Division of Health Care Financing and Policy
Nevada Medicaid Managed Care

State Fiscal Year 2018–2019 External Quality Review Technical Report

November 2019

HSAG HEALTH SERVICES ADVISORY GROUP

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Acknowledgements and Copyrights

1. Executive Summary

Overview of the SFY 2018–2019 External Quality Review

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, requires that states that contract with Medicaid managed care organizations (MCOs) and prepaid ambulatory health plans (PAHPs) shall provide for an independent external quality review (EQR) by a qualified external quality review organization (EQRO) of the quality outcomes and timeliness of, and access to, services provided by contracted MCOs. The U.S. Department of Health and Human Services (DHHS), Centers for Medicare & Medicaid Services (CMS) regulates requirements and procedures for the EQR. The final rule provided in Title 42 of the Code of Federal Regulations (CFR) Section 438 implements the provisions outlined in the BBA related to Medicaid managed care oversight and EQR and outlines the responsibility of each state's contracted EQRO to prepare an annual technical report that describes the manner in which data were aggregated and analyzed and how conclusions were drawn as to the quality and timeliness of, and access to, care and services furnished by the states' MCOs and PAHP. The data comes from activities conducted in accordance with the 42 CFR §438.358. To meet these requirements, the State of Nevada, Department of Health and Human Services, Division of Health Care Financing and Policy (the DHCFP), contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO). HSAG has served as the EQRO for the DHCFP since 1999.

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

The Nevada Medicaid MCOs included in the state fiscal year (SFY) 2018–2019 external quality review (EQR) were **Anthem Blue Cross and Blue Shield Healthcare Solutions** (**Anthem**), **Health Plan of Nevada** (**HPN**), and **SilverSummit Healthplan, Inc.** (**SilverSummit**), which operate in both Clark and Washoe counties. In 2017, the DHCFP procured a dental PAHP, **LIBERTY Dental Plan of Nevada, Inc.** (**LIBERTY**), to serve as the DHCFP's dental benefits administrator (DBA) for Clark and Washoe counties. This report presents the results from the EQR activities performed during SFY 2018–2019 for the MCOs and **LIBERTY**.

The SFY 2018–2019 EQR Technical Report includes a review of recipients' access to care and the quality of services received by recipients of Title XIX, Medicaid, and Title XXI, CHIP. The report focuses on three mandatory EQR activities, which were federally required during SFY 2018–2019. In addition to the mandatory activities, HSAG performed a set of optional activities at the request of the DHCFP. Those activities are detailed in Section 3 of this report.

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

- Activity objectives

- Technical methods of data collection and analysis (Appendix A-1)
- Descriptions of data obtained
- Conclusions drawn from the data

The report also includes an assessment of each MCOs' and the PAHP's strengths and weaknesses, as well as recommendations for improvement. For the MCOs, this report provides a comparison of the three health plans that operate in the Nevada Medicaid managed care program.

Lastly, consistent with 42 CFR §438.364(a)(6), HSAG has included in Section 11 of this report an assessment of the degree to which each MCO has effectively addressed recommendations for quality improvement that HSAG made in the previous year.

Internal Quality Assurance Program (IQAP) Compliance Review of MCOs

The purpose of the SFY 2018–2019 IQAP review of compliance was to determine each MCO's compliance with various access and operations standards specific to member services and experiences. To accomplish this objective, HSAG:

- Determined each plan's compliance with the five standards related to member services and experiences.
- Conducted checklist reviews to validate that the MCO met contract and federal requirements for member rights and responsibilities and member handbook information.
- Conducted a review of individual files for the areas of grievances, appeals, care management, and service denials.

Table 1-1 summarizes the MCOs' results for these IQAP standards, checklists, and file reviews for the SFY 2018–2019 IQAP compliance review. In addition, the table presents the overall composite score for each MCO for all areas reviewed.

Table 1-1—Summary of MCO Scores for the IQAP Compliance Review

IQAP Compliance Activity	Anthem	HPN	SilverSummit
IQAP Standards Score	95.8%	96.4%	94.3 %
Checklists Score	100%	100%	95.6%
File Review Score	100%	99.1%	87.4%
Overall Composite Score	**98.9%**	**98.5%**	**90.2%**

The overall composite score for **Anthem** was 98.9 percent; for **HPN** it was 98.5 percent; and for **SilverSummit** it was 90.2 percent. The compliance scores showed the MCOs' demonstrated adherence to most of the standards and contract requirements reviewed. Detailed results of the IQAP review are presented in Section 4 of this report.

Validation of Performance Measures—National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) Compliance Audits of MCOs

Medicaid Findings

Table 1-2 displays the HEDIS 2019 Medicaid performance measure rate results for **Anthem**, **HPN**, and **SilverSummit** and the Medicaid aggregate, which represents the average of all MCOs' measure rates weighted by the eligible population. Since **SilverSummit** was a new MCO in HEDIS 2019, HEDIS 2018 rates and 2018–2019 rate comparisons are not available; therefore, green and red shading could not be applied to **SilverSummit**'s rates in Table 1-2. Measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures in the Utilization domain are designed to capture the frequency of services provided by the MCO. With the exception of the *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total*, higher or lower rates in this domain do not necessarily indicate better or worse performance. Therefore, these rates are provided for informational purposes only.

Table 1-2—HEDIS 2019 Results for Medicaid

HEDIS Measure	Anthem	HPN	SilverSummit	Medicaid**
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services (AAP)[1]				
Ages 20–44 Years	73.27%	73.09%	62.35%	72.19%
Ages 45–64 Years	80.05%	78.58%	72.28%	78.55%
Ages 65 Years and Older	NA	33.08%	NA	35.36%
Total	75.38%	74.92%	65.40%	74.26%
Children and Adolescents' Access to Primary Care Practitioners (CAP)				
Ages 12–24 Months	94.78%	94.20%	88.56%	94.04%
Ages 25 Months–6 Years	84.36%	83.38%	71.50%	83.21%
Ages 7–11 Years	85.94%	86.45%	NA	86.22%
Ages 12–19 Years	84.54%	84.83%	NA	84.72%
Children's Preventive Care				
Adolescent Well-Care Visits (AWC)				
Adolescent Well-Care Visits	**56.45%**	48.66%	36.50%	50.60%
Childhood Immunization Status (CIS)[1]				
Combination 2	72.99%	72.02%	46.25%	72.08%
Combination 3	**69.83%**	68.37%	43.13%	68.65%
Combination 4	**69.34%**	67.64%	43.13%	68.04%

HEDIS Measure	Anthem	HPN	SilverSummit	Medicaid**
Combination 5	**59.85%**	**60.10%**	34.38%	59.63%
Combination 6	34.79%	**39.42%**	16.25%	37.09%
Combination 7	**59.37%**	**59.61%**	34.38%	59.15%
Combination 8	34.79%	**39.42%**	16.25%	37.09%
Combination 9	30.41%	**35.52%**	13.13%	33.00%
Combination 10	30.41%	**35.52%**	13.13%	33.00%
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	**89.29%**	**89.05%**	67.70%	88.74%
Combination 2 (Meningococcal, Tdap, HPV)	41.12%	43.55%	19.25%	42.20%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
Body Mass Index (BMI) Percentile Documentation—Total	**82.73%**	78.59%	70.56%	79.86%
Counseling for Nutrition—Total	**74.21%**	68.37%	66.42%	70.58%
Counseling for Physical Activity—Total	67.88%	64.96%	60.58%	65.92%
Well-Child Visits in the First 15 Months of Life (W15)				
Six or More Well-Child Visits	**68.06%**	63.75%	51.88%	65.35%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.17%	66.42%	59.37%	68.91%
Women's Health and Maternity Care				
Breast Cancer Screening (BCS)[1]				
Breast Cancer Screening	51.93%	54.13%	NA	53.44%
Prenatal and Postpartum Care (PPC)				
Timeliness of Prenatal Care	**80.78%**	**80.54%**	66.42%	79.14%
Postpartum Care	59.37%	**64.96%**	48.42%	61.07%
Care for Chronic Conditions				
Comprehensive Diabetes Care (CDC)[1]				
Hemoglobin A1c (HbA1c) Testing	77.37%	81.02%	79.08%	79.70%
*HbA1c Poor Control (>9.0%)**	45.01%	43.31%	57.66%	44.76%
HbA1c Control (<8.0%)	47.45%	49.64%	34.55%	47.98%
Eye Exam (Retinal) Performed	52.31%	**62.77%**	46.47%	58.33%

HEDIS Measure	Anthem	HPN	SilverSummit	Medicaid**
Medical Attention for Nephropathy	87.59%	85.16%	87.59%	86.11%
Blood Pressure Control (<140/90 mm Hg)	52.31%	63.26%	46.23%	58.61%
Controlling High Blood Pressure (CBP)[2]				
Controlling High Blood Pressure	52.55%	**62.53%**	43.55%	58.03%
Medication Management for People With Asthma (MMA)[1]				
Medication Compliance 50%—Total	**61.19%**	59.39%	NA	60.11%
Medication Compliance 75%—Total	35.90%	36.08%	NA	36.01%
Behavioral Health				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)[1]				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	35.32%	41.95%	35.06%	38.54%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)[1]				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	80.48%	76.38%	78.06%	78.05%
Follow-Up After Emergency Department (ED) Visit for Alcohol or Other Drug (AOD) Abuse or Dependence (FUA)				
7-Day Follow-Up—Total	9.25%	15.48%	11.93%	12.84%
30-Day Follow-Up—Total	13.99%	21.02%	15.33%	17.79%
Follow-Up After ED Visit for Mental Illness (FUM)[2]				
7-Day Follow-Up—Total	28.77%	**47.82%**	26.19%	38.76%
30-Day Follow-Up—Total	41.41%	**57.48%**	35.46%	49.25%
Follow-Up After Hospitalization for Mental Illness (FUH)[1]				
7-Day Follow-Up—Total	33.52%	29.11%	22.40%	30.08%
30-Day Follow-Up—Total	50.33%	49.80%	36.72%	48.01%
Follow-Up Care for Children Prescribed Attention Deficit-Hyperactivity Disorder (ADHD) Medication (ADD)				
Initiation Phase	46.77%	**52.29%**	NA	49.75%
Continuation and Maintenance Phase	**66.10%**	**69.77%**	NA	67.35%
Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)				
Initiation of AOD Treatment—Total	**49.65%**	40.22%	**46.30%**	44.57%
Engagement of AOD Treatment—Total	14.78%	10.01%	13.37%	12.24%

HEDIS Measure	Anthem	HPN	SilverSummit	Medicaid**
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)				
Total	23.18%	20.00%	23.08%	21.53%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)*[1]				
Total	**0.00%**	**2.25%**	**1.92%**	1.46%
Utilization				
Ambulatory Care—Total (per 1,000, Member Months) (AMB)				
*ED Visits—Total**	56.03	54.66	61.33	55.86
Outpatient Visits—Total[1]	288.52	297.98	258.11	290.38
***Mental Health Utilization—Total (MPT)*[2]**				
Inpatient—Total	1.39%	0.82%	1.63%	1.11%
Intensive Outpatient or Partial Hospitalization—Total	0.61%	0.22%	0.16%	0.35%
Outpatient—Total	10.14%	8.13%	12.14%	9.28%
ED—Total	0.50%	0.03%	0.10%	0.21%
Telehealth—Total	0.03%	0.00%	0.06%	0.02%
Any Service—Total	10.68%	8.30%	12.80%	9.63%
Overuse/Appropriateness of Care				
Use of Opioids At High Dosage (UOD)*[2]				
Use of Opioids at High Dosage	7.24%	7.86%	3.77%	7.43%
Use of Opioids From Multiple Providers (UOP)*[2]				
Multiple Prescribers	21.55%	26.56%	23.52%	24.92%
Multiple Pharmacies	1.61%	4.26%	4.37%	3.51%
Multiple Prescribers and Multiple Pharmacies	0.83%	2.12%	2.81%	1.80%

[1] Due to changes in the technical specifications for this measure, NCQA recommends trending between HEDIS 2019 and prior years be considered with caution.

[2] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS 2019 and prior years; therefore, prior years' rates are not displayed, and rate comparisons are not performed for this measure.

* A lower rate indicates better performances for this measure.

***Medicaid* refers to the HEDIS rates that are applicable to members under the Medicaid managed care program and does not include data from FFS Medicaid.

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

Bolded rates indicate that the performance measure rate for HEDIS 2019 was at or above the minimum performance standard (MPS).

Indicates that the HEDIS 2019 rate declined by 5 percentage points or more from HEDIS 2018.

Indicates that the HEDIS 2019 rate improved by 5 percentage points or more from HEDIS 2018.

Nevada Check Up Findings

Table 1-3 displays, by MCO, the HEDIS 2019 Nevada Check Up performance measure rate results for **Anthem**, **HPN**, **SilverSummit**, and the Nevada Check Up aggregate, which represents the average of all MCOs' measure rates weighted by the eligible population. Since **SilverSummit** was a new MCO in HEDIS 2019, HEDIS 2018 rates and 2018–2019 rate comparisons are not available; therefore, green and red shading could not be applied to **SilverSummit**'s rates in Table 1-3. Measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures in the Utilization domain are designed to capture the frequency of services provided by the MCO. With the exception of the *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total*, higher or lower rates in this domain do not necessarily indicate better or worse performance. Therefore, these rates are provided for informational purposes only.

Table 1-3—HEDIS 2018 Results for Nevada Check Up

HEDIS Measure	Anthem	HPN	SilverSummit	NV Check Up
Access to Care				
Children and Adolescents' Access to Primary Care Practitioners (CAP)				
Ages 12–24 Months	**99.56%**	**97.81%**	94.12%	98.15%
Ages 25 Months–6 Years	**91.09%**	**91.10%**	83.54%	90.78%
Ages 7–11 Years	92.04%	93.27%	NA	92.78%
Ages 12–19 Years	91.03%	90.82%	NA	90.89%
Children's Preventive Care				
Adolescent Well-Care Visits (AWC)				
Adolescent Well-Care Visits	**67.40%**	60.10%	45.28%	61.74%
Childhood Immunization Status (CIS)[1]				
Combination 2	87.21%	87.57%	NA	87.23%
Combination 3	**84.02%**	**84.32%**	NA	84.04%
Combination 4	**84.02%**	**83.73%**	NA	83.69%
Combination 5	74.43%	76.63%	NA	75.53%
Combination 6	**47.95%**	46.15%	NA	46.63%
Combination 7	74.43%	76.33%	NA	75.36%
Combination 8	**47.95%**	46.15%	NA	46.63%
Combination 9	42.47%	42.01%	NA	42.02%
Combination 10	42.47%	42.01%	NA	42.02%

HEDIS Measure	Anthem	HPN	SilverSummit	NV Check Up
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	**93.63%**	**93.92%**	NA	93.43%
Combination 2 (Meningococcal, Tdap, HPV)	51.96%	56.20%	NA	54.34%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile Documentation—Total	**87.83%**	83.45%	76.16%	84.77%
Counseling for Nutrition—Total	**79.56%**	74.70%	69.59%	76.26%
Counseling for Physical Activity—Total	**73.48%**	72.02%	64.72%	72.28%
Well-Child Visits in the First 15 Months of Life (W15)				
Six or More Well-Child Visits	**82.26%**	73.19%	NA	76.18%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	77.62%	77.62%	59.56%	76.85%
Care for Chronic Conditions				
Medication Management for People With Asthma (MMA)[1]				
Medication Compliance 50%—Total	**59.62%**	55.22%	NA	56.72%
Medication Compliance 75%—Total	36.54%	33.33%	NA	34.43%
Behavioral Health				
Follow-Up After ED Visit for Mental Illness (FUM)[2]				
7-Day Follow-Up—Total	NA	66.67%	NA	57.14%
30-Day Follow-Up—Total	NA	80.00%	NA	69.05%
Follow-Up After Hospitalization for Mental Illness (FUH)[1]				
7-Day Follow-Up—Total	NA	NA	NA	53.57%
30-Day Follow-Up—Total	NA	NA	NA	73.21%
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
Initiation Phase	42.42%	**58.11%**	NA	53.27%
Continuation and Maintenance Phase	NA	NA	NA	NA
Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)				
Initiation of AOD Treatment—Total	NA	NA	NA	30.00%
Engagement of AOD Treatment—Total	NA	NA	NA	10.00%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)				
Total	NA	25.58%	NA	26.67%

HEDIS Measure	Anthem	HPN	SilverSummit	NV Check Up
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)**[1]				
Total	NA	**0.00%**	NA	0.00%
Utilization				
Ambulatory Care—Total (per 1,000, Member Months) (AMB)				
*ED Visits—Total**	25.74	22.99	26.36	24.20
Outpatient Visits—Total[1]	242.04	246.47	192.98	240.82
Mental Health Utilization—Total (MPT)[2]				
Inpatient—Total	0.26%	0.18%	0.73%	0.25%
Intensive Outpatient or Partial Hospitalization—Total	0.34%	0.14%	0.05%	0.20%
Outpatient—Total	6.96%	6.55%	7.14%	6.74%
ED—Total	0.14%	0.03%	0.00%	0.07%
Telehealth—Total	0.00%	0.00%	0.00%	0.00%
Any Service—Total	7.02%	6.60%	7.30%	6.80%

[1] Due to changes in the technical specifications for this measure, NCQA recommends trending between HEDIS 2019 and prior years be considered with caution.

[2] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS 2019 and prior years; therefore, prior years' rates are not displayed, and rate comparisons are not performed for this measure.

* A lower rate indicates better performances for this measure.

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

Bolded rates indicate that the performance measure rate for HEDIS 2019 was at or above the MPS.

Indicates that the HEDIS 2019 rate declined by 5 percentage points or more from HEDIS 2018.

Indicates that the HEDIS 2019 rate improved by 5 percentage points or more from HEDIS 2018.

A summary of each MCO's HEDIS results are presented in Section 5 of this report.

Validation of Performance Improvement Projects (PIPs) for MCOs

In SFY 2018–2019, the MCOs continued using the rapid-cycle PIP approach for the two DHCFP selected PIP topics: *Follow-up After Emergency Department Visit for Mental Health Diagnosis (FUM)* and *Increase 3–6-Year-Old Well-Child Primary Care Practitioner (PCP) Visits*. During validation, HSAG determined if criteria for each module were *Achieved.* Any validation criteria not applicable (*N/A*) were not scored. As the PIP progresses, and at the completion of Module 5, HSAG will use the validation findings from modules 1 through 5 for each PIP to determine a level of confidence representing the validity and reliability of the PIP. Table 1-4 details the level of achievement for each module submitted by each MCO for both PIPs.

Table 1-4—PIP Results

PIP Title	Anthem PIP Module Results	HPN PIP Module Results	SilverSummit PIP Module Results
Follow-up After Emergency Department Visit for Mental Health Diagnosis (FUM)	Module 4 #1: *Achieved* Module 4 #2: *Not Achieved* Module 5*: Low Confidence*	Module 4 #1: *Not Achieved* Module 4 #2: *Not Achieved* Module 5: *Low Confidence*	Module 3: *Achieved*
Increase Well-Child Visits for Children 3–6 Years of Age (W34)	Module 4 #1: *Not Achieved* Module 4 #2: *Not Achieved* Module 5: *Reported PIP Results Were Not Credible*	Module 4 #1: *Not Achieved* Module 4 #2: *Not Achieved* Module 5: *Low Confidence*	Module 3: *Achieved*

Table 1-4 shows that **Anthem** and **HPN** completed two Module 4's per topic and one Module 5 per topic, while **SilverSummit** completed Module 3. All MCOs PIPs were methodologically sound projects; however, not all validation criteria were achieved across the validated modules. For **Anthem**'s *FUM* PIP, the SMART Aim goal was exceeded. However, the improvement was prior to intervention testing; therefore, HSAG could not link the demonstrated improvement to the quality improvement processes or interventions conducted by the MCO. This resulted in the *Low Confidence* assigned to the PIP. For the *W34* PIP, the approved methodology for the SMART Aim measure was not used in the final SMART Aim run chart and resulted in a confidence level of *Reported PIP Results Were Not Credible*. For **HPN**'s *FUM* and *W34* PIPs, the MCO did not provide the required data and the SMART Aim goal was not achieved, resulting in the *Low Confidence* rating for both topics. **SilverSummit** progressed to completing Module 3 and determining interventions to test using Plan-Do-Study-Act (PDSA) cycles. **SilverSummit** achieved the validation criteria for both Module 3's submitted for validation. Details of each MCO's PIP validation are presented in Section 6 of this report.

Encounter Data Validation (EDV) of MCOs

During SFY 2017–2018, the DHCFP contracted HSAG to conduct an EDV study. The goal of the study was to determine the extent to which professional, institutional, and pharmacy encounters submitted to the DHCFP by contracted MCOs are complete and accurate.

In alignment with the CMS *EQR Protocol 4: Validation of Encounter Data Reported by the MCO: A Voluntary Protocol for External Quality Review (EQR)*, Version 2.0, September 2012,[1-1] HSAG conducted the following three core evaluation activities for the EDV activity:

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 4: Validation of Encounter Data Reported by the MCO: A Voluntary Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: June 7, 2018.

- Information systems (IS) review—assessment of the DHCFP's and/or MCOs' information systems and processes
- Comparative analysis—analysis of the DHCFP's electronic encounter data completeness and accuracy through a comparative analysis between the DHCFP's electronic encounter data and the data extracted from the MCOs' data systems
- Medical record review (MRR)—analysis of the DHCFP's electronic encounter data completeness and accuracy through a review of a sample of medical records for physician services rendered during the study period

Information Systems Review

The IS review component of the study provided self-reported qualitative information from the DHCFP and the MCOs regarding encounter data processes. Based on contractual requirements and the DHCFP data submission requirements (e.g., companion guides), both MCOs have established encounter data submission and oversight processes, although formal documentation (e.g., policies and procedures) may not have been submitted with each MCO's questionnaire response. While each MCO has a defined encounter data system and processes for receiving inbound claims and encounter data and for submitting encounter data to the DHCFP, questionnaire responses revealed variations in data processes, especially those related to submission of payment data.

Both MCOs provided high-level descriptions of the reports and/or data edits used to monitor the accuracy and completeness of data submitted by vendors (e.g., pharmacy claims) and providers. It was unclear from the MCO responses whether the lack of supporting documentation provided with the questionnaires reflects an MCO's incomplete processing of the questionnaire or the general unavailability of such documents. Both outcomes suggest a lack of systematic documentation (e.g., policies and procedures, monitoring mechanisms) that may contribute to inconsistency in the processing and quality of encounter data over time, especially pertaining to specific data-processing scenarios (e.g., receiving, processing, and submitting payment data or adjusted claims).

When considering encounter data monitoring from the State's perspective, the DHCFP has established performance standards for the MCOs' submission, accuracy, and timeliness of encounter data. The DHCFP reported having no evaluation metrics in place to assess the quality of MCOs' monthly encounter submissions, nor is a formal process established by which to determine the accuracy and completeness of the MCOs' encounter data.

Comparative Analysis

HSAG conducted a series of comparative analyses, which were divided into two analytic sections:

- Record Completeness
- Data Element Completeness and Accuracy

Record Completeness

The overall record omission rates were low for all three encounter types (i.e., professional, institutional, and pharmacy). Overall, the pharmacy encounter type exhibited the most complete data with the lowest overall record omission and record surplus rates—i.e., 0.0 percent and 2.7 percent, respectively, while the institutional encounter type had the most incomplete data with the highest record omission (2.1 percent) and record surplus rates (6.3 percent).

Data Element Completeness and Accuracy

Overall, the levels of completeness for key data elements associated with the professional encounters were generally very high, except for the *Rendering Provider Number/NPI (National Provider Identifier)* field. During the data submission process, the DHCFP confirmed that the *Billing Provider Number/NPI* is used as a substitute *NPI* value in instances of missing *Rendering Provider Number/NPI.* However, both MCOs had missing values for these records, resulting in a high surplus rate for this field. The levels of completeness for key data elements for the institutional encounters were also generally very high for nearly all key data elements evaluated. Fields with relatively incomplete data included the *Procedure Code Modifier*, *Primary Surgical Procedure Code*, and *Secondary Diagnosis Code*.

All pharmacy data elements had high accuracy rates for the pharmacy encounters, and nine of 12 of the key data elements evaluated for the professional encounters each had an overall accuracy rate of at least 99.0 percent, except for *Recipient ID*, *Header Paid Amount*, and *Detail Paid Amount* (i.e., 45.3 percent, 84.4 percent, and 83.9 percent, respectively).

The statewide accuracy rates for all data elements evaluated within the institutional encounters were high, except for *Recipient ID* and *Secondary Diagnosis Code* (i.e., 43.4 percent and 78.6 percent, respectively). HPN's accuracy rate for the *Recipient ID* field (i.e., 0.0 percent for institutional and professional encounters) contributed to the low overall accuracy rate. The discrepancy was due to the DHCFP and HPN having entirely different values for this field.

Medical Record Review

Medical and clinical records are considered the "gold standard" for documenting Medicaid recipients' access to and quality of healthcare services. HSAG evaluated the DHCFP's encounter data completeness and accuracy via a review of medical records for physician services rendered between July 1, 2016, and June 30, 2017. This component of the study answered the following question: *Are the data elements Date of Service, Diagnosis Code, Procedure Code, and Procedure Code Modifier found on the professional encounters complete and accurate when compared to information contained within the medical records?*

HSAG conducted the following activities to answer the study question:

- Identified the eligible population and generated samples from data extracted from the DHCFP's data warehouse.

- Assisted MCOs to procure medical records from providers, as appropriate.
- Reviewed medical records against the DHCFP's encounter data.
- Calculated study indicators.

The following are summaries of the key findings from the MRR component of the study.

Encounter Data Completeness

Omissions identified in the medical records (services reported in the encounter data but not supported in the medical records) and omissions in the encounter data (services documented in the medical records but not reported in the encounter data) illustrate discrepancies in completeness of the DHCFP's encounter data. Overall, the DHCFP's encounter data are relatively complete for key data elements (i.e., *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) that were evaluated when compared to the medical records.

The *Date of Service* data element within the encounter data was well supported by the recipients' medical records, as evidenced by the low medical record omission rate of 3.4 percent. However, the *Diagnosis Code* (23.5 percent), *Procedure Code* (21.1 percent), and *Procedure Code Modifier* (35.4 percent) data elements within the encounter data were moderately supported by the medical records. Both Anthem and HPN had similar rates for medical record omission for all data elements, where the difference between the MCOs' rates was less than 5 percentage points for each of the evaluated data elements.

In contrast, the relatively low encounter data omission rates indicate that the key data elements (i.e., *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) found in the recipients' medical records were well-supported by the data found in the electronic data extracted from the DHCFP's data warehouse, with rates ranging from 2.8 percent (*Date of Service*) to 5.6 percent (*Procedure Code*). Both Anthem and HPN had similar rates for encounter data omission for all data elements, where the difference between the MCOs' rates was less than 5 percentage points for each of the evaluated data elements.

Encounter Data Accuracy

Overall, when key data elements were present in both the DHCFP's encounter data and the medical records and were evaluated independently, the data elements were found to be accurate. Among the data elements evaluated, 98.7 percent of *Diagnosis Codes*, 94.5 percent of *Procedure Codes*, and 98.9 percent of *Procedure Code Modifiers* present in both sources were accurate.

Nearly 50 percent of the dates of service present in both sources accurately represented all three data elements (*Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) when compared to the recipients' medical records.

Network Adequacy Validation (NAV) of MCOs

During SFY 2018–2019, HSAG prepared a provider crosswalk and conducted a baseline provider composition analysis (PCA) of the Medicaid provider network for all MCOs. In preparation for the release of the protocol, HSAG applied the provider crosswalk file to the MCOs' provider networks to assess network composition differences across MCOs. Additionally, in future years, the provider crosswalk is a tool that can be used for network adequacy validation analyses (e.g., time/distance and provider ratio analyses). The goals of the SFY 2018–2019 NAV were:

- To understand the MCOs' provider data structure and methods for classifying providers, as assessed by the provider data structure questionnaire.
- To create a provider crosswalk that outlines consistent definitions and methods for identifying providers in the identified provider categories.
- To conduct a baseline PCA that assesses the number of providers in each provider category after applying the results of the provider crosswalk to the MCOs' submitted data.

HSAG collaborated with the DHCFP to build provider crosswalks, which describe how to identify a variety of providers in the following categories: PCPs, specialists, behavioral health providers, and healthcare facilities. Provider categories were identified using a combination of provider type, provider specialty, taxonomy code, and/or professional degree. These provider crosswalks will be used to consistently categorize providers for future network adequacy validation activities.

In using the crosswalks to conduct the PCA, HSAG identified, in general, a greater number of unique providers in the DHCFP's provider data files than the MCOs' provider data. Across the DHCFP and the MCOs, there were limited numbers of pediatric specialist providers. The most common pediatric specialist was pediatric cardiologist, but neither the DHCFP nor the MCOs reported any pediatric dermatologists or pediatric physical medicine providers.

The most common behavioral health provider category was counselor for the DHCFP, **Anthem**, and **SilverSummit**; however, behavior analyst/technician was the most common behavioral health provider category for **HPN**. HSAG identified no outpatient mental health facilities in the DHCFP's or **HPN**'s provider data. This may indicate a lack of facilities in the provider data or a potential challenge to identifying the facilities through the defined classification schemes.

None of the MCOs nor the DHCFP identified pediatric hospitals in their data. **Anthem** is the only MCO that had no hospice facilities. While the DHCFP and **HPN** had 138 and 443 pharmacies identified in their data, respectively, **Anthem** reported nine pharmacies and **SilverSummit** reported only two. This may be due to a lack of pharmacies in the provider networks or an inability to identify them in the provider data.

Summary of the Quality and Timeliness of, and Access to, Care Furnished by MCOs

Anthem

Overall, **Anthem** demonstrated mixed performance related to the domains of quality and timeliness of, and access to, care. The most notable improvement demonstrated by **Anthem** related to the following Medicaid measures that improved by five percentage points or more from HEDIS 2018 to HEDIS 2019: *Adolescent Well-Care Visits, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile, Medication Management for People with Asthma—Medication Compliance 50%, Follow-Up Care for Children Prescribed ADHD Medication*, and *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation Phase.* **Anthem** also demonstrated strong performance for each of the member-focused standards reviewed as part of the IQAP compliance review. There were roughly 15 measures that declined from HEDIS 2018 to HEDIS 2019 across all domains, although some of the declines were slight. The following three measures declined by five percentage points or more: *Comprehensive Diabetes Care—HbA1c Testing, Follow-Up After Hospitalization for Mental Illness—7-Day Follow Up* and *30-Day Follow-Up*. **Anthem** should determine which declines were significant and what intervention might be needed to improve declining rates.

HPN

Overall, **HPN** demonstrated better performance related to the quality of care domain and mixed performance related to the timeliness and access to care domains. The most notable improvement demonstrated by HPN related to the following Medicaid measures that improved by five percentage points or more from HEDIS 2018 to HEDIS 2019: *Childhood Immunization Status—Combinations 5, 6, 7, 8, 9, and 10; Immunization for Adolescents—Combination 1; Prenatal and Postpartum Care; Follow-Up After ED Visit for AOD Abuse or Dependence; Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up; Follow-Up Care for Children Prescribed ADHD Medicaid—Continuation and Maintenance Phase;* and *Metabolic Monitoring for Children and Adolescents on Antipsychotics*. **HPN** also demonstrated strong performance for each of the member-focused standards reviewed as part of the IQAP compliance review. **HPN** only saw one Medicaid measure, *Adults' Access to Preventive/Ambulatory Health Services—Ages 65 Years and Older,* decline by more than five percentage points. The same measure actually declined by 27.45 percentage points, which is significant and should be investigated by **HPN** staff members as to why the denominator for this age group is so much higher than the denominators for other MCOs for the same age group and what drove the sharp decline.

SilverSummit

Since **SilverSummit** was a new MCO for HEDIS 2019, performance for **SilverSummit**'s Medicaid and Nevada Check Up populations were not evaluated in terms of access to and quality and timeliness of care. **SilverSummit**'s performance will be assessed in future reports once additional data are available.

LIBERTY Dental

The following sections summarize the EQR activities that were performed for the dental PAHP.

IQAP Compliance Review

The purpose of the SFY 2018–2019 IQAP review of compliance was to determine **LIBERTY**'s compliance with various access and operations standards specific to member services and experiences. To accomplish this objective, HSAG:

- Determined **LIBERTY**'s compliance with the five standards related to member services and experiences.
- Conducted checklist reviews to validate that **LIBERTY** met contract and federal requirements for member rights and responsibilities and member handbook information.
- Conducted a review of individual files for the areas of grievances, appeals, and service denials.

Table 1-5 displays the **LIBERTY**'s IQAP compliance review scores for the IQAP standards, checklists, and file reviews.

Table 1-5—Summary of LIBERTY Scores for the IQAP Compliance Review

IQAP Compliance Activity	LIBERTY
IQAP Standards Score	87.3%
Checklists Score	100%
File Review Score	97.1%
Overall Composite Score	**94.1%**

The lowest of the scores related to the IQAP standards, which demonstrates **LIBERTY**'s compliance in some areas and non-compliance in other areas. The areas with the greatest opportunity for improvement for IQAP standards were related to Standard VII—*Continuity and Coordination of Care*, Standard IX—*Grievances and Appeals*, and Standard X—*Coverage and Authorization of Services*, which received scores of 75.0 percent, 80.3 percent, and 87.5 percent, respectively.

The file reviews showed relatively strong performance. The area with the greatest opportunity for improvement for file reviews related to appeals, which highlighted compliance with 42 of 44 elements. Documentation that demonstrated **LIBERTY** made reasonable efforts to give oral notice of resolution to

the member for an expedited appeal was not found in the appeal file. Further, one expedited appeal was not resolved within the required 72-hour time frame.

It was noted during the file reviews that the dental record request letter to the provider included instructions that providers could email the dental records containing protected health information (PHI) to the DBA. It was not clear if encrypted and secure email would be used and **LIBERTY** did not instruct the provider to use secure methods to transmit PHI. During **LIBERTY**'s Readiness Review completed in 2017, this issue was also noted. **LIBERTY** submitted a corrective action plan (CAP) that included revisions to the dental request letter template that instructed the provider that email encryption must be used if the dental provider chose to send dental records via email; however, the CAP was not implemented. While **LIBERTY**'s email system may be secure and encrypted, a dental provider's email system may not be. An increased risk for a breach of PHI when transmitting dental records from unsecure emails remains a serious concern. HSAG recommended that **LIBERTY** staff members have further discussion with DHCFP staff members to determine next steps to address this matter.

Performance Measure Validation

Medicaid Findings

LIBERTY was only required to report two measures for the Medicaid population: *Annual Dental Visit—Total* and *Percentage of Eligibles Who Received Preventive Dental Services*. The only measure rate with an established MPS (*Annual Dental Visit—Total*) fell below the MPS for HEDIS 2019.

Table 1-6—Medicaid HEDIS Performance Measures Results for LIBERTY

Measures	HEDIS 2019 Rate	MPS
Annual Dental Visit (ADV)		
Total	50.67%	57.62%
Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH)		
Percentage of Eligibles Who Received Preventive Dental Services	39.76%	—

— Indicates that DHCFP has not established an MPS for this measure for HEDIS 2019.

Nevada Check Up Findings

LIBERTY was only required to report two measures for the Nevada Check Up population: *Annual Dental Visit—Total* and *Percentage of Eligibles Who Received Preventive Dental Services*. The only measure rate with an established MPS (*Annual Dental Visit—Total*) fell below the MPS for HEDIS 2019.

Table 1-7—Nevada Check Up HEDIS Performance Measures Results for LIBERTY

Measures	HEDIS 2019 Rate	MPS
Annual Dental Visit (ADV)		
Total	66.33%	71.63%
Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH)		
Percentage of Eligibles Who Received Preventive Dental Services	54.01%	—

— Indicates that DHCFP has not established an MPS for this measure for HEDIS 2019.

Performance Improvement Projects

In SFY 2018–2019, HSAG, **LIBERTY**, and the DHCFP collaborated to determine the PIP topics for the two mandatory PIPs. The selected topics are: *Improve Caries Risk Assessment Completion Rate* and *Annual Dental Visits*. During validation, HSAG determined if criteria for each module were *Achieved.* Any validation criteria not applicable (*N/A*) were not scored. As the PIP progresses, and at the completion of Module 5, HSAG will use the validation findings from modules 1 through 5 for each PIP to determine a level of confidence representing the validity and reliability of the PIP. Table 1-8 details the level of achievement for each module submitted by the PAHP for both PIPs.

Table 1-8—LIBERTY PIP Results

PIP Title	LIBERTY PIP Module Results
Improving Caries Risk Assessment Completion Rate	Module 1: *Achieved* Module 2: *Achieved* Module 3*: Achieved*
Improving Annual Dental Visits	Module 1: *Achieved* Module 2: *Achieved* Module 3: *Achieved*

Table 1-8 shows that **LIBERTY** successfully completed modules 1 through 3 and developed methodologically sound projects. **LIBERTY** demonstrated the use of internal and external quality improvement teams, developed collaborative partnerships, and used quality improvement science tools to identify opportunities for improvement and determine appropriate targeted interventions to test. Details of the PAHP's PIP validations are presented in Section 10 of this report.

Network Adequacy Validation

During SFY 2018–2019, HSAG prepared a provider crosswalk and conducted a baseline PCA of the Medicaid provider network for the DBA/PAHP, **LIBERTY**. In preparation for the publication of the EQR validation of network adequacy protocol, HSAG applied the provider crosswalk file to **LIBERTY**'s provider network to assess network composition. Additionally, in future years, the

provider crosswalk is a tool that can be used for network adequacy validation analyses (e.g., time/distance and provider ratio analyses). The goals of the SFY 2018–2019 NAV were:

- To understand **LIBERTY**'s provider data structure and methods for classifying providers as assessed by the provider data structure questionnaire.
- To create a provider crosswalk that outlines consistent definitions and methods for identifying providers in the identified dental provider categories.
- To conduct a baseline PCA that assesses the number of providers in each provider category after applying the results of the provider crosswalk to **LIBERTY**'s submitted data.

HSAG collaborated with the DHCFP to build a provider crosswalk, which describes how to identify a variety of providers. Provider categories were identified using a combination of provider type, provider specialty, taxonomy code, and/or professional degree.

In using the crosswalks to conduct the PCA, HSAG found that, in general, the DHCFP had a greater number of unique providers in its provider data files than **LIBERTY**. Specifically, **LIBERTY** reported no periodontists, prosthodontists, or orthodontists. However, it is important to note that orthodontic care is carved out of the managed care dental benefit, which may explain why orthodontists were not identified in **LIBERTY**'s data.

2. Overview of Nevada Managed Care Program

Nevada State Managed Care Program

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

In April 1997, Nevada implemented voluntary managed care with several vendors. It contracted with **Health Plan of Nevada** (**HPN**) and **Amil International** (**Amil**) to provide services in Clark County, and with **Hometown Health Plan** for services in Washoe County through 2001.

In 2002, contracts were procured again with **Nevada Health Solutions** and **HPN** in both Clark and Washoe counties. **Anthem** and **HPN** won the contracts when Medicaid procured them again in November 2006. **Anthem** left the Nevada market in January 2009 and was replaced by **Amerigroup**. In 2012, the State of Nevada, Department of Health and Human Services, Division of Health Care Financing and Policy (the DHCFP) re-procured the managed care contracts, with services to begin July 1, 2013. Both **HPN** and **Amerigroup** were selected to serve as the MCOs in Clark and Washoe counties through June 30, 2017. In 2016, the DHCFP again re-procured the managed care contracts, with services starting July 1, 2017. The following bidders were selected to serve in Clark and Washoe counties: **HPN**; **Anthem Blue Cross and Blue Shield Healthcare Solutions** (**Anthem**), previously known as **Amerigroup**; **SilverSummit Healthplan Inc.** (**SilverSummit**), and **Aetna Better Health**. However, on August 31, 2017, **Aetna Better Health** terminated its contract with the DHCFP and, effective September 1, 2017, members were transitioned to one of the remaining three MCOs. In 2017, the DHCFP procured a dental prepaid ambulatory health plan (PAHP), **LIBERTY Dental Plan** (**LIBERTY**), to serve as the DHCFP's dental benefits administrator (DBA) for Clark and Washoe counties. This report displays the results from the EQR activities performed during state fiscal year (SFY) 2018–2019.

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

- Native Americans who are members of federally recognized tribes except when the MCO is the Indian Health Service, an Indian health program, or urban Indian program operated by a tribe or tribal organization under a contract, grant, cooperative agreement, or compact with the Indian Health Service.

- Children younger than 19 years of age who are receiving services through a family-centered, community-based, coordinated care system that receives grant funds under Section 501(a)(1)(D) of Title V and is defined by the State in terms of either program participation or special health care needs (also known as children with special health care needs—CSHCN).
- FMC adults determined as seriously mentally ill (SMI). Newly eligible SMI adults are enrolled in an MCO if they reside within the managed care geographic service area and cannot opt out of managed care, where available, based on a determination of SMI.
- FMC children diagnosed as severely emotionally disturbed (SED).

Demographics of Nevada State Managed Care Program

The Division of Welfare and Supportive Services carries out the eligibility and aid code determination functions for the Medicaid and Nevada Check Up applicant and eligible population.

Table 2-1 presents the gender and age bands of Nevada Medicaid- and CHIP-enrolled recipients enrolled in all managed care catchment areas as of June 2019.

Table 2-1—Nevada Medicaid and CHIP Managed Care Demographics

Gender/Age Band	June 2019 Members
Males and Females <1 Year of Age	18,163
Males and Females 1–2 Years of Age	29,086
Males and Females 3–14 Years of Age	147,515
Females 15–18 Years of Age	17,576
Males 15–18 Years of Age	17,102
Females 19–34 Years of Age	67,091
Males 19–34 Years of Age	36,384
Females 35+ Years of Age	63,669
Males 35+ Years of Age	50,020
Total Medicaid	**446,606**
Males and Females <1 Year of Age	141
Males and Females 1–2 Years of Age	1,459
Males and Females 3–14 Years of Age	16,336
Females 15–18 Years of Age	2,421
Males 15–18 Years of Age	2,557
Total CHIP	**22,914**
Total Medicaid and CHIP	**469,520**

Table 2-2 presents enrollment of Medicaid recipients by MCO and county for June 2019.

Table 2-2—June 2019 Nevada MCO Medicaid Recipients

MCO	Total Eligible Clark County	Total Eligible Washoe County
HPN	199,198	26,966
Anthem	152,782	20,414
SilverSummit	41,200	6,046
Total	**393,180**	**53,426**

Table 2-3 presents enrollment of CHIP recipients in the Nevada Check Up program by MCO and by county for June 2019.

Table 2-3—June 2019 Nevada MCO CHIP (Nevada Check Up) Recipients

MCO	Total Eligible Clark County	Total Eligible Washoe County
HPN	10,176	2,462
Anthem	7,052	1,343
SilverSummit	1,548	333
Total	**18,776**	**4,138**

Dental benefits for eligible Medicaid beneficiaries are coordinated and paid for by the DHCFP's DBA, **LIBERTY**. As of June 2019, 464,321 Medicaid beneficiaries were enrolled with **LIBERTY** for dental coverage.

Nevada State Quality Strategy

The U.S. Department of Health and Human Services (HHS) Centers for Medicare & Medicaid Services (CMS) Medicaid managed care regulations at Title 42 of the Code of Federal Regulations (CFR) §438.340 require Medicaid state agencies that operate Medicaid managed care programs to develop and implement a written quality strategy to assess and improve the quality of health care services offered to Medicaid members. The written strategy must describe the standards that a state and its contracted MCOs and prepaid inpatient health plans must meet. This section outlines the goals and objectives of the DHCFP Quality Strategy as well as the annual evaluation of the strategy for SFY 2018–2019.

Quality Strategy Goals and Objectives

The DHCFP's mission is to purchase and ensure the provision of quality health care services, including Medicaid services, to low-income Nevadans in the most efficient manner. Furthermore, the DHCFP seeks to promote equal access to health care at an affordable cost to Nevada taxpayers, to restrain the

growth of health care costs, and to review Medicaid and other State health care programs to determine the potential to maximize federal revenue opportunities. The Nevada Department of Health and Human Services (DHHS) director has identified three priority focus areas for Nevada Medicaid: prevention, early intervention, and quality treatment. Consistent with the State's mission and DHHS priority areas, the purpose of the DHCFP's Quality Strategy is to:

- Establish a comprehensive quality improvement system that was consistent with the Triple Aim adopted by CMS to achieve better care for patients, better health for communities, and lower costs through improvement in the health care system.
- Provide a framework for the DHCFP to design and implement a coordinated and comprehensive system to proactively drive quality throughout the Nevada Medicaid and 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 recipients have access to high-quality and culturally appropriate care.
- Identify creative and efficient models of care delivery that are steeped in best practice and make health care more affordable for individuals, families, and the state government.
- Improve recipient satisfaction with care and services.
- Ensure that persons transitioning to managed care from fee-for-service (FFS) and persons transitioning between MCOs receive appropriate therapeutic, medical, and behavioral health services as part of the transition of care policy noted in the *Medicaid Services Manual* (MSM), Chapter 3603.17.

Consistent with the National Quality Strategy and epidemiological and prevalence data displayed in Table 2-4, the DHCFP established quality goals and objectives to improve the health and wellness of Nevada Medicaid and Nevada Check Up members. Unless otherwise indicated, all objectives will follow the Quality Improvement System for Managed Care (QISMC) methodology to improve rates. Table 2-4 details the quality goals and objectives for the Nevada Medicaid managed care program.

Table 2-4—Nevada Medicaid MCO Goals and Objectives for Medicaid and Nevada Check Up

Goal 1:	Improve the Health and Wellness of Nevada's Medicaid Population by Increasing the Use of Preventive Services.
Objective #	**Objective Description**
Objective 1.1a:	Increase children and adolescents' access to PCPs (CAP)—12–24 months
Objective 1.1b:	Increase children and adolescents' access to PCPs (CAP)—25 months–6 years
Objective 1.1c:	Increase children and adolescents' access to PCPs (CAP)—7–11 years
Objective 1.1d:	Increase children and adolescents' access to PCPs (CAP)—12–19 years

Goal 1:	Improve the Health and Wellness of Nevada's Medicaid Population by Increasing the Use of Preventive Services.
Objective #	**Objective Description**
Objective 1.2:	Increase well-child visits (W15)—0–15 months
Objective 1.3:	Increase well-child visits (W34)—3–6 years
Objective 1.4a:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—BMI percentile
Objective 1.4b:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—counseling for nutrition
Objective 1.4c:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—counseling for physical activity
Objective 1.5a:	Increase immunizations for adolescents (IMA)—Meningococcal, Tdap
Objective 1.5b:	Increase immunizations for adolescents (IMA)—Meningococcal, Tdap, HPV
Objective 1.6a:	Increase childhood immunization status (CIS)—Combination 2
Objective 1.6b:	Increase childhood immunization status (CIS)—Combination 3
Objective 1.6c:	Increase childhood immunization status (CIS)—Combination 4
Objective 1.6d:	Increase childhood immunization status (CIS)—Combination 5
Objective 1.6e:	Increase childhood immunization status (CIS)—Combination 6
Objective 1.6f:	Increase childhood immunization status (CIS)—Combination 7
Objective 1.6g:	Increase childhood immunization status (CIS)—Combination 8
Objective 1.6h:	Increase childhood immunization status (CIS)—Combination 9
Objective 1.6i:	Increase childhood immunization status (CIS)—Combination 10
Objective 1.7:	Increase adolescent well-care visits (AWC)
Objective 1.8:	Increase breast cancer screening (BCC)
Objective 1.9a:	Increase adults' access to preventive/ambulatory health services (AAP)—20–44 Years
Objective 1.9b:	Increase adults' access to preventive/ambulatory health services (AAP)—45–64 Years
Objective 1.9c:	Increase adults' access to preventive/ambulatory health services (AAP)—65 Years and older
Objective 1.9d:	Increase adults' access to preventive/ambulatory health services (AAP)—Total

Goal 2:	Increase Use of Evidence-Based Practices for Members With Chronic Conditions.
Objective #	**Objective Description**
Objective 2.1a:	Increase rate of HbA1c testing for members with diabetes (CDC)
Objective 2.1b:	Decrease rate of HbA1c poor control (>9.0%) for members with diabetes (CDC)*
Objective 2.1c:	Increase rate of HbA1c good control (<8.0%) for members with diabetes (CDC)
Objective 2.1d:	Increase rate of eye exams performed for members with diabetes (CDC)

Goal 2:	Increase Use of Evidence-Based Practices for Members With Chronic Conditions.
Objective #	**Objective Description**
Objective 2.1e:	Increase medical attention for nephropathy for members with diabetes (CDC)
Objective 2.1f:	Increase blood pressure control (<140/90 mm Hg) for members with diabetes (CDC)
Objective 2.2a:	Increase medication management for people with asthma (MMA)—medication compliance 50 percent
Objective 2.2b:	Increase medication management for people with asthma (MMA)—medication compliance 75 percent
Objective 2.3	Increase rate of controlling high blood pressure (CBP)

Goal 3:	Improve Appropriate Use of Opioids.
Objective #	**Objective Description**
Objective 3.1:	Reduce use of opioids at high dosage (per 1,000 members) (UOD)*
Objective 3.2a:	Reduce use of opioids from multiple providers (per 1,000 members) (UOP)—multiple prescribers*
Objective 3.2b:	Reduce use of opioids from multiple providers (per 1,000 members) (UOP)—multiple pharmacies*
Objective 3.2c:	Reduce use of opioids from multiple providers (per 1,000 members) (UOP)—multiple prescribers and multiple pharmacies*

Goal 4:	Improve the Health and Wellness of New Mothers and Infants and Increase New-Mother Education About Family Planning and Newborn Health and Wellness.
Objective #	**Objective Description**
Objective 4.1:	Increase timeliness of prenatal care (PPC)
Objective 4.2:	Increase the rate of postpartum visits (PPC)

Goal 5:	Increase Use of Evidence-Based Practices for Members With Behavioral Health Conditions.
Objective #	**Objective Description**
Objective 5.1a:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication (ADD)—initiation phase
Objective 5.1b:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication (ADD)—continuation and maintenance phase
Objective 5.2:	Reduce use of multiple concurrent antipsychotics in children and adolescents (APC)*
Objective 5.3:	Increase adherence to antipsychotic medications for individuals with schizophrenia (SAA)
Objective 5.4:	Increase follow-up after hospitalization for mental illness (FUH)—7-day
Objective 5.5:	Increase follow-up after hospitalization for mental illness (FUH)—30-day

Goal 5:	Increase Use of Evidence-Based Practices for Members With Behavioral Health Conditions.
Objective #	**Objective Description**
Objective 5.6:	Increase diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications (SSD)
Objective 5.7a:	Increase follow-up after ED visit for AOD abuse or dependence (FUA)—7-day
Objective 5.7b:	Increase follow-up after ED visit for AOD abuse or dependence (FUA)—30-day
Objective 5.8a:	Increase follow-up after ED visit for mental illness (FUM)—7-day
Objective 5.8b:	Increase follow-up after ED visit for mental illness (FUM)—30-day
Objective 5.9a:	Increase initiation and engagement of AOD abuse or dependence treatment (IET)—initiation of treatment
Objective 5.9b:	Increase initiation and engagement of AOD abuse or dependence treatment (IET)—engagement of treatment
Objective 5.10:	Increase metabolic monitoring for children and adolescents on antipsychotics (APM)

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

Goal 6:	Reduce and/or Eliminate Health Care Disparities for Medicaid Recipients.
Objective #	**Objective Description**
Objective 6.1:	Ensure that health plans maintain, submit for review, and annually revise cultural competency plans.
Objective 6.2:	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.
Objective 6.3:	Ensure that each MCO submits an annual evaluation of its cultural competency programs to the DHCFP. The MCOs must receive a 100 percent *Met* compliance score for all criteria listed in the MCO contract for cultural competency program development, maintenance, and evaluation.

Goal 7:	Increase Utilization of Dental Services.
Objective #	**Objective Description**
Objective 7.1:	Increase annual dental visits
Objective 7.2:	Increase percentage of eligible members who received preventive dental services

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

In 2018, the DHCFP established a minimum performance standard (MPS) for each objective. Further, the DHCFP established additional performance tiers that serve as "stretch goals" for each objective. The purpose of establishing the MPS and performance tiers for each objective was to create a set of reasonable targets that MCOs could achieve through continuous focus and improvement for each of the indicators that represent an objective. This will allow the DHCFP to use this methodology, as appropriate, in the development of its quality rating system.

Annual Quality Strategy Evaluation

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

Table 2-5 shows the number of rates reported, the number of reported rates that were comparable to the MPS, the number of rates that achieved the MPS, the number of rates that achieved performance tiers 1 or 2, and the number of rates that achieved performance tier 3. For Goal 6, Reduce and/or Eliminate Health Care Disparities for Medicaid Recipients, all three MCOs received a *Met* score for the criteria detailed in the objectives. The *Met* status for those objectives is not summarized in Table 2-4. For additional detail, please see Appendix B of this report.

Table 2-5—2018–2019 Quality Strategy Goals and Objectives Summary of Performance by the MCOs*

	Anthem Medicaid	HPN Medicaid	SilverSummit Medicaid*	Anthem Check Up	HPN Check Up	SilverSummit Check Up*
Number of Rates Reported	54	55	47	24	28	7
Number of Rates Comparable to MPS and Performance Tiers	50	51	43	24	28	7
Rates Achieving the MPS	**14**	**16**	**2**	**13**	**7**	**0**
Rates Achieving Tier 1 or Tier 2	4	5	1	5	2	0
Rates Achieving Tier 3	1	0	1	2	2	0

*SFY 2019–2020 was the first reporting year for **SilverSummit**; therefore, caution should be exercised when evaluating **SilverSummit**'s results, as the denominators for the measures are much lower than the other MCOs.

The DHCFP will establish MPS and performance tiers for **LIBERTY**'s performance measures in SFY 2020–2021.

Quality Initiatives and Emerging Practices

Emerging practices can be achieved by incorporating evidence-based guidelines into operational structures, policies, and procedures. Emerging practices are born out of continuous quality improvement efforts to improve health services, health outcomes, systems processes, and operational procedures. The goal of these efforts is to improve the quality of and access to services and to improve health outcomes. Only through continual measurement and analyses to determine the efficacy of an intervention can an emerging practice be identified. Therefore, the DHCFP encourages the MCOs and the DBA to continually track and monitor the effectiveness of quality improvement initiatives and interventions, using a Plan-Do-Study-Act (PDSA) cycle, to determine if the benefit of the intervention outweighs the effort and cost.

Another method used by the DHCFP to promote best and emerging practices among the MCOs is to ensure that the State's contractual requirements for the MCOs are at least as stringent as those described in the federal rules and regulations for managed care (42 CFR Part 438—Managed Care). The DHCFP actively promotes the use of nationally recognized protocols and standards of care to measure health plan performance. Section 9 of this report details the quality activities and interventions the MCOs implemented to improve access and quality of services provided to the Medicaid population.

Pay-For-Performance Opportunities for Both MCOs

For the managed care contract that started July 1, 2017, each MCO may receive pay-for-performance (P4P) bonus awards for up to six performance indicators based on its performance on each indicator. Given the financial incentive, the MCOs likely will see a positive return on investment for interventions implemented to improve the rates for the following P4P measures:

- *Children and Adolescents Access to Primary Care Practitioners—12 Months–24 Months*
- *Children and Adolescents Access to Primary Care Practitioners—25 Months–6 Years*
- *Children and Adolescents Access to Primary Care Practitioners—12 Years–19 Years*
- *Childhood Immunization Status—Combination 10*
- *Comprehensive Diabetes Care—HbA1c Testing*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

3. Description of EQR Activities

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, requires that states that contract with Medicaid managed care organizations (MCOs) shall provide for an independent external quality review (EQR) by a qualified external quality review organization (EQRO) of the quality and timeliness of, and access to, services provided by contracted MCOs. The U.S. Department of Health and Human Services (DHHS), Centers for Medicare & Medicaid Services (CMS) regulates requirements and procedures for the EQR. The final rule provided in Title 42 of the Code of Federal Regulations (CFR) Section 438 implements the provisions outlined in the BBA related to Medicaid managed care oversight and EQR and outlines the responsibility of each state's contracted EQRO to prepare an annual technical report that describes the manner in which data were aggregated and analyzed and how conclusions were drawn as to the quality and timeliness of, and access to, care and services furnished by the states' MCOs. The data comes from activities conducted in accordance with the 42 CFR §438.358, referred to as *mandatory activities* as detailed in 42 CFR §438.358(b) and *optional activitie*s as detailed in 42 CFR §438.358(c).

Mandatory Activities

In accordance with 42 CFR §438.356, the State of Nevada, Department of Health and Human Services, Division of Health Care Financing and Policy (the DHCFP), contracted with Health Service Advisory Group, Inc. (HSAG), as the EQRO for the State of Nevada to conduct the mandatory EQR activities as set forth in 42 CFR §438.358(b). In state fiscal year (SFY) 2018–2019, HSAG conducted the following mandatory EQR activities for the Nevada Medicaid and Nevada Check Up programs:

- **Compliance monitoring evaluation:** SFY 2018–2019 was the second year in the three-year review cycle for the Internal Quality Assurance Program (IQAP) review of compliance. The purpose of the SFY 2018–2019 IQAP review was to assess each MCO's and the dental benefits administrator's (DBA's) compliance with the review standards found in 42 CFR §438 Subparts A–F and the State contract requirements found in the DHCFP Contract 3260. The results of the IQAP review are presented in Section 4 for the MCOs and Section 10 for the DBA.
- **Validation of performance measures:** HSAG validated each HEDIS performance measure identified by the State to evaluate its accuracy as reported by, or on behalf of, the MCOs. Results of the validation of HEDIS measures are presented in Section 5 for the MCOs. HSAG also conducted performance measure validation of the performance measures used for the dental program. Results of the DBA performance measure validation are found in Section 10.
- **Validation of performance improvement projects (PIPs):** HSAG validated the MCOs' and DBA's PIPs to determine if they were designed to achieve, through ongoing measurement and intervention, significant and sustained improvement in clinical and nonclinical care. HSAG also evaluated if the PIPs would have a favorable effect on health outcomes and enrollee satisfaction. Results of the validation of MCO PIPs are presented in Section 6. Results of the DBA PIPs are presented in Section 10.

Optional Activities

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

- **Encounter data validation (EDV):** During SFY 2017–2018, the DHCFP contracted HSAG to conduct an EDV study. The goal of the study was to determine the extent to which professional, institutional, and pharmacy encounters submitted to the DHCFP by the contracted MCOs are complete and accurate. Due to the length of the study, the study was divided into two phases. Phase one focused on an information system (IS) review and comparative analysis between DHCFP's electronic encounter data and the data extracted from the MCOs' data systems. Phase two consisted of a medical record review whereby HSAG completed an analysis of the DHCFP's electronic encounter data completeness and accuracy through a review of a sample of medical records for physician services rendered during the study period. Phase two and the final report were completed in SFY 2018–2019. The results of the EDV study are presented in Section 8 of this report.
- **Network adequacy validation**: During SFY 2018–2019, HSAG conducted the beginning stages of a network adequacy validation study. According to the federal regulations for managed care that were released in May 2016, the activity related to 42 CFR §438.358(b)(1)(iv), validation of network adequacy, shall commence no later than one year from the issuance of the associated EQR protocol. In preparation for the release of the protocol, HSAG prepared a provider crosswalk file that can be used as a baseline for future network adequacy tasks. HSAG conducted a baseline provider composition analysis (PCA), applying the proposed provider crosswalk to the plans' provider networks to assess network composition differences across MCOs and the DBA/prepaid ambulatory health plan (PAHP).
- **Quality Strategy evaluation**: HSAG evaluated the State's Quality Strategy and the managed care program's achievement of the goals and objectives identified in the strategy. HSAG's evaluation of the activities that occurred in support of the State's Quality Strategy is presented in Section 2.
- **Consumer Assessment of Healthcare Providers and Systems (CAHPS) analysis**: HSAG provided an analysis of the results of CAHPS activities conducted by the MCOs, which is presented in Section 7.
- **Technical Assistance**: HSAG provided technical assistance to the DHCFP with activities related to the Nevada Comprehensive Care Waiver (NCCW) program, which is the fee-for-service (FFS) care management program that resulted from Nevada's Section 1115 Research and Demonstration Waiver that was approved by CMS. The DHCFP contracted with a care management organization (CMO) to provide care management services to the enrolled population. The CMO's care management program is called the Health Care Guidance Program (HCGP). At the time of this report, HSAG was in the process of conducting a performance measure validation audit of non-pay-for-performance (non-P4P) measures used to monitor the HCGP's progress in achieving the goals and objectives of the NCCW demonstration waiver. As a result, data is not available for this SFY 2018–2019 EQR Technical Report.

4. Internal Quality Assurance Program (IQAP) Review—SFY 2018–2019

Overview

In accordance with Title 42 of the Code of Federal Regulations (CFR) §438.358(b)(1)(iii), a state or its external quality review organization (EQRO) must conduct a review within a three-year period to determine a Medicaid managed care organization's (MCO's) compliance with federal standards and standards established by the State for access to care, structure and operations, and quality measurement and improvement. To meet this requirement, the State of Nevada, Department of Health and Human Services, Division of Health Care Financing and Policy (the DHCFP) contracted with Health Services Advisory Group, Inc. (HSAG), to complete a comprehensive review of compliance with State and federal standards for **Anthem Blue Cross and Blue Shield Healthcare Solutions** (**Anthem**), **Health Plan of Nevada** (**HPN**), and **SilverSummit Healthplan, Inc.** (**SilverSummit**), in state fiscal year (SFY) 2017–2018, which initiated a new three-year cycle of the Internal Quality Assurance Program (IQAP) Review of Compliance. This three-year cycle will include an annual review of grouped standards for each of the three years, as presented in Table 4-1 below:

Table 4-1—IQAP Compliance Review Schedule

Standard	Year 1 SFY 2017–2018	Year 2 SFY 2018–2019	Year 3 SFY 2019–2020
Provider Network Management			
1. Credentialing and Recredentialing	✓		
2. Availability and Accessibility of Services	✓		
3. Subcontracts and Delegation	✓		
4. Provider Dispute and Complaint Resolution	✓		
5. Provider Information	✓		
Member Services and Experiences			
6. Member Rights and Responsibilities		✓	
7. Member Information		✓	
8. Continuity and Coordination of Care		✓	
9. Grievance and Appeals		✓	
10. Coverage and Authorization of Services		✓	
Managed Care Operations			
11. Internal Quality Assurance Program			✓
12. Cultural Competency Program			✓
13. Confidentiality and Recordkeeping			✓
14. Enrollment and Disenrollment			✓
15. Program Integrity			✓

Objectives

The purpose of the SFY 2018–2019 IQAP Compliance Review was to assess each MCO's compliance with the standards that focused on requirements for member services and experiences. To accomplish this objective, HSAG:

- Determined each MCO's performance in complying with five standards and their associated elements.
- Conducted a review of individual files for the areas of grievances, appeals, care management, and service denials.
- Conducted checklist reviews to verify that the MCO informed members of their rights and responsibilities and that the information provided in the member handbook met State and federal requirements.

The IQAP standards were derived from the requirements as set forth in the *Department of Human Services, Division of Health Care Financing and Policy Request for Proposal No. 3260 for Managed Care*, and all attachments and amendments in effect during the review period—July 1, 2018, through December 31, 2018. HSAG followed the guidelines set forth in the Centers for Medicare & Medicaid Services' (CMS') *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012[4-1] to create the process, tools, and interview questions used for the SFY 2018–2019 IQAP Compliance Review.

MCO-Specific Results – Anthem

IQAP Standards

A review of the IQAP standards shows how well an MCO has interpreted the required elements of the managed care contract and developed the necessary policies, procedures, and plans to carry out the required MCO functions. Table 4-2 presents the **Anthem** results for the five IQAP standards evaluated for SFY 2018–2019. A total of 96 elements were reviewed. Each element was scored as *Met*, *Partially Met,* or *Not Met* based on evidence found in MCO documents, policies, procedures, reports, meeting minutes, and interviews with MCO staff members.

[4-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Sept 26, 2018.

Table 4-2—Summary of Scores for the IQAP Standards

IQAP Standard #	Standard Name	Total Elements	Total Applicable Elements	Number of Elements				Total Compliance Score
				M	*PM*	*NM*	*NA*	
VI	Member Rights and Responsibilities	13	13	12	1	0	0	96.2%
VII	Member Information	13	13	13	0	0	0	100%
VIII	Continuity and Coordination of Care	16	16	16	0	0	0	100%
IX	Grievances and Appeals	33	33	26	7	0	0	89.4%
X	Coverage and Authorization of Services	21	21	21	0	0	0	100%
Total Compliance Score		**96**	**96**	**88**	**8**	**0**	**0**	**95.8%**

M=*Met*, ***PM***=*Partially Met*, ***NM***=*Not Met*, ***NA***=*Not Applicable*

Total Elements: The total number of elements in 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) to the weighted number that received a score of *Partially Met* (0.5 point), then dividing this total by the total number of applicable elements.

Of the 96 applicable elements, **Anthem** received *Met* scores for 88 elements and *Partially Met* scores for eight elements; no elements received a *Not Met* score. The findings suggest that **Anthem** developed the necessary policies, procedures, and plans to operationalize most of the required elements of its contract to demonstrate compliance with the contract. Further, interviews with **Anthem** staff showed that staff members were knowledgeable about the requirements of the contract and the policies and procedures that the MCO employed to meet contractual requirements.

The areas with the greatest opportunity for improvement for IQAP standards were related to Standard VI Member Rights and Responsibilities (96.2 percent) and Standard IX Grievances and Appeals (89.4 percent).

Checklist Reviews

Table 4-3 presents the scores for the checklists. HSAG reviewed all requirements related to the member rights and responsibilities and the member handbook to verify compliance with state and federal requirements. HSAG scored the elements required via the checklist. The checklist review area was scored based on the total number of **Anthem**'s compliant elements divided by the total number of applicable elements.

Table 4-3—Checklist Score

Associated IQAP Standard #	Description of Checklist Review	# of Applicable Elements	# of Compliant Elements	Score (% of Compliant Elements)
VI	Member Rights and Responsibilities	12	12	100%
VII	Member Handbook	33	33	100%
Checklist Totals		**45**	**45**	**100%**

The results generated by the checklists serve as additional indicators of the MCO's ability to develop the required outreach information and to ensure that the information contains all contractually required elements. Of the 45 elements reviewed for the checklists, **Anthem** received *Met* scores for all 45 elements. The findings suggest that **Anthem** had strong compliance in each of the areas evaluated by the checklists and that **Anthem** developed the necessary manuals, handbooks, and policies according to contract requirements.

File Reviews

For the file reviews, each file review area was scored based on the total number of **Anthem**'s compliant elements divided by the total number of applicable elements for each individual file reviewed. Table 4-4 presents **Anthem**'s scores for the file reviews.

Table 4-4—Summary of Scores for the File Reviews

Associated IQAP Standard #	Description of File Review	# of Records Reviewed	# of Applicable Elements	# of Compliant Elements	Score (% of Compliant Elements)
VII	Care Management	10	140	140	100%
IX	Grievances	10	30	30	100%
IX	Appeals	10	40	40	100%
X	Denials	10	30	30	100%
	File Review Totals	**40**	**240**	**240**	**100%**

File reviews are important to the overall findings of the IQAP review because the results show how well an MCO operationalized and followed the policies it developed for the required elements of the contract.

Anthem demonstrated 100 percent compliance with all 140 applicable elements reviewed in the care management file reviews.

For the grievance file reviews, **Anthem** demonstrated 100 percent compliance with all 30 elements reviewed.

Anthem's appeals policies were inconsistent with the contractual and federal standards pertaining to:

- The acceptance of appeals orally and in writing to establish the earliest possible file date.
- Expedited appeals being resolved as expeditiously as the member's medical condition requires but no later than 72 hours from the date of receipt of the expedited appeal request.
- That when the MCO or fair hearing officer reverses an action to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO authorizes or provides the disputed services promptly and as expeditiously as the recipient's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.
- The provision that when additional time is needed to make an expedited decision, the MCO provides notice to the member with the reason for the extension and informs the member of the right to file a grievance.

The appeal file review for **Anthem**, however, showed that inconsistencies in the policies did not adversely affect the manner in which the appeals were processed by the MCO. All 40 appeal file elements reviewed were compliant with the processing time frames and requirements.

Anthem's service authorization and notice of action policies were inconsistent with the contractual and federal standards pertaining to:

- Providing notice at least 10 days before the date of action when the action is a termination, suspension, or reduction of previously authorized covered services and that this time frame may be shortened to five days if probable recipient fraud has been verified; and
- Providing notice on the date that the time frames expire when service authorization decisions are not reached within the time frames for either standard or expedited service authorizations.

The service denial file reviews for **Anthem**, however, showed that inconsistencies in the policies did not adversely affect the processing of service authorization requests. The file reviews for service denials showed that all 30 elements were compliant with the requirements.

MCO-Specific Results – HPN

IQAP Standards

A review of the IQAP standards shows how well an MCO has interpreted the required elements of the managed care contract and developed the necessary policies, procedures, and plans to carry out the required MCO functions. Table 4-5 presents the **HPN** results for the five IQAP standards evaluated for SFY 2018–2019. A total of 96 elements were reviewed. Each element was scored as *Met*, *Partially Met,* or *Not Met* based on evidence found in MCO documents, policies, procedures, reports, meeting minutes, and interviews with MCO staff members.

Table 4-5—Summary of Scores for the IQAP Standards

IQAP Standard #	Standard Name	Total Elements	Total Applicable Elements	Number of Elements				Total Compliance Score
				M	*PM*	*NM*	*NA*	
VI	Member Rights and Responsibilities	13	13	13	0	0	0	100%
VII	Member Information	13	13	13	0	0	0	100%
VIII	Continuity and Coordination of Care	16	16	16	0	0	0	100%
IX	Grievances and Appeals	33	33	28	3	2	0	89.4%
X	Coverage and Authorization of Services	21	21	21	0	0	0	100%
Total Compliance Score		**96**	**96**	**91**	**3**	**2**	**0**	**96.4%**

M=*Met*, ***PM***=*Partially Met*, ***NM***=*Not Met*, ***NA***=*Not Applicable*

Total Elements: The total number of elements in 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) to the weighted number that received a score of *Partially Met* (0.5 point), then dividing this total by the total number of applicable elements.

Of the 96 applicable elements, **HPN** received *Met* scores for 91 elements, *Partially Met* scores for three elements, and *Not Met* scores for two elements. The findings suggest that **HPN** developed the necessary policies, procedures, and plans to operationalize most of the required elements of its contract to demonstrate compliance with the contract. Further, interviews with **HPN** staff showed that staff members were knowledgeable about the requirements of the contract and the policies and procedures that the MCO employed to meet contractual requirements.

As shown in the above table, the area with the greatest opportunity for improvement for IQAP standards was related to grievances and appeals, for which **HPN** received a score of 89.4 percent.

Checklist Reviews

Table 4-6 presents the scores for the checklists. HSAG reviewed all requirements related to the member rights and responsibilities and the member handbook to verify compliance with state and federal requirements. HSAG scored the elements required via the checklist. The checklist review area was scored based on the total number of **HPN**'s compliant elements divided by the total number of applicable elements.

Table 4-6—Checklist Score

Associated IQAP Standard #	Description of Checklist Review	# of Applicable Elements	# of Compliant Elements	Score (% of Compliant Elements)
VI	Member Rights and Responsibilities	12	12	100%
VII	Member Handbook	33	33	100%
	Checklist Totals	**45**	**45**	**100%**

The results generated by the checklists serve as additional indicators of the MCO's ability to develop the required outreach information and to ensure that the information contains all contractually required elements. Of the 45 elements reviewed for the checklists, **HPN** received scores of *Met* for all 45 elements. The findings suggest that **HPN** had strong compliance in each of the areas evaluated by the checklists and that **HPN** developed the necessary manuals, handbooks, and policies according to contract requirements.

File Reviews

For the file reviews, each file review area was scored based on the total number of **HPN**'s compliant elements divided by the total number of applicable elements for each individual file reviewed. Table 4-7 presents **HPN**'s scores for the file reviews.

Table 4-7—Summary of Scores for the File Reviews

Associated IQAP Standard #	Description of File Review	# of Records Reviewed	# of Applicable Elements	# of Compliant Elements	Score (% of Compliant Elements)
VII	Care Management	10	139	139	100%
IX	Grievances	10	30	30	100%
IX	Appeals	10	37	35	94.6%
X	Denials	10	30	30	100%
	File Review Totals	**40**	**236**	**234**	**99.1%**

File reviews are important to the overall findings of the IQAP review because the results show how well an MCO operationalized and followed the policies it developed for the required elements of the contract.

HPN demonstrated 100 percent compliance with all 139 applicable elements reviewed in the care management file review, which indicates the MCO's strong compliance with the care management standards detailed in the contract.

For the grievance file reviews, **HPN** demonstrated 100 percent compliance with all 30 elements reviewed. All files reviewed demonstrated **HPN**'s strong compliance with the grievance standard detailed in the contract.

The area with the greatest opportunity for improvement for file review was related to appeals, for which **HPN** demonstrated compliance with 35 of 37 (94.6 percent) applicable elements reviewed. One appeal file included an expedited appeal request. The expedited appeal was not resolved within the required time frame, and there was no evidence that the MCO sent the member a notice to extend the resolution time frame as required.

Although **HPN** received 100 percent compliance for all required elements related to the service denial file review, **HPN**'s authorization policies were inconsistent with contractual and federal standards. Specifically, **HPN**'s policies did not include the provision that if the MCO denies a member's request for disenrollment for lack of good cause, the MCO must send a notice of decision in writing to the member on the date of decision.

MCO-Specific Results – SilverSummit

IQAP Standards

A review of the IQAP standards shows how well an MCO has interpreted the required elements of the managed care contract and developed the necessary policies, procedures, and plans to carry out the required MCO functions. Table 4-8 presents the **HPN** results for the five IQAP standards evaluated for SFY 2018–2019. A total of 96 elements were reviewed. Each element was scored as *Met*, *Partially Met,*

or *Not Met* based on evidence found in MCO documents, policies, procedures, reports, meeting minutes, and interviews with MCO staff members.

Table 4-8—Summary of Scores for the IQAP Standards

IQAP Standard #	Standard Name	Total Elements	Total Applicable Elements	Number of Elements				Total Compliance Score
				M	*PM*	*NM*	*NA*	
VI	Member Rights and Responsibilities	13	13	10	2	1	0	84.6%
VII	Member Information	13	13	12	1	0	0	96.2%
VIII	Continuity and Coordination of Care	16	16	13	3	0	0	90.6%
IX	Grievances and Appeals	33	33	31	2	0	0	97.0%
X	Coverage and Authorization of Services	21	21	20	1	0	0	97.6%
Total Compliance Score		**96**	**96**	**86**	**9**	**1**	**0**	**94.3%**

M=*Met*, ***PM***=*Partially Met*, ***NM***=*Not Met*, ***NA***=*Not Applicable*

Total Elements: The total number of elements in 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) to the weighted number that received a score of *Partially Met* (0.5 point), then dividing this total by the total number of applicable elements.

Of the 96 applicable elements, **SilverSummit** received *Met* scores for 86 elements, *Partially Met* scores for nine elements, and a *Not Met* score for one element. The findings suggest that **SilverSummit** developed the necessary policies, procedures, and plans to operationalize most of the required elements of its contract and demonstrate compliance with the contract. Further, interviews with **SilverSummit** staff showed that staff members were knowledgeable about the requirements of the contract and the policies and procedures that the MCO employed to meet contractual requirements.

The areas with the greatest opportunity for improvement for IQAP standards were related to member rights and responsibilities, continuity and coordination of care, and member information, with scores of 84.6 percent, 90.6 percent, and 96.2 percent, respectively.

Checklist Reviews

Table 4-9 presents the scores for the checklists. HSAG reviewed all requirements related to the member rights and responsibilities and the member handbook to verify compliance with State and federal requirements. HSAG scored the elements required via the checklist. The checklist review area was scored based on the total number of **SilverSummit**'s compliant elements divided by the total number of applicable elements.

Table 4-9—Checklist Score

Associated IQAP Standard #	Description of Checklist Review	# of Applicable Elements	# of Compliant Elements	Score (% of Compliant Elements)
VI	Member Rights and Responsibilities	12	12	100%
VII	Member Handbook	33	31	93.9%
	Checklist Totals	**45**	**43**	**95.6%**

The results generated by the checklists serve as additional indicators of the MCO's ability to develop the required outreach information and to ensure that the information contains all contractually required elements. Of the 45 elements reviewed for the checklists, **SilverSummit** received scores of *Met* for 43 elements. The findings showed that **SilverSummit** demonstrated 100 percent compliance with the requirements related to member rights and responsibilities. The Member Handbook checklist, however, demonstrated opportunities for improvement as the handbook contained only 31 of the 33 required elements. Specifically, the handbook did not contain language to inform members of the procedures for accessing nonemergency transportation.

File Reviews

For the file reviews, each file review area was scored based on the total number of **SilverSummit**'s compliant elements divided by the total number of applicable elements for each individual file reviewed. Table 4-10 presents **SilverSummit**'s scores for the file reviews.

Table 4-10—Summary of Scores for the File Reviews

Associated IQAP Standard #	Description of File Review	# of Records Reviewed	# of Applicable Elements	# of Compliant Elements	Score (% of Compliant Elements)
VII	Care Management	10	132	109	82.6%
IX	Grievances	10	30	30	100%
IX	Appeals	10	39	36	92.3%
X	Denials	10	30	27	90%
	File Review Totals	**40**	**231**	**202**	**87.4%**

File reviews are important to the overall findings of the IQAP review because the results show how well an MCO operationalized and followed the policies it developed for the required elements of the contract.

The area with the greatest opportunity for improvement in files reviewed was related to care management, which demonstrated compliance with 109 of 132 elements (82.6 percent). All care management files reviewed lacked documentation of (1) the primary care provider's (PCP's) notification

that members met the criteria for and were enrolled in care management, and (2) PCP involvement in care planning.

Nine of 10 care management files included a comprehensive assessment. One care management file contained an assessment which did not include documentation that the cultural and linguistic needs of the member were assessed.

Eight of the 10 complex care management files reviewed had person-centered treatment plans developed within 90 days of enrollment into care management. Two care management files did not have person-centered treatment plans developed within 90 days.

SilverSummit demonstrated 100 percent compliance with all 30 elements reviewed in the grievance file reviews and received a score of 100 percent. The score suggests that **SilverSummit** implemented the processes described in policy and contractual requirements. For the appeals file review, **SilverSummit** demonstrated compliance with 36 of 39 elements reviewed (92.3 percent). The file review showed that **SilverSummit** did not send a notice of extension to the member for one standard appeal that was resolved outside the 30-day time frame. One appeal file did not include evidence that the acknowledgement letter was sent to the member as required.

SilverSummit received 90 percent compliance for 27 of 30 applicable elements related to the service denial file review. For three of the files reviewed, **SilverSummit** did not send a notice of decision to the member within the required 14-day time frame.

Overall, the results from the file reviews suggest that **SilverSummit** did not consistently follow the policies it developed for care management or for processing appeals and service authorization denials.

Plan Comparison

Table 4-11 through Table 4-14 detail the compliance results for all MCOs.

Table 4-11—MCO Compliance Review

Associated IQAP Standard #	Standard Name	Anthem	HPN	SilverSummit
VI	Member Rights and Responsibilities	96.2%	100%	84.6%
VII	Member Information	100%	100%	96.2%
VIII	Continuity and Coordination of Care	100%	100%	90.6%
IX	Grievances and Appeals	89.4%	89.4%	97.0%
X	Coverage and Authorization of Services	100%	100%	97.6%
	Compliance Score	**95.8%**	**96.4%**	**94.3%**

For the IQAP Standards Review, **Anthem** received a score of 95.8 percent, **HPN** a score of 96.4 percent, and **SilverSummit** a score of 94.3 percent. The scores showed the MCOs demonstrated a strong adherence to most of the standards and contract requirements.

Table 4-12—MCO Checklist Review

Associated IQAP Standard #	Description of Checklist	Anthem	HPN	SilverSummit
VI	Member Rights and Responsibilities	100%	100%	100%
VII	Member Information	100%	100%	93.9%
	Checklist Score	**100%**	**100%**	**95.6%**

All MCOs received 100 percent compliance for the member rights and responsibilities checklist review for IQAP Standard VI. **Anthem** and **HPN** each received a compliance score of 100 percent for the member information checklist review for Standard VII, and **SilverSummit** received a compliance score of 93.9 percent.

Table 4-13—MCO File Review

Associated IQAP Standard #	Description of File Review	Anthem	HPN	SilverSummit
VIII	Care Management	100%	100%	82.6%
IX	Grievances	100%	100%	100%
IX	Appeals	100%	94.6%	92.3%
X	Denials	100%	100%	90%
	File Review Score	**100%**	**99.1%**	**87.4%**

While **Anthem** and **HPN** received compliance scores of 100 percent for all required elements reviewed in the care management, grievance and service denial file reviews, the MCOs policies were inconsistent with contractual and federal standards. In the files reviewed, the inconsistencies between policy and practice did not negatively impact the file review scores. **SilverSummit** received a 100 percent compliance score for the grievances file review. This compliance result suggests that **SilverSummit** followed the policies it developed to operationalize the required elements of the MCO contract.

Table 4-14—MCO Composite Scores

	Anthem	HPN	SilverSummit
Composite Score for All Review Elements	98.9%	98.5%	90.2%

The overall composite score for **Anthem** was 98.9 percent; for **HPN** it was 98.5 percent; and for **SilverSummit** it was 90.2 percent. The compliance scores showed the MCOs' demonstrated a strong adherence to most standards and contract requirements.

Conclusions and Recommendations

For **Anthem**, HSAG recommended the following:

- Ensure that written notice is provided to affected members within the required time frame in cases in which a PCP has been terminated from the health plan.
- Ensure that its written process describing the processing time frames for appeals is consistent with contractual and federal requirements.
- Ensure that its process and time frames for service authorizations and denials are consistent with contractual and federal requirements.

In response to the SFY 2018–2019 IQAP Compliance Review, **Anthem** submitted multiple corrective action plans to the DHCFP, which at the time of this report, were being reviewed by the DHCFP.

For **HPN**, HSAG recommended the following:

- Implement mechanisms to ensure that when applicable, notification for an extension is sent to the member and that the notification contains the required information.
- Ensure that for expedited resolution for appeals, it resolves expedited appeals and provides notice, as expeditiously as the member's health condition requires, not to exceed 72 hours after **HPN** receives the expedited appeal request.
- Ensure that it provides notice of action to the member and the member's provider by the date of the action.

In response to the SFY 2018–2019 IQAP Compliance Review, **HPN** submitted multiple corrective action plans to the DHCFP, which at the time of this report, were being reviewed by the DHCFP.

For **SilverSummit**, HSAG recommended the following:

- Inform members of the procedures for using nonemergency transportation and provide an explanation of how transportation is provided.
- Develop mechanisms to ensure that the member's case file contains documentation indicating the PCP is:
  - Informed when a member is identified as meeting care management criteria.
  - Informed when a member is enrolled in care management services.
  - Involved in a member's care plan development.

- Ensure that all assessments completed for members enrolled in care management are comprehensive and assess the member's cultural and linguistic needs, and that person-centered treatment plans are developed within the time frame required by the DHCFP contract.
- Ensure that all standard appeals are resolved, and that notice is given within 30 days of the date the MCO received the appeal.
- Ensure that appeal acknowledgement letters are sent to the member as required.
- Ensure that a decision is made within the required time frame for all service authorization requests.

In response to the SFY 2018–2019 IQAP Compliance Review, **SilverSummit** submitted multiple corrective action plans to the DHCFP, which at the time of this report, were being reviewed by the DHCFP.

5. Validation of Performance Measures—NCQA HEDIS Compliance Audit—SFY 2018–2019

Overview

In accordance with Title 42 of the Code of Federal Regulations (CFR) §438.358(b)(1)(ii), a state or its external quality review organization (EQRO) must validate performance measures calculated and reported by managed care organizations (MCOs). To meet this requirement, the State of Nevada, Department of Health and Human Services, Division of Health Care Financing and Policy (the DHCFP) contracted with Health Services Advisory Group. Inc. (HSAG), to complete a comprehensive National Committee for Quality Assurance (NCQA) Health Effectiveness Data and Information Set (HEDIS) compliance audit of the HEDIS measures calculated and reported by **Anthem Blue Cross and Blue Shield Healthcare Solutions** (**Anthem**), **Health Plan of Nevada** (**HPN**), and **SilverSummit Healthplan, Inc.** (**SilverSummit**), in state fiscal year (SFY) 2018–2019.

Objectives

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

Table 5-1 lists the required HEDIS 2019 measures for the Medicaid and Nevada Check Up populations.

Table 5-1—Required HEDIS 2019 Measures

HEDIS Measures	Medicaid Population*	Nevada Check-Up Population	Quality	Access	Timeliness
Access to Care					
Adults' Access to Preventive/Ambulatory Health Services (AAP)—Ages 20–44 Years, *Ages 45–64 Years*, *Ages 65 Years and Older*, and *Total*	√			√	
Children and Adolescents' Access to Primary Care Practitioners (CAP)—Ages 12–24 Months, *Ages 25 Months–6 Years*, *Ages 7–11 Years*, and *Ages 12–19 Years*	√	√		√	
Children's Preventive Care					
Adolescent Well-Care Visits (AWC)	√	√	√	√	
Childhood Immunization Status (CIS)—Combinations 2–10	√	√	√		

HEDIS Measures	Medicaid Population*	Nevada Check-Up Population	Quality	Access	Timeliness
Immunizations for Adolescents (IMA)—Combination 1 (Meningococcal, Tdap) and *Combination 2 (Meningococcal, Tdap, HPV)*	√	√	√		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—BMI Percentile—Total, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total*	√	√	√		
Well-Child Visits in the First 15 Months of Life (W15)—Six or More Well-Child Visits	√	√	√	√	
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)	√	√	√	√	
Women's Health and Maternity Care					
Breast Cancer Screening (BCS)	√		√		
Prenatal and Postpartum Care (PPC)—Timeliness of Prenatal Care and *Postpartum Care*	√		√	√	√
Care for Chronic Conditions					
Comprehensive Diabetes Care (CDC)—HbA1c Testing, *HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, *Eye Exam (Retinal) Performed*, *Medical Attention for Nephropathy*, and *Blood Pressure Control (<140/90 mm Hg)*	√		√		
Controlling High Blood Pressure (CBP)	√		√		
Medication Management for People with Asthma (MMA)—Medication Compliance 50%—Total and *Medication Compliance 75%—Total*	√	√	√		
Behavioral Health					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	√		√		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	√		√		
Follow-Up After ED Visit for Alcohol and Other Drug (AOD) Abuse Dependence	√		√	√	√

HEDIS Measures	Medicaid Population*	Nevada Check-Up Population	Quality	Access	Timeliness
(FUA)—7-Day Follow-Up—Total and *30-Day Follow-Up—Total*					
Follow-Up After ED Visit for Mental Illness (FUM)—7-Day Follow-Up—Total and *30-Day Follow-Up—Total*	√	√	√	√	√
Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Total and *30-Day Follow-Up—Total*	√	√	√	√	√
Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Initiation Phase and *Continuation and Maintenance Phase*	√	√	√	√	√
Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)—Initiation of AOD Treatment—Total and *Engagement of AOD Treatment—Total*	√	√	√	√	√
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)—Total	√	√	√		
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)—Total	√	√	√		
Utilization					
Ambulatory Care (AMB)—ED Visits—Total and *Outpatient Visits—Total*	√	√			
Mental Health Utilization (MPT)—Inpatient—Total, *Intensive Outpatient or Partial Hospitalization—Total*, *Outpatient—Total*, *ED—Total*, *Telehealth—Total*, and *Any Service—Total*	√	√			
Overuse/Appropriateness of Care					
Use of Opioids at High Dosage (UOD)	√		√		
Use of Opioids from Multiple Providers (UOP)—Multiple Prescribers, Multiple Pharmacies, and Multiple Prescribers and Multiple Pharmacies	√		√		

* The *Medicaid Population* refers to members under the Medicaid managed care program and does not include members in FFS Medicaid.

MCO-Specific Results—Anthem

Medicaid Results

The Medicaid HEDIS 2018 and 2019 rates for **Anthem** are presented in Table 5-2, along with rate comparisons and performance target ratings. Measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, a decrease in the rate from 2018 to 2019 represents performance improvement and an increase in the rate from 2018 to 2019 represents performance decline. Measures in the Utilization domain are designed to capture the frequency of services provided by the MCO. With the exception of the *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total*, higher or lower rates in this domain do not necessarily indicate better or worse performance. Therefore, these rates are provided for informational purposes only.

Table 5-2—Medicaid HEDIS Performance Measures Results for Anthem

HEDIS Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	2018–2019 Rate Comparison
Access to Care			
Adults' Access to Preventive/Ambulatory Health Services (AAP)[1]			
Ages 20–44 Years	72.55%	73.27%	0.72
Ages 45–64 Years	79.38%	80.05%	0.67
Ages 65 Years and Older	77.55%	NA	NC
Total	74.69%	75.38%	0.69
Children and Adolescents' Access to Primary Care Practitioners (CAP)			
Ages 12–24 Months	94.89%	94.78%	-0.11
Ages 25 Months–6 Years	83.97%	84.36%	0.39
Ages 7–11 Years	85.98%	85.94%	-0.04
Ages 12–19 Years	83.53%	84.54%	1.01
Children's Preventive Care			
Adolescent Well-Care Visits (AWC)			
Adolescent Well-Care Visits	51.09%	**56.45%**	5.36
Childhood Immunization Status (CIS)[1]			
Combination 2	70.07%	72.99%	2.92
Combination 3	65.94%	**69.83%**	3.89
Combination 4	65.21%	**69.34%**	4.13
Combination 5	55.23%	**59.85%**	4.62
Combination 6	33.09%	34.79%	1.70
Combination 7	54.74%	**59.37%**	4.63

HEDIS Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	2018–2019 Rate Comparison
Combination 8	32.85%	34.79%	1.94
Combination 9	28.47%	30.41%	1.94
Combination 10	28.22%	30.41%	2.19
Immunizations for Adolescents (IMA)			
Combination 1 (Meningococcal, Tdap)	84.67%	**89.29%**	4.62
Combination 2 (Meningococcal, Tdap, HPV)	40.63%	41.12%	0.49
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)			
BMI Percentile Documentation—Total	77.37%	**82.73%**	5.36
Counseling for Nutrition—Total	71.29%	**74.21%**	2.92
Counseling for Physical Activity—Total	67.64%	67.88%	0.24
Well-Child Visits in the First 15 Months of Life (W15)			
Six or More Well-Child Visits	68.04%	**68.06%**	0.02
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)			
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.24%	73.17%	-0.07
Women's Health and Maternity Care			
Breast Cancer Screening (BCS)[1]			
Breast Cancer Screening	50.64%	51.93%	1.29
Prenatal and Postpartum Care (PPC)			
Timeliness of Prenatal Care	80.15%	**80.78%**	0.63
Postpartum Care	62.11%	59.37%	-2.74
Care for Chronic Conditions			
Comprehensive Diabetes Care (CDC)[1]			
HbA1c Testing	82.48%	77.37%	-5.11
*HbA1c Poor Control (>9.0%)**	41.61%	45.01%	3.40
HbA1c Control (<8.0%)	50.12%	47.45%	-2.67
Eye Exam (Retinal) Performed	53.28%	52.31%	-0.97
Medical Attention for Nephropathy	90.27%	87.59%	-2.68
Blood Pressure Control (<140/90 mm Hg)	54.26%	52.31%	-1.95
Controlling High Blood Pressure (CBP)[2]			
Controlling High Blood Pressure	—	52.55%	NC
Medication Management for People With Asthma (MMA)[1]			
Medication Compliance 50%—Total	55.71%	**61.19%**	5.48
Medication Compliance 75%—Total	32.70%	35.90%	3.20

HEDIS Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	2018–2019 Rate Comparison
Behavioral Health			
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)[1]			
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	38.05%	35.32%	-2.73
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)[1]			
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	81.46%	80.48%	-0.98
Follow-Up After ED Visit for AOD Abuse or Dependence (FUA)			
7-Day Follow-Up—Total	7.22%	9.25%	2.03
30-Day Follow-Up—Total	10.92%	13.99%	3.07
Follow-Up After ED Visit for Mental Illness (FUM)[2]			
7-Day Follow-Up—Total	—	28.77%	NC
30-Day Follow-Up—Total	—	41.41%	NC
Follow-Up After Hospitalization for Mental Illness (FUH)[1]			
7-Day Follow-Up—Total	40.13%	33.52%	-6.61
30-Day Follow-Up—Total	56.26%	50.33%	-5.93
Follow-Up Care for Children Prescribed ADHD Medication (ADD)			
Initiation Phase	39.66%	46.77%	7.11
Continuation and Maintenance Phase	61.02%	**66.10%**	5.08
Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)			
Initiation of AOD Treatment—Total	42.83%	**49.65%**	6.82
Engagement of AOD Treatment—Total	12.72%	14.78%	2.06
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)			
Total	21.03%	23.18%	2.15
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)*[1]			
Total	1.42%	**0.00%**	-1.42
Utilization			
Ambulatory Care—Total (per 1,000, Member Months) (AMB)			
*ED Visits—Total**	56.58	56.03	-0.55
Outpatient Visits—Total[1]	287.88	288.52	0.64
Mental Health Utilization—Total (MPT)[2]			
Inpatient—Total	—	1.39%	NC
Intensive Outpatient or Partial Hospitalization—Total	—	0.61%	NC

HEDIS Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	2018–2019 Rate Comparison
Outpatient—Total	—	10.14%	NC
ED—Total	—	0.50%	NC
Telehealth—Total	—	0.03%	NC
Any Service—Total	—	10.68%	NC
Overuse/Appropriateness of Care			
Use of Opioids at High Dosage (UOD)*,[2]			
Use of Opioids at High Dosage	—	7.24%	NC
Use of Opioids From Multiple Providers (UOP)*,[2]			
Multiple Prescribers	—	21.55%	NC
Multiple Pharmacies	—	1.61%	NC
Multiple Prescribers and Multiple Pharmacies	—	0.83%	NC

[1] Due to changes in the technical specifications for this measure, NCQA recommends trending between HEDIS 2019 and prior years be considered with caution.

[2] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS 2019 and prior years; therefore, prior years' rates are not displayed, and rate comparisons are not performed for this measure.

* A lower rate indicates better performances for this measure.

— Indicates that the health plan was not previously required to report this measure or that the rate is not appropriate to display due to changes in the technical specifications.

NC indicates the 2018–2019 Rate Comparison could not be calculated because data are not available for both years.

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

Bolded rates indicate that the performance measure rate for HEDIS 2019 was at or above the minimum performance standards (MPS).

Indicates that the HEDIS 2019 rate declined by 5 percentage points or more from HEDIS 2018.

Indicates that the HEDIS 2019 rate improved by 5 percentage points or more from HEDIS 2018.

Anthem did not meet any of the MPS for measures within the Access to Care domain. The HEDIS 2019 measure rates showed little relative change from HEDIS 2018 for all seven reportable rates, indicating that **Anthem** should explore potential barriers in access to care (e.g., lack of transportation to and from the doctor's office, limited hours for the provider).[5-1]

For the Children's Preventive Care domain, nine of 17 measure rates (52.9 percent) for **Anthem** met the MPS, indicating overall improved performance in the domain. Of note, two of the nine measures (*Adolescent Well-Care Visits* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total*) also improved by more than 5

[5-1] Chapter 4: Monitoring Access to Care in Medicaid. MACPAC. Available at: https://www.macpac.gov/wp-content/uploads/2017/03/Monitoring-Access-to-Care-in-Medicaid.pdf. Accessed on: Aug 14, 2019.

percentage points from HEDIS 2018 to meet the MPS in HEDIS 2019. Although only five of 11 measure rates (45.5 percent) related to vaccinations for children and adolescents met the MPS, all 11 measure rates improved from HEDIS 2018 to HEDIS 2019. Of note, most of **Anthem**'s *Childhood Immunization Status* measure rates that fell below the MPS were due to the measles, mumps, and rubella (MMR); hepatitis A; and influenza vaccination rates improving at a lower rate than the other vaccinations.

Within the Women's Health and Maternity Care domain, one of three measure rates (*Prenatal and Postpartum Care—Timeliness of Prenatal Care*) met the MPS for HEDIS 2019. The *Prenatal and Postpartum Care—Postpartum Care* measure rate decreased by more than 2 percentage points from HEDIS 2018 and fell below the MPS by over 5 percentage points, indicating that **Anthem** should explore the reasons for the declining rates for postpartum care.

For the Care for Chronic Conditions domain, all six of **Anthem**'s *Comprehensive Diabetes Care* measure rates fell below the MPS and decreased in performance from HEDIS 2018, with the *Comprehensive Diabetes Care—HbA1c Testing* rate decreasing by over five percentage points. **Anthem** should ensure that members with diabetes receive regular HbA1c tests and appropriate training on how to self-manage their condition, including proper HbA1c control. Controlling HbA1c levels is critical, as it has the potential to reduce a patient's risk of developing kidney, nerve, or eye disease.[5-2]

Within the Behavioral Health domain, only three of 14 rates (21.4 percent) met the MPS for HEDIS 2019, with both *Follow-Up After Hospitalization for Mental Illness* indicators falling below the MPS and demonstrating a decrease of over 5 percentage points from HEDIS 2018. **Anthem** should conduct an analysis to determine the cause of the worsening performance.

Conversely, **Anthem** demonstrated high performance for measures related to behavioral health medications for the pediatric population. Of note, both *Follow-Up Care for Children Prescribed ADHD Medication* measure rates increased by more than 5 percentage points from HEDIS 2018, and the *Continuation and Maintenance Phase* indicator rate surpassed the Tier 1 quality improvement system for managed care (QISMC) goal. Also, **Anthem**'s *Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total* rate surpassed the Tier 3 QISMC goal with a rate of 0 percent.

NCQA recommends a break in trending between HEDIS 2019 and prior years for all measures within the Overuse/Appropriateness of Care domain; therefore, these rates should continue to be monitored, and improvement efforts should be focused on reducing the prevalence of these prescriptions.

[5-2] U.S. Department of Health and Human Services Health Resources and Services Administration. *Diabetes HbA1c {Poor Control}*. Available at: https://www.hrsa.gov/sites/default/files/quality/toolbox/508pdfs/diabetesmodule.pdf. Accessed on: August 13, 2019.

Nevada Check Up Results

The Nevada Check Up HEDIS 2018 and 2019 rates for **Anthem** are presented in Table 5-3, along with rate comparisons. Measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, a decrease in the rate from 2018 to 2019 represents performance improvement and an increase in the rate from 2018 to 2019 represents performance decline. Measures in the Utilization domain are designed to capture the frequency of services provided by the MCO. With the exception of the *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total*, higher or lower rates in this domain do not necessarily indicate better or worse performance. Therefore, these rates are provided for informational purposes only.

Table 5-3—Nevada Check Up HEDIS Performance Measures Results for Anthem

HEDIS Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	2018–2019 Rate Comparison
Access to Care			
Children and Adolescents' Access to Primary Care Practitioners (CAP)			
Ages 12–24 Months	99.12%	**99.56%**	0.44
Ages 25 Months–6 Years	91.10%	**91.09%**	-0.01
Ages 7–11 Years	93.08%	92.04%	-1.04
Ages 12–19 Years	90.11%	91.03%	0.92
Children's Preventive Care			
Adolescent Well-Care Visits (AWC)			
Adolescent Well-Care Visits	65.82%	**67.40%**	1.58
Childhood Immunization Status (CIS)[1]			
Combination 2	90.24%	87.21%	-3.03
Combination 3	81.71%	**84.02%**	2.31
Combination 4	81.71%	**84.02%**	2.31
Combination 5	75.61%	74.43%	-1.18
Combination 6	38.21%	**47.95%**	9.74
Combination 7	75.61%	74.43%	-1.18
Combination 8	38.21%	**47.95%**	9.74
Combination 9	36.18%	42.47%	6.29
Combination 10	36.18%	42.47%	6.29
Immunizations for Adolescents (IMA)			
Combination 1 (Meningococcal, Tdap)	90.37%	**93.63%**	3.26
Combination 2 (Meningococcal, Tdap, HPV)	54.96%	51.96%	-3.00

HEDIS Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	2018–2019 Rate Comparison
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)			
BMI Percentile Documentation—Total	84.67%	**87.83%**	3.16
Counseling for Nutrition—Total	73.48%	**79.56%**	6.08
Counseling for Physical Activity—Total	70.80%	**73.48%**	2.68
Well-Child Visits in the First 15 Months of Life (W15)			
Six or More Well-Child Visits	83.24%	**82.26%**	-0.98
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)			
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	77.37%	77.62%	0.25
Care for Chronic Conditions			
Medication Management for People With Asthma (MMA)[1]			
Medication Compliance 50%—Total	54.84%	**59.62%**	4.78
Medication Compliance 75%—Total	30.11%	36.54%	6.43
Behavioral Health			
Follow-Up After ED Visit for Mental Illness (FUM)[2]			
7-Day Follow-Up—Total	—	NA	NC
30-Day Follow-Up—Total	—	NA	NC
Follow-Up After Hospitalization for Mental Illness (FUH)[1]			
7-Day Follow-Up—Total	50.00%	NA	NC
30-Day Follow-Up—Total	65.79%	NA	NC
Follow-Up Care for Children Prescribed ADHD Medication (ADD)			
Initiation Phase	44.12%	42.42%	-1.70
Continuation and Maintenance Phase	NA	NA	NC
Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)			
Initiation of AOD Treatment—Total	NA	NA	NC
Engagement of AOD Treatment—Total	NA	NA	NC
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)			
Total	NA	NA	NC
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)*[1]			
Total	NA	NA	NC
Utilization			
Ambulatory Care—Total (per 1,000, Member Months) (AMB)			
*ED Visits—Total**	27.04	25.74	-1.30
Outpatient Visits—Total[1]	248.86	242.04	-6.82

HEDIS Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	2018–2019 Rate Comparison
Mental Health Utilization—Total (MPT)[2]			
Inpatient—Total	—	0.26%	NC
Intensive Outpatient or Partial Hospitalization—Total	—	0.34%	NC
Outpatient—Total	—	6.96%	NC
ED—Total	—	0.14%	NC
Telehealth—Total	—	0.00%	NC
Any Service—Total	—	7.02%	NC

[1] Due to changes in the technical specifications for this measure, NCQA recommends trending between HEDIS 2019 and prior years be considered with caution.

[2] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS 2019 and prior years; therefore, prior years' rates are not displayed, and rate comparisons are not performed for this measure.

* A lower rate indicates better performances for this measure.

— Indicates that the health plan was not previously required to report this measure or that the rate is not appropriate to display due to changes in the technical specifications.

NC indicates the 2018–2019 Rate Comparison could not be calculated because data are not available for both years.

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

Bolded rates indicate that the performance measure rate for HEDIS 2019 was at or above the MPS.

Indicates that the HEDIS 2019 rate declined by 5 percentage points or more from HEDIS 2018.

Indicates that the HEDIS 2019 rate improved by 5 percentage points or more from HEDIS 2018.

Within the Access to Care domain, rates for two of four *Children and Adolescents' Access to Primary Care Practitioner* measure rates met the MPS in HEDIS 2019, with the *Ages 12–24 Months* indicator rate surpassing the Tier 3 QISMC goal, demonstrating strength for **Anthem**'s Check Up population.

Within the Children's Preventive Care domain, 10 of 17 measure rates (58.8 percent) for **Anthem**'s Check Up population met the MPS in HEDIS 2019 and five measure rates improved by more than 5 percentage points from HEDIS 2018.

Additionally, all three of the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure rates met the MPS and two of these rates (*BMI Percentile Documentation—Total* and *Counseling for Nutrition—Total*) exceeded the Tier 1 QISMC goal, indicating strength for **Anthem**'s Check Up population.

One of two measure rates in the Chronic Conditions domain (*Medication Management for People With Asthma—Medication Compliance 50%—Total*) met the MPS and both measure rates improved by over 4 percentage points from HEDIS 2018. **Anthem** should continue to ensure that members with asthma receive appropriate medications to properly control their condition.

Anthem's only reportable rate in the behavioral health domain (*Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*) fell below the MPS by over 13 percentage points and decreased by almost 2 percentage points from HEDIS 2018. **Anthem** should ensure that the children newly prescribed ADHD medication receive appropriate monitoring for dose-response, which can vary widely from person to person, and for side-effects (e.g., weight change, jitteriness, upset sleep schedule).[5-3]

Within the Utilization domain, **Anthem**'s rates for the *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total* measure should continue to be monitored.

Summary of Anthem Strengths

The following Medicaid performance measures were identified as strengths for **Anthem** based on rate increases of 5 percentage points from prior years and meeting the MPS for HEDIS 2019:

- *Adolescent Well-Care Visits*
- *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*
- *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total*
- *Medication Management for People With Asthma—Medication Compliance 50%—Total*
- *Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total*[5-4]
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total*

The following Nevada Check Up performance measures were identified as strengths for **Anthem** based on rate increases of 5 percentage points from prior years and meeting the MPS for HEDIS 2019:

- *Childhood Immunization Status—Combinations 6* and *8*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total*

5-3 ADHD Medications for Children: Side Effects and Research. *Child Development Advice And Parenting Help For Parents*. Available at: childdevelopmentinfo.com/add-adhd/adhd-medications-children-medication-list-side-effects-research/. Accessed on: Aug 16, 2019.

5-4 Please note, the rate for this measure surpassed the MPS but did not improve by 5 percentage points; however, the rate is 0 percent and cannot improve any further.

Summary of Anthem Opportunities for Improvement

The following Medicaid performance measure indicator was identified as an opportunity for improvement for **Anthem** based on rate declines greater than 5 percentage points and not meeting the MPS for HEDIS 2019:

- *Comprehensive Diabetes Care—HbA1c Testing*
- *Follow-Up After Hospitalization for Mental Illness*

No Nevada Check Up performance measures were identified as opportunities for improvement for **Anthem** based on rate declines greater than 5 percentage points from prior years and not meeting the MPS in HEDIS 2019.

MCO-Specific Results—HPN

Medicaid Results

The Medicaid HEDIS 2018 and 2019 rates for **HPN** are presented in Table 5-4, along with rate comparisons. Measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, a decrease in the rate from 2018 to 2019 represents performance improvement and an increase in the rate from 2018 to 2019 represents performance decline. Measures in the Utilization domain are designed to capture the frequency of services provided by the MCO. With the exception of the *Ambulatory Care (per 1,000 Member Months)—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 purposes only.

Table 5-4—Medicaid HEDIS Performance Measures Results for HPN

HEDIS Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	2018–2019 Rate Comparison
Access to Care			
Adults' Access to Preventive/Ambulatory Health Services (AAP)[1]			
Ages 20–44 Years	73.01%	73.09%	0.08
Ages 45–64 Years	80.02%	78.58%	-1.44
Ages 65 Years and Older	60.53%	33.08%	-27.45
Total	75.50%	74.92%	-0.58
Children and Adolescents' Access to Primary Care Practitioners (CAP)			
Ages 12–24 Months	93.95%	94.20%	0.25
Ages 25 Months–6 Years	84.16%	83.38%	-0.78
Ages 7–11 Years	86.59%	86.45%	-0.14
Ages 12–19 Years	84.58%	84.83%	0.25
Children's Preventive Care			
Adolescent Well-Care Visits (AWC)			
Adolescent Well-Care Visits	46.72%	48.66%	1.94
Childhood Immunization Status (CIS)[1]			
Combination 2	71.05%	72.02%	0.97
Combination 3	64.96%	68.37%	3.41
Combination 4	64.72%	67.64%	2.92
Combination 5	54.74%	**60.10%**	5.36
Combination 6	30.66%	**39.42%**	8.76
Combination 7	54.50%	**59.61%**	5.11

HEDIS Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	2018–2019 Rate Comparison
Combination 8	30.66%	**39.42%**	8.76
Combination 9	26.03%	**35.52%**	9.49
Combination 10	26.03%	**35.52%**	9.49
Immunizations for Adolescents (IMA)			
Combination 1 (Meningococcal, Tdap)	82.24%	**89.05%**	6.81
Combination 2 (Meningococcal, Tdap, HPV)	42.58%	43.55%	0.97
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)			
BMI Percentile Documentation—Total	83.21%	78.59%	-4.62
Counseling for Nutrition—Total	68.37%	68.37%	0.00
Counseling for Physical Activity—Total	65.21%	64.96%	-0.25
Well-Child Visits in the First 15 Months of Life (W15)			
Six or More Well-Child Visits	61.31%	63.75%	2.44
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)			
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	70.07%	66.42%	-3.65
Women's Health and Maternity Care			
Breast Cancer Screening (BCS)[1]			
Breast Cancer Screening	56.04%	54.13%	-1.91
Prenatal and Postpartum Care (PPC)			
Timeliness of Prenatal Care	71.29%	**80.54%**	9.25
Postpartum Care	59.12%	**64.96%**	5.84
Care for Chronic Conditions			
Comprehensive Diabetes Care (CDC)[1]			
HbA1c Testing	78.59%	81.02%	2.43
*HbA1c Poor Control (>9.0%)**	44.77%	43.31%	-1.46
HbA1c Control (<8.0%)	46.72%	49.64%	2.92
Eye Exam (Retinal) Performed	59.37%	**62.77%**	3.40
Medical Attention for Nephropathy	87.35%	85.16%	-2.19
Blood Pressure Control (<140/90 mm Hg)	66.18%	63.26%	-2.92
Controlling High Blood Pressure (CBP)[2]			
Controlling High Blood Pressure	—	**62.53%**	NC
Medication Management for People With Asthma (MMA)[1]			
Medication Compliance 50%—Total	57.39%	59.39%	2.00
Medication Compliance 75%—Total	35.33%	36.08%	0.75

HEDIS Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	2018–2019 Rate Comparison
Behavioral Health			
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)[1]			
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	41.59%	41.95%	0.36
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)[1]			
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	77.99%	76.38%	-1.61
Follow-Up After ED Visit for AOD Abuse or Dependence (FUA)			
7-Day Follow-Up—Total	10.46%	15.48%	5.02
30-Day Follow-Up—Total	14.29%	21.02%	6.73
Follow-Up After ED Visit for Mental Illness (FUM)[2]			
7-Day Follow-Up—Total	—	**47.82%**	NC
30-Day Follow-Up—Total	—	**57.48%**	NC
Follow-Up After Hospitalization for Mental Illness (FUH)[1]			
7-Day Follow-Up—Total	25.04%	29.11%	4.07
30-Day Follow-Up—Total	43.18%	49.80%	6.62
Follow-Up Care for Children Prescribed ADHD Medication (ADD)			
Initiation Phase	48.28%	**52.29%**	4.01
Continuation and Maintenance Phase	51.76%	**69.77%**	18.01
Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)			
Initiation of AOD Treatment—Total	36.51%	40.22%	3.71
Engagement of AOD Treatment—Total	7.91%	10.01%	2.10
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)			
Total	13.13%	20.00%	6.87
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)*[1]			
Total	5.29%	**2.25%**	-3.04
Utilization			
Ambulatory Care—Total (per 1,000, Member Months) (AMB)			
*ED Visits—Total**	55.15	54.66	-0.49
Outpatient Visits—Total[1]	299.51	297.98	-1.53
Mental Health Utilization—Total (MPT)[2]			
Inpatient—Total	—	0.82%	NC
Intensive Outpatient or Partial Hospitalization—Total	—	0.22%	NC

HEDIS Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	2018–2019 Rate Comparison
Outpatient—Total	—	8.13%	NC
ED—Total	—	0.03%	NC
Telehealth—Total	—	0.00%	NC
Any Service—Total	—	8.30%	NC
Overuse/Appropriateness of Care			
***Use of Opioids At High Dosage (UOD)**[*,2]*			
Use of Opioids at High Dosage	—	7.86%	NC
***Use of Opioids From Multiple Providers (UOP)**[*,2]*			
Multiple Prescribers	—	26.56%	NC
Multiple Pharmacies	—	4.26%	NC
Multiple Prescribers and Multiple Pharmacies	—	2.12%	NC

[1] Due to changes in the technical specifications for this measure, NCQA recommends trending between HEDIS 2019 and prior years be considered with caution.

[2] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS 2019 and prior years; therefore, prior years' rates are not displayed, and rate comparisons are not performed for this measure.

* A lower rate indicates better performances for this measure.

— Indicates that the health plan was not previously required to report this measure or that the rate is not appropriate to display due to changes in the technical specifications.

NC indicates the 2018–2019 Rate Comparison could not be calculated because data are not available for both years.

Bolded rates indicate that the performance measure rate for HEDIS 2019 was at or above the MPS.

Indicates that the HEDIS 2019 rate declined by 5 percentage points or more from HEDIS 2018.

Indicates that the HEDIS 2019 rate improved by 5 percentage points or more from HEDIS 2018.

Within the Access to Care domain, none of the eight measure rates for **HPN** met the MPS for HEDIS 2019, and seven of eight measure rates remained fairly similar from HEDIS 2018. Of note, the rate for *Adults' Access to Preventive/Ambulatory Health Services—Ages 65 Years and Older* fell by more than 25 percentage points from HEDIS 2018 to HEDIS 2019. **HPN** should explore the reasons for stagnant performance and the reason for the sharp decline in the *Adults' Access to Preventive/Ambulatory Health Services—Ages 65 Years and Older* measure rate.

For the Children's Preventive Care domain, seven of 17 measure rates (41.2 percent) increased by more than 5 percentage points from HEDIS 2018 and met the MPS. All seven of these rates were related to vaccinations for children and adolescents, demonstrating improved performance for **HPN**.

Conversely, all three measure rates related to well-child and well-care visits for children and adolescents and all three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure rates fell below the MPS. Well-child visits are an opportunity for primary care practitioners (PCPs) to track physical development (e.g., height, weight, vision, hearing),

mental/emotional development (e.g., autism screening, attention deficit hyperactivity disorder), administer necessary vaccinations to prevent illness, and provide anticipatory guidance to caregivers. This allows PCPs to identify potential issues, such as diabetes or high blood pressure, and implement interventions at an early age, including counseling for nutrition and physical activity.[5-5] **HPN** should work with providers to identify any barriers that may prevent children and adolescents from receiving necessary well-child and well-care visits.

HPN's performance within the Women's Health and Maternity Care domain showed overall improved performance, with both *Prenatal and Postpartum Care* indicators increasing by more than 5 percentage points and meeting the MPS for HEDIS 2019. Of note, the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* indicator improved by nearly 10 percentage points and surpassed the Tier 1 QISMC goal. **HPN**'s *Breast Cancer Screening* rate fell below the MPS and decreased from HEDIS 2018. **HPN** should work to ensure that women receive appropriate screenings for breast cancer by identifying and addressing barriers to mammography (e.g., lack of patient knowledge or understanding of the importance of breast cancer screenings, lack of patient or provider knowledge about current recommended mammography screening schedule and guidelines).[5-6]

Within the Care for Chronic Conditions domain, one *Comprehensive Diabetes Care* measure rate (*Eye Exam [Retinal] Performed*) met the MPS for HEDIS 2019; and four of the six *Comprehensive Diabetes Care* measure rates (66.7 percent) demonstrated improvement from HEDIS 2018 to HEDIS 2019. The *Comprehensive Diabetes Care—Medical Attention for Nephropathy* and *Blood Pressure Control (<140/90 mm hg)* measure rates both showed decreases from HEDIS 2018 to HEDIS 2019 and each fell below the MPS by more than 2 percentage points. Although NCQA recommended a break in trending for *Controlling High Blood Pressure* due to specification changes, **HPN** met the MPS for this measure rate.

Within the Behavioral Health domain, 11 of the 12 measure rates (91.7 percent) that could be compared to prior years' rates showed improvement from HEDIS 2018, with five measure rates improving by more than 5 percentage points, indicating strong overall improvement for **HPN** in this domain. Of note, both measure rates for *Follow-Up Care for Children Prescribed ADHD Medication* met the MPS and the *Continuation and Maintenance Phase* measure rate increased by more than 18 percentage points and surpassed the Tier 2 QISMC goal.

Conversely, the measure rates for *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* and *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* each fell below the MPS by more than 4 percentage points. This indicates that **HPN**'s members with schizophrenia or bipolar disorder may not be receiving appropriate care and support.

[5-5] American Academy of Pediatrics. Recommendations for Preventive Pediatric Health Care. Available at: https://www.aap.org/en-us/Documents/periodicity_schedule.pdf. Accessed on: Aug 16, 2019.

[5-6] Centers for Disease Control and Prevention. The Manual of Intervention Strategies to Increase Mammography Rates. Available at: https://www.cdc.gov/cancer/nbccedp/pdf/prumanual.pdf. Accessed on: Aug 21, 2019.

NCQA recommended a break in trending between HEDIS 2019 and prior years for all measures within the Overuse/Appropriateness of Care domain; therefore, these rates should continue to be monitored, and improvement efforts should be focused on reducing the prevalence of these prescriptions.

Nevada Check Up Results

The Nevada Check Up HEDIS 2018 and 2019 rates for **HPN** are presented in Table 5-5, along with rate comparisons. Measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, a decrease in the rate from 2018 to 2019 represents performance improvement and an increase in the rate from 2018 to 2019 represents performance decline. Measures in the Utilization domain are designed to capture the frequency of services provided by the MCO. With the exception of the *Ambulatory Care (per 1,000 Member Months)—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 purposes only.

Table 5-5—Nevada Check Up HEDIS Performance Measures Results for HPN

HEDIS Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	2018–2019 Rate Comparison
Access to Care			
Children and Adolescents' Access to Primary Care Practitioners (CAP)			
Ages 12–24 Months	96.33%	**97.81%**	1.48
Ages 25 Months–6 Years	88.12%	**91.10%**	2.98
Ages 7–11 Years	92.25%	93.27%	1.02
Ages 12–19 Years	90.61%	90.82%	0.21
Children's Preventive Care			
Adolescent Well-Care Visits (AWC)			
Adolescent Well-Care Visits	59.61%	60.10%	0.49
Childhood Immunization Status (CIS)[1]			
Combination 2	85.91%	87.57%	1.66
Combination 3	81.54%	**84.32%**	2.78
Combination 4	81.54%	**83.73%**	2.19
Combination 5	74.16%	76.63%	2.47
Combination 6	44.30%	46.15%	1.85
Combination 7	74.16%	76.33%	2.17
Combination 8	44.30%	46.15%	1.85
Combination 9	40.94%	42.01%	1.07
Combination 10	40.94%	42.01%	1.07

HEDIS Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	2018–2019 Rate Comparison
Immunizations for Adolescents (IMA)			
Combination 1 (Meningococcal, Tdap)	86.62%	**93.92%**	7.30
Combination 2 (Meningococcal, Tdap, HPV)	51.82%	56.20%	4.38
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)			
BMI Percentile Documentation—Total	83.70%	83.45%	-0.25
Counseling for Nutrition—Total	73.48%	74.70%	1.22
Counseling for Physical Activity—Total	69.59%	72.02%	2.43
Well-Child Visits in the First 15 Months of Life (W15)			
Six or More Well-Child Visits	68.33%	73.19%	4.86
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)			
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.48%	77.62%	4.14
Care for Chronic Conditions			
Medication Management for People With Asthma (MMA)[1]			
Medication Compliance 50%—Total	53.65%	55.22%	1.57
Medication Compliance 75%—Total	34.90%	33.33%	-1.57
Behavioral Health			
Follow-Up After ED Visit for Mental Illness (FUM)[2]			
7-Day Follow-Up—Total	—	66.67%	NC
30-Day Follow-Up—Total	—	80.00%	NC
Follow-Up After Hospitalization for Mental Illness (FUH)[1]			
7-Day Follow-Up—Total	68.57%	NA	NC
30-Day Follow-Up—Total	80.00%	NA	NC
Follow-Up Care for Children Prescribed ADHD Medication (ADD)			
Initiation Phase	55.36%	**58.11%**	2.75
Continuation and Maintenance Phase	NA	NA	NC
Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)			
Initiation of AOD Treatment—Total	25.64%	NA	NC
Engagement of AOD Treatment—Total	7.69%	NA	NC
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)			
Total	16.67%	25.58%	8.91
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)*[1]			
Total	NA	**0.00%**	NC

HEDIS Measure	HEDIS 2018 Rate	HEDIS 2019 Rate	2018–2019 Rate Comparison
Utilization			
Ambulatory Care—Total (per 1,000, Member Months) (AMB)			
*ED Visits—Total**	23.87	22.99	-0.88
Outpatient Visits—Total[1]	248.74	246.47	-2.27
Mental Health Utilization—Total (MPT)[2]			
Inpatient—Total	—	0.18%	NC
Intensive Outpatient or Partial Hospitalization—Total	—	0.14%	NC
Outpatient—Total	—	6.55%	NC
ED—Total	—	0.03%	NC
Telehealth—Total	—	0.00%	NC
Any Service—Total	—	6.60%	NC

[1] Due to changes in the technical specifications for this measure, NCQA recommends trending between HEDIS 2019 and prior years be considered with caution.

[2] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS 2019 and prior years; therefore, prior years' rates are not displayed, and rate comparisons are not performed for this measure.

* A lower rate indicates better performances for this measure.

— Indicates that the health plan was not previously required to report this measure or that the rate is not appropriate to display due to changes in the technical specifications.

NC indicates the 2018–2019 Rate Comparison could not be calculated because data are not available for both years.

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

Bolded rates indicate that the performance measure rate for HEDIS 2019 was at or above the MPS.

Indicates that the HEDIS 2019 rate declined by 5 percentage points or more from HEDIS 2018.

Indicates that the HEDIS 2019 rate improved by 5 percentage points or more from HEDIS 2018.

Within the Access to Care domain, two of four measure rates (*Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months* and *Ages 25 Months–6 Years*) met the MPS for HEDIS 2019, and all four measure rates showed improvement from HEDIS 2018. The remaining two measure rates (*Ages 7–11 Years* and *Ages 12–19 Years*) were within one percentage point of meeting their respective MPS.

While only three of the 17 measure rates (17.6 percent) in the Children's Preventive Care domain met the MPS, all measure rates, except for *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total*, showed improvement from HEDIS 2018 to HEDIS 2019. Of note, **HPN**'s measure rate for *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* increased by more than 7 percentage points and exceeded the Tier 3 QISMC goal.

Within the Care for Chronic Conditions domain, both of the *Medication Management for People With Asthma* measure rates fell below the MPS by more than 3 percentage points. **HPN** should continue to ensure that members with asthma receive appropriate medications to properly control their condition.

Within the Behavioral Health domain, two of five reportable rates (40.0 percent) met the MPS, with the *Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total* measure rate surpassing the Tier 3 QISMC goal. Although **HPN**'s *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measure rate improved by nearly 9 percentage points from HEDIS 2018 to HEDIS 2019, it still fell below the MPS by more than 3 percentage points.

Within the Utilization domain, **HPN**'s rates for the *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total* measure should continue to be monitored.

Summary of HPN Strengths

The following Medicaid performance measures were identified as strengths for **HPN** based on a rate increase of at least 5 percentage points from prior years and meeting the MPS for HEDIS 2019:

- *Childhood Immunization Status—Combination 5, 6, 7, 8, 9, and 10*
- *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*
- *Prenatal and Postpartum Care*

The following Nevada Check Up performance measures were identified as strengths for **HPN** based on a rate increase of at least 5 percentage points from prior years and meeting the MPS for HEDIS 2019:

- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*

Summary of HPN Opportunities for Improvement

The following Medicaid performance measures were identified as opportunities for improvement for **HPN** based on a rate decline of 5 or more percentage points from prior years and not meeting the MPS for HEDIS 2019:

- *Adults' Access to Preventive/Ambulatory Health Services—Ages 65 Years and Older*

No Nevada Check Up performance measures were identified as opportunities for improvement for **HPN** based on a rate decline of 5 or more percentage points from prior years and not meeting the MPS for HEDIS 2019.

MCO-Specific Results—SilverSummit

Medicaid Results

The Medicaid HEDIS 2019 rates for **SilverSummit** are presented in Table 5-4. Since **SilverSummit** was a new MCO in HEDIS 2019, HEDIS 2018 rates and 2018–2019 rate comparisons are not available. Measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures in the Utilization domain are designed to capture the frequency of services provided by the MCO. With the exception of the *Ambulatory Care (per 1,000 Member Months)—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 purposes only.

Table 5-6—Medicaid HEDIS Performance Measures Results for SilverSummit

HEDIS Measure	HEDIS 2019 Rate
Access to Care	
Adults' Access to Preventive/Ambulatory Health Services (AAP)[1]	
Ages 20–44 Years	62.35%
Ages 45–64 Years	72.28%
Ages 65 Years and Older	NA
Total	65.40%
Children and Adolescents' Access to Primary Care Practitioners (CAP)	
Ages 12–24 Months	88.56%
Ages 25 Months–6 Years	71.50%
Ages 7–11 Years	NA
Ages 12–19 Years	NA
Children's Preventive Care	
Adolescent Well-Care Visits (AWC)	
Adolescent Well-Care Visits	36.50%
Childhood Immunization Status (CIS)[1]	
Combination 2	46.25%
Combination 3	43.13%
Combination 4	43.13%
Combination 5	34.38%
Combination 6	16.25%
Combination 7	34.38%
Combination 8	16.25%
Combination 9	13.13%

HEDIS Measure	HEDIS 2019 Rate
Combination 10	13.13%
Immunizations for Adolescents (IMA)	
Combination 1 (Meningococcal, Tdap)	67.70%
Combination 2 (Meningococcal, Tdap, HPV)	19.25%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	
BMI Percentile Documentation—Total	70.56%
Counseling for Nutrition—Total	66.42%
Counseling for Physical Activity—Total	60.58%
Well-Child Visits in the First 15 Months of Life (W15)	
Six or More Well-Child Visits	51.88%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)	
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	59.37%
Women's Health and Maternity Care	
Breast Cancer Screening (BCS)[1]	
Breast Cancer Screening	NA
Prenatal and Postpartum Care (PPC)	
Timeliness of Prenatal Care	66.42%
Postpartum Care	48.42%
Care for Chronic Conditions	
Comprehensive Diabetes Care (CDC)[1]	
HbA1c Testing	79.08%
*HbA1c Poor Control (>9.0%)**	57.66%
HbA1c Control (<8.0%)	34.55%
Eye Exam (Retinal) Performed	46.47%
Medical Attention for Nephropathy	87.59%
Blood Pressure Control (<140/90 mm Hg)	46.23%
Controlling High Blood Pressure (CBP)[2]	
Controlling High Blood Pressure	43.55%
Medication Management for People With Asthma (MMA)[1]	
Medication Compliance 50%—Total	NA
Medication Compliance 75%—Total	NA
Behavioral Health	
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)[1]	
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	35.06%

HEDIS Measure	HEDIS 2019 Rate
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)[1]	
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	78.06%
Follow-Up After ED Visit for AOD Abuse or Dependence (FUA)	
7-Day Follow-Up—Total	11.93%
30-Day Follow-Up—Total	15.33%
Follow-Up After ED Visit for Mental Illness (FUM)[2]	
7-Day Follow-Up—Total	26.19%
30-Day Follow-Up—Total	35.46%
Follow-Up After Hospitalization for Mental Illness (FUH)[1]	
7-Day Follow-Up—Total	22.40%
30-Day Follow-Up—Total	36.72%
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	
Initiation Phase	NA
Continuation and Maintenance Phase	NA
Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)	
Initiation of AOD Treatment—Total	**46.30%**
Engagement of AOD Treatment—Total	13.37%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	
Total	23.08%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)*[1]	
Total	**1.92%**
Utilization	
Ambulatory Care—Total (per 1,000, Member Months) (AMB)	
*ED Visits—Total**	61.33
Outpatient Visits—Total[1]	258.11
Mental Health Utilization—Total (MPT)[2]	
Inpatient—Total	1.63%
Intensive Outpatient or Partial Hospitalization—Total	0.16%
Outpatient—Total	12.14%
ED—Total	0.10%
Telehealth—Total	0.06%
Any Service—Total	12.80%

HEDIS Measure	HEDIS 2019 Rate
Overuse/Appropriateness of Care	
***Use of Opioids At High Dosage (UOD)**[2]*	
Use of Opioids at High Dosage	3.77%
***Use of Opioids From Multiple Providers (UOP)**[2]*	
Multiple Prescribers	23.52%
Multiple Pharmacies	4.37%
Multiple Prescribers and Multiple Pharmacies	2.81%

[1] Due to changes in the technical specifications for this measure, NCQA recommends trending between HEDIS 2019 and prior years be considered with caution.

[2] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS 2019 and prior years.

* A lower rate indicates better performances for this measure.

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

Bolded rates indicate that the performance measure rate for HEDIS 2019 was at or above the MPS.

Since **SilverSummit** was a first-year MCO during HEDIS 2019, rate comparisons could not be made. **SilverSummit** should continue to monitor rates to ensure their performance trends toward meeting the QISMC goals.

Nevada Check Up Results

The Nevada Check Up HEDIS 2019 rates for **SilverSummit** are presented in Table 5-5. Since **SilverSummit** was a new MCO in HEDIS 2019, HEDIS 2018 rates and 2018–2019 rate comparisons are not available. Measures for which lower rates suggest better performance are indicated by an asterisk (*). Measures in the Utilization domain are designed to capture the frequency of services provided by the MCO. With the exception of the *Ambulatory Care (per 1,000 Member Months)—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 purposes only.

Table 5-7—Nevada Check Up HEDIS Performance Measures Results for SilverSummit

HEDIS Measure	HEDIS 2019 Rate
Access to Care	
Children and Adolescents' Access to Primary Care Practitioners (CAP)	
Ages 12–24 Months	94.12%
Ages 25 Months–6 Years	83.54%
Ages 7–11 Years	NA
Ages 12–19 Years	NA

HEDIS Measure	HEDIS 2019 Rate
Children's Preventive Care	
Adolescent Well-Care Visits (AWC)	
Adolescent Well-Care Visits	45.28%
Childhood Immunization Status (CIS)[1]	
Combination 2	NA
Combination 3	NA
Combination 4	NA
Combination 5	NA
Combination 6	NA
Combination 7	NA
Combination 8	NA
Combination 9	NA
Combination 10	NA
Immunizations for Adolescents (IMA)	
Combination 1 (Meningococcal, Tdap)	NA
Combination 2 (Meningococcal, Tdap, HPV)	NA
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	
BMI Percentile Documentation—Total	76.16%
Counseling for Nutrition—Total	69.59%
Counseling for Physical Activity—Total	64.72%
Well-Child Visits in the First 15 Months of Life (W15)	
Six or More Well-Child Visits	NA
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)	
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	59.56%
Care for Chronic Conditions	
Medication Management for People With Asthma (MMA)[1]	
Medication Compliance 50%—Total	NA
Medication Compliance 75%—Total	NA
Behavioral Health	
Follow-Up After ED Visit for Mental Illness (FUM)[2]	
7-Day Follow-Up—Total	NA
30-Day Follow-Up—Total	NA
Follow-Up After Hospitalization for Mental Illness (FUH)[1]	
7-Day Follow-Up—Total	NA

HEDIS Measure	HEDIS 2019 Rate
30-Day Follow-Up—Total	NA
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	
Initiation Phase	NA
Continuation and Maintenance Phase	NA
Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)	
Initiation of AOD Treatment—Total	NA
Engagement of AOD Treatment—Total	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	
Total	NA
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)*[1]	
Total	NA
Utilization	
Ambulatory Care—Total (per 1,000, Member Months) (AMB)	
*ED Visits—Total**	26.36
Outpatient Visits—Total[1]	192.98
Mental Health Utilization—Total (MPT)[2]	
Inpatient—Total	0.73%
Intensive Outpatient or Partial Hospitalization—Total	0.05%
Outpatient—Total	7.14%
ED—Total	0.00%
Telehealth—Total	0.00%
Any Service—Total	7.30%

[1] Due to changes in the technical specifications for this measure, NCQA recommends trending between HEDIS 2019 and prior years be considered with caution.

[2] Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS 2019 and prior years.

* A lower rate indicates better performances for this measure.

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

Bolded rates indicate that the performance measure rate for HEDIS 2019 was at or above the MPS.

Since **SilverSummit** was a first-year MCO during HEDIS 2019, rate comparisons could not be made. **SilverSummit** should continue to monitor rates to ensure their performance trends toward meeting the QISMC goals.

Summary of SilverSummit Strengths

Due to **SilverSummit** being a new MCO for HEDIS 2019, 2018–2019 rate comparisons could not be made because HEDIS 2018 measure rates are not available. **SilverSummit**'s performance for Medicaid and Nevada Check Up populations will be assessed in future reports once more data are available.

Summary of SilverSummit Opportunities for Improvement

Due to **SilverSummit** being a new MCO for HEDIS 2019, 2018–2019 rate comparisons could not be made because HEDIS 2018 measure rates are not available. **SilverSummit**'s performance for Medicaid and Nevada Check Up populations will be assessed in future reports once more data are available.

Plan Comparison

The HEDIS 2019 measure rates for **HPN**, **Anthem**, **SilverSummit**, and the statewide weighted average results for the Medicaid and Nevada Check Up populations are shown in Table 1-2 and Table 1-3 respectively.

Medicaid Results

Data Completeness

Table 5-8 provides an estimate of data completeness for the hybrid performance measures. These measures used administrative data (i.e., claims, encounter, and supplemental data) and supplemented the results with medical record review data. Measures that used only administrative data were not included. The table shows the HEDIS 2019 rates and the percentage of each reported rate that was determined solely through administrative data for the MCOs. Rates shaded green indicate that more than 90 percent of the final rate was derived using administrative data. Rates shaded red indicate that less than 50 percent of the final rate was derived using administrative data. Higher or lower rates of encounter data completeness do not necessarily indicate better or worse performance. Therefore, these rates are provided for information purposes only.

Table 5-8—Estimated Encounter Data Completeness for Medicaid Hybrid Measures

HEDIS Measure	Anthem HEDIS 2019 Rate	Anthem Percent from Administrative Data	HPN HEDIS 2019 Rate	HPN Percent from Administrative Data	SilverSummit HEDIS 2019 Rate	SilverSummit Percent from Administrative Data
Children's Preventive Care						
Adolescent Well-Care Visits (AWC)						
Adolescent Well-Care Visits	56.45%	82.33%	48.66%	98.00%	36.50%	90.67%
Childhood Immunization Status (CIS)						
Combination 2	72.99%	95.33%	72.02%	82.77%	46.25%	81.08%
Combination 3	69.83%	94.77%	68.37%	82.56%	43.13%	79.71%
Combination 4	69.34%	94.74%	67.64%	82.37%	43.13%	79.71%
Combination 5	59.85%	94.31%	60.10%	81.78%	34.38%	78.18%
Combination 6	34.79%	93.01%	39.42%	79.63%	16.25%	73.08%
Combination 7	59.37%	94.26%	59.61%	81.63%	34.38%	78.18%
Combination 8	34.79%	93.01%	39.42%	79.63%	16.25%	73.08%
Combination 9	30.41%	92.00%	35.52%	78.08%	13.13%	66.67%
Combination 10	30.41%	92.00%	35.52%	78.08%	13.13%	66.67%
Immunizations for Adolescents (IMA)						
Combination 1 (Meningococcal, Tdap)	89.29%	96.46%	89.05%	96.17%	67.70%	89.91%
Combination 2 (Meningococcal, Tdap, HPV)	41.12%	95.86%	43.55%	93.30%	19.25%	74.19%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)						
BMI Percentile Documentation—Total	82.73%	58.24%	78.59%	62.54%	70.56%	53.79%
Counseling for Nutrition—Total	74.21%	**48.85%**	68.37%	59.07%	66.42%	**45.05%**
Counseling for Physical Activity—Total	67.88%	**38.35%**	64.96%	56.18%	60.58%	**39.36%**
Well-Child Visits in the First 15 Months of Life (W15)						
Six or More Well-Child Visits	68.06%	89.80%	63.75%	95.80%	51.88%	87.10%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)						
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.17%	96.25%	66.42%	98.17%	59.37%	97.54%

HEDIS Measure	Anthem HEDIS 2019 Rate	Anthem Percent from Administrative Data	HPN HEDIS 2019 Rate	HPN Percent from Administrative Data	SilverSummit HEDIS 2019 Rate	SilverSummit Percent from Administrative Data
Women's Health and Maternity Care						
Prenatal and Postpartum Care (PPC)						
Timeliness of Prenatal Care	80.78%	75.60%	80.54%	77.34%	66.42%	71.06%
Postpartum Care	59.37%	72.54%	64.96%	83.52%	48.42%	64.82%
Care for Chronic Conditions						
Comprehensive Diabetes Care (CDC)						
HbA1c Testing	77.37%	96.54%	81.02%	97.90%	79.08%	97.54%
HbA1c Poor Control (>9.0%)	45.01%	91.35%	43.31%	98.31%	57.66%	83.97%
HbA1c Control (<8.0%)	47.45%	69.23%	49.64%	88.24%	34.55%	**47.89%**
Eye Exam (Retinal) Performed	52.31%	92.09%	62.77%	88.76%	46.47%	97.91%
Medical Attention for Nephropathy	87.59%	100%	85.16%	98.29%	87.59%	100%
Blood Pressure Control (<140/90 mm Hg)	52.31%	**13.95%**	63.26%	**6.92%**	46.23%	**10.00%**
Controlling High Blood Pressure (CBP)						
Controlling High Blood Pressure	52.55%	**17.59%**	62.53%	**9.73%**	43.55%	**11.73%**

= More than 90 percent of the final rate was derived from administrative data.

= 50 percent or less of the final rate was derived from administrative data.

The MCOs reported a total of 26 rates for the Medicaid population using the hybrid methodology. For 16 of 26 (61.5 percent) hybrid measure rates reported by **Anthem**, 90 percent or more of their numerator-positive results were identified from administrative data only, indicating high levels of encounter data completeness. Eight of 26 (30.8 percent) hybrid measure rates reported by **HPN** were derived using more than 90 percent administrative data. For five of 26 (19.2 percent) hybrid measure rates reported by **SilverSummit,** 90 percent or more of their numerator-positive results were identified from administrative data only. For all three MCOs, the rates for *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* and *Controlling High Blood Pressure* were derived using 50 percent or less administrative data. Additionally, **Anthem** and **SilverSummit**'s rates for *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total* and *Counseling for Physical Activity—Total* were derived using less than 50 percent administrative data. However, for these measures the numerator-positive hits are often detected primarily through medical record review, not administrative data.

Nevada Check Up Results

Data Completeness

Table 5-9 provides an estimate of data completeness for the hybrid performance measures. These measures used administrative data (i.e., claims, encounter, and supplemental data) and supplemented the results with medical record review data. Measures that used only administrative data were not included. The table shows the HEDIS 2019 rates and the percentage of each reported rate that was determined solely through administrative data for the MCOs. Rates shaded green indicate that more than 90 percent of the final rate was derived using administrative data. Rates shaded red indicate that less than 50 percent of the final rate was derived using administrative data. Higher or lower rates of encounter data completeness do not necessarily indicate better or worse performance. Therefore, these rates are provided for information purposes only.

Table 5-9—Estimated Encounter Data Completeness for Nevada Check Up Hybrid Measures

HEDIS Measure	Anthem HEDIS 2019 Rate	Anthem Percent from Administrative Data	HPN HEDIS 2019 Rate	HPN Percent from Administrative Data	SilverSummit HEDIS 2019 Rate	SilverSummit Percent from Administrative Data
Children's Preventive Care						
Adolescent Well-Care Visits (AWC)						
Adolescent Well-Care Visits	67.40%	90.61%	60.10%	97.98%	45.28%	93.87%
Childhood Immunization Status (CIS)						
Combination 2	87.21%	94.76%	87.57%	85.47%	NA	NA
Combination 3	84.02%	94.57%	84.32%	84.91%	NA	NA
Combination 4	84.02%	94.57%	83.73%	84.81%	NA	NA
Combination 5	74.43%	94.48%	76.63%	84.94%	NA	NA
Combination 6	47.95%	96.19%	46.15%	85.26%	NA	NA
Combination 7	74.43%	94.48%	76.33%	84.88%	NA	NA
Combination 8	47.95%	96.19%	46.15%	85.26%	NA	NA
Combination 9	42.47%	96.77%	42.01%	84.51%	NA	NA
Combination 10	42.47%	96.77%	42.01%	84.51%	NA	NA
Immunizations for Adolescents (IMA)						
Combination 1 (Meningococcal, Tdap)	93.63%	97.64%	93.92%	95.08%	NA	NA
Combination 2 (Meningococcal, Tdap, HPV)	51.96%	95.75%	56.20%	94.37%	NA	NA

HEDIS Measure	Anthem HEDIS 2019 Rate	Anthem Percent from Administrative Data	HPN HEDIS 2019 Rate	HPN Percent from Administrative Data	SilverSummit HEDIS 2019 Rate	SilverSummit Percent from Administrative Data
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)						
BMI Percentile Documentation—Total	87.83%	56.23%	83.45%	61.52%	76.16%	55.59%
Counseling for Nutrition—Total	79.56%	51.38%	74.70%	57.00%	69.59%	**41.26%**
Counseling for Physical Activity—Total	73.48%	**42.05%**	72.02%	53.04%	64.72%	**39.85%**
Well-Child Visits in the First 15 Months of Life (W15)						
Six or More Well-Child Visits	82.26%	88.89%	73.19%	94.55%	NA	NA
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)						
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	77.62%	97.49%	77.62%	98.43%	59.56%	96.30%

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

= More than 90 percent of the final rate was derived from administrative data.

= 50 percent or less of the final rate was derived from administrative data.

The MCOs reported a total of 17 rates for the Nevada Check Up population using the hybrid methodology. For 13 of 17 (76.5 percent) hybrid measure rates reported by **Anthem,** 90 percent or more of their numerator-positive results were identified from administrative data only. Five of 17 (29.4 percent) hybrid measure rates reported by **HPN** were derived using more than 90 percent administrative data. For two of 17 (11.8 percent) hybrid measure rates reported by **SilverSummit**, 90 percent or more of their numerator-positive results were identified from administrative data only. **Anthem** and **SilverSummit**'s rates for *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total* measure indicator and **SilverSummit**'s rate for *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total* were derived using less than 50 percent administrative data. However, for these measures, numerator-positive hits are often detected primarily through medical record review, not administrative data.

Anthem Conclusions and Recommendations

Conclusions

Performance for **Anthem**'s Medicaid population was evaluated in terms of access to and quality and timeliness of care. Only measures that have at least two years of data in this report are included in the evaluation of quality, access, and timeliness.

For measures related to quality, six of 40 measures (15.0 percent) demonstrated rate increases of at least 5 percentage points in HEDIS 2019 from HEDIS 2018 and 14 of 40 measures (35.0 percent) met the MPS in 2019. The following measures related to quality had rate increases greater than 5 percentage points and met the MPS in 2019:

- *Adolescent Well-Care Visits*
- *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*
- *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total*
- *Medication Management for People With Asthma—Medication Compliance 50%—Total*
- *Use of Multiple Concurrent Antipsychotics in Children and Adolescents*[5-7]
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total*

For measures related to access to care, four of 20 measures (20.0 percent) demonstrated rate increases of at least 5 percentage points in HEDIS 2019 from HEDIS 2018 and five of 20 measures (25.0 percent) met the MPS in 2019. The following measures related to access had rate increases greater than 5 percentage points and met the MPS in 2019:

- *Adolescent Well-Care Visits*
- *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*
- *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total*

For measures related to timeliness of care, three of 10 measures (30.0 percent) demonstrated rate increases of at least 5 percentage points in HEDIS 2019 from HEDIS 2018 and three of 10 measures (30.0 percent) met the MPS in 2019. The following measures related to timeliness had rate increases greater than 5 percentage points and met the MPS in 2019:

- *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*

[5-7] Please note, the rate for this measure surpassed the MPS but did not improve by 5 percentage points; however, the rate is 0 percent and cannot improve any further.

- *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total*

Conversely, for measures related to quality, three of 40 measures (7.5 percent) had rate declines of at least 5 percentage points in HEDIS 2019 from HEDIS 2018 and 26 of 40 measures (65.0 percent) did not meet the MPS in 2019. The following measures related to quality had rate declines of at least 5 percentage points and did not meet the MPS in 2019:

- *Comprehensive Diabetes Care—HbA1c Testing*
- *Follow-Up After Hospitalization for Mental Illness*

For measures related to access of care, two of 20 measures (10.0 percent) had rate declines of at least 5 percentage points in HEDIS 2019 from HEDIS 2018 and 15 of 20 measures (75.0 percent) did not meet the MPS in 2019. The following measure related to access had rate declines of more than 5 percentage points and did not meet the MPS in 2019:

- *Follow-Up After Hospitalization for Mental Illness*

For measures related to timeliness of care, two of 10 measures (20.0 percent) had rate declines of at least 5 percentage points in HEDIS 2019 from HEDIS 2018 and seven of 10 measures (70.0 percent) did not meet the MPS in 2019. The following measure related to timeliness had rate declines of more than 5 percentage points and did not meet the MPS in 2019:

- *Follow-Up After Hospitalization for Mental Illness*

For **Anthem**'s Nevada Check Up population, six of 20 measures (30.0 percent) related to quality had rate increases of at least 5 percentage points in HEDIS 2019 from HEDIS 2018 and 11 of 20 measures (55.0 percent) met the MPS in 2019. The following measures related to quality had rate increases of at least 5 percentage points and met the MPS in 2019:

- *Childhood Immunization Status—Combinations 6* and *8*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total*

For measures related to access to care, zero of eight measures had rate increases of at least 5 percentage points in HEDIS 2019 from HEDIS 2018 and four of eight measures (50.0 percent) met the MPS in 2019. None of **Anthem**'s Nevada Check Up measures related to access had rate increases of at least 5 percentage points and met the MPS in 2019.

For the one measure related to timeliness of care, it did not have a rate increase of at least 5 percentage points and did not meet the MPS in 2019.

Conversely, for measures related to quality, zero of 20 of measures had rate declines greater than 5 percentage points in HEDIS 2019 from HEDIS 2018 and nine of 20 measures (45.0 percent) did not

meet the MPS in 2019. None of **Anthem**'s Nevada Check Up measures related to quality had rate declines greater than 5 percentage points and did not meet the MPS in 2019.

For measures related to access of care, zero of eight measures had rate declines greater than 5 percentage points in HEDIS 2019 from HEDIS 2018 and four of eight measures (50.0 percent) did not meet the MPS in 2019. None of **Anthem**'s Nevada Check Up measures related to access had rate declines greater than 5 percentage points and did not meet the MPS in 2019.

For the one measure related to timeliness of care, it did not have a rate decline greater than 5 percentage points in HEDIS 2019 from HEDIS 2018 and did not meet the MPS in 2019.

Recommendations

Anthem should investigate the reasons for declines in rates of 5 percentage points or more for the following Medicaid measures:

- *Comprehensive Diabetes Care—HbA1c Testing*
- *Follow-Up After Hospitalization for Mental Illness*

HPN Conclusions and Recommendations

Conclusions

Performance for **HPN**'s Medicaid population was evaluated in terms of access to and quality and timeliness of care. Only measures that have at least two years of data in this report are included in the evaluation of quality, access, and timeliness.

For measures related to quality, 14 of 40 measures (35.0 percent) demonstrated rate increases of at least 5 percentage points in HEDIS 2019 from HEDIS 2018 and 13 of 40 measures (32.5 percent) met the MPS in 2019. The following measures related to quality had rate increases greater than 5 percentage points and met the MPS in 2019:

- *Childhood Immunization Status—Combinations 5*, *6*, *7*, *8*, *9*, and *10*
- *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*
- *Prenatal and Postpartum Care*

For measures related to access to care, six of 21 measures (28.6 percent) demonstrated rate increases of at least 5 percentage points in HEDIS 2019 from HEDIS 2018 and four of 21 measures (19.0 percent) met the MPS in 2019. The following measures related to access had rate increases greater than 5 percentage points and met the MPS in 2019:

- *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*
- *Prenatal and Postpartum Care*

For measures related to timeliness of care, six of 10 measures (60.0 percent) demonstrated rate increases of at least 5 percentage points in HEDIS 2019 from HEDIS 2018 and four of 10 measures (40.0 percent) met the MPS in 2019. The following measures related to timeliness had rate increases greater than 5 percentage points and met the MPS in 2019:

- *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*
- *Prenatal and Postpartum Care*

Conversely, for measures related to quality, zero of 40 measures had rate declines of at least 5 percentage points in HEDIS 2019 from HEDIS 2018 and 27 of 40 measures (67.5 percent) did not meet the MPS in 2019. None of the measures related to quality had rate declines of at least 5 percentage points and did not meet the MPS in 2019.

For measures related to access of care, one of 21 measures (4.8 percent) had rate declines of at least 5 percentage points in HEDIS 2019 from HEDIS 2018 and 17 of 21 measures (81.0 percent) did not meet the MPS in 2019. The following measure related to access had rate declines of more than 5 percentage points and did not meet the MPS in 2019:

- *Adults' Access to Preventative/Ambulatory Health Services—Ages 65 Years and Older*

For measures related to timeliness of care, zero of 10 measures had rate declines of at least 5 percentage points in HEDIS 2019 from HEDIS 2018 and six of 10 measures (60.0 percent) did not meet the MPS in 2019. None of the measures related to timeliness had rate declines of more than 5 percentage points and did not meet the MPS in 2019.

For **HPN**'s Nevada Check Up population, two of 21 measures (9.5 percent) related to quality had rate increases of at least 5 percentage points in HEDIS 2019 from HEDIS 2018 and four of 21 measures (19.0 percent) met the MPS in 2019. The following measure related to quality had a rate increase of at least 5 percentage points and met the MPS in 2019:

- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*

For **HPN**'s Nevada Check Up population, zero of eight measures related to access had rate increases of at least 5 percentage points in HEDIS 2019 from HEDIS 2018 and three of eight measures (37.5 percent) met the MPS in 2019. None of the measures related to access had rate increases of at least 5 percentage points and met the MPS in 2019.

For the one measure related to timeliness of care, it did not have a rate increase of at least 5 percentage points in HEDIS 2019 from HEDIS 2018 and the one measure with an MPS met the goal in 2019.

Conversely, for measures related to quality, zero of 21 of measures had rate declines greater than 5 percentage points in HEDIS 2019 from HEDIS 2018 and 17 of 21 measures (81.0 percent) did not meet the MPS in 2019. None of the measures related to quality had rate declines greater than 5 percentage points and did not meet the MPS in 2019.

For measures related to access of care, zero of eight measures had rate declines greater than 5 percentage points in HEDIS 2019 from HEDIS 2018 and five of eight measures (62.5 percent) did not meet the MPS in 2019. None of **HPN**'s Nevada Check Up measures related to access had rate declines greater than 5 percentage points and did not meet the MPS in 2019.

For the one measure related to timeliness of care, it did not have a rate decline greater than 5 percentage points in HEDIS 2019 from HEDIS 2018 and the one measure with an MPS met the goal in 2019.

Recommendations

HPN should investigate the reason for the decline in rate of more than 5 percentage points for the *Adults' Access to Preventive/Ambulatory Health Services—Ages 65 Years and Older* measure.

SilverSummit Conclusions and Recommendations

Conclusions

Since **SilverSummit** was a new MCO for HEDIS 2019, performance for **SilverSummit**'s Medicaid and Nevada Check Up populations were not evaluated in terms of access to and quality and timeliness of care. **SilverSummit**'s performance will be assessed in future reports once additional data are available.

Recommendations

Since **SilverSummit** was a new MCO for HEDIS 2019, performance for **SilverSummit**'s Medicaid and Nevada Check Up populations were not evaluated in terms of quality, access, and timeliness of care. **SilverSummit**'s performance will be assessed in future reports once additional data are available.

6. Validation of Performance Improvement Projects—SFY 2018–2019

Overview

The Code of Federal Regulations (CFR), specifically 42 CFR §438.350, requires states that contract with managed care organizations (MCOs) to conduct an external quality review (EQR) of each contracting MCO. An EQR includes analysis and evaluation by an external quality review organization (EQRO) of aggregated information on healthcare quality, timeliness, and access. Health Services Advisory Group, Inc. (HSAG), serves as the EQRO for the State of Nevada, Department of Health and Human Services, Division of Health Care Financing and Policy (the DHCFP)—responsible for the overall administration and monitoring of the Nevada Medicaid managed care program.

As one of the mandatory EQR activities required by 42 CFR §438.358(b)(1)(i) HSAG, as the State's EQRO, validated the performance improvement projects (PIPs) through an independent review process. In its PIP evaluation and validation, HSAG used the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[6-1]

Objectives

PIPs provide a structured method to assess and improve processes, thereby outcomes, of care for the population that an MCO serves. MCOs conduct PIPs to assess and improve the quality of clinical and nonclinical healthcare and services received by recipients.

The primary objective of PIP validation is to determine compliance with the requirements of 42 CFR §438.330(b)(1)(i) and §438.330(d)(2)(i-iv) including:

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

For the rapid-cycle PIP approach, HSAG developed five modules with an accompanying reference guide. Throughout state fiscal year (SFY) 2018–2019, HSAG continued to provide guidance, training,

[6-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: March 6, 2019.

and oversight for the MCOs PIPs. HSAG continues to be involved from the onset of the PIPs to determine methodological soundness and to ensure that MCOs have the knowledge and guidance needed to be successful, not only in documenting its approach but also in applying the rapid-cycle quality improvement methods and tools that are central to achieving improved outcomes.

MCO-Specific Results—Anthem

In SFY 2018–2019, **Anthem Blue Cross and Blue Shield Healthcare Solutions** (**Anthem**) continued with the DHCFP selected PIP topics: *Follow-up After Emergency Room (ER) Discharge (FUM)* and *Well-Child Visits for Children 3–6 Years of Age (W34)*. The topics selected by the DHCFP addressed CMS requirements related to quality outcomes—specifically, the quality and timeliness of and access to care and services.

For each topic, **Anthem** defined a Global Aim and SMART Aim. The SMART Aim statement includes the narrowed population, the baseline rate, a set goal, and the end date. HSAG provided the parameters to the MCO for establishing the SMART Aim for each PIP.

Table 6-1 presents each topic and the SMART Aim statement as documented by the MCO. **Anthem** was required to specify the outcome being measured, the baseline value for the outcome measure, a quantifiable goal for the outcome measure, and the end date for attaining the goal.

Table 6-1—PIP Titles and SMART Aim Statements

PIP Title	SMART Aim Statement
Follow-up After Emergency Room (ER) Discharge (FUM)	By December 31, 2018, the MCO aims to increase the compliance rates of the 7-day follow-up visits with any practitioner after discharge from UMC [University Medical Center] E.D. in Clark County for members 6 years of age and older with a principle discharge diagnosis of mental illness from 19.8% to 23.8%.
Well-Child Visits for Children 3 to 6 Years of Age (W34)	By December 31, 2018, the MCO aims to increase the W34 compliance rate for children 3–6 years of age, residing in Clark County, assigned to a Children's Urgent Care practitioner, from 28.9% to 38.9%.

Validation Findings

Anthem completed and submitted Module 4 and Module 5 for validation for each topic. The following section outlines the validation findings for each of these modules.

Module 4: Plan-Do-Study-Act (PDSA)

Module 4 is the intervention testing phase of the rapid-cycle PIP. In this module, the MCO conducts small tests of change using PDSA cycles.

Follow-Up After Emergency Department Visit for Mental Illness (FUM)

Anthem tested two interventions and completed two Module 4's.

The first intervention involved using Serenity Counseling to provide community-based mental health treatment services. Serenity Counseling conducted telephonic outreach to targeted members to schedule the required seven-day follow-up appointment following an emergency department (ED) discharge. All outreach efforts and outcomes were tracked weekly and sent to **Anthem** during the testing period. An increase in the number of members who received a follow-up visit within seven days of the ED visit discharge for a mental health diagnosis was predicted. The MCO documented that the initial testing results showed a lack of contact information in the MCO's system as a primary barrier to reaching members eligible for the intervention. Of the 316 identified members discharged throughout the testing period, five members were successfully contacted by Serenity Counseling, and 296 members had no contact information. Serenity Counseling was unable to reach members without contact information to schedule services. The intervention was modified to address the accuracy of member contact information. With the second cycle of testing, Serenity Counseling was able to contact 20 members. Of the 20 members, three scheduled appointments, eight declined services, and nine were scheduled for intake seeking permanent placement with Serenity Counseling. At the end of testing, the MCO indicated that there was no improvement in member compliance for the seven-day follow-up appointment and chose to abandon the intervention.

Upon validation of the submitted module, there were no opportunities for improvement identified, and **Anthem** received *Achieved* scores for all evaluation elements.

For the second intervention tested, **Anthem** collaborated with Well Care Behavioral and Medical clinic (Well Care), a provider of acute mental health services. After analyzing data, **Anthem** identified that the place of service code was not being used correctly for billing. This intervention focused on education and reeducation of Well Care billing staff. After training on the use of the quick reference guide (QRG), **Anthem** predicted an increase in the number of claims submitted correctly by Well Care for seven-day follow-up visits. Prior to training, a pre-test was given to each participant to measure how much participants already knew about the concepts to be covered in the training course. At the conclusion of the training, participants were given a post-test, which was identical to the pre-test, to measure their ability to apply knowledge learned in the course. **Anthem** reported that for the 35 members seen in the UMC ED, 14 were compliant for the required seven-day follow-up visit, and 12 of those members were seen by Well Care. All 12 members seen by Well Care were compliant with the seven-day follow-up visit. The MCO adopted this intervention based on the positive preliminary results; however, this intervention could not impact the SMART Aim goal due to the rolling 12-month methodology with the intervention testing period ending November 30, 2018.

Upon validation of the second Module 4, HSAG identified that **Anthem** did not incorporate all of HSAG's feedback provided during the review of the *Intervention Plan*, the intervention effectiveness measure required revisions to be methodologically sound, and the narrative summary of results did not align with the measure because the measure was not set up correctly. Due to these deficiencies, not all evaluation elements received *Achieved* scores.

Well-Child Visits for Children 3 to 6 Years of Age (W34)

Anthem tested two interventions and completed two Module 4's.

The first intervention focused on using an **Anthem** outreach associate to contact targeted members and schedule the well-child visit appointment. Having **Anthem** outreach associates contact targeted members was predicted to increase the number of well-child visits scheduled during the testing period. The MCO tested the intervention as intended, and the following are the results.

- Of the 197 members called, 14 (7.1 percent) members were reached.
- Of the 14 members reached, 100 percent scheduled an appointment.
- Of the 14 members reached who scheduled an appointment, 11 (78.6 percent) attended the scheduled appointment.
- Of the 11 members reached who scheduled an appointment, nine (81.8 percent) members were between the ages of 3 and 4.

As the intervention progressed and appointments were scheduled by the outreach associate, the number of members who attended the appointment increased. Despite the Children's Urgent Care (CUC) practice stating that the largest barrier to completing visits was the member not showing up for the appointment, 78.6 percent of members contacted who scheduled an appointment via the outreach associate attended the appointment. The MCO deemed the intervention successful and determined that having dedicated associates conducting the outreach increased member compliance.

Upon validation of the first Module 4, HSAG identified that the SMART Aim measure data reported in the module did not appear to follow the rolling 12-month methodology. The numerators appeared to follow a cumulative methodology starting in February 2018. Each data point should have represented a 12-month period, with the month reported being the last month of the rolling 12-month period. HSAG also identified problems and incorrect analyses in the summary of results. Due to the identified errors, not all Module 4 evaluation elements received *Achieved* scores.

The second intervention tested involved targeted education and reeducation for the CUC office staff on how to accurately code for well-child visits. **Anthem** predicted that after training and use of the reference guide, the number of well-child visit claims submitted accurately by the CUC billing staff would increase. The MCO administered a pre- and post-test to the office participants and tested the intervention as intended. Following are the results.

- Of the 347 CUC eligible members, 13 (3.8 percent) were compliant and 334 (96.3 percent) were noncompliant.
- Of the 334 noncompliant members, 166 claims were submitted for 111 unique members.
- Of the 111 unique members, 92 (82.9 percent) had one or more claims submitted accurately.
- Of the 111 unique members, 46 (41.4 percent) had three or more claims submitted accurately.

Anthem deemed this intervention successful; however, the intervention could not have impacted the SMART Aim goal due to the timing of the intervention and the rolling 12-month methodology with the intervention testing period ending November 30, 2018. **Anthem** indicated it will continue to distribute and encourage use of the well-child visit QRG because of the positive testing results. Because **Anthem** permits same-day sick and well visit billing, the MCO indicated it will continue to educate providers through provider solution visits, orientation, the provider portal, and fax blasts.

Upon validation of the second Module 4, HSAG identified the same issue as with the first Module 4 intervention. Based on the run chart submitted, the MCO did not follow the rolling 12-month methodology for the SMART Aim measure. The run chart line followed a cumulative measure methodology line. Due to the identified errors, not all Module 4 evaluation elements received *Achieved* scores.

Module 5: PIP Conclusions

HSAG organized and analyzed **Anthem**'s PIP data to draw conclusions about the MCO's quality improvement efforts. Based on its review, HSAG determined the overall methodological validity of the PIP, as well as the overall success in achieving the SMART Aim goal.

HSAG evaluated the appropriateness and validity of the SMART Aim measure, as well as trends in the SMART Aim measurements, in comparison with the reported baseline rate and goal. The data displayed in the SMART Aim run chart were used to determine whether the SMART Aim goal was achieved.

Follow-Up After Emergency Department Visit for Mental Illness (FUM)

Table 6-2—SMART Aim Measure Results

SMART Aim	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
The percentage of 7-day follow-up visits with any practitioner after discharge from UMC E.D. in Clark County for members 6 years of age and older with a principle discharge diagnosis of mental illness.	19.8%	23.8%	29.3%	*Low Confidence*

Upon validation of Module 5, **Anthem** received *Achieved* scores for all but one evaluation element. The SMART Aim goal was exceeded with a percentage of 25.9; however, the improvement occurred prior to intervention testing. HSAG could not link the demonstrated improvement to the quality improvement processes or interventions conducted by **Anthem** resulting in the assigned *Low Confidence* rating.

Well-Child Visits for Children 3 to 6 Years of Age (W34)

Table 6-3—SMART Aim Measure Results

SMART Aim	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
The percentage of W34 visits for children 3–6 years of age, residing in Clark County, assigned to a Children's Urgent Care practitioner.	28.9%	38.9%	67.6%	*Reported Results Were Not Credible*

It appeared, based on the run chart submitted by the MCO, that the goal was exceeded. However, HSAG determined issues with the SMART Aim run chart calculations. Based on the submitted run chart, **Anthem** did not follow the rolling 12-month methodology for the SMART Aim measure approved in Module 2. The run chart line followed a cumulative measure methodology line, and the numerators appear to follow a cumulative methodology starting in February 2018. Because the approved methodology outlined in Module 2 was not followed, the assigned level of confidence for the PIP was *Reported PIP Results Were Not Credible.*

Upon validation of Module 5, HSAG identified errors with the calculation and reporting of the SMART Aim measure and an incorrect summary of results. Due to the identified errors, not all Module 5 evaluation elements received *Achieved* scores.

MCO-Specific Results—HPN

In SFY 2018–2019, **Health Plan of Nevada** (**HPN**) continued with the DHCFP selected PIP topics: *Follow-up After Emergency Room (ER) Discharge (FUM)* and *Well-Child Visits for Children 3–6 Years of Age (W34)*. The topics selected by the DHCFP addressed CMS requirements related to quality outcomes—specifically, the quality and timeliness of and access to care and services.

For each topic, **HPN** defined a Global Aim and SMART Aim. The SMART Aim statement includes the narrowed population, the baseline rate, a set goal, and the end date. HSAG provided the parameters to the MCO for establishing the SMART Aim for each PIP.

Table 6-4 presents each topic and the SMART Aim statement as documented by the MCO. **HPN** was required to specify the outcome being measured, the baseline value for the outcome measure, a quantifiable goal for the outcome measure, and the end date for attaining the goal.

Table 6-4—PIP Titles and SMART Aim Statements

PIP Title	SMART Aim Statement
Follow-up After Emergency Department Visit for Mental Illness (FUM)	By December 31, 2018, **HPN** aims to increase the rate of 7-day follow-up visits with any practitioner for the CHAP-TANF [Children's Health Assurance Program-Temporary Assistance for Needy Families], Expansion and Check Up members ages 6 and older, who were seen in the emergency department at Desert Springs Hospital and Medical Center, with a principal diagnosis of mental health disorder, and assessed by the Mobile Response Team (MRT), from 66.7% to 90.0%.
Well-Child Visits, 3–6 Years of Life (W34)	By December 31, 2018, **HPN** aims to increase the rate of well-child visits for Medicaid members 6 years of age, residing in ZIP code 89115, from 63.7% to 75.0%.

Validation Findings

HPN completed and submitted Module 4 and Module 5 for validation for each topic. The following section outlines the validation findings for each of these modules.

Follow-Up After Emergency Department Visit for Mental Illness (FUM)

HPN tested two interventions and completed two Module 4's.

The first intervention involved providing a telehealth visit with a behavioral health provider to members while they were in the emergency department (ED). The MCO is contracted with Nevada Behavioral Health (NBH) to conduct mobile response team (MRT) assessments at Desert Springs Hospital and Medical Center. **HPN** predicted that by offering a telehealth visit with a behavioral health provider directly following the MRT assessment, the rate of seven-day follow-up visit compliance would increase. As members visited the ED, it was expected that they would agree to a telehealth visit before being discharged; however, that did not prove to be true. At the beginning of the intervention period, more members agreed to the ED telehealth visit; however, August and September data showed that members were not completing telehealth visits as originally expected. The MCO documented that during a meeting with NBH, NBH stated that the hospital staff and the members felt the telehealth visit was repetitive of the ED process, as members were evaluated multiple times and asked the same questions. In addition, the MCO identified that some members were not interested in follow-up care due to more immediate social needs, and members that already accessed the telehealth visit during their previous ED visit were familiar with the process. Based on the testing outcomes, **HPN** chose to abandon the intervention. The MRT will continue to assess members in the ED and offer a telehealth visit upon discharge. The MCO proposed to build on the current process and provide transportation for members to complete their follow-up visits with NBH at the support center.

Upon validation of Module 4, HSAG identified that **HPN** did not provide the numerator, denominator, or percentages for the run chart; therefore, HSAG was unable to validate the reported data. Due to this deficiency, not all Module 4 evaluation elements received *Achieved* scores.

For the second intervention, the MCO chose to continue to collaborate with NBH and provide transportation for members to the NBH Support Center for the follow-up visit after they were seen in the ED. This intervention addressed the MCO's top two priority failure modes as listed in Module 3: 1) member does not have transportation and 2) member does not understand mental illness/symptom fluctuation. Additionally, the MCO indicated that this intervention was chosen based on feedback received and results from the first intervention. Providing immediate transportation to the NBH Support Center upon ED discharge was predicted to increase seven-day follow-up visit compliance and eliminate barriers associated with transportation and/or scheduling conflicts. Contrary to initial predictions, the data showed that members were not receptive to transportation to the NBH Support Center. Members who were not transported to receive services either refused transportation, opted for a bus pass, had a ride from personal acquaintances, or the NBH Support Center was closed at the time of discharge. Additionally, as with the first intervention, this intervention involved members who had already accessed transportation to the NBH Support Center during their previous ED visit and were familiar

with the process. Based on the testing outcomes, **HPN** chose to continue testing this intervention. The MCO's rationale for this decision was based on the suggested success this intervention could have at other EDs in Las Vegas. The MCO indicated it will work with NBH to slowly expand this intervention to other contracted EDs.

Upon validation of Module 4, HSAG identified the same issue as with the first Module 4. **HPN** did not provide the numerator, denominator, or percentages for the run chart and due to this deficiency, not all Module 4 evaluation elements received *Achieved* scores.

Well-Child Visits for Children 3 to 6 Years of Age (W34)

HPN tested two interventions and completed two Module 4's.

For the first intervention, **HPN** partnered with a contracted provider to provide well-child visits within the member's home. This intervention was chosen due to common barriers associated with office visits, such as lack of transportation and accessibility, that have been expressed by external partners. By offering provider in-home well-child visits, **HPN** predicted an increase in compliance for the completed well-child visits among the targeted population. **HPN** encountered challenges contacting the members to schedule the in-home visit. The challenges included incorrect phone numbers, parent/guardian nonresponsive, and/or parent/guardian not interested in participating. Another challenge involved the first provider group not being able to participate as planned, and getting another provider caused a delay in the start of the testing. There was no improvement in the well-child visit rate among the targeted population. It was originally predicted that this intervention would have resulted in a high rate of completed well-child visits by the end of the intervention period. Unfortunately, as **HPN** began making calls it became apparent to the MCO that phone numbers listed for most of the members were inaccurate. Due to the low rate of member and in-home well-child visits completed, the MCO chose to abandon this intervention.

For the second intervention tested, the MCO chose to provide a gift card incentive to the parent/guardian of members who complete a well-child visit. To confirm the visit occurred, the MCO mailed a letter to the member's parent/guardian to take to the appointment for the provider to sign and date. The member's parent/guardian was then responsible for mailing the signed letter back to **HPN** using the provided self-addressed, stamped envelope. By offering an incentive, **HPN** predicted an increase in the percentage of well-child visits completed for the targeted population. The response rate was low which the MCO indicated could be attributed to not having the correct mailing address. **HPN** began calling the members to confirm receipt of the letters; however, many phone numbers were incorrect. As with the first intervention, the MCO attempted to obtain additional phone numbers by running the existing phone numbers through a national database, as well as contacting the contracted PCP. Unfortunately, **HPN** indicated that these additional methods did not produce the needed information, and any phone numbers/addresses that were obtained often matched the information the MCO already had. This intervention was abandoned.

Upon validation of the submitted module, HSAG determined that **HPN** documented an incorrect percentage for the month of December. The MCO did not provide the numerator, denominator, or

percentages for the run chart. Due to these deficiencies, not all Module 4 evaluation elements received *Achieved* scores.

Module 5: PIP Conclusions

HSAG organized and analyzed **HPN**'s PIP data to draw conclusions about the MCO's quality improvement efforts. Based on its review, HSAG determined the overall methodological validity of the PIP, as well as the overall success in achieving the SMART Aim goal. The validation findings for **HPN**'s PIPs are presented in Table 6-5.

HSAG evaluated the appropriateness and validity of the SMART Aim measure, as well as trends in the SMART Aim measurements, in comparison with the reported baseline rate and goal. The data displayed in the SMART Aim run chart were used to determine whether the SMART Aim goal was achieved.

Follow-Up After Emergency Department Visit for Mental Illness (FUM)

Table 6-5—SMART Aim Measure Results for the Follow-Up PIP

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
The percentage of 7-day follow-up visits with any practitioner for the CHAP-TANF [Children's Health Assurance Program-Temporary Assistance for Needy Families], Expansion and Check Up members ages 6 and older who were seen in the emergency department at Desert Springs Hospital and Medical Center with a principal diagnosis of mental health disorder and assessed by the Mobile Response Team (MRT).	66.7%	90%	72%	*Low Confidence*

HPN established a goal of increasing the percentage of seven-day follow-up visits for the targeted population to 90 percent. The MCO set an initial goal of 75 percent; however, that would have required only 12 members to be impacted over a 12-month period assuming a similar denominator. HSAG recommended that **HPN** revisit the goal. The MCO did revise the goal to 90 percent, and the SMART Aim goal was not achieved. However, it should be noted that the SMART Aim goal would not have been achieved if it had remained at 75 percent. The highest rate achieved was 72 percent for the last data point plotted. All data points for the SMART Aim measure were below the baseline except for the last two months, November and December 2018.

Upon validation of Module 5, the SMART Aim goal was not achieved and **HPN** did not include the required data. Not all Module 5 evaluation elements received *Achieved* scores and a level of *Low Confidence* was assigned to the PIP.

Well-Child Visits, 3–6 Years of Life (W34)

Table 6-6—SMART Aim Measure Results for the Well-Child PIP

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
The percentage of well-child visits for Medicaid members 6 years of age, residing in ZIP code 89115.	63.7%	75.0%	56.4%	*Low Confidence*

HPN established a goal of increasing the percentage of well-child visits for Medicaid members 6 years of age, residing in ZIP code 89115, to 75.0 percent and this goal was not achieved. The highest rate achieved was 56.4 percent for the last data point plotted. All data points for the SMART Aim measure were below the baseline for the 12-month rolling period.

Upon validation of Module 5, the SMART Aim goal was not achieved and **HPN** reported an incorrect percentage for December in the submission. The MCO also did not include the required data. Due to these deficiencies, not all Module 5 evaluation elements received *Achieved* scores and a level of *Low Confidence* was assigned to the PIP.

MCO-Specific Results—SilverSummit

In SFY 2018–2019, **SilverSummit Healthplan, Inc.** (**SilverSummit**), continued with the DHCFP selected PIP topics: *Follow-up After Emergency Room (ER) Discharge (FUM)* and *Well-Child Visits for Children 3–6 Years of Age (W34)*. The topics selected by the DHCFP addressed CMS requirements related to quality outcomes—specifically, the quality and timeliness of and access to care and services.

For each topic, **SilverSummit** defined a Global Aim and SMART Aim. The SMART Aim statement includes the narrowed population, the baseline rate, a set goal, and the end date. HSAG provided the parameters to the MCO for establishing the SMART Aim for each PIP.

Table 6-7 presents each topic and the SMART Aim statement as documented by the MCO. **SilverSummit** was required to specify the outcome being measured, the baseline value for the outcome measure, a quantifiable goal for the outcome measure, and the end date for attaining the goal.

Table 6-7—PIP Titles and SMART Aim Statements

PIP Title	SMART Aim Statement
Follow-up After Emergency Room (ER) Discharge (FUM)	By June 30, 2019, increase the rate of follow-up with any practitioner within 7 days of an emergency department discharge from Sunrise Medical Center and Mountain View hospital with a primary diagnosis of behavioral health from 42.9% to 75%.
Well-Child Visits for Children 3 to 6 Years of Age (W34)	By June 30, 2019, increase the well-child visit rate among children 3–6 years of age at Nevada Health Centers from 44.7% to 75%.

Validation Findings

SilverSummit progressed to completing and submitting Module 3 for validation for each topic. The following section outlines the validation findings for each of these modules.

Module 3: Intervention Determination

Module 3 is the intervention determination phase of the PIP. In this module, the MCO will ask and answer the question, "What changes can we make that will result in improvement?"

Follow-up After Emergency Department Visit for Mental Illness Diagnosis (FUM)

SilverSummit completed a process map and a failure modes effects analysis (FMEA) to determine the areas within its process that demonstrated the greatest need for improvement and have the most impact on the desired outcomes. **SilverSummit** identified the following three subprocesses:

- Nevada Hospitalist Group (Preferred) calls and visits the member prior to discharge from the emergency department.
- Nevada Behavioral Health calls to see member while in the emergency department prior to discharge.
- Sunrise/Mountain View Hospital does not notify **SilverSummit** that member was in the emergency department.

SilverSummit determined the following failure modes to be top priority for developing interventions:

- **SilverSummit** is unaware that a member is in Sunrise/Mountain View's emergency department with a behavioral health diagnosis.
- Member is not seen by Nevada Hospitalist Group while in Sunrise/Mountain View's emergency department prior to being discharged by the emergency department physician.
- Nevada Behavioral Health does not see the member prior to discharge from Sunrise/Mountain View's emergency department and is unaware member is in the facility.

The following are interventions **SilverSummit** selected to test in Module 4.

- Access Sunrise/Mountain View Hospital's computer system to obtain information every 24 hours for emergency department discharges with behavioral health diagnoses.
- Have someone from Nevada Hospitalist Group see the member while in the Sunrise/Mountain View Hospital emergency department, arrange the seven-day follow up appointment, and/or notify **SilverSummit** of the emergency department visit and discharge.
- Update the contract with Nevada Behavioral Health to include additional options for members to be seen while in the emergency department prior to discharge.

Upon initial validation of Module 3, HSAG identified that **SilverSummit** should include a representative from the external partner as part of the process map and FMEA team. The MCO was required to revise the process map so that the process map was completed at the level of the narrowed focus. The process map also needed to include identified and prioritized subprocesses, and the MCO needed to define all referenced acronyms. The MCO was also required to revise the FMEA and all associated tables following revisions to the process map. After receiving technical assistance from HSAG, **SilverSummit** made the necessary corrections and submitted the module for final validation. For the final validation, **SilverSummit** received *Achieved* scores for all evaluation elements.

Increase 3–6-Year-Old Well-Child PCP Visits (W34)

SilverSummit completed three process maps and an FMEA to determine the areas within its processes that had the greatest need for improvement and the most impact on intended outcomes. **SilverSummit** identified the following three subprocesses on which to focus efforts:

- Pay for Performance (P4P) education on member analytic tool that shows gaps in member care.
- Claims data query to determine gaps in care (compliance).
- Outreach calls to discuss gaps in care.

SilverSummit determined that the top three failure modes to develop interventions:

- Nevada Health Center staff are not using analytic tool for data. Staff do not understand how to use tool.
- Denied or rejected claims and lack of historical data.
- Invalid or out-of-date member contact information, unsuccessful outreach, or successful outreach but parents decline well-child visit for multiple reasons.

The following are interventions **SilverSummit** selected to test in Module 4.

- Educate providers on the analytic tool and provide long-term support. P4P staff will meet with targeted clinics monthly to discuss gaps in care and brainstorm possible interventions.
- Introduce the provider analytic tool when a provider is enrolled with the MCO.
- Offer webinars to reach more providers at one time (multiple locations).
- Educate Nevada Health Center staff on the claim process and correct codes to use for a well-child visit.
- Configure providers correctly in the MCO's claims payment system.
- Provide data to providers on their members' gaps in care for well-child visits ages 3 to 6.
- Conduct phone outreach to parents and caregivers of children needing well-child visits. During phone outreach, education will be provided about the value of preventive care. Arrange for transportation, if needed.

The MCO submitted three process maps in the first Module 3 submission. Upon initial validation, HSAG identified that **SilverSummit** needed to revise the process maps to reflect the selected narrowed focus and targeted area of improvement for the PIP. The identified subprocesses also required proper

labeling of prioritization and subprocesses needed to align to those listed in the FMEA table. **SilverSummit** also needed to revise the FMEA table so that identified failure causes and failure effects aligned with the failure modes. In addition, **SilverSummit** was required to address the potential interventions once the required changes to the process map and FMEA were made. After receiving technical assistance from HSAG and additional resubmissions, **SilverSummit** made the necessary corrections and received *Achieved* scores for all evaluation elements.

At the time of the SFY 2018–2019 EQR Technical Report, **SilverSummit** had submitted its first intervention plan (the plan step for each PDSA cycle) for each topic. HSAG reviewed the intervention plans and provided written feedback and technical assistance to the MCO. The MCO is currently in the "Do" stage, testing interventions for each topic. HSAG will report the Module 4—Intervention Testing results and Module 5—PIP Conclusions in the SFY 2019-2020 EQR Technical Report.

Plan Comparison

Table 6-8 includes the PIP validation results for Modules 4 and 5 for **Anthem** and **HPN** and Module 3 for **SilverSummit**.

Table 6-8—PIP Validation Results for All Plans

PIP Title	Anthem PIP Module Results	HPN PIP Module Results	SilverSummit PIP Module Results
Follow-up After Emergency Department Visit for Mental Health Diagnosis (FUM)	Module 4 #1: *Achieved* Module 4 #2: *Not Achieved* Module 5*: Low Confidence*	Module 4 #1: *Not Achieved* Module 4 #2: *Not Achieved* Module 5: *Low Confidence*	Module 3: *Achieved*
Increase Well-Child Visits for Children 3–6 Years of Age (W34)	Module 4 #1: *Not Achieved* Module 4 #2: *Not Achieved* Module 5: *Reported PIP Results Were Not Credible*	Module 4 #1: *Not Achieved* Module 4 #2: *Not Achieved* Module 5: *Low Confidence*	Module 3: *Achieved*

The validation results above illustrate that most of the validation criteria for Modules 4 and 5 for **Anthem** and **HPN** were not achieved. Three of four PIPs received a *Low Confidence* rating because the SMART Aim goal was not achieved. **Anthem**'s *Increase Well-Child Visits for Children 3–6 Years of Age (W34)* PIP received *Reported PIP Results Were Not Credible* because the approved SMART Aim data collection methodology was not followed, and data were reported incorrectly in the final SMART Aim run chart.

Due to **SilverSummit** becoming operational in Nevada in SFY 2018, the MCO is on a different timeline and had not progressed to the point of completing the 18 month PIP cycle; therefore, it cannot be compared to **Anthem** and **HPN**. **SilverSummit** successfully completed intervention determination for both topics (Module 3) and is testing interventions through June 30, 2019.

Conclusions and Recommendations

HSAG offers the following recommendations to **Anthem** and **HPN**:

- Apply lessons learned and knowledge gained from its efforts and HSAG's feedback throughout the PIP to future PIPs and other quality improvement activities.
- Continue to look for methods and/or processes to obtain updated correct member contact information as this continues to be an ongoing documented challenge.
- Ensure the approved SMART Aim measure data collection methodology is followed for the duration of the PIP.
- Contact HSAG if it encounters methodological challenges during the PIP process.

The following recommendations are for **SilverSummit**:

- Test interventions through a series of thoughtful and incremental PDSA cycles. The MCO's PIP team should ensure it communicates the reasons for making changes to intervention strategies and how those changes will lead to improvement.
- When planning a test of change, think proactively (i.e., scale/ramp up to build confidence in the change and eventually implement policy to sustain changes).
- When developing the intervention testing methodology, determine the best method for identifying the intended effect of an intervention prior to testing. The intended effect of the intervention should be known up front to help determine which data need to be collected.
- Ensure it is making a prediction in each plan step of the PDSA cycle and discussing the basis for the prediction. This will help keep the theory for improvement in the project at the forefront for everyone involved.
- The key driver diagram and FMEA should be updated as it moves through the intervention testing process.
- Contact HSAG upon encountering any methodological challenges and/or barriers when testing interventions.
- Reference the *Rapid-Cycle PIP Reference Guide* as it progresses to the next phase of the PIP (Modules 4 and 5) and request technical assistance, as needed.

7. CAHPS Surveys—SFY 2018–2019

Overview

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys ask members to report on and evaluate their experiences with healthcare. These surveys cover topics that are important to consumers, such as the communication skills of providers and the accessibility of services. **Anthem Blue Cross and Blue Shield Healthcare Solutions** (**Anthem**), **Health Plan of Nevada** (**HPN**), and **SilverSummit Healthplan, Inc.** (**SilverSummit**), were responsible for obtaining a CAHPS vendor to administer the CAHPS surveys on their behalf.

Objectives

The primary objective of the CAHPS surveys was to effectively and efficiently obtain information on members' experiences with their health care and health plan.

MCO-Specific Results—Anthem

Table 7-1 shows **Anthem**'s 2019 adult Medicaid CAHPS top-box scores. In 2019, a total of 2,430 adult members were administered a survey, of whom 273 completed a survey. After ineligible members were excluded, the response rate was 11.3 percent. In 2018, the average National Committee for Quality Assurance (NCQA) response rate for the adult Medicaid population was 21.8 percent, higher than **Anthem**'s response rate.[7-1]

Table 7-1—Anthem Adult Medicaid CAHPS Results

	2019 Top-Box Scores
Composite Measures	
Getting Needed Care	76.3%
Getting Care Quickly	73.6%
How Well Doctors Communicate	86.5%
Customer Service	NA
Shared Decision Making	NA

[7-1] 2019 NCQA national response rate information for the CAHPS 5.0 Adult Medicaid Survey was not available at the time this report was produced.

	2019 Top-Box Scores
Global Ratings	
Rating of All Health Care	46.1%
Rating of Personal Doctor	56.9%
Rating of Specialist Seen Most Often	57.0%
Rating of Health Plan	56.0%
Effectiveness of Care*	
Advising Smokers and Tobacco Users to Quit	69.3%
Discussing Cessation Medications	39.3%
Discussing Cessation Strategies	28.6%

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

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

Indicates the 2019 score is at least 5 percentage points less than the 2018 national average.

Anthem's 2019 top-box scores for the adult Medicaid population were lower than the 2018 NCQA adult Medicaid national averages for 10 measures:

- *Getting Needed Care*
- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Rating of All Health Care*
- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*
- *Rating of Health Plan*
- *Advising Smokers and Tobacco Users to Quit*
- *Discussing Cessation Medications*
- *Discussing Cessation Strategies*

Of these, nine measure scores were at least 5 percentage points less than the 2018 national averages:

- *Getting Needed Care*
- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Rating of All Health Care*
- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*

- *Advising Smokers and Tobacco Users to Quit*
- *Discussing Cessation Medications*
- *Discussing Cessation Strategies*

Table 7-2 shows **Anthem**'s 2019 general child Medicaid CAHPS top-box scores.[7-2] In 2019, a total of 4,042 general child members were administered a survey, of whom 425 completed a survey.[7-3] After ineligible members were excluded, the response rate was 10.6 percent. In 2018, the average NCQA response rate for the child Medicaid population was 20.8 percent, higher than **Anthem**'s response rate.[7-4]

Table 7-2—Anthem General Child Medicaid CAHPS Results

	2019 General Child Top-Box Scores
Composite Measures	
Getting Needed Care	76.0%
Getting Care Quickly	83.1%
How Well Doctors Communicate	87.2%
Customer Service	84.6%
Shared Decision Making	NA
Global Ratings	
Rating of All Health Care	64.7%
Rating of Personal Doctor	73.2%
Rating of Specialist Seen Most Often	NA
Rating of Health Plan	70.1%

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

Indicates the 2019 score is at least 5 percentage points less than the 2018 national average.

7-2 The child Medicaid CAHPS results presented in Table 7-2 for **Anthem** are based on the results of the general child population only.

7-3 The total number of members surveyed and who completed surveys is based on **Anthem**'s general child CAHPS sample only (i.e., does not include the CCC supplemental sample of members who were surveyed).

7-4 2019 NCQA national response rate information for the CAHPS 5.0 Child Medicaid with CCC Survey was not available at the time this report was produced.

Anthem's 2019 top-box scores for the general child Medicaid population were lower than the 2018 NCQA general child Medicaid national averages for seven measures:

- *Getting Needed Care*
- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Customer Service*
- *Rating of All Health Care*
- *Rating of Personal Doctor*
- *Rating of Health Plan*

Of these, four measure scores were at least 5 percentage points less than the 2018 national averages:

- *Getting Needed Care*
- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Rating of All Health Care*

Table 7-3 shows **Anthem**'s 2019 Children with Chronic Conditions (CCC) Medicaid CAHPS top-box scores.[7-5] In 2019, a total of 152 child members with a chronic condition completed a survey.[7-6]

Table 7-3—Anthem CCC Medicaid CAHPS Results

	2019 CCC Supplemental Top-Box Scores
Composite Measures	
Getting Needed Care	NA
Getting Care Quickly	NA
How Well Doctors Communicate	NA
Customer Service	NA
Shared Decision Making	NA
Global Ratings	
Rating of All Health Care	54.8%
Rating of Personal Doctor	68.4%
Rating of Specialist Seen Most Often	NA
Rating of Health Plan	68.8%

[7-5] The child Medicaid CAHPS results presented in Table 7-3 for **Anthem** are based on the results of the CCC population only.
[7-6] The total number of members who completed surveys is based on **Anthem**'s CCC supplemental CAHPS sample only.

	2019 CCC Supplemental Top-Box Scores
CCC Composite Measures/Items	
Access to Specialized Services	NA
Family Centered Care (FCC): Personal Doctor Who Knows Child	NA
Coordination of Care for Children with Chronic Conditions	NA
Access to Prescription Medicines	NA
FCC: Getting Needed Information	82.2%

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

Indicates the 2019 score is at least 5 percentage points less than the 2018 national average.

Anthem's 2019 top-box scores for the CCC Medicaid population were lower than the 2018 NCQA CCC Medicaid national averages for three measures:

- *Rating of All Health Care*
- *Rating of Personal Doctor*
- *FCC: Getting Needed Information*

Of these, three measure scores were at least 5 percentage points less than the 2018 national averages:

- *Rating of All Health Care*
- *Rating of Personal Doctor*
- *FCC: Getting Needed Information*

Anthem's 2019 top-box scores for the CCC Medicaid population were higher than the 2018 NCQA CCC Medicaid national averages for one measure:

- *Rating of Health Plan*

Table 7-4 shows **Anthem**'s 2019 Nevada Check Up CAHPS top-box scores.[7-7] Since NCQA does not publish separate rates for the Children's Health Insurance Program (CHIP), national comparisons could not be made. In 2019, a total of 1,600 Nevada Check Up general child members were administered a survey, of whom 234 completed a survey.[7-8] After ineligible members were excluded, the response rate was 14.7 percent.

Table 7-4—Anthem Nevada Check Up CAHPS Results

	2019 General Child Top-Box Scores
Composite Measures	
Getting Needed Care	NA
Getting Care Quickly	NA
How Well Doctors Communicate	88.3%
Customer Service	NA
Shared Decision Making	NA
Global Ratings	
Rating of All Health Care	69.8%
Rating of Personal Doctor	76.6%
Rating of Specialist Seen Most Often	NA
Rating of Health Plan	71.7%

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

7-7 The Nevada Check Up CAHPS results presented in Table 7-4 for **Anthem** are based on the results of the general child population only.

7-8 The total number of members surveyed and who completed surveys is based on **Anthem**'s Nevada Check Up general child CAHPS sample only.

Table 7-5 shows **Anthem**'s 2019 Nevada Check Up CAHPS top-box scores for the CCC population.[7-9] Since NCQA does not publish separate rates for the CHIP program, national comparisons could not be made. In 2019, a total of 40 Nevada Check Up child members with a chronic condition completed a survey.[7-10]

Table 7-5—Anthem CCC Nevada Check Up CAHPS Results

	2019 CCC Supplemental Top-Box Scores
Composite Measures	
Getting Needed Care	NA
Getting Care Quickly	NA
How Well Doctors Communicate	NA
Customer Service	NA
Shared Decision Making	NA
Global Ratings	
Rating of All Health Care	NA
Rating of Personal Doctor	NA
Rating of Specialist Seen Most Often	NA
Rating of Health Plan	NA
CCC Composite Measures/Items	
Access to Specialized Services	NA
Family Centered Care (FCC): Personal Doctor Who Knows Child	NA
Coordination of Care for Children with Chronic Conditions	NA
Access to Prescription Medicines	NA
FCC: Getting Needed Information	NA

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

Anthem's 2019 rates could not be reported for the Nevada Check Up CCC population since all measures did not meet the minimum number of responses.

[7-9] The child Medicaid CAHPS results presented in Table 7-5 for **Anthem** are based on the results of the Nevada Check Up CCC population only.

[7-10] The total number of members who completed surveys is based on **Anthem**'s Nevada Check Up CCC supplemental CAHPS sample only.

MCO-Specific Results—HPN

Table 7-6 shows **HPN**'s 2019 adult Medicaid CAHPS top-box scores. In 2019, a total of 2,700 members were administered a survey, of whom 343 completed a survey. After ineligible members were excluded, the response rate was 12.9 percent. In 2018, the average NCQA response rate for the adult Medicaid population was 21.8 percent, higher than **HPN**'s response rate.[7-11]

Table 7-6—HPN Adult Medicaid CAHPS Results

	2019 Top-Box Scores
Composite Measures	
Getting Needed Care	83.3%
Getting Care Quickly	78.3%
How Well Doctors Communicate	88.8%
Customer Service	90.8%
Shared Decision Making	78.0%
Global Ratings	
Rating of All Health Care	50.4%
Rating of Personal Doctor	64.1%
Rating of Specialist Seen Most Often	63.1%
Rating of Health Plan	60.7%
Effectiveness of Care*	
Advising Smokers and Tobacco Users to Quit	57.8%
Discussing Cessation Medications	34.7%
Discussing Cessation Strategies	27.2%

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

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

Indicates the 2019 score is at least 5 percentage points less than the 2018 national average.

[7-11] 2019 NCQA national response rate information for the CAHPS 5.0 Adult Medicaid Survey was not available at the time this report was produced.

HPN's 2019 top-box scores for the adult Medicaid population were lower than the 2018 NCQA adult Medicaid national averages for nine measures:

- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Shared Decision Making*
- *Rating of All Health Care*
- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*
- *Advising Smokers and Tobacco Users to Quit*
- *Discussing Cessation Medications*
- *Discussing Cessation Strategies*

Of these, three measure scores were at least 5 percentage points less than the 2018 national averages:

- *Advising Smokers and Tobacco Users to Quit*
- *Discussing Cessation Medications*
- *Discussing Cessation Strategies*

HPN's 2019 top-box scores for the adult Medicaid population were higher than the 2018 NCQA adult Medicaid national averages for three measures:

- *Getting Needed Care*
- *Customer Service*
- *Rating of Health Plan*

Table 7-7 shows **HPN**'s 2019 child Medicaid CAHPS top-box rates.[7-12] In 2019, a total of 2,887 general child members were administered a survey, of whom 397 completed a survey.[7-13] After ineligible members were excluded, the response rate was 13.8 percent. In 2018, the average NCQA response rate for the child Medicaid population was 20.8 percent, higher than **HPN**'s response rate.[7-14]

[7-12] The child Medicaid CAHPS results presented in Table 7-7 for **HPN** are based on the results of the general child population only.

[7-13] The total number of members surveyed and who completed surveys is based on **HPN**'s general child CAHPS sample only (i.e., does not include the CCC supplemental sample of members who were surveyed).

[7-14] 2019 NCQA national response rate information for the CAHPS 5.0 Child Medicaid with CCC Survey was not available at the time this report was produced.

Table 7-7—HPN General Child Medicaid CAHPS Results

	2019 General Child Top-Box Scores
Composite Measures	
Getting Needed Care	82.8%
Getting Care Quickly	88.0%
How Well Doctors Communicate	91.7%
Customer Service	89.4%
Shared Decision Making	NA
Global Ratings	
Rating of All Health Care	67.2%
Rating of Personal Doctor	75.6%
Rating of Specialist Seen Most Often	NA
Rating of Health Plan	75.5%

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

HPN's 2019 top-box scores for the general child Medicaid population were lower than the 2018 NCQA general child Medicaid national averages for five measures:

- *Getting Needed Care*
- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Rating of All Health Care*
- *Rating of Personal Doctor*

HPN's 2019 top-box scores for the general child Medicaid population were higher than the 2018 NCQA general child Medicaid national averages for two measures:

- *Customer Service*
- *Rating of Health Plan*

Table 7-8 shows **HPN**'s 2019 CCC Medicaid CAHPS top-box scores.[7-15] In 2019, a total of 245 child members with a chronic condition completed a survey.[7-16]

Table 7-8—HPN CCC Medicaid CAHPS Results

	2019 CCC Supplemental Top-Box Scores
Composite Measures	
Getting Needed Care	86.3%
Getting Care Quickly	90.6%
How Well Doctors Communicate	89.6%
Customer Service	NA
Shared Decision Making	NA
Global Ratings	
Rating of All Health Care	66.0%
Rating of Personal Doctor	75.5%
Rating of Specialist Seen Most Often	74.8%
Rating of Health Plan	67.1%
CCC Composite Measures/Items	
Access to Specialized Services	NA
Family Centered Care (FCC): Personal Doctor Who Knows Child	87.9%
Coordination of Care for Children with Chronic Conditions	NA
Access to Prescription Medicines	92.0%
FCC: Getting Needed Information	85.9%

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

Indicates the 2019 score is at least 5 percentage points less than the 2018 national average.

HPN's 2019 top-box scores for the CCC Medicaid population were lower than the 2018 NCQA CCC Medicaid national averages for eight measures:

- *Getting Needed Care*
- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Rating of All Health Care*

[7-15] The child Medicaid CAHPS results presented in Table 7-8 for **HPN** are based on the results of the CCC population only.
[7-16] The total number of members who completed surveys is based on **HPN**'s CCC supplemental CAHPS sample only.

- *Rating of Personal Doctor*
- *Rating of Health Plan*
- *Family Centered Care (FCC): Personal Doctor Who Knows Child*
- *FCC: Getting Needed Information*

Of these, two measure scores were at least 5 percentage points less than the 2018 national averages:

- *How Well Doctors Communicate*
- *FCC: Getting Needed Information*

HPN's 2019 top-box scores for the CCC Medicaid population were higher than the 2018 NCQA CCC Medicaid national averages for two measures:

- *Rating of Specialist Seen Most Often*
- *Access to Prescription Medicines*

Table 7-9 shows **HPN**'s 2019 Nevada Check Up CAHPS top-box rates for the general child population.[7-17] Since NCQA does not publish separate rates for the CHIP program, national comparisons could not be made. In 2019, a total of 2,310 Nevada Check Up general child members were surveyed and 418 completed a survey.[7-18] After ineligible members were excluded, the response rate was 18.2 percent.

Table 7-9—HPN Nevada Check Up CAHPS Results

	2019 General Child Top-Box Scores
Composite Measures	
Getting Needed Care	85.2%
Getting Care Quickly	87.9%
How Well Doctors Communicate	92.0%
Customer Service	86.7%
Shared Decision Making	NA
Global Ratings	
Rating of All Health Care	72.9%
Rating of Personal Doctor	77.7%
Rating of Specialist Seen Most Often	NA
Rating of Health Plan	77.1%

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

[7-17] The Nevada Check Up CAHPS results presented in Table 7-9 for **HPN** are based on the results of the general child population only.
[7-18] The total number of members surveyed and who completed surveys is based on **HPN**'s general child CAHPS sample only (i.e., does not include the CCC supplemental sample of members who were surveyed).

Table 7-10 shows **HPN**'s 2019 Nevada Check Up CAHPS top-box scores for the CCC population.[7-19] Since NCQA does not publish separate rates for CHIP, national comparisons could not be made. In 2019, 150 Nevada Check Up child members with a chronic condition completed a survey.[7-20]

Table 7-10—HPN CCC Nevada Check Up CAHPS

	2019 CCC Supplemental Top-Box Scores
Composite Measures	
Getting Needed Care	NA
Getting Care Quickly	NA
How Well Doctors Communicate	93.3%
Customer Service	NA
Shared Decision Making	NA
Global Ratings	
Rating of All Health Care	72.7%
Rating of Personal Doctor	79.7%
Rating of Specialist Seen Most Often	NA
Rating of Health Plan	72.0%
CCC Composite Measures/Items	
Access to Specialized Services	NA
Family Centered Care (FCC): Personal Doctor Who Knows Child	NA
Coordination of Care for Children with Chronic Conditions	NA
Access to Prescription Medicines	89.2%
FCC: Getting Needed Information	90.0%

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

[7-19] The child Medicaid CAHPS results presented in Table 7-10 for **HPN** are based on the results of the Nevada Check Up CCC population only.

[7-20] The total number of members who completed surveys is based on **HPN**'s Nevada Check Up CCC supplemental CAHPS sample only.

MCO-Specific Results—SilverSummit

Table 7-11 shows **SilverSummit**'s 2019 adult Medicaid CAHPS top-box scores. In 2019, a total of 1,890 members were administered a survey, of whom 176 completed a survey. After ineligible members were excluded, the response rate was 9.4 percent. In 2018, the average NCQA response rate for the adult Medicaid population was 21.8 percent, higher than **SilverSummit**'s response rate.[7-21]

Table 7-11—SilverSummit Adult Medicaid CAHPS Results

	2019 Top-Box Scores
Composite Measures	
Getting Needed Care	NA
Getting Care Quickly	NA
How Well Doctors Communicate	88.8%
Customer Service	NA
Shared Decision Making	NA
Global Ratings	
Rating of All Health Care	39.0%
Rating of Personal Doctor	49.2%
Rating of Specialist Seen Most Often	NA
Rating of Health Plan	50.6%
Effectiveness of Care*	
Advising Smokers and Tobacco Users to Quit	NR
Discussing Cessation Medications	NR
Discussing Cessation Strategies	NR

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

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

Indicates the 2019 score is at least 5 percentage points less than the 2018 national average.

SilverSummit's 2019 top-box scores for the adult Medicaid population were lower than the 2018 NCQA adult Medicaid national averages for four measures:

- *How Well Doctors Communicate*
- *Rating of All Health Care*
- *Rating of Personal Doctor*
- *Rating of Health Plan*

[7-21] 2019 NCQA national response rate information for the CAHPS 5.0 Adult Medicaid Survey was not available at the time this report was produced.

Of these, three measure scores were at least 5 percentage points less than the 2018 national averages:

- *Rating of All Health Care*
- *Rating of Personal Doctor*
- *Rating of Health Plan*

Table 7-12 shows **SilverSummit**'s 2019 child Medicaid CAHPS top-box rates.[7-22] In 2019, a total of 2,310 general child members were administered a survey, of whom 153 completed a survey.[7-23] After ineligible members were excluded, the response rate was 6.7 percent. In 2018, the average NCQA response rate for the child Medicaid population was 20.8 percent, higher than **SilverSummit**'s response rate.[7-24]

Table 7-12—SilverSummit General Child Medicaid CAHPS Results

	2019 General Child Top-Box Scores
Composite Measures	
Getting Needed Care	NA
Getting Care Quickly	NA
How Well Doctors Communicate	NA
Customer Service	NA
Shared Decision Making	NA
Global Ratings	
Rating of All Health Care	56.9%
Rating of Personal Doctor	58.8%
Rating of Specialist Seen Most Often	NA
Rating of Health Plan	58.0%

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

Indicates the 2019 score is at least 5 percentage points less than the 2018 national average.

7-22 The child Medicaid CAHPS results presented in Table 7-7 for **SilverSummit** are based on the results of the general child population only.

7-23 The total number of members surveyed and who completed surveys is based on **SilverSummit**'s general child CAHPS sample only (i.e., does not include the CCC supplemental sample of members who were surveyed).

7-24 2019 NCQA national response rate information for the CAHPS 5.0 Child Medicaid with CCC Survey was not available at the time this report was produced.

SilverSummit's 2019 top-box scores for the general child Medicaid population were lower than the 2018 NCQA general child Medicaid national averages for three measures:

- *Rating of All Health Care*
- *Rating of Personal Doctor*
- *Rating of Health Plan*

Of these, three measure scores were at least 5 percentage points less than the 2018 national averages:

- *Rating of All Health Care*
- *Rating of Personal Doctor*
- *Rating of Health Plan*

Table 7-13 shows **SilverSummit**'s 2019 CCC Medicaid CAHPS top-box scores.[7-25] In 2019, a total of 85 child members with a chronic condition completed a survey.[7-26]

Table 7-13—SilverSummit CCC Medicaid CAHPS Results

	2019 CCC Supplemental Top-Box Scores
Composite Measures	
Getting Needed Care	NA
Getting Care Quickly	NA
How Well Doctors Communicate	NA
Customer Service	NA
Shared Decision Making	NA
Global Ratings	
Rating of All Health Care	NA
Rating of Personal Doctor	NA
Rating of Specialist Seen Most Often	NA
Rating of Health Plan	NA
CCC Composite Measures/Items	
Access to Specialized Services	NA
Family Centered Care (FCC): Personal Doctor Who Knows Child	NA
Coordination of Care for Children with Chronic Conditions	NA
Access to Prescription Medicines	NA
FCC: Getting Needed Information	NA

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

SilverSummit's 2019 rates could not be reported for the CCC Medicaid population since all measures did not meet the minimum number of responses.

[7-25] The child Medicaid CAHPS results presented in Table 7-8 for **SilverSummit** are based on the results of the CCC population only.
[7-26] The total number of members who completed surveys is based on **SilverSummit**'s CCC supplemental CAHPS sample only.

Table 7-14 shows **SilverSummit**'s 2019 Nevada Check Up CAHPS top-box rates for the general child population.[7-27] Since NCQA does not publish separate rates for the CHIP program, national comparisons could not be made. In 2019, a total of 874 Nevada Check Up general child members were surveyed and 99 completed a survey.[7-28] After ineligible members were excluded, the response rate was 11.5 percent.

Table 7-14—SilverSummit Nevada Check Up CAHPS Results

	2019 General Child Top-Box Scores
Composite Measures	
Getting Needed Care	NA
Getting Care Quickly	NA
How Well Doctors Communicate	NA
Customer Service	NA
Shared Decision Making	NA
Global Ratings	
Rating of All Health Care	NA
Rating of Personal Doctor	NA
Rating of Specialist Seen Most Often	NA
Rating of Health Plan	NA

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

SilverSummit's 2019 rates could not be reported for the Nevada Check Up population since all measures did not meet the minimum number of responses.

[7-27] The Nevada Check Up CAHPS results presented in Table 7-9 for **SilverSummit** are based on the results of the general child population only.

[7-28] The total number of members surveyed and who completed surveys is based on **SilverSummit**'s general child CAHPS sample only (i.e., does not include the CCC supplemental sample of members who were surveyed).

Table 7-15 shows **SilverSummit**'s 2019 Nevada Check Up CAHPS top-box scores for the CCC population.[7-29] Since NCQA does not publish separate rates for CHIP, national comparisons could not be made. In 2019, 16 Nevada Check Up child members with a chronic condition completed a survey.[7-30]

Table 7-15—SilverSummit CCC Nevada Check Up CAHPS

	2019 CCC Supplemental Top-Box Scores
Composite Measures	
Getting Needed Care	NA
Getting Care Quickly	NA
How Well Doctors Communicate	NA
Customer Service	NA
Shared Decision Making	NA
Global Ratings	
Rating of All Health Care	NA
Rating of Personal Doctor	NA
Rating of Specialist Seen Most Often	NA
Rating of Health Plan	NA
CCC Composite Measures/Items	
Access to Specialized Services	NA
Family Centered Care (FCC): Personal Doctor Who Knows Child	NA
Coordination of Care for Children with Chronic Conditions	NA
Access to Prescription Medicines	NA
FCC: Getting Needed Information	NA

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

SilverSummit's 2019 rates could not be reported for the Nevada Check Up CCC population since all measures did not meet the minimum number of responses.

[7-29] The child Medicaid CAHPS results presented in Table 7-10 for **SilverSummit** are based on the results of the Nevada Check Up CCC population only.

[7-30] The total number of members who completed surveys is based on **SilverSummit**'s Nevada Check Up CCC supplemental CAHPS sample only.

Plan Comparison

This section presents a comparative analysis of survey results.

Response Rates

Table 7-16 shows **Anthem**'s, **HPN**'s, and **SilverSummit**'s 2019 response rates for the adult Medicaid, child Medicaid, and Nevada Check Up populations. In addition, the 2018 NCQA national average response rate is displayed for comparison purposes, where applicable.

Table 7-16–Plan Comparisons: Response Rates

Population	Anthem Response Rate	HPN Response Rate	SilverSummit Response Rate	2018 NCQA National Average Response Rate
Adult Medicaid	11.3%	12.9%	9.4%	21.8%
Child Medicaid	10.6%	13.8%	6.7%	20.8%
Nevada Check Up	14.7%	18.2%	11.5%	NA*

* NCQA does not provide national averages for the CHIP population. This is denoted with Not Applicable (NA).

Comparative Analysis

A comparative analysis identified whether one MCO performed statistically and significantly higher, the same, or lower on each measure compared to the program average. Table 7-17 through Table 7-21 show the plan comparisons of the following populations for **Anthem**, **HPN**, and **SilverSummit**: adult Medicaid, child Medicaid, and Nevada Check Up. Statistically significant differences between the top-box scores for **Anthem**, **HPN**, and **SilverSummit** are noted with arrows.

Table 7-17–Plan Comparisons: Adult Medicaid

	Anthem Adult	HPN Adult	SilverSummit Adult
Composite Measures			
Getting Needed Care	76.3%	83.3% ↑	NA
Getting Care Quickly	73.6%	78.3%	NA
How Well Doctors Communicate	86.5%	88.8%	88.8%
Customer Service	NA	90.8%	NA
Shared Decision Making	NA	78.0%	NA

	Anthem Adult	HPN Adult	SilverSummit Adult
Global Ratings			
Rating of All Health Care	46.1%	50.4%	39.0%
Rating of Personal Doctor	56.9%	64.1% ↑	49.2% ↓
Rating of Specialist Seen Most Often	57.0%	63.1%	NA
Rating of Health Plan	56.0%	60.7%	50.6%
Effectiveness of Care*			
Advising Smokers and Tobacco Users to	69.3% ↑	57.8% ↓	NR
Discussing Cessation Medications	39.3%	34.7%	NR
Discussing Cessation Strategies	28.6%	27.2%	NR

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

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

↑ Indicates the 2019 score is statistically significantly higher than the program average.

↓ Indicates the 2019 score is statistically significantly lower than the program average.

Table 7-18–Plan Comparisons: General Child

	Anthem General Child	HPN General Child	SilverSummit General Child
Composite Measures			
Getting Needed Care	76.0%	82.8%	NA
Getting Care Quickly	83.1%	88.0%	NA
How Well Doctors Communicate	87.2%	91.7%	NA
Customer Service	84.6%	89.4%	NA
Shared Decision Making	NA	NA	NA
Global Ratings			
Rating of All Health Care	64.7%	67.2%	56.9%
Rating of Personal Doctor	73.2%	75.6% ↑	58.8% ↓
Rating of Specialist Seen Most Often	NA	NA	NA
Rating of Health Plan	70.1%	75.5% ↑	58.0% ↓

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

↑ Indicates the 2019 score is statistically significantly higher than the program average.

↓ Indicates the 2019 score is statistically significantly lower than the program average.

Table 7-19–Plan Comparisons: Nevada Check Up General Child

	Anthem Nevada Check Up General Child	HPN Nevada Check Up General Child	SilverSummit Nevada Check Up General Child
Composite Measures			
Getting Needed Care	NA	85.2%	NA
Getting Care Quickly	NA	87.9%	NA
How Well Doctors Communicate	88.3%	92.0%	NA
Customer Service	NA	86.7%	NA
Shared Decision Making	NA	NA	NA
Global Ratings			
Rating of All Health Care	69.8%	72.9% ↑	NA
Rating of Personal Doctor	76.6%	77.7%	NA
Rating of Specialist Seen Most Often	NA	NA	NA
Rating of Health Plan	71.7%	77.1% ↑	NA

A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as Not Applicable (NA).
↑ Indicates the 2019 score is statistically significantly higher than the program average.
↓ Indicates the 2019 score is statistically significantly lower than the program average.

Table 7-20–Plan Comparisons: Children with Chronic Conditions

	Anthem CCC	HPN CCC	SilverSummit CCC
Composite Measures			
Getting Needed Care	NA	86.3% ↑	NA
Getting Care Quickly	NA	90.6%	NA
How Well Doctors Communicate	NA	89.6%	NA
Customer Service	NA	NA	NA
Shared Decision Making	NA	NA	NA
Global Ratings			
Rating of All Health Care	54.8%	66.0%	NA
Rating of Personal Doctor	68.4%	75.5%	NA
Rating of Specialist Seen Most Often	NA	74.8%	NA
Rating of Health Plan	68.8%	67.1%	NA
CCC Composite Measures/Items			
Access to Specialized Services	NA	NA	NA
Family Centered Care (FCC): Personal Doctor Who Knows Child	NA	87.9%	NA
Coordination of Care for Children with Chronic Conditions	NA	NA	NA
Access to Prescription Medicines	NA	92.0%	NA
FCC: Getting Needed Information	82.2%	85.9%	NA

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

↑ Indicates the 2019 score is statistically significantly higher than the program average.

↓ Indicates the 2019 score is statistically significantly lower than the program average.

Table 7-21–Plan Comparisons: Nevada Check Up Children with Chronic Conditions

	Anthem Nevada Check Up CCC	HPN Nevada Check Up CCC	SilverSummit Nevada Check Up CCC
Composite Measures			
Getting Needed Care	NA	NA	NA
Getting Care Quickly	NA	NA	NA
How Well Doctors Communicate	NA	93.3%	NA
Customer Service	NA	NA	NA
Shared Decision Making	NA	NA	NA
Global Ratings			
Rating of All Health Care	NA	72.7%	NA
Rating of Personal Doctor	NA	79.7%	NA
Rating of Specialist Seen Most Often	NA	NA	NA
Rating of Health Plan	NA	72.0%	NA
CCC Composite Measures/Items			
Access to Specialized Services	NA	NA	NA
Family Centered Care (FCC): Personal Doctor Who Knows Child	NA	NA	NA
Coordination of Care for Children with Chronic Conditions	NA	NA	NA
Access to Prescription Medicines	NA	89.2%	NA
FCC: Getting Needed Information	NA	90.0%	NA

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

↑ Indicates the 2019 score is statistically significantly higher than the program average.

↓ Indicates the 2019 score is statistically significantly lower than the program average.

Conclusions and Recommendations

Anthem

Health Services Advisory Group, Inc. (HSAG), recommends that **Anthem** continue to work with its CAHPS vendor to obtain a sufficient number of completed surveys that will enable reporting of all CAHPS measures. NCQA recommends targeting 411 completed surveys per survey administration. **Anthem** had measures that did not meet the minimum 100 responses for the adult Medicaid population, general child and CCC Medicaid populations, and Nevada Check Up general child and CCC populations.

For the adult Medicaid population, HSAG recommends that **Anthem** focus on improving members' overall satisfaction with their healthcare, personal doctor, and specialist, as well as on quality improvement initiatives to provide medical assistance with smoking and tobacco use cessation. In addition, **Anthem** should focus on improving members' access to and timeliness of care, as well as how well doctors communicate with members. The following measures were at least 5 percentage points lower than the 2018 NCQA adult Medicaid national averages: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*.

For the general child Medicaid population, **Anthem** should focus on improving *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Rating of All Health Care*, since the rates for these measures were at least 5 percentage points lower than the 2018 NCQA child Medicaid national averages. For the CCC Medicaid population, **Anthem** had four reportable measures: *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Health Plan*, and *FCC: Getting Needed Information*. **Anthem** should focus on improving *Rating of All Health Care*, *Rating of Personal Doctor*, and *FCC: Getting Needed Information*, since the rates were at least 5 percentage points lower than the 2018 NCQA CCC Medicaid national averages.

CAHPS measures like *Getting Needed Care* and *Getting Care Quickly* are access-related and lower rates indicate a perception that members cannot obtain needed care with providers or that members cannot obtain services as quickly as desired. As part of its follow-up to HSAG recommendations in the previous year's technical report, **Anthem** detailed several key performance improvement strategies targeted at improving CAHPS response rates as well as the top-box rates for the CAHPS measures. Section 11 contains more information. HSAG encourages **Anthem** to evaluate those interventions to determine if they are having the desired effect. For the remaining CAHPS measures that fell below the Medicaid national averages (*How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Rating of Health Plan*, *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*), interventions targeted at the provider level and provider communication and interaction with Medicaid members most likely will have the greatest impact on the measures.

HPN

HSAG recommends that **HPN** continue to work with its CAHPS vendor to ensure that a sufficient number of completed surveys is obtained to enable reporting of all CAHPS measures. NCQA recommends targeting 411 completed surveys per survey administration. **HPN** had measures that did not meet the minimum number of responses for the general child and CCC Medicaid populations and Nevada Check Up general child and CCC populations. Without sufficient responses, MCOs lack information that can be critical to designing and implementing targeted interventions that can improve access to, and the quality and timeliness of, care.

HSAG recommends that **HPN** focus quality improvement initiatives on enhancing members' experiences with *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies* for the adult Medicaid population, since these rates were at least 5 percentage points lower than the 2018 NCQA adult Medicaid national averages. For the general child Medicaid population, **HPN** should focus on improving *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, and *Rating of Personal Doctor*, since the rates were lower than the 2018 NCQA child Medicaid national averages. For the CCC Medicaid population, **HPN** should focus on improving *How Well Doctors Communicate* and *FCC: Getting Needed Information*, since the rates for these measures were at least 5 percentage points lower than the 2018 NCQA CCC Medicaid national averages.

As part of its follow-up to HSAG recommendations in the previous year's technical report, **HPN** detailed several key performance improvement strategies targeted at improving CAHPS response rates and the top-box rates for CAHPS measures. Section 11 contains more information.

SilverSummit

HSAG recommends that **SilverSummit** continue to work with its CAHPS vendor to ensure that a sufficient number of completed surveys is obtained to enable reporting of all CAHPS measures. NCQA recommends targeting 411 completed surveys per survey administration. **SilverSummit** had measures that did not meet the minimum number of responses for the adult Medicaid population, general child and CCC Medicaid populations, and Nevada Check Up general child and CCC populations. Without sufficient responses, MCOs lack information that can be critical to designing and implementing targeted interventions that can improve access to, and the quality and timeliness of, care.

For the adult Medicaid and general child Medicaid populations, HSAG recommends that **SilverSummit** focus on improving members' overall satisfaction with their healthcare, personal doctor, and health plan, since the rates for these measures were at least 5 percentage points lower than the 2018 NCQA adult and child Medicaid national averages. For the CCC Medicaid and Nevada Check Up populations, all measures had fewer than 100 responses; therefore, the results were not reported.

8. Encounter Data Validation—SFY 2018–2019

Overview

Accurate and complete encounter data are critical to the success of any managed care program. State Medicaid agencies rely on the quality of encounter data submissions from contracted managed care organizations (MCOs) so as to monitor and improve quality of care, establish performance measure rates, generate accurate and reliable reports, and obtain utilization and cost information. The completeness and accuracy of these data are essential in the State's overall management and oversight of its Medicaid managed care program.

In alignment with the Centers for Medicaid & Medicare Services (CMS) *EQR Protocol 4: Validation of Encounter Data Reported by the MCO: A Voluntary Protocol for External Quality Review (EQR)*, Version 2.0, September 2012,[8-1] Health Services Advisory Group, Inc. (HSAG), conducted the following three core evaluation activities for the encounter data validation (EDV) activity:

- Information systems (IS) review—assessment of the State of Nevada, Department of Health and Human Services, Division of Health Care Financing and Policy's (the DHCFP's) and/or MCOs' information systems and processes
- Comparative analysis—detailed examination of the DHCFP's electronic encounter data completeness and accuracy through a comparative analysis between the DHCFP's electronic encounter data and the data extracted from the MCOs' data systems
- Medical record review (MRR)—analysis of the DHCFP's electronic encounter data completeness and accuracy through a review of a sample of medical records for physician services rendered during the study period.

HSAG used data with dates of service between July 1, 2016 and June 30, 2017 from both the DHCFP and the MCOs for this study. Only two of the three MCOs operated in the Nevada managed care program prior to the contract start date of July 1, 2017. Therefore, HSAG conducted the EDV study for those two MCOs: **Anthem Blue Cross and Blue Shield Healthcare Solutions** (**Anthem**) and **Health Plan of Nevada** (**HPN**).

[8-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 4: Validation of Encounter Data Reported by the MCO: A Voluntary Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: June 7, 2018.

Objectives

Information Systems Review

The IS review seeks to define how each participant in the encounter data process collects and processes encounter data such that the data flow from the MCOs to the DHCFP is understood. The IS review is key to understanding whether the IS infrastructures are likely to produce complete and accurate encounter data.

Comparative Analysis

The goal of the comparative analysis is to evaluate the extent to which encounters submitted to the DHCFP by the MCOs are complete and accurate, based on corresponding information stored in each MCO's data systems. This step corresponds to another important validation activity described in the CMS protocol—i.e., analyses of MCO electronic encounter data for accuracy and completeness on reporting.

Medical Record Review

As outlined in the CMS protocol, the MRR is a complex and resource-intensive process. Medical and clinical records are considered the "gold standard" for documenting Medicaid recipients' access to and quality of healthcare services. As such, this component of the EDV study is to determine whether data elements found in the encounter data are complete and accurate when compared to the information contained within the medical records.

IS Review Findings

While the DHCFP receives 837 Professional (837P), 837 Institutional (837I), and National Council for Prescription Drug Programs (NCPDP) files directly from the MCOs, these files may have been generated initially by MCO subcontractors in different formats. The DHCFP reported that each MCO submits professional, institutional, and pharmacy data through the State's encounter system to a data warehouse maintained by DXC Technology (DXC); however, separate information on each MCO's encounter data submissions for behavioral health, vision, and transportation services were not defined.

Both MCOs reported that they submit paid, denied, and adjusted claims and encounters to the DHCFP; although, **HPN** noted not including rejected point-of-service (POS) claims in the NCPDP files. Additionally, both MCOs reported needing to modify encounters to accommodate the DHCFP's encounter data submission standards. Both MCOs followed the NCPDP and the DHCFP guidelines for submitting adjusted encounters to the DHCFP after original encounters were submitted.

While both MCOs reported that they prepare encounter data submissions based on the DHCFP's requirements, neither MCO provided policies and procedures documents or a detailed description of the organizational requirements supporting their encounter data submissions. In considering the data exchange process between the DHCFP and the MCOs, the DHCFP reported not having undergone a formal Information Systems Capabilities Assessment (ISCA) and provided no additional data flow documentation beyond the encounter data companion guides and the encounter claims technical system design document; however, the State provided documentation that highlighted its understanding of data processing and minimizing data loss or corruption resulting from potential system failures.

Each MCO's questionnaire elements regarding encounter data collection, storage, and processing focused on payment-related data, including third party liability (TPL) data. Both MCOs indicated that they submit zero-pay claims to the DHCFP, but only one MCO indicated that it requires its capitated providers to submit TPL data. Additionally, both MCOs reported using a variety of methods for obtaining members' information on other (non- Medicaid) insurance to ensure the appropriate payor for claims. However, neither MCO described its TPL processes for vendor data or how TPL processes differed from processes for Medicare crossover claims.

The DHCFP did not identify processes that may modify the data as they move between databases and did note that current system documentation and file layouts do not clearly delineate derived and non-derived data fields. However, the DHCFP reported that DXC reformats data fields to facilitate data warehouse loads and that DXC is not aware of MCO-submitted data elements modified during data processing.

To submit accurate, timely encounter data to the DHCFP, each MCO must ensure oversight of data submitted by vendors and providers. Both MCOs provided high-level descriptions of the reports and/or data edits used to monitor the accuracy and completeness of data submitted by vendors (e.g., pharmacy claims) and providers. Additionally, the MCOs reported using the 999 transaction response file and the DHCFP Error File (a proprietary flat file) to support their encounter data submission activities. To underscore the importance of collecting and maintaining accurate, timely encounter data, each MCO indicated that encounter data served a variety of reporting needs. Both MCOs also provided feedback regarding challenges associated with submitting encounter data to the DHCFP.

When considering encounter data monitoring from the State's perspective, the DHCFP reported that it has no evaluation metrics in place to assess the quality of MCOs' monthly encounter submissions; nor is a formal process established by which to determine the accuracy and completeness of the MCOs' encounter data. However, the State has established performance standards for the MCOs' submission, accuracy, and timeliness of encounter data.

Comparative Analysis Findings

HSAG conducted a comparative analysis on the professional, institutional, and pharmacy encounter data maintained by DHCFP and the MCOs. The analysis examined the extent to which encounters submitted by the MCOs and maintained in the DHCFP's data warehouse (and the data subsequently extracted and submitted by the DHCFP to HSAG for the study) were accurate and complete when compared to data submitted by the MCOs to HSAG.

To compare the DHCFP's and the MCOs' submitted data, HSAG developed a comparable match key between the two data sources. Data fields used in developing the match key varied by MCO and encounter type, but generally included the internal control number (ICN) and claim line number. These data elements were concatenated to create a unique match key, which became the unique identifier for each encounter detail line in the DHCFP's and each MCO's data.

Record completeness

Two aspects of record completeness are used—record omission and record surplus.

Encounter record omission and surplus rates are summary metrics designed to evaluate discrepancies between two data sources—i.e., primary and secondary. The primary data source refers to data maintained by an organization (e.g., MCO) responsible for sending data to another organization (e.g., the DHCFP). The data acquired by the receiving organization is referred to as the secondary data source. By comparing these two data sources (i.e., primary and secondary), the analysis yields the percentage of records contained in one source and not the other, and vice versa. As such, encounter record omission refers to the percentage of encounters reported in the primary data source but missing from the secondary data source. For this analysis, the omission rate identifies the percentage of encounters reported by an MCO that are missing from the DHCFP's data. Similarly, the encounter record surplus rate refers to the percentage of encounters reported in the secondary data source (the DHCFP) that are missing from the primary data source (MCO).

Table 8-1 illustrates the percentage of records present in the files submitted by the MCOs that were not found in the DHCFP's files (record omission) and the percentage of records present in the DHCFP's files but not present in the files submitted by the MCOs (record surplus). **Lower rates indicate better performance for both record omission and record surplus.**

Table 8-1—Record Omission and Surplus Rates: By MCO and Encounter Type

	Professional Encounters		Institutional Encounters		Pharmacy Encounters	
MCO	Omission	Surplus	Omission	Surplus	Omission	Surplus
Anthem	2.1%	2.3%	4.0%	2.0%	0.0%	< 0.1%
HPN	1.4%	4.0%	0.5%	9.4%	0.0%	4.3%
Overall	**1.7%**	**3.2%**	**2.1%**	**6.3%**	**0.0%**	**2.7%**

Key findings from Table 8-1 are:

- The overall record omission rates were low for all three encounter types (i.e., professional, institutional, and pharmacy). Pharmacy encounters exhibited the most complete data with the lowest overall record omission and record surplus rates. The institutional encounters exhibited the least complete data with the highest overall record omission and record surplus rates.
- The overall record surplus rates were much higher across the three encounter types when compared to the overall record omission.
  - For professional encounters, **HPN** had a record surplus rate of 4.0 percent while **Anthem**'s surplus rate was at 2.3 percent. Approximately 18.6 percent of **HPN**'s surplus records were associated with records submitted on July 14, 2017. Of note, **Anthem**'s files contained more than 16,000 complete duplicate records, which were removed prior to conducting the comparative analysis.
  - The overall record surplus rate for institutional encounters was higher than the overall record omission. **HPN**'s record surplus rate of 9.4 percent contributed to the higher overall surplus rate compared to the omission rate. Over 50 percent of **HPN**'s 210,219 surplus institutional records were associated with an *Encounter Claim Status Process* value of "D," indicating claims denied due to the MCO's internal processing of the encounters.
  - For the submitted pharmacy encounters, **HPN** had a record surplus rate of 4.3 percent while Anthem had a record surplus rate of less than 0.1 percent. Of the 127,047 surplus records, nearly all (more than 99.9 percent) had a two-digit ICN of "75." The DHCFP indicated that these were associated with voided claims submitted by **HPN**.

Data Element Completeness and Accuracy

Data element completeness measures were based on the number of records that matched in both the DHCFP files and the MCO files. Element-level completeness is evaluated based on element omission and element surplus rates. The element omission rate represents the percentage of records with values present in the MCO's submitted files but not in the DHCFP data warehouse. Similarly, the element surplus rate reports the percentage of records with values present in the DHCFP data warehouse but not in the MCO's submitted files. The data elements are considered relatively complete when they have low element omission and surplus rates.

Data element accuracy is limited to those records present in both data sources with values present in both data sources. Records with values missing from both data sources were not included in the denominator. The numerator is the number of records with the same non-missing values for a given data element. Higher data element accuracy rates indicate that the values populated for a data element in the DHCFP's submitted encounter data are more accurate.

Table 8-2 displays the element omission, surplus, and accuracy results for each key data element from the professional encounters. **For the element omission and element surplus indicators, lower rates indicate better performance, while for element accuracy indicator, higher rates indicate better performance**.

Table 8-2—Data Element Omission, Surplus, and Accuracy: Professional Encounters

	Element Omission			Element Surplus			Element Accuracy		
Key Data Element	Overall Rate	Anthem	HPN	Overall Rate	Anthem	HPN	Overall Rate	Anthem	HPN
Recipient ID	**< 0.1%**	< 0.1%	< 0.1%	**0.0%**	0.0%	0.0%	**45.3%**	100.0%	0.0%
Header Service From Date	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**> 99.9%**	> 99.9%	100.0%
Header Service To Date	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**> 99.9%**	> 99.9%	100.0%
Billing Provider Number/NPI	**< 0.1%**	0.0%	< 0.1%	**< 0.1%**	0.0%	< 0.1%	**99.3%**	100.0%	98.7%
Rendering Provider Number/NPI	**0.0%**	0.0%	0.0%	**32.4%**	37.5%	28.2%	**> 99.9%**	100.0%	> 99.9%
Referring Provider Number/NPI	**< 0.1%**	0.0%	< 0.1%	**< 0.1%**	0.0%	< 0.1%	**100.0%**	—	100.0%
Primary Diagnosis Code	**0.0%**	0.0%	0.0%	**< 0.1%**	0.0%	< 0.1%	**> 99.9%**	> 99.9%	> 99.9%
Secondary Diagnosis Code	**< 0.1%**	< 0.1%	< 0.1%	**< 0.1%**	0.0%	< 0.1%	**> 99.9%**	99.9%	> 99.9%
Procedure Code	**< 0.1%**	< 0.1%	< 0.1%	**0.0%**	0.0%	0.0%	**99.8%**	99.5%	> 99.9%
Procedure Code Modifier	**< 0.1%**	0.1%	0.0%	**< 0.1%**	0.1%	0.0%	**> 99.9%**	> 99.9%	100.0%
Header Paid Amount	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**84.4%**	99.7%	71.8%
Detail Paid Amount	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**83.9%**	95.2%	74.6%

"—" denotes that no records are present in both data sources with values present in both sources.

Key findings from Table 8-2 are:

- Overall, the statewide data element omission and surplus rates were very low for Nevada's professional encounters for all data elements, except for *Rendering Provider Number/NPI*.
- The overall element surplus rate for *Rendering Provider Number/NPI* was relatively high. **Anthem** had a surplus rate of 37.5 percent, while **HPN**'s surplus rate for this field was 28.2 percent. It appears that the DHCFP had populated encounter lines with null values for *Rendering Provider Number/NPI* with the *Billing Provider Number/NPI*. However, both **Anthem** and **HPN** did not modify this field when values are missing, which resulted in the high surplus rates. During the data submission process, the DHCFP confirmed that the *Billing Provider Number/NPI* is used as a substitute *NPI* value in the instance of missing *Rendering Provider Number/NPI*.
- Nine of the twelve key data elements evaluated for professional encounters each had an overall accuracy rate of at least 99.0 percent. *Recipient ID, Header Paid Amount,* and *Detail Paid Amount* demonstrated lower accuracy.
- **HPN**'s accuracy rate for the *Recipient ID* field (i.e., 0.0 percent) contributed to the low overall accuracy rate. The discrepancy was due to the DHCFP and **HPN** submitting entirely different values although the fields were of the same length.

- The overall accuracy rates for *Header Paid Amount* and *Detail Paid Amount* were 84.4 percent and 83.9 percent, respectively. **Anthem** had higher accuracy rates for both fields compared to **HPN**. **Anthem**'s accuracy rates for *Header Paid Amount* and *Detail Paid Amount* were 99.7 percent and 95.2 percent, respectively. **HPN**'s accuracy rates for the *Header Paid Amount* field and the *Detail Paid Amount* field were 71.8 percent and 74.6 percent respectively. For the DHCFP's encounters, more than 90.0 percent of the payment amount discrepancies were associated with zero-dollar amounts; **HPN** submitted non-zero-dollar amounts.

Table 8-3 displays the element omission, surplus, and accuracy results for each key data element from the institutional encounters. **For the element omission and element surplus indicators, lower rates indicate better performance, while for element accuracy indicator, higher rates indicate better performance.**

Table 8-3—Data Element Omission, Surplus, and Accuracy: Institutional Encounters

	Element Omission			Element Surplus			Element Accuracy		
Key Data Element	Overall Rate	Anthem	HPN	Overall Rate	Anthem	HPN	Overall Rate	Anthem	HPN
Recipient ID	**< 0.1%**	< 0.1%	< 0.1%	**0.0%**	0.0%	0.0%	**43.4%**	100.0%	0.0%
Header Service From Date	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**99.5%**	99.7%	99.3%
Header Service To Date	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**99.0%**	99.1%	99.0%
Billing Provider Number/NPI	**< 0.1%**	0.0%	< 0.1%	**0.0%**	0.0%	0.0%	**99.9%**	100.0%	99.8%
Attending Provider Number/NPI	**0.0%**	0.0%	0.0%	**< 0.1%**	0.0%	< 0.1%	**100.0%**	100.0%	100.0%
Primary Diagnosis Code	**0.0%**	0.0%	0.0%	**< 0.1%**	0.0%	< 0.1%	**100.0%**	100.0%	100.0%
Secondary Diagnosis Code	**0.3%**	< 0.1%	0.6%	**39.4%**	0.0%	69.6%	**78.6%**	99.9%	2.9%
Procedure Code	**0.9%**	0.5%	1.2%	**0.1%**	0.1%	0.0%	**97.8%**	94.9%	100.0%
Procedure Code Modifier	**10.9%**	11.6%	10.4%	**< 0.1%**	0.1%	0.0%	**89.2%**	85.9%	92.4%
Primary Surgical Procedure Code	**5.1%**	11.8%	0.0%	**5.7%**	13.1%	0.0%	**> 99.9%**	0.0%	100.0%
Secondary Surgical Procedure Code	**2.4%**	5.5%	0.0%	**5.2%**	8.1%	3.1%	**99.0%**	—	99.0%
Revenue Code	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**98.7%**	97.0%	> 99.9%
Diagnosis-Related Group (DRG)	**0.1%**	0.1%	0.0%	**< 0.1%**	0.1%	0.0%	**98.6%**	98.1%	99.0%
Header Paid Amount	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**> 99.9%**	100.0%	> 99.9%
Detail Paid Amount	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**99.1%**	97.9%	> 99.9%

"—" denotes that no records are present in both data sources with values present in both sources.

Key findings from Table 8-3 are:

- Overall, the institutional encounters were mostly complete at the data element level. The overall omission rates for most data elements evaluated were low, except for *Procedure Code Modifier* and *Primary Surgical Procedure Code,* which had overall omission rates of 10.9 percent and 5.1 percent, respectively. The relatively high overall omission rate for the *Primary Surgical Procedure Code* was due to **Anthem** submitting the Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) codes within this field, while values were missing in the DHCFP's submission. As a result, **Anthem** had a high omission rate of 11.8 percent for this field.
- The overall surplus rates were also low for all data elements, except for *Secondary Diagnosis Code* and *Primary Surgical Procedure Code*, which had overall surplus rates of 39.4 percent and 5.7 percent, respectively. **HPN**'s surplus rate of 69.6 percent contributed to the high surplus rate for the *Secondary Diagnosis Code* field. However, the results for the *Secondary Diagnosis Code* should be interpreted with caution, as the field values may have been populated in other secondary diagnosis code positions, such as *Third Diagnosis Code* or *Fourth Diagnosis Code*. The relatively high overall surplus rate for the *Primary Surgical Procedure Code* was due to **Anthem** not submitting the ICD-10 Surgical Procedure Codes within this field, while the DHCFP populated this field, resulting in **Anthem**'s surplus rate of 13.1 percent.
- The statewide accuracy rates for all data elements evaluated within institutional encounters were high, except for *Recipient ID* and *Secondary Diagnosis Code.* **HPN**'s accuracy rate for the *Recipient ID* field (i.e., 0.0 percent) contributed to the low overall accuracy rate. The discrepancy was due to the DHCFP and **HPN** having entirely different values, although the fields were the same length. **HPN**'s accuracy rate of 2.9 percent contributed to the low overall accuracy rate for the *Secondary Diagnosis Code* field. However, the results for the *Secondary Diagnosis Code* should be interpreted with caution as the field values may have been populated in other secondary diagnosis code positions, such as *Third Diagnosis Code* or *Fourth Diagnosis Code*.

Table 8-4 displays the element omission, surplus, and accuracy results for each key data element from the pharmacy encounters. **For the element omission and element surplus indicators, lower rates indicate better performance, while for element accuracy indicator, higher rates indicate better performance.**

Table 8-4—Data Element Omission, Surplus, and Accuracy: Pharmacy Encounters

	Element Omission			Element Surplus			Element Accuracy		
Key Data Element	Overall Rate	Anthem	HPN	Overall Rate	Anthem	HPN	Overall Rate	Anthem	HPN
Recipient ID	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**100.0%**	100.0%	100.0%
Header Service From Date	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**100.0%**	100.0%	100.0%
Billing Provider Number/NPI	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**100.0%**	100.0%	100.0%
Prescribing Provider Number/NPI	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**100.0%**	100.0%	100.0%

Key Data Element	Element Omission			Element Surplus			Element Accuracy		
	Overall Rate	Anthem	HPN	Overall Rate	Anthem	HPN	Overall Rate	Anthem	HPN
National Drug Code (NDC)	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**> 99.9%**	99.9%	100.0%
Drug Quantity	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**99.0%**	97.3%	100.0%
Header Paid Amount	**0.0%**	0.0%	0.0%	**0.0%**	0.0%	0.0%	**99.7%**	100.0%	99.5%

Key findings from Table 8-4 are:

- Overall, the statewide data element omission and element surplus rates were 0.0 percent for all pharmacy key data elements evaluated. HSAG used the *Dispensed Date* to measure data element completeness for *Header Service From Date* as the DHCFP does not collect this field for pharmacy data in its data warehouse.
- All pharmacy data elements exhibited high accuracy rates for pharmacy encounters. The *Drug Quantity* field demonstrated the lowest data element accuracy at 99.0 percent. **HPN** presented 100.0 percent accuracy on all data elements, except *Header Paid Amount* (i.e., 99.5 percent). **Anthem** presented 100.0 percent accuracy on all data elements, except for *National Drug Code* and *Drug Quantity* (i.e., 99.9 percent and 97.3 percent, respectively).

Medical Record Review Findings

Medical records are considered the "gold standard" for documenting Medicaid recipients' access to and quality of services. The IS review examined the MCOs' data-handling processes, with the goal of enabling HSAG to understand how various systems interact and potentially impact the MCOs' abilities to submit complete, reasonable, and accurate data to the DHCFP. The comparative analysis component of the study seeks to determine the completeness and validity of the DHCFP's encounter data as well as how comparable these data are to the MCOs' data from which these data are based. MRR further assesses data quality through investigating the completeness and accuracy of the DHCFP's encounters compared to the information documented in the corresponding medical records for Medicaid recipients.

Encounter Data Completeness

HSAG evaluated encounter data completeness by identifying differences between key data elements from the DHCFP-based professional encounters and the corresponding medical records submitted for the analysis. These data elements included *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*. Medical record omission and encounter data omission represent two aspects of encounter data completeness through their identification of vulnerabilities in the process of claims documentation and communication among providers, MCOs, and the DHCFP.

Medical record omission occurred when an encounter data element (i.e., *Date of Service*, *Diagnosis Code*, *Procedure Code*, or *Procedure Code Modifier*) was not documented in the medical record

associated with a specific DHCFP encounter. Medical record omissions suggest opportunities for improvement within the provider's internal processes, such as billing processes and record documentation.

Encounter data omission occurred when an encounter data element (i.e., *Date of Service*, *Diagnosis Code*, *Procedure Code*, or *Procedure Code Modifier*) was documented in the medical record but not found in the associated DHCFP encounter. Encounter omissions also suggest opportunities for improvement in the areas of claims submissions and/or processing routes among the providers, MCOs, and the DHCFP.

HSAG evaluated the medical record and the encounter data omission rates for each MCO using the dates of service selected by HSAG and an additional date of service selected by the provider, if one was available. If more than one additional date of service was available from the medical record, the provider was instructed to select the one closest to HSAG's selected date of service. **For both rates, lower values indicate better performance**

Table 8-5 displays the medical record and encounter data omission rates for each key data element.

Table 8-5—Encounter Data Completeness

	Medical Record Omission			Encounter Data Omission		
Key Data Elements	Statewide Rate	Anthem Rate	HPN Rate	Statewide Rate	Anthem Rate	HPN Rate
Date of Service	3.4%	2.1%	4.4%	2.8%	3.9%	2.1%
Diagnosis Code	23.5%	22.8%	24.0%	4.9%	4.2%	5.4%
Procedure Code	21.1%	18.6%	22.9%	5.6%	6.5%	4.9%
Procedure Code Modifier	35.4%	36.6%	34.6%	3.9%	1.9%	5.4%

The final sample cases included in the evaluation consisted of 411 cases randomly selected per MCO, along with any submitted second dates of service for each sampled recipient. Two indicators were evaluated:

- Medical record omission, which occurred when an encounter data element was not documented in the medical record associated with a specific encounter.
- Encounter data omission, which occurred when an encounter data element was documented in the medical record but was not found in the associated encounters.

Overall, the medical record omission rates were higher than the encounter data omission rates for all key data elements (i.e., *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) included in the analysis. The dates of service within the encounter data were well supported by the recipients' medical records, as evidenced by the low medical record omission rate of 3.4 percent. However, the *Diagnosis Code* (23.5 percent), *Procedure Code* (21.1 percent), and *Procedure Code Modifier* (35.4 percent) data elements within the encounter data were moderately supported by the medical records. As determined during the review, some common reasons for medical record omissions included the following:

- The medical record was not submitted for the study.
- The provider did not document the services performed in the medical record despite submitting a claim or encounter.
- The provider did not provide the service(s) found in the encounter data.

Both **Anthem** and **HPN** had similar rates for medical record omission for all data elements, where the difference between the MCOs' rates was less than 5 percentage points for each of the evaluated data elements.

In contrast, the relatively low encounter data omission rates indicate that the key data elements (i.e., *Date of Service*, *Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) found in the recipients' medical records were well supported by the data found in the electronic data extracted from the DHCFP's data warehouse, with rates ranging from 2.8 percent (*Date of Service*) to 5.6 percent (*Procedure Code*). Some potential reasons for encounter data omissions included the following:

- The encounter data from the DHCFP only included up to four diagnosis codes per encounter record, while MCOs may submit more than four diagnosis codes on the 837 professional files.
- The provider's billing office made a coding error or did not submit the procedure code despite performing the service(s).
- A lag occurred between the provider providing the service(s) and the submission of the encounter to the MCOs and/or the DHCFP.
- Deficiencies existed in the MCOs' encounter data submission processes.

Both **Anthem** and **HPN** had similar rates for encounter data omission for all data elements, where the difference between the MCOs' rates was less than 5 percentage points for each of the evaluated data elements.

Encounter Data Accuracy

Table 8-6 displays the element accuracy rates for each key data element and the all-element accuracy rates.

Table 8-6—Encounter Data Accuracy Summary

Key Data Elements	Statewide Rate	Anthem Rate	HPN Rate	Statewide Main Error Type
Diagnosis Code	98.7%	98.3%	99.0%	Specificity Error (57.9%) Inaccurate Coding (42.1%)
Procedure Code	94.5%	95.6%	93.7%	Inaccurate Coding (57.2%) Lower Level of Services in Medical Records (39.0%) Higher Level of Services in Medical Records (3.8%)
Procedure Code Modifier	98.9%	99.2%	98.6%	—
All-Element Accuracy	45.7%	46.5%	45.1%	—

"—" denotes that the error type analysis was not applicable to a given data element.

Overall, when key data elements were present in both the DHCFP's encounter data and the medical records and were evaluated independently the data elements were found to be accurate. Among the data elements evaluated, 98.7 percent of diagnosis codes, 94.5 percent of procedure codes, and 98.9 percent of procedure code modifiers present in both sources were accurate. The most common error type for the diagnosis code data element was a specificity error. For the procedure code data element, 57.2 percent of the identified errors were associated with the use of inaccurate codes and 39.0 percent of the procedure code errors involved providers submitting a higher level of service code than that supported in the recipients' medical records.

Nearly 50 percent of the dates of service present in both sources accurately represented all three data elements (*Diagnosis Code*, *Procedure Code*, and *Procedure Code Modifier*) when compared to the recipients' medical records.

Both participating MCOs had similar rates for *Diagnosis Code*, *Procedure Code*, *Procedure Code Modifier,* and *All-Element Accuracy*.

Conclusions and Recommendations

Based on HSAG's review of the encounter data submitted by the DHCFP and the MCOs, HSAG identified several opportunities for continued improvement in the overall quality of Nevada's encounter data. Although overall results of the comparative analysis component of the EDV study indicate relatively complete and accurate data, instances of high rates of omission, surplus, and errors—coupled with variation between MCOs—suggest some systemic issues with the transmission of data between the MCOs and the DHCFP. Similarly, the MRR component of the study indicated complete and accurate data in the DHCFP's data warehouse. However, high rates of medical record omission suggest opportunities to improve the quality of the DHCFP's encounter data. To improve the quality of encounter data submissions from contracted MCOs, HSAG offers the following recommendations to assist DHCFP and the MCOs address opportunities for improvement:

- The DHCFP noted that procedure memos or contract amendments are used to ensure that updates to the State's data submission requirements are implemented and communicated to each MCO. However, one MCO noted in its information systems review questionnaire response that the lack of an updated EDI companion guide presents a challenge when submitting encounter data to the DHCFP. The HIPAA Transaction Standard Companion Guides supplied for this study by the DHCFP were dated May 2014. The DHCFP should determine the appropriate frequency for updating the companion guides and communicate with the MCOs to ensure that the MCOs apply the most recent companion guides to encounter data submissions.
- The MCOs' responses to the information systems review questionnaires indicated that a DHCFP-designed flat file is provided to the MCOs in lieu of 277 transaction response files. The DHCFP should assess comparability between the contents of the current proprietary flat files and the 277 transaction response files to ensure that the MCOs receive all data elements needed to address encounter data submission concerns.

- Findings from the information systems review indicate that **Anthem** is currently developing a more robust process for monitoring the timeliness of claims and encounter data submitted by providers. The DHCFP should follow up with **Anthem** to determine the timeline for establishing the enhanced monitoring process as well as to request sample monitoring reports. Based on the DHCFP's review of the monitoring reports, the DHCFP may determine whether to recommend similar reports as an MCO best practice.
- The results from the comparative analysis indicated that encounters submitted by the MCOs and maintained in the DHCFP's data warehouse (and subsequently extracted by the DHCFP for this study) were relatively complete and accurate when compared to data submitted to HSAG by the MCOs. However, HSAG recommends that the DHCFP continue efforts to monitor encounter data submissions and address any identified data issues with the MCOs' encounter file submissions. As the DHCFP reported having no standard processes for monitoring encounter data accuracy and completeness, HSAG suggests that the DHCFP consider the following:
  - Develop a monitoring strategy to routinely examine encounter volume. As part of a larger encounter data quality strategy or program, these metrics would help to ensure timely identification of potential problems and establish expectations of contracted MCOs.
  - Implement a performance monitoring system that supports the development of standards to monitor the MCOs' encounter data quality and contract compliance.
  - Work with the MCOs to develop a monitoring program that requires the MCOs to audit providers' claims and encounter data submissions for completeness and accuracy.
  - Routinely review and modify existing MCO contracts and encounter submission guidelines as needed to include language outlining specific requirements for submitting complete data to the DHCFP.
- HSAG identified, from both the DHCFP and the MCOs, errors in the data files extracted for the study. HSAG recommends that the DHCFP and the MCOs consider implementing standard quality controls to ensure accurate data extracts from their respective systems. Through the development of standard data extraction procedures and quality control, the number of errors associated with extracted data could be reduced. HSAG suggests that minimum data quality checks include the following:
  - Extract data according to the data submission requirements document.
  - Verify that control totals are reasonable for each requested data file.
  - Determine if duplicate records are expected and/or reasonable.
  - Determine if the distribution and population of data field values are expected and/or reasonable.
  - Conduct for all records a check to identify any data fields with missing values.
- Based on the study findings from the medical review component of the study, HSAG recommends that the DHCFP consider the following:
  - The DHCFP encounter data only contain up to four diagnosis codes per encounter record although the MCOs may submit more than four diagnosis codes on the 837 professional files. To improve the completeness for the diagnosis code fields, the DHCFP should consider updating its processes so that more than four diagnosis code fields are available in the data warehouse.

- The DHCFP should consider requiring that MCOs audit provider encounter submissions for completeness and accuracy. The DHCFP may want to require MCOs to develop periodic provider education and training regarding encounter data submissions, medical record documentation, and coding practices. These activities should include a review of both State and national coding requirements and standards, especially for new providers contracted with the MCOs. In addition, HSAG recommends that the DHCFP consider requiring MCOs to perform periodic reviews of submitted claims to verify appropriate coding and completeness to ensure encounter data quality. Results from these reviews may be submitted to the DHCFP and used in its ongoing encounter data monitoring.

Study Limitations

- Findings associated with the information systems review were based on self-reported questionnaire responses submitted to HSAG by the DHCFP and the MCOs. HSAG did not confirm the statements made in the questionnaires.
- The administrative review results presented in this study are dependent on the quality of encounter data submitted by the DHCFP and the MCOs. Any substantial and systematic errors in the extraction and transmission of encounter data may bias the results and compromise the validity and reliability of study findings.
- The primary focus of the administrative review component of the EDV study was to assess the extent and magnitude of record and data element discrepancies between the DHCFP's and the MCOs' submitted encounter data. When possible, HSAG conducted supplemental analyses into the characteristics of omitted and surplus records when discrepancies were identified. However, these secondary investigations were limited and should be used for informational purposes only.
- The findings from the comparative analysis were associated with encounters with dates of service between July 1, 2016, and June 30, 2017. As such, results may not reflect the current quality of the DHCFP's encounter data or changes implemented since July 2017.
- This EDV study included two of the three MCOs that had already operated in the Nevada managed care program prior to the contract start date of July 1, 2017. Therefore, the results presented in this study do not represent the full quality of Nevada's current encounter data.
- When evaluating the results from the MRR component of the study, it is important to understand the following limitations:
  - Successful evaluation of recipients' medical records depends on the ability to locate and collect complete and accurate medical records. Therefore, validation results could have been affected by medical records that were not located (e.g., provider refusal) and medical records that were incomplete (e.g., submission of a visit summary instead of the complete medical record).
  - Study findings of the MRR relied solely on the documentation contained in recipients' medical records; therefore, results are dependent on the overall quality of physicians' medical records. For example, a physician may have performed a service but not documented it in the recipient's medical record. As such, HSAG would have counted this occurrence as a negative finding. This

study was unable to differentiate cases in which a service was not performed versus a service that was performed but not documented in the medical record.

- In some cases, limitations associated with the DHCFP's encounter data processes may unintentionally impact study results. For example, the DHCFP's encounter data may only process and store a certain number of data fields for the diagnosis codes while MCOs' claims systems often support more diagnosis fields. Additionally, no limitations exist on the number of diagnoses that may be documented in the recipients' medical records. As a result, omission in the diagnosis codes may be related to the inability of a system to store additional data regardless of whether it is present in the medical records of the MCOs' encounter data systems.
- The findings from the MRR were associated with encounters with dates of service between July 1, 2016, and June 30, 2017. As such, results may not reflect the current quality of the DHCFP's encounter data or changes implemented since July 2017.
- The findings from the MRR component of this study are associated with physician visits and may not be applicable to other claim types.

9. Network Adequacy Validation—SFY 2018–2019

Overview

Under the contract for External Quality Review (EQR), the State of Nevada Department of Health and Human Services, Division of Health Care Financing and Policy (the DHCFP) requested that Health Services Advisory Group, Inc. (HSAG) prepare a provider crosswalk and conduct a baseline provider composition analysis (PCA) of the Medicaid provider network for all managed care organizations (MCOs) during fiscal year (FY) 2018–2019. According to the federal regulations for managed care that were released in May 2016, the activity related to 42 Code of Federal Regulations (CFR) §438.358(b)(1)(iv), validation of network adequacy, shall commence no later than one year from the issuance of the associated EQR protocol. In preparation for the release of the protocol, HSAG applied provider the crosswalk file to the MCOs' provider networks to assess network composition differences across MCOs. Additionally, in future years, the provider crosswalk is a tool that can be used for network adequacy validation analyses (e.g., time/distance and provider ratio analyses).

The providers included in the PCA include all ordering, referring, and servicing providers contracted to provide care through one of Nevada's Medicaid MCOs:

- **Health Plan of Nevada** (**HPN**)
- **Anthem Blue Cross and Blue Shield Healthcare Solutions** (**Anthem**)
- **SilverSummit Healthplan, Inc.** (**SilverSummit**)

Objectives

The objectives of the network adequacy activities were:

- To understand the MCOs' provider data structure and methods for classifying providers, as assessed by the provider data structure questionnaire.
- To create a provider crosswalk that outlines consistent definitions and methods for identifying providers in the identified provider categories.
- To conduct a baseline provider composition analysis that assesses the number of providers in each provider category after applying the results of the provider crosswalk to the MCOs' submitted data.

Provider Data Structure Findings

HSAG distributed the provider Data Structure Questionnaire to the three MCOs to help determine the structure of their provider data files and methods for classifying providers. The MCOs responded to seven questions and provided both general and specific information related to the following:

- The structure of their provider data files with fields and indicators available in the data
- MCOs' use of single case agreements
- Data cleaning and standardization process

Structure of the Provider Files

Each MCO described its data system and how the provider data are stored. **HPN** maintains a Network Development Contracting (NDC) database built in Microsoft Access to store provider demographic information. **Anthem** and **SilverSummit** utilize commercially available provider data management systems (i.e., Facets and Portico, respectively).

For all MCOs, provider data are required to be updated when there is a change in provider status. The MCOs confirm provider information every three years for re-credentialing. Most provider information (e.g., provider type, specialty, taxonomy) is collected via self-report from the providers. While most MCOs collect provider type, provider specialty, taxonomy, and degree attained, **Anthem** noted it does not collect provider type and **HPN** noted it does not collect taxonomy in the NDC system. Also, **HPN** does not collect provider type and provider specialty as two separate fields, instead it collects one field called specialty/class.

All MCOs indicated that PCPs, active providers, and providers accepting new patients were identifiable in their provider data files. Only **Anthem** and **SilverSummit** were able to identify prenatal providers, while none of the MCOs indicated they had specific indicators in the data to identify Home- and Community-Based Services (HCBS) providers. Additionally, all MCOs, except for **HPN**, indicated their provider data have a field to capture panel capacity for PCPs.

Single Case Agreements

Single case agreements are an important aspect in the analysis of network adequacy since MCOs frequently use single case agreements or letters of agreement when special circumstances are needed to ensure members' access to providers. Each MCO indicated a different method for handling single case agreements in the provider data. **Anthem** stated that providers operating under single case agreements are not identifiable in its provider data. **HPN** indicated it has a separate Excel spreadsheet to track letters of agreement. **SilverSummit** indicated single case agreements are not loaded into its provider data systems but are tracked and routed for claims through its claims processing system.

Data Cleaning and Standardization

Each MCO indicated that they clean and monitor the provider data files. Specifically, **Anthem**'s Provider Relations team verifies the information through secret shopper survey calls and visits to the providers' offices. **HPN** maintains data integrity by ensuring its Provider Data team is the only team with read and write access to the provider database. Additionally, **HPN**'s staff members conduct monthly audits of the online provider database. **SilverSummit** conducts outreach to network providers

and it also contracts with a third-party vendor that conducts outreach and obtains attestations from providers that verify their demographic information is correct. Additionally, **SilverSummit** requires large provider groups to submit monthly updates to their rosters.

Provider Composition Analysis Findings

Using provider data from the DHCFP and the MCOs, HSAG developed crosswalk definitions for each provider category, including a description of the logic needed to identify corresponding providers from each MCO's submitted data. HSAG and the DHCFP reviewed the proposed crosswalks, and HSAG finalized the crosswalks with the DHCFP's input.

This section summarizes statewide PCA findings for the three MCOs and the DHCFP's provider data. Out-of-state providers were included in the PCA if they practice in one of the catchment areas. Many of these providers are geographically closer to recipients living near the Nevada border than some providers practicing within the state. These catchment area providers are subject to the same requirements as in-state providers regarding covered services and prior authorization requirements.

HSAG classified provider categories pertaining to the three MCOs in the following domains:

- PCPs
- Specialists
- Behavioral Health Providers
- Healthcare Facilities

Table 9-1 shows the number of PCPs contracted with the DHCFP's fee-for-service (FFS) program and each of the MCOs. Results are shown by both the total number of provider records and the number of unique providers. The total provider record counts tended to be greater than the unique provider National Provider Identifier (NPI) counts because one provider can serve at multiple locations, have multiple Medicaid provider IDs associated with the same NPI or have multiple taxonomy codes. Red shading indicates that no providers were identified in the MCOs' or the DHCFP's data for the provider category.

Table 9-1—Distribution of All Providers Registered in the DHCFP and MCOs by PCP Categories in Nevada and Catchment Areas

Provider Category	DHCFP		Anthem		HPN		SilverSummit	
	Total Provider Records	Number of Unique Providers by NPI	Total Provider Records	Number of Unique Providers by NPI	Total Provider Records	Number of Unique Providers by NPI	Total Provider Records	Number of Unique Providers by NPI
PCPs (Individual)								
Family Practitioner	1,270	907	987	243	613	357	574	248
Internist	1,820	1,362	941	330	991	599	1,293	424
OB/GYN	595	428	385	200	233	178	286	129
Pediatric	887	673	461	218	560	282	347	154
General Practitioner	387	320	42	15	33	21	16	6
FQHCs and RHCs								
FQHCs/RHCs	189	142	16	9	19	19	264	108
PCP Extenders								
Nurse Practitioner	2,172	1,633	1,576	588	0	0	1,302	464
Physician Assistant	1,202	899	952	302	0	0	508	214

The key findings from Table 9-1 are:

- Consistently, the DHCFP had more providers identified as PCPs than the MCOs, for all PCP categories.
- Across all MCOs and the DHCFP, the most common PCPs were internists, family practitioners, and pediatricians.
- There was a wide variation in the number of contracted Federally Qualified Health Centers and Rural Health Centers (FQHCs/RHCs). The DHCFP identified 142 unique FQHCs/RHCs, whereas, **Anthem** only reported nine.
- **HPN** reported no PCP extenders in its data. This may be due to a lack of PCP extenders in the provider network or an inability to identify them in the provider data.

Table 9-2 shows the number of specialists contracted with the DHCFP's FFS program and each of the MCOs. Results are shown by both the total number of provider records and the number of unique providers. Red shading indicates that no providers were identified in the MCOs' or the DHCFP's data for the provider category.

Table 9-2—Distribution of All Providers Registered in the DHCFP and MCOs by Specialty Provider Categories in Nevada and Catchment Areas

Provider Category	DHCFP		Anthem		HPN		SilverSummit	
	Total Provider Records	Number of Unique Providers by NPI	Total Provider Records	Number of Unique Providers by NPI	Total Provider Records	Number of Unique Providers by NPI	Total Provider Records	Number of Unique Providers by NPI
Specialists								
Allergist	12	10	23	9	13	9	10	6
Pediatric Allergist	11	10	1	1	0	0	2	1
Cardiologist	418	313	408	115	462	160	615	120
Pediatric Cardiologist	68	52	25	16	50	17	27	17
Dermatologist	139	103	90	29	49	25	40	20
Pediatric Dermatologist	0	0	0	0	0	0	0	0
Otolaryngologist	153	119	61	34	58	40	38	19
Pediatric Otolaryngologist	0	0	0	0	0	0	3	1
Endocrinologist	100	66	37	18	29	20	36	18
Pediatric Endocrinologist	0	0	17	7	34	24	36	18
Gastroenterologist	218	170	124	61	128	75	116	57
Pediatric Gastroenterologist	0	0	13	8	9	6	12	7
General Surgery	310	265	170	93	158	110	203	94
Pediatric Surgery	33	32	25	16	13	7	11	4
Geriatric	41	31	20	12	16	9	25	11
Infectious Disease	106	85	42	21	32	24	64	27
Pediatric Infectious Disease	0	0	3	2	8	5	6	2
Maternal/Fetal Medicine	105	97	284	99	215	67	270	72
Nephrologist	127	95	279	85	142	78	154	66
Pediatric Nephrologist	0	0	5	3	6	4	5	3
Neurologist	400	322	186	87	113	77	169	75
Pediatric Neurologist	30	21	11	8	7	5	8	6
Oncologist/Hematologist	214	162	93	49	83	60	70	43
Pediatric Oncologist/Hematologist	42	37	23	10	20	11	24	9
Orthopedic Surgeon	363	306	242	98	148	99	87	47
Orthopedic Surgeon (Pediatric)	0	0	3	1	8	4	3	1
Podiatrist	108	78	57	24	36	23	34	15
Pulmonologist	144	119	72	42	81	59	87	36
Pediatric Pulmonologist	15	11	10	4	8	5	10	4
Physical Medicine	27	17	66	35	81	45	200	60

Provider Category	DHCFP		Anthem		HPN		SilverSummit	
	Total Provider Records	Number of Unique Providers by NPI	Total Provider Records	Number of Unique Providers by NPI	Total Provider Records	Number of Unique Providers by NPI	Total Provider Records	Number of Unique Providers by NPI
Physical Medicine (Pediatric)	0	0	0	0	0	0	0	0
Rheumatologist	54	41	21	9	15	11	24	10
Pediatric Rheumatologist	0	0	5	3	5	3	5	2
Urologist	117	84	63	29	48	26	83	30
Pediatric Urologist	0	0	13	5	14	6	28	5
Vision Care Provider	1,062	838	565	160	585	119	117	48
Pediatric Vision Care Provider	2	2	17	5	28	7	0	0
Rehabilitation (Non-Medical Individual Provider)								
Physical Therapist	526	514	1,084	262	2,198	265	477	192
Occupational Therapist	269	260	233	107	502	108	215	88
Speech Therapist	1,136	1,096	225	150	276	145	221	111
Audiologist	1,223	1,178	39	25	77	40	72	23

The key findings from Table 9-2 are:

- Across all MCOs and the DHCFP, the most common specialty providers were cardiologists, general surgeons, neurologists, vision care providers, and non-medical rehabilitation providers.
- There was a wide variation in the number of contracted vision care providers, speech therapists, and audiologists. The DHCFP identified 838 unique vision care providers, 1,096 unique speech therapists, and 1,178 unique audiologists, whereas, the MCOs only reported fewer than 200 vision care providers and speech therapists, and fewer than 50 audiologists.
- **SilverSummit** reported no pediatric vision care providers in its data, while the DHCFP, **Anthem**, and **HPN** each reported at least two pediatric vision care providers. However, this may be due to a lack of pediatric vision care providers (i.e., pediatric optometrists and pediatric ophthalmologists) in the provider network or an inability to identify them in the provider data.
- **HPN** reported no pediatric allergists in its data. However, the DHCFP only reported 10, while the other two MCOs each reported one provider.
- The DHCFP, **Anthem**, and **HPN** reported no pediatric otolaryngologists in their data. However, **SilverSummit** reported one.
- The DHCFP and the MCOs reported no pediatric dermatologists or physical medicine (pediatric) providers in their data.
- The DHCFP did not have the following pediatric provider categories in its data: pediatric endocrinologist, pediatric gastroenterologist, pediatric infectious disease, pediatric nephrologist,

orthopedic surgeon (pediatric), pediatric rheumatologist, pediatric urologist. For these provider categories, all three MCOs reported at least one provider in their data.

Table 9-3 shows the number of behavioral health providers contracted with the DHCFP's FFS program and each of the MCOs. Results are shown by both the total number of provider records and the number of unique providers. Red shading indicates that no providers were identified in the MCOs' or the DHCFP's data for the provider category.

Table 9-3—Distribution of All Providers Registered in the DHCFP and MCOs by Behavioral Health Provider Categories in Nevada and Catchment Areas

Provider Category	DHCFP		Anthem		HPN		SilverSummit	
	Total Provider Records	Number of Unique Providers by NPI	Total Provider Records	Number of Unique Providers by NPI	Total Provider Records	Number of Unique Providers by NPI	Total Provider Records	Number of Unique Providers by NPI
Behavior Analysts/Technicians								
Behavior Analyst/Technician	308	305	118	102	335	269	198	103
Counselors								
Counselor	1,039	1,036	667	433	69	66	622	290
Substance Abuse Counselor	31	31	225	180	111	98	113	79
Marriage/Family Therapists								
Marriage/Family Therapist	122	121	588	398	200	176	539	252
Psychologists								
Psychologist	202	186	171	105	9	8	128	65
Pediatric Psychologist	9	8	9	4	0	0	8	3
Social Workers								
Social Worker	169	163	579	364	182	161	631	296
Psychiatrists								
Psychiatrist	295	223	323	116	136	107	372	113
Pediatric Psychiatrist	47	32	44	19	0	0	56	17
Outpatient Mental Health Facilities								
Outpatient Mental Health Facilities	0	0	59	35	0	0	418	187
Substance Abuse Facilities/Clinics								
Substance Abuse Facilities/Clinics	41	40	5	3	0	0	12	10

The key findings from Table 9-3 are:

- For the DHCFP, **Anthem**, and **SilverSummit**, the most common behavioral health provider category was counselor. **HPN**'s provider data identified more behavior analysts/technicians than any other behavioral health provider categories.
- **HPN** is the only MCO that had no pediatric psychologists, pediatric psychiatrists, or substance abuse facilities/clinics identified in its data. Outpatient mental health facilities is the only behavioral health provider category in which the DHCFP did not have identified providers.
- The DHCFP had fewer providers than all MCOs for the following provider categories: substance abuse counselor and marriage/family therapist.
- The DHCFP identified 1,036 unique counselors while the MCOs had approximately 790 combined.

Table 9-4 shows the number of facilities contracted with the DHCFP's FFS program and each of the MCOs. Results are shown by both the total number of provider records and the number of unique providers. Red shading indicates that no providers were identified in the MCOs' or the DHCFP's data for the provider category.

Table 9-4—Distribution of All Providers Registered in the DHCFP and MCOs by Facilities Categories in Nevada and Catchment Areas

Provider Category	DHCFP		Anthem		HPN		SilverSummit	
	Total Provider Records	Number of Unique Providers by NPI	Total Provider Records	Number of Unique Providers by NPI	Total Provider Records	Number of Unique Providers by NPI	Total Provider Records	Number of Unique Providers by NPI
Ambulatory Surgical Center/Outpatient Hospital	158	87	38	32	64	55	34	27
Personal Care Attendants /Home Health Facility	180	178	24	16	50	34	65	50
Dialysis/ESRD Facility	5	5	32	28	14	14	32	27
Hospice	40	26	0	0	23	13	7	4
Inpatient Hospital	54	37	23	19	12	10	59	27
Pediatric Hospital	0	0	0	0	0	0	0	0
Intermediate Care Facility/ID*	5	5	0	0	0	0	0	0
Pharmacy	250	138	12	9	443	443	4	2
Psychiatry Inpatient Hospital	14	9	8	7	8	8	11	7
Radiology (Facilities/Clinics)	31	25	10	2	101	24	3	2
Skilled Nursing Facility	41	35	29	28	36	26	23	18

* Services provided by Intermediate Care Facility/ID facilities are carved out of the managed care benefits.

The key findings from Table 9-4 are:

- The DHCFP's data identified five intermediate care facilities, while none of the MCOs' provider data identified intermediate care facilities. Since services provided by intermediate care facilities are carved out of the managed care benefits, this finding is expected.
- None of the MCOs nor the DHCFP identified pediatric hospitals in their data.
- **Anthem** is the only MCO that had no hospice facilities.
- While the DHCFP and **HPN** had 138 and 443 pharmacies identified in their data, respectively, **Anthem** reported nine pharmacies and **SilverSummit** reported only two. This may be due to a lack of pharmacies in the provider networks or an inability to identify them in the provider data.
- While all the MCOs reported 14 or more dialysis/ESRD facilities, the DHCFP reported only five.

Conclusions and Recommendations

Conclusions

The development of the provider crosswalks and the PCA are the baseline steps in preparing for future network adequacy analyses. In the process of conducting these baseline analyses, HSAG distributed the provider Data Structure Questionnaire to the MCOs, which highlighted differences in the methods being used to collect and store provider data. The findings from the provider Data Structure Questionnaire also highlighted the inconsistent collection and use of some crucial fields in the provider data (i.e., provider type and provider specialty). While the provider Data Structure Questionnaire identified some inconsistencies in data collection and storage, it also highlighted that all MCOs are conducting some monitoring and maintenance of the provider data regularly.

HSAG collaborated with the DHCFP to build provider crosswalks, which describe how to identify a variety of providers in the following categories: PCPs, specialists, behavioral health providers, and healthcare facilities. Provider categories were identified using a combination of provider type, provider specialty, taxonomy code, and/or professional degree.

In using the crosswalks to conduct the PCA, HSAG found that, in general, the DHCFP had a greater number of unique providers in its provider data files than the individual MCOs. Across the DHCFP and the MCOs, there were limited numbers of pediatric specialist providers. The most common pediatric specialist was pediatric cardiologist, but neither the DHCFP nor the MCOs reported any pediatric dermatologists or physical medicine (pediatric) providers.

HSAG identified no outpatient mental health facilities in the DHCFP's or **HPN**'s provider data. This may indicate a lack of facilities in the provider data or a potential challenge in identifying the facilities through the defined classification schemes.

The baseline PCA will set a baseline for future analyses to ensure that provider categories can be assigned consistently across the DHCFP and the MCOs. It also highlights the importance of defining

provider categories prior to moving to future network adequacy assessments to ensure that analyses are consistent across MCOs. The provider crosswalk prepared for this activity can be used to ensure that providers are consistently categorized for future network adequacy validation analyses, including time/distance and provider ratio analyses.

Recommendations

The goal of this study was to establish a foundation upon which the DHCFP can build robust managed care network adequacy expectations and oversight processes. As such, HSAG offers the following recommendations based on the findings detailed in this report:

- To facilitate future network adequacy validations, the DHCFP should develop standardized definitions for all required provider categories and instructions for reporting additional provider categories defined by the MCOs.
- While developing the provider crosswalks, HSAG identified a lack of consistent use of the provider type and provider specialty fields across the MCOs and a lack of consistent use of taxonomy codes by the DHCFP. The DHCFP should collaborate with the MCOs to ensure consistent data collection for these crucial provider data fields for all provider data.
- HSAG's PCA identified numerous spelling variations and/or special characters for the MCOs' s data values for provider type, specialty, and credentials. The MCOs should assess available data values in their provider data systems and standardize available data value options.

10. LIBERTY Dental

Compliance Review

The purpose of the state fiscal year (SFY) 2018–2019 Internal Quality Assurance Program (IQAP) Compliance Review was to assess the dental benefits administrator's (DBA's) compliance with the compliance review standards found in 42 Code of Federal Regulations (CFR) §438 Subparts A–F and the State contract requirements found in the State of Nevada, Department of Health and Human Resources, Division of Health Care Financing and Policy (the DHCFP) Contract 3425. The SFY 2018–2019 IQAP Compliance Review focused on the requirements for member services and experiences found in Subparts A, C, D, and F. The review period was January 1, 2018, through June 30, 2018. This report details **LIBERTY Dental Plan of Nevada, Inc.**'s (**LIBERTY**'s) compliance with the following:

- **IQAP Standards:** State and federal managed care requirements, which were categorized into five contract standards.
- **Checklists:** Contractual requirements related to the member handbook as well as member rights and responsibilities.
- **File Reviews:** Contractual requirements related to processing grievances, appeals, and service denials.

IQAP Standards

Table 10-1 presents **LIBERTY**'s scores for the IQAP standards. Details regarding **LIBERTY**'s compliance with the five IQAP standards, including the score that **LIBERTY** received for each element within each standard, are found in Appendix A-2, SFY 2018–2019 IQAP Compliance Review Tool for **LIBERTY**.

Table 10-1—Summary of Scores for the IQAP Standards

IQAP Standard #	Standard Name	Total Elements	Total Applicable Elements	Number of Elements				Total Compliance Score
				M	*PM*	*NM*	*NA*	
VI	Member Rights and Responsibilities	11	11	11	0	0	0	100%
VII	Member Information	11	11	11	0	0	0	100%
VIII	Continuity and Coordination of Care	4	4	2	2	0	0	75.0%
IX	Grievances and Appeals	33	33	20	13	0	0	80.3%
X	Coverage and Authorization of Services	24	24	18	6	0	0	87.5%
Total Compliance Score		**83**	**83**	**62**	**21**	**0**	**0**	**87.3%**

M=*Met*, ***PM***=*Partially Met*, ***NM***=*Not Met*, ***NA***=*Not Applicable*

Total Elements: The total number of elements in 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) to the weighted number that received a score of *Partially Met* (0.5 point), then dividing this total by the total number of applicable elements.

A review of the IQAP standards shows how well **LIBERTY** has interpreted the required elements of the managed care contract and developed the necessary policies, procedures, and plans to carry out the required functions of the DBA. Of the 83 applicable elements, **LIBERTY** received *Met* scores for 62 elements, *Partially Met* scores for 21 elements, and no elements received a *Not Met* score. The findings suggest that **LIBERTY** should further develop the necessary policies, procedures, and plans to operationalize the required elements of its contract to demonstrate compliance with the contract. Further, interviews with **LIBERTY** staff showed that staff members were knowledgeable about most of the requirements of the contract and the policies and procedures that **LIBERTY** employed to meet contractual requirements.

The areas with the greatest opportunity for improvement for IQAP standards were related to Standard VIII—*Continuity and Coordination of Care*, Standard IX—*Grievances and Appeals*, and Standard X—*Coverage and Authorization of Services*, which received scores of 75 percent, 80.3 percent, and 87.5 percent, respectively.

Checklist Reviews

Table 10-2 presents the scores for the checklists. Health Services Advisory Group, Inc. (HSAG), reviewed all requirements related to the member handbook and member's rights and responsibilities to verify compliance with State and federal requirements. HSAG scored the elements required via the checklists. The checklists review area was scored based on the total number of **LIBERTY**'s compliant elements divided by the total number of applicable elements.

Table 10-2—Checklist Score

Associated IQAP Standard #	Checklist	# of Applicable Elements	# of Compliant Elements	Score (% of Compliant Elements)
VI	Member Rights and Responsibilities	14	14	100%
VII	Member Information	27	27	100%
	Checklist Totals	**41**	**41**	**100%**

The results generated by the checklists serve as additional indicators of **LIBERTY**'s ability to develop the required outreach information and to ensure that the information contains all contractually required elements. Of the 41 elements reviewed for the checklists, **LIBERTY** received scores of *Met* for all elements. The findings suggest that **LIBERTY** had strong compliance in each of the areas evaluated by the checklists and that **LIBERTY** developed the necessary manuals, handbooks, and policies according to contract requirements.

File Reviews

For the file reviews, each file review area was scored based on the total number of **LIBERTY**'s compliant elements divided by the total number of applicable elements for each individual file reviewed.

Table 10-3 presents **LIBERTY**'s scores for the file reviews.

Table 10-3—Summary of Scores for the File Reviews

Associated IQAP Standard #	Description of File Review	# of Records Reviewed	# of Applicable Elements	# of Compliant Elements	Score (% of Compliant Elements)
IX	Grievances	10	30	30	100%
IX	Appeals	10	44	42	95.5%
X	Service Denials	10	30	29	96.7%
	File Review Totals	**30**	**104**	**101**	**97.1%**

File reviews are important to the overall findings of the IQAP review because the results show how well **LIBERTY** operationalized and followed the policies it developed for the required elements of the contract. Of the 104 total elements reviewed for the file reviews, **LIBERTY** received scores of *Met* for 101 elements.

The area with the greatest opportunity for improvement for file reviews was related to appeals, which demonstrated compliance with 42 of 44 elements. Documentation that demonstrated **LIBERTY** made reasonable efforts to give oral notice of resolution to the member for an expedited appeal was not found in the appeal file. Further, one expedited appeal was not resolved within the required 72-hour time frame.

It was noted during the file reviews that the dental record request letter to the provider included instructions that providers could email the dental records containing protected health information (PHI) to the DBA. It was unclear if encrypted and secure email would be used and **LIBERTY** did not instruct the provider to use secure methods to transmit PHI. During **LIBERTY**'s Readiness Review completed in 2017, this issue was also noted. **LIBERTY** submitted a corrective action plan (CAP) which included revisions to the dental request letter template instructing the provider that email encryption must be used if the dental provider chose to send dental records via email; however, the CAP was not implemented. While **LIBERTY**'s email system may be secure and its emails encrypted, these conditions may not be true for a dental provider. An increased risk for a breach of PHI when transmitting dental records from unsecured emails remains a serious concern. HSAG recommended that **LIBERTY** staff members have further discussion with DHCFP staff members to determine next steps to address this matter.

Validation of Performance Improvement Projects

The primary objective of performance improvement project (PIP) validation is to determine compliance with the requirements of 42 CFR §438.330(b)(1)(i) and §438.330(d)(2)(i-iv) including:

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

In SFY 2018–2019, HSAG, **LIBERTY**, and the DHCFP collaborated to determine the PIP topics for the two mandatory PIPs. The selected topics are: ***Improve Caries Risk Assessment Completion Rate*** and ***Annual Dental Visits***. The topics selected addressed the Centers for Medicare and Medicaid Services requirements related to quality outcomes—specifically, the quality and timeliness of and access to care and services.

For each topic, **LIBERTY** defined a Global Aim and SMART Aim. The SMART Aim statement includes the narrowed population, the baseline rate, a set goal, and the end date. HSAG provided the parameters to the dental prepaid ambulatory health plan (PAHP) for establishing the SMART Aim for each PIP.

Table 10-4 presents each topic and the SMART Aim statement as documented by the PAHP. **LIBERTY** was required to specify the outcome being measured, the baseline value for the outcome measure, a quantifiable goal for the outcome measure, and the end date for attaining the goal.

Table 10-4—PIP Titles and SMART Aim Statements

PIP Title	SMART Aim Statement
Improve Caries Risk Assessment Completion Rate	By December 31, 2019, increase the percentage of completed caries risk assessments for children 1–6 years of age seen at Kid Dental LLC and Smile Reef Pediatric Dentistry from 0.22% to 12.0%.
Annual Dental Visits	By December 31, 2019, increase the percentage of one-year old children assigned to Palm Valley Dental who have a dental visit completed from 0.40% to 10.4%.

Validation Findings

LIBERTY completed and submitted modules 1 through 3 for validation . The following section outlines the validation findings for each module.

Module 1: PIP Initiation

The objective of Module 1 is for the PAHP to ask and answer the first fundamental question, "What are we trying to accomplish?" In this phase, for both PIPs, **LIBERTY** determined the narrowed focus, developed its PIP team, established external partnerships, determined the Global and SMART Aim, and developed the key driver diagram.

Improve Caries Risk Assessment Completion Rate

Upon initial validation of Module 1, HSAG identified that **LIBERTY** needed an executive sponsor for the PIP, that the SMART Aim goal should be reconsidered because the goal set required that only 23 members needed to have a completed caries risk assessment over a 16-month period, and that additional information was required describing the interventions in the key driver diagram. After receiving technical assistance, **LIBERTY** made the necessary corrections, achieving the validation criteria across all evaluation elements.

Improving Annual Dental Visits

Upon initial validation of Module 1, HSAG identified that **LIBERTY** needed an executive sponsor for the PIP and that additional information was required in explanation of the interventions in the key driver diagram. After receiving technical assistance, **LIBERTY** made the necessary corrections, achieving the validation criteria across all evaluation elements within the resubmission.

Module 2: SMART Aim Data Collection

The objective of Module 2 is for the PAHP to ask and answer the question, "How will we know that a change is improvement?" In this phase, for both PIPs **LIBERTY** defined how and when it will be evident that improvement is being achieved.

Improve Caries Risk Assessment Completion Rate

LIBERTY defined the SMART Aim measure as follows:

Numerator: The number of NV Medicaid enrollees ages 1 to 6 that had a dental service performed at Kid Dental, LLC or Smile Reef Pediatric Dentistry and had a caries risk assessment reported, including CDT codes D0601, D0602, and D0603 measured monthly using a 12-month rolling methodology that will begin on January 1, 2018 and end December 31, 2019.

Denominator: The number of unique NV Medicaid enrollees ages 1 to 6 that had a dental service performed at Kid Dental, LLC or Smile Reef Pediatric Dentistry measured monthly using a 12-month rolling methodology that will begin on January 2018 and end December 31, 2019.

For the SMART Aim measure, data will be submitted to **LIBERTY** from the two providers in the form of claims. The PAHP will work directly with the dental offices to ensure that all claims are submitted

timely (within 30 calendar days) throughout the PIP cycle. Various staff of the Claims Department will be responsible for the collection and recording of the data into the claims system. The PAHP's system will capture the required data and produce reports that can be customized for the need of the PIP.

Upon initial validation of Module 2, no opportunities for improvement were identified and **LIBERTY** achieved all validation criteria.

Improving Annual Dental Visits

LIBERTY defined the SMART Aim measure as follows:

Numerator: NV Medicaid one-year-old children continuously enrolled *180 days with one or more dental services (any valid CDT code excluding codes D9000-D9999) performed at Palm Valley Dental (#016698) measured monthly using a 12-month rolling methodology that will begin on January 2018 and end December 31, 2019.

*For the period January 1, 2018 through June 30, 2018, enrollees will only be required to be continuously enrolled from January 1, 2018 through the end of the reporting period, as eligibility history is limited to January 1, 2018, and forward.

Denominator: NV Medicaid 1-year-old children continuously enrolled and assigned to Palm Valley Dental (#016698) for *180 continuous days, measured monthly using a 12-month rolling methodology that will begin on January 2018 and end December 31, 2019.

For the SMART Aim measure, data will be submitted to **LIBERTY** from the targeted provider in the form of claims. The PAHP will work directly with the dental office to ensure that all claims are submitted timely (within 30 calendar days) throughout the PIP cycle. Various staff of the Claims Department will be responsible for the collection and recording of the data into the claims system. The PAHP's system will capture the required data and produce reports that can be customized for the need of the PIP.

Upon initial validation of Module 2, no opportunities for improvement were identified and **LIBERTY** achieved all validation criteria.

Module 3: Intervention Determination

Module 3 is the intervention determination phase of the PIP. In this module, the PAHP will ask and answer the question, "What changes can we make that will result in improvement?"

Improve Caries Risk Assessment Completion Rate

LIBERTY completed a process map and an failure modes and effects analysis (FMEA) to determine the areas within its processes with the greatest need for improvement and which would have the most impact on desired outcomes. **LIBERTY** identified the following four subprocesses:

- Dentist completes the Caries Risk Assessment form.
- Dentist submits the Caries Risk Assessment form to **LIBERTY**.
- Caries Risk Assessment form routed through correct department and process at **LIBERTY**.
- Caries Risk Assessment form was completed properly.

Using the risk-priority numbering method to prioritize the identified failure modes within these subprocesses, **LIBERTY** determined the following failure modes to be top priority for developing the interventions that will be tested using Plan-Do-Study-Act (PDSA) cycles in Module 4.

- Dentist performs the caries risk assessment but does not fill out the Caries Risk Assessment form.
- Dentist submits claim for procedure code only, without the Caries Risk Assessment form.
- Dentist does not understand how to fill out the Caries Risk Assessment form.

The following are interventions that **LIBERTY** selected to test in Module 4.

- **LIBERTY** will contact Kid Dental, LLC and Smile Reef Pediatric Dentistry via telephonic methods and inform the office staff of the added compensation benefits of successfully completing and submitting the Caries Risk Assessment form.
- Require the completed form be submitted before payment can be released.
- **LIBERTY** provider representatives will schedule on-site training with Kid Dental, LLC and Smile Reef Pediatric Dentistry. In addition, the PAHP will create a formalized training template that focuses on completing a Caries Risk Assessment form and will also provide related assistive online tools and resources.

Upon initial validation of Module 3, HSAG identified that **LIBERTY** needed to revise its process map so that it represented the current process for the narrowed-focus providers. The PAHP also needed to correct the documentation in the Failure Mode Priority Ranking table, provide additional information on potential interventions, and ensure that interventions listed to test in Module 4 were directed toward the two narrowed-focus providers. After receiving technical assistance from HSAG, **LIBERTY** made the necessary corrections and submitted the module for final validation. For the final validation, **LIBERTY** received *Achieved* scores for all evaluation elements.

Improving Annual Dental Visits

LIBERTY completed a process map and FMEA to determine the areas within its current process that had the greatest need for improvement and would have the most impact on intended outcomes. **LIBERTY** identified the following four subprocesses on which to focus efforts:

- Parent/guardian understanding importance of child age 1 or younger seeing a dentist.
- Parent/guardian scheduling appointment for child.
- Parent/guardian taking child to scheduled appointment.

Using the risk-priority numbering method to prioritize the identified failure modes within these subprocesses, **LIBERTY** determined that the top four failure modes to develop interventions and test through the use of PDSA cycles in Module 4 were:

- Parent/guardian does not receive information about the importance of or need to take child to primary care dentist (Palm Valley Dental) on or before age 2 or when the child gets his or her first tooth. In addition, parent or guardian is not aware of or does not like the child's assignment to Palm Valley Dental.
- Appointment availability at Palm Valley Dental is limited or is not agreeable with parent or guardian's work schedule.
- Parent/guardian does not have reliable transportation.
- Parent/guardian forgets about scheduled appointment.

The following are interventions that **LIBERTY** selected to test in Module 4.

- **LIBERTY** will contact, via phone, the parents or guardians of members 1 year of age or younger who are assigned to Palm Valley Dental and have not had a scheduled visit in the current calendar year to educate on the importance of completing a dental exam before the age of 2. During this outreach call, the PAHP will also assess the parent or guardian's awareness of or satisfaction with the child's assignment to Palm Valley Dental.
- **LIBERTY** will work with Palm Valley Dental to ensure that the office offers extended hours at least one day a month or is open one Saturday or Sunday.
- **LIBERTY** will contact, via phone or texting campaign, the parents and guardians of members 1 year of age and younger who are assigned to Palm Valley Dental and have not had a scheduled visit in the current calendar year to inform them of available transportation as well as how to access those services. Palm Valley Dental staff members will be trained on transportation benefits and how to access transportation services so the office staff can inform and offer transportation directly to members during appointment scheduling and reminders.
- **LIBERTY** will work with Palm Valley Dental to ensure that an adequate appointment reminder system is in place and coordinate so that additional appointment reminders and scripts can be sent by **LIBERTY** as well via telephonic outreach and texting campaigns.

Upon initial validation of Module 3, HSAG identified that **LIBERTY** needed to revise its process so that it represented the current process for narrowed-focus providers. HSAG also recommended that the PAHP reconsider some potential interventions, including website/application and robotic call outreach. The PAHP needed to provide additional information for how it would inform members on the transportation benefit. HSAG also identified that the failure modes listed for potential interventions were not the top-ranked failure modes. **LIBERTY** needed to revise how reliability and sustainability would be addressed for all interventions**.** After receiving technical assistance from HSAG, **LIBERTY** made the necessary corrections and submitted the module for final validation. For the final validation, **LIBERTY** received *Achieved* scores for all evaluation elements.

At the time of this SFY 2018–2019 External Quality Review (EQR) Technical Report, **LIBERTY** had completed its PIPs through Module 3 and initiated the intervention planning phase of Module 4. HSAG will report the Module 4—Intervention Testing results and Module 5—PIP Conclusions in the SFY 2019–2020 EQR Technical Report.

Conclusions and Recommendations

The PIP validation findings suggest that **LIBERTY** successfully completed modules 1 through 3 and developed methodologically sound projects. **LIBERTY** was also successful in building internal and external quality improvement teams and developing collaborative partnerships with targeted providers and facilities.

HSAG offers the following recommendations to **LIBERTY**:

- As **LIBERTY** progresses to testing interventions through a series of thoughtful and incremental PDSA cycles, the PAHP's PIP team should ensure it is communicating the reasons for making changes to intervention strategies and how those changes will lead to improvement.
- When planning a test of change, **LIBERTY** should think proactively (i.e., scaling/ramping up to build confidence in the change and eventually implementing policy to sustain changes).
- When developing the intervention testing methodology, **LIBERTY** should determine the best method for identifying the intended effect of an intervention prior to testing. The intended effect of the intervention should be known up front to help determine which data need to be collected.
- As **LIBERTY** tests new interventions, it should ensure it is making a prediction in each *Plan* step of the PDSA cycle and discussing the basis for the prediction. This will help keep the theory for improvement in the project in the forefront for everyone involved.
- All completed intervention plans (the "P" stage) should be submitted to HSAG for review prior to progressing to the "Do" stage of testing a new intervention.
- The key driver diagram and FMEA for both PIPs should be updated as **LIBERTY** moves through the intervention testing process.

Validation of Performance Measures

Medicaid Results

Table 10-5 displays the Healthcare Effectiveness Data and Information Set (HEDIS) 2019 Medicaid performance measure rate results for **LIBERTY** and the DHCFP minimum performance standards (MPS), where applicable.

Table 10-5—Medicaid HEDIS Performance Measures Results for LIBERTY

Measures	HEDIS 2019 Rate	MPS
Annual Dental Visit (ADV)		
Total	50.67%	57.62%
Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH)		
Percentage of Eligibles Who Received Preventive Dental Services	39.76%	—

— Indicates that the DHCFP has not established an MPS for this measure for HEDIS 2019.

LIBERTY fell below the MPS by approximately 7 percentage points for the *Annual Dental Visit—Total* measure rate in HEDIS 2019 for the Medicaid population. The *Percentage of Eligibles Who Received Preventive Dental Services* measure is a first-year measure and should be monitored for performance.

Nevada Check Up Results

Table 10-6 displays the HEDIS 2019 Nevada Check Up performance measure rate results for **LIBERTY** and the DHCFP MPS, where applicable.

Table 10-6—Medicaid HEDIS Performance Measures Results for LIBERTY

Measures	HEDIS 2019 Rate	MPS
Annual Dental Visit (ADV)		
Total	66.33%	71.63%
Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH)		
Percentage of Eligibles Who Received Preventive Dental Services	54.01%	—

— Indicates that the DHCFP has not established an MPS for this measure for HEDIS 2019.

LIBERTY fell below the MPS by approximately 5 percentage points for the *Annual Dental Visit—Total* measure rate in HEDIS 2019 for the Nevada Check Up population. The *Percentage of Eligibles Who Received Preventive Dental Services* measure is a first-year measure and should be monitored for performance.

Network Adequacy Validation (NAV)

Under the contract for EQR, the DHCFP requested that HSAG prepare a provider crosswalk and conduct a baseline provider composition analysis (PCA) of the Medicaid provider network for all managed care organizations (MCOs) and the dental benefits administrator (DBA)/prepaid ambulatory health plan (PAHP) during fiscal year (FY) 2018–2019. According to the federal regulations for managed care that were released in May 2016, the activity related to 42 CFR §438.358(b)(1)(iv), validation of network adequacy, shall commence no later than one year from the issuance of the associated EQR protocol. In preparation for the release of the protocol, HSAG applied the provider crosswalk file to the PAHP's provider network to assess network composition. Additionally, in future years, the provider crosswalk is a tool that can be used for future network validation analyses (e.g., time/distance and provider ratio analyses).

Objectives

The objectives of the network adequacy activities were:

- To understand the PAHP's provider data structure and methods for classifying providers as assessed by the provider data structure questionnaire.
- To create a provider crosswalk that outlines consistent definitions and methods for identifying providers in the identified dental provider categories.
- To conduct a baseline PCA analysis that assesses the number of providers in each provider category after applying the results of the provider crosswalk to the PAHP's submitted data.

Provider Data Structure Findings

Structure of the Provider Files

The PAHP described its data system and how the provider data are stored. **LIBERTY** maintains a single source data system that stores and tracks all elements required to track its provider networks.

LIBERTY's provider data are required to be updated when there is a change in provider status. **LIBERTY** confirms provider information every three years for re-credentialing. Most provider information (e.g., provider type, specialty, taxonomy) is collected via self-report from the providers. Additionally, **LIBERTY** indicated that active providers and providers accepting new patients were identifiable in their provider data files.

Single Case Agreements

Single case agreements are an important aspect in the analysis of network adequacy since PAHPs frequently use single case agreements or letters of agreement when special circumstances are needed to

ensure members' access to providers. **LIBERTY** indicated that the providers are mapped in its data system to the applicable contract.

Data Cleaning and Standardization

In order to clean and monitor the provider data files, **LIBERTY** conducts an address standardization against the United States Postal Service (USPS) databases for all new provider offices. Additionally, **LIBERTY** assigns each office a network manager who is responsible for conducting an initial visit or call and then follows up annually to ensure the provider profile is current.

Provider Composition Analysis Results for the PAHP

This section describes PCA findings specific to the PAHP and the provider categories included within the range of services covered.

Table 10-7 shows the number of PAHP providers contracted with the DHCFP's fee-for service (FFS) program and **LIBERTY**. Results are shown by both the total number of provider records and the number of unique providers. The total provider record counts tended to be more than the unique provider National Provider Index (NPI) counts because one provider can serve at multiple locations or have multiple Medicaid provider IDs associated with the same NPI. Red shading indicates that no providers were identified in the MCOs' or the DHCFP's data for the provider category.

Table 10-7—Distribution of All Providers Registered in the DHCFP and LIBERTY by Dental Provider Categories in Nevada and Catchment Areas

Provider Category	DHCFP		LIBERTY	
	Total Provider Records	Number of Unique Providers by NPI	Total Provider Records	Number of Unique Providers by NPI
General Dentist	727	617	1,790	297
Pediatric Dentist	100	88	212	37
Endodontist	1	1	37	2
Periodontist	4	3	0	0
Prosthodontist	4	3	0	0
Oral Surgeon	50	37	145	15
Orthodontist*	72	71	0	0
Dental Hygienist	20	20	12	10

* Orthodontic care is carved out of the managed care dental benefits.

The key findings from Table 10-7 are:

- The DHCFP had more dental providers than **LIBERTY** for all provider categories, except endodontists, where the DHCFP reported one provider and **LIBERTY** reported two.

- The DHCFP reported three periodontists, three prosthodontists, and 71 orthodontists, while **LIBERTY** reported no providers for these provider categories.
- The DHCFP had 617 general dentists in its data, while only 297 were identified in **LIBERTY**'s provider data.

Conclusions and Recommendations

Conclusions

The development of the provider crosswalks and the PCA are the baseline steps in preparing for future network adequacy analyses. In the process of conducting these baseline analyses, HSAG distributed the provider Data Structure Questionnaire to the PAHP. The findings from the provider Data Structure Questionnaire illustrated the steps that **LIBERTY** takes to clean, monitor, update, and store provider data. Provider information is confirmed every three years during the credentialing process. Additionally, **LIBERTY** assigns each office a network manager who is responsible for conducting an initial visit or call and then follows up annually to ensure the provider profile is current.

HSAG collaborated with the DHCFP to build provider crosswalks, which describe how to identify a variety of providers. Provider categories were identified using a combination of provider type, provider specialty, taxonomy code, and/or professional degree.

In using the crosswalks to conduct the PCA, HSAG found that, in general, the DHCFP had a greater number of unique providers in its provider data files than **LIBERTY**. Specifically, **LIBERTY** did not report any periodontists, prosthodontists, or orthodontists. However, it is important to note that orthodontic care is carved out of the managed care dental benefit, which may explain why orthodontists were not identified in **LIBERTY**'s data.

The baseline PCA will set a baseline for future analyses to ensure that provider categories can be assigned consistently across the DHCFP and the PAHP. It also highlights the importance of defining provider categories prior to moving to future network adequacy assessments to ensure that analyses are consistent and well-defined.

Recommendations

The goal of this study was to establish a foundation upon which the DHCFP can build robust managed care network adequacy expectations and oversight processes. As such, HSAG offers the following recommendations based on the findings detailed in this report:

- To facilitate future network adequacy validations, the DHCFP should develop standardized definitions for all required provider categories and instructions for reporting additional provider categories defined by the PAHP.

11. Follow-Up on Recommendations

Introduction

As the external quality review organization (EQRO) for the State of Nevada, Department of Health and Human Services, Division of Health Care Financing and Policy (the DHCFP), Health Services Advisory Group, Inc. (HSAG), conducted the following external quality review (EQR) activities for the Nevada managed care organizations (MCOs) during state fiscal year (SFY) 2016–2017:

- Internal Quality Assurance Plan (IQAP) Compliance Review
- Validation of Healthcare Effectiveness Data and Information Set (HEDIS) performance measures
- Validation of performance improvement projects (PIPs)
- Analysis of each MCO's Consumer Assessment of Healthcare Providers and Systems (CAHPS)Survey for adults, children, and children with chronic conditions

For each EQR activity, HSAG provided MCO-specific findings and, if indicated, recommendations to the MCO. On an annual basis, the EQRO is required to report, as part of the technical report that is the State's deliverable to the Centers for Medicare & Medicaid Services (CMS), the MCO-specific results and the degree to which each MCO addressed any recommendations made by the EQRO. There were no recommendations related to the IQAP Compliance Review since the MCO had already resolved all areas of noncompliance prior to the issuance of the SFY 2017–2018 EQR Technical Report. Furthermore, there were no recommendations made for the DBA

The DHCFP established a collaborative environment to promote sharing of information about emerging practices identified by the MCOs, which would take place at a quarterly on-site meeting that includes MCO, the DHCFP, and HSAG staff members as well as external stakeholders. The collaborative sharing among the staffs from the DHCFP and the MCOs promotes continual quality improvement of the Nevada Medicaid and Nevada Check Up programs, and it has enabled the DHCFP to track progress toward meeting the goals and objectives identified in the DHCFP's quality strategy. Each health plan is responsible for identifying, through routine data analysis and evaluation, quality improvement initiatives that support improvement in quality, access, and timeliness of services delivered to Medicaid members. By testing the efficacy of these initiatives over time, the MCOs can determine which of them yield the greatest improvement.

It is at these collaborative quarterly meetings that MCOs present the results of data analyses and evaluations that address recommendations made by HSAG. MCOs also present the interventions and initiatives that have yielded success for their membership and, consequently, performance measure rates. Presented below is a summary of how the MCOs addressed the recommendations that HSAG made based on the previous year's EQR activities.

Validation of Performance Measures—NCQA HEDIS Compliance Audit

HSAG conducted an NCQA HEDIS Compliance Audit to assess MCO performance with respect to the *HEDIS 2018 Technical Specifications* and to review the MCOs' performance on the HEDIS measures. HSAG validated all measures reported by **Anthem Blue Cross and Blue Shield Healthcare Solutions** (**Anthem**) and **Health Plan of Nevada** (**HPN**). **SilverSummit Healthplan, Inc.** (**SilverSummit**), had not been operational long enough to participate in the HEDIS compliance audit; therefore, there were no recommendations made for **SilverSummit**.

Anthem's Response to HSAG's Recommendations

Table 11-1 and Table 11-2 detail HSAG's recommendations related to validation of performance measures for **Anthem** as well as **Anthem**'s response.

Table 11-1—Validation of Performance Measures—Recommendations and Anthem Response 1

HSAG HEDIS Recommendation 1
Although **Anthem** met its QISMC goals for several measures for the Medicaid and Nevada Check Up populations, the DHCFP should continue efforts to increase the QISMC goals and encourage the health plans to continue improvement efforts. Additionally, **Anthem** should investigate the reasons for declines in rates of 5 percentage points or more for the following Medicaid measures: • *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* • *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*
Anthem HEDIS Response 1
Anthem provided the following response to HSAG. For *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*, **Anthem**: • Continued partnering with eye vendor, EyeQuest, to provide monthly Gaps In Care (GIC) reports to providers and provide HEDIS coding education to providers to capture appropriate testing and results. • Implemented text campaign in 2018 to members to educate on eye exams for comprehensive diabetes care (CDC) and make appointments with primary care provider (PCP). • Continued outreach from health plan to members to get members scheduled for CDC appointments. • Continued case management/disease management programs for eligible members. For *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*, **Anthem**: • Implemented text campaign in 2018 to members to educate on blood pressure (BP) control and to encourage members to schedule appointments with PCP. • Continued provider/medical assistant (MA) HEDIS education on BP taking/re-taking techniques and documentation into medical record. • Implemented provider office "Clinic Days" in 2018 for PCPs to schedule and see members to get needed screening and treatment. • Continued case management/disease management programs for eligible members. • Continued education in member newsletters, health tips, and marketing/health fair screening events.

Table 11-2—Validation of Performance Measures—Recommendations and Anthem Response 2

HSAG HEDIS Recommendation 2
Anthem should investigate the reasons for declines in rates of 5 percentage points or more for the following Nevada Check Up measures: • *Childhood Immunization Status—Combinations 6, 8, 9,* and *10*
Anthem HEDIS Response 2
Anthem provided the following response to HSAG. For *Childhood Immunization Status—Combinations 6, 8, 9,* and *10*, **Anthem**: • Continued standard supplemental data source with the Nevada immunization registry. • Continued Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) reminders through 2018. • Implemented text campaign in 2018 to members to educate on immunizations and to encourage members to schedule PCP appointments. • Telephonic member outreach, based on GIC list, to educate them on childhood immunization status (CIS) and to assist them with scheduling an appointment with their PCP. • Continued education to providers on CIS and HEDIS measure compliance. • Implemented "Clinic Days" in 2018 to work with members to see PCP and get needed immunizations. • CIS reminders and education in annual member newsletter.

HPN's Response to HSAG's Recommendations

Table 11-3 and Table 11-4 detail HSAG's recommendations related to performance measure validation for **HPN** as well as **HPN**'s response.

Table 11-3—HEDIS—Recommendations and HPN Response 1

HSAG HEDIS Recommendation 1
Although **HPN** met its QISMC goals for several measures for the Medicaid and Nevada Check Up populations, the DHCFP should continue efforts to increase the QISMC goals to encourage the health plans to continue improvement efforts. Additionally, **HPN** should investigate the reasons for declines in rates of 5 percentage points or more for the following Medicaid measures: • *Childhood Immunization Status—Combinations 3, 4, 5, 6, 7, 8, 9, and 10* • *Comprehensive Diabetes Care—HbA1c Testing* • *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* • *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
HPN HEDIS Response 1
HPN provided the following response: **HPN** completes an annual analysis of the final HEDIS results for all Medicaid measures. This analysis includes an evaluation of county, zip code, race, age, and gender compliance to determine any health disparities as well as measure details to determine areas of opportunities for improvement. In addition, **HPN**

HPN HEDIS Response 1
elicits member, provider and stakeholder feedback to determine additional barriers. Strategies and goals are created to address the identified disparities and/or areas of opportunities. **HPN** continues an ongoing elevation to determine the success of the strategies and additional areas of improvement. **HPN**'s analysis of the Childhood Immunization Status Combinations identified the two influenza (flu) vaccines as an area of opportunity and identified some of the following contributions to non-compliance: • The belief/practice that the flu shot is optional for children under the age of two. • Parent/legal guardian belief that the flu shot causes the flu. • Parent/legal guardian is unaware that their child needs two flu shots. • The actual time frame of the availability of the vaccine for children (VFC) influenza vaccine. • Provider and member's parent/legal guardian lack of understanding of the allowable time between the two separate vaccinations. • The influenza vaccination is typically delivered independently outside of well-child visits and other immunizations. • Provider not scheduling appointments for next vaccination or explaining when vaccination will be available before parent/legal guardian leaves the office. **HPN** initiated several member and provider interventions to increase compliance. These interventions were successful in increasing the influenza vaccination utilization from 36.25 percent in 2017 to 43.80 percent in 2018. This aided in the increase of the *Childhood Immunization Status Combination 10* 3.16 percentage points from 2014 to 2018 and 9.49 percentage points from 2017 to 2018. The analysis of the *Comprehensive Diabetes Care—HbA1c Testing* identified some of the following contributions to non-compliance: • Provider not using standing orders for lab draws. • Providers scheduling annual lab draws at the end of the year without time to reschedule for no shows. • Off-site labs requiring members to schedule or make time for another appointment which may also require scheduling transportation. • Member's lack of understanding the difference between regularly checking blood sugar at home and a HbA1c lab draw. **HPN** initiated several member and provider interventions to increase compliance. These interventions were successful in increasing the *Comprehensive Diabetes Care—HbA1c Testing* 2.43 percentage points from 2017 to 2018. The analysis of the *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* identified some of the following contributions to non-compliance: • Provider not scheduling at least two or more follow-up appointments before parent/legal guardian leaves the office. • Member' parent/legal guardian not attending scheduled follow-up appointments.

HPN HEDIS Response 1
• Provider and member's parent/legal guardian lack of understanding the time frames to complete at least two follow-up visits on different dates of service from 31–300 days after the earliest dispensing date for ADHD mediation. • Provider only using in-office follow-up appointments when one of the follow-up appointments can be completed via telehealth. • Provider not correlating prescription refill dates to the date of the scheduled follow-up appointments. **HPN** initiated several member and provider interventions to increase compliance. These interventions were successful in increasing the *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* 11.75 percentage points from 2015 to 2018 and 18.01 percentage points from 2017 to 2018. The analysis of the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* identified some of the following contributions to non-compliance: • Provider and member's lack of understanding the time frame to complete initial prenatal care visit within the first trimester or within 42 days of enrollment with **HPN**. • Members not identified early enough in the pregnancy or when enrolled with **HPN** for **HPN** to help the member meet the time frames. • Member not invested in prenatal care. • Providers not completing an initial prenatal appointment when the mother comes in for a pregnancy test. • Initial prenatal visit not linked to an actual office visit. • Initial prenatal visit not completed with the appropriate provider types. **HPN** initiated several member and provider interventions to increase compliance. These interventions were successful in increasing the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* 2.92 percentage points from 2015 to 2018 and 9.35 percentage points from 2017 to 2018. **HPN** will continue to complete annual and ongoing analysis of the HEDIS measures and elicit member, provider, and stakeholder feedback to determine areas of opportunity and continue to develop strategies to increase compliance.

Table 11-4—HEDIS—Recommendations and HPN Response 2

HSAG HEDIS Recommendation 2
HPN should investigate the reasons for declines in rates of 5 percentage points or more for the following Nevada Check Up immunization combination indicators: • *Childhood Immunization Status—Combinations 6, 8, 9,* and *10*
HPN HEDIS Response 2
HPN provided the following response. **HPN** completes an annual analysis of the final HEDIS results for all Check Up measures. This analysis includes an evaluation of county, zip code, race, age, and gender compliance to determine any health disparities and to measure details to determine areas of opportunities for improvement. In addition, **HPN** elicits member, provider, and stakeholder feedback to determine additional barriers. Strategies and goals are created to address the identified disparities and/or areas of opportunities. **HPN** continues an ongoing evaluation to determine the success of the strategies and additional areas of improvement. **HPN**'s analysis of the Childhood Immunization Status Combinations identified the two influenza (flu) vaccines as an area of opportunity and identified some of the following contributions to non-compliance: • The belief/practice that the flu shot is optional for children under the age of two. • Parent/legal guardian belief that the flu shot causes the flu. • Parent/legal guardian is unaware that their child needs two flu shots. • The actual time frame of the availability of the VFC influenza vaccine. • Provider and member's parent/legal guardian lack of understanding the allowable time between the two separate vaccinations. • The influenza vaccination is typically delivered independently outside of well-child visits and other immunizations. • Provider not scheduling appointments for next vaccination or when vaccination is available before parent/legal guardian leaves the office. **HPN** initiated several member and provider interventions to increase compliance. These interventions were successful in increasing utilization for the influenza vaccine from 47.65 percent in 2017 to 49.11 percent in 2018. This aided in the increase of the *Childhood Immunization Status Combination 10* 0.28 percentage points from 2014 to 2018 and 1.07 percentage points from 2017 to 2018. **HPN** will continue to complete annual and ongoing analysis of the HEDIS measures and elicit member, provider, and stakeholder feedback to determine areas of opportunity and continue to develop strategies to increase compliance.

Performance Improvement Projects

HSAG validated the PIPs submitted by each MCO. In SFY 2017–2018, the MCOs continued using the rapid-cycle PIP approach for the two DHCFP selected PIP topics. The PIPs were: *Follow-Up After Emergency Room (ER) Discharge*, and *Well-Child Visits for Children 3 to 6 Years of Age*. The topics addressed CMS requirements related to quality outcomes, specifically the quality and timeliness of, and access to, care and services. Upon final validation, each PIP was given a validation score of either *High Confidence*, *Confidence*, *Low Confidence*, or *PIP Results Were Not Credible*.

Anthem's Response to HSAG's Recommendations

Table 11-5 and Table 11-6 detail HSAG's recommendations related to validation of performance improvement projects for **Anthem** as well as **Anthem**'s response.

Table 11-5—PIP Validation—Recommendation and Anthem's Response

HSAG PIP Recommendation 1
As each MCO moves through the quality improvement process and conducts PDSA cycles, it should: • Ensure it is communicating the reasons for making changes to intervention strategies and how those changes will lead to improvement. Without a common understanding and agreement about the causes that effect improvement, the team may misdirect resources and improvement activities toward changes that do not lead to improvement. • Update the key driver diagram and failure modes and effects analysis (FMEA) for both PIPs while testing interventions. • Reference the *Rapid-Cycle PIP Reference Guide* as the MCO progresses through subsequent phases of the PIP and request technical assistance, as needed.
Anthem PIP Response 1
Anthem provided the following response to HSAG. • The PIP team will continue to meet bi-weekly to discuss and review intervention strategies based on incoming data and feedback from the participating provider and evaluate how it relates to meeting intervention goals. • The PIP team met bi-weekly and reviewed both PIPs' Key Driver Diagrams, reviewed the FMEA during the testing process, made updates where appropriate, and submitted it for approval to HSAG. The PIP team will continue to evaluate these reviews during bi-weekly meetings during all testing periods of the PIP interventions and seek technical assistance (TA) with HSAG when needed. • The PIP team used, and will continue to use, the reference guide in all phases of the PIP processes for guidance and direction. In addition, the PIP team used, and will continue to use, regularly scheduled TA calls and ad hoc TA calls with HSAG during the course of the PIP process to ensure the understanding and completeness of all PIP deliverables.

Table 11-6—PIP Validation—Recommendation and Anthem's Response

HSAG PIP Recommendation 2
When planning for and testing changes, the MCO should: • Be proactive with changes (i.e., scale/ramp up to build confidence in the change and eventually implement policy to sustain changes). • Determine the best method to identify the intended effect of an intervention prior to testing. The intended effect of the intervention should be known upfront to help determine which data need to be collected. • Make a prediction in each plan step of the PDSA cycle and discuss the basis for the prediction. This will help keep the theory for improvement in the project at the forefront for everyone involved. • Conduct a series of thoughtful and incremental PDSA cycles to accelerate the rate of improvement and collect detailed, process-level data to ensure enough data are collected to illustrate the effects of the intervention. • Contact HSAG if the MCO encounters methodological challenges and/or barriers when testing interventions.
Anthem PIP Response 2
Anthem provided the following response to HSAG. • The PIP Team used Lexis-Nexis for both *the Follow-Up after Emergency Department Visit for Mental Illness* (FUM) and *Well-Child Visits in the Third Fourth, Fifth, and Sixth Years of Life* (W34) PIPs shortly after implementation of the first intervention to enhance member contact efforts. The barrier to success was identified as an inability to contact members for scheduling. The intended effects of all interventions were discussed by the PIP workgroup during the intervention determination process and documented in meeting minutes for reference for the team to review to ensure the intervention stayed on track for its intended purpose. The PIP team will continue to develop clear intervention intentions and review often during the intervention testing periods during bi-weekly team meetings. • The PIP team recognized the importance of making predictions in each plan step of the PDSAs, as recommended. The PIP team will emphasize the importance of reviewing predictions during bi-weekly meetings by highlighting these key areas to ensure the team kept the theory of improvement front and center. • The PIP team met bi-weekly and discussed data collection for the PDSAs for each intervention throughout the intervention testing periods to document the effects of the intervention. The PIP team continued to place high value on the PDSA cycles and conducted and discussed data evaluations during bi-weekly meetings to ensure information collected was relevant to the intervention. • The PIP team valued the regularly scheduled TA calls and ad hoc TA calls, which provided the team with an opportunity to interact with HSAG; the team will continue to reach out to HSAG throughout the life of the PIP cycle.

HPN's Response to HSAG's Recommendations

Table 11-7 and Table 11-8 details HSAG's recommendations related to performance improvement project validation for **HPN** as well as **HPN**'s response.

Table 11-7—PIP Validation—Recommendations and HPN Response 1

HSAG PIP Recommendation 1
As the MCO moves through the quality improvement process and conducts PDSA cycles, it should: • Ensure it communicates the reasons for making changes to intervention strategies and how those changes will lead to improvement. Without a common understanding and agreement about the causes that effect improvement, the team may misdirect resources and improvement activities toward changes that do not lead to improvement. • Update the key driver diagram and FMEA for both PIPs while testing interventions. • Reference the *Rapid-Cycle PIP Reference Guide* as the MCO progresses through subsequent phases of the PIP and request technical assistance, as needed.
HPN PIP Response 1
HPN provided the following response. **HPN** has reviewed and included the recommendations in the previous PIP cycles and will continue to do so in future PIP cycles. • **HPN** will continue to request regularly scheduled technical assistance calls with HSAG to ensure approval of all activities, including, but not limited to, changes to intervention strategies. • **HPN** updated the key driver diagram and the FMEA for both PIPs while testing the interventions. • **HPN** will continue to refer to the *Rapid-Cycle PIP Reference Guide* and any HSAG provided trainings regarding the HSAG Rapid Cycle PIP process. Any questions or concerns will be addressed with HSAG during the regularly scheduled technical assistance calls.

Table 11-8—PIP Validation—Recommendations and HPN Response 2

HSAG PIP Recommendation 2
When planning for and testing changes, the MCO should: • Be proactive with changes (i.e., scale/ramp up to build confidence in the change and eventually implement policy to sustain changes). • Determine the best method to identify the intended effect of an intervention prior to testing. The intended effect of the intervention should be known upfront to help determine which data need to be collected. • Make a prediction in each plan step of the PDSA cycle and discuss the basis for the prediction. This will help keep the theory for improvement in the project at the forefront for everyone involved. • Conduct a series of thoughtful and incremental PDSA cycles to accelerate the rate of improvement and collect detailed, process-level data to ensure enough data are collected to illustrate the effects of the intervention. • Contact HSAG if the MCO encounters methodological challenges and/or barriers when testing interventions.

HPN PIP Response 2
HPN provided the following response. **HPN** has reviewed and included the recommendations in the previous PIP cycles and will continue to do so in future PIP cycles. • **HPN** was proactive with any changes related to the planning and testing of each intervention. **HPN** will continue this process in all future PIPs. • Prior to testing, **HPN** determined the best method to identify the intended effect of each intervention to ensure appropriate data was gathered in a timely manner. • The **HPN** PIP team formulated predictions for each planned step of the PDSA cycle and outlined the basis of these predictions for each intervention. These predictions fostered a theory of continuous improvement within the first intervention and onto the second interventions conducted. **HPN** will continue to use this predictive modeling. • For each PIP topic, **HPN** conducted a series of thoughtful and incremental PDSA cycles to accelerate the rate of improvement. **HPN** collected detailed, process-level data to ensure enough data was collected to illustrate the effects of the intervention. **HPN** will continue this process in all future PIPs. • All methodological challenges and/or barriers were addressed with HSAG during the regularly scheduled technical assistance calls. **HPN** will continue to request regularly scheduled technical assistance calls with HSAG in all future PIPs.

SilverSummit's Response to HSAG's Recommendations

Table 11-9 details **SilverSummit**'s response to HSAG's recommendations for validation of performance improvement projects.

Table 11-9—PIP Validation—Recommendations and SilverSummit Response 1

HSAG PIP Recommendation 1
As the MCO moves through the quality improvement process and conducts PDSA cycles, it should: • Ensure it communicates the reasons for making changes to intervention strategies and how those changes will lead to improvement. Without a common understanding and agreement about the causes that effect improvement, the team may misdirect resources and improvement activities toward changes that do not lead to improvement. • Update the key driver diagram and FMEA for both PIPs while testing interventions. • Reference the *Rapid-Cycle PIP Reference Guide* as the MCO progresses through subsequent phases of the PIP and request technical assistance, as needed.
SilverSummit PIP Response 1
SilverSummit provided the following response. 1. **SilverSummit** is using the *Rapid-Cycle PIP Reference Guide* and PowerPoint presentations for Module 1 and developing a learning tool to assist staff who are participating in the development and initiation of each PIP. 2. **SilverSummit** updated the driver diagram and FMEA during the testing phase for the interventions. 3. **SilverSummit** has requested and received the PowerPoint presentations for each Module from HSAG, used the *Rapid-Cycle PIP Reference Guide*, and developed a workflow process for each step in completing each module.

CAHPS Surveys

The CAHPS surveys ask members to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers, such as the communication skills of providers and the accessibility of services. The MCOs were responsible for obtaining a CAHPS vendor to administer the CAHPS surveys on their behalf. The primary objective of the CAHPS surveys was to effectively and efficiently obtain information on the level of satisfaction that patients have with their health care experiences. HSAG analyzed and reported the CAHPS survey results provided by each **Anthem** and **HPN**. **SilverSummit** had not been operational long enough to complete a CAHPS survey; therefore, there were no recommendations made for **SilverSummit**.

Anthem's Response to HSAG's Recommendations

Table 11-10 through Table 11-13 detail HSAG's recommendations related to CAHPS for **Anthem** as well as **Anthem**'s response.

Table 11-10—CAHPS—Recommendations and Anthem Response 1

HSAG CAHPS Recommendation 1
HSAG recommends that **Anthem** continue to work with its CAHPS vendor to obtain a sufficient number of completed surveys that will enable reporting of all CAHPS measures. NCQA recommends targeting 411 completed surveys per survey administration. **Anthem** had measures that did not meet the minimum 100 responses for the adult Medicaid population, general child and children with chronic conditions (CCC) Medicaid populations, and Nevada Check Up general child and CCC populations.
Anthem CAHPS Response 1
In response to the recommendation, **Anthem**: • Oversampled its CAHPS survey at 80% for the adult Medicaid population and 145% for the child Medicaid population. • Continued oversampling for future surveys to ensure adequate responses. • Continued education to members by posting "Your Opinion Matters" at all member touch points. • Implemented a text campaign for 2019 survey to remind/encourage members to complete survey, if they received a survey.

Table 11-11—CAHPS—Recommendations and Anthem Response 2

HSAG CAHPS Recommendation 2
For the adult population, HSAG recommends that **Anthem** focus on improving members' overall satisfaction with their healthcare, personal doctor, and health plan, as well as on quality improvement initiatives to provide medical assistance with smoking and tobacco use cessation. The following measures were at least 5 percentage points lower than the 2017 NCQA adult Medicaid national averages: *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Health Plan*, *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*.

Anthem CAHPS Response 2
In response to the recommendation, **Anthem**: • Continued CAHPS education, with continuing medical education (CME), for providers. • Continued partnership with National Jewish Health (NJH) to provide smoking cessation program. • Implemented a texting program in 2019 for smoking cessation education and quit smoking referrals to NJH. • Continued Voice of the Customer (VOC) survey and analysis.

Table 11-12—CAHPS—Recommendations and Anthem Response 3

HSAG CAHPS Recommendation 3
For the general child Medicaid population, **Anthem** should focus on improving *Getting Needed Care*, *How Well Doctors Communicate*, *Rating of Personal Doctor*, and *Rating of Health Plan*, since the rates for these measures were lower than the 2017 NCQA child Medicaid national averages. For the CCC Medicaid population, **Anthem** had only one reportable measure: *Rating of Health Plan*. **Anthem** should focus on improving *Rating of Health Plan*, since the rate was at least 5 percentage points lower than the 2017 NCQA CCC Medicaid national average.
Anthem CAHPS Response 3
In response to the recommendation, **Anthem**: • Continued Live Health Online (LHO), Urgent Care Center (UCC), PCP Afterhours, 24-hour Nurse Helpline and analyze quarterly geo reports to ensure network adequacy. • Continued CAHPS education, with CME, for providers.

Table 11-13—CAHPS—Recommendations and Anthem Response 4

HSAG CAHPS Recommendation 4
CAHPS measures like *Getting Needed Care* and *Getting Care Quickly* are access-related and lower rates indicate a perception that members cannot obtain needed care with providers or that members cannot obtain services as quickly as desired. As part of its follow-up to HSAG recommendations in the previous year's technical report, **Anthem** detailed several key performance improvement strategies targeted at improving CAHPS response rates and the top-box rates for the CAHPS measures. Section 9 contains more information. HSAG encourages **Anthem** to evaluate those interventions to determine if they are having the desired effect. For the remaining CAHPS measures that fell below the Medicaid national averages (*How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Rating of Health Plan*, *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*), interventions targeted at the provider level and provider communication and interaction with Medicaid members most likely will have the greatest impact on the measures.
Anthem CAHPS Response 4
In response to the recommendation, **Anthem**: • Continued CAHPS education, with CME, for providers. • Continued to educate providers on Anthem's smoking cessation program through NJH. • Continued member text campaign for smoking cessation.

HPN's Response to HSAG's Recommendations

Table 11-11 through Table 11-12 detail HSAG's recommendations related to CAHPS for **HPN** as well as **HPN**'s response.

Table 11-14—CAHPS—Recommendations and HPN Response 1

HSAG CAHPS Recommendation 1
HSAG recommends that **HPN** continue to work with its CAHPS vendor to ensure that a sufficient number of completed surveys is obtained to enable reporting of all CAHPS measures. NCQA recommends targeting 411 completed surveys per survey administration. **HPN** had measures that did not meet the minimum number of responses for the adult Medicaid population, general child and CCC Medicaid populations, and Nevada Check Up general child and CCC populations. Without sufficient responses, MCOs lack information that can be critical to designing and implementing targeted interventions that can improve access to, and the quality and timeliness of, care.
HPN CAHPS Response 1
HPN provided the following response. In order to meet the recommended 411 completed surveys **HPN** increased oversampling for the Medicaid Adult population survey to 100 percent and for the Medicaid Child population survey to 75 percent. In addition, **HPN** continues to deploy various strategies to increase the response rate for all surveys. These strategies are member, provider, stakeholder, and **HPN** employee focused. **HPN** will continue to evaluate increasing oversampling and additional strategies to continue to increase response rates.

Table 11-15—CAHPS—Recommendations and HPN Response 2

HSAG CAHPS Recommendation 2
HSAG recommends that **HPN** focus quality improvement initiatives on enhancing members' experiences with *Getting Needed Care, Getting Care Quickly, Rating of a Personal Doctor, Advising Smokers and Tobacco Users to Quit, Discussing Cessation Medications,* and *Discussing Cessation Strategies* for the adult Medicaid population, since these rates were at least 5 percentage points lower than the 2017 NCQA adult Medicaid national averages. For the general child Medicaid population, **HPN** should focus on improving *Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Rating of All Health Care,* and *Rating of Personal Doctor,* since the rates were lower than the 2017 NCQA child Medicaid national averages. For the CCC Medicaid population, **HPN** should focus on improving *Rating of All Health Care* and *Family Centered Care (FCC): Personal Doctor Who Knows Child,* since the rates for these measures were at least 5 percentage points lower than the 2017 NCQA CCC Medicaid national averages.

HPN CAHPS Response 2
HPN provided the following response. **HPN**'s Medicaid and Check Up CAHPS multidisciplinary workgroup reviewed the 2018 CAHPS results and determined areas of opportunity. The workgroup also reviews other sources of member feedback, such as grievances, member groups, net promoter score, and verbatim comments. In addition, members of the **HPN** workgroup participate in the UnitedHealthcare National CAHPS workgroup, which reviews other Medicaid plans results and best practices to achieve higher ratings. **HPN** creates strategies and goals based on all of these sources to address the areas of opportunities. **HPN** initiated several interventions to increase compliance, including: • Member interventions: – Increased education of **HPN**'s Tobacco Cessation Program through various communication channels. – Increased education of the availability of alternative options of care to a traditional office visit. – Increased the methods of personal member connection to increase awareness and assist with any member areas of concerns. • Provider interventions: – Increased education of **HPN**'s Tobacco Cessation Program and provided flyers to hand out to **HPN** members. – Via clinical practice consultants and provider advocates, provided face-to-face training on the CAHPS survey to providers and reviewed best practices and tips to increase patient experience to address concerns regarding members' overall satisfaction with their provider, ways to effectively communicate, ways to encourage providers to make personal connections, and ways to reduce wait times and ensure members are seen in a timely manner. – Continued to partner with our providers to expand hours, locations, and alternative methods of care. – Continued to evaluate our provider network and look for expansion opportunities. These interventions were successful in increasing Medicaid Adult results for *Getting Needed Care* 8.11 percentage points, *Getting Care Quickly* 2.53 percentage points, *Rating of a Personal Doctor* 2.05 percentage points, *Advising Smokers and Tobacco Users to Quit* 0.29 percentage points, *Discussing Cessation Medications* 8.47 percentage points, and *Discussing Cessation Strategies* 9.55 percentage points. These interventions were successful in increasing Medicaid Child results for *Getting Needed Care* 2.90 percentage points, *Getting Care Quickly* 1.65 percentage points, *Rating of All Health Care* 3.97 percentage points, and *Rating of Personal Doctor* 2.80 percentage points. These interventions were successful in increasing Medicaid Child CCC results for *Rating of All Health Care* 6.25 percentage points and *FCC: Personal Doctor Who Knows Child* 2.95 percentage points. **HPN** will continue to review CAHPS results and other sources of member feedback to determine areas of opportunity and will continue to develop strategies to increase compliance.

Appendix A-1. Technical Methods of Data Collection and Analysis for MCOs

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, requires that states that contract with Medicaid managed care organizations (MCOs) shall provide for an independent external quality review (EQR) by a qualified external quality review organization (EQRO) of the quality outcomes and timeliness of, and access to, services provided by contracted MCOs. The U.S. Department of Health and Human Services (DHHS), Centers for Medicare & Medicaid Services (CMS) regulates requirements and procedures for the EQR. The final rule provided in Title 42 of the Code of Federal Regulations (CFR) Section 438 implements the provisions outlined in the BBA related to Medicaid managed care oversight and EQR as well as the responsibility of each state's contracted EQRO to prepare an annual technical report that describes the manner in which data were aggregated and analyzed and how conclusions were drawn as to the quality and timeliness of, and access to, care and services furnished by the states' MCOs. The data comes from activities conducted in accordance with the 42 CFR §438.358. To meet these requirements, the State of Nevada, Department of Health and Human Services, Division of Health Care Financing and Policy (the DHCFP), contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO). HSAG has served as the EQRO for the DHCFP since 1999.

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

- ***Quality***—CMS defines "quality" in the final rule at 42 CFR §438.320 as follows:

  "Quality, as it pertains to external quality review, means the degree to which an MCO, prepaid inpatient health plan (PIHP), prepaid ambulatory health plan (PAHP), or primary care case manager (PCCM) entity (described in §438.310(c)(2)) increases the likelihood of desired health outcomes of its enrollees through its (1) structural and operational characteristics, (2) the provision of services that are consistent with current professional, evidence-based-knowledge, and (3) interventions for performance improvement."[A1-1]
- ***Timeliness***—National Committee for Quality Assurance (NCQA) defines "timeliness" relative to utilization decisions as follows:

  "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[A1-2] It further discusses the intent of this standard to minimize any disruption in the provision of healthcare. HSAG extends this definition of

[A1-1] Federal Register. *Code of Federal Regulations, Title 42, Volume 4*, May 6, 2016. Available at: https://www.ecfr.gov/cgi-bin/text-idx?rgn=div5&node=42:4.0.1.1.8#se42.4.438_1320. Accessed on: September 26, 2018.

[A1-2] NCQA. *2014 Standards and Guidelines for the Accreditation of Health Plans.* Available at: https://iss.ncqa.org/RDSat/ATMain.asp?ProductType=License&ProductID=313&activityID=54453. Accessed on: September 15, 2014.

timeliness to include other managed care provisions that impact services to members and that require a timely response from the MCO (e.g., processing expedited member appeals and providing timely follow-up care)."

- ***Access***—CMS defines "access" in the final rule at 42 CFR §438.320 as follows:

  "Access, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (Network adequacy standards) and §438.206 (Availability of services)." [A1-3]

This appendix, Appendix A-1, describes the technical methods for data collection and analysis for each of the following EQR activities performed for the MCOs: Internal Quality Assurance Program compliance review, performance measure validation, validation of performance improvement projects, CAHPS surveys, encounter data validation, and network adequacy validation. The objectives for each of these activities are described in the respective sections of this report. Appendix A-2 describes the technical methods for data collection and analysis for each of the EQR activities performed for the dental PAHP.

Internal Quality Assurance Program (IQAP)

The purpose of the state fiscal year (SFY) 2018–2019 Internal Quality Assurance Program (IQAP) On-Site Review of Compliance was to determine each MCO's compliance with federal and State managed care standards. For this review of compliance, HSAG reviewed each MCO's managed care and quality program activities during July 1, 2018, through December 31, 2018.

The IQAP standards were derived from the requirements as set forth in the *Department of Human Services, Division of Health Care Financing and Policy Request for Proposal No. 3260 for Managed Care*, and all attachments and amendments in effect during the review period—July 1, 2018 through December 31, 2018. HSAG followed the guidelines set forth in CMS' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012[A1-4] to create the process, tools, and interview questions used for the SFY 2018–2019 IQAP Compliance Review.

[A1-3] Federal Register. *Code of Federal Regulations, Title 42, Volume 4*, May 6, 2016. Available at: https://www.ecfr.gov/cgi-bin/text-idx?rgn=div5&node=42:4.0.1.1.8#se42.4.438_1320. Accessed on: Oct 22, 2019.

[A1-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Oct 22, 2019.

Methods for Data Collection

Before beginning the compliance review, HSAG developed data collection tools to document the review. The requirements in the tools were selected based on applicable federal and State regulations and requirements outlined in the contract between the DHCFP and the MCOs. HSAG conducted pre-on-site, on-site, and post-on-site review activities.

Pre-on-site review activities included:

- Developing the compliance review tools.
- Preparing an MCO questionnaire.
- Preparing and forwarding to each MCO a customized letter, that included instructions for completing the MCO questionnaire, review tools, and instructions for submitting the requested documentation to HSAG for its desk review.
- Scheduling the on-site reviews.
- Hosting a pre-review technical assistance session with the MCOs.
- Developing the agenda for each MCO on-site review.
- Providing the detailed agenda to each MCO to facilitate preparation for HSAG's review.
- Conducting a pre-on-site desk review of documents. HSAG conducted a desk review of documents that each MCO submitted to HSAG. The desk review enabled HSAG reviewers to increase their knowledge and understanding of each MCO's operations, identify areas needing clarification, and begin compiling information before the on-site review.
- Generating a list of 10 sample files plus an oversample of five files for the grievances, appeals and service denials file reviews.
- Conducting a desk review of the files that HSAG requested from each MCO.

On-site review activities included:

- An opening conference with introductions as well as a review of the agenda and logistics for HSAG's on-site review activities.
- A review of the documents that HSAG requested each MCO to make available on-site.
- A review of the data systems that each MCO used in its operations, which includes, but is not limited to, care management, grievance and appeal tracking, and utilization management.
- Interviews conducted with each MCO's key administrative and program staff members.
- A closing conference during which HSAG reviewers summarized their general findings.

HSAG documented its findings in the data collection (compliance review) tool, which now serves as a comprehensive record of HSAG's findings, performance scores assigned to each requirement, and the actions required to bring the MCOs' performance into compliance for those requirements that HSAG assessed as less than fully compliant.

Post-on-site review activities: HSAG reviewers aggregated findings to produce a comprehensive compliance review report. In addition, HSAG created the corrective action plan (CAP) template, which contains the findings and recommendations for each element scored *Partially Met* or *Not Met*. When submitting its CAP to the DHCFP, the MCO must use the CAP template to propose its plan to bring all elements scored *Partially Met* or *Not Met* into compliance with the applicable standard(s).

Description of Data Obtained

To assess the MCOs' compliance with federal regulations, State rules, and contract requirements, HSAG obtained information from a wide range of written documents produced by the MCOs, including, but not limited to, the following:

- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.
- The member handbook and other written informational materials.
- Narrative and/or data reports across a broad range of performance and content areas.
- Written plans that guide specific operational areas, which included but were not limited to: service authorization, utilization management, care management and coordination.
- MCO-maintained files for grievances, appeals, service denials, and care management.
- MCO questionnaire.

HSAG obtained additional information for the compliance review through interaction, discussions, and interviews with the MCOs' key staff members during the on-site review.

IQAP Standards, Checklists, and Files Reviewed

Table A1-1 through Table A1-3 list the standards reviewed, provider manual checklist, and files reviewed to determine compliance with State and federal standards.

Table A1-1—IQAP Standards

IQAP Standard #	IQAP Standard Name	Number of Elements
VI	Member Rights and Responsibilities	13
VII	Member Information	13
VIII	Continuity and Coordination of Care	16
IX	Grievances and Appeals	33
X	Coverage and Authorization of Services	21
	Total Number of IQAP Elements	**96**

Table A1-2—Provider Manual Checklist

Associated IQAP Standard #	Checklist Name	Number of Elements
VI	Member Rights and Responsibilities	12
VII	Member Handbook	33
	Total Number of Checklist Elements	**45**

Table A1-3—File Reviews

Associated IQAP Standard #	File Review Name	Number of Elements
VIII	Care Management	160
IX	Grievances	30
IX	Appeals	40
X	Denials	30
	Total Number of File Review Elements	**260**

Data Aggregation and Analysis

IQAP Standards

HSAG used scores of *Met*, *Partially Met*, and *Not Met* to indicate the degree to which each MCO's performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to an MCO during the period covered by HSAG's review. This scoring methodology is consistent with CMS' final protocol, *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. The protocol describes the scoring as follows:

- ***Met*** indicates full compliance defined as *both* of the following:
  - All documentation listed under a regulatory provision, or component thereof, was present.
  - Staff members were able to provide responses to reviewers that were consistent with each other and with the documentation.
- ***Partially Met*** indicates partial compliance defined as *either* of the following:
  - Compliance with all documentation requirements existed, but staff members were unable to consistently articulate processes during interviews.
  - Staff members were able to describe and verify the existence of processes during the interview, but documentation was incomplete or inconsistent with practice.
- ***Not Met*** indicates noncompliance defined as *either* of the following:
  - No documentation was present, and staff members had 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 be identified and any findings of *Not Met* or *Partially Met* resulted in an overall finding of noncompliance, regardless of the findings noted for the remaining components.

From the scores that HSAG reviewers assigned for each requirement, HSAG calculated a total percentage-of-compliance score for each IQAP standard and an overall percentage-of-compliance score across the IQAP standards. HSAG calculated the total score for each standard by adding the weighted score for each requirement in the standard receiving a score of *Met* (value: 1 point), *Partially Met* (value: 0.50 point), or *Not Met* (0 points), then dividing the summed weighted scores by the total number of applicable requirements for that standard.

HSAG determined the overall percentage-of-compliance score across the review areas by following the same method used to calculate the scores for each standard (i.e., by summing the weighted values of the scores, then dividing the result by the total number of applicable requirements).

Checklists

For the checklists reviewed, HSAG reviewers scored each applicable element within the checklist as either *Yes*, the element was contained within the associated document; or *No*, the element was not contained within the document. Elements not applicable to the MCO were scored *Not Applicable* and were not included in the denominator of the total score. To obtain a percentage score, HSAG added the total number of elements that received *Yes* scores, then divided by the total number of applicable elements.

File Reviews

HSAG conducted file reviews of the MCO's records for care management, grievances, appeals, and service denials to verify that the MCO had put into practice what the MCO had documented in its policy. For the file reviews, HSAG selected 10 files of each type of record from the full universe of records provided by the MCO. The file reviews were not intended to be a statistically significant representation of all the MCO's files. Rather, the file review highlighted instances that practices described in policy were not followed by MCO staff. Based on the results of the file reviews, the MCO 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.

For the file reviews, HSAG reviewers scored each applicable element within the file review tool as either *Yes*, the element was contained within the file; or *No*, the element was not contained in the file. Elements not applicable to the MCO were scored *Not Applicable* and were not included in the denominator of the total score. To obtain a percentage score, HSAG added the total number of elements that received a *Yes* score, then divided by the total number of applicable elements.

Aggregating the Scores

To draw conclusions about the quality and timeliness of, and access to, care and services that the MCO provided to members, HSAG aggregated and analyzed the data resulting from desk and on-site review activities. The data that HSAG aggregated and analyzed included:

- Documented findings describing the MCO's performance in complying with each IQAP standard requirement.
- Scores assigned to the MCO's performance for each requirement.
- The total percentage-of-compliance score calculated for each IQAP standard.
- The overall percentage-of-compliance score calculated across the IQAP standards.
- The overall percentage-of-compliance score calculated for each file review.
- The overall percentage-of-compliance score calculated for each checklist.
- Documentation of the actions required to bring performance into compliance with the requirements for which HSAG assigned scores of *Partially Met* or *Not Met*.

Corrective Action Plan

HSAG provided each MCO with a template to prepare its CAP for submission to the DHCFP. The template listed each element for which HSAG assigned a score of *Partially Met* or *Not Met*, as well as the associated findings and recommendations made to bring the organization's performance into full compliance with the requirement. Each MCO was instructed to use the template to submit its CAP to bring any elements scored *Partially Met* or *Not Met* into compliance with the applicable standard(s).

The following criteria were used to evaluate the sufficiency of the CAP:

- The completeness of the CAP document in addressing each required action and assigning a responsible individual, a timeline/completion date, and specific actions/interventions that the organization will implement to bring the element into compliance.
- The degree to which the planned activities/interventions met the intent of the requirement.
- The degree to which the planned interventions were anticipated to bring the organization into compliance with the requirement.
- The appropriateness of the timeline for correcting the deficiency.

MCOs were required to resubmit CAPs if any items did not meet the criteria for CAP submissions. DHCFP maintained ultimate authority for approving or disapproving CAPs.

Performance Measure Validation/HEDIS Audit

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

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

In addition, activities conducted prior to on-site meetings with each MCO's representatives included written and email correspondence explaining the scope of the audit, methods used, and time frames for major audit activities; a compilation of a standardized set of comprehensive working papers for the audit; a determination of the number of sites and locations for on-site meetings, demonstrations, and interviews with critical personnel; the preparation of an on-site agenda; a review of the certified measures approved by NCQA; and a detailed review of a select set of HEDIS measures that the DHCFP requires for reporting.

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

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

The analysis of the validation of performance measures involved tracking and reporting rates for the measures required for reporting by the DHCFP for Medicaid and Nevada Check Up. The audited measures (and the programs to which they apply) are presented in Table A1-4.

Table A1-4—SFY 2017–2018 Performance Measures for Nevada Medicaid and Nevada Check Up

	Performance Measure	Method	Populations	
			Medicaid	Nevada Check Up
1	*Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)*	Admin	✓	
2	*Adolescent Well-Care Visits (AWC)*	Hybrid	✓	✓
3	*Adults' Access to Preventive/Ambulatory Health Services (AAP)*	Admin	✓	
4	*Ambulatory Care (AMB)*	Admin	✓	✓
5	*Breast Cancer Screening (BCS)*	Admin	✓	
6	*Childhood Immunization Status—Combinations 2–10 (CIS)*	Hybrid	✓	✓
7	*Children and Adolescents' Access to Primary Care Practitioners (CAP)*	Admin	✓	✓
8	*Comprehensive Diabetes Care—Excluding <7 indicator (CDC)*	Hybrid	✓	
9	*Controlling High Blood Pressure (CBP)*	Hybrid	✓	
10	*Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)*	Admin	✓	
11	*Follow-Up After ED Visit for AOD Abuse Dependence (FUA)*	Admin	✓	
12	*Follow-Up After ED Visit for Mental Illness (FUM)*	Admin	✓	✓
13	*Follow-Up After Hospitalization for Mental Illness (FUH)*	Admin	✓	✓
14	*Follow-Up Care for Children Prescribed ADHD Medication (ADD)*	Admin	✓	✓
15	*Immunizations for Adolescents (IMA)*	Hybrid	✓	✓

	Performance Measure	Method	Populations	
			Medicaid	Nevada Check Up
16	*Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)*	Admin	✓	✓
17	*Medication Management for People with Asthma (MMA)*	Admin	✓	✓
18	*Mental Health Utilization (MPT)*	Admin	✓	✓
19	*Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)*	Admin	✓	✓
20	*Prenatal and Postpartum Care (PPC)*	Hybrid	✓	
21	*Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)*	Admin	✓	✓
22	*Use of Opioids at High Dosage (UOD)*	Admin	✓	
23	*Use of Opioids from Multiple Providers (UOP)*	Admin	✓	
24	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)*	Hybrid	✓	✓
25	*Well-Child Visits in the First 15 Months of Life (W15)*	Hybrid	✓	✓
26	*Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34)*	Hybrid	✓	✓

Validation of Performance Improvement Projects (PIPs)

The DHCFP requires its MCOs to conduct PIPs annually. The topics for the SFY 2018–2019 PIP validation cycle were:

- *Follow-up After Emergency Department Visit for Mental Illness (FUM)*
- *Increase the Rate of Well Child Visits, 3–6 Years of Life (W34)*

The topics selected by the DHCFP addressed CMS requirements related to quality outcomes—specifically, the quality and timeliness of and access to care and services.

For each PIP topic, the MCOs defined a Global and SMART Aim. The SMART Aim statement includes the narrowed population, the baseline rate, a set goal for the project, and the end date. HSAG provided the following parameters to the MCOs for establishing the SMART Aim for each PIP:

- **S**pecific: The goal of the project: What is to be accomplished? Who will be involved or affected? Where will it take place?
- **M**easurable: The indicator to measure the goal: What is the measure that will be used? What is the current data figure (i.e., count, percent, or rate) for that measure? What do you want to increase/decrease that number to?

- **A**ttainable: Rationale for setting the goal: Is the achievement you want to attain based on a particular best practice/average score/benchmark? Is the goal attainable (not too low or too high)?
- **R**elevant: The goal addresses the problem to be improved.
- **T**ime-bound: The timeline for achieving the goal.

PIP Components and Process

The key concepts of the rapid-cycle PIP framework include forming a core PIP team, setting aims, establishing measures, determining interventions, testing interventions, and spreading successful changes. The core component of this approach involves testing changes on a small scale, using a series of Plan-Do-Study-Act (PDSA) cycles and applying rapid-cycle learning principles over the course of the improvement project to adjust intervention strategies so that improvement can occur more efficiently and lead to long-term sustainability. The duration of rapid-cycle PIPs is 18 months.

For this PIP framework, HSAG developed five modules with an accompanying reference guide. Prior to issuing each module, HSAG held technical assistance sessions with the MCOs to educate about application of the modules. The five modules are defined as:

- **Module 1—PIP Initiation:** Module 1 outlines the framework for the project. The framework includes the topic rationale and supporting data, building a PIP team, setting aims (Global and SMART), and completing a key driver diagram.
- **Module 2—SMART Aim Data Collection:** In Module 2, the SMART Aim measure is operationalized and the data collection methodology is described. SMART Aim data are displayed using a run chart.
- **Module 3—Intervention Determination:** In Module 3, there is increased focus into the quality improvement activities reasonably thought to impact the SMART Aim. Interventions are identified using tools such as process mapping, failure modes and effects analysis (FMEA), and failure mode priority ranking, for testing via PDSA cycles in Module 4.
- **Module 4—Plan-Do-Study-Act:** The interventions selected in Module 3 are tested and evaluated through a thoughtful and incremental series of PDSA cycles.
- **Module 5—PIP Conclusions:** In Module 5, the MCO summarizes key findings and outcomes, presents comparisons of successful and unsuccessful interventions, lessons learned, and the plan to spread and sustain successful changes for improvement achieved.

Approach to PIP Validation

In SFY 2018–2019, HSAG obtained the data needed to conduct the PIP validation from each MCO's module submission forms. These forms provided detailed information about each of the PIPs and the activities completed.

The MCO submitted each module according to the approved timeline. After the initial validation of each module, the MCO received HSAG's feedback and technical assistance and resubmitted the modules until all validation criteria were met. This process ensured that the methodology was sound before the MCO progressed to the next phase of the PIP.

The goal of HSAG's PIP validation is to ensure that the DHCFP and key stakeholders can have confidence that any reported improvement is related and can be directly linked to the quality improvement strategies and activities the MCO conducted during the PIP. HSAG's scoring methodology evaluated whether the MCO executed a methodologically sound improvement project and confirmed that any achieved improvement could be clearly linked to the quality improvement strategies implemented by the MCO.

PIP Validation Scoring

During validation, HSAG determines if criteria for each module are *Achieved.* Any validation criteria not applicable (*N/A*) were not scored. As the PIP progresses, and at the completion of Module 5, HSAG will use the validation findings from modules 1 through 5 for each PIP to determine a level of confidence representing the validity and reliability of the PIP. Using a standardized scoring methodology, HSAG will assign a level of confidence and report the overall validity and reliability of the findings as one of the following:

- ***High confidence*** = The PIP was methodologically sound, the SMART Aim was achieved, the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested, and the MCO accurately summarized the key findings.
- ***Confidence*** = The PIP was methodologically sound, the SMART Aim was achieved, and the MCO accurately summarized the key findings. However, some, but not all, quality improvement processes conducted and/or intervention(s) tested were clearly linked to the demonstrated improvement.
- ***Low confidence*** = (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes conducted and/or intervention(s) tested were poorly executed and could not be linked to the improvement.

Reported PIP results were not credible = The PIP methodology was not executed as approved.

CAHPS Survey

Three populations were surveyed for **Anthem Blue Cross and Blue Shield Healthcare Solutions (Anthem)**, **Health Plan of Nevada (HPN)**, and **SilverSummit Healthplan, Inc. (SilverSummit)**: adult Medicaid, child Medicaid, and Nevada Check Up. DSS Research, an NCQA-certified vendor, administered the 2019 CAHPS surveys for **Anthem** and **HPN**. SPH Analytics, an NCQA-certified vendor, administered the 2019 CAHPS surveys for **SilverSummit**.

The technical method of data collection was through the CAHPS 5.0H Adult Medicaid Health Plan Survey to the adult population, and the CAHPS 5.0H Child Medicaid Health Plan Survey (with Children with Chronic Conditions [CCC] measurement set) to the child Medicaid and Nevada Check Up populations. **Anthem**, **HPN**, and **SilverSummit** used a mixed-mode methodology for data collection (i.e., mailed surveys followed by telephone interviews of non-respondents to the mailed surveys). Respondents were given the option of completing the survey in Spanish. For **Anthem**, members were only given the option to call the telephone number provided on the survey cover letter if they wanted to complete the survey in Spanish. For **HPN**, all members selected in the sample received both an English and Spanish mail survey. In addition, the survey cover letter provided a telephone number for members to call if they wanted to complete the survey in Spanish. For **SilverSummit**, all members selected in the sample received both an English and Spanish mail survey.

CAHPS Measures

The survey questions were categorized into various measures of satisfaction. These measures included four global ratings, five composite scores, and three Effectiveness of Care measures for the adult population only. Additionally, five CCC composite measures/items were used for CCC eligible population. The global ratings reflected patients' overall satisfaction with their personal doctor, specialist, health plan, and all healthcare. The composite scores were derived from sets of questions to address different aspects of care (e.g., getting needed care and how well doctors communicate). The CCC composite measures/items evaluated the satisfaction of families with children with chronic conditions accessing various services (e.g., specialized services, prescription medications). The Effectiveness of Care measures assessed the various aspects of providing assistance with smoking and tobacco use cessation.

Top-Box Score Calculations

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

For each of the five composite measures and CCC composite measures/items, the percentage of respondents who chose a positive response was calculated. CAHPS composite question response choices fell into one of two categories: (1) Never, Sometimes, Usually, or Always; or (2) No or Yes. A positive or top-box response for the composite measures and CCC composites/items was defined as a response of Usually/Always or Yes. The percentage of top-box responses is referred to as a global proportion for the composite measures and CCC composite measures/items. For the Effectiveness of Care measures, responses of Always/Usually/Sometimes were used to determine if the respondent qualified for inclusion in the numerator. The scores presented follow NCQA's methodology of calculating a rolling average using the current and prior year results. When a minimum of 100 responses for a measure was not achieved, the result of the measure was denoted as Not Applicable (NA).

NCQA National Average Comparisons

A substantial increase or decrease is denoted by a change of 5 percentage points or more. Colors are used to note substantial differences. Green indicates a top-box score that was at least 5 percentage points greater than the 2018 NCQA national average.[A1-5] Red indicates a top-box score that was at least 5 percentage points less than the 2018 NCQA national average.

Plan Comparisons

Statistically significant differences between the 2019 top-box rates for the adult Medicaid, child Medicaid (general child and CCC), and Nevada Check Up populations for **Anthem**, **HPN**, and **SilverSummit** are noted with arrows. An MCO that performed statistically significantly higher than the program average is denoted with an upward (↑) arrow. Conversely, an MCO that performed statistically significantly lower than the program average is denoted with a downward (↓) arrow. An MCO that is not statistically significantly different than the program average is not denoted with an arrow.

Encounter Data Validation (EDV)

In alignment with the CMS *EQR Protocol 4: Validation of Encounter Data Reported by the MCO: A Voluntary Protocol for External Quality Review (EQR)*, Version 2.0, September 2012,[A1-6] HSAG conducted the following three core evaluation activities for the EDV activity:

- Information system (IS) review—assessment of the DHCFP's and/or MCOs' information systems and processes
- Comparative analysis—detailed examination of the DHCFP's electronic encounter data completeness and accuracy through a comparative analysis between the DHCFP's electronic encounter data and the data extracted from the MCOs' data systems
- Medical record review (MRR)—analysis of the DHCFP's electronic encounter data completeness and accuracy through a review of a sample of medical records for physician services rendered during the study period

HSAG used data with dates of service between July 1, 2016, and June 30, 2017, from both the DHCFP and the MCOs for this study. Only two of the three MCOs operated in the Nevada managed care

[A1-5] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2018.* Washington, DC: NCQA, September 2018.

[A1-6] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 4: Validation of Encounter Data Reported by the MCO: A Voluntary Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Oct 22, 2019.

program prior to the contract start date of July 1, 2017; therefore, HSAG conducted the EDV study for those two MCOs: **Anthem** and **HPN**.

Information Systems (IS) Review

The IS review seeks to define how each participant in the encounter data process collects and processes encounter data such that the data flow from the MCOs to the DHCFP is understood. The IS review is key to understanding whether the IS infrastructures are likely to produce complete and accurate encounter data. To ensure the collection of critical information, HSAG employs a three-stage review process that includes a document review, development and fielding of a customized encounter data assessment, and follow-up with key staff members.

Stage 1—Document Review

HSAG initiated the EDV activity with a thorough desk review of documents related to encounter data initiatives and validation activities currently put forth by the DHCFP. Documents requested included data dictionaries, process flow charts, data system diagrams, encounter system edits, sample rejection reports, workgroup meeting minutes, and the DHCFP's current encounter data submission requirements. The information obtained from this review assisted in the development of a targeted questionnaire to address important topics of interest to the DHCFP.

Stage 2—Development and Fielding of a Customized Encounter Data Assessment

To conduct a customized encounter data assessment, HSAG first evaluated the MCOs' most recent Information Systems Capabilities Assessment (ISCA) to determine whether or not the information was complete and up to date. HSAG then developed a questionnaire, customized in collaboration with the DHCFP, to gather information and specific procedures for data processing, personnel, and data acquisition capabilities. Where applicable, this assessment also included a review of supplemental documentation regarding other data systems, including enrollment and providers. Lastly, this review included specific topics of interest to the DHCFP. For example, the reviews included questions regarding the processing and submission of zero-paid claims to assess the completeness and accuracy of claims submitted to the MCO vendor(s) by sub-capitated providers.

The questionnaire for the DHCFP had similar domains; however, it focused on the DHCFP's data exchange with the MCOs.

Stage 3—Key Informant Interviews

After reviewing the completed assessments, HSAG followed up with key DHCFP and MCO information technology personnel to clarify any questions that stemmed from the questionnaire responses.

Overall, the IS reviews allowed HSAG to document current processes and develop a thematic process map identifying critical points that impact the submission of quality encounter data. From this analysis,

HSAG was able to provide actionable recommendations related to the existing encounter data systems and pertaining to areas for improvement or enhancement.

Comparative Analysis

The goal of the comparative analysis is to evaluate the extent to which encounters submitted to the DHCFP by the MCOs are complete and accurate, based on corresponding information stored in each MCO's data systems. This step corresponds to another important validation activity described in the CMS protocol—i.e., analyses of MCO electronic encounter data for accuracy and completeness on reporting. In this activity, HSAG developed a data requirements document requesting claims and encounter data from both the DHCFP and the MCOs. Follow-up technical assistance sessions occurred approximately two weeks after distributing the data requirements documents, thereby allowing the MCOs time to review and prepare questions for the sessions.

HSAG used data from both the DHCFP and each MCO with dates of service between July 1, 2016, and June 30, 2017, to evaluate the accuracy and completeness of the encounter data. To ensure that the extracted data from both sources represented the same universe of encounters, the data targeted professional, institutional, and pharmacy encounters submitted to the DHCFP before November 30, 2017. This anchor date allowed sufficient time for SFY 2016–2017 encounters to be submitted, processed, and available for evaluation in the DHCFP data warehouse.

Once HSAG received data files from all data sources, the analytic team conducted a preliminary file review to ensure that data were sufficient to conduct the evaluation. The preliminary file review included the following basic checks:

- Data extraction—Data were extracted based on the data requirements document.
- Percentage present—Required data fields are present on the file and have values assigned in those fields.
- Percentage of valid values—Values included are the expected values (e.g., valid ICD-10 codes in the diagnosis field).
- Evaluation of matching claim numbers—The percentage of claim numbers that match between the data extracted from the DHCFP's data warehouse and the MCOs' data submitted to HSAG.

Based on the results of the preliminary file review, HSAG generated a report that highlighted major findings requiring both MCOs and the DHCFP to resubmit data.

Once HSAG received and processed the final set of data from the DHCFP and each MCO, HSAG conducted a series of comparative analyses, which were divided into two analytic sections.

First, HSAG assessed record-level data completeness using the following metrics for each encounter data type:

- The number and percentage of records present in the MCOs' submitted files but not in the DHCFP's data warehouse (record omission)
- The number and percentage of records present in the DHCFP's data warehouse but not in the MCOs' submitted files (record surplus)

Second, based on the number of records present in both data sources, HSAG further examined completeness and accuracy for key data elements listed in Table A1-5. The analyses focused on an element-level comparison for each data element.

Table A1-5—Key Data Elements for Comparative Analysis

Key Data Elements	Professional	Institutional	Pharmacy
Recipient ID	√	√	√
Header Service From Date*	√	√	√
Header Service To Date	√	√	
Billing Provider Number/National Provider Identifier (NPI)	√	√	√
Rendering Provider Number/NPI	√		
Referring/Prescribing/Admitting Provider Number/NPI	√	√	√
Primary Diagnosis Code	√	√	
Secondary Diagnosis Code	√	√	
Procedure Code	√	√	
Procedure Code Modifier	√	√	
Primary Surgical Procedure Code		√	
Secondary Surgical Procedure Code		√	
National Drug Code (NDC)			√
Drug Quantity			√
Revenue Code		√	
Diagnosis-Related Group (DRG)		√	
Header Paid Amount	√	√	√
Detail Paid Amount	√	√	

* *Dispensed Date* is used instead of *Header Service From Date* because the DHCFP does not collect this field for the pharmacy data in its data warehouse.

HSAG evaluated element-level completeness based on the following metrics:

- The number and percentage of records with values present in the MCOs' submitted files but not in the DHCFP's data warehouse (element omission)

- The number and percentage of records with values present in the DHCFP's data warehouse but not in the MCOs' submitted files (element surplus)

Element-level accuracy was limited to those records with values present in both the MCOs' submitted files and the DHCFP's data warehouse. For any given data element, HSAG determined:

- The number and percentage of records with the same values in both the MCOs' submitted files and the DHCFP's data warehouse (element accuracy).
- The number and percentage of records present in both data sources and with the same values for select data elements relevant to each encounter data type (all-element accuracy).

Medical Record Review

As outlined in the CMS protocol, MRR is a complex and resource-intensive process. Medical and clinical records are considered the "gold standard" for documenting Medicaid recipients' access to and quality of healthcare services.

During fiscal year (FY) 2017–18, HSAG evaluated encounter data completeness and accuracy through a review of medical records for physician services rendered between July 1, 2016, and June 30, 2017. This study answered the following question:

- *Are the data elements in Table A1-6 found on the professional encounters complete and accurate when compared to information contained within the medical records?*

Table A1-6—Key Data Elements for MRR

Key Data Element	
Date of Service	Diagnosis Code
Procedure Code	Procedure Code Modifier

To answer the study question, HSAG conducted the following activities:

- Identified the eligible population and generated samples from data extracted from the DHCFP data warehouse.
- Assisted the MCOs in procuring medical records from providers, as appropriate.
- Reviewed medical records against the DHCFP's encounter data.
- Calculated study indicators and presented study results to the DHCFP.

Study Population

To be eligible for the MRR, a recipient had to be continuously enrolled in the same MCO during the study period (i.e., between July 1, 2016, and June 30, 2017) and had to have at least one professional visit during the study period. In addition, recipients with Medicare or other insurance coverages were

excluded from the eligible population since the DHCFP does not have complete encounter data for all services these recipients received. After reviewing the encounter data extracted from the DHCFP data warehouse, HSAG discussed with the DHCFP how to identify "professional visits" from the encounter data by restricting provider type, place of service, and procedure code. Table A1-7 displays the DHCFP's agreed-upon criteria to determine which "professional visits" should be included in the study.

Table A1-7—Criteria for Professional Visits Included in the Study

Data Element	Criteria
Provider Type	Physician, MD, Osteopath, DO
	Physician assistants
	Certified nurse practitioner
	Nurse midwife
	Podiatrist
	Indian Health Service and Tribal Clinics
	Behavioral Health Outpatient
Place of Service	Federally Qualified Health Center
	Independent Clinic
	Office
	Public Health Clinic
	Urgent Care Facility
Procedure Code	If all detail lines for a visit have the following procedure codes, the visit was excluded from the study since these procedure codes are for services outside the scope of work for this study (e.g., durable medical equipment [DME], dental, and vision): • A procedure code starting with "E," "D," "K," or "V" • Procedure codes between A0021 and A0999 (i.e., codes for transportation services) • Procedure codes between A4206 and A9999 (i.e., codes for medical and surgical supplies, miscellaneous, and investigational procedures) • Procedure codes between T4521 and T4544 (i.e., codes for incontinence supplies) • Procedure codes between L0112 and L4631 (i.e., codes for orthotic devices and procedures) • Procedure codes between L5000 and L9900 (i.e., codes for prosthetic devices and procedures)

Sampling Strategy

HSAG used a two-stage sampling technique to select samples based on the recipient enrollment and encounter data extracted from the DHCFP data warehouse. HSAG first identified all recipients who met the study population eligibility criteria, and random sampling was used to select 411 recipients[A1-7] from the eligible population for each of the two MCOs. For each selected sampled recipient, HSAG used the SURVEYSELECT procedure in SAS®[A1-8] to randomly select one professional visit[A1-9] that occurred in the study period (i.e., between July 1, 2016, and June 30, 2017). Additionally, to evaluate whether any dates of service were omitted from the DHCFP data warehouse, HSAG reviewed a second date of service rendered by the same provider during the review period. The providers selected the second date of service, which was closest to the selected date of service, from the medical records for each sampled recipient. If a sampled recipient did not have a second visit with the same provider during the review period, HSAG evaluated only one date of service for that recipient. As such, the final number of cases reviewed were between 411 and 822 cases in total for each MCO.

Since an equal number of cases were selected from each MCO to ensure an adequate sample size when reporting rates at the MCO level, adjustments were required to calculate the statewide rates to account for population differences among the MCOs. When reporting statewide rates, HSAG weighted each MCO's raw rates based on the volume of professional visits among the eligible population for that MCO. This approach ensured that no MCO was over- or underrepresented in the statewide rates.

Medical Record Procurement

Upon receiving the final sample list from HSAG, MCOs were responsible for procuring the sampled recipients' medical records from their contracted providers for services that occurred during the study period. In addition, MCOs were responsible for submitting the documentation to HSAG. To improve the procurement rate, HSAG conducted a one-hour technical assistance call with participating MCOs to review the EDV project and procurement protocols after distributing the sample list. MCOs were instructed to submit medical records electronically via a secure file transfer protocol site to ensure the protection of personal health information. During the procurement process, HSAG worked with the MCOs to answer questions and monitor the number of medical records submitted. For example, HSAG provided an initial submission update when 40 percent of the records were expected to be submitted and a final submission status update following completion of the procurement period.

All electronic medical records HSAG received were maintained on a secure site, which allowed HSAG's trained reviewers to validate the cases from a centralized location under supervision and oversight. As with all MRR and research activities, HSAG maintains a thorough Health Insurance

[A1-7] The sample size of 411 is based on a 95 percent confidence level and a margin of error of 5 percent for potential MCO-to-MCO comparisons.

[A1-8] SAS and all other SAS Institute Inc. product or service names are registered trademarks or trademarks of SAS Institute Inc. in the USA and other countries. ® indicates USA registration.

[A1-9] To ensure that the MRR includes all services provided on the same date of service, encounters with the same date of service and same rendering provider were consolidated into one visit for sampling purposes.

Portability and Accountability Act of 1996 (HIPAA) compliance and protection program, in accordance with federal regulations that includes recurring training, and policies and procedures that address physical security, electronic security, and day-to-day operations.

Review of Medical Records

HSAG's experienced medical record reviewers were responsible for abstracting the medical records. To successfully complete the study, the project lead worked with the medical record review team (MRT) beginning with the methodology phase. The MRT was involved with the tool design phase and tool testing to ensure that the abstracted data were complete and accurate. Based on the study methodology, clinical guidelines, and the tool design/testing results, the MRT drafted an abstraction instruction document specific to the study for training purposes. Concurrent with record procurement activities, the MRT trained the medical record reviewers on the specific study protocols and conducted interrater reliability and rater-to-standard testing. All medical record reviewers had to achieve a 95 percent accuracy rate for the training/testing cases before they were allowed to review medical records.

During the MRR activity, HSAG's trained reviewers collected and documented findings in an HSAG-designed electronic data collection tool. The tool was designed with edits to assist in the accuracy of data collection. The validation included a review of specific data elements identified in sample cases and compared to corresponding documentation in the medical record. Interrater reliability among reviewers and reviewer accuracy were evaluated regularly throughout the study. Issues and decisions raised during this evaluation process were documented in the abstraction instruction document and communicated to all reviewers in a timely manner. In addition, HSAG analysts reviewed the export files from the abstraction tool on an ongoing basis to ensure the abstraction results were complete, accurate, and consistent.

The validation of encounter data incorporated a unique two-way approach through which encounters were chosen from both the electronic encounter data and medical records and were subsequently compared with one another. Claims/encounters chosen from the DHCFP data system were compared with the medical record and visit records from the medical record were compared with the DHCFP encounter data. This process allowed the study to identify services documented in the recipients' medical records that were missing from the DHCFP system and to identify surplus encounters that were present in the DHCFP data system but not documented in the recipients' medical records. For services in both data sources, an analysis of coding accuracy was completed. Information that exists in both data sources but whose values do not match was considered discrepant.

Study Indicators

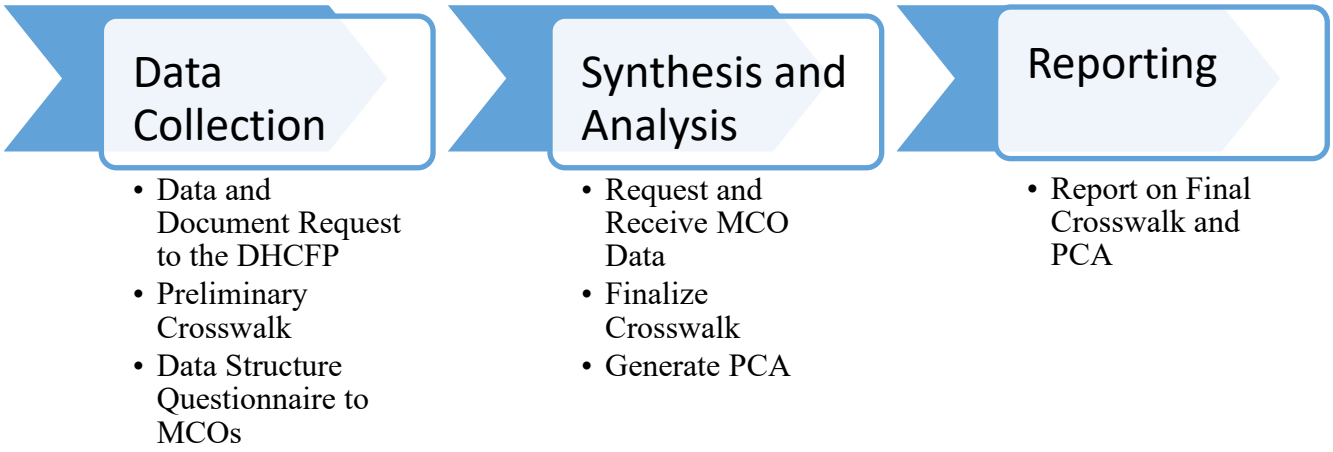
Once HSAG's trained reviewers completed the MRR, HSAG analysts exported information collected from the electronic tool, reviewed the data, and conducted the analysis. HSAG used four study indicators to report the MRR results:

- *Medical record omission rate*: the percentage of dates of service identified in the electronic encounter data that are not found in the recipients' medical records.
- *Encounter data omission rate*: the percentage of dates of service from recipients' medical records that are not found in the electronic encounter data.
- *Accuracy rate of coding*: the percentage of diagnosis codes, procedure codes, and procedure code modifiers associated with validated dates of service from the electronic encounter data that were correctly coded based on the recipients' medical records.
- *Overall accuracy rate:* the percentage of dates of service with all data elements coded correctly among all the validated dates of service from the electronic encounter data.

Network Adequacy Validation

HSAG conducted the FY 2018–2019 network adequacy tasks in three phases (Figure A1-1) using a desk review approach to collect and review the provider data needed to develop the provider crosswalks and conduct the baseline provider composition analysis (PCA).

Figure A1-1—Network Adequacy Tasks for FY 2018–2019



Data Collection

Network Adequacy Documentation Request and Review

HSAG reviewed the DHCFP's documentation on current network adequacy standards for the Medicaid MCOs. Additionally, HSAG submitted a brief Data Structure Questionnaire to the MCOs to obtain

targeted information regarding their provider data structure(s) and methods for classifying providers (e.g., methods for identifying primary care providers [PCPs] or Early and Periodic Screening, Diagnostic and Treatment [EPSDT] providers). Questionnaire responses assisted HSAG in preparing data requests for the MCOs, to ensure that HSAG included all pertinent data fields in the data request.

Data Request

Concurrent with data collection from the MCOs, HSAG collaborated with the DHCFP to identify the provider categories to be included in the assessment. For the MCOs, these provider categories included PCPs, specialists, behavioral health providers, and healthcare facilities.

HSAG requested Medicaid provider network files from the DHCFP. To define the requested data, HSAG submitted a detailed data requirements document for the provider data to the DHCFP. HSAG requested data for providers actively enrolled as of October 1, 2018. HSAG requested the following key data elements: unique provider identifier, enrollment status, provider type, provider specialty, and PCP indicator.

Preliminary Crosswalk

Upon receipt of the provider data, HSAG reviewed the files and followed up regarding questions identified during the data review process. After final review of the file, HSAG began developing the preliminary provider crosswalks based on current provider categorizations used by the DHCFP's fee-for-service (FFS) provider data, previous provider crosswalks, and collaborative discussions between the DHCFP and HSAG.

Synthesis and Analysis

Finalize Provider Crosswalk

Using the preliminary crosswalks and the Data Structure Questionnaire responses, HSAG requested that each MCO submit provider network data using a standardized data requirements document approved by the DHCFP. Upon receipt of the provider data from the MCOs, HSAG reviewed the files and requested follow-up information, as needed.

Using the MCOs' provider data files, HSAG evaluated the provider classification fields available from each MCO (e.g., provider type, specialty, credential, and/or taxonomy codes). HSAG then mapped this classification information to the provider categories specific to each MCO type, producing the preliminary provider crosswalks.

HSAG assessed and reconciled differences across the MCOs and collaborated with the DHCFP to review any questions identified while evaluating the distributions. Based on the data provided by the MCOs and collaborations with the DHCFP, HSAG refined and finalized the provider crosswalks.

Provider Composition Analysis

HSAG applied the results of the provider crosswalk to the data submitted by the MCOs to conduct a baseline PCA. The PCA included frequency counts of providers by provider category for each MCO. The analysis was conducted by county and statewide.

Study Limitations

Study findings and conclusions may be affected by limitations related to the study design and source data.

- Findings associated with the MCOs' Data Structure Questionnaire responses were based on self-reported questionnaire responses submitted to HSAG by the MCOs. HSAG did not confirm the statements made in the questionnaires that were not directly reflected in the MCOs' provider data.
- The PCA results presented in this study are dependent on the quality of provider data submitted by the DHCFP and the MCOs. Any substantial and systematic errors in the extraction and transmission of the provider data may have biased the results and compromised the validity and reliability of the study findings.
  - While the use of alternate spellings and/or special characters do not affect the conceptual framework of the provider categories in the crosswalks, these data inconsistencies will result in providers being missing from the tabulations. For example, the data values, "Nurse Midwife" and "Nurse Mid-Wife" represent the same provider specialty and should be incorporated into data cleaning efforts by the MCOs.
- The primary focus of the provider crosswalk development was to generate standardized definitions consisting of provider types, specialties, credentials, and/or taxonomy codes to be used in identifying providers classified into the categories selected by the DHCFP. While the provider categories in this study represent a comprehensive array of healthcare providers, each MCO's provider network may include providers that support additional healthcare services covered by Nevada Medicaid.
- The primary focus of the PCA was to assess the distribution of providers affiliated with each MCO for the selected provider categories. The DHCFP has not directed the MCOs to use standard categorization criteria. As such, a lack of providers identified during the PCA may indicate a lack of contracted providers or it may indicate an inability to identify providers using the classifications outlined in the provider crosswalks.
- PCA findings were associated with the MCOs' provider data files for all ordering, referring, servicing, and billing providers active as of October 1, 2018. As such, results may not reflect the current status of the MCOs' provider data or changes implemented since October 2018.
- Since the DHCFP provided additional information regarding the identification of substance abuse counselors using taxonomy codes not stored within the DHCFP's provider data, the identification of substance abuse providers for the DHCFP used additional data beyond the original provider data submission. Of note, the MCOs were not given the opportunity to provide additional information about their providers.

Appendix A-2. Technical Methods of Data Collection and Analysis for PAHPs

This appendix, Appendix A-2, describes the technical methods for data collection and analysis for each of the following external quality review (EQR) activities performed for the dental prepaid ambulatory health plans (PAHPs): Internal Quality Assurance Program (IQAP) compliance review, performance measure validation, validation of performance improvement projects, and network adequacy validation.

Internal Quality Assurance Program

Before beginning the compliance review, Health Services Advisory Group, Inc. (HSAG), developed data collection tools to document the review. The requirements in the tools were selected based on applicable federal and State regulations and requirements outlined in the contract between the State of Nevada, Department of Health and Human Services, Division of Health Care Financing and Policy (the DHCFP) and **LIBERTY Dental Plan of Nevada, Inc.** (**LIBERTY**). HSAG conducted pre-on-site, on-site, and post-on-site review activities.

Pre-on-site review activities included:

- Developing the compliance review tools.
- Preparing and forwarding to **LIBERTY** a customized questionnaire, instructions for completing the questionnaire, and instructions for submitting the requested documentation to HSAG for its desk review.
- Conducting a technical assistance session to assist **LIBERTY** in preparing for the compliance review.
- Scheduling the on-site review.
- Developing the agenda for the on-site review.
- Providing the detailed agenda and the data collection (compliance review) tool to **LIBERTY** to facilitate preparation for HSAG's review.
- Conducting a pre-on-site desk review of documents. HSAG conducted a desk review of key documents and other information obtained from the DHCFP and of documents that **LIBERTY** submitted to HSAG. The desk review enabled HSAG reviewers to increase their knowledge and understanding of **LIBERTY**'s operations, identify areas needing clarification, and begin compiling information before the on-site review.
- Generating a list of 10 sample cases plus an oversample of five cases for each file review.
- Completing the desk review of grievance, appeal, and service denial files.

On-site review activities included:

- An opening conference with introductions and a review of the agenda and logistics for HSAG's on-site review activities.

- A review of the documents that HSAG requested **LIBERTY** make available on-site.
- A review of the member cases that HSAG requested from **LIBERTY**.
- A review of the data systems that **LIBERTY** used in its operations, which includes, but is not limited to, care management, grievance and appeal tracking, quality improvement tracking, and quality measure reporting.
- Interviews conducted with **LIBERTY**'s key administrative and program staff members.
- A closing conference during which HSAG reviewers summarized their general findings.

HSAG documented its findings in the data collection (compliance review) tool, which serves as a comprehensive record of HSAG's findings, performance scores assigned to each requirement, and actions required to bring **LIBERTY**'s performance into compliance for those requirements that HSAG assessed as less than fully compliant.

Post-on-site review activities: HSAG reviewers aggregated findings to produce this comprehensive compliance review report. In addition, HSAG created a corrective action plan (CAP) template, which contains the findings and recommendations for each element scored *Partially Met* or *Not Met*. When submitting its CAP to the DHCFP, **LIBERTY** was required to use this template to propose its plan to bring all elements scored *Partially Met* or *Not Met* into compliance with the applicable standard(s).

Description of Data Obtained

To assess **LIBERTY**'s compliance with federal regulations, State rules, and contract requirements, HSAG obtained information from a wide range of written documents produced by **LIBERTY**, including, but not limited to, the following:

- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.
- The provider manual and other **LIBERTY** communication to providers and subcontractors.
- The member handbook and other written informational materials.
- Narrative and/or data reports across a broad range of performance and content areas.
- Written plans that guide specific operational areas, which included but were not limited to utilization management, quality management, care management and coordination, health management, and service authorization.
- **LIBERTY**-maintained files for grievances, appeals, and service denials.
- Dental benefits administrator (DBA) questionnaire.

HSAG obtained additional information for the compliance review through interaction, discussions, and interviews with **LIBERTY**'s key staff members during the on-site review.

IQAP Standards, Checklists, and Files Reviewed

Table A2-1 through Table A2-3 list the standards, checklists, and files reviewed to determine compliance with State and federal standards.

Table A2-1—IQAP Standards

IQAP Standard #	IQAP Standard Name	Number of Elements
VI	Member Rights and Responsibilities	11
VII	Member Information	11
VIII	Continuity and Coordination of Care	4
IX	Grievances and Appeals	33
X	Coverage and Authorization of Services	24
	Total Number of IQAP Elements	**83**

Table A2-2—Checklists

Associated IQAP Standard #	Checklist Name	Number of Elements
VI	Member Rights and Responsibilities	14
VII	Member Handbook	27
	Total Number of Checklist Elements	**41**

Table A2-3—File Reviews

Associated IQAP Standard #	File Review Name	Number of Elements
IX	Grievances	4
IX	Appeals	8
X	Service Denials	3
	Total Number of Elements Reviewed in Each File	**15**

Data Aggregation and Analysis

IQAP Standards

HSAG used scores of *Met*, *Partially Met*, and *Not Met* to indicate the degree to which **LIBERTY**'s performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to **LIBERTY** during the period covered by HSAG's review. This scoring methodology is consistent with CMS' final protocol, *EQR Protocol 1: Assessment of Compliance with Medicaid*

Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR), Version 2.0, September 2012.[A2-1] The protocol describes the scoring as follows:

- ***Met*** indicates full compliance defined as *both* of the following:
  - All documentation listed under a regulatory provision, or component thereof, was present.
  - Staff members were able to provide responses to reviewers that were consistent with each other and with the documentation.
- ***Partially Met*** indicates partial compliance defined as *either* of the following:
  - Compliance with all documentation requirements existed, but staff members were unable to consistently articulate processes during interviews.
  - Staff members were able to describe and verify the existence of processes during the interview, but documentation was incomplete or inconsistent with practice.
- ***Not Met*** indicates noncompliance defined as *either* of the following:
  - No documentation was present, and staff members had 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 be identified and any findings of *Not Met* or *Partially Met* resulted in an overall finding of noncompliance, regardless of the findings noted for the remaining components.

From the scores that HSAG reviewers assigned for each requirement, HSAG calculated a total percentage-of-compliance score for each IQAP standard and an overall percentage-of-compliance score across the IQAP standards. HSAG calculated the total score for each standard by adding the weighted score for each requirement in the standard receiving a score of *Met* (value: 1 point), *Partially Met* (value: 0.50 point), or *Not Met* (0 points), then dividing the summed weighted scores by the total number of applicable requirements for that standard.

HSAG determined the overall percentage-of-compliance score across the review areas by following the same method used to calculate the scores for each standard (i.e., by summing the weighted values of the scores, then dividing the result by the total number of applicable requirements).

Checklists

For the checklists reviewed, HSAG reviewers scored each applicable element within the checklist as either *Yes*, the element was contained within the associated document; or *No*, the element was not contained within the document. Elements not applicable to **LIBERTY** were scored *Not Applicable* and were not included in the denominator of the total score. To obtain a percentage score, HSAG added the

[A2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Oct 22, 2019.

total number of elements that received *Yes* scores, then divided by the total number of applicable elements.

File Reviews

HSAG conducted file reviews of **LIBERTY**'s records of grievances, appeals, and service denials to verify that **LIBERTY**'s documented policy had been put into practice in its policy. For grievances, appeals, and service denials, HSAG selected 10 files of each type of record from the full universe of records provided by **LIBERTY**. The file reviews were not intended to be a statistically significant representation of all of **LIBERTY**'s files. Rather, the file review highlighted instances of practices described in policy not being followed by **LIBERTY** staff. Based on the results of the file reviews, **LIBERTY** 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.

For the file reviews, HSAG reviewers scored each applicable element within the file review tool as either *Yes*, the element was contained within the file; or *No*, the element was not contained in the file. Elements not applicable to **LIBERTY** were scored *Not Applicable* and were not included in the denominator of the total score. To obtain a percentage score, HSAG added the total number of elements that received a *Yes* score, then divided by the total number of applicable elements.

Aggregating the Scores

To draw conclusions about the quality and timeliness of, and access to, care and services that **LIBERTY** provided to members, HSAG aggregated and analyzed the data resulting from desk and on-site review activities. The data that HSAG aggregated and analyzed included the following:

- Documented findings describing **LIBERTY**'s performance in complying with each IQAP standard requirement.
- Scores assigned to **LIBERTY**'s performance for each requirement.
- The total percentage-of-compliance score calculated for each IQAP standard.
- The overall percentage-of-compliance score calculated across the IQAP standards.
- The overall percentage-of-compliance score calculated for each file review.
- The overall percentage-of-compliance score calculated for each checklist.
- Documentation of the actions required to bring performance into compliance with the requirements for which HSAG assigned scores of *Partially Met* or *Not Met*.

Based on the results of the data aggregation and analysis, HSAG prepared and forwarded draft reports to the DHCFP staff members for their review and comment prior to issuing final reports.

Performance Measure Validation

The CMS performance measure validation (PMV) protocol identifies key types of data that should be reviewed as part of the validation process. The following list describes the type of data collected and how HSAG analyzed these data:

- **Information Systems Capabilities Assessment Tool (ISCAT): LIBERTY** completed and submitted an ISCAT for HSAG's review of the required performance measures. HSAG used the responses from the ISCAT to complete the pre-on-site assessment of information systems.
- **Source code (programming language) for performance measures: LIBERTY** was required to submit the source code used to calculate each performance measure being validated. HSAG completed a line-by-line review of the supplied source code to ensure compliance with the measure specifications required by DHCFP. HSAG identified any areas of deviation from the descriptions, evaluating the impact to the measure and assessing the degree of bias (if any).
- **Supporting documentation:** HSAG requested documentation that would provide reviewers with additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. HSAG reviewed all supporting documentation, identifying issues or areas needing clarification for further follow-up.

On-Site Activities

HSAG conducted an on-site visit with **LIBERTY**. HSAG collected information using several methods, including interviews, system demonstration, review of data output files, primary source verification (PSV), observation of data processing, and review of data reports. The on-site visit activities included the following:

- **Opening meeting:** The opening meeting included an introduction of the validation team and key **LIBERTY** staff members involved in the PMV activities. The review purpose, the required documentation, basic meeting logistics, and queries to be performed were discussed.
- **Review of ISCAT documentation:** This session was designed to be interactive with key PAHP staff so that the validation team could obtain a complete picture of all steps taken to generate responses to the ISCAT and evaluate the degree of compliance with written documentation. HSAG conducted interviews to confirm findings from the documentation review, expanded or clarified outstanding issues, and ascertained that written policies and procedures were used and followed in daily practice.
- **Evaluation of system compliance:** The evaluation included a review of the information systems, focusing on the processing of enrollment and disenrollment data. Additionally, HSAG evaluated the processes used to collect and calculate the performance measures, including accurate numerator and denominator identification, and algorithmic compliance (which evaluated whether the PAHP had performed rate calculations correctly, combined data appropriately, and counted numerator events accurately). Based on the desk review of each ISCAT, HSAG conducted interviews with key PAHP staff familiar with the processing, monitoring, and calculation of the performance measures. HSAG

used interviews to confirm findings from the documentation review, expand or clarify outstanding issues, and verify that the PAHP used and followed written policies and procedures in daily practice.

- **Overview of data integration and control procedures:** The overview included discussion and observation of source code logic, a review of how all data sources were combined, and a review of how the analytic file was produced for the reporting of selected performance measure data. HSAG reviewed the backup documentation on data integration and addressed data control and security procedures during this session.
- **Primary source verification:** HSAG performed additional validation using PSV to further validate the output files. PSV is a review technique used to confirm that the information from the primary source matches the output information used for reporting. The PAHP provided HSAG with a listing of members, from which HSAG selected a sample. HSAG selected a random sample from the list of members and requested that the PAHP provide proof of service documents or system screen shots that allowed for validation against the source data in the system. During the on-site review, these data were also reviewed live in the PAHP's systems for verification, which provided the PAHP an opportunity to explain its processes regarding any exception processing or unique, case-specific nuances that may not impact final measure reporting. There may be instances in which a sample case is acceptable based on on-site clarification and follow-up documentation provided by the PAHP.

  Using this technique, HSAG assessed the processes used to input, transmit, and track the data; confirm entry; and detect errors. HSAG selected cases across measures to verify that the PAHP has system documentation that shows that the PAHP appropriately included records for measure reporting. This technique does not rely on a specific number of cases for review to determine compliance; rather, it is used to detect errors from a small number of cases. If errors were detected, the outcome was determined based on the type of error. For example, the review of one case may have been sufficient in detecting a programming language error, and as a result, no additional cases related to that issue may have been reviewed. In other scenarios, one case error detected may result in the selection of additional cases to better examine the extent of the issue and its impact on reporting.
- **Closing conference:** The closing conference included a summation of preliminary findings based on the review of the ISCAT and on-site visit and revisited the documentation requirements for any post-on-site activities.

Validation of Performance Improvement Projects (PIPs)

The DHCFP requires its PAHP to conduct PIPs annually. The topics for the state fiscal year (SFY) 2018–2019 PIP validation cycle were:

- *Improve Caries Risk Assessment Completion Rate*
- *Annual Dental Visits*

The topics selected by the DHCFP addressed CMS requirements related to quality outcomes—specifically, the quality and timeliness of and access to care and services.

For each PIP topic, the PAHP defined a Global and SMART Aim. The SMART Aim statement includes the narrowed population, the baseline rate, a set goal for the project, and the end date. HSAG provided the following parameters to the PAHP for establishing the SMART Aim for each PIP:

- **S**pecific: The goal of the project: What is to be accomplished? Who will be involved or affected? Where will it take place?
- **M**easurable: The indicator to measure the goal: What is the measure that will be used? What is the current data figure (i.e., count, percent, or rate) for that measure? What do you want to increase/decrease that number to?
- **A**ttainable: Rationale for setting the goal: Is the achievement you want to attain based on a particular best practice/average score/benchmark? Is the goal attainable (not too low or too high)?
- **R**elevant: The goal addresses the problem to be improved.
- **T**ime-bound: The timeline for achieving the goal.

PIP Components and Process

The key concepts of the rapid-cycle PIP framework include forming a core PIP team, setting aims, establishing measures, determining interventions, testing interventions, and spreading successful changes. The core component of this approach involves testing changes on a small scale, using a series of Plan-Do-Study-Act (PDSA) cycles and applying rapid-cycle learning principles over the course of the improvement project to adjust intervention strategies so that improvement can occur more efficiently and lead to long-term sustainability. The duration of rapid-cycle PIPs is 18 months.

For this PIP framework, HSAG developed five modules with an accompanying reference guide. Prior to issuing each module, HSAG held technical assistance sessions with the PAHP to educate about application of the modules. The five modules are defined as:

- **Module 1—PIP Initiation:** Module 1 outlines the framework for the project. The framework includes the topic rationale and supporting data, building a PIP team, setting aims (Global and SMART), and completing a key driver diagram.
- **Module 2—SMART Aim Data Collection:** In Module 2, the SMART Aim measure is operationalized and the data collection methodology is described. SMART Aim data are displayed using a run chart.
- **Module 3—Intervention Determination:** In Module 3, there is increased focus into the quality improvement activities reasonably thought to impact the SMART Aim. Interventions are identified using tools such as process mapping, failure modes and effects analysis (FMEA), and failure mode priority ranking, for testing via PDSA cycles in Module 4.
- **Module 4—Plan-Do-Study-Act:** The interventions selected in Module 3 are tested and evaluated through a thoughtful and incremental series of PDSA cycles.

- **Module 5—PIP Conclusions:** In Module 5, the PAHP summarizes key findings and outcomes, presents comparisons of successful and unsuccessful interventions, lessons learned, and the plan to spread and sustain successful changes for improvement achieved.

Approach to PIP Validation

In SFY 2018–2019, HSAG obtained the data needed to conduct the PIP validation from the PAHP's module submission forms. These forms provided detailed information about each of the PIPs and the activities completed.

The PAHP submitted each module according to the approved timeline. After the initial validation of each module, the PAHP received HSAG's feedback and technical assistance and resubmitted the modules until all validation criteria were met. This process ensured that the methodology was sound before the PAHP progressed to the next phase of the PIP.

The goal of HSAG's PIP validation is to ensure that the DHCFP and key stakeholders can have confidence that any reported improvement is related and can be directly linked to the quality improvement strategies and activities the PAHP conducted during the PIP. HSAG's scoring methodology evaluated whether the PAHP executed a methodologically sound improvement project and confirmed that any achieved improvement could be clearly linked to the quality improvement strategies implemented by the PAHP.

PIP Validation Scoring

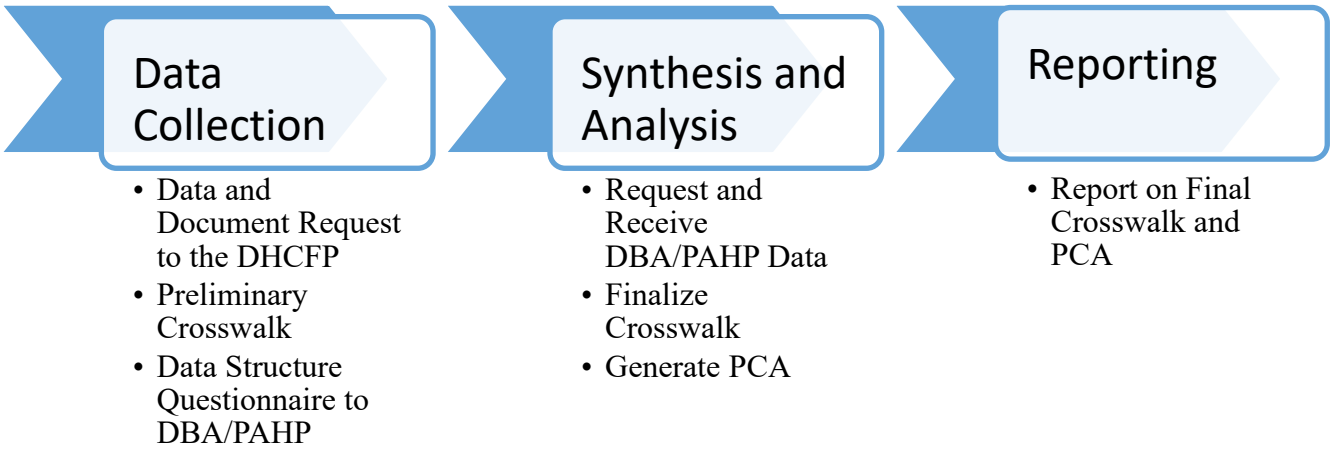
During validation, HSAG determines if criteria for each module are *Achieved.* Any validation criteria not applicable (*N/A*) were not scored. As the PIP progresses, and at the completion of Module 5, HSAG will use the validation findings from modules 1 through 5 for each PIP to determine a level of confidence representing the validity and reliability of the PIP. Using a standardized scoring methodology, HSAG will assign a level of confidence and report the overall validity and reliability of the findings as one of the following:

- ***High confidence*** = The PIP was methodologically sound, the SMART Aim was achieved, the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested, and the PAHP accurately summarized the key findings.
- ***Confidence*** = The PIP was methodologically sound, the SMART Aim was achieved, and the PAHP accurately summarized the key findings. However, some, but not all, quality improvement processes conducted and/or intervention(s) tested were clearly linked to the demonstrated improvement.
- ***Low confidence*** = (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes conducted and/or intervention(s) tested were poorly executed and could not be linked to the improvement.
- ***Reported PIP results were not credible*** = The PIP methodology was not executed as approved

Network Adequacy Validation

HSAG conducted the FY 2018–2019 network adequacy tasks in three phases (Figure A2-1) using a desk review approach to collect and review the provider data needed to develop the provider crosswalks and conduct the baseline provider composition analysis (PCA).

Figure A2-1—Network Adequacy Tasks for FY 2018–2019



Data Collection

Network Adequacy Documentation Request and Review

HSAG reviewed the DHCFP's documentation on current network adequacy standards for the Medicaid PAHP. Additionally, HSAG submitted a brief Data Structure Questionnaire to the PAHP to obtain targeted information regarding their provider data structure(s) and methods for classifying providers (e.g., methods for identifying primary care providers [PCPs] or Early and Periodic Screening, Diagnostic and Treatment [EPSDT] providers). Questionnaire responses assisted HSAG in preparing data requests for the PAHP, to ensure that HSAG included all pertinent data fields in the data request.

Data Request

Concurrent with data collection from the PAHP, HSAG collaborated with the DHCFP to identify the provider categories to be included in the assessment. For the PAHP, these provider categories included general dentists, pediatric dentists, and other specialty dental providers (e.g., orthodontists).

HSAG requested Medicaid provider network files from the DHCFP. To define the requested data, HSAG submitted a detailed data requirements document for the provider data to the DHCFP. HSAG requested data for providers actively enrolled as of October 1, 2018. HSAG requested the following key data elements: unique provider identifier, enrollment status, provider type, provider specialty, and PCP indicator.

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Using the PAHP's provider data files, HSAG evaluated the provider classification fields available from the PAHP (e.g., provider type, specialty, credential, and/or taxonomy codes). HSAG then mapped this classification information to the provider categories specific to the PAHP type, producing the preliminary provider crosswalks.

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Study Limitations

Study findings and conclusions may be affected by limitations related to the study design and source data.

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- The PCA results presented in this study are dependent on the quality of provider data submitted by the DHCFP, the PAHP. Any substantial and systematic errors in the extraction and transmission of the provider data may have biased the results and compromised the validity and reliability of the study findings.

  - While the use of alternate spellings and/or special characters do not affect the conceptual framework of the provider categories in the crosswalks, these data inconsistencies will result in providers missing from the tabulations. For example, the data values, "Nurse Midwife" and "Nurse Mid-Wife" represent the same provider specialty and should be incorporated into data cleaning efforts by the PAHP.

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- The primary focus of the PCA was to assess the distribution of providers affiliated with the PAHP for the selected provider categories. The DHCFP has not directed the PAHP to use standard categorization criteria. As such, a lack of providers identified during the PCA may indicate a lack of contracted providers or it may indicate an inability to identify providers using the classifications outlined in the provider crosswalks.
- PCA findings were associated with the PAHP's provider data files for all ordering, referring, servicing, and billing providers active as of October 1, 2018. As such, results may not reflect the current status of the PAHP's provider data or changes implemented since October 2018.

Appendix B. Goals and Objectives Tracking

Nevada 2018–2019 Quality Strategy
Goals and Objectives for Medicaid

Unless otherwise indicated, all objectives will follow the quality improvement system for managed care (QISMC) methodology to improve rates.

Goal 1:	Improve the Health and Wellness of Nevada's Medicaid Population by Increasing the Use of Preventive Services.							
Objective	**QISMC Objective**	**Anthem 2019**	**HPN 2019**	**SilverSummit 2019**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
1.1a:	Increase children and adolescents' access to PCPs (CAP)–12–24 months	94.78%	94.20%	88.56%	94.93%	95.50%	96.06%	96.62%
1.1b:	Increase children and adolescents' access to PCPs (CAP)–25 months–6 years	84.36%	83.38%	71.50%	85.66%	87.26%	88.85%	90.44%
1.1c:	Increase children and adolescents' access to PCPs (CAP)–7–11 years	85.94%	86.45%	NA	87.69%	89.06%	90.42%	91.79%
1.1d:	Increase children and adolescents' access to PCPs (CAP)–12–19 years	84.54%	84.83%	NA	85.77%	87.35%	88.93%	90.51%
1.2:	Increase well-child visits (W15)–0–15 months	**68.06%**	63.75%	51.88%	67.99%	71.54%	75.10%	78.66%
1.3:	Increase well-child visits (W34)–3–6 years	73.17%	66.42%	59.37%	74.37%	77.22%	80.06%	82.91%
1.4a:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)–BMI percentile documentation	**82.73%**	78.59%	70.56%	82.70%	84.62%	86.55%	88.47%
1.4b:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)–counseling for nutrition	**74.21%**	68.37%	66.42%	72.63%	75.67%	78.71%	81.75%

Goal 1:	Improve the Health and Wellness of Nevada's Medicaid Population by Increasing the Use of Preventive Services.							
Objective	**QISMC Objective**	**Anthem 2019**	**HPN 2019**	**SilverSummit 2019**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
1.4c:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)–counseling for physical activity	67.88%	64.96%	60.58%	69.60%	72.98%	76.35%	79.73%
1.5a:	Increase immunizations for adolescents (IMA)–Meningococcal, Tdap	**89.29%**	**89.05%**	67.70%	84.85%	86.54%	88.22%	89.90%
1.5b:	Increase immunizations for adolescents (IMA)–Meningococcal, Tdap, HPV	41.12%	43.55%	19.25%	47.65%	53.46%	59.28%	65.10%
1.6a:	Increase childhood immunization status (CIS)–Combination 2	72.99%	72.02%	46.25%	73.55%	76.49%	79.43%	82.37%
1.6b:	Increase childhood immunization status (CIS)–Combination 3	**69.83%**	68.37%	43.13%	68.86%	72.32%	75.78%	79.24%
1.6c:	Increase childhood immunization status (CIS)–Combination 4	**69.34%**	67.64%	43.13%	68.45%	71.95%	75.46%	78.96%
1.6d:	Increase childhood immunization status (CIS)–Combination 5	**59.85%**	**60.10%**	34.38%	59.46%	63.97%	68.47%	72.98%
1.6e:	Increase childhood immunization status (CIS)–Combination 6	34.79%	**39.42%**	16.25%	38.58%	45.40%	52.23%	59.05%
1.6f:	Increase childhood immunization status (CIS)–Combination 7	**59.37%**	**59.61%**	34.38%	59.15%	63.69%	68.23%	72.77%
1.6g:	Increase childhood immunization status (CIS)–Combination 8	34.79%	**39.42%**	16.25%	38.48%	45.31%	52.15%	58.98%
1.6h:	Increase childhood immunization status (CIS)–Combination 9	30.41%	**35.52%**	13.13%	34.42%	41.70%	48.99%	56.28%

Goal 1:	Improve the Health and Wellness of Nevada's Medicaid Population by Increasing the Use of Preventive Services.							
Objective	**QISMC Objective**	**Anthem 2019**	**HPN 2019**	**SilverSummit 2019**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
1.6i:	Increase childhood immunization status (CIS)–Combination 10	30.41%	**35.52%**	13.13%	34.32%	41.62%	48.91%	56.21%
1.7:	Increase adolescent well-care visits (AWC)	**56.45%**	48.66%	36.50%	53.52%	58.68%	63.85%	69.01%
1.8:	Increase breast cancer screening (BCS)	51.93%	54.13%	NA	58.90%	63.46%	68.03%	72.60%
1.9a:	Increase adults' access to preventive/ambulatory health services (AAP)–20–44 Years	73.27%	73.09%	62.35%	75.55%	78.26%	80.98%	83.70%
1.9b:	Increase adults' access to preventive/ambulatory health services (AAP)–45–64 Years	80.05%	78.58%	72.28%	81.82%	83.84%	85.86%	87.88%
1.9c:	Increase adults' access to preventive/ambulatory health services (AAP)–65 Years and older	NA	33.08%	NA	67.19%	70.83%	74.48%	78.12%
1.9d:	Increase adults' access to preventive/ambulatory health services (AAP)–Total	75.38%	74.92%	65.40%	77.67%	80.15%	82.63%	85.11%

Goal 2:	Increase Use of Evidence-Based Practices for Members With Chronic Conditions.							
Objective	**QISMC Objective**	**Anthem 2019**	**HPN 2019**	**SilverSummit 2019**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
2.1a:	Increase rate of HbA1c testing for members with diabetes (CDC)	77.37%	81.02%	79.08%	81.98%	83.98%	85.99%	87.99%
2.1b:	Decrease rate of HbA1c poor control (>9.0%) for members with diabetes (CDC)**	45.01%	43.31%	57.66%	39.28%	34.91%	30.55%	26.18%
2.1c:	Increase rate of HbA1c good control (<8.0%) for members with diabetes (CDC)	47.45%	49.64%	34.55%	53.14%	58.34%	63.55%	68.76%

Goal 2:	Increase Use of Evidence-Based Practices for Members With Chronic Conditions.							
Objective	**QISMC Objective**	**Anthem 2019**	**HPN 2019**	**SilverSummit 2019**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
2.1d:	Increase rate of eye exams performed for members with diabetes (CDC)	52.31%	**62.77%**	46.47%	61.47%	65.75%	70.03%	74.31%
2.1e:	Increase medical attention for nephropathy for members with diabetes (CDC)	87.59%	85.16%	87.59%	89.55%	90.71%	91.87%	93.03%
2.1f:	Increase blood pressure control (<140/90 mm Hg) for members with diabetes (CDC)	52.31%	63.26%	46.23%	65.72%	69.53%	73.34%	77.15%
2.2a:	Increase medication management for people with asthma (MMA)—medication compliance 50 percent	**61.19%**	59.39%	NA	61.04%	65.37%	69.70%	74.03%
2.2b:	Increase medication management for people with asthma (MMA)—medication compliance 75 percent	35.90%	36.08%	NA	40.84%	47.42%	53.99%	60.56%
2.3	Increase rate of controlling high blood pressure (CBP) †	52.55%	**62.53%**	43.55%	55.58%	60.51%	65.45%	70.38%

Goal 3:	Improve Appropriate Use of Opioids.							
Objective	**QISMC Objective**	**Anthem 2019**	**HPN 2019**	**SilverSummit 2019**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
3.1:	Reduce use of opioids at high dosage (UOD)** ,†	7.24%	7.86%	3.77%	NC	NC	NC	NC
3.2a:	Reduce use of opioids from multiple providers (UOP)—multiple prescribers**,†	21.55%	26.56%	23.52%	NC	NC	NC	NC
3.2b:	Reduce use of opioids from multiple providers (UOP)—multiple pharmacies**,†	1.61%	4.26%	4.37%	NC	NC	NC	NC
3.2c:	Reduce use of opioids from multiple providers (UOP)—multiple prescribers and multiple pharmacies**,†	0.83%	2.12%	2.81%	NC	NC	NC	NC

Goal 4:	Improve the Health and Wellness of New Mothers and Infants and Increase New-Mother Education About Family Planning and Newborn Health and Wellness.							
Objective	**QISMC Objective**	**Anthem 2019**	**HPN 2019**	**SilverSummit 2019**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
4.1:	Increase timeliness of prenatal care (PPC)	**80.78%**	**80.54%**	66.42%	77.87%	80.33%	82.79%	85.25%
4.2:	Increase the rate of postpartum visits (PPC)	59.37%	**64.96%**	48.42%	64.46%	68.41%	72.36%	76.31%

Goal 5:	Increase Use of Evidence-Based Practices for Members With Behavioral Health Conditions.							
Objective	**QISMC Objective**	**Anthem 2019**	**HPN 2019**	**SilverSummit 2019**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
5.1a:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication (ADD)—initiation phase	46.77%	**52.29%**	NA	50.09%	55.63%	61.18%	66.72%
5.1b:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication (ADD)—continuation and maintenance phase	**66.10%**	**69.77%**	NA	60.00%	64.45%	68.89%	73.34%
5.2:	Reduce use of multiple concurrent antipsychotics in children and adolescents (APC)**	**0.00%**	**2.25%**	**1.92%**	3.28%	2.91%	2.55%	2.18%
5.3:	Increase adherence to antipsychotic medications for individuals with schizophrenia (SAA)	35.32%	41.95%	35.06%	46.08%	52.07%	58.06%	64.05%
5.4:	Increase follow-up after hospitalization for mental illness (FUH)—7-day	33.52%	29.11%	22.40%	39.45%	46.18%	52.90%	59.63%
5.5:	Increase follow-up after hospitalization for mental illness (FUH)—30-day	50.33%	49.80%	36.72%	54.86%	59.87%	64.89%	69.90%

Goal 5:	Increase Use of Evidence-Based Practices for Members With Behavioral Health Conditions.							
Objective	**QISMC Objective**	**Anthem 2019**	**HPN 2019**	**SilverSummit 2019**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
5.6:	Increase diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications (SSD)	80.48%	76.38%	78.06%	81.43%	83.50%	85.56%	87.62%
5.7a:	Increase follow-up after ED visit for AOD abuse or dependence (FUA)—7-day	9.25%	15.48%	11.93%	18.21%	27.30%	36.38%	45.47%
5.7b:	Increase follow-up after ED visit for AOD abuse or dependence (FUA)—30-day	13.99%	21.02%	15.33%	21.60%	30.31%	39.02%	47.73%
5.8a:	Increase follow-up after ED visit for mental illness (FUM)—7-day†	28.77%	**47.82%**	26.19%	47.67%	53.49%	59.30%	65.12%
5.8b:	Increase follow-up after ED visit for mental illness (FUM)—30-day†	41.41%	**57.48%**	35.46%	55.92%	60.82%	65.71%	70.61%
5.9a:	Increase initiation and engagement of AOD abuse or dependence treatment (IET)—initiation of treatment	**49.65%**	40.22%	**46.30%**	45.24%	51.33%	57.41%	63.50%
5.9b:	Increase initiation and engagement of AOD abuse or dependence treatment (IET)—engagement of treatment	14.78%	10.01%	13.37%	18.94%	27.94%	36.95%	45.96%
5.10:	Increase metabolic monitoring for children and adolescents on antipsychotics (APM)	23.18%	20.00%	23.08%	25.33%	33.62%	41.92%	50.22%

** A lower rate indicates better performances for this measure.

† Due to changes in the technical specifications for this measure, the National Committee for Quality Assurance (NCQA) recommends a break in trending between the Healthcare Effectiveness Data and Information Set (HEDIS) 2019 and prior years. Due to the QISMC goals being based on HEDIS 2018 statewide aggregate rates, where applicable, comparisons to QISMC goals should be considered with caution.

NC indicates that the HEDIS 2019 QISMC goals are unavailable for this measure.

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

Bolded rates indicate that the performance measure rate for HEDIS 2019 was at or above the minimum performance standards (MPS).

Indicates that the HEDIS 2019 rate surpassed the Tier 3 QISMC goal.

Goal 6:	Reduce and/or Eliminate Health Care Disparities for Medicaid Recipients.				
Objective	**Objective Description**	**Anthem**	**HPN**	**SilverSummit**	**MPS**
6.1:	Ensure that health plans maintain, submit for review, and annually revise cultural competency plans.	Met	Met	Met	Met
6.2:	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	Met	Met	Met
6.3:	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	Met	Met	Met

Nevada 2018–2019 Quality Strategy
Goals and Objectives for Nevada Check Up

Unless otherwise indicated, all objectives will follow the QISMC methodology to improve rates.

Goal 1:	Improve the Health and Wellness of Nevada's Nevada Check Up Population by Increasing the Use of Preventive Services.							
Objective	**QISMC Objective**	**Anthem 2019**	**HPN 2019**	**SilverSummit 2019**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
1.1a:	Increase children and adolescents' access to PCPs (CAP)–12–24 months	**99.56%**	**97.81%**	94.12%	97.78%	98.02%	98.27%	98.52%
1.1b:	Increase children and adolescents' access to PCPs (CAP)–25 months–6 years	**91.09%**	**91.10%**	83.54%	90.45%	91.51%	92.57%	93.63%
1.1c:	Increase children and adolescents' access to PCPs (CAP)–7–11 years	92.04%	93.27%	NA	93.31%	94.06%	94.80%	95.54%
1.1d:	Increase children and adolescents' access to PCPs (CAP)–12–19 years	91.03%	90.82%	NA	91.41%	92.36%	93.32%	94.27%
1.2:	Increase well-child visits (W15)–0–15 months	**82.26%**	73.19%	NA	77.38%	79.90%	82.41%	84.92%
1.3:	Increase well-child visits (W34)–3–6 years	77.62%	77.62%	59.56%	77.63%	80.11%	82.60%	85.08%
1.4a:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)–BMI percentile documentation	**87.83%**	83.45%	76.16%	85.65%	87.25%	88.84%	90.44%
1.4b:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)–counseling for nutrition	**79.56%**	74.70%	69.59%	76.13%	78.78%	81.44%	84.09%
1.4c:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)–counseling for physical activity	**73.48%**	72.02%	64.72%	73.04%	76.03%	79.03%	82.02%

Goal 1:	Improve the Health and Wellness of Nevada's Nevada Check Up Population by Increasing the Use of Preventive Services.							
Objective	**QISMC Objective**	**Anthem 2019**	**HPN 2019**	**SilverSummit 2019**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
1.5a:	Increase immunizations for adolescents (IMA)–Meningococcal, Tdap	**93.63%**	**93.92%**	NA	89.03%	90.25%	91.47%	92.69%
1.5b:	Increase immunizations for adolescents (IMA)–Meningococcal, Tdap, HPV	51.96%	56.20%	NA	57.54%	62.26%	66.97%	71.69%
1.6a:	Increase childhood immunization status (CIS)–Combination 2	87.21%	87.57%	NA	89.07%	90.29%	91.50%	92.72%
1.6b:	Increase childhood immunization status (CIS)–Combination 3	**84.02%**	**84.32%**	NA	83.46%	85.30%	87.13%	88.97%
1.6c:	Increase childhood immunization status (CIS)–Combination 4	**84.02%**	**83.73%**	NA	83.46%	85.30%	87.13%	88.97%
1.6d:	Increase childhood immunization status (CIS)–Combination 5	74.43%	76.63%	NA	77.33%	79.85%	82.37%	84.89%
1.6e:	Increase childhood immunization status (CIS)–Combination 6	**47.95%**	46.15%	NA	47.40%	53.24%	59.09%	64.93%
1.6f:	Increase childhood immunization status (CIS)–Combination 7	74.43%	76.33%	NA	77.33%	79.85%	82.37%	84.89%
1.6g:	Increase childhood immunization status (CIS)–Combination 8	**47.95%**	46.15%	NA	47.40%	53.24%	59.09%	64.93%
1.6h:	Increase childhood immunization status (CIS)–Combination 9	42.47%	42.01%	NA	44.91%	51.03%	57.15%	63.27%
1.6i:	Increase childhood immunization status (CIS)–Combination 10	42.47%	42.01%	NA	44.91%	51.03%	57.15%	63.27%
1.7:	Increase adolescent well-care visits (AWC)	**67.40%**	60.10%	45.28%	65.46%	69.30%	73.13%	76.97%

Goal 1:	Improve the Health and Wellness of Nevada's Nevada Check Up Population by Increasing the Use of Preventive Services.							
Objective	**QISMC Objective**	**Anthem 2019**	**HPN 2019**	**SilverSummit 2019**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
1.8:	Increase breast cancer screening (BCS)	—	—	—	—	—	—	—
1.9a:	Increase adults' access to preventive/ambulatory health services (AAP)–20–44 Years	—	—	—	—	—	—	—
1.9b:	Increase adults' access to preventive/ambulatory health services (AAP)–45–64 Years	—	—	—	—	—	—	—
1.9c:	Increase adults' access to preventive/ambulatory health services (AAP)–65 Years and older	—	—	—	—	—	—	—
1.9d:	Increase adults' access to preventive/ambulatory health services (AAP)–Total	—	—	—	—	—	—	—

Goal 2:	Increase Use of Evidence-Based Practices for Members With Chronic Conditions.							
Objective	**QISMC Objective**	**Anthem 2019**	**HPN 2019**	**SilverSummit 2019**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
2.1a:	Increase rate of HbA1c testing for members with diabetes (CDC)	—	—	—	—	—	—	—
2.1b:	Decrease rate of HbA1c poor control (>9.0%) for members with diabetes (CDC)**	—	—	—	—	—	—	—
2.1c:	Increase rate of HbA1c good control (<8.0%) for members with diabetes (CDC)	—	—	—	—	—	—	—
2.1d:	Increase rate of eye exams performed for members with diabetes (CDC)	—	—	—	—	—	—	—

Goal 2:	Increase Use of Evidence-Based Practices for Members With Chronic Conditions.							
Objective	**QISMC Objective**	**Anthem 2019**	**HPN 2019**	**SilverSummit 2019**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
2.1e:	Increase medical attention for nephropathy for members with diabetes (CDC)	—	—	—	—	—	—	—
2.1f:	Increase blood pressure control (<140/90 mm Hg) for members with diabetes (CDC)	—	—	—	—	—	—	—
2.2a:	Increase medication management for people with asthma (MMA)—medication compliance 50 percent	**59.62%**	55.22%	NA	58.64%	63.23%	67.83%	72.42%
2.2b:	Increase medication management for people with asthma (MMA)—medication compliance 75 percent	36.54%	33.33%	NA	40.00%	46.66%	53.33%	60.00%
2.3	Increase rate of controlling high blood pressure (CBP) †	—	—	—	—	—	—	—

Goal 3:	Improve Appropriate Use of Opioids.							
Objective	**QISMC Objective**	**Anthem 2019**	**HPN 2019**	**SilverSummit 2019**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
3.1:	Reduce use of opioids at high dosage (UOD)** ,†	—	—	—	—	—	—	—
3.2a:	Reduce use of opioids from multiple providers (UOP)—multiple prescribers**,†	—	—	—	—	—	—	—
3.2b:	Reduce use of opioids from multiple providers (UOP)—multiple pharmacies**,†	—	—	—	—	—	—	—
3.2c:	Reduce use of opioids from multiple providers (UOP)—multiple prescribers and multiple pharmacies**,†	—	—	—	—	—	—	—

Goal 4:	Improve the Health and Wellness of New Mothers and Infants and Increase New-Mother Education About Family Planning and Newborn Health and Wellness.							
Objective	**QISMC Objective**	**Anthem 2019**	**HPN 2019**	**SilverSummit 2019**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
4.1:	Increase timeliness of prenatal care (PPC)	—	—	—	—	—	—	—
4.2:	Increase the rate of postpartum visits (PPC)	—	—	—	—	—	—	—

Goal 5:	Increase Use of Evidence-Based Practices for Members With Behavioral Health Conditions.							
Objective	**QISMC Objective**	**Anthem 2019**	**HPN 2019**	**SilverSummit 2019**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
5.1a:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication (ADD)—initiation phase	42.42%	**58.11%**	NA	56.00%	60.89%	65.78%	70.67%
5.1b:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication (ADD)—continuation and maintenance phase	NA	NA	NA	NC	NC	NC	NC
5.2:	Reduce use of multiple concurrent antipsychotics in children and adolescents (APC)**	NA	**0.00%**	NA	6.75%	6.00%	5.25%	4.50%
5.3:	Increase adherence to antipsychotic medications for individuals with schizophrenia (SAA)	—	—	—	—	—	—	—
5.4:	Increase follow-up after hospitalization for mental illness (FUH)—7-day	NA	NA	NA	63.01%	67.12%	71.23%	75.34%
5.5:	Increase follow-up after hospitalization for mental illness (FUH)—30-day	NA	NA	NA	75.34%	78.08%	80.82%	83.56%

Goal 5:	Increase Use of Evidence-Based Practices for Members With Behavioral Health Conditions.							
Objective	**QISMC Objective**	**Anthem 2019**	**HPN 2019**	**SilverSummit 2019**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
5.6:	Increase diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications (SSD)	—	—	—	—	—	—	—
5.7a:	Increase follow-up after ED visit for AOD abuse or dependence (FUA)—7-day	—	—	—	—	—	—	—
5.7b:	Increase follow-up after ED visit for AOD abuse or dependence (FUA)—30-day	—	—	—	—	—	—	—
5.8a:	Increase follow-up after ED visit for mental illness (FUM)—7-day†	NA	66.67%	NA	79.47%	81.75%	84.03%	86.31%
5.8b:	Increase follow-up after ED visit for mental illness (FUM)—30-day†	NA	80.00%	NA	82.63%	84.56%	86.49%	88.42%
5.9a:	Increase initiation and engagement of AOD abuse or dependence treatment (IET)—initiation of treatment	NA	NA	NA	38.33%	45.18%	52.04%	58.89%
5.9b:	Increase initiation and engagement of AOD abuse or dependence treatment (IET)—engagement of treatment	NA	NA	NA	18.33%	27.41%	36.48%	45.56%
5.10:	Increase metabolic monitoring for children and adolescents on antipsychotics (APM)	NA	25.58%	NA	28.87%	36.78%	44.68%	52.58%

** A lower rate indicates better performances for this measure.

† Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS 2019 and prior years. Due to the QISMC goals being based on HEDIS 2018 statewide aggregate rates, where applicable, comparisons to QISMC goals should be considered with caution.

— Indicates that the health plan was not required to report this measure.

NC indicates the HEDIS 2019 QISMC goals are unavailable for this measure.

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

Bolded rates indicate that the performance measure rate for HEDIS 2019 was at or above the MPS.

Indicates that the HEDIS 2019 rate surpassed the Tier 3 QISMC goal.

Goal 6:	Reduce and/or Eliminate Health Care Disparities for Nevada Check Up Recipients.				
Objective	**Objective Description**	**Anthem**	**HPN**	**SilverSummit**	**MPS**
6.1:	Ensure that health plans maintain, submit for review, and annually revise cultural competency plans.	Met	Met	Met	Met
6.2:	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	Met	Met	Met
6.3:	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	Met	Met	Met

Nevada 2018–2019 Quality Strategy
Goals and Objectives for LIBERTY Dental

Medicaid

State fiscal year (SFY) 2019–2020 was the first year that **LIBERTY** reported rates. DHCFP will establish MPS and performance tiers for Objective 7.2 based on future data. The rates detailed below are for Medicaid.

Goal 7:	Increase Utilization of Dental Services.					
Objective	**Objective Description**	**LIBERTY**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
7.1:	Increase annual dental visits	50.67%	57.62%	62.33%	67.04%	74.75%
7.2:	Increase percentage of eligible members who received preventive dental services	39.76%	TBD	TBD	TBD	TBD

Nevada Check Up

SFY 2019–2020 was the first year that **LIBERTY** reported rates. The DHCFP will establish MPS and performance tiers for Objective 7.2 based on future data. The rates detailed below are for Nevada Check Up.

Goal 7:	Increase Utilization of Dental Services.					
Objective	**Objective Description**	**LIBERTY**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
7.1:	Increase annual dental visits	66.33%	71.63%	74.78%	77.94%	81.09%
7.2:	Increase percentage of eligible members who received preventive dental services	54.01%	TBD	TBD	TBD	TBD