Standard	Anthem	Molina	SilverSummit	UHC HPN	LIBERTY	Nevada Managed Care Program
Standard III—Emergency and Poststabilization Services	100%	100%	100%	100%	100%	**100%**
Standard IV—Availability of Services	83%	83%	83%	83%	80%	**83%**
Standard V—Assurances of Adequate Capacity and Services	80%	100%	20%	100%	80%	**76%**
Standard VI—Coordination and Continuity of Care	82%	93%	89%	93%	78%	**88%**
Standard VII—Coverage and Authorization of Services	81%	85%	85%	93%	83%	**86%**
Combined Total	**84%**	**89%**	**82%**	**92%**	**80%**	**86%**

[1] DHCFP determined that the requirements under Standard I—Disenrollment: Requirements and Limitations was not applicable to **LIBERTY**.

Network Adequacy Validation

HSAG assessed the MCOs' provider-to-member ratios and determined that all Nevada MCOs exceeded DHCFP's requirements. Provider-to-member ratio results across all MCOs by provider category and by county are presented in Table 7-12. HSAG also assessed the MCOs' submitted time or distance reports and found commonality among all MCOs that met the 100 percent threshold for time or distance. Time or distance results that met the 100 percent threshold are presented in Table 7-13 by provider category and county. HSAG also found commonality among all MCOs that fell below the 100 percent threshold for time or distance requirements by provider category and by county. Time or distance results that fell below the 100 percent threshold are presented in Table 7-14. To see where HSAG did not observe commonality among all MCOs, please refer to the MCO-specific reported results.

LIBERTY's network adequacy results are not included in the following tables, as the provider categories were not consistent with those of the MCOs. However, all MCEs obtained a *High Confidence* validation rating determination for all standards and indicators in scope of review.

Table 7-12—Provider Ratios by Provider Category, County, and MCO

Provider Category	County	Nevada MCOs			
		Providers per 1,500 Members (Anthem)	Providers per 1,500 Members (Molina)	Providers per 1,500 Members (SilverSummit)	Providers per 1,500 Members (UHC HPN)
PCP not practicing in conjunction with healthcare professional*	Clark	13.66	7.73	17.65	2.42
	Washoe	46.55	13.37	33.40	6.81
Specialists	Clark	137.81	39.47	97.89	2.65
	Washoe	296.56	81.55	263.03	10.98

* If the PCP practices in conjunction with a healthcare professional (i.e., nurse practitioner or physician's assistant), the ratio is increased to one FTE PCP for every 1,800 members. DHCFP's 402 network adequacy reporting template did not break out PCP practices in conjunction with a healthcare professional.

Table 7-13—Provider Categories by County That Met 100 Percent Threshold Across All MCOs

Provider Category	County	Nevada MCOs			
		Anthem	Molina	SilverSummit	UHC HPN
Endocrinologist	Washoe	100%	100%	100%	100%
Endocrinologist, Pediatric	Washoe	100%	100%	100%	100%
Infectious Disease	Washoe	100%	100%	100%	100%
Infectious Disease, Pediatric	Washoe	100%	100%	100%	100%
Rheumatologist	Washoe	100%	100%	100%	100%
Rheumatologist, Pediatric	Washoe	100%	100%	100%	100%
Oncologist/Radiologist	Washoe	100%	100%	100%	100%
Oncologist/Radiologist, Pediatric	Clark	100%	100%	100%	100%
Oncologist/Radiologist, Pediatric	Washoe	100%	100%	100%	100%
Qualified Mental Health Professional (QMHP)	Washoe	100%	100%	100%	100%
QMHP, Pediatric	Clark	100%	100%	100%	100%
QMHP, Pediatric	Washoe	100%	100%	100%	100%
All Hospitals	Washoe	100%	100%	100%	100%

Table 7-14—Provider Categories by County That Fell Below the 100 Percent Threshold Across All MCOs

Provider Category	County	Nevada MCOs			
		Anthem	Molina	SilverSummit	UHC HPN
Primary Care, Adults	Clark	99.9%	99.9%	99.9%	99.9%
Primary Care, Adults	Washoe	99.7%	99.6%	99.6%	99.9%
OB/GYN (Adult Females)	Clark	99.6%	99.6%	99.9%	99.9%
OB/GYN (Adult Females)	Washoe	99.7%	96.2%	99.5%	96.8%
Pediatrician	Clark	99.9%	99.9%	99.9%	99.9%
Pediatrician	Washoe	99.7%	99.7%	99.7%	99.6%
Psychiatric Inpatient Hospital	Clark	99.9%	99.9%	99.9%	99.9%
Pharmacy	Clark	99.9%	99.9%	99.9%	99.9%
Pharmacy	Washoe	99.7%	99.7%	99.7%	99.8%

Consumer Assessment of Healthcare Providers and Systems Analysis

A comparative analysis identified whether one MCO performed statistically significantly higher or lower on each measure compared to the program average (i.e., combined results of **Anthem**, **UHC HPN**, **Molina**, and **SilverSummit**). Table 7-15 through Table 7-17 show the MCO comparison results of the adult Medicaid, child Medicaid, and Nevada Check Up populations for **Anthem**, **UHC HPN**, **Molina**, and **SilverSummit**. **LIBERTY**'s dental satisfaction survey results are not included in the following tables, as the methodology for the survey was not consistent with CAHPS.

Table 7-15—MCO Comparisons: Adult Medicaid

	Anthem	Molina	SilverSummit	UHC HPN	Program Average
Composite Measures					
Getting Needed Care	NA	NA	78.36%	NA	76.48%
Getting Care Quickly	NA	NA	NA	NA	76.30%
How Well Doctors Communicate	NA	NA	89.46%	NA	90.72%
Customer Service	NA	NA	NA	NA	88.88%
Global Ratings					
Rating of All Health Care	NA	NA	55.28%	NA	52.49%
Rating of Personal Doctor	62.50%	NA	65.65%	NA	63.80%
Rating of Specialist Seen Most Often	NA	NA	NA	NA	60.91%

	Anthem	Molina	SilverSummit	UHC HPN	Program Average
Rating of Health Plan	66.00%	51.46%	57.92%	63.96%	60.15%
Medical Assistance with Smoking and Tobacco Use Cessation Measure Items*					
Advising Smokers and Tobacco Users to Quit	NA	NA	NA	NA	60.43%
Discussing Cessation Medications	NA	NA	NA	NA	34.62%
Discussing Cessation Strategies	NA	NA	NA	NA	35.62%

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

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

↑ Indicates the 2024 score is statistically significantly higher than the program average.

↓ Indicates the 2024 score is statistically significantly lower than the program average.

Table 7-16—MCO Comparisons: Child Medicaid

	Anthem		Molina		SilverSummit		UHC HPN		Program Average	
	General Child	CCC	General Child	CCC	General Child	CCC	General Child	CCC	General Child	CCC
Composite Measures										
Getting Needed Care	NA	NA	NA	NA	NA	NA	NA	NA	84.09%	81.71%
Getting Care Quickly	NA	NA	NA	NA	NA	NA	NA	NA	85.08%	88.43%
How Well Doctors Communicate	NA	NA	NA	NA	NA	NA	NA	NA	90.76%	91.23%
Customer Service	NA	NA	NA	NA	NA	NA	NA	NA	88.73%	89.42%
Global Ratings										
Rating of All Health Care	NA	NA	NA	NA	72.00%	NA	NA	NA	71.69%	62.21%
Rating of Personal Doctor	NA	NA	69.00%	NA	69.92%	64.15%	73.91%	NA	70.16%	68.03%
Rating of Specialist Seen Most Often	NA	NA	NA	NA	NA	NA	NA	NA	NA	75.68%
Rating of Health Plan	NA	NA	56.69% ↓	NA	78.11% ↑	68.07%	76.92%	76.64% ↑	71.40%	67.87%
CCC Composite Measures/Items										
Access to Specialized Services	—	NA	—	NA	—	NA	—	NA	—	NA
Family Centered Care (FCC): Personal Doctor Who Knows Child	—	NA	—	NA	—	NA	—	NA	—	89.90%

	Anthem		Molina		SilverSummit		UHC HPN		Program Average	
	General Child	CCC	General Child	CCC	General Child	CCC	General Child	CCC	General Child	CCC
Coordination of Care for Children With Chronic Conditions	—	NA	—	NA	—	NA	—	NA	—	NA
Access to Prescription Medicines	—	NA	—	NA	—	NA	—	NA	—	90.24%
FCC: Getting Needed Information	—	NA	—	NA	—	NA	—	NA	—	90.32%

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

↑ Indicates the 2024 score is statistically significantly higher than the program average.

↓ Indicates the 2024 score is statistically significantly lower than the program average.

— Indicates the measure does not apply to the population.

Table 7-17—MCO Comparisons: Nevada Check Up

	Anthem		Molina		SilverSummit		UHC HPN		Program Average	
	General Child	CCC	General Child	CCC	General Child	CCC	General Child	CCC	General Child	CCC
Composite Measures										
Getting Needed Care	NA	NA	NA	NA	NA	NA	NA	NA	87.36%	NA
Getting Care Quickly	NA	NA	NA	NA	NA	NA	NA	NA	83.73%	NA
How Well Doctors Communicate	89.64% ↓	NA	NA	NA	NA	NA	94.04%	NA	92.96%	95.12%
Customer Service	NA	NA	NA	NA	NA	NA	NA	NA	90.46%	NA
Global Ratings										
Rating of All Health Care	71.13% ↓	NA	NA	NA	NA	NA	76.00%	NA	76.67%	75.65%
Rating of Personal Doctor	74.62%	NA	NA	NA	80.20%	NA	82.50%	NA	79.02%	80.15%
Rating of Specialist Seen Most Often	NA	NA	NA	NA	NA	NA	NA	NA	76.52%	NA
Rating of Health Plan	78.40%	NA	NA	NA	76.19%	NA	78.06%	NA	76.99%	72.97%
CCC Composite Measures/Items										
Access to Specialized Services	—	NA	—	NA	—	NA	—	NA	—	NA
Family Centered Care (FCC): Personal Doctor Who Knows Child	—	NA	—	NA	—	NA	—	NA	—	NA

	Anthem		Molina		SilverSummit		UHC HPN		Program Average	
	General Child	CCC	General Child	CCC	General Child	CCC	General Child	CCC	General Child	CCC
Coordination of Care for Children With Chronic Conditions	—	NA	—	NA	—	NA	—	NA	—	NA
Access to Prescription Medicines	—	NA	—	NA	—	NA	—	NA	—	87.61%
FCC: Getting Needed Information	—	NA	—	NA	—	NA	—	NA	—	91.30%

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

↑ Indicates the 2024 score is statistically significantly higher than the program average.

↓ Indicates the 2024 score is statistically significantly lower than the program average.

— Indicates the measure does not apply to the population.

8. Programwide Conclusions and Recommendations

HSAG performed a comprehensive assessment of the performance of the MCEs and identified their strengths and weaknesses related to the provision of healthcare services. The aggregated findings from all EQR activities were thoroughly analyzed and reviewed across the continuum of program areas and the activities that comprise the Nevada Managed Care Program to identify programwide conclusions. The programwide conclusions are not intended to be inclusive of all EQR activity results; rather, only those results that had a substantial impact on a Nevada Quality Strategy goal. HSAG presents these programwide conclusions and corresponding recommendations to DHCFP to drive progress toward achieving the goals of the Nevada Quality Strategy and support improvement in the quality, timeliness, and accessibility of healthcare services furnished to Nevada Medicaid and Nevada Check Up members. Table 8-1 provides the programwide conclusions and recommendations. Table 8-1 displays each Nevada Quality Strategy goal and indicates whether the EQR activity results positively (✓), negatively (✗), or minimally (**m**) impacted the Nevada Managed Care Program's progress toward achieving the applicable goals, and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to Medicaid members. If no trends were identified through an EQR activity that substantially impacted a goal, a dash (–) is noted in Table 8-1.

Table 8-1—Programwide Conclusions and Recommendations

Performance Impact on Goals and Objectives[32]		Performance Domain
Goal 1—Improve the health and wellness of Nevada's Medicaid population by increasing the use of preventive services by December 31, 2024		
✓	The MCOs' *Child and Adolescent Well Care Visit (WCV)* PIP positively impacted achieving Objectives 1.2(a) through 1.2(c) as all four MCOs achieved statistically significant improvement in the associated performance indicators.	☒ Quality ☒ Timeliness ☒ Access
✓	The Nevada Managed Care Program met Objectives 1.2(b) *Increase child and adolescent well-care visits (WCV)—12-17 years* for the Medicaid population and 1.8(a) *Increase chlamydia screening in women (CHL)—16-20 years* for the Medicaid and Nevada Check Up population. Additionally, rates for 11 of 18 objectives for Medicaid and rates for 10 of 14 objectives for Nevada Check Up demonstrated an increase in performance from the prior year.	
✓	All four MCOs in the Nevada Managed Care Program exceeded DHCFP's network adequacy requirements for provider-to-member-ratios for PCPs.	

[32] All EQR activities were included in HSAG's analysis, as applicable, if the activity results substantially impacted the Quality Strategy goals and objectives. However, only the Quality Strategy objectives with an established MPS and reportable aggregate rates are included in HSAG's analysis for Table 8-1. HSAG's analysis did not include all performance measures validated through the PMV and performance measures without an established MPS or a reportable aggregate rate were excluded.

	Performance Impact on Goals and Objectives[32]	Performance Domain
✓	Although no MCO met the 100 percent threshold for the *Primary Care, Adults* and *Pediatrician* time or distance standards for Clark County, all four MCOs performed at or above 99.9 percent. Additionally, although no MCO met the 100 percent threshold for the *Primary Care, Adults* and *Pediatrician* time or distance standards for Washoe County, all four MCOs performed at or above 99.6 percent.	
x	The MCOs' *Adults' Access to Preventive/Ambulatory Health Services (AAP)* PIP had limited impact on achieving Objectives 1.7(a) and 1.7(b) as three of the four MCOs did not achieve statistically significant improvement in the associated performance indicators.	
x	The Nevada Managed Care Program did not meet the MPS for 16 of 18 objectives for the Medicaid and 13 of 14 objectives for the Nevada Check Up population. Additionally, rates for seven of 18 objectives for the Medicaid population and rates for four of 14 objectives for the Nevada Check Up population demonstrated a decrease in performance from the prior year.	
–	No trends were identified through the compliance review and CAHPS activities that substantially impacted Goal 1.	
Goal 2—Increase use of evidence-based practices for members with chronic conditions by December 31, 2024		
✓	The Nevada Managed Care Program met Objectives 2.3 *Increase rate of controlling high blood pressure* and 2.5 *Decrease the rate of adult acute inpatient stays that were followed by an unplanned readmission for any diagnosis within 30 days after discharge (PCR)–Observed readmissions* for the Medicaid population. Additionally, rates for five of seven objectives for Medicaid demonstrated an increase in performance from the prior year.	☒ Quality ☒ Timeliness ☒ Access
✓	All four MCOs within the Nevada Managed Care Program exceeded DHCFP's network adequacy requirements for provider-to-member-ratios for specialty providers.	
m	The MCOs' *Plan All-Cause Readmissions (PCR)* PIP minimally impacted Objective 2.5 as only two of the four MCOs achieved statistically significant improvement in the associated performance indicators.	
x	The Nevada Managed Care Program did not meet the MPS for five of seven objectives for the Medicaid and zero of one objective for the Nevada Check Up population. Additionally, rates for two of seven objectives for the Medicaid population demonstrated a decrease in performance from the prior year.	
–	No trends were identified through the compliance review and CAHPS activities that substantially impacted Goal 2.	

Performance Impact on Goals and Objectives[32]		Performance Domain
Goal 3—Reduce misuse of opioids by December 31, 2024		
✓	The Nevada Managed Care Program met Objective 3.1 *Reduce use of opioids at high dosage (HDO)* for the Medicaid population. Additionally, rates for two of four objectives for Medicaid demonstrated a slight increase in performance from the prior year.	☒ Quality ☐ Timeliness ☐ Access
✗	The Nevada Managed Care Program did not meet the MPS for one of four objectives for the Medicaid population. Additionally, rates for two of four objectives for the Medicaid population demonstrated a decrease in performance from the prior year.	
–	No trends were identified through the compliance review and CAHPS activities that substantially impacted Goal 3.	
Goal 4—Improve the health and wellness of pregnant women and infants by December 31, 2024		
✓	The MCOs' *Prenatal and Postpartum Care (PPC)* PIP positively impacted achieving Objectives 4.1(a) and 4.1(b) as all four MCOs achieved statistically significant improvement in the associated performance indicators.	☒ Quality ☒ Timeliness ☒ Access
✓	Rates for four of five objectives for the Medicaid population demonstrated a slight increase in performance from the prior year.	
✓	Although no MCO met the 100 percent threshold for the *OB/GYN (Adult Females)* time or distance standards for Clark County, all four MCOs performed at or above 99.6 percent.	
✗	The Nevada Managed Care Program did not meet the MPS for all five objectives for the Medicaid population. Additionally, rates for one of five objectives for the Medicaid population demonstrated a slight decrease in performance from the prior year.	
✗	No MCO met the 100 percent threshold for the *OB/GYN (Adult Females)* time or distance standard for both Washoe and Clark Counties. Additionally, two MCOs in Washoe County only met a threshold of 96.2 percent and 96.8 percent.	
–	No trends were identified through the compliance review and CAHPS activities that substantially impacted Goal 4.	

	Performance Impact on Goals and Objectives[32]	Performance Domain
Goal 5—Increase use of evidence-based practices for members with behavioral health conditions by December 31, 2024		
✓	The Nevada Managed Care Program met Objectives 5.4 *Increase diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications (SSD)* and 5.11(a) *Increase the rate of inpatient, residential treatment and detoxification visits or discharges for a diagnosis of substance use disorder (SUD) among patients 13 years of age and older that resulted in follow-up care for a diagnosis of SUD within 7 days (FUI)* for the Medicaid population. For the Nevada Check Up population, the Nevada Managed Care Program met four objectives: 5.3(a) and 5.3(b) *Increase follow-up after hospitalization for mental illness (FUM)—7-day* and *30-day* and 5.6(a) and 5.6(b) *Increase follow-up after ED visit for mental illness (FUM)—7-day* and *30-day.* Additionally, rates for 15 of 21 objectives for Medicaid and six of 10 objectives for Nevada Check Up demonstrated an increase in performance from the prior year.	☒ Quality ☒ Timeliness ☒ Access
✓	For all outpatient behavioral health related provider categories under the time or distance standards (*Psychologist; Psychologist*, *Pediatric*; *Psychiatrist*; *Board Certified Child and Adolescent Psychiatrist*; *Qualified Mental Health Professional (QMHP)*; and *QMHP, Pediatric*), all four MCOs performed at or above 99.9 percent threshold.	
m	The MCOs' *Follow-Up After Emergency Department Visit for Mental Illness (FUM)* PIP minimally impacted Objective 5.6(a) and 5.6(b) as only one of the four MCOs achieved statistically significant improvement in the associated performance indicators.	
✗	The MCOs' *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)* PIP had limited impact on achieving Objectives 5.7(a) and 5.7(b) as none of the MCOs achieved statistically significant improvement in the associated performance indicators.	
✗	The Nevada Managed Care Program did not meet the MPS for 19 of 21 objectives for the Medicaid population and six of 10 objectives for the Nevada Check Up population. Additionally, rates for six of 21 objectives for the Medicaid population and four of 10 objectives for the Nevada Check Up population demonstrated a decrease in performance from the prior year.	
–	No trends were identified through the compliance review and CAHPS activities that substantially impacted Goal 5.	
Goal 6—Increase utilization of dental services by December 31, 2024		
✓	The PAHP's *Increase Preventive Services for Children* PIP positively impacted achieving Objectives 6.1, 6.2, 6.3(a) and 6.3(b) as the PAHP achieved a *High Confidence* rating in its PIP design.	☒ Quality ☒ Timeliness ☒ Access
✓	Rates for all four objectives for the Medicaid population and rates for two of four objectives for the Nevada Check Up population demonstrated a slight increase in performance from the prior year.	

Performance Impact on Goals and Objectives[32]		Performance Domain
✓	The Nevada Managed Care Program exceeded DHCFP's network adequacy requirements for provider-to-member-ratios for dental PCPs.	
✗	The Nevada Managed Care Program did not meet the MPS for all four objectives for the Medicaid population and all four objectives for the Nevada Check Up population. Additionally, although there were no rate decreases for the Medicaid population, rates for two of four objectives for the Nevada Check Up population demonstrated a decrease in performance from the prior year.	
–	No trends were identified through the compliance review and CAHPS activities that substantially impacted Goal 6.	
Goal 7—Reduce and/or eliminate health care disparities for Medicaid members by December 31, 2024		
✓	All MCEs met their contract obligations related to cultural competency programs and stratification of member data as required.	☒ Quality ☒ Timeliness ☒ Access
✓	DHCFP required the data for the *Prenatal and Postpartum Care (PPC)* PIP to be stratified by race and ethnicity to help identify health disparities for the African American population. All MCOs stratified data for this PIP as required.	
–	No trends were identified through the compliance review and CAHPS activities that substantially impacted Goal 7.	

Recommendations

Based on findings identified through the EQR activities that impacted the goals and objectives in DHCFP's Quality Strategy, HSAG identified the following recommendations to support improvement in the quality, timeliness, and access to healthcare services furnished to Nevada Managed Care Program members:

- To comply with the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F), DHCFP should update the contracts with its MCEs as follows within the required effective dates for each specific requirement:
  - Require the MCEs to respond to prior authorization requests for covered items and services within seven calendar days for standard requests to improve patient care outcomes and ensure members have more timely access to services.
  - Require the MCEs to publicly report prior authorization data for members and providers to better understand the types of items and services which require prior authorization and how each MCE performed over time for approvals and denials. This requirement is to assure transparency and accountability in the healthcare system and allow for the efficiency of prior authorization practices of each MCE, and enables the MCEs to assess trends, identify areas for improvement, and work towards continuous process improvement while maintaining necessary checks for quality and appropriateness of care.
- To comply with the Medicaid and CHIP Managed Care Access, Finance, and Quality Final Rule (CMS–2439–F), DHCFP should implement the following within the required effective dates for each specific requirement:
  - Review the maximum appointment wait times standards (e.g., 10 business days for outpatient mental health and SUD appointments) and update its contracts with its MCEs, as applicable.
  - Contract with an independent vendor to perform secret shopper surveys of MCE compliance with appointment wait times and accuracy of provider directories and require directory inaccuracies to be sent to

Recommendations

DHCFP within three days of discovery. Results from the secret shopper survey will provide assurances to DHCFP that the MCEs' networks have the capacity to serve the expected enrollment in their service area and that they offer appropriate access to preventive and primary care services for their members.

  - Although DHCFP currently requires its MCEs to contract with a CAHPS survey vendor, the new rule requires an annual member experience survey to be conducted by DHCFP, or its contracted vendor, to ensure consistency in administration within its managed care program. Because the member experience survey results will provide direct and candid input from members, DHCFP and its MCEs can use the results to determine if their networks offer an appropriate range of services and access as well as if they provide a sufficient number, mix, and geographic distribution of providers to meet their members' needs. DHCFP will be required to post the results of the survey on its website annually in accordance with 42 CFR §438.10(c)(3).

- To ensure accurate and consistent reporting of MCE network adequacy standards, DHCFP should evaluate its expectations for how the MCEs must calculate the time and distance standards and provide written guidance to its MCEs (e.g., contract amendment, reporting template instructions) to confirm they have a clear understanding of DHCFP's specifications for calculating network adequacy (e.g., should MCEs report network adequacy standards and indicators by time *and* distance or by time *or* distance). DHCFP should also update its required network adequacy reporting template to align with DHCFP's network adequacy standards and indicators outlined in the contract (e.g., reporting on adult and pediatric populations separately). Updates to the contracts and reporting template should improve DHCFP's and the MCEs' ability to monitor for any gaps in network adequacy that may be a contributing barrier to members accessing timely care and services.

Appendix A. External Quality Review Activity Methodologies

Methods for Conducting EQR Activities

Validation of Performance Improvement Projects

Activity Objectives

Validating PIPs is one of the mandatory external quality review activities described at 42 CFR §438.330(b)(1). In accordance with §438.330(d), MCEs are required to have a quality assessment and performance improvement program which includes PIPs that focus on both clinical and nonclinical areas. Each PIP must be designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction, and must include the following:

- Measuring performance using objective quality indicators
- Implementing system interventions to achieve QI
- Evaluating effectiveness of the interventions
- Planning and initiating activities for increasing and sustaining improvement

Due to the timing of initiation of the PIPs, for the SFY 2023 validation, HSAG used the CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019.[33] For the SFY 2024 validation, HSAG used *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 1).[34]

HSAG's validation of PIPs includes two key components of the QI process:

1. HSAG evaluates the technical structure of the PIP to ensure that the MCEs design, conduct, and report the PIPs in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the PIP design (e.g., Aim statement, population, performance indicator(s), sampling methods, and data collection methodology) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that the reported PIP results are accurate and capable of measuring sustained improvement.
2. HSAG evaluates the implementation of the PIP. Once, designed, the MCE's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the

[33] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Oct 20, 2023.

[34] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf. Accessed on: Oct 20, 2023.

identification of barriers and subsequent development of relevant interventions. Through this component, HSAG evaluates how well the MCEs improve its rates through implementation of effective processes (i.e., barriers analyses, intervention design, and evaluation results).

Technical Methods of Data Collection and Analysis

The HSAG PIP team consisted of, at a minimum, an analyst with expertise in statistics and study design and a clinician with expertise in performance improvement processes. HSAG, in collaboration with DHCFP, developed the PIP Submission Form. Each MCE completed this form and submitted it to HSAG for review. The PIP Submission Form standardized the process for submitting information regarding the PIPs and ensured that all CMS PIP protocol requirements were addressed.

For the MCE PIPs, HSAG, with DHCFP's input and approval, developed a PIP Validation Tool to ensure uniform validation of PIPs. Using this tool, HSAG evaluated each of the PIPs according to the CMS EQR Protocol 1. The CMS EQR Protocol 1 identifies nine steps that should be validated for each PIP.

The nine steps included in the PIP Validation Tool are listed below:

CMS EQR Protocol 1 Steps	
Step Number	**Description**
1	Review the Selected PIP Topic
2	Review the PIP Aim Statement
3	Review the Identified PIP Population
4	Review the Sampling Method
5	Review the Selected Performance Indicator(s)
6	Review the Data Collection Procedures
7	Review the Data Analysis and Interpretation of PIP Results
8	Assess the Improvement Strategies
9	Assess the Likelihood that Significant and Sustained Improvement Occurred

HSAG used the following methodology to evaluate the SFY 2023 PIPs conducted by the MCEs to determine whether a PIP was valid and to assess the percentage of compliance with CMS' protocol for conducting PIPs.

Each required step is evaluated on one or more elements that form a valid PIP. The HSAG PIP Team scores each evaluation element within a given step as *Met*, *Partially Met*, *Not Met*, *Not Applicable,* or *Not Assessed*. HSAG designates evaluation elements pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all critical elements must be *Met*. Given the importance of critical elements to the scoring methodology, any critical element that receives a *Not Met* score results in

an overall validation rating for the PIP of *Not Met*. The MCEs are assigned a *Partially Met* score if 60 percent to 79 percent of all evaluation elements are *Met* or one or more critical elements are *Partially Met*. HSAG provides a General Feedback with a *Met* validation score when enhanced documentation would have demonstrated a stronger understanding and application of the PIP steps and evaluation elements.

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

HSAG assessed the implications of the PIP's findings on the likely validity and reliability of the results and assigned a level of confidence based on the following:

- *Met*: High confidence/confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 to 100 percent of all evaluation elements were *Met* across all activities.
- *Partially Met*: Low confidence in reported PIP results. All critical evaluation elements were *Met*, and 60 to 79 percent of all evaluation elements were *Met* across all activities; or one or more critical evaluation elements were *Partially Met*.
- *Not Met*: All critical evaluation elements were *Met*, and less than 60 percent of all evaluation elements were *Met* across all activities; or one or more critical evaluation elements were *Not Met.*

The MCEs had an opportunity to resubmit a revised PIP Submission Form and additional information in response to HSAG's initial validation scores of *Partially Met* or *Not Met* and to address any Validation Feedback, regardless of whether the evaluation element was critical or noncritical. HSAG conducted a final validation for any resubmitted PIPs. HSAG offered technical assistance to any MCE that requested an opportunity to review the initial validation scoring prior to resubmitting the PIP.

HSAG used the following methodology to evaluate the SFY 2024 PIPs conducted by the MCEs to determine whether a PIP was valid and to assess the percentage of compliance with CMS' protocol for conducting PIPs.

Each required step is evaluated on one or more elements that form a valid PIP. The HSAG PIP Review Team scores each evaluation element within a given step as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed*. HSAG designates evaluation elements pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all critical elements must be *Met*.

In alignment with CMS EQR Protocol 1, HSAG assigns two PIP validation ratings, summarizing overall PIP performance. One validation rating reflects HSAG's confidence that the MCE adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. This validation rating is based on the scores for applicable evaluation elements in Steps 1 through 8 of the PIP Validation Tool. The second validation rating is only assigned

for PIPs that have progressed to the Outcomes stage (Step 9) and reflects HSAG's confidence that the PIP's performance indicator results demonstrated evidence of significant improvement. The second validation rating is based on scores from Step 9 in the PIP Validation Tool. For each applicable validation rating, HSAG reports the percentage of applicable evaluation elements that received a *Met* validation score and the corresponding confidence level: *High Confidence*, *Moderate Confidence*, *Low Confidence*, or *No Confidence*. The confidence level definitions for each validation rating are as follows:

1. **Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP (Steps 1 Through 8)**
   - *High Confidence*: High confidence in reported PIP results. All critical evaluation elements were *Met*, and 90 percent to 100 percent of all evaluation elements were *Met* across all steps.
   - *Moderate Confidence*: Moderate confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 percent to 89 percent of all evaluation elements were *Met* across all steps.
   - *Low Confidence*: Low confidence in reported PIP results. Across all steps, 65 percent to 79 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Partially Met*.
   - *No Confidence*: No confidence in reported PIP results. Across all steps, less than 65 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Not Met*.
2. **Overall Confidence That the PIP Achieved Significant Improvement (Step 9)**
   - *High Confidence*: All performance indicators demonstrated *statistically significant* improvement over the baseline.
   - *Moderate Confidence*: One of the three scenarios below occurred:
     - All performance indicators demonstrated improvement over the baseline, and some but not all performance indicators demonstrated *statistically significant* improvement over the baseline.
     - All performance indicators demonstrated improvement over the baseline, and none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
     - Some but not all performance indicators demonstrated improvement over baseline, and some but not all performance indicators demonstrated *statistically significant* improvement over baseline.
   - *Low Confidence*: The remeasurement methodology was not the same as the baseline methodology for at least one performance indicator or some but not all performance indicators demonstrated improvement over the baseline and none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
   - *No Confidence*: The remeasurement methodology was not the same as the baseline methodology for all performance indicators or none of the performance indicators demonstrated improvement over the baseline.

Upon completion of the final validation, HSAG prepared a report of its findings and recommendations for each MCE. These reports, which complied with 42 CFR §438.364, were provided to DHCFP and the MCEs.

Description of Data Obtained and Related Time Period

Table A-1 displays each MCO's PIP topics and the data sources used for the performance indicator(s) of each PIP. Table A-2 displays the PAHP's PIP topics and the data sources used for the performance indicator of each PIP. HSAG obtained the data needed to conduct the PIP validation from each MCE's PIP submission form. These forms provided detailed information about each of the PIPs and the activities completed.

The MCE submitted each PIP submission form according to the approved timeline. After the initial validation of the submission form, the MCE received HSAG's feedback and technical assistance and resubmitted the submission form. This process ensured that the design methodology for each PIP was sound before the MCE progressed to the next step of the PIP.

For the SFY 2024 PIP activities, the MCOs calculated the baseline and Remeasurement 1 data for each PIP using data from the time period of January 1, 2022, to December 31, 2022 for baseline and January 1, 2023, through December 31, 2023 for Remeasurement 1. Performance outcomes for Remeasurement 2 will be remeasured in SFY 2025 using data from, January 1, 2024, through December 31, 2024. The PAHP calculated baseline data for each PIP using data from the time period of January 1, 2023, to December 31, 2023. Performance outcomes for Remeasurement 1 will be measured in SFY 2025 using data from January 1, 2024, through December 31, 2024.

Table A-1—PIP Topics and Data Sources for the MCOs

PIP Topics	Data Source
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	Administrative: Programmed query from claims/encounters and pharmacy data
Adults' Access to Preventive/Ambulatory Health Services (AAP)	Administrative: Programmed query from claims/encounters
Child and Adolescent Well Care Visit (WCV)	Administrative: Programmed query from claims/encounters
Follow-up After Emergency Department Visit for Mental Illness (FUM)	Administrative: Programmed query from hospital and outpatient claims/encounter data
Prenatal and Postpartum Care (PPC)	Administrative: Programmed query from hospital, outpatient, lab claims/encounters and pharmacy data
Plan All-Cause Readmissions (PCR)	Administrative: Programmed query from hospital claims/encounters data

Table A-2—PIP Topic and Data Sources for the PAHP

PIP Topic	Data Source
Increase Preventive Services for Children	Administrative: Programmed query from claims/encounters data
Coordination of Transportation Services	Administrative: Telephone service/call center data and appointment/access data

Process for Drawing Conclusions

To draw conclusions about the quality, timeliness, and accessibility of care and services that the MCEs provided to members, HSAG validated the PIPs to ensure that the MCEs used a sound methodology in their design of each PIP. The process assesses the validation findings on the likely validity and reliability of the design methodology by assigning a validation score of *High Confidence*, *Moderate Confidence, Low Confidence,* or *No Confidence*.

Performance Measure Validation

Activity Objectives

The objective of the PMV activity is to ensure that each MCE calculates and reports performance measure rates consistent with the established specifications and that the results can be compared to one another.

DHCFP requires its MCOs to undergo a PMV audit annually. In order to meet the PMV requirements, HSAG, as the EQRO for DHCFP, conducts an NCQA HEDIS Compliance Audit for each MCO. HSAG adheres to NCQA's *HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*,[35] which outlines the accepted approach for auditors to use when conducting an IS capabilities assessment and an evaluation of the MCOs' ability to process medical, member, and practitioner information and measure production processes to determine compliance with HEDIS measure specifications.

For the PAHP, HSAG conducted the validation activities in accordance with CMS EQR *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity,* February 2023 (EQR Protocol 2),[36] which outlines the accepted approach for auditors to use when conducting an IS capabilities assessment and an evaluation of the PAHP's ability to process medical, member, and practitioner information and measure production processes to determine compliance with performance measure specifications.

[35] National Committee for Quality Assurance. *HEDIS Compliance Audit Standards, Policies, and Procedures, Volume 5*. Washington D.C.; 2020.

[36] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols,* February 2023. Available at: https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf. Accessed on: Oct 20, 2023.

Technical Methods of Data Collection and Analysis

MCOs

HSAG adhered to NCQA's *HEDIS Compliance Audit Standards, Policies, and Procedures, Volume 5*, which outlines the accepted approach for auditors to use when conducting an Information Systems Capabilities Assessment and an evaluation of compliance with performance measure specifications for an MCO. All HSAG lead auditors are CHCAs.

Following is a description of how HSAG obtained the data for the PMV analyses.

HSAG obtained data for the PMV analyses through the PMV activities. The PMV involved three phases: audit validation activities, audit review meetings, and follow-up and reporting. The following provides a summary of HSAG's activities with the MCOs, as applicable, within each of the audit phases. Throughout all audit phases, HSAG actively engages with the MCOs to ensure all audit requirements are met, providing technical assistance and guidance as needed. The audit process is iterative to support these entities in understanding all audit requirements and in being able to report valid rates for all required performance measures. HSAG obtained information through interactions, discussions, and formal interviews with key MCO plan staff members and through observations of system demonstrations and data processing.

Audit Validation Activities Phase (October 2023 through May 2024)

- Forwarded HEDIS MY 2023 Record of Administration, Data Management, and Processes (Roadmap) upon release from NCQA.
- Forwarded an introductory packet that included the list of performance measures selected by DHCFP for each population, the HEDIS MY 2023 Roadmap, a timeline for each of the required audit tasks, and guidance on the process requirements.
- Provided frequent communication throughout the audit season, some of which included reminders of upcoming deadlines, required processes, DHCFP reporting requirements, performance measure clarifications, and NCQA updates.
- Scheduled virtual audit review dates.
- Conducted kick-off calls to introduce the audit team, discuss the audit review agenda, provide guidance on HEDIS Compliance Audit processes, and ensure that MCOs were aware of important deadlines.
- Conducted survey sample frame validation for the CAHPS surveys required by DHCFP before the NCQA-certified survey vendor draws the final samples and administers the surveys.
- Reviewed completed HEDIS Roadmaps to assess compliance with the audit standards, and provided the Information Systems standard tracking report which listed outstanding items and areas that required additional clarification.
- Reviewed source code used for calculating the non-HEDIS performance measure rates to ensure compliance with State specifications.

- Verified NCQA Certified Measures[37] were used for calculating the HEDIS performance measure rates using an NCQA Certified Measure vendor or by contracting directly with NCQA to complete automated source code review (ASCR).
- Conducted validation for all supplemental data sources intended for reporting and provided a final supplemental data validation report that listed the types of supplemental data reviewed and the validation results.
- Conducted preliminary rate review to assess data completeness and accuracy early in the audit process to allow time for making corrections, if needed, prior to final rate submission.
- Conducted medical record review validation (MRRV) to ensure the integrity of medical record review (MRR) processes for performance measures that required medical record data for HEDIS reporting.

Audit Review Meetings Phase (January 2024 through April 2024)

- Conducted virtual audit review meetings to assess capabilities to collect and integrate data from internal and external sources and produce reliable performance measure results.
- Provided preliminary audit findings.

Follow-Up and Reporting Phase (May 2024 through July 2024)

- Worked collaboratively to resolve any outstanding items and corrective actions, if applicable, and provided a final IS standard tracking report that documented the resolution of each item.
- Conducted final rate review and provided a rate analysis report that included a comparison to the preliminary rate submission and prior two years' rates (if available) and showed how the rates compared to the NCQA HEDIS MY 2022 Audit Means and Percentiles. The report also included requests for clarification on any notable changes in rates, eligible populations, and measures with rates that remained the same from year to year.
- Approved the final rates and assigned a final, audited result to each selected measure.
- Produced and provided final audit reports containing a summary of all audit activities.

PAHP

HSAG performed an audit of the PAHP's reporting processes for its Medicaid and Nevada Check Up populations. PMV involved three phases: audit validation activities, audit review, and follow-up and reporting. The following provides a summary of HSAG's activities with the PAHP within each phase. Throughout all audit phases, HSAG actively engages with the PAHP to ensure all audit requirements are met, providing technical assistance and guidance as needed. The audit process is iterative to support the PAHP in understanding all audit requirements and in being able to report valid rates for all required performance measures.

[37] HEDIS Certified Measures[SM] is a service mark of the NCQA.

Audit Validation Phase (October 2023 through May 2024)

- Forwarded Information Systems Capabilities Assessment Tool (ISCAT) to PAHP.
- Scheduled virtual audit review date.
- Conducted kick-off call to introduce the audit team, discuss the virtual audit review agenda, provide guidance on PMV processes, and ensure that the PAHP was aware of important deadlines.
- Reviewed completed ISCAT to assess the PAHP's IS.
- Reviewed source code used for calculating the performance measure rates to ensure compliance with the technical specifications.
- Conducted validation for all supplemental data sources intended for reporting and provided a final supplemental data validation report that listed the types of supplemental data reviewed and the validation results.
- Conducted preliminary rate review to assess data completeness and accuracy early in the audit process to allow time for making corrections, if needed, prior to final rate submission.

Audit Review Meetings Phase (January 2024 through April 2024)

- Conducted virtual audit review to assess the PAHP's capabilities to collect and integrate data from internal and external sources and produce reliable performance measure results.
- Provided preliminary audit findings.

Follow-Up and Reporting Phase (May 2024 through July 2024)

- Worked collaboratively to resolve any outstanding items and corrective actions, if applicable.
- Conducted final rate review and provided a rate analysis report that included a comparison to the preliminary rate submission and prior years' rates (if available). The report also included requests for clarification on any notable changes in rates, eligible populations, and measures with rates that remained the same from year to year.
- Approved the final rates and assigned a final, audited result to each selected measure.
- Produced and provided a final audit report containing a summary of all audit activities.

Description of Data Obtained and Related Time Period

Through the methodology, HSAG obtained a number of different information sources to conduct the PMV.

For the PAHP, these included:

- ISCAT.
- Source code, computer programming, and query language (if applicable) used to calculate the selected performance measure rates.
- Supporting documentation such as file layouts, system flow diagrams, system log files, and policies and procedures.

For both the MCOs and the PAHP, HSAG also obtained information through interaction, discussion, and formal interviews with key MCO and PAHP staff members, as well as through observing system demonstrations and data processing.

Process for Drawing Conclusions

To draw conclusions about the quality, timeliness, and accessibility of care and services that the MCEs provided to members, HSAG determined results for each performance measure at the indicator level and assigned each an audit designation in alignment with the applicable guidelines for each type of audit. For the MCO HEDIS audits, HSAG assigned each performance indicator an audit designation of *Reportable (R)*, *Not Applicable (NA)*, or *Biased Rate (BR)*, according to NCQA's *HEDIS Measurement Year 2023 Volume 5: HEDIS Compliance Audit: Standards, Policies and Procedures.* For the PAHP PMV audit, HSAG assigned each performance measure indicator an audit designation of *Reportable (R)* or *Do Not Report (DNR)*, according to CMS EQR Protocol 2. HSAG further analyzed the quantitative results (e.g., performance indicator results) and qualitative results (e.g., IS data collection and reporting processes) to identify strengths and weaknesses and determine whether each strength and weakness impacted one or more of the domains of quality, timeliness, or access. HSAG considered rates that met or exceeded the state-established MPS and/or demonstrated an increase in performance of +/- 5 percent as a substantial strength; rates that did not meet the state-established MPS and/or demonstrated a decline in performance of +/- 5 percent were considered a substantial weakness. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to each MCE's Medicaid and Nevada Check Up members.

Compliance Review

Activity Objectives

SFY 2024 began a new three-year compliance review cycle, in which HSAG reviewed the first half of the federal standards for compliance. The remaining federal standards will be reviewed in SFY 2025, and in Year Three (SFY 2026), a comprehensive evaluation of the MCEs' implementation of corrective actions taken to remediate any requirements (i.e., elements) that received a *Not Met* score during the first two years of the compliance review cycle (SFYs 2024 and 2025) will be conducted.

As demonstrated in Table A-3, HSAG will complete a comprehensive review of compliance with all federal requirements as stipulated in 42 CFR §438.358 within a three-year period.

Table A-3—Nevada Compliance Review Three-Year Cycle for the MCEs

Standards	Associated Federal Citation[1]		Year One (SFY 2024)	Year Two (SFY 2025)	Year Three (SFY 2026)
	Medicaid	CHIP			
Standard I—Disenrollment: Requirements and Limitations[3]	§438.56	§457.1212	✓		Review of the MCE's Year

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

[1] The compliance review standards comprise a review of all requirements, known as elements, under the associated federal citation, including all requirements that are cross-referenced within each federal standard, as applicable (e.g., Standard X—Grievance and Appeal Systems includes a review of §438.228 and all requirements under Subpart F of 42 CFR Part 438).

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

[3] DHCFP determined that the requirements under Standard I—Disenrollment: Requirements and Limitations was not applicable to the PAHP.

Technical Methods of Data Collection and Analysis

Prior to beginning the SFY 2024 compliance review, HSAG developed data collection tools, referred to as compliance review tools, to document the findings from the review. The content of the tools was selected based on applicable federal and State regulations and on the requirements set forth in the contract between DHCFP and the MCEs as they related to the scope of the review. The review processes used by HSAG to evaluate the MCE's compliance were consistent with CMS EQR Protocol 3.

For each MCE, HSAG's desk review consisted of the following activities:

Pre-Site Review Activities:

- Collaborated with DHCFP to develop the scope of work, compliance review methodology, and compliance review tools (i.e., Standards review tools).

- Prepared and forwarded to the MCE a timeline, description of the compliance process, pre-site review information packet, a submission requirements checklist, and a post-site review document tracker.
- Scheduled the site review with the MCE.
- Hosted a pre-site review preparation session with all MCEs.
- Generated a list of 10 sample records for the MCEs for care management and service and payment denial case file reviews.
- Conducted a desk review of supporting documentation the MCE submitted to HSAG.
- Followed up with each MCE, as needed, based on the results of HSAG's preliminary desk review.
- Developed an agenda for the site review interview sessions and provided the agenda to the MCE to facilitate preparation for HSAG's review.

Site Review Activities:

- Conducted an opening conference, with introductions and a review of the agenda and logistics for HSAG's review activities.
- Interviewed MCE key program staff members.
- Conducted an IS review of the data systems that the MCEs used in their operations, applicable to the standards/elements under review.
- Conducted a review of case files to determine compliance in the program areas under review, including care management and service and payment denial records.
- Conducted a closing conference during which HSAG reviewers summarized their preliminary findings, as appropriate.

Post-Site Review Activities:

- Conducted a review of additional documentation submitted by the MCE.
- Documented findings and assigned each element a score of *Met*, *Not Met*, or *NA* for the Standards review (as described in the Data Aggregation and Analysis section) within the compliance review tool.
- Prepared an MCE-specific report detailing the findings of HSAG's review.
- Prepared an MCE-specific CAP template and required the MCEs to develop and submit its remediation plans for each element that received a *Not Met* score.

Data Aggregation and Analysis:

HSAG used scores of *Met* and *Not Met* to indicate the degree to which the MCE's performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to the MCE during the period covered by HSAG's review. This scoring methodology is consistent with CMS EQR Protocol 3. The protocol describes the scoring as follows:

Met indicates full compliance defined as *all* of the following:

- All documentation listed under a regulatory provision, or component thereof, is present.

- Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.
- Documentation, staff responses, case file reviews, and IS reviews confirmed implementation of the requirement.

Not Met indicates noncompliance defined as *one or more* of the following:

- There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews.
- Staff members can describe and verify the existence of processes during the interviews, but documentation is incomplete or inconsistent with practice.
- Documentation, staff responses, case file reviews, and IS reviews did not demonstrate adequate implementation of the requirement.
- No documentation is present and staff members have little or no knowledge of processes or issues addressed by the regulatory provisions.
- For those provisions with multiple components, key components of the provision could not be identified and any findings of *Not Met* would result in an overall provision finding of noncompliance, regardless of the findings noted for the remaining components.

From the scores that it assigned for each of the requirements, HSAG calculated a total percentage-of-compliance score for each standard and an overall percentage-of-compliance score across the standards. HSAG calculated the total score for each standard by totaling the number of Met (1 point) elements and the number of Not Met (0 points) elements, then dividing the summed score by the total number of applicable elements for that standard. Elements not applicable to the MCE were scored NA and were not included in the denominator of the total score.

HSAG determined the overall percentage-of-compliance score across the areas of review by following the same method used to calculate the scores for each standard (i.e., by summing the total values of the scores and dividing the result by the total number of applicable elements).

HSAG conducted file reviews of the MCEs' records for care management and service and payment denials to verify that the MCEs had put into practice what the MCEs had documented in its policy. HSAG selected 10 records each for care management and service and payment denials from the full universe of records provided by each MCE. The file reviews were not intended to be a statistically significant representation of all the MCEs' files. Rather, the file reviews highlighted instances in which practices described in policy were not followed by MCE staff members. Based on the results of the file reviews, MCEs must determine whether any area found to be out of compliance was the result of an anomaly or if a more serious breach in policy occurred. Findings from the file reviews were documented within the applicable standard and element in the compliance review tool.

To draw conclusions about the quality, timeliness, and accessibility of care and services provided to members within the program areas under review, HSAG aggregated and analyzed the data resulting from its desk and site review activities. The data that HSAG aggregated and analyzed included:

- Documented findings describing the MCE's progress in achieving compliance with State and federal requirements.
- Scores assigned to the MCE's performance for each requirement.
- The total compliance score calculated for each of the standards included as part of the SFY 2024 compliance review.
- The overall compliance score calculated across the standards.
- Documented actions required to bring performance into compliance with the requirements for which HSAG assigned a score of *Not Met*.
- Documented recommendations for program enhancement, when applicable.

Description of Data Obtained

To assess the MCE's compliance with federal regulations, State rules, and contract requirements, HSAG obtained information from a wide range of written documents produced by the MCE, including, but not limited to:

- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.
- Management/monitoring reports and audits.
- Narrative and/or data reports across a broad range of performance and content areas).
- Case files for prior authorization denials, care plans, credentialing and recredentialing records, grievance records, appeal records, contracts with delegated entities, etc.

HSAG obtained additional information for the compliance review through IS reviews of the MCE's data systems and through interactions, discussions, and interviews with the MCE's key staff members. Table A-4 lists the major data sources HSAG used to determine the MCE's performance in complying with requirements and the time period to which the data applied.

Table A-4—Description of MCE Data Sources and Applicable Time Period

Data Obtained	Time Period to Which the Data Applied
Documentation submitted for HSAG's desk review and additional documentation available to HSAG during or after the site review	Documentation in effect between July 1, 2023, and December 31, 2023
Information obtained from a review of a sample of care management case files	Listing of all members newly enrolled into care management on or after January 1, 2023
Information obtained from a review of a sample of service and payment denial files	Listing of all denials between July 1, 2023, and December 31, 2023
Information obtained through interviews	March 25, 2024—April 3, 2024
Documentation submitted post-site review	March 27, 2024—April 5, 2024

Process for Drawing Conclusions

To draw conclusions and provide an understanding of the strengths and weaknesses for each MCE individually, HSAG used the results of the program areas reviewed, including comprehensive case file reviews for two program areas. As any element not achieving compliance required a formal action plan, HSAG determined each MCE's substantial strengths and weaknesses as follows:

- Strength—Any program area that did not require a CAP (i.e., achieved a compliance score of 100 percent)
- Weakness—Any program area with three or more elements with a *Not Met* score.

HSAG further analyzed the qualitative results of each strength and weakness (i.e., findings that resulted in the strength or weakness) to draw conclusions about the quality, timeliness, and accessibility of care and services that the MCE provided to members by determining whether each strength and weakness impacted one or more of the domains of quality, timeliness, and access. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to the MCE's Medicaid members.

Network Adequacy Validation

Activity Objectives

42 CFR §438.350(a) requires states that contract with MCOs, prepaid inpatient health plans (PIHPs), and PAHPs, collectively referred to as MCEs, to have a qualified EQRO perform an annual EQR that includes validation of network adequacy to ensure provider networks are sufficient to provide timely and accessible care to Medicaid and CHIP beneficiaries across the continuum of services.

The objectives of the validation of network adequacy are to:

- Assess the accuracy of DHCFP-defined network adequacy indicators reported by the MCEs.
- Evaluate the collection of provider data, reliability and validity of network adequacy data, methods used to assess network adequacy, and systems and processes used.
- Determine an indicator-level validation rating, which refers to the overall confidence that an acceptable methodology was used for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators, as set forth by DHCFP.

Technical Methods of Data Collection and Analysis

HSAG collected network adequacy data from the MCEs via a secure file transfer protocol (SFTP) site and via virtual NAV audits. HSAG used the collected data to conduct the validation of network adequacy in accordance with the CMS EQR Protocol 4. *Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 4).

HSAG conducted a virtual review with the MCEs and collected information using several methods, including interviews, system demonstrations, review of source data output files, PSV, observation of data processing, and review of final network adequacy indicator-level reports. The virtual review activities performed for each MCE included the following:

- Opening meeting
- Review of the ISCAT and supporting documentation
- Evaluation of underlying systems and processes
- Overview of data collection, integration, methods, and control procedures
- Network adequacy source data PSV and results
- Closing conference

HSAG conducted interviews with key MCE staff members who were involved with the calculation and reporting of network adequacy indicators.

Description of Data Obtained and Related Time Period

HSAG prepared a document request packet that was submitted to each MCE outlining the activities conducted during the validation process. The document request packet included a request for documentation to support HSAG's ability to assess each MCE's information systems and processes, network adequacy indicator methodology, and accuracy of network adequacy reporting at the indicator level. Documents requested included an ISCAT, a timetable for completion, and instructions for submission. HSAG worked with the MCEs to identify all data sources informing calculation and reporting at the network adequacy indicator level for the time period covering Quarter 4, October 1–December 31, 2023. HSAG obtained the following data and documentation from the MCEs to conduct the NAV audits:

- Information systems data from the ISCAT
- Network adequacy logic for calculation of network adequacy indicators
- Network adequacy data files
- Network adequacy monitoring data
- Supporting documentation, including policies and procedures, data dictionaries, system flow diagrams, system log files, and data collection process descriptions

Process for Drawing Conclusions

To draw conclusions about the quality, timeliness, and accessibility of care and services that each MCE provided to members, HSAG used the results of the ISCA combined with the detailed validation of each indicator to assess whether the network adequacy indicator results were valid, accurate, and reliable, and whether the MCE's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. The overall validation rating refers to HSAG's overall confidence that acceptable methodology was used for all phases of data collection, analysis, and interpretation of the network adequacy indicators.

By assessing each MCE's performance and NAV reporting process, HSAG identified areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement.

Consumer Assessment of Healthcare Providers and Systems Analysis

Activity Objectives

The CAHPS activity assesses member experience with an MCO and its providers, and the quality of care they receive. The goal of the CAHPS Health Plan Surveys is to provide feedback that is actionable and will aid in improving members' overall experiences.

Technical Methods of Data Collection and Analysis

Three populations were surveyed for **Anthem**, **UHC HPN**, **Molina**, and **SilverSummit**: adult Medicaid, child Medicaid, and Nevada Check Up. Center for the Study of Services, an NCQA-certified survey vendor, administered the 2024 CAHPS surveys for **Anthem.** SPH Analytics, Inc., an NCQA-certified survey vendor, administered the 2024 CAHPS surveys for **UHC HPN**, **Molina**, and **SilverSummit**.

The technical method of data collection was through the CAHPS 5.1H Adult Medicaid Health Plan Survey to the adult population and the CAHPS 5.1H Child Medicaid Health Plan Survey (with the CCC measurement set) to the child Medicaid and Nevada Check Up populations. **Anthem**, **UHC HPN**, and **SilverSummit** used a mixed-mode methodology for data collection whereby members were mailed surveys that provided the option to complete the survey via the Internet, followed by telephone interviews of nonrespondents to the mailed surveys. **Molina** used a mixed-mode methodology for data collection whereby members were mailed surveys followed by telephone interviews of nonrespondents to the mailed surveys. For **Anthem**, **UHC HPN**, **Molina**, and **SilverSummit**, all members selected in the sample received both an English and Spanish mail survey and had the option to complete the survey over the telephone or via the Internet in Spanish, where applicable.

CAHPS Measures

The CAHPS 5.1H Health Plan Surveys included a set of standardized items (39 items for the CAHPS 5.1H Adult Medicaid Health Plan Survey and 76 items for the CAHPS 5.1H Child Medicaid Health Plan Survey with CCC measurement set) that assessed adult members' and parents/caretakers of child members' experience with care. The survey questions were categorized into measures of experience. These measures included four global ratings, four composite scores, three medical assistance with smoking and tobacco use cessation measure items (adult population only), and five CCC composite measures/items (CCC eligible population only). The global ratings reflected members' overall experience with their personal doctor, specialist, health plan, and all healthcare. The composite measures were derived from sets of questions to address different aspects of care (e.g., *Getting Needed Care* and *How Well Doctors Communicate*). The medical assistance with smoking and tobacco use cessation measure items assessed the various aspects of providing assistance with smoking and tobacco use

cessation. The CCC composite measures/items evaluated the experience of families with children with chronic conditions accessing various services (e.g., specialized services, prescription medications).

Top-Box Score Calculations

For each of the four global ratings, HSAG calculated the percentage of respondents who chose a positive experience rating on a scale of 0 to 10. The definition of a top-box response for the global ratings included a value of 9 or 10. For each of the four composite scores and CCC composite measures/items, HSAG calculated the percentage of respondents who chose a top-box response. CAHPS composite question response choices fell into one of two categories: (1) "Never," "Sometimes," "Usually," or "Always" or (2) "No" or "Yes." A top-box response for the composites included responses of "Usually/Always" or "Yes." For the medical assistance with smoking and tobacco use cessation measure items, responses of "Always/Usually/Sometimes" were used to determine if the respondent qualified for inclusion in the numerator. The scores presented for these items follow NCQA's methodology of calculating a rolling average using the current and prior year results. HSAG presented the positive rates in the report for **Anthem**, **UHC HPN**, **Molina**, and **SilverSummit**, which are based on the CAHPS survey results calculated by their CAHPS survey vendor. Each MCO provided HSAG with the requested CAHPS survey data for purposes of calculating confidence intervals for each of the global ratings and composite measures presented in this report.

When a minimum of 100 respondents for a measure was not achieved, the result of the measure was denoted as *Not Applicable (NA)*.

NCQA National Average Comparisons

Colors and arrows were used to note substantial differences. An MCO that performed statistically significantly higher than the 2023 NCQA national average was denoted with a green upward arrow (↑).[38] Conversely, an MCO that performed statistically significantly lower than the 2023 NCQA national average was denoted with a red downward arrow (↓). An MCO that did not perform statistically significantly higher or lower than the 2023 NCQA national average was not denoted with an arrow. Since NCQA does not publish separate scores for CHIP, national comparisons could not be made for the Nevada Check Up program.

Plan Comparisons

Statistically significant differences between the 2024 top-box scores for the adult Medicaid, child Medicaid (general child and CCC), and Nevada Check Up (general child and CCC) populations for **Anthem**, **UHC HPN**, **Molina**, and **SilverSummit** were noted with colors and arrows. An MCO that performed statistically significantly higher than the program average (i.e., combined results of **Anthem**, **UHC HPN**, **Molina**, and **SilverSummit**) was denoted with a green upward arrow (↑). Conversely, an MCO that performed statistically significantly lower than the program average was denoted with a red

[38] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2023.* Washington, DC: NCQA, September 2023.

downward arrow (↓). An MCO that did not perform statistically significantly different than the program average was not denoted with an arrow.

Description of Data Obtained and Related Time Period

Based on NCQA protocol, adult members included as eligible for the survey were 18 years of age or older as of December 31, 2023, and child members included as eligible for the survey were 17 years of age or younger as of December 31, 2023. Adult members and parents/caretakers of child members for **Anthem**, **UHC HPN**, and **SilverSummit** completed the surveys from February to May 2024. Adult members and parents/caretakers of child members for **Molina** completed the surveys from March to May 2024.

Process for Drawing Conclusions

To draw conclusions about the quality, timeliness, and accessibility of care and services that each MCO provided to members, HSAG used the information supplied by the MCOs to evaluate the results of the survey. HSAG compared each MCO's 2024 survey results to the 2023 NCQA national averages to determine if there were any statistically significant differences.

To begin to draw conclusions from the data, HSAG categorized the rates as statistically significantly higher than the national average, neither statistically significantly higher nor lower than the national average, or statistically significantly lower than the national average. HSAG concluded that MCOs could improve the measure rates that were lower than the national average and encouraged the MCOs to focus on activities to assist in increasing measure rates to be higher than the national average for subsequent surveys. HSAG drew conclusions concerning quality of care, timeliness of care, and/or access to care by evaluating the questions included in each of the measures presented in this report. This assignment to domains is depicted in Table A-5.

Table A-5—Assignment of CAHPS Survey Measures to the Quality of, Timeliness of, and Access to Care Domains

CAHPS Topic	Quality	Timeliness	Access
Rating of Health Plan	✓		
Rating of All Health Care	✓		
Rating of Personal Doctor	✓		
Rating of Specialist Seen Most Often	✓		
Getting Needed Care	✓		✓
Getting Care Quickly	✓	✓	
How Well Doctors Communicate	✓		
Customer Service	✓		
Advising Smokers and Tobacco Users to Quit (adult population only)	✓		
Discussing Cessation Medications (adult population only)	✓		
Discussing Cessation Strategies (adult population only)	✓		

CAHPS Topic	Quality	Timeliness	Access
Access to Specialized Services (CCC population only)	✓		✓
FCC: Personal Doctor Who Knows Child (CCC population only)	✓		
Coordination of Care for Children with Chronic Conditions (CCC population only)	✓		
Access to Prescription Medicines (CCC population only)	✓		✓
FCC: Getting Needed Information (CCC population only)	✓		

Dental Satisfaction Survey

Activity Objectives

The dental satisfaction survey activity assesses adult members' and parents/caretakers of child members' experiences with the PAHP and its dental providers, and the quality of care they/their child receive. The goal of the dental satisfaction survey is to provide feedback that is actionable and will aid in improving members' overall experiences with dental care services.

Technical Methods of Data Collection and Analysis

The technical method of data collection was through administration of an adult dental survey and a child dental survey, which was modified from the CAHPS Dental Plan Survey (currently available for the adult population only). SPH Analytics, Inc. administered the 2024 dental satisfaction survey to **LIBERTY**'s adult Medicaid, child Medicaid, and Nevada Check Up populations. **LIBERTY** used a mixed-mode methodology for data collection (i.e., mailed surveys followed by telephone interviews of non-respondents to the mailed surveys, plus a web-based survey). All members selected in the sample received an English or Spanish version of the survey.

Dental Satisfaction Survey Measures

The dental satisfaction survey questions were categorized into various measures of experience. These measures included four global ratings, three composite measures, and three individual item measures. The global ratings reflected adult members' and parents'/caretakers' of child members overall experience with their/their child's regular dentist, all dental care, ease of finding a dentist, and the dental plan. The composite measures were derived from sets of questions to address different aspects of dental care (e.g., *Care from Dentists and Staff* and *Access to Dental Care).* The individual item measures are individual questions that examine a specific area of care (e.g., *Care from Regular Dentists).*

Top-Box Score Calculations

For each of the global ratings, the percentage of respondents who chose a top experience rating, or top-box response (i.e., a response value of 9 or 10 on a scale of 0 to 10) was calculated.

For each of the composite measures and individual item measures, the percentage of respondents who chose a positive or top-box response was calculated. Composite and individual item question response choices were: (1) "Never," "Sometimes," "Usually," or "Always;" (2) "Definitely Yes," "Somewhat Yes," "Somewhat No," or "Definitely No;" or (3) "Definitely Yes," "Probably Yes," "Probably No," or "Definitely No." A positive or top-box response for the composite measures and individual item measures was defined as a response of "Usually/Always" or "Definitely Yes/Somewhat Yes." For the *Access to Dental Care* composite measure, a response of "Never/Sometimes" was considered a top-box score for the question within the composite that asked members how often they had to spend more than 15 minutes in the waiting room before someone saw them/their child for a dental appointment. When a minimum of 100 respondents for a measure was not achieved, the measure result was denoted as *Not Applicable (NA)*.

Description of Data Obtained and Related Time Period

Adult members included as eligible for the survey were 21 years of age or older as of January 1, 2024. Child members included as eligible for the survey were 20 years of age or younger as of January 1, 2024. Surveys were administered from February 2024 to May 2024.

Process for Drawing Conclusions

To draw conclusions about the quality, timeliness, and accessibility of care and services that **LIBERTY** provided to members, HSAG had intended to compare the prior year's results to the current year's results to determine if the results were statistically significantly different. However, because a minimum of 100 respondents was not obtained for any measure for the prior year and for most of the measures for the current year, a comparison of the results could not be completed and conclusions about the quality, timeliness, and accessibility of care and services could not be assessed. HSAG also assigned each of the measures to one or more of these three domains. This assignment to domains is depicted in Table A-6.

Table A-6—Assignment of Dental Satisfaction Survey Measures to the Quality, Timeliness, and Access Domains

Dental Survey Topic	Quality	Timeliness	Access
Rating of Regular Dentist	✓		
Rating of All Dental Care	✓		
Rating of Finding a Dentist	✓		✓
Rating of Dental Plan	✓		
Care from Dentists and Staff	✓		
Access to Dental Care	✓	✓	✓
Dental Plan Services	✓		
Care from Regular Dentist (child population only)	✓		
Would Recommend Regular Dentist (child population only)	✓		
Would Recommend Dental Plan	✓		

Nevada 2022–2024 Quality Strategy
Goals and Objectives for Medicaid and Nevada Check Up

The Nevada Quality Strategy objectives were developed in alignment with national performance measures, including HEDIS and the Adult and Child Core Sets, to assess the Nevada Managed Care Program's progress in meeting its Quality Strategy goals. Performance is evaluated annually and reported through the annual EQR technical report.

To establish performance targets, DHCFP uses the QISMC methodology developed by the Department of Health & Human Services Health Care Financing Administration. Performance goals (i.e., MPS) are established by reducing by 10 percent the gap between the performance measure baseline rate and 100 percent (or 0 percent for inverse measures [i.e., lower rates indicate better performance]). For example, if the baseline rate was 55 percent, the MCE would be expected to improve the rate by 4.5 percentage points to 59.5 percent. This is calculated as 4.5% = 10% x (100% – 55%). The methodology for calculating performance metrics for initiatives relating to specific provider groups (e.g., CCBHC, State-Directed Payment, and P-COAT) is included in Section 2, and performance rates are not included as part of this tracking table.

During SFY 2022 and SFY 2023, DHCFP established an MPS for each objective using performance measurement data from MY 2020 Medicaid and Nevada Check Up aggregate performance data. For performance measures newly reported for MY 2022 in SFY 2023 and performance measures for which NCQA recommended a break in trending between MY 2022 and prior years due to significant changes in the measure specifications, DHCFP, in collaboration with HSAG, established MPSs using MY 2022 baseline data from the statewide aggregated rates. Each objective that shows improvement equal to or greater than the performance target (i.e., MPS) is considered achieved, and suggests the Nevada Managed Care Program has made progress toward reaching the associated goal. **MPSs that were met for SFY 2024 are denoted by green shading.**

Goal 1—Improve the Health and Wellness of Nevada's Medicaid population by increasing the use of preventive services by December 31, 2024.									
			Measure Set					MPS	
Objective #	Objective Description	Measure Steward	HEDIS	Adult Core Set	Child Core Set	Medicaid Aggregate MY 2023	Nevada Check Up Aggregate MY 2023	Medicaid	Nevada Check Up
1.1a:	Increase well-child visits in the first 30 months of life (W30)—0–15 months (6 or more well-child visits)+	NCQA	✓		✓	57.11%	68.01%	62.88%	73.00%
1.1b:	Increase well-child visits in the first 30 months of life (W30)—15–30 months (2 or more well-child visits) +	NCQA	✓		✓	61.24%	64.74%	70.56%	82.95%
1.2a:	Increase child and adolescent well-care visits (WCV)—3–11 years+	NCQA	✓		✓	51.38%	54.29%	52.50%	59.37%
1.2b:	Increase child and adolescent well-care visits (WCV)—12–17 years+	NCQA	✓		✓	46.00%	50.90%	45.85%	54.57%
1.2c:	Increase child and adolescent well-care visits (WCV)—18–21 years+	NCQA	✓		✓	22.70%	33.39%	29.68%	38.72%
1.3a:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—BMI percentile+	NCQA	✓		✓	83.40%	83.18%	85.76%	85.62%
1.3b:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—Counseling for nutrition+	NCQA	✓		✓	74.78%	74.65%	77.65%	77.08%
1.3c:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)–Counseling for physical activity+	NCQA	✓		✓	70.92%	72.45%	74.96%	74.09%
1.4a:	Increase immunizations for adolescents (IMA)—Combination 1+	NCQA	✓		✓	82.07%	90.77%	87.81%	94.17%
1.4b:	Increase immunizations for adolescents (IMA)—Combination 2+	NCQA	✓		✓	31.98%	42.22%	48.91%	57.30%

Goal 1—Improve the Health and Wellness of Nevada's Medicaid population by increasing the use of preventive services by December 31, 2024.									
			Measure Set					MPS	
Objective #	Objective Description	Measure Steward	HEDIS	Adult Core Set	Child Core Set	Medicaid Aggregate MY 2023	Nevada Check Up Aggregate MY 2023	Medicaid	Nevada Check Up
1.5a:	Increase childhood immunization status (CIS)—Combination 3+	NCQA	✓		✓	54.41%	69.89%	68.95%	82.36%
1.5b:	Increase childhood immunization status (CIS)—Combination 7+	NCQA	✓		✓	47.71%	66.13%	62.11%	76.15%
1.5c:	Increase childhood immunization status (CIS)—Combination 10+	NCQA	✓		✓	19.34%	27.15%	38.58%	48.22%
1.6:	Increase breast cancer screening (BCS-E) +	NCQA	✓	✓		45.49%	—	54.27%	—
1.7a:	Increase adults' access to preventive/ambulatory health services (AAP)—20–44 years+	NCQA	✓			60.57%	—	69.68%	—
1.7b:	Increase adults' access to preventive/ambulatory health services (AAP)—45–64 years+	NCQA	✓			68.74%	—	76.59%	—
1.8a:	Increase chlamydia screening in women (CHL)—16–20 years+	NCQA	✓		✓	53.57%	52.69%	53.24%	45.62%
1.8b:	Increase chlamydia screening in women (CHL)—21–24 years+	NCQA	✓	✓		61.60%	NA	65.10%	MNA

Goal 2—Increase use of evidence-based practices for members with chronic conditions by December 31, 2024.									
			Measure Set					MPS	
Objective #	Objective Description	Measure Steward	HEDIS	Adult Core Set	Child Core Set	Medicaid Aggregate MY 2023	Nevada Check Up Aggregate MY 2023	Medicaid	Nevada Check Up
2.1a:	Increase rate of HbA1c control (<8.0%) for members with diabetes (HBD)+	NCQA	✓			49.02%	—	50.84%	—
2.1b:	Reduce rate of HbA1c poor control (>9.0%) for members with diabetes (HBD)*+	NCQA	✓	✓		43.36%	—	40.52%	—
2.2:	Increase blood pressure control (<140/90 mm Hg) for members with diabetes (BPD)+	NCQA	✓			59.69%	—	60.51%	—
2.3:	Increase rate of controlling high blood pressure (CBP)+	NCQA	✓	✓		59.63%	—	58.81%	—
2.4a:	Increase the asthma medication ratio (AMR)—5–18 years+	NCQA	✓		✓	59.04%	63.67%	75.97%	76.68%
2.4b:	Increase the asthma medication ratio (AMR)—19–64 years+	NCQA	✓	✓		46.00%	NA	55.66%	MNA
2.5:	Decrease the rate of adult acute inpatient stays that were followed by an unplanned readmission for any diagnosis within 30 days after discharge (PCR)–Observed readmissions*+	NCQA	✓	✓		10.85%	—	11.28%	—

Goal 3—Reduce misuse of opioids by December 31, 2024.									
			Measure Set					MPS	
Objective #	Objective Description	Measure Steward	HEDIS	Adult Core Set	Child Core Set	Medicaid Aggregate MY 2023	Nevada Check Up Aggregate MY 2023	Medicaid	Nevada Check Up
3.1:	Reduce use of opioids at high dosage (HDO)* +	NCQA	✓			8.11%	—	8.23%	—
3.2:	Reduce use of opioids from multiple providers (UOP)—Multiple prescribers*+	NCQA	✓			22.60%	—	22.14%	—
3.3a:	Reduce the rate of adult members with at least 15 days of prescription opioids in a 30-day period (COU)* †	NCQA	✓			7.65%	—	6.92%	—
3.3b:	Reduce the rate of adult members with at least 31 days of prescription opioids in a 62-day period (COU)* †	NCQA	✓			5.98%	—	5.47%	—

Goal 4—Improve the health and wellness of pregnant women and infants by December 31, 2024.									
			Measure Set					MPS	
Objective #	Objective Description	Measure Steward	HEDIS	Adult Core Set	Child Core Set	Medicaid Aggregate MY 2023	Nevada Check Up Aggregate MY 2023	Medicaid	Nevada Check Up
4.1a:	Increase timeliness of prenatal care (PPC) +	NCQA	✓		✓	79.98%	NA	85.02%	MNA
4.1b:	Increase the rate of postpartum visits (PPC) +	NCQA	✓	✓		72.75%	NA	74.13%	MNA
4.2a:	Increase the rate of deliveries in which members were screened for clinical depression during pregnancy using a standardized instrument (PND-E) †	NCQA	✓			0.23%	—	10.00%	—

Goal 4—Improve the health and wellness of pregnant women and infants by December 31, 2024.									
			Measure Set					MPS	
Objective #	Objective Description	Measure Steward	HEDIS	Adult Core Set	Child Core Set	Medicaid Aggregate MY 2023	Nevada Check Up Aggregate MY 2023	Medicaid	Nevada Check Up
4.2b:	Increase the rate of deliveries in which members received follow-up care within 30 days of a positive depression screen finding (PND-E) +	NCQA	✓			NA	—	MNA	—
4.3a:	Increase the rate of deliveries in which members were screened for clinical depression using a standardized instrument during the postpartum period (PDS-E) †	NCQA	✓			0.04%	—	10.00%	—
4.3b:	Increase the rate of deliveries in which members received follow-up care within 30 days of a depression screen finding (PDS-E) +	NCQA	✓			NA	—	MNA	—
4.4	Increase the rate of deliveries in the measurement period in which women received influenza and tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccinations (PRS-E) †	NCQA	✓			7.03%	—	15.07%	—

Goal 5—Increase use of evidence-based practices for members with behavioral health conditions by December 31, 2024.									
			Measure Set					MPS	
Objective #	Objective Description	Measure Steward	HEDIS	Adult Core Set	Child Core Set	Medicaid Aggregate MY 2023	Nevada Check Up Aggregate MY 2023	Medicaid	Nevada Check Up
5.1a:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication (ADD)—Initiation phase+	NCQA	✓		✓	50.76%	46.15%	55.68%	50.75%
5.1b:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication (ADD)—Continuation and maintenance phase+♦	NCQA	✓		✓	64.80%	NA	72.54%	MNA
5.2:	Increase adherence to antipsychotic medications for individuals with schizophrenia (SAA) +	NCQA	✓	✓		38.73%	—	45.22%	—
5.3a:	Increase follow-up after hospitalization for mental illness (FUH)—7-day+	NCQA	✓	✓	✓	32.70%	55.91%	41.37%	52.00%
5.3b:	Increase follow-up after hospitalization for mental illness (FUH)—30-day+	NCQA	✓	✓	✓	49.56%	78.49%	56.67%	65.20%
5.4:	Increase diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications (SSD) +	NCQA	✓	✓		77.45%	—	77.29%	—
5.5a:	Increase follow-up after ED visit for AOD abuse or dependence (FUA)—7-day†	NCQA	✓	✓	✓	17.40%	NA	23.59%	MNA
5.5b:	Increase follow-up after ED visit for AOD abuse or dependence (FUA)—30-day†	NCQA	✓	✓	✓	27.36%	NA	28.26%	MNA
5.6a:	Increase follow-up after ED visit for mental illness (FUM)—7-day+	NCQA	✓	✓	✓	47.02%	77.78%	47.85%	77.50%
5.6b:	Increase follow-up after ED visit for mental illness (FUM)—30-day+	NCQA	✓	✓	✓	55.67%	82.22%	56.82%	77.50%

Goal 5—Increase use of evidence-based practices for members with behavioral health conditions by December 31, 2024.									
			Measure Set					MPS	
Objective #	Objective Description	Measure Steward	HEDIS	Adult Core Set	Child Core Set	Medicaid Aggregate MY 2023	Nevada Check Up Aggregate MY 2023	Medicaid	Nevada Check Up
5.7a:	Increase initiation and engagement of AOD abuse or dependence treatment (IET)—Initiation of treatment†	NCQA	✓	✓		46.37%	32.31%	47.63%	37.69%
5.7b:	Increase initiation and engagement of AOD abuse or dependence treatment (IET)—Engagement of treatment†	NCQA	✓	✓		15.43%	12.31%	21.54%	12.77%
5.8:	Increase the rate of children with and adolescents with ongoing antipsychotic medication use who had metabolic testing during the year (APM) +	NCQA	✓		✓	36.87%	34.21%	38.41%	45.36%
5.9a:	Increase the rate of antidepressant medication management (AMM)—Effective acute phase treatment+	NCQA	✓	✓		54.63%	—	56.85%	—
5.9b:	Increase the rate of antidepressant medication management (AMM)—Effective continuation phase treatment+	NCQA	✓	✓		37.19%	—	41.55%	—
5.10:	Increase the use of first-line psychosocial care for children and adolescents on antipsychotics (APP) †	NCQA	✓		✓	54.53%	58.54%	63.72%	MNA
5.11a:	Increase the rate of inpatient, residential treatment and detoxification visits or discharges for a diagnosis of substance use disorder (SUD) among patients 13 years of age and older that resulted in follow-up care for a diagnosis of SUD within 7 days (FUI) †	NCQA	✓			46.16%	—	34.67%	—
5.11b:	Increase the rate of inpatient, residential treatment and detoxification visits or discharges for a diagnosis of substance use disorder (SUD) among patients 13 years of age and older that resulted in follow-up care for a diagnosis of SUD within 30 days (FUI) †	NCQA	✓			28.78%	—	50.37%	—

Goal 5—Increase use of evidence-based practices for members with behavioral health conditions by December 31, 2024.									
			Measure Set					MPS	
Objective #	Objective Description	Measure Steward	HEDIS	Adult Core Set	Child Core Set	Medicaid Aggregate MY 2023	Nevada Check Up Aggregate MY 2023	Medicaid	Nevada Check Up
5.12:	Increase the rate of opioid use disorder (OUD) pharmacotherapy treatment events among members ages 16 and older that continue for at least 180 days (6 months) (OUD)—total †	NCQA	✓			52.45%	—	59.25%	—
5.13a:	Increase the rate of screening for depression and follow-up plan for members (CDF)—12–17 years†∞	CMS			✓	0.60%	0.46%	10.41%	10.27%
5.13b:	Increase the rate of screening for depression and follow-up plan for members (CDF)—18–64 years†∞	CMS		✓		2.81%	1.92%	11.21%	10.71%

Goal 6—Increase utilization of dental services by December 31, 2024.									
			Measure Set					MPS	
Objective #	Objective Description	Measure Steward	HEDIS	Adult Core Set	Child Core Set	Medicaid Aggregate MY 2023	Nevada Check Up Aggregate MY 2023	Medicaid	Nevada Check Up
6.1:	Increase the rate of children under age 21 who received a comprehensive or periodic oral evaluation within the reporting year—Total (OEV-CH)[1†]	DQA**			✓	39.75%	51.30%	45.68%	55.14%
6.2:	Increase the rate of children aged 1 through 20 years who received at least 2 topical fluoride applications within the reporting year—Dental or Oral Health Services—Total (TFL-CH)[1†]	DQA			✓	17.30%	25.88%	24.63%	31.73%

Goal 6—Increase utilization of dental services by December 31, 2024.									
			Measure Set					MPS	
Objective #	Objective Description	Measure Steward	HEDIS	Adult Core Set	Child Core Set	Medicaid Aggregate MY 2023	Nevada Check Up Aggregate MY 2023	Medicaid	Nevada Check Up
6.3a:	Increase the rate of enrolled children who have ever received sealants on a permanent first molar tooth: at least one sealant by 10th birthdate (SFM-CH)[1†]	DQA			✓	56.69%	60.64%	59.73%	66.50%
6.3b:	Increase the rate of enrolled children who have ever received sealants on a permanent first molar tooth: all four molars sealed by 10th birthdate (SFM-CH)[1†]	DQA			✓	38.30%	40.75%	44.36%	49.11%

Goal 7—Reduce and/or eliminate health care disparities for Medicaid members by December 31, 2024		
Objective #	Objective Description	DHCFP Evaluation (*Met*/*Not Met*)
7.1	Ensure that health plans maintain, submit for review, and annually revise cultural competency plans.	***Met***
7.2	Stratify data for performance measures by race and ethnicity to determine where disparities exist. Continually identify, organize, and target interventions to reduce disparities and improve access to appropriate services for the Medicaid and Nevada Check Up population.	***Met***
7.3	Ensure that each MCO submits an annual evaluation of its cultural competency programs to the DHCFP. The MCOs must receive a 100 percent *Met* compliance score for all criteria listed in the MCO contract for cultural competency program development, maintenance, and evaluation.	***Met***

[1] This goal only applies to **LIBERTY**; therefore, the rates displayed are not aggregate rates.

♦ Individual MCO denominators for this measure and/or indicator were less than 30 resulting in an "NA" audit designation; however, when the MCO rates were combined to generate the statewide aggregate rate, the denominator was large enough to be reported and subsequently compared to the MPS.

+ Indicates measure has an MPS based on MY 2020 data as baseline data and is based on a QISMC goal.

† Indicates measure has a new MPS developed from MY 2022 data as baseline data and is based on a QISMC goal.

∞ MCOs reported *CDF—18—64 years and CDF—65 years and older* to align with the CMS Adult Core Set FFY 2024 technical specifications. HSAG assessed each indicator separately to determine whether the MCOs met or exceeded DHCFP's QISMC goal for *CDF—18 years and older.*

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

** Dental Quality Alliance.

Dash (—) indicates that the MCO was not required to report this measure and/or the objective does not apply to the population.

MNA indicates the MPS will be established when the baseline rate is available.

NA (not applicable) indicates that the MCO followed the specifications, but the denominator was too small (i.e., <30) to report a valid rate.

Indicates that the HEDIS MY 2023 Medicaid aggregate or Nevada Check Up aggregate performance measure rate met or exceeded the DHCFP-established