Division of Health Care Financing and Policy
Nevada Medicaid Managed Care

State Fiscal Year 2017–2018 External Quality Review Technical Report

November 2018

HSAG HEALTH SERVICES ADVISORY GROUP

Contents

Acknowledgements and Copyrights

1. Executive Summary

Overview of the SFY 2017–2018 External Quality Review

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, requires states to prepare an annual technical report that describes the manner in which data were aggregated and analyzed and how conclusions were drawn as to the quality and timeliness of, and access to, care and services furnished by the states' managed care organizations (MCOs). The data come from activities conducted in accordance with the Code of Federal Regulations (CFR) at 42 CFR §438.358. To meet these requirements, the State of Nevada, Department of Health and Human Services, Division of Health Care Financing and Policy (the DHCFP), contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO). HSAG has served as the EQRO for the DHCFP since 2000.

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

The Nevada Medicaid MCOs included in the state fiscal year (SFY) 2017–2018 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 prepaid ambulatory health plan (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 2017–2018 as well as the readiness review of **LIBERTY**.

The SFY 2017–2018 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 2017–2018. 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)
- Descriptions of data obtained
- Conclusions drawn from the data

The report also includes an assessment of the MCOs' strengths and weaknesses, as well as recommendations for improvement and 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 9 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)

The purpose of the SFY 2017–2018 IQAP review of compliance was to determine the health plans' compliance with various access, structure, and operations standards specific to provider network management. To accomplish this objective, HSAG:

- Determined each plan's compliance with the five standards related to provider network management.
- Conducted checklist reviews to validate that the MCO apprised providers of the MCO's provider-related policies in the provider manual, including the provider dispute and complaint resolution process.
- Conducted a review of individual files for delegated subcontractor management, credentialing, and recredentialing.[1-1]

Table 1-1 summarizes the MCOs' results for these IQAP standards, checklists, and file reviews for the SFY 2017–2018 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 Standards

IQAP Compliance Activity	Anthem	HPN	SilverSummit
IQAP Standards Score	94.5%	96.8%	99.2%
Checklists Score	100%	100%	100%
File Review Score	100%	100%	100%
Overall Composite Score	**99.2%**	**99.5%**	**99.8%**

The overall composite score for **Anthem** was 99.2 percent; for **HPN** it was 99.5 percent; and for **SilverSummit** it was 99.8 percent. The compliance scores demonstrate the MCOs' strong application of the provider network management requirements of the MCO contract. Detailed results of the IQAP review are presented in Section 4 of this report.

[1-1] Recredentialing occurs every three years after initial credentialing. **SilverSummit** entered the Nevada market July 1, 2017; therefore, it had not been an MCO long enough for recredentialing to be applicable.

Validation of Performance Measures—NCQA HEDIS Compliance Audits

HSAG conducted an NCQA HEDIS Compliance Audit to assess **Anthem** and **HPN** performance with respect to the *HEDIS 2017 Technical Specifications* and to review the MCOs' performance on the HEDIS measures. **SilverSummit** had not been operational long enough to undergo a HEDIS audit. For HEDIS 2018, the MCOs were required to report 26 measures for the Medicaid population and 16 measures for the Nevada Check Up population. HSAG validated all measures reported by the MCOs.

The audit demonstrated that both MCOs had strong policies and procedures to collect, process, and report HEDIS data for the Medicaid and Nevada Check Up populations, and both MCOs were in full compliance with the *HEDIS 2017 Technical Specifications*. The claims and encounter data systems the MCOs employed used sophisticated scanning processes and advanced software to ensure accurate data processing. Both MCOs used software, the source code of which NCQA certified, to generate HEDIS measure rates. This ensured accurate measure calculation.

Medicaid Findings

Table 1-2 shows, by MCO, the HEDIS 2018 Medicaid performance measure rate results for **Anthem** and **HPN** and the Medicaid aggregate, which represents the average of both MCOs' measure rates weighted by the eligible population. 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 the MCO provides. Except for 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 1-2—HEDIS 2018 Results for Medicaid

HEDIS Measure	Anthem	HPN	Medicaid
Access to Care			
Adults' Access to Preventive/Ambulatory Health Services (AAP)			
Ages 20–44 Years	72.55%	73.01%	72.83%
Ages 45–64 Years	79.38%	80.02%	79.80%
Ages 65 Years and Older	77.55%	60.53%	63.54%
Total	74.69%	75.50%	75.19%
Children and Adolescents' Access to Primary Care Practitioners (CAP)			
Ages 12—24 Months	94.89%	93.95%	94.37%
Ages 25 Months–6 Years	83.97%	84.16%	84.07%
Ages 7–11 Years	85.98%	86.59%	86.32%
Ages 12–19 Years	83.53%	84.58%	84.19%

HEDIS Measure	Anthem	HPN	Medicaid
Children's Preventive Care			
Adolescent Well-Care Visits (AWC)			
Adolescent Well-Care Visits	51.09%	46.72%	48.35%
Childhood Immunization Status (CIS)			
Combination 2	70.07%	71.05%	70.61%
Combination 3	65.94%	64.96%	65.40%
Combination 4	65.21%	64.72%	64.94%
Combination 5	55.23%	54.74%	54.96%
Combination 6	33.09%	30.66%	31.75%
Combination 7	54.74%	54.50%	54.61%
Combination 8	32.85%	30.66%	31.64%
Combination 9	28.47%	26.03%	27.13%
Combination 10	28.22%	26.03%	27.02%
Immunizations for Adolescents (IMA)			
Combination 1 (Meningococcal, Tdap)	84.67%	82.24%	83.17%
Combination 2 (Meningococcal, Tdap, HPV)	40.63%	42.58%	41.83%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)			
BMI Percentile—Total	77.37%	83.21%	80.78%
Counseling for Nutrition—Total	71.29%	68.37%	69.59%
Counseling for Physical Activity—Total	67.64%	65.21%	66.22%
Well-Child Visits in the First 15 Months of Life (W15)			
Six or More Well-Child Visits	68.04%	61.31%	64.43%
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%	70.07%	71.52%
Women's Health and Maternity Care			
Breast Cancer Screening (BCS)			
Breast Cancer Screening	50.64%	56.04%	54.33%
Prenatal and Postpartum Care (PPC)			
Timeliness of Prenatal Care	80.15%	71.29%	75.41%
Postpartum Care	62.11%	59.12%	60.51%

HEDIS Measure	Anthem	HPN	Medicaid
Care for Chronic Conditions			
Comprehensive Diabetes Care (CDC)			
HbA1c Testing	82.48%	78.59%	79.98%
*HbA1c Poor Control (>9.0%)**	41.61%	44.77%	43.64%
HbA1c Control (<8.0%)	50.12%	46.72%	47.93%
Eye Exam (Retinal) Performed	53.28%	59.37%	57.19%
Medical Attention for Nephropathy	90.27%	87.35%	88.39%
Blood Pressure Control (<140/90 mm Hg)	54.26%	66.18%	61.91%
Controlling High Blood Pressure (CBP)			
Controlling High Blood Pressure	47.45%	52.55%	50.64%
Medication Management for People With Asthma (MMA)			
Medication Compliance 50%—Total	55.71%	57.39%	56.71%
Medication Compliance 75%—Total	32.70%	35.33%	34.27%
Behavioral Health			
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)			
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	38.05%	41.59%	40.09%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)			
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	81.46%	77.99%	79.37%
Follow-Up After ED Visit for AOD Abuse or Dependence (FUA)			
7-Day Follow-Up—Total	7.22%	10.46%	9.12%
30-Day Follow-Up—Total	10.92%	14.29%	12.89%
Follow-Up After ED Visit for Mental Illness (FUM)			
7-Day Follow-Up	27.87%	50.45%	41.86%
30-Day Follow-Up	40.80%	57.30%	51.02%
Follow-Up After Hospitalization for Mental Illness (FUH)			
7-Day Follow-Up	40.13%	25.04%	32.72%
30-Day Follow-Up	56.26%	43.18%	49.84%

HEDIS Measure	Anthem	HPN	Medicaid
Follow-Up Care for Children Prescribed ADHD Medication (ADD)			
Initiation Phase	39.66%	48.28%	44.54%
Continuation and Maintenance Phase	61.02%	51.76%	55.56%
Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)			
Initiation of AOD Treatment—Total	42.83%	36.51%	39.16%
Engagement of AOD Treatment—Total	12.72%	7.91%	9.93%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)			
Total	21.03%	13.13%	17.03%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)			
*Total**	1.42%	5.29%	3.64%
Utilization			
Ambulatory Care (per 1,000 Member Months) (AMB)			
*ED Visits—Total**	56.58	55.15	55.74
Outpatient Visits—Total	287.88	299.51	294.74
Mental Health Utilization—Total (MPT)			
Inpatient—Total	0.76%	0.23%	0.45%
Intensive Outpatient or Partial Hospitalization—Total	0.07%	0.03%	0.04%
Outpatient—Total	9.10%	7.25%	8.01%
ED—Total	0.18%	0.02%	0.09%
Telehealth—Total	0.00%	0.00%	0.00%
Any Service—Total	9.94%	7.42%	8.46%
Overuse/Appropriateness of Care			
Use of Opioids at High Dosage (per 1,000 Members) (UOD)			
*Use of Opioids at High Dosage**	68.87	74.31	72.57
Use of Opioids From Multiple Providers (per 1,000 Members) (UOP)*			
Multiple Prescribers	240.26	342.62	309.12
Multiple Pharmacies	36.01	70.89	59.48
Multiple Prescribers and Multiple Pharmacies	26.23	47.87	40.79

* A lower rate indicates better performances for this measure.

Nevada Check Up Findings

Table 1-3 shows, by MCO, the HEDIS 2018 Nevada Check Up performance measure rate results for **Anthem** and **HPN** and the Nevada Check Up aggregate. The aggregate represents the average of both MCOs' measure rates weighted by the eligible population.

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

HEDIS Measure	Anthem	HPN	NV Check Up
Access to Care			
Children and Adolescents' Access to Primary Care Practitioners (CAP)			
Ages 12—24 Months	99.12%	96.33%	97.53%
Ages 25 Months–6 Years	91.10%	88.12%	89.39%
Ages 7–11 Years	93.08%	92.25%	92.57%
Ages 12–19 Years	90.11%	90.61%	90.45%
Children's Preventive Care			
Adolescent Well-Care Visits (AWC)			
Adolescent Well-Care Visits	65.82%	59.61%	61.62%
Childhood Immunization Status (CIS)			
Combination 2	90.24%	85.91%	87.86%
Combination 3	81.71%	81.54%	81.62%
Combination 4	81.71%	81.54%	81.62%
Combination 5	75.61%	74.16%	74.81%
Combination 6	38.21%	44.30%	41.55%
Combination 7	75.61%	74.16%	74.81%
Combination 8	38.21%	44.30%	41.55%
Combination 9	36.18%	40.94%	38.79%
Combination 10	36.18%	40.94%	38.79%
Immunizations for Adolescents (IMA)			
Combination 1 (Meningococcal, Tdap)	90.37%	86.62%	87.81%
Combination 2 (Meningococcal, Tdap, HPV)	54.96%	51.82%	52.82%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)			
BMI Percentile—Total	84.67%	83.70%	84.06%
Counseling for Nutrition—Total	73.48%	73.48%	73.48%

HEDIS Measure	Anthem	HPN	NV Check Up
Counseling for Physical Activity—Total	70.80%	69.59%	70.04%
Well-Child Visits in the First 15 Months of Life (W15)			
Six or More Well-Child Visits	83.24%	68.33%	74.87%
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%	73.48%	75.14%
Care for Chronic Conditions			
Medication Management for People With Asthma (MMA)			
Medication Compliance 50%—Total	54.84%	53.65%	54.04%
Medication Compliance 75%—Total	30.11%	34.90%	33.33%
Behavioral Health			
Follow-Up After ED Visit for Mental Illness (FUM)			
7-Day Follow-Up	NA	82.98%	77.19%
30-Day Follow-Up	NA	85.11%	80.70%
Follow-Up After Hospitalization for Mental Illness (FUH)			
7-Day Follow-Up	50.00%	68.57%	58.90%
30-Day Follow-Up	65.79%	80.00%	72.60%
Follow-Up Care for Children Prescribed ADHD Medication (ADD)			
Initiation Phase	44.12%	55.36%	51.11%
Continuation and Maintenance Phase	NA	NA	NA
Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)			
Initiation of AOD Treatment—Total	NA	25.64%	31.48%
Engagement of AOD Treatment—Total	NA	7.69%	9.26%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)			
Total	NA	16.67%	20.97%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)			
*Total**	NA	NA	7.50%
Utilization			
Ambulatory Care (per 1,000 Member Months) (AMB)			
*ED Visits—Total**	27.04	23.87	25.08
Outpatient Visits—Total	248.86	248.74	248.78

HEDIS Measure	Anthem	HPN	NV Check Up
Mental Health Utilization—Total (MPT)			
Inpatient—Total	0.27%	0.01%	0.11%
Intensive Outpatient or Partial Hospitalization—Total	0.08%	0.04%	0.05%
Outpatient—Total	6.78%	5.46%	5.97%
ED—Total	0.01%	0.01%	0.01%
Telehealth—Total	0.00%	0.00%	0.00%
Any Service—Total	7.11%	5.48%	6.10%

* A lower rate indicates better performances for this measure.
NA indicates the denominator for the measure is too small to report (less than 30).

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

Validation of Performance Improvement Projects (PIPs)

In SFY 2017–2018, 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 1: *Achieved* Module 2: *Achieved* Module 3: *Achieved*	Module 1: *Achieved* Module 2: *Achieved* Module 3: *Achieved*	Module 1: *Achieved* Module 2: *Achieved*
Increase Well-Child Visits for Children 3–6 Years of Age (W34)	Module 1: *Achieved* Module 2: *Achieved* Module 3: *Achieved*	Module 1: *Achieved* Module 2: *Achieved* Module 3: *Achieved*	Module 1: *Achieved* Module 2: *Achieved*

Table 1-4 shows that **Anthem** and **HPN** successfully completed Modules 1 through 3 and developed methodologically sound projects. **Anthem** and **HPN** demonstrated the use of internal and external quality improvement teams, developing collaborative partnerships, and using quality improvement science tools to identify opportunities for improvement and determine appropriate targeted interventions to test. Since **SilverSummit** was new to the Nevada managed care program, the MCO was required to

collect baseline data over a longer period, which only allowed **SilverSummit** to complete its PIPs through Module 2. The validation results show that **SilverSummit** completed Modules 1 and 2 and developed methodologically sound projects. **SilverSummit** also demonstrated the use of internal and external quality improvement teams and the development of collaborative partnerships with its targeted providers and facilities. Details of each MCO's PIP validation are presented in Section 6 of this report.

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

Anthem

Overall, **Anthem** demonstrated strengths related to measures and activities that related to quality of care. Performance measures like *Immunizations for Adolescents*, *Well Child Visits in the First 15 Months of Life*, *Well Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life, Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%), HbA1c Control (<8.0%), Medical Attention for Nephropathy*, *Prenatal and Postpartum Care*, and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* require the provider to perform the services that meet numerator compliance and properly document these services in the medical record so the service may be captured in the HEDIS rate. The intervention strategies that **Anthem** employed to improve the previous year's PIP rates for *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* and for reducing behavioral health readmissions likely have had residual beneficial effects that continue to affect performance measures. Further, **Anthem**'s campaign to increase outreach to providers, coach providers on proper documentation and coding to show numerator compliance with HEDIS measures, and fill gaps in care noted by the MCO appear to positively support improvement in HEDIS rates for these measures. Quality-related performance measures like *Medication Management for People with Asthma* and *Follow-Up Care for Children Prescribed ADHD Medication* show stronger performance when provider efforts are supported by case management efforts on the MCO's part. Proper management of medications and follow-up with providers enables members to better adhere to medication regimens.

Performance measures that also fall within the access to care domain, like *Adolescent Well Care Visits, Timeliness of Prenatal Care*, *Postpartum Care*, *Follow-Up Care for Children Prescribed ADHD Medication*, and *Well Child Visits in the First 15 Months of Life* and *Well Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life,* demonstrate strong performance and are indicative of MCO- and provider-level initiatives that impact access to services within a specified time period to improve the efficacy of care. During the IQAP review of compliance, wherein HSAG assessed standards related to **Anthem**'s network monitoring and management, **Anthem** staff members described efforts to increase the number of contracted providers to address gaps related to service availability, as detailed in the previous year's CAHPS survey. **Anthem** reported adding 337 more providers to its network. Further, **Anthem** developed a provider program for continuing medical education (CME) that focuses on member experience and is available to all providers. **Anthem** staff members also described the MCO's efforts to increase education and incentives for pregnant women so they could obtain the required

prenatal and postpartum care visits and to have increased incentives for providers to submit service encounters for all prenatal and postpartum service visits. Efforts to improve access to care, as evidenced by provider network monitoring and management IQAP results mixed with the MCO's efforts to improve access-related HEDIS and CAHPS measures, have led to improvements in accessibility and timeliness of care overall.

HPN

Overall, **HPN** demonstrated strengths related to measures and activities that fell within the domain of quality of care. Performance measures like *Adolescent Well Care Visits, Well Child Visits in the First 15 Months of Life*, *Well Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life, Medication Management for People With Asthma,* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* require the provider to perform the services that meet numerator compliance as well as properly document the services in the medical record. Over the last several years, **HPN** staff members have reported an increase in member outreach regarding immunizations and well-child visits, as well as provider outreach and education by **HPN** clinical staff members to educate providers on addressing gaps in care. Based on the MCO's performance, it is plausible that these interventions are having an impact.

Performance measures that are also access-related measures—like *Adolescent Well Care Visits, Well Child Visits in the First 15 Months of Life*, and *Well Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*—demonstrated strong performance and are indicative of MCO- and provider-level initiatives that impact access to services within a specified time to increase the efficacy of care. The IQAP compliance review of **HPN**'s network monitoring and management activities demonstrated **HPN**'s strong adherence to the contractual requirements related to network management. Further, **HPN**'s secret shopper survey of provider offices has shown that 99 percent of providers had an open panel and were able to see Medicaid members. Declining rates for an access-related performance measure like *Timeliness of Prenatal Care* show that additional improvement efforts are still required. **HPN** has recognized this and has modified its OB case management program to include an outreach team that assists pregnant women with scheduling appointments and coordinating transportation to and from appointments. **HPN** also has identified provider-level interventions to address the declining rate for the access-related measure, *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase.*

SilverSummit

In the IQAP review of compliance, **SilverSummit** demonstrated strong adherence to the contract standards related to network monitoring and management. Because **SilverSummit** entered the Nevada managed care program July 1, 2017, and had not been a Nevada MCO long enough for the collection and reporting of HEDIS data, there are no performance measure rates to report for **SilverSummit**.

HCGP Performance Measure Validation (PMV)

The DHCFP sought to verify that **AxisPoint Health** (**APH**) collected and reported complete and accurate performance measure data annually for contractually required performance measures selected for the Health Care Guidance Program (HCGP). HSAG validated **APH**'s performance measures using the EQR Protocol 2[1-2] developed by the Centers for Medicare & Medicaid Services (CMS) as its guide. HSAG's PMV activity focused on the following objectives:

1. Assess the accuracy of the required performance measures reported by **APH**.
2. Determine the extent to which the measures that **APH** calculated followed the DHCFP's specifications and reporting requirements.

HSAG validated a set of performance measures selected by the DHCFP for validation. The measures primarily consisted of performance measures that were contractually required by the DHCFP but were not part of the HCGP pay-for-performance (P4P) program. These measures are referred to as the non-P4P measures.

This audit reviewed 22 performance measures. **APH** determined that all but one were reportable for the reporting period under review; however, there were several issues identified during the on-site audit. Details of the results of the HCGP PMV are provided in Section 8.

The HCGP concluded on June 30, 2018. The DHCFP phased out the HCGP in accordance with the Special Terms and Conditions set by CMS.

LIBERTY Dental Readiness Review

In March 2017, the DHCFP selected **LIBERTY Dental Plan of Nevada, Inc.** (**LIBERTY**) to provide DBA services to Medicaid and Nevada Check Up recipients. In SFY 2017–2018 HSAG conducted a readiness review of **LIBERTY** on behalf of the DHCFP. The review consisted of two components: (1) Operational Readiness Review, and (2) Information Systems (IS) Readiness Review. Detailed results are provided in Section 10 of this report.

Operational Readiness Review Results

Table 1-5 through Table 1-7 detail the overall scores for the operational readiness review. Table 1-5 details the scores for all elements contained in each of the 15 review standards.

[1-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 1, 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 1-5—Summary of Scores for the Operational Readiness Review Standards: LIBERTY

Readiness Review Standard	Total Applicable Elements	Total Critical Elements	Number of Elements		
			Complete	Incomplete	Incomplete—Critical*
Total Operational Readiness Review Elements	165	92	153	4	8
Percent Complete (No Action Required)			**92.7% (153/165)**		
Percent Incomplete (Action Required)			**2.4% (4/165)**		
Percent Incomplete-Critical (Action Required*)			**4.8% (8/165)**		

Totals rounded to the nearest tenth of 1 percent.
* Incomplete—Critical elements were required to be prioritized and resolved before enrolling members.
Total Elements: The total number of elements in each standard.
Total Critical Elements: The total number of elements designated as critical within the standard.

Table 1-6 details the results of the credentialing file review for **LIBERTY**.

Table 1-6—Summary of Results for File Reviews: LIBERTY

File Review Name	# of Records Reviewed	# of Applicable Elements	# of Compliant Elements	% of Compliant Elements
Credentialing	15	238	229	96.2%
File Review Totals	**15**	**238**	**229**	**96.2%**

Table 1-7 details the scores of the file reviews for the checklists reviewed for **LIBERTY**.

Table 1-7—Summary of Checklist Results: LIBERTY

Checklist	# of Applicable Elements	# of Compliant Elements	% of Compliant Elements
Checklist Total	**73**	**71**	**97.3%**

LIBERTY submitted its remediation plan for all operational readiness review elements scored *Incomplete* or *Incomplete—Critical* by the required date. All incomplete items were resolved before the start of the program.

Information System Readiness Review Results

Table 1-8 details the scores for all elements contained in each of the three IS readiness review standards using the *Complete*, *Incomplete*, and *Incomplete—Critical* rating methodology established for the systems desk review evaluation tools.

Table 1-8—Summary of Scores for the Information Systems Readiness Review Standards: LIBERTY

Readiness Review Standard	Total Applicable Elements	Total Critical Elements	Number of Elements		
			Complete	Incomplete	Incomplete—Critical*
Total IS Readiness Review Elements	10	4	4	5	1
Percent Complete (No Action Required)			**40.0% (4/10)**		
Percent Incomplete (Action Required)			**50.0% (5/10)**		
Percent Incomplete—Critical (Action Required*)			**10.0% (1/10)**		

Totals rounded to the nearest tenth of 1 percent.
* Incomplete—Critical elements were required to be completed before enrolling members.
Total Elements: The total number of elements in each standard.
Total Critical Elements: The total number of elements designated as critical within the standard.

Table 1-9 displays the scores for the claims systems testing.

Table 1-9—Summary of Scores for the Claims Systems Testing: LIBERTY

Claim Type	# of Scenarios	# of Claims Scored as *Met*	# of Claims Scored as *Partially Met*	# of Claims Scored as *Not Met*	% of Compliant Claims*
Claim Scenarios Total	**38**	**38**	**0**	**0**	**100%**

Table 1-10 displays the scores for encounter data validation testing.

Table 1-10—Summary of Scores for the Encounter Data Validation: LIBERTY

Claim Type	Number of Applicable Claim Lines	Number of Claim Lines Submitted	File Transmission Size Threshold	Claim Lines Contained the Required Elements	Encounter File Aligned With Companion Guide	Overall Encounter Data Compliance
Dental	**70**	**76***	***Met***	***Met***	***Met***	**100%**

* Test Encounter Data File included 6 claims lines not related to testing scenarios provided.

LIBERTY submitted its remediation plan for all IS readiness review elements scored *Incomplete* or *Incomplete—Critical* by the due date. All incomplete items were resolved before the start of the program.

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 an 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 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**; and **SilverSummit Healthplan Inc.** (**SilverSummit**). 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 SFY 2017–2018.

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. In January 2014, the DHCFP expanded Medicaid coverage to persons with incomes up to 138 percent of the federal poverty level, which was allowed under the Affordable Care Act. The number of persons who enrolled in Medicaid as a result of the expansion greatly exceeded the DHCFP's original expectations. Most newly eligible persons reside in the managed care catchment areas; therefore, both MCOs experienced significant increases in enrollment compared to prior years. For example, in June 2013, enrollment in managed care was 193,455 and in June 2017, enrollment in managed care was 489,091, which is more than a 150 percent increase.

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 2018.

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

Gender/Age Band	June 2018 Members
Males and Females <1 Year of Age	18,465
Males and Females 1–2 Years of Age	29,165
Males and Females 3–14 Years of Age	147,946
Females 15–18 Years of Age	17,452
Males 15–18 Years of Age	16,959
Females 19–34 Years of Age	71,311
Males 19–34 Years of Age	41,632
Females 35+ Years of Age	67,379
Males 35+ Years of Age	54,604
Total Medicaid	**464,913**
Males and Females <1 Year of Age	169
Males and Females 1–2 Years of Age	1,647
Males and Females 3–14 Years of Age	17,345
Females 15–18 Years of Age	2,524
Males 15–18 Years of Age	2,493
Total CHIP	**24,178**
Total Medicaid and CHIP	**489,091**

Table 2-2 presents enrollment of Medicaid recipients by MCO and county for June 2018.

Table 2-2—June 2018 Nevada MCO Medicaid Recipients

MCO	Total Eligible Clark County	Total Eligible Washoe County
HPN	218,980	29,690
Anthem	145,880	19,415
SilverSummit	44,029	6,919
Total	**408,889**	**56,024**

Table 2-3 presents enrollment of CHIP recipients in the Nevada Check Up program by MCO and by county for June 2018.

Table 2-3—June 2018 Nevada MCO CHIP (Nevada Check Up) Recipients

MCO	Total Eligible Clark County	Total Eligible Washoe County
HPN	11,300	2,585
Anthem	7,036	1,352
SilverSummit	1,582	323
Total	**19,918**	**4,260**

Network Capacity Analysis

With the May 2016 release of revised federal regulations for managed care, CMS required states to set standards to ensure ongoing state assessment and certification of MCO, prepaid inpatient health plan, and prepaid ambulatory health plan networks; set threshold standards to establish network adequacy measures for a specified set of providers; establish criteria to develop network adequacy standards for managed long-term services and supports programs; and ensure the transparency of network adequacy standards. The requirement stipulates that states must establish time and distance standards for the following network provider types: primary care (adult and pediatric); obstetricians/gynecologists; behavioral health; specialist (adult and pediatric); hospital; pharmacy; pediatric dental; and additional provider types when they promote the objectives of the Medicaid program for the provider type to be subject to such time and distance standards. The DHCFP is working with the Nevada Department of Insurance to finalize these standards and will use the final standards as part of its network capacity monitoring of the managed care program.

Nevada State Quality Strategy

The U.S. Department of Health and Human Services (HHS) Centers for Medicare & Medicaid Services (CMS) Medicaid managed care regulations at 42 CFR §438.340 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 2017–2018.

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.

Consistent with the national quality strategy, the DHCFP established the following quality goals for the Quality Strategy 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 increase rates by 10 percent.

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

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

Objective 1.1b: Increase children and adolescents' access to PCPs (25 months–6 years).

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

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

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

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

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

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

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

Objective 1.5: Increase immunizations for adolescents.

Objective 1.8: Increase adolescent well-care visits.[2-1]

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

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

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

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

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

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

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

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

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

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

[2-1] Objective 1.6, increase annual dental visits, and Objective 1.7, increase human papillomavirus vaccine for female adolescents, were removed from the MCOs' reporting in SFY 2017–2018.

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

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

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

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

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

Objective 4.1: Increase the rate of postpartum visits.

Objective 4.2: Increase timeliness of prenatal care.

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

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

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

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

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

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

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

Goal 6: Increase reporting of CMS quality measures.

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

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

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

To establish performance targets, the DHCFP uses a QISMC methodology. Performance goals are established by reducing by 10 percent the gap between the performance measure baseline rate and 100 percent. For example, if the baseline rate is 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.

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 six goals and the objectives used to measure achievement of the goals. SFY 2014–2015 marked the baseline year of measurement for the Quality Strategy goals and objectives and also established the QISMC goal for each of the objectives.

Table 2-4 shows the MCOs' achievement of goals and objectives in SFY 2017–2018. HSAG updates the tracking table annually and produces the results in each year's annual EQR technical report. For additional detail, please see Appendix B of this report. **SilverSummit** had not been operational long enough for performance measure rates to be reported; therefore, **SilverSummit** is not represented in Table 2-4 or in Appendix B of this report.

Table 2-4—2017–2018 Quality Strategy Goals and Objectives Summary of Achievement by MCO*

Metric	Anthem Medicaid	Anthem Check Up	HPN Medicaid	HPN Check Up
Number of Comparable Rates (Previous Year to Current Year)	36	26	36	26
Number of Rates That Improved	15/36 (42%)	15/26 (58%)	12/36 (33%)	16/26 (62%)
Number of Rates That Stayed the Same	3/36 (8%)	3/26 (12%)	4/36 (11%)	3/26 (12%)
Number of Rates That Declined	18/36 (50%)	8/26 (31%)	20/36 (56%)	7/26 (27%)
Number of Rates That Achieved QISMC Goal	25/36 (69%)	17/26 (65%)	17/36 (47%)	16/26 (62%)

* Note: This table denotes changes in rates from SFY 2016–2017 to SFY 2017–2018 only and does not indicate that changes are statistically significant.

The DHCFP modifies the performance targets for each of the objectives every two years, thereby raising the performance bar for the MCOs. Most QISMC goals were set based on SFY 2014–2015 results. In SFY 2015–2016, the DHCFP added performance measures to the list of performance measures that MCOs were required to report. For those newly added measures, SFY 2014–2015 rates were not available; therefore, HSAG used SFY 2015–2016 rates to set the QISMC goals for these measures and noted whether the SFY 2017–2018 performance measure rates met the QISMC goal.

Using SFY 2017–2018 as the baseline period, the DHCFP will work with HSAG to establish new minimum performance standards (MPS) and performance tiers to evaluate each MCO's future performance. The 2019–2020 quality strategy will include the newly established MPS and performance tiers for the MCOs as well as the dental PAHP, **LIBERTY**.

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 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*

The results of the first remeasurement year for the P4P measures will be reported in the SFY 2018–2019 EQR Technical Report.

Annual Health Care Guidance Program (HCGP) Quality Strategy Evaluation

The Nevada Comprehensive Care Waiver, known as the Health Care Guidance Program, expired on June 30, 2018. The DHCFP phased out the HCGP in accordance with the Special Terms and Conditions set by CMS. The DHCFP currently is researching other care management models that will meet the needs of Nevada Medicaid recipients.

3. Description of EQR Activities

Mandatory Activities

In accordance with 42 Code of Federal Regulations (CFR) §438.356, the DHCFP contracted with Health Service Advisory Group, Inc. (HSAG) as the external quality review organization (EQRO) for the State of Nevada to conduct the mandatory external quality review (EQR) activities as set forth in 42 CFR §438.358. In SFY 2017–2018, HSAG conducted the following mandatory EQR activities for the Nevada Medicaid and Nevada Check Up programs:

- **Compliance monitoring evaluation:** SFY 2017–2018 initiated a new three-year review cycle for the Internal Quality Assurance Program (IQAP) review of compliance. The purpose of the SFY 2017–2018 IQAP review was to assess each MCO'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 review focused on the requirements for provider network management found in Subparts A, C, and D. Results of the IQAP review are presented in Section 4.
- **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.
- **Validation of PIPs:** HSAG validated the MCOs' PIPs to determine if they were designed to achieve, through ongoing measurement and intervention, significant and sustained improvement in clinical and nonclinical care. HSAG also evaluated if the PIPs would have a favorable effect on health outcomes and enrollee satisfaction. Results of the validation of MCO PIPs are presented in Section 6.

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:

- Evaluated the State's Quality Strategy and the managed care program's achievement of the goals and objectives identified in the strategy. HSAG's evaluation of the activities that occurred in support of the State's Quality Strategy is presented in Section 2.
- Provided an analysis of the results of CAHPS activities conducted by the MCOs, which is presented in Section 7.
- Provided technical assistance to the DHCFP with activities related to the Nevada Comprehensive Care Waiver (NCCW) program, 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 the Centers for Medicaid & Medicare Services (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). HSAG's technical assistance activities included:

  - Evaluating the HCGP Quality Strategy, which was developed in response to the requirements included in the 1115 Research and Demonstration Waiver special terms and conditions.
  - Participating in monthly meetings with the DHCFP staff members and quarterly meetings with the HCGP vendor to ensure that quality-related activities remain on track. HSAG also developed a set of quality modules that the HCGP vendor must use to guide its quality-related presentations during the quarterly meetings.
  - Performing a performance measure validation audit of non-P4P measures used to monitor the HCGP's progress in achieving the goals and objectives of the NCCW demonstration waiver, which is presented in Section 8.
- Performed an information systems and operational readiness review of **LIBERTY**, which is presented in Section 10.
- Calculated performance measures for the FFS population that can be used as baseline rates for the DHCFP's Access to Care Monitoring Review Plan.
- Conducted a CAHPS survey of the FFS child population that can be used as baseline rates for the DHCFP's Access to Care Monitoring Review Plan.
- Initiated an encounter data validation study to be complete in SFY 2018–2019.

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

4. Internal Quality Assurance Program (IQAP) Review—SFY 2017–2018

Overview

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, requires that states contract with an external quality review organization (EQRO) to conduct an annual evaluation of their managed care organizations (MCOs) to determine each MCO's compliance with federal and the State's managed care standards. The U.S. Department of Health and Human Services (DHHS), Centers for Medicare & Medicaid Services (CMS) regulates requirements and procedures for the external quality review (EQR). The DHCFP contracted with HSAG to conduct EQR services for the Nevada Medicaid and Nevada Check Up managed care programs.

According to 42 Code of Federal Regulations (CFR) §438.358, which describes the activities related to external quality reviews, a state or its EQRO must conduct a review within a three-year period to determine a Medicaid MCO's compliance with federal standards and standards established by the State for access to care, structure and operations, and quality measurement and improvement. To meet this requirement, the DHCFP contracted with HSAG to perform a comprehensive review of compliance with State and federal standards for **Anthem**, **HPN**, and **SilverSummit** in SFY 2017–2018, which initiated a new three-year cycle of 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 follows:

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 2017–2018 IQAP Review of Compliance was to determine each MCO's compliance with various access, structure, and operations standards specific to provider network management. 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 credentialing and recredentialing.
- Conducted checklist reviews to validate that the MCO apprised providers of its provider-related policies in the provider manual, including the provider dispute and complaint resolution process.

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, 2017, through December 31, 2017. 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[4-1] to create the process, tools, and interview questions used for the SFY 2017–2018 IQAP Compliance Review.

MCO-Specific Results—Anthem

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 2017–2018. A total of 64 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 4-2—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*	
I	Credentialing and Recredentialing	15	15	15	0	0	0	100%
II	Availability and Accessibility of Services	26	26	25	0	1	0	96.2%
III	Subcontracts and Delegation	13	13	10	1	2	0	80.8%

[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.

IQAP Standard #	Standard Name	Total Elements	Total Applicable Elements	Number of Elements				Total Compliance Score
				M	*PM*	*NM*	*NA*	
IV	Provider Dispute and Complaint Resolution	7	7	7	0	0	0	100%
V	Provider Information	3	3	3	0	0	0	100%
Total Compliance Score		**64**	**64**	**60**	**1**	**3**	**0**	**94.5%**

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 64 applicable elements, **Anthem** received *Met* scores for 60 elements, *Partially Met* scores for one element, and *Not Met* scores for three elements. The findings suggest that **Anthem** developed the necessary policies, procedures, and plans to operationalize the required elements of its contract and 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 II, *Availability and Accessibility of Services* and Standard III, *Subcontracts and Delegation*. For Standard II, *Availability and Accessibility of Services*, the Geo Access Report from third quarter 2017 showed there were a total of six members within the MCO's service area where the closest PCP was 64.3 miles away. Having PCPs assigned to members greater than 25 miles from the member's place of residence is acceptable if the MCO receives a written request from the member to access a PCP greater than 25 miles from the member's residence. **Anthem** staff members confirmed that the MCO did not have written request from the members to obtain services from a PCP that was greater than 25 miles from each member's residence.

For Standard III, *Subcontracts and Delegation*, **Anthem** provided agreements for eight delegated subcontractors, but there was no evidence submitted during the desk review or after the onsite review, as requested, to support approval was obtained from the DHCFP prior to implementing the delegated subcontracts.

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. Table 4-3 presents the scores for the checklists. HSAG reviewed all requirements related to the provider manual 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 Review

Associated IQAP Standard #	Description of Checklist Review	# of Applicable Elements	# of Compliant Elements	Score (% of Compliant Elements)
V	Provider Manual	10	10	100%
	Checklist Totals	**10**	**10**	**100%**

Of the 10 elements reviewed for the checklist, **Anthem** received *Met* scores for all elements. The findings suggest that **Anthem** had strong compliance in each of the areas evaluated by the checklist and that **Anthem** developed the necessary manuals, handbooks, and policies according to contract requirements.

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)
I	Initial Credentialing	10	160	160	100%
I	Recredentialing	10	199	199	100%
III	Delegated Subcontractor	8	33	33	100%
	File Review Totals	**28**	**392**	**392**	**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. Of the 392 total elements reviewed for the file reviews, **Anthem** received *Met* scores for all 392 elements. These results suggest that **Anthem** followed the policies it developed to operationalize the required elements of its contract.

MCO-Specific Results—HPN

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 2017–2018. A total of 64 elements were reviewed but upon the review, two of the elements were determined to be not applicable (NA). One element determined to be not applicable applied to Standard I–*Credentialing and Recredentialing,* wherein **HPN** did not delegate credentialing activities. The second element that was not applicable was in Standard III –*Subcontracts and Delegation,* wherein **HPN** staff

members reported that **HPN** does not have physician incentive plans. 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. Detailed findings can be found in the report, *FY 2017–2018 IQAP On-Site Review of Compliance for HPN.*

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*	
I	Credentialing and Recredentialing	15	14	14	0	0	1	100%
II	Availability and Accessibility of Services	26	26	23	2	1	0	92.3%
III	Subcontracts and Delegation	13	12	12	0	0	1	100%
IV	Provider Dispute and Complaint Resolution	7	7	7	0	0	0	100%
V	Provider Information	3	3	3	0	0	0	100%
Total Compliance Score		**64**	**62**	**59**	**2**	**1**	**2**	**96.8%**

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 62 applicable elements, **HPN** received *Met* scores for 59 elements, *Partially Met* scores for two elements, and *Not Met* scores for one element. The findings suggest that **HPN** developed the necessary policies, procedures, and plans to operationalize the required elements of its contract and 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.

The area with the greatest opportunity for improvement within the IQAP standards was related to Standard II, *Availability and Accessibility of Services*. Specifically, the provider contract, member handbook, and **HPN** policy for access and availability contained different requirements for primary care provider (PCP) appointment availability. **HPN** must ensure that PCP appointment standards are consistent with the degree of urgency described in the MCO contract and that the correct standards are used to monitor provider compliance.

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. Table 4-6 presents the scores for the checklists. HSAG reviewed all requirements related to the Provider Manual 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)
V	Provider Manual	10	10	100%
	Checklist Totals	**10**	**10**	**100%**

Of the 10 elements reviewed for the checklist, **HPN** received *Met* scores for all 10 elements. The findings suggest that **HPN** had strong compliance in each of the areas evaluated by the checklist and that **HPN** developed the necessary manuals, handbooks, and policies according to contract requirements.

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)
I	Initial Credentialing	10	160	160	100%
I	Recredentialing	10	195	195	100%
III	Delegated Subcontractor	1	4	4	100%
	File Review Totals	**21**	**359**	**359**	**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. Of the 359 total elements reviewed for the file reviews, **HPN** received *Met* scores for all 359 elements. All the areas reviewed scored 100 percent. These results suggest that **HPN** followed the policies it developed to operationalize the required elements of its contract.

MCO-Specific Results—SilverSummit

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 **SilverSummit** results for the five IQAP standards evaluated for SFY 2017–2018. A total of 64 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. Detailed findings can be found in the report, *FY 2017–2018 IQAP On-Site Review of Compliance for SilverSummit.*

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*	
I	Credentialing and Recredentialing	15	15	15	0	0	0	100%
II	Availability and Accessibility of Services	26	26	25	1	0	0	98.1%
III	Subcontracts and Delegation	13	13	13	0	0	0	100%
IV	Provider Dispute and Complaint Resolution	7	7	7	0	0	0	100%
V	Provider Information	3	3	3	0	0	0	100%
Total Compliance Score		**64**	**64**	**63**	**1**	**0**	**0**	**99.2%**

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 64 applicable elements, **SilverSummit** received *Met* scores for 63 elements, *Partially Met* scores for one element, and *Not Met* scores for no elements. The findings suggest that **SilverSummit** developed the necessary policies, procedures, and plans to operationalize 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 related to Standard II, *Availability and Accessibility of Services*, and using Geo Access Reports to monitor the network, identify gaps in the network, and make the necessary adjustments needed to fill gaps in the network for specialty providers. Although **SilverSummit** staff members stated that they identified gaps in the network and were working to address those gaps, the Geo Access Reports still showed deficiencies in meeting the network availability requirements outlined in the contract. **SilverSummit** should monitor its network on a regular basis including the use of GeoAccess mapping and data-driven analyses to ensure compliance with access standards, and take appropriate corrective action, if necessary, to comply with such access standards.

Table 4-9 presents the scores for the checklists. HSAG reviewed all requirements related to the Provider Manual 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)
V	Provider Manual	10	10	100%
	Checklist Totals	**10**	**10**	**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 10 elements reviewed for the checklist, **SilverSummit** received *Met* scores for 10 elements. The findings suggest that **SilverSummit** had strong compliance in each of the areas evaluated by the checklist and that **SilverSummit** developed the necessary provider manual according to contract requirements.

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)
I	Initial Credentialing	10	159	159	100%
I	Recredentialing*	N/A	N/A	N/A	N/A
III	Delegated Subcontractor	5	24	24	100%
	File Review Totals	**15**	**183**	**183**	**100%**

* Recredentialing occurs every three years after initial credentialing. **SilverSummit** entered the Nevada market July 1, 2017; therefore, it had not been an MCO long enough for recredentialing to be applicable.

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. Of the 183 total elements reviewed for the file reviews, **SilverSummit** received *Met* scores for 183 elements. All the areas reviewed scored 100 percent. These results suggest that **SilverSummit** developed contractually compliant policies and procedures and that the MCO followed the policies it developed to operationalize the required elements of its contract.

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
I	Credentialing and Recredentialing	100%	100%	100%
II	Availability and Accessibility of Services	96.2%	92.3%	98.1%
III	Subcontracts and Delegation	80.08%	100%	100%
IV	Provider Dispute and Complaint Resolution	100%	100%	100%
V	Provider Information	100%	100%	100%
	Compliance Score	**94.5%**	**96.8%**	**99.2%**

Table 4-12—MCO Checklist Review

Associated IQAP Standard #	Description of Checklist	Anthem	HPN	SilverSummit
V	Provider Manual	100%	100%	100%
	Checklist Score	**100%**	**100%**	**100%**

Table 4-13—MCO File Review

Associated IQAP Standard #	Description of File Review	Anthem	HPN	SilverSummit
I	Initial Credentialing	100%	100%	100%
I	Recredentialing	100%	100%	NA*
III	Delegated Subcontractor	100%	100%	100%
	File Review Score	**100%**	**100%**	**100%**

* Recredentialing occurs every three years after initial credentialing. **SilverSummit** entered the Nevada market July 1, 2017; therefore, it had not been an MCO long enough for recredentialing to be applicable.

Table 4-14—MCO Composite Scores

	Anthem	HPN	SilverSummit
Composite Score for All Review Elements	**99.2%**	**99.5%**	**99.8%**

For the IQAP Standards Review, **Anthem** received a score of 94.5 percent, **HPN** a score of 96.8 percent, and **SilverSummit** a score of 99.2 percent. The scores showed the MCOs demonstrated a strong adherence to the standards and contract requirements.

All MCOs received 100 percent compliance for the provider manual checklist file review for IQAP Standard V. Likewise, **Anthem** and **HPN** each received a compliance score of 100 percent for *Initial Credentialing*, *Recredentialing*, and *Delegated Subcontractor* file reviews that apply to IQAP Standard I and III, respectively. **SilverSummit** received a 100 percent compliance score for *Initial Credentialing* and *Delegated Subcontractor*. These compliance results suggest that each MCO followed the policies it developed to operationalize the required elements of the MCO contract.

Overall Recommendations

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

- Ensure the DHCFP has approved all delegated agreements before implementation, and that they contain all applicable items and requirements as set forth in the DHCFP Managed Care Contract.
- Ensure the DHCFP has approved all delegated entities providing administrative services before implementation.
- By the service start date and whenever a change occurs, **Anthem** must submit to DHCFP for review and approval the names of any material subcontractors hired to perform any of the requirements of the contract and the names of their principals.

In response to the SFY 2017–2018 IQAP Compliance Review, **Anthem** submitted a corrective action plan to the DHCFP, which the DHCFP approved.

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

- Ensure that appointment availability standards for PCP appointments are consistent with the MCO contract and ensure that the standards communicated to providers and members are consistent with the degree of urgency described in the MCO contract.
- Ensure that the appointment standards used to monitor provider compliance are consistent with the degree of urgency described in the MCO contract.
- Assess MCO performance against contractually required standards.

In response to the SFY 2017–2018 IQAP Compliance Review, **HPN** submitted a corrective action plan to the DHCFP, which the DHCFP approved.

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

- The MCO should monitor its network on a regular basis, including the use of GeoAccess mapping and data-driven analyses to ensure compliance with access standards, and it should take appropriate corrective action, if necessary, to comply with such access standards.

In response to the SFY 2017–2018 IQAP Compliance Review, **SilverSummit** submitted a corrective action plan to the DHCFP, which the DHCFP approved.

5. Validation of Performance Measures—NCQA HEDIS Compliance Audit—SFY 2017–2018

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 2018 measures for the Medicaid and Nevada Check Up populations. HSAG evaluates MCO performance related to quality, access, and timeliness domains; therefore, check marks to indicate which population(s) and domain(s) are applicable to each measure have been added.

Table 5-1—Required HEDIS 2018 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	√	√	√		
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	√	√	√	√	

HEDIS Measures	Medicaid Population	Nevada Check-Up Population	Quality	Access	Timeliness
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)—Hemoglobin A1c (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 Emergency Department (ED) Visit for Alcohol and Other Drug (AOD) Abuse Dependence (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 and *30-Day Follow-Up*	√	√	√	√	√
Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up and *30-Day Follow-Up*	√	√	√	√	√
Follow-Up Care for Children Prescribed ADHD Medication (ADD)—Initiation Phase and *Continuation and Maintenance Phase*	√	√	√	√	√

HEDIS Measures	Medicaid Population	Nevada Check-Up Population	Quality	Access	Timeliness
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	√		√		

MCO-Specific Results—Anthem

Medicaid Results

The Medicaid HEDIS 2015, 2016, 2017, and 2018 rates for **Anthem** are presented in Table 5-2, along with HEDIS 2015 to HEDIS 2018 rate comparisons. Measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, a decrease in the rate from 2015 to 2018 represents performance improvement and an increase represents performance decline. Measures in the Utilization domain are designed to capture the frequency of services the MCO provides. Except for *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 5-2—Medicaid HEDIS Performance Measures Results for Anthem

HEDIS Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	HEDIS 2017 Rate	HEDIS 2018 Rate	2015–2018 Rate Comparison
Access to Care					
Adults' Access to Preventive/Ambulatory Health Services (AAP)					
Ages 20–44 Years	—	—	—	72.55%	NC
Ages 45–64 Years	—	—	—	79.38%	NC
Ages 65 Years and Older	—	—	—	77.55%	NC
Total	—	—	—	74.69%	NC
Children and Adolescents' Access to Primary Care Practitioners (CAP)					
Ages 12—24 Months	91.14%	94.15%	93.83%	94.89%	3.75
Ages 25 Months–6 Years	81.30%	83.55%	82.25%	83.97%	2.67
Ages 7–11 Years	85.60%	87.12%	86.59%	85.98%	0.38
Ages 12–19 Years	81.53%	83.76%	82.95%	83.53%	2.00
Children's Preventive Care					
Adolescent Well-Care Visits (AWC)					
Adolescent Well-Care Visits	42.13%	38.43%	47.69%	51.09%	8.96
Childhood Immunization Status (CIS)					
Combination 2	66.20%	73.15%	72.92%	70.07%	3.87
Combination 3	60.88%	66.67%	67.13%	65.94%	5.06
Combination 4	58.80%	65.28%	66.67%	65.21%	6.41
Combination 5	50.23%	57.18%	56.71%	55.23%	5.00
Combination 6	33.33%	32.41%	36.11%	33.09%	-0.24
Combination 7	48.38%	56.48%	56.25%	54.74%	6.36
Combination 8	33.10%	32.41%	36.11%	32.85%	-0.25
Combination 9	28.24%	29.63%	32.18%	28.47%	0.23
Combination 10	28.01%	29.63%	32.18%	28.22%	0.21
Immunizations for Adolescents (IMA)					
Combination 1 (Meningococcal, Tdap)	—	71.93%	79.40%	84.67%	NC
Combination 2 (Meningococcal, Tdap, HPV)[1]	—	—	—	40.63%	NC

HEDIS Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	HEDIS 2017 Rate	HEDIS 2018 Rate	2015–2018 Rate Comparison
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)					
BMI Percentile—Total	—	64.12%	70.14%	77.37%	NC
Counseling for Nutrition—Total	—	54.40%	62.73%	71.29%	NC
Counseling for Physical Activity—Total[2]	—	43.75%	56.48%	67.64%	NC
Well-Child Visits in the First 15 Months of Life (W15)					
Six or More Well-Child Visits	50.58%	52.78%	62.50%	68.04%	17.46
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	65.66%	66.33%	68.72%	73.24%	7.58
Women's Health and Maternity Care					
Breast Cancer Screening (BCS)[1]					
Breast Cancer Screening	—	—	—	50.64%	NC
Prenatal and Postpartum Care (PPC)					
Timeliness of Prenatal Care	69.77%	75.41%	83.33%	80.15%	10.38
Postpartum Care	46.74%	53.16%	62.50%	62.11%	15.37
Care for Chronic Conditions					
Comprehensive Diabetes Care (CDC)[2]					
HbA1c Testing	81.90%	79.63%	81.02%	82.48%	0.58
*HbA1c Poor Control (>9.0%)**	46.40%	46.76%	46.30%	41.61%	-4.79
HbA1c Control (<8.0%)	43.16%	46.30%	45.60%	50.12%	6.96
Eye Exam (Retinal) Performed	55.45%	55.09%	59.49%	53.28%	-2.17
Medical Attention for Nephropathy	75.17%	89.58%	90.28%	90.27%	15.10
Blood Pressure Control (<140/90 mm Hg)	62.18%	55.32%	61.11%	54.26%	-7.92
Controlling High Blood Pressure (CBP)					
Controlling High Blood Pressure	—	—	—	47.45%	NC
Medication Management for People With Asthma (MMA)					
Medication Compliance 50%—Total	—	50.22%	56.19%	55.71%	NC
Medication Compliance 75%—Total	—	26.84%	32.16%	32.70%	NC

HEDIS Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	HEDIS 2017 Rate	HEDIS 2018 Rate	2015–2018 Rate Comparison
Behavioral Health					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	—	—	—	38.05%	NC
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	—	—	81.46%	NC
Follow-Up After ED Visit for AOD Abuse or Dependence (FUA)					
7-Day Follow-Up—Total	—	—	—	7.22%	NC
30-Day Follow-Up—Total	—	—	—	10.92%	NC
Follow-Up After ED Visit for Mental Illness (FUM)					
7-Day Follow-Up	—	—	—	27.87%	NC
30-Day Follow-Up	—	—	—	40.80%	NC
Follow-Up After Hospitalization for Mental Illness (FUH)[1]					
7-Day Follow-Up	—	—	—	40.13%	NC
30-Day Follow-Up	—	—	—	56.26%	NC
Follow-Up Care for Children Prescribed ADHD Medication (ADD)					
Initiation Phase	—	36.68%	43.51%	39.66%	NC
Continuation and Maintenance Phase	—	40.91%	64.91%	61.02%	NC
Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)					
Initiation of AOD Treatment—Total	—	—	—	42.83%	NC
Engagement of AOD Treatment—Total	—	—	—	12.72%	NC
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)					
Total	—	—	—	21.03%	NC
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)[2]					
*Total**	—	0.00%	3.74%	1.42%	NC

HEDIS Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	HEDIS 2017 Rate	HEDIS 2018 Rate	2015–2018 Rate Comparison
Utilization					
Ambulatory Care (per 1,000 Member Months) (AMB)					
*ED Visits—Total**	53.27	55.08	54.02	56.58	3.31
Outpatient Visits—Total	286.25	294.01	287.09	287.88	1.63
Mental Health Utilization—Total (MPT)					
Inpatient—Total	0.42%	1.18%	1.16%	0.76%	0.34
Intensive Outpatient or Partial Hospitalization—Total	0.13%	0.28%	0.24%	0.07%	-0.06
Outpatient—Total[1]	—	—	—	9.10%	NC
ED—Total[1]	—	—	—	0.18%	NC
Telehealth—Total[1]	—	—	—	0.00%	NC
Any Service—Total	5.79%	7.21%	8.63%	9.94%	4.15
Overuse/Appropriateness of Care					
Use of Opioids at High Dosage (per 1,000 Members) (UOD)					
*Use of Opioids at High Dosage**	—	—	—	68.87	NC
Use of Opioids From Multiple Providers (per 1,000 Members) (UOP)*					
Multiple Prescribers	—	—	—	240.26	NC
Multiple Pharmacies	—	—	—	36.01	NC
Multiple Prescribers and Multiple Pharmacies	—	—	—	26.23	NC

[1] Due to significant changes in the HEDIS 2018 technical specifications for this measure, comparison to prior rates is not appropriate; therefore, historical rates are not displayed in this report.
[2] Due to changes in the technical specifications for this measure, exercise caution when comparing rates between HEDIS 2015, 2016, 2017, and 2018.
* 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 technical specification changes.
NC indicates the 2015–2018 Rate Comparison could not be calculated because data are not available for both years or because an increase or decrease in the rate does not necessarily indicate better or worse performance.

Within the Access to Care domain, **Anthem** met three of four QISMC goals (detailed in Appendix B) for the *Children and Adolescents' Access to Primary Care Practitioners* measure for HEDIS 2018, with the rates for all indicators staying within 2 percentage points from HEDIS 2017 to HEDIS 2018.

Within the Children's Preventive Care domain, **Anthem**'s rate for the *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* measure increased from HEDIS 2016 to HEDIS 2018,

demonstrating a strength. Conversely, the *Childhood Immunization Status* measure rates for all combinations demonstrated a decline in performance from HEDIS 2017 to HEDIS 2018.

Along with demonstrating notable increases in performance (i.e., increases of more than 5 percentage points) from HEDIS 2015 to HEDIS 2018 for the *Adolescent Well-Care Visits*, *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*, and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* measures, these rates met all three of **Anthem**'s corresponding QISMC goals for 2018. The most notable increase was for the *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* measure indicator, in which the rate increased by 17.46 percentage points. Additionally, the rates for *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total* increased from HEDIS 2016 to HEDIS 2018 by 13.25, 16.89, and 23.89 percentage points, respectively.

Within the Women's Health and Maternity Care domain, the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and the *Postpartum Care* measure rates demonstrated notable increases in performance from HEDIS 2015 to HEDIS 2018, with *Postpartum Care* increasing by 15.37 percentage points. Additionally, **Anthem** met the QISMC goal for both *Prenatal and Postpartum Care* indicators for 2017 and 2018.

For the Care for Chronic Conditions domain, the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* indicator demonstrated a notable decline in performance from HEDIS 2015 to HEDIS 2018, with a decrease of 7.92 percentage points. Additionally, the HEDIS 2018 rates for *Medication Management for People With Asthma* demonstrated improvement from HEDIS 2016, with increases of approximately 5 percentage points for each indicator. **Anthem** demonstrated improved performance within this domain for 2018, meeting the QISMC goals for four of eight rates in 2018 compared to only two of eight rates in 2017.

Anthem demonstrated a strength within the Behavioral Health domain with *Use of Multiple Concurrent Antipsychotics in Children and Adolescents,* having a relative rate difference of more than 60 percent from HEDIS 2017 to HEDIS 2018. Conversely, although the HEDIS 2018 measure rates for *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Continuation and Maintenance Phase* have increased from HEDIS 2016, **Anthem**'s rates experienced declines of approximately 4 percentage points for each indicator from HEDIS 2017 to HEDIS 2018. Additionally, **Anthem** only met the QISMC goal for the *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* measure indicator in 2018, whereas they met the QISMC goal for both *Follow-Up Care for Children Prescribed ADHD Medication* measure indicators in 2017.

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.

Measures within the Overuse/Appropriateness of Care domain are new for HEDIS 2018; therefore, these rates should be monitored and improvement efforts should focus on reducing the prevalence of these prescriptions.

Nevada Check Up Results

The Nevada Check Up HEDIS 2015, 2016, 2017, and 2018 rates for **Anthem** are presented in Table 5-3, along with HEDIS 2015 to HEDIS 2018 rate comparisons. Measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, a decrease in the rate from 2015 to 2018 represents performance improvement and an increase represents performance decline. Measures in the Utilization domain are designed to capture the frequency of services the MCO provides. Except for *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 5-3—Nevada Check Up HEDIS Performance Measures Results for Anthem

HEDIS Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	HEDIS 2017 Rate	HEDIS 2018 Rate	2015–2018 Rate Comparison
Access to Care					
Children and Adolescents' Access to Primary Care Practitioners (CAP)					
Ages 12—24 Months	95.83%	98.73%	98.18%	99.12%	3.29
Ages 25 Months–6 Years	90.48%	89.53%	89.45%	91.10%	0.62
Ages 7–11 Years	92.62%	92.91%	91.83%	93.08%	0.46
Ages 12–19 Years	92.18%	88.95%	91.08%	90.11%	-2.07
Children's Preventive Care					
Adolescent Well-Care Visits (AWC)					
Adolescent Well-Care Visits	56.48%	56.34%	60.88%	65.82%	9.34
Childhood Immunization Status (CIS)					
Combination 2	74.55%	85.90%	91.16%	90.24%	15.69
Combination 3	73.64%	78.21%	82.87%	81.71%	8.07
Combination 4	73.64%	77.56%	81.22%	81.71%	8.07
Combination 5	54.55%	68.59%	72.93%	75.61%	21.06
Combination 6	45.45%	46.79%	47.51%	38.21%	-7.24
Combination 7	54.55%	67.95%	72.38%	75.61%	21.06
Combination 8	45.45%	46.79%	47.51%	38.21%	-7.24
Combination 9	32.73%	42.95%	44.75%	36.18%	3.45
Combination 10	32.73%	42.95%	44.75%	36.18%	3.45

HEDIS Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	HEDIS 2017 Rate	HEDIS 2018 Rate	2015–2018 Rate Comparison
Immunizations for Adolescents (IMA)					
Combination 1 (Meningococcal, Tdap)	—	81.61%	83.61%	90.37%	NC
Combination 2 (Meningococcal, Tdap, HPV)[1]	—	—	—	54.96%	NC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)					
BMI Percentile—Total	—	62.04%	71.30%	84.67%	NC
Counseling for Nutrition—Total	—	55.56%	65.28%	73.48%	NC
Counseling for Physical Activity—Total[2]	—	47.69%	59.72%	70.80%	NC
Well-Child Visits in the First 15 Months of Life (W15)					
Six or More Well-Child Visits	70.37%	78.05%	78.92%	83.24%	12.87
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	71.30%	70.28%	76.16%	77.37%	6.07
Care for Chronic Conditions					
Medication Management for People With Asthma (MMA)					
Medication Compliance 50%—Total	—	47.76%	58.43%	54.84%	NC
Medication Compliance 75%—Total	—	26.87%	24.72%	30.11%	NC
Behavioral Health					
Follow-Up After ED Visit for Mental Illness (FUM)					
7-Day Follow-Up	—	—	—	NA	NC
30-Day Follow-Up	—	—	—	NA	NC
Follow-Up After Hospitalization for Mental Illness (FUH)[1]					
7-Day Follow-Up	—	—	—	50.00%	NC
30-Day Follow-Up	—	—	—	65.79%	NC
Follow-Up Care for Children Prescribed ADHD Medication (ADD)					
Initiation Phase	—	NA	41.67%	44.12%	NC
Continuation and Maintenance Phase	—	NA	NA	NA	NC
Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)					
Initiation of AOD Treatment—Total	—	—	—	NA	NC
Engagement of AOD Treatment—Total	—	—	—	NA	NC

HEDIS Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	HEDIS 2017 Rate	HEDIS 2018 Rate	2015–2018 Rate Comparison
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)					
Total	—	—	—	NA	NC
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)					
*Total**	—	NA	NA	NA	NC
Utilization					
Ambulatory Care (per 1,000 Member Months) (AMB)					
*ED Visits—Total**	23.94	26.14	26.30	27.04	3.10
Outpatient Visits—Total	268.54	263.50	258.30	248.86	-19.68
Mental Health Utilization—Total (MPT)					
Inpatient—Total	0.33%	0.46%	0.42%	0.27%	-0.06
Intensive Outpatient or Partial Hospitalization—Total	0.18%	0.32%	0.16%	0.08%	-0.10
Outpatient—Total[1]	—	—	—	6.78%	NC
ED—Total[1]	—	—	—	0.01%	NC
Telehealth—Total[1]	—	—	—	0.00%	NC
Any Service—Total	4.31%	5.76%	5.68%	7.11%	2.80

[1] Due to significant changes in the HEDIS 2018 technical specifications for this measure, comparison to prior rates is not appropriate; therefore, historical rates are not displayed in this report.
[2] Due to changes in the technical specifications for this measure, exercise caution when comparing rates between HEDIS 2015, 2016, 2017, and 2018.
* 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 technical specification changes.
NC indicates the 2015–2018 Rate Comparison could not be calculated because data are not available for both years or because an increase or decrease in the rate does not necessarily indicate better or worse performance.
NA indicates the denominator for this measure is too small to report (less than 30).

Within the Access to Care domain, **Anthem**'s rates for all *Children and Adolescents' Access to Primary Care Practitioners* indicators, except *Ages 12–19 Years*, demonstrated positive performance from HEDIS 2015 to HEDIS 2018; however, **Anthem** continued to meet only one of four QISMC goals in 2018.

Anthem demonstrated a notable increase in performance (i.e., an increase of more than 5 percentage points) from HEDIS 2015 to HEDIS 2018 for several measure rates, including: *Adolescent Well-Care Visits*; *Childhood Immunization Status—Combinations 2*, *3*, *4*, *5*, and *7*; *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*. The most notable increases were for the *Childhood Immunization Status—*

Combinations 5 and *7* measure indicators. Both rates increased by 21.06 percentage points, driven by an increase in rotavirus immunizations. Conversely, the *Childhood Immunization Status—Combinations 6* and *8* indicators demonstrated a decline in performance from HEDIS 2015 to HEDIS 2018. Both rates decreased by 7.24 percentage points, primarily driven by a decline in flu vaccination rates. Of note, **Anthem** met 12 of 16 QISMC goals for this domain in 2018, whereas it met 14 of 16 QISMC goals in 2017.

The *Medication Management for People With Asthma* measure rates demonstrated improvement in performance from HEDIS 2016 within the Care for Chronic Conditions domain. Additionally, **Anthem** continued to meet the QISMC goal for the *Medication Compliance 50%—Total* indicator in 2018.

Of the reportable rates within the Behavioral Health domain, **Anthem**'s rate for the *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* increased from HEDIS 2017; however, **Anthem** did not meet its QISMC goal for this measure in 2018.

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 measure indicators were identified as strengths for **Anthem** based on rate increases of at least 5 percentage points from prior years and meeting QISMC goals for HEDIS 2018:

- *Adolescent Well-Care Visits*
- *Childhood Immunization Status—Combinations 3*, *4*, *5*, and *7*
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, and *Medical Attention for Nephropathy*
- *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*
- *Medication Management for People With Asthma—Medication Compliance 50%—Total*
- *Prenatal and Postpartum Care*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
- *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

The following Nevada Check Up performance measure indicators were identified as strengths for **Anthem** based on rate increases of at least 5 percentage points from prior years and meeting QISMC goals for HEDIS 2018:

- *Adolescent Well-Care Visits*
- *Childhood Immunization Status—Combinations 2, 3*, *4*, *5*, and *7*

- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*
- *Medication Management for People With Asthma—Medication Compliance 50%—Total*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
- *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

Summary of Anthem Opportunities for Improvement

The following Medicaid performance measure indicators were identified as opportunities for improvement for **Anthem** based on rate declines greater than 5 percentage points and not meeting QISMC goals for HEDIS 2018:

- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*[5-1]

Several Nevada Check Up immunization combination indicators were identified as opportunities for improvement for **Anthem** based on rate declines greater than 5 percentage points from prior years and not meeting QISMC goals in HEDIS 2018:

- *Childhood Immunization Status—Combinations 6*, *8*, *9*, and *10*

MCO-Specific Results—HPN

Medicaid Results

The Medicaid HEDIS 2015, 2016, 2017, and 2018 rates for **HPN** are presented in Table 5-4, along with HEDIS 2015 to HEDIS 2018 rate comparisons. Measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, a decrease in the rate from 2015 to 2018 represents performance improvement and an increase represents performance decline. Measures in the Utilization domain are designed to capture the frequency of services the MCO provides. Except for *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.

[5-1] Due to changes in NCQA's HEDIS 2016 technical specifications for this measure, exercise caution when comparing HEDIS 2015 to HEDIS 2016, 2017, and 2018 rates.

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

HEDIS Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	HEDIS 2017 Rate	HEDIS 2018 Rate	2015–2018 Rate Comparison
Access to Care					
Adults' Access to Preventive/Ambulatory Health Services (AAP)					
Ages 20–44 Years	—	—	—	73.01%	NC
Ages 45–64 Years	—	—	—	80.02%	NC
Ages 65 Years and Older	—	—	—	60.53%	NC
Total	—	—	—	75.50%	NC
Children and Adolescents' Access to Primary Care Practitioners (CAP)					
Ages 12—24 Months	91.42%	94.80%	95.17%	93.95%	2.53
Ages 25 Months–6 Years	79.24%	84.29%	83.81%	84.16%	4.92
Ages 7–11 Years	83.93%	87.36%	87.57%	86.59%	2.66
Ages 12–19 Years	80.80%	85.21%	85.51%	84.58%	3.78
Children's Preventive Care					
Adolescent Well-Care Visits (AWC)					
Adolescent Well-Care Visits	37.47%	44.04%	44.77%	46.72%	9.25
Childhood Immunization Status (CIS)					
Combination 2	70.80%	74.94%	73.72%	71.05%	0.25
Combination 3	66.18%	70.32%	71.05%	64.96%	-1.22
Combination 4	66.18%	70.07%	71.05%	64.72%	-1.46
Combination 5	53.04%	55.72%	61.07%	54.74%	1.70
Combination 6	39.42%	38.44%	34.79%	30.66%	-8.76
Combination 7	53.04%	55.72%	61.07%	54.50%	1.46
Combination 8	39.42%	38.44%	34.79%	30.66%	-8.76
Combination 9	32.36%	31.14%	30.41%	26.03%	-6.33
Combination 10	32.36%	31.14%	30.41%	26.03%	-6.33
Immunizations for Adolescents (IMA)					
Combination 1 (Meningococcal, Tdap)	—	79.81%	80.78%	82.24%	NC
Combination 2 (Meningococcal, Tdap, HPV)[1]	—	—	—	42.58%	NC

HEDIS Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	HEDIS 2017 Rate	HEDIS 2018 Rate	2015–2018 Rate Comparison
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)					
BMI Percentile—Total	—	70.32%	71.78%	83.21%	NC
Counseling for Nutrition—Total	—	57.91%	62.29%	68.37%	NC
Counseling for Physical Activity—Total[2]	—	52.07%	59.61%	65.21%	NC
Well-Child Visits in the First 15 Months of Life (W15)					
Six or More Well-Child Visits	51.58%	53.77%	62.77%	61.31%	9.73
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	60.83%	64.48%	65.21%	70.07%	9.24
Women's Health and Maternity Care					
Breast Cancer Screening (BCS)[1]					
Breast Cancer Screening	—	—	—	56.04%	NC
Prenatal and Postpartum Care (PPC)					
Timeliness of Prenatal Care	77.62%	73.97%	72.75%	71.29%	-6.33
Postpartum Care	58.88%	57.18%	59.12%	59.12%	0.24
Care for Chronic Conditions					
Comprehensive Diabetes Care (CDC)[2]					
HbA1c Testing	84.18%	85.64%	82.73%	78.59%	-5.59
*HbA1c Poor Control (>9.0%)**	44.53%	45.74%	42.82%	44.77%	0.24
HbA1c Control (<8.0%)	43.80%	46.47%	48.42%	46.72%	2.92
Eye Exam (Retinal) Performed	55.96%	56.93%	61.31%	59.37%	3.41
Medical Attention for Nephropathy	82.73%	92.21%	90.75%	87.35%	4.62
Blood Pressure Control (<140/90 mm Hg)	70.32%	60.83%	50.36%	66.18%	-4.14
Controlling High Blood Pressure (CBP)					
Controlling High Blood Pressure	—	—	—	52.55%	NC
Medication Management for People With Asthma (MMA)					
Medication Compliance 50%—Total	—	46.96%	53.37%	57.39%	NC
Medication Compliance 75%—Total	—	24.14%	32.81%	35.33%	NC

HEDIS Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	HEDIS 2017 Rate	HEDIS 2018 Rate	2015–2018 Rate Comparison
Behavioral Health					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	—	—	—	41.59%	NC
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	—	—	77.99%	NC
Follow-Up After ED Visit for AOD Abuse or Dependence (FUA)					
7-Day Follow-Up—Total	—	—	—	10.46%	NC
30-Day Follow-Up—Total	—	—	—	14.29%	NC
Follow-Up After ED Visit for Mental Illness (FUM)					
7-Day Follow-Up	—	—	—	50.45%	NC
30-Day Follow-Up	—	—	—	57.30%	NC
Follow-Up After Hospitalization for Mental Illness (FUH)[1]					
7-Day Follow-Up	—	—	—	25.04%	NC
30-Day Follow-Up	—	—	—	43.18%	NC
Follow-Up Care for Children Prescribed ADHD Medication (ADD)					
Initiation Phase	—	46.65%	43.68%	48.28%	NC
Continuation and Maintenance Phase	—	58.02%	49.28%	51.76%	NC
Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)					
Initiation of AOD Treatment—Total	—	—	—	36.51%	NC
Engagement of AOD Treatment—Total	—	—	—	7.91%	NC
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)					
Total	—	—	—	13.13%	NC
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)[2]					
*Total**	—	1.80%	2.26%	5.29%	NC

HEDIS Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	HEDIS 2017 Rate	HEDIS 2018 Rate	2015–2018 Rate Comparison
Utilization					
Ambulatory Care (per 1,000 Member Months) (AMB)					
*ED Visits—Total**	45.67	49.39	52.60	55.15	9.48
Outpatient Visits—Total	275.76	292.44	298.12	299.51	23.75
Mental Health Utilization—Total (MPT)					
Inpatient—Total	0.27%	0.77%	0.78%	0.23%	-0.04
Intensive Outpatient or Partial Hospitalization—Total	0.16%	0.23%	0.30%	0.03%	-0.13
Outpatient—Total[1]	—	—	—	7.25%	NC
ED—Total[1]	—	—	—	0.02%	NC
Telehealth—Total[1]	—	—	—	0.00%	NC
Any Service—Total	4.66%	5.90%	6.80%	7.42%	2.76
Overuse/Appropriateness of Care					
Use of Opioids at High Dosage (per 1,000 Members) (UOD)					
*Use of Opioids at High Dosage**	—	—	—	74.31	NC
Use of Opioids From Multiple Providers (per 1,000 Members) (UOP)*					
Multiple Prescribers	—	—	—	342.62	NC
Multiple Pharmacies	—	—	—	70.89	NC
Multiple Prescribers and Multiple Pharmacies	—	—	—	47.87	NC

[1] Due to significant changes in the HEDIS 2018 technical specifications for this measure, comparison to prior rates is not appropriate; therefore, historical rates are not displayed in this report.
[2] Due to changes in the technical specifications for this measure, exercise caution when comparing rates between HEDIS 2015, 2016, 2017, and 2018.
* 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 technical specification changes.
NC indicates the 2015–2018 Rate Comparison could not be calculated because data are not available for both years or because an increase or decrease in the rate does not necessarily indicate better or worse performance.

Within the Access to Care domain, **HPN** demonstrated disparate performance between the age indicators for the *Adults' Access to Preventive/Ambulatory Health Services* measure, with almost a 20 percentage-point difference between the *Ages 65 Years and Older* indicator and the *Ages 45–64 Years* indicator. HPN met the QISMC goals for the four *Children and Adolescents' Access to Primary Care Practitioners* measure indicators in 2018.

For the Children's Preventive Care domain, **HPN**'s rate for the *Immunization for Adolescents—Combination 1 (Meningococcal, Tdap)* measure increased from HEDIS 2016 to HEDIS 2018. Conversely, the *Childhood Immunization Status* measure rates demonstrated a decline in performance from HEDIS 2017 to HEDIS 2018, driven by the declines in every immunization indicator. Additionally, the health plan did not meet the QISMC goal in 2018 for any of the childhood immunization rates despite meeting the goal for five indicators in 2017.

Along with demonstrating notable increases in performance (i.e., increase of more than 5 percentage points) from HEDIS 2015 to HEDIS 2018 for the measures *Adolescent Well-Care Visits*, *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*, and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*, the rates for these measures met all three of **HPN**'s corresponding QISMC goals for both 2017 and 2018. The most notable increases from HEDIS 2015 to HEDIS 2018 were for the *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* and *Adolescent Well-Care Visits* measure indicators, where rates increased by 9.73 and 9.25 percentage points, respectively. Additionally, the rates for *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total* increased from HEDIS 2016 to HEDIS 2018 by 12.89, 10.46, and 13.14 percentage points, respectively.

HPN's performance within the Women's Health and Maternity Care domain demonstrated opportunities for improvement, with the rate for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure demonstrating a notable decline of 6.33 percentage points from HEDIS 2015 to HEDIS 2018. Additionally, **HPN** did not meet any of the QISMC goals for this domain.

Within the Care for Chronic Conditions domain, the measure rates for all *Comprehensive Diabetes Care* measure indicators, except for the *Blood Pressure Control (<140/90 mmHg)* indicator, demonstrated a decline in performance from HEDIS 2017 to HEDIS 2018, suggesting opportunities for improvement. The *Blood Pressure Control (<140/90 mmHg)* rate increased by approximately 16 percentage points from HEDIS 2017 to HEDIS 2018, demonstrating a strength for **HPN**. Additionally, the rates for the *Medication Management for People With Asthma* measure demonstrated improvement from HEDIS 2016 to HEDIS 2018. **HPN** met three of eight QISMC goals in 2018 compared to meeting four of eight QISMC goals in 2017.

Within the Behavioral Health domain, **HPN**'s rates for *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and for *Continuation and Maintenance Phase* demonstrated improvement from HEDIS 2017 to HEDIS 2018, with rate increases of 4.60 and 2.48 percentage points, respectively. However, **HPN**'s HEDIS 2018 rate for the *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* is still 6.26 percentage points below its HEDIS 2016 rate, demonstrating that opportunities for improvement exist for this measure. Additionally, **HPN**'s performance for the *Use of Multiple Concurrent Antipsychotics in Children and Adolescents* was poor, with a relative performance decline of more than 190 percent from HEDIS 2016, suggesting improvement efforts should focus on the use of antipsychotics in children. Additionally, **HPN** did not meet any of the QISMC goals for this domain.

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.

Measures within the Overuse/Appropriateness of Care domain are new for HEDIS 2018; therefore, these rates should be monitored and improvement efforts should focus on reducing the prevalence of these prescriptions.

Nevada Check Up Results

The Nevada Check Up HEDIS 2015, 2016, 2017, and 2018 rates for **HPN** are presented in Table 5-5, along with HEDIS 2015 to HEDIS 2018 rate comparisons. Measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, a decrease in the rate from 2015 to 2018 represents performance improvement and an increase represents performance decline. Measures in the Utilization domain are designed to capture the frequency of services the MCO provides. With the exception of *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 Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	HEDIS 2017 Rate	HEDIS 2018 Rate	2015–2018 Rate Comparison
Access to Care					
Children and Adolescents' Access to Primary Care Practitioners (CAP)					
Ages 12—24 Months	94.70%	99.48%	98.50%	96.33%	1.63
Ages 25 Months–6 Years	87.20%	89.55%	89.61%	88.12%	0.92
Ages 7–11 Years	93.83%	93.54%	92.98%	92.25%	-1.58
Ages 12–19 Years	90.79%	90.78%	91.29%	90.61%	-0.18
Children's Preventive Care					
Adolescent Well-Care Visits (AWC)					
Adolescent Well-Care Visits	55.47%	52.83%	54.74%	59.61%	4.14
Childhood Immunization Status (CIS)					
Combination 2	83.46%	87.93%	84.38%	85.91%	2.45
Combination 3	77.17%	84.48%	82.14%	81.54%	4.37
Combination 4	76.38%	83.91%	82.14%	81.54%	5.16
Combination 5	66.14%	79.89%	71.88%	74.16%	8.02
Combination 6	48.03%	52.30%	41.52%	44.30%	-3.73

HEDIS Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	HEDIS 2017 Rate	HEDIS 2018 Rate	2015–2018 Rate Comparison
Combination 7	65.35%	79.31%	71.88%	74.16%	8.81
Combination 8	47.24%	51.72%	41.52%	44.30%	-2.94
Combination 9	42.52%	50.00%	37.50%	40.94%	-1.58
Combination 10	41.73%	49.43%	37.50%	40.94%	-0.79
Immunizations for Adolescents (IMA)					
Combination 1 (Meningococcal, Tdap)	—	87.35%	87.59%	86.62%	NC
Combination 2 (Meningococcal, Tdap, HPV)[1]	—	—	—	51.82%	NC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)					
BMI Percentile—Total	—	72.02%	73.24%	83.70%	NC
Counseling for Nutrition—Total	—	60.34%	61.07%	73.48%	NC
Counseling for Physical Activity—Total[2]	—	57.18%	58.39%	69.59%	NC
Well-Child Visits in the First 15 Months of Life (W15)					
Six or More Well-Child Visits	60.00%	68.00%	63.49%	68.33%	8.33
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	71.95%	70.13%	67.64%	73.48%	1.53
Care for Chronic Conditions					
Medication Management for People With Asthma (MMA)					
Medication Compliance 50%—Total	—	47.62%	51.02%	53.65%	NC
Medication Compliance 75%—Total	—	26.98%	27.89%	34.90%	NC
Behavioral Health					
Follow-Up After ED Visit for Mental Illness (FUM)					
7-Day Follow-Up	—	—	—	82.98%	NC
30-Day Follow-Up	—	—	—	85.11%	NC
Follow-Up After Hospitalization for Mental Illness (FUH)[1]					
7-Day Follow-Up	—	—	—	68.57%	NC
30-Day Follow-Up	—	—	—	80.00%	NC
Follow-Up Care for Children Prescribed ADHD Medication (ADD)					
Initiation Phase	—	39.53%	48.89%	55.36%	NC

HEDIS Measures	HEDIS 2015 Rate	HEDIS 2016 Rate	HEDIS 2017 Rate	HEDIS 2018 Rate	2015–2018 Rate Comparison
Continuation and Maintenance Phase	—	NA	NA	NA	NC
Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)					
Initiation of AOD Treatment—Total	—	—	—	25.64%	NC
Engagement of AOD Treatment—Total	—	—	—	7.69%	NC
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)					
Total	—	—	—	16.67%	NC
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)					
*Total**	—	NA	NA	NA	NC
Utilization					
Ambulatory Care (per 1,000 Member Months) (AMB)					
*ED Visits—Total**	18.83	21.00	22.11	23.87	5.04
Outpatient Visits—Total	259.27	259.29	252.28	248.74	-10.53
Mental Health Utilization—Total (MPT)					
Inpatient—Total	0.19%	0.14%	0.22%	0.01%	-0.18
Intensive Outpatient or Partial Hospitalization—Total	0.50%	0.55%	0.77%	0.04%	-0.46
Outpatient—Total[1]	—	—	—	5.46%	NC
ED—Total[1]	—	—	—	0.01%	NC
Telehealth—Total[1]	—	—	—	0.00%	NC
Any Service—Total	3.87%	4.71%	5.19%	5.48%	1.61

[1] Due to significant changes in the HEDIS 2018 technical specifications for this measure, comparison to prior rates is not appropriate; therefore, historical rates are not displayed in this report.
[2] Due to changes in the technical specifications for this measure, exercise caution when comparing rates between HEDIS 2015, 2016, 2017, and 2018.
* 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 technical specification changes.
NC indicates the 2015–2018 Rate Comparison could not be calculated because data are not available for both years or because an increase or decrease in the rate does not necessarily indicate better or worse performance.
NA indicates the denominator for this measure is too small to report (less than 30).

HPN's rates for all four *Children and Adolescents' Access to Primary Care Practitioners* indicators declined from HEDIS 2017 to HEDIS 2018 and only met the QISMC goal for one rate in 2018, compared to two rates in 2017.

For the Children's Preventive Care domain, **HPN** demonstrated a notable increase in performance (i.e., increase of more than 5 percentage points) from HEDIS 2015 to HEDIS 2018 for several measure rates, including: *Childhood Immunization Status—Combinations 4*, *5*, and *7*; and *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*. Despite the notable increase for *Childhood Immunization Status—Combinations 4*, *5*, and *7* from HEDIS 2015 to HEDIS 2018, **HPN** should continue to monitor these rates because HEDIS 2018 performance on these indicators is still well below the HEDIS 2016 performance levels. Of note, **HPN** met nine of 16 QISMC goals for this domain in 2018, compared to four of 16 QISMC goals in 2017.

Within the Care for Chronic Conditions domain, the rates for the *Medication Management for People With Asthma* measure indicators demonstrated improvement from HEDIS 2016 to HEDIS 2018. **HPN** met both QISMC goals in 2018, whereas it did not meet either QISMC goal in 2017.

HPN demonstrated a strength within the Behavioral Health domain with a rate increase of 15.83 percentage points from HEDIS 2016 to HEDIS 2018 for the *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* indicator, continuing to meet the QISMC goal in 2018.

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 measure indicators were identified as strengths for **HPN** based on a rate increase of at least 5 percentage points from prior years and meeting QISMC goals for HEDIS 2018:

- *Adolescent Well-Care Visits*
- *Medication Management for People With Asthma*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
- *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

The following Nevada Check Up performance measure indicators were identified as strengths for **HPN** based on a rate increase of at least 5 percentage points from prior years and meeting QISMC goals for HEDIS 2018:

- *Childhood Immunization Status—Combinations 4*, *5*, and *7*
- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*
- *Medication Management for People With Asthma*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
- *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*

Summary of HPN Opportunities for Improvement

The following Medicaid performance measure indicators 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 QISMC goals for HEDIS 2018:

- *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*

The following Nevada Check Up performance measure indicators 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 QISMC goals for HEDIS 2018:

- *Childhood Immunization Status—Combinations 6*, *8*, *9*, and *10*

MCO Comparison

The HEDIS 2018 measure rates for **HPN**, **Anthem**, and the statewide weighted average results for the Medicaid and Nevada Check Up populations are shown in Table 5-6 and Table 5-7.

Medicaid Findings

Table 5-6 shows, by MCO, the HEDIS 2018 Medicaid performance measure rate results for **Anthem** and **HPN** and the Medicaid aggregate, which represents the average of both MCOs' measure rates weighted by the eligible population. 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. Except for 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—HEDIS 2018 Results for Medicaid

HEDIS Measure	Anthem	HPN	Medicaid
Access to Care			
Adults' Access to Preventive/Ambulatory Health Services (AAP)			
Ages 20–44 Years	72.55%	73.01%	72.83%
Ages 45–64 Years	79.38%	80.02%	79.80%
Ages 65 Years and Older	77.55%	60.53%	63.54%

HEDIS Measure	Anthem	HPN	Medicaid
Total	74.69%	75.50%	75.19%
Children and Adolescents' Access to Primary Care Practitioners (CAP)			
Ages 12—24 Months	94.89%	93.95%	94.37%
Ages 25 Months–6 Years	83.97%	84.16%	84.07%
Ages 7–11 Years	85.98%	86.59%	86.32%
Ages 12–19 Years	83.53%	84.58%	84.19%
Children's Preventive Care			
Adolescent Well-Care Visits (AWC)			
Adolescent Well-Care Visits	51.09%	46.72%	48.35%
Childhood Immunization Status (CIS)			
Combination 2	70.07%	71.05%	70.61%
Combination 3	65.94%	64.96%	65.40%
Combination 4	65.21%	64.72%	64.94%
Combination 5	55.23%	54.74%	54.96%
Combination 6	33.09%	30.66%	31.75%
Combination 7	54.74%	54.50%	54.61%
Combination 8	32.85%	30.66%	31.64%
Combination 9	28.47%	26.03%	27.13%
Combination 10	28.22%	26.03%	27.02%
Immunizations for Adolescents (IMA)			
Combination 1 (Meningococcal, Tdap)	84.67%	82.24%	83.17%
Combination 2 (Meningococcal, Tdap, HPV)	40.63%	42.58%	41.83%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)			
BMI Percentile—Total	77.37%	83.21%	80.78%
Counseling for Nutrition—Total	71.29%	68.37%	69.59%
Counseling for Physical Activity—Total	67.64%	65.21%	66.22%
Well-Child Visits in the First 15 Months of Life (W15)			
Six or More Well-Child Visits	68.04%	61.31%	64.43%
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%	70.07%	71.52%

HEDIS Measure	Anthem	HPN	Medicaid
Women's Health and Maternity Care			
Breast Cancer Screening (BCS)			
Breast Cancer Screening	50.64%	56.04%	54.33%
Prenatal and Postpartum Care (PPC)			
Timeliness of Prenatal Care	80.15%	71.29%	75.41%
Postpartum Care	62.11%	59.12%	60.51%
Care for Chronic Conditions			
Comprehensive Diabetes Care (CDC)			
HbA1c Testing	82.48%	78.59%	79.98%
*HbA1c Poor Control (>9.0%)**	41.61%	44.77%	43.64%
HbA1c Control (<8.0%)	50.12%	46.72%	47.93%
Eye Exam (Retinal) Performed	53.28%	59.37%	57.19%
Medical Attention for Nephropathy	90.27%	87.35%	88.39%
Blood Pressure Control (<140/90 mm Hg)	54.26%	66.18%	61.91%
Controlling High Blood Pressure (CBP)			
Controlling High Blood Pressure	47.45%	52.55%	50.64%
Medication Management for People With Asthma (MMA)			
Medication Compliance 50%—Total	55.71%	57.39%	56.71%
Medication Compliance 75%—Total	32.70%	35.33%	34.27%
Behavioral Health			
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)			
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	38.05%	41.59%	40.09%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)			
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	81.46%	77.99%	79.37%
Follow-Up After ED Visit for AOD Abuse or Dependence (FUA)			
7-Day Follow-Up—Total	7.22%	10.46%	9.12%
30-Day Follow-Up—Total	10.92%	14.29%	12.89%

HEDIS Measure	Anthem	HPN	Medicaid
Follow-Up After ED Visit for Mental Illness (FUM)			
7-Day Follow-Up	27.87%	50.45%	41.86%
30-Day Follow-Up	40.80%	57.30%	51.02%
Follow-Up After Hospitalization for Mental Illness (FUH)			
7-Day Follow-Up	40.13%	25.04%	32.72%
30-Day Follow-Up	56.26%	43.18%	49.84%
Follow-Up Care for Children Prescribed ADHD Medication (ADD)			
Initiation Phase	39.66%	48.28%	44.54%
Continuation and Maintenance Phase	61.02%	51.76%	55.56%
Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)			
Initiation of AOD Treatment—Total	42.83%	36.51%	39.16%
Engagement of AOD Treatment—Total	12.72%	7.91%	9.93%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)			
Total	21.03%	13.13%	17.03%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)			
*Total**	1.42%	5.29%	3.64%
Utilization			
Ambulatory Care (per 1,000 Member Months) (AMB)			
*ED Visits—Total**	56.58	55.15	55.74
Outpatient Visits—Total	287.88	299.51	294.74
Mental Health Utilization—Total (MPT)			
Inpatient—Total	0.76%	0.23%	0.45%
Intensive Outpatient or Partial Hospitalization—Total	0.07%	0.03%	0.04%
Outpatient—Total	9.10%	7.25%	8.01%
ED—Total	0.18%	0.02%	0.09%
Telehealth—Total	0.00%	0.00%	0.00%
Any Service—Total	9.94%	7.42%	8.46%
Overuse/Appropriateness of Care			
Use of Opioids at High Dosage (per 1,000 Members) (UOD)			
*Use of Opioids at High Dosage**	68.87	74.31	72.57

HEDIS Measure	Anthem	HPN	Medicaid
Use of Opioids From Multiple Providers (per 1,000 Members) (UOP)*			
Multiple Prescribers	240.26	342.62	309.12
Multiple Pharmacies	36.01	70.89	59.48
Multiple Prescribers and Multiple Pharmacies	26.23	47.87	40.79

* A lower rate indicates better performances for this measure.

The HEDIS 2018 rates demonstrated similar performance for both **Anthem** and **HPN** within the Access to Care domain. The rates for both plans were within 1 percentage point for every measure indicator except for *Adults' Access to Preventive/Ambulatory Health Services—Ages 65 Years and Older,* where **Anthem**'s rate exceeded **HPN**'s by just over 17 percentage points. Although both plans demonstrated similar performance in the Access to Care domain, improvement efforts should still focus on ensuring all adult and child members have access to care.

Within the Children's Preventive Care domain, **Anthem** and **HPN** had similar results for ensuring children and adolescents received necessary immunizations, as all immunization measure rates were within 6 percentage points. Of note, both plans demonstrated strong performance for the *Immunization for Adolescents—Combination 1 (Meningococcal, Tdap)* indicator.

Anthem's performance for *Adolescent Well-Care Visits*; *Well-Child Visits in the First 15 Months of Life*; and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* exceeded **HPN**'s, indicating that **HPN** should focus improvement efforts on ensuring children and adolescents receive appropriate well-care and well-child visits. Additionally, both health plans demonstrated high performance for every rate within the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure, demonstrating a strength.

For the Women's Health and Maternity Care domain, both **Anthem** and **HPN** demonstrated low performance for all measures, indicating improvement efforts should focus on providing appropriate care to women. Of note, **HPN**'s rate for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure indicator fell more than 8 percentage points below **Anthem**'s rate, demonstrating an area of concern since providing appropriate prenatal care impacts the well-being of both the mother and child. Additionally, **Anthem** should ensure that all women between the ages of 50 and 74 receive appropriate screening for breast cancer, since its rate was more than 5 percentage points below **HPN**'s rate.

Within the Care for Chronic Conditions domain, both **Anthem** and **HPN** demonstrated low performance for the *Controlling High Blood Pressure*, *Comprehensive Diabetes Care—HbA1c Testing*, and *Medication Management for People With Asthma—Medication Compliance 50%—Total* measures, indicating opportunities for improvement. For the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* measure indicator, performance varied between the two health plans; **Anthem**'s rate was almost 12 percentage points lower than **HPN**'s rate. For the remaining six measure

rates within this domain, the health plans performed relatively similarly, with rates for both plans falling within 3 percentage points of each other.

For measures within the Behavioral Health domain related to medication management, **Anthem** demonstrated mixed performance while this area represents an opportunity for improvement for **HPN**. **Anthem** performed better than **HPN** for *Use of Multiple Concurrent Antipsychotics in Children and Adolescents* and *Metabolic Monitoring for Children and Adolescents on Antipsychotics* by approximately 4 and 8 percentage points, respectively.

The remainder of the measures within the Behavioral Health domain focus on continuation of care for members with specific behavioral health diagnoses. Performance varied between the health plans, with 7 of 10 measure rates having a relative difference of 30 percent or greater. **HPN** demonstrated high performance for *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Follow-Up After ED Visit for Mental Illness,* whereas **Anthem** demonstrated high performance for the *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* measure rate. **HPN**'s rates for the *Follow-Up After ED Visit for Mental Illness* measure indicators were more than 13 percentage points higher than **Anthem**'s rates for these measure indicators. Conversely, **Anthem**'s rates for the *Follow-Up After Hospitalization for Mental Illness* measure indicators were at least 13 percentage points higher than **HPN**'s rates for these measure indicators.

Within the Overuse/Appropriateness of Care domain, both plans demonstrated similar performance for the *Use of Opioids at High Dosage (per 1,000 Members)* measure, with **HPN** performing slightly below **Anthem**. For *Use of Opioids From Multiple Providers (per 1,000 members)*, the rates for **HPN** were far higher than the rates for **Anthem**, with relative differences of 42.60 percent for *Multiple Prescribers*, 96.86 percent for *Multiple Pharmacies*, and 82.50 percent for *Multiple Prescribers and Multiple Pharmacies*. This suggests opportunities for improvement for **HPN**, since their members appear to have higher rates of inappropriate opioid use.

Nevada Check Up Findings

Table 5-7 shows, by MCO, the HEDIS 2018 Nevada Check Up performance measure rate results for **Anthem** and **HPN** and the Nevada Check Up aggregate, which represents the average of both MCOs' measure rates weighted by the eligible population.

Table 5-7—HEDIS 2018 Results for Nevada Check Up

HEDIS Measure	Anthem	HPN	NV Check Up
Access to Care			
Children and Adolescents' Access to Primary Care Practitioners (CAP)			
Ages 12—24 Months	99.12%	96.33%	97.53%
Ages 25 Months–6 Years	91.10%	88.12%	89.39%
Ages 7–11 Years	93.08%	92.25%	92.57%

HEDIS Measure	Anthem	HPN	NV Check Up
Ages 12–19 Years	90.11%	90.61%	90.45%
Children's Preventive Care			
Adolescent Well-Care Visits (AWC)			
Adolescent Well-Care Visits	65.82%	59.61%	61.62%
Childhood Immunization Status (CIS)			
Combination 2	90.24%	85.91%	87.86%
Combination 3	81.71%	81.54%	81.62%
Combination 4	81.71%	81.54%	81.62%
Combination 5	75.61%	74.16%	74.81%
Combination 6	38.21%	44.30%	41.55%
Combination 7	75.61%	74.16%	74.81%
Combination 8	38.21%	44.30%	41.55%
Combination 9	36.18%	40.94%	38.79%
Combination 10	36.18%	40.94%	38.79%
Immunizations for Adolescents (IMA)			
Combination 1 (Meningococcal, Tdap)	90.37%	86.62%	87.81%
Combination 2 (Meningococcal, Tdap, HPV)	54.96%	51.82%	52.82%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)			
BMI Percentile—Total	84.67%	83.70%	84.06%
Counseling for Nutrition—Total	73.48%	73.48%	73.48%
Counseling for Physical Activity—Total	70.80%	69.59%	70.04%
Well-Child Visits in the First 15 Months of Life (W15)			
Six or More Well-Child Visits	83.24%	68.33%	74.87%
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%	73.48%	75.14%
Care for Chronic Conditions			
Medication Management for People With Asthma (MMA)			
Medication Compliance 50%—Total	54.84%	53.65%	54.04%
Medication Compliance 75%—Total	30.11%	34.90%	33.33%

HEDIS Measure	Anthem	HPN	NV Check Up
Behavioral Health			
Follow-Up After ED Visit for Mental Illness (FUM)			
7-Day Follow-Up	NA	82.98%	77.19%
30-Day Follow-Up	NA	85.11%	80.70%
Follow-Up After Hospitalization for Mental Illness (FUH)			
7-Day Follow-Up	50.00%	68.57%	58.90%
30-Day Follow-Up	65.79%	80.00%	72.60%
Follow-Up Care for Children Prescribed ADHD Medication (ADD)			
Initiation Phase	44.12%	55.36%	51.11%
Continuation and Maintenance Phase	NA	NA	NA
Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)			
Initiation of AOD Treatment—Total	NA	25.64%	31.48%
Engagement of AOD Treatment—Total	NA	7.69%	9.26%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)			
Total	NA	16.67%	20.97%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)			
*Total**	NA	NA	7.50%
Utilization			
Ambulatory Care (per 1,000 Member Months) (AMB)			
*ED Visits—Total**	27.04	23.87	25.08
Outpatient Visits—Total	248.86	248.74	248.78
Mental Health Utilization—Total (MPT)			
Inpatient—Total	0.27%	0.01%	0.11%
Intensive Outpatient or Partial Hospitalization—Total	0.08%	0.04%	0.05%
Outpatient—Total	6.78%	5.46%	5.97%
ED—Total	0.01%	0.01%	0.01%
Telehealth—Total	0.00%	0.00%	0.00%
Any Service—Total	7.11%	5.48%	6.10%

* A lower rate indicates better performances for this measure.
NA indicates the denominator for the measure is too small to report (less than 30).

Performance within the Access to Care domain showed **Anthem** performed by nearly 3 percentage points better than **HPN** for the *Children and Adolescents' Access to Primary Care Practitioners—Ages 12–24 Months* and the *Ages 25 Months–6 Years* indicators.

Overall, the health plans demonstrated positive performance for the Children's Preventive Care domain. The majority of the *Childhood Immunization Status* and *Immunization for Adolescents* measure indicator rates had little variation in performance between **Anthem** and **HPN**. **Anthem**'s rates for *Adolescent Well-Care Visits*, *Well-Child Visits in the First 15 Months of Life*, and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* exceeded **HPN**'s rates by 6.21, 14.91, and 3.89 percentage points, respectively. The health plans demonstrated similar high performance for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure.

For the Care for Chronic Conditions domain, both health plans performed similarly for the *Medication Management for People With Asthma—Medication Compliance 50%—Total* indicator, while **HPN** performed 4.79 percentage points higher than **Anthem** for the *Medication Compliance 75%—Total* indicator.

Within the Behavioral Health domain, the measure rates for *Follow-Up After Hospitalization for Mental Illness* differed substantially between the health plans, with **HPN**'s rates for the *7-Day Follow-Up* and *30-Day Follow-Up* indicators exceeding **Anthem**'s rates by 18.57 and 14.21 percentage points, respectively. Similarly, **HPN**'s rate for the *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* measure indicator exceeded **Anthem**'s rate by 11.24 percentage points. **Anthem** has opportunities to improve in areas related to follow-up for behavioral health conditions.

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, as well as measures that only used medical record review data (i.e., *Controlling High Blood Pressure*). Table 5-8 shows the HEDIS 2018 rates and the percentage of each reported rate determined solely through administrative data for both 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 Measures	Anthem HEDIS 2018 Rate	Anthem Percent from Administrative Data	HPN HEDIS 2018 Rate	HPN Percent from Administrative Data
Children's Preventive Care				
Adolescent Well-Care Visits (AWC)				
Adolescent Well-Care Visits	51.09%	79.52%	46.72%	95.83%
Childhood Immunization Status (CIS)				
Combination 2	70.07%	95.83%	71.05%	84.25%
Combination 3	65.94%	95.94%	64.96%	84.27%
Combination 4	65.21%	95.90%	64.72%	84.21%
Combination 5	55.23%	96.04%	54.74%	83.56%
Combination 6	33.09%	96.32%	30.66%	84.92%
Combination 7	54.74%	96.00%	54.50%	83.48%
Combination 8	32.85%	96.30%	30.66%	84.92%
Combination 9	28.47%	96.58%	26.03%	84.11%
Combination 10	28.22%	96.55%	26.03%	84.11%
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	84.67%	98.28%	82.24%	95.86%
Combination 2 (Meningococcal, Tdap, HPV)	40.63%	95.81%	42.58%	94.29%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile—Total	77.37%	**47.80%**	83.21%	59.65%
Counseling for Nutrition—Total	71.29%	**41.98%**	68.37%	60.50%
Counseling for Physical Activity—Total	67.64%	**29.86%**	65.21%	55.97%
Well-Child Visits in the First 15 Months of Life (W15)				
Six or More Well-Child Visits	68.04%	76.14%	61.31%	89.68%
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%	91.69%	70.07%	97.22%

HEDIS Measures	Anthem HEDIS 2018 Rate	Anthem Percent from Administrative Data	HPN HEDIS 2018 Rate	HPN Percent from Administrative Data
Women's Health and Maternity Care				
Prenatal and Postpartum Care (PPC)				
Timeliness of Prenatal Care	80.15%	70.74%	71.29%	73.72%
Postpartum Care	62.11%	63.07%	59.12%	74.07%
Care for Chronic Conditions				
Comprehensive Diabetes Care (CDC)				
HbA1c Testing	82.48%	97.05%	78.59%	98.45%
HbA1c Poor Control (>9.0%)	41.61%	87.13%	44.77%	99.46%
HbA1c Control (<8.0%)	50.12%	81.07%	46.72%	96.35%
Eye Exam (Retinal) Performed	53.28%	89.50%	59.37%	93.03%
Medical Attention for Nephropathy	90.27%	97.57%	87.35%	99.44%
Blood Pressure Control (<140/90 mm Hg)	54.26%	**1.35%**	66.18%	**1.47%**

= 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 25 rates for the Medicaid population using the hybrid methodology. Fourteen rates that **Anthem** reported (56 percent of **Anthem**'s hybrid rates) were derived using more than 90 percent administrative data, indicating high levels of encounter data completeness. Nine rates that **HPN** reported (36 percent of **HPN**'s hybrid rates) were derived using more than 90 percent administrative data. For both MCOs, the rates for *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* were derived using 50 percent or less administrative data. Additionally, **Anthem**'s rates for all three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* indicators were derived using less than 50 percent administrative data. However, for these measures the numerator-positive hits were often detected primarily through medical record review, not administrative data. Of note, **Anthem** reported slightly higher measure rates using substantially more supplemental data than **HPN** for nine of 11 indicators for *Childhood Immunization Status* and *Immunization for Adolescents*.

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 2018 rates and the percentage of each reported rate determined solely through administrative data for both 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 Measures	Anthem HEDIS 2018 Rate	Anthem Percent from Administrative Data	HPN HEDIS 2018 Rate	HPN Percent from Administrative Data
Children's Preventive Care				
Adolescent Well-Care Visits (AWC)				
Adolescent Well-Care Visits	65.82%	88.46%	59.61%	97.14%
Childhood Immunization Status (CIS)				
Combination 2	90.24%	95.95%	85.91%	81.25%
Combination 3	81.71%	96.52%	81.54%	81.48%
Combination 4	81.71%	96.52%	81.54%	81.07%
Combination 5	75.61%	96.24%	74.16%	81.45%
Combination 6	38.21%	96.81%	44.30%	78.79%
Combination 7	75.61%	96.24%	74.16%	81.00%
Combination 8	38.21%	96.81%	44.30%	78.79%
Combination 9	36.18%	96.63%	40.94%	79.51%
Combination 10	36.18%	96.63%	40.94%	79.51%
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	90.37%	99.06%	86.62%	94.94%
Combination 2 (Meningococcal, Tdap, HPV)	54.96%	97.94%	51.82%	90.14%

HEDIS Measures	Anthem HEDIS 2018 Rate	Anthem Percent from Administrative Data	HPN HEDIS 2018 Rate	HPN Percent from Administrative Data
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile—Total	84.67%	55.17%	83.70%	61.92%
Counseling for Nutrition—Total	73.48%	**40.40%**	73.48%	58.94%
Counseling for Physical Activity—Total	70.80%	**30.24%**	69.59%	53.50%
Well-Child Visits in the First 15 Months of Life (W15)				
Six or More Well-Child Visits	83.24%	84.03%	68.33%	83.44%
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	77.37%	95.28%	73.48%	95.70%

= 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. Twelve rates that **Anthem** reported (approximately 71 percent of **Anthem**'s hybrid rates) were derived using more than 90 percent administrative data. Four rates that **HPN** reported (approximately 24 percent of **HPN**'s hybrid rates) were derived using more than 90 percent administrative data. **Anthem**'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* measure indicators were derived using less than 50 percent administrative data. However, for this measure, numerator-positive hits often are 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 quality, access, and timeliness of care. Note that some of the measures are related to more than one domain and are referenced in each applicable domain separately. Additionally, only measures with at least two years of reportable data presented in this report are included in the evaluation of quality, access, and timeliness of care. For measures related to quality, 19 of 29 measures demonstrated rate increases of at least 5 percentage points in HEDIS 2018 from prior years and 19 of 29 measures met the QISMC goals in 2018. The following measures related to quality had rate increases greater than 5 percentage points and met the QISMC goals in 2018:

- *Adolescent Well-Care Visits*

- *Childhood Immunization Status—Combinations 3*, *4*, *5*, and *7*
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, and *Medical Attention for Nephropathy*
- *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*
- *Medication Management for People With Asthma—Medication Compliance 50%—Total*
- *Prenatal and Postpartum Care*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
- *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

For measures related to access to care, six of 11 demonstrated rate increases of at least 5 percentage points in HEDIS 2018 compared to prior years and nine of 11 measures met the QISMC goals in 2018. The following measures related to access had rate increases greater than 5 percentage points and met the QISMC goals in 2018:

- *Adolescent Well-Care Visits*
- *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*
- *Prenatal and Postpartum Care*
- *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

For measures related to timeliness of care, three of four measures demonstrated rate increases of at least 5 percentage points in HEDIS 2018 compared to previous years and three of four measures met the QISMC goals in 2018. The following measures related to timeliness had rate increases greater than 5 percentage points and met the QISMC goal in 2018:

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

Conversely, for measures related to quality, two of 29 had rate declines of at least 5 percentage points in HEDIS 2018 from prior years and 10 of 29 did not meet the QISMC goals in 2018. The following measures related to quality had rate declines of at least 5 percentage points and did not meet the QISMC goals in 2018:

- *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*
- *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)*

In the area related to access of care, 0 of 11 measures had rate declines of at least 5 percentage points in HEDIS 2018 from prior years and two of 11 measures did not meet the QISMC goals in 2018. None of the measures related to access had rate declines of more than 5 percentage points and did not meet the QISMC goals in 2018.

For measures related to timeliness of care, 0 of four measures had rate declines of at least 5 percentage points in HEDIS 2018 from prior years and one of four measures did not meet the QISMC goals in 2018. None of the measures related to timeliness had rate declines of more than 5 percentage points and did not meet the QISMC goals in 2018.

For **Anthem**'s Nevada Check Up population, 13 of 19 measures related to quality had rate increases of at least 5 percentage points in HEDIS 2018 from prior years and 13 of 19 met the QISMC goals in 2018. The following measures related to quality had rate increases of at least 5 percentage points and met the QISMC goals in 2018:

- *Adolescent Well-Care Visits*
- *Childhood Immunization Status—Combinations 2, 3, 4, 5,* and *7*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*
- *Medication Management for People With Asthma—Medication Compliance 50%—Total*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
- *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

For measures related to access to care, three of eight had rate increases of at least 5 percentage points in HEDIS 2018 from prior years and four of eight met the QISMC goals in 2018. The following measures related to access had rate increases of at least 5 percentage points and met the QISMC goal in 2018:

- *Adolescent Well-Care Visits*
- *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

For measures related to timeliness of care, 0 of one measure had a rate increase of at least 5 percentage points and the one measure with a QISMC goal did not meet the goal in 2018. None of **Anthem**'s Nevada Check Up measures related to timeliness had rate increases of at least 5 percentage points and met the QISMC goals in 2018.

Conversely, for measures related to quality, four of 19 had rate declines greater than 5 percentage points in HEDIS 2018 from prior years and six of 19 measures did not meet the QISMC goals in 2018. The following measure related to quality had rate declines greater than 5 percentage points and did not meet the QISMC goals in 2018:

- *Childhood Immunization Status—Combinations 6, 8, 9,* and *10*

In the area related to access of care, 0 of eight measures had rate declines greater than 5 percentage points in HEDIS 2018 from prior years and four of eight did not meet the QISMC goals in 2018. None of **Anthem**'s Nevada Check Up measures related to access had rate declines greater than 5 percentage points and did not meet the QISMC goal in 2018.

For measures related to timeliness of care, 0 of one measure had rate declines greater than 5 percentage points in HEDIS 2018 from prior years and the one measure with a QISMC goal did not meet the goal in 2018. None of **Anthem**'s Nevada Check Up measures related to timeliness had rate declines greater than 5 percentage points in HEDIS 2018 from prior years and did not meet the QISMC goals in 2018.

Recommendations

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 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*

HPN Conclusions and Recommendations

Conclusions

Performance for **HPN**'s Medicaid population was evaluated in terms of quality, access, and timeliness of care. Note that some of the measures related to more than one domain are referenced in each applicable domain separately. Additionally, only measures with at least two years of reportable data presented in this report are included in the evaluation of quality, access, and timeliness of care. For measures related to quality, nine of 29 measures demonstrated rate increases of at least 5 percentage points in HEDIS 2018 from prior years, and 10 of 29 measures met the QISMC goals in 2018. The following measures related to quality had rate increases of at least 5 percentage points and met the QISMC goals in 2018:

- *Adolescent Well-Care Visits*
- *Medication Management for People With Asthma*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
- *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

For measures related to access to care, three of 11 measures demonstrated rate increases of at least 5 percentage points in HEDIS 2018 from prior years and seven of 11 measures met the QISMC goals in 2018. The following measures related to access had rate increases of at least 5 percentage points and met the QISMC goals in 2018:

- *Adolescent Well-Care Visits*
- *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

For measures related to timeliness of care, 0 of four measures demonstrated rate increases of at least 5 percentage points in HEDIS 2018 from prior years and 0 of four measures met the QISMC goals in 2018. None of **HPN**'s measures related to timeliness had rate increases of at least 5 percentage points and met the QISMC goals in 2018.

Conversely, for measures related to quality, 11 of 29 demonstrated rate declines greater than 5 percentage points in HEDIS 2018 from prior years and 19 of 29 did not meet the QISMC goals in 2018. The following measures related to quality had rate declines greater than 5 percentage points and did not meet the QISMC goals in 2018:

- *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*

In the area related to access of care, two of 11 measures demonstrated rate declines greater than 5 percentage points in HEDIS 2018 from prior years and four of 11 did not meet the QISMC goals in 2018. The following measures related to access had rate declines greater than 5 percentage points and did not meet the QISMC goal in 2018:

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

For measures related to timeliness of care, two of four demonstrated rate declines greater than 5 percentage points in HEDIS 2018 from prior years and all four with QISMC goals in this area did not meet the goals in 2018. The following measures related to timeliness had rate declines greater than 5 percentage points and did not met the QISMC goal in 2018:

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

For **HPN**'s Nevada Check Up population, 12 of 19 measures related to quality demonstrated rate increases of at least 5 percentage points in HEDIS 2018 from prior years and 12 of 19 met the QISMC goals in 2018. The following measures related to quality had rate increases of at least 5 percentage points and met the QISMC goals in 2018:

- *Childhood Immunization Status—Combinations 4*, *5*, and *7*
- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*
- *Medication Management for People With Asthma*

- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
- *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*

For measures related to access to care, four of eight demonstrated rate increases of at least 5 percentage points in HEDIS 2018 from prior years and three of eight met the QISMC goals in 2018. The following measures related to access had rate increases of at least 5 percentage points and met the QISMC goal in 2018:

- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*
- *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*

For measures related to timeliness of care, one of one demonstrated a rate increases of at least 5 percentage points in HEDIS 2018 from prior years and the one measure with a QISMC goal met the goal in 2018. The following measure related to access had rate increases of at least 5 percentage points and met the QISMC goal in 2018:

- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*

Conversely, for measures related to quality, four of 19 measures demonstrated declines greater than 5 percentage points in HEDIS 2018 from prior years and seven of 19 measures did not meet the QISMC goals in 2018. Several immunization combination indicators related to quality had rate declines greater than 5 percentage points and did not meet the QISMC goals in 2018:

- *Childhood Immunization Status—Combinations 6*, *8*, *9*, and *10*

For measures related to access of care, 0 of eight demonstrated declines greater than 5 percentage points in HEDIS 2018 from prior years and five of eight did not meet the QISMC goals in 2018. None of **HPN**'s Nevada Check Up measure rates related to access of care had rate declines greater than 5 percentage points and did not meet the QISMC goals in 2018 as well.

For measures related to timeliness of care, 0 of one measure demonstrated a decline greater than 5 percentage points in HEDIS 2018 from prior years and the one measure with a QISMC goal met the goal in 2018. None of **HPN**'s Nevada Check Up measure rates related to timeliness of care had a rate decline greater than 5 percentage points and did not meet the QISMC goals in 2018 as well.

Recommendations

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 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*

6. Validation of Performance Improvement Projects—SFY 2017–2018

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) that is 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 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 health care 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 companion guide. Throughout SFY 2017–2018, HSAG continued to provide guidance, training, 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

[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: Sept 26, 2018.

in documenting its approach but also in applying the rapid-cycle quality improvement methods that are central to achieving improved outcomes.

MCO-Specific Results—Anthem

In SFY 2017–2018, the DHCFP selected two new PIP topics for the MCOs: *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 PIP topic, **Anthem** 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 parameters to the MCO for establishing the SMART Aim for each PIP.

Table 6-1 presents each PIP 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 target 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 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 Modules 1 through 3 for validation. The following section outlines the validation findings for each of these modules.

Module 1: PIP Initiation

The objective of Module 1 is for the MCO to ask and answer the first fundamental question, "What are we trying to accomplish?" In this phase, for both PIPs, **Anthem** determined the narrowed focus, developed its PIP team, established external partnerships, determined the Global and SMART Aim, and developed the key driver diagram.

Follow-up After Emergency Room (ER) Discharge (FUM)

Upon initial validation of Module 1, HSAG identified that **Anthem** needed to correct the focus of the PIP (30-day follow-up to 7-day follow-up), revise its SMART Aim statement to include the relevant components for the measure and narrowed focus, and remove interventions from the key driver diagram that were part of a normal Plan-Do-Study-Act (PDSA) cycle and not actual interventions. After receiving technical assistance from HSAG, **Anthem** made the necessary corrections and resubmitted the module for final validation. For the final validation, **Anthem** received *Achieved* scores for all evaluation elements.

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

Upon initial validation of Module 1, HSAG identified that **Anthem** needed to correct the reporting of its comparative data and remove the passive interventions (i.e., mailing offers and reminders to members) from the key driver diagram. After receiving technical assistance from HSAG, **Anthem** made the necessary corrections and resubmitted the module for final validation. For the final validation, **Anthem** received *Achieved* scores for all evaluation elements.

Module 2: SMART Aim Data Collection

The objective of Module 2 is for the MCO to ask and answer the question, "How will we know that a change is improvement?" In this phase, for both PIPs, **Anthem** defined how and when it will be evident that improvement is being achieved.

Follow-up After Emergency Room (ER) Discharge (FUM)

Anthem defined the SMART Aim measure as follows:

Numerator: Total number of University Medical Center of Nevada (UMC) FUM eligible ER visits from the denominator during the rolling 12-month measurement period, with a principal diagnosis of a mental health disorder, that had a follow-up visit with any practitioner within seven days after the ER visit (eight days total). Follow-up visits that occur on the date of the ER discharge are included.

Denominator: Total number of UMC FUM eligible ER visits within the rolling 12-month measurement period with a principal diagnosis of a mental health disorder for members six years of age and older. Discharges occur from the first day of the rolling 12-month period through the first day of the last month of the rolling 12-month period.

On the first business day of the month, **Anthem** will query claims data and apply its vendors' HEDIS algorithms to identify UMC's FUM-eligible ER visits for the 12-month rolling measurement period. Using the SMART Aim denominator, the MCO will run a query to identify the eligible members who had a follow-up visit with any practitioner within seven days after the discharge from UMC's ER. The results will be displayed monthly on the SMART Aim run chart.

Upon initial validation of Module 2, HSAG identified that **Anthem** needed to completely define the SMART Aim measure using the rolling 12-month methodology and correct the data plotted in the SMART Aim run chart. After receiving technical assistance from HSAG, **Anthem** made the necessary corrections and submitted the module for final validation. For the final validation, **Anthem** received *Achieved* scores for all evaluation elements.

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

Anthem defined the SMART Aim measure as follows:

Numerator: All Children's Urgent Care (CUC) W34 eligible members ages 3 to 6, residing in Clark County, from the denominator's rolling 12-month measurement period, that had a well-child visit within the rolling 12-month measurement period.

Denominator: All W34 eligible members ages 3 to 6, residing in Clark County, who are assigned to a CUC practitioner within the rolling 12-month measurement period.

Anthem will use claims data for the rolling 12-month data collection methodology. On the first business day of the month, data will be queried to generate a list of eligible members ages 3 to 6 who were assigned to CUC during the rolling 12-month period. Using the SMART Aim denominator, the MCO will query claims data to identify members who had a well-child visit within the rolling 12-month measurement period. A Microsoft (MS) Excel spreadsheet with a list of the remaining W34 eligible members without a well-child visit within the current rolling 12-month measurement period will be sent to the CUC office manager via a secure encrypted email. Throughout the month, the CUC office manager will record in the MS Excel spreadsheet the W34 eligible members who received a well-child visit during the current rolling 12-month measurement period. On the last business day of the month, the CUC office manager will send the completed MS Excel spreadsheet back to **Anthem** through secure encrypted email. The results will be displayed monthly on the SMART Aim run chart.

Upon initial validation of Module 2, HSAG identified that **Anthem** needed to completely define the SMART Aim measure using the rolling 12-month methodology and define all steps in the data collection process. **Anthem** received technical assistance from HSAG and submitted a revised module for validation. During the final validation, HSAG identified that all not corrections were made, and an additional submission would be required. **Anthem** received additional guidance, made final revisions, and resubmitted the module. For the final validation, **Anthem** received *Achieved* scores for all evaluation elements.

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 Room (ER) Discharge (FUM)

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

- Determine and implement member treatment plan.
- **Anthem** is notified of member discharge.
- Member is discharged.

Using the risk-priority numbering method to prioritize the identified failure modes within these subprocesses, **Anthem** determined the following failure modes to be top priority for developing the interventions that will be tested using PDSA cycles in Module 4.

- The member was discharged with a mental health primary diagnosis and did not receive information to follow up with a primary care practitioner within seven days.
- **Anthem** is not notified of the member's discharge.

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

- Provide members with a fact sheet that includes information on behavioral health resources.
- Use a daily auto-generated MS Excel spreadsheet containing real-time UMC ER discharge data to identify members who had been discharged.
- Use a third-party vendor to provide care coordination to assist members discharged from UMC ER needing behavioral health resources.

Upon initial validation of Module 3, HSAG identified that **Anthem** needed to revise its process map so the selected subprocesses in the FMEA aligned with the opportunities for improvement identified in the process map. The MCO also needed to revise its FMEA so the identified failure causes, and failure effects aligned with the listed failure modes. After receiving technical assistance from HSAG, **Anthem** made the necessary corrections and submitted the module for final validation. For the final validation, **Anthem** received *Achieved* scores for all evaluation elements.

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

Anthem completed a process map and FMEA to determine the areas within its process that had the greatest need for improvement and would have the most impact on the intended outcomes. **Anthem** identified the following four subprocesses on which to focus its efforts:

- Medical assistant (MA) conducts outreach calls to W34 eligible members who have not had a well-child visit in the current measurement year, and no contact was made.
- Medical doctor (MD) examines patient, child too sick to perform well-child visit, well-child visit is scheduled, and member does not attend appointment.

- MA conducts outreach calls to W34 eligible members who have not had a well-child visit in the current measurement year, reach the member, and schedule an appointment.
- MA conducts outreach calls to W34 eligible members who have not had a well-child visit in the current measurement year.

Using the risk-priority numbering method to prioritize the identified failure modes within these subprocesses, **Anthem** determined that the top three failure modes to develop interventions and test through the use of PDSA cycles in Module 4 were:

- MA has contact information but is unable to connect with the member to schedule a well-child visit due to inaccurate contact information.
- Outreach is not completed internally.
- Well-child visit scheduled; however, staff often fail to educate the member of the importance of the well-child visit, and the member does not attend.

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

- Use Lexis Nexis member-scrubbed contact data and share the data with the provider office to improve outreach success.
- Use **Anthem** associates for telephonic outreach to contact CUC provider members eligible for a W34 visit and schedule an appointment.
- Implementation of a standardized outreach process in the CUC provider's office to facilitate education and consistency of practice.

Upon initial validation of Module 3, HSAG identified that **Anthem** needed to revise its process map so the selected subprocesses in the FMEA aligned with the opportunities for improvement identified in the process map. The MCO also needed to revise its FMEA so the identified failure causes, and failure effects aligned with the failure modes. In addition, **Anthem** was required to revise its documentation so all narrative documentation in the process map and FMEA were consistent. After receiving technical assistance from HSAG, **Anthem** made the necessary corrections and submitted the module for final validation. For the final validation, **Anthem** received *Achieved* scores for all evaluation elements.

At the time of the SFY 2017–2018 EQR Technical Report, **Anthem** 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 validation outcomes in the SFY 2018–2019 EQR Technical Report.

MCO-Specific Results—HPN

In SFY 2017–2018, the DHCFP selected two new PIP topics for the MCOs: *Follow-up After Emergency Department Visit for Mental Illness (FUM)* and *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, **HPN** 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 parameters to the MCO for establishing the SMART Aim for each PIP.

Table 6-2 presents each PIP 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 target date for attaining the goal.

Table 6-2—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 six 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 six years of age, residing in ZIP code 89115, from 63.7% to 75.0%.

Validation Findings

HPN completed and submitted Modules 1 through 3 for validation. The following section outlines the validation findings for each of these modules.

Module 1: PIP Initiation

The objective of Module 1 is for the MCO to ask and answer the first fundamental question, "What are we trying to accomplish?" In this phase, for both PIPs, **HPN** determined the narrowed focus, developed its PIP team, established external partnerships, determined the Global and SMART Aim, and developed the key driver diagram.

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

Upon initial validation of Module 1, HSAG identified that **HPN** needed to revise how the SMART Aim statement was stated because not all components were accurate based on the focus of the PIP. HSAG also identified that some of the potential interventions listed in the key driver diagram were components of a PDSA cycle and not actual interventions. After receiving technical assistance from HSAG, **HPN** made the necessary corrections and resubmitted the module for final validation. For the final validation, **HPN** received *Achieved* scores for all evaluation elements.

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

Upon initial validation of Module 1, HSAG identified that **HPN** needed to correct its comparative data and ensure that the data were reported accurately and consistently throughout the module. HSAG also recommended that the passive interventions (i.e., mailings and newsletters) listed in the key driver diagram be removed. After receiving technical assistance from HSAG, **HPN** made the necessary corrections and resubmitted the module for final validation. For the final validation, **HPN** received *Achieved* scores for all evaluation elements.

Module 2: SMART Aim Data Collection

The objective of Module 2 is for the MCO to ask and answer the question, "How will we know that a change is improvement?" In this phase, for both PIPs, **HPN** defined how and when it will be evident that improvement is being achieved.

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

HPN defined the SMART Aim measure as follows:

Numerator: Total number of emergency department (ED) visits for the eligible CHAP-TANF expansion and Nevada Check-up members 6 years of age and older, who were seen at Desert Springs Hospital and Medical Center ED, with a principal diagnosis of mental illness and assessed by the Mobile Response Team during the rolling 12-month measurement period, and had a follow-up visit with any practitioner within seven days of the ED visit.

Denominator: Total number of ED visits for the eligible CHAP-TANF expansion and Nevada Check-up members 6 years of age and older, who were seen at Desert Springs Hospital and Medical Center ED, with a principal diagnosis of mental illness, and assessed by the Mobile Response Team during the rolling 12-month measurement period.

On the last business day of each month, **HPN**'s Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) coordinator will extract a report from MicroStrategy in Microsoft (MS) Excel format for the eligible ED visits for the targeted population at Desert Springs Hospital and Medical Center who had a follow-up visit with any practitioner within seven days of the ED visit. The results will be displayed monthly on the SMART Aim run chart.

Upon initial validation of Module 2, HSAG identified that **HPN** needed to revise the structure of the SMART Aim measure to include all required components of the rolling 12-month methodology, as well as all required components for the SMART Aim measure. Revisions were also required to the data collection process, and the MCO needed to include a copy of the data collection tool to be used. After receiving technical assistance from HSAG and two resubmissions, **HPN** received *Achieved* scores across all evaluation elements in the final validation.

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

HPN defined the SMART Aim measure as follows:

Numerator: Total number of CHAP-TANF and Nevada Check-up members 6 years of age, residing in ZIP code 89115, who had at least one well-child visit during the rolling 12-month measurement period.

Denominator: Total number of CHAP-TANF and Nevada Check-up members 6 years of age, residing in ZIP code 89115, during the rolling 12-month measurement period.

On the last business day of each month, **HPN**'s EPSDT coordinator will extract a report from MicroStrategy in MS Excel format for the eligible targeted population who had at least one well-child visit during the rolling 12-month measurement period. The results will be displayed monthly on the SMART Aim run chart.

Upon initial validation of Module 2, HSAG identified that **HPN** needed to revise the structure of the SMART Aim measure to include all required components of the rolling 12-month methodology and provide an explanation for how it will address claims lag for timely identification of members needing a well-child visit. The MCO also needed to include a copy of the data collection tool to be used. After receiving technical assistance from HSAG and resubmitting the module for final validation, **HPN** received *Achieved* scores for all evaluation elements.

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 (FUM)

HPN completed a process map and an FMEA to determine the areas within its process with the greatest need for improvement and that would have the most impact on intended outcomes. **HPN** identified the following three subprocesses:

- Member attends follow-up visit within seven days of the ED visit.
- Mobile Response Team emphasizes the importance of completing a follow-up visit within seven days of the ED visit.
- Health plan receives notification of the member's follow-up plan.

Using the risk-priority numbering method to prioritize the identified failure modes within these subprocesses, **HPN** determined the following failure modes to be top priority for the development of interventions that will be tested using PDSA cycles in Module 4.

- Member does not have transportation to keep the scheduled follow-up visit.

- Member symptoms have subsided temporarily and he or she does not understand mental illness/system fluctuation.
- Member does not have dependent care.

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

- Provide the member with a telehealth visit with a behavioral health provider while in the ED.
- Provide the member with transportation resources that the MCO and the mental health provider offer.

Upon initial validation of Module 3, HSAG identified that **HPN** needed to revise its process map so the selected subprocesses were numbered by priority based on having the greatest potential of impacting the SMART Aim and not sequentially based on order in the process map. The MCO also needed to revise the FMEA so the failure modes were logically linked to the prioritized subprocesses, failure effects, and failure causes. In addition, the listed interventions would need to be revised based on changes made to the FMEA. After receiving technical assistance from HSAG, **HPN** made the necessary corrections and submitted the module for final validation. For the final validation, **HPN** achieved all the validation criteria.

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

HPN completed a process map and FMEA to determine areas within its process that had the greatest need for improvement and that would have the most impact on the desired outcomes. **HPN** identified the following three subprocesses:

- Member attends visit.
- Primary care practitioner calls the noncompliant member's parent or guardian to schedule well-child visit.
- Parent or legal guardian schedules well-child visit.

Using the risk-priority numbering method to prioritize the identified failure modes within these subprocesses, **HPN** determined the following failure modes to be top priority for developing the interventions that will be tested using PDSA cycles in Module 4.

- Appointments are not offered during convenient hours.
- Parent/legal guardian and member do not have transportation to keep scheduled appointment.
- Member does not attend visit due to parent/legal guardian's lack of childcare for other children/dependents.

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

- Partner with a contracted provider to provide well-child visits in the member's home.
- Provide the parent/legal guardian/member with transportation resources.

Upon initial validation of Module 3, HSAG identified that **HPN** needed to revise its process map to start with the identification of children 6 years of age residing in ZIP code 89115 and that the subprocesses be numbered by priority based on having the greatest potential of impacting the SMART Aim and not sequentially based on order in the process map. The MCO also needed to revise the FMEA so that the failure modes were logically linked to the prioritized subprocesses, failure effects, and failure causes. In addition, the interventions would need to be revised based on changes made to the FMEA. After receiving technical assistance from HSAG, **HPN** made the necessary corrections and submitted the module for final validation. For the final validation, **HPN** achieved all validation criteria.

At the time of the SFY 2017–2018 EQR Technical Report, **HPN** 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 validation outcomes in the SFY 2018–2019 EQR Technical Report.

MCO-Specific Results—SilverSummit

In SFY 2017–2018, the DHCFP selected two new PIP topics for the MCOs: *Follow-up After Emergency Department Visit for Mental Health Diagnosis (FUM)* and *Increase 3–6-Year-Old Well-Child Primary Care Practitioner (PCP) Visits (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, **SilverSummit** 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 parameters to the MCO for establishing the SMART Aim for each PIP.

Table 6-3 presents each PIP 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 target date for attaining the goal.

Table 6-3—PIP Titles and SMART Aim Statements

PIP Title	SMART Aim Statement
Follow-up After Emergency Department Visit for Mental Health Diagnosis (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%.
Increase 3–6-Year-Old Well-Child Primary Care Practitioner (PCP) Visits (W34)	By June 30, 2019, increase the well-child visit rate among children 3–6 years of age at Nevada Health Centers, CIMA Medical Center, and Clinical Santa Maria (CIMA #2) from 25.9% to 55%.

Validation Findings

SilverSummit completed and submitted Modules 1 and 2 for validation. The following section outlines the validation findings for each module.

Module 1: PIP Initiation

The objective of Module 1 is for the MCO to ask and answer the first fundamental question, "What are we trying to accomplish?" In this phase, for both PIPs, **SilverSummit** determined the narrowed focus, developed its PIP team, established external partnerships, determined the Global and SMART Aim, and developed the key driver diagram. (See Appendix A, Module Submission Forms.)

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

Upon initial validation of Module 1, HSAG identified that corrections needed to be made to the MCO's overall plan data, comparative data reported for each ED facility, the SMART Aim statement, and key driver diagram. HSAG also noted that the data in the spreadsheet provided in the PIP did not match the spreadsheet previously provided by **SilverSummit** during a technical assistance call. After receiving technical assistance and two resubmissions, **SilverSummit** achieved the validation criteria across all evaluation elements.

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

Upon initial validation of Module 1, HSAG identified that there were inconsistencies and unclear documentation related to the selection of the narrowed focus and the comparative data provided. HSAG provided technical assistance to the MCO to review initial validation findings and discuss the necessary changes. **SilverSummit** made the necessary corrections and submitted an updated, corrected module. For the final validation, **SilverSummit** achieved all the validation criteria for Module 1.

Module 2: SMART Aim Data Collection

The objective of Module 2 is for the MCO to ask and answer the question, "How will we know that a change is improvement?" In this phase, for both PIPs, **SilverSummit** defined how and when it will be evident that improvement is being achieved.

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

SilverSummit defined the SMART Aim measure as follows:

Numerator: The total number of follow-up visits that occurred with any healthcare provider within seven days after an ED visit from Sunrise Medical Center and Mountain View Hospital with a primary diagnosis of mental health disorder during the rolling 12-month measurement period.

Denominator: The total number of ED visits from Sunrise Medical Center and Mountain View Hospital with a primary diagnosis of mental health disorder during the rolling 12-month measurement period.

Data will come from claims out of **SilverSummit**'s data warehouse. During the first week of every month, the MCO's data analyst will run a query of the eligible ED visits for the 12-month rolling measurement period. Using the SMART Aim denominator, the MCO will run a query to identify the eligible members who had a follow-up visit with any practitioner within seven days after the discharge

from Sunrise Medical Center and Mountain View Hospital. The results will be displayed monthly on the SMART Aim run chart.

Upon initial validation of Module 2, opportunities for improvement were identified with the MCO's SMART Aim measure development. **SilverSummit** documented the numerator and denominator based on members. The *FUM* measure is based on visits. The MCO needed to modify components of the HEDIS measure to the rolling 12-month methodology so monthly data could be collected and reported. **SilverSummit** also needed to correct the SMART Aim run chart to include all required components accurately. HSAG provided technical assistance to the MCO following the initial validation. The MCO required two resubmissions before all validation criteria were achieved.

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

SilverSummit defined the SMART Aim measure as follows:

Numerator: The total number of members assigned to Nevada Health Centers, CIMA Medical Centers LLC, and Clinical Santa Mara (CIMA #2) who are 3 to 6 years of age as of the last day of the rolling 12-month measurement period and had at least one well-child visit. Well-child visits can occur anytime during the rolling 12-month measurement period.

Denominator: The total number of members assigned to Nevada Health Centers, CIMA Medical Centers LLC, and Clinical Santa Mara (CIMA #2) who are 3 to 6 years of age as of the last day of the e rolling 12-month measurement period.

Data will be extracted from **SilverSummit** data warehouse the first week of every month for prior month's services and codes filtered for well-child visits. The monthly rate will be calculated by dividing the numerator by the denominator and displayed monthly on the SMART Aim run chart.

Upon initial validation of Module 2, opportunities for improvement were identified with the MCO's SMART Aim measure development. **SilverSummit** needed to modify components of the HEDIS measure to the rolling 12-month methodology so monthly data could be collected and reported. The MCO also needed to ensure that data reported in Modules 1 and 2 were consistent and accurate. **SilverSummit** also needed to correct the SMART Aim run chart to include all required components accurately. HSAG provided technical assistance to the MCO following the initial validation. The MCO required two resubmissions before all validation criteria were achieved.

At the time of this SFY 2017–2018 EQR Technical Report, **SilverSummit** had completed its PIPs through Module 2 and initiated the intervention determination phase of Module 3. HSAG will report the Module 3 and Module 4 findings in the SFY 2018–2019 EQR Technical Report.

Plan Comparison

Table 6-4 includes the PIP results for Modules 1 through 3 for **Anthem** and **HPN**. Table 6-4 also includes the PIP results for Modules 1 and 2 for **SilverSummit**.

Table 6-4—MCO 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 1: *Achieved* Module 2: *Achieved* Module 3: *Achieved*	Module 1: *Achieved* Module 2: *Achieved* Module 3: *Achieved*	Module 1: *Achieved* Module 2: *Achieved*
Increase Well-Child Visits for Children 3 to 6 Years of Age (W34)	Module 1: *Achieved* Module 2: *Achieved* Module 3: *Achieved*	Module 1: *Achieved* Module 2: *Achieved* Module 3: *Achieved*	Module 1: *Achieved* Module 2: *Achieved*

In Table 6-4, the PIP validation results demonstrate that **Anthem** and **HPN** successfully completed Modules 1 through 3 and developed methodologically sound projects. **Anthem** and **HPN** also were successful in building internal and external quality improvement teams, developing collaborative partnerships, and using quality improvement science tools to identify opportunities for improvement and determine appropriate targeted interventions to test. The validation results further demonstrate that **SilverSummit** successfully completed Modules 1 and 2 and developed methodologically sound projects. **SilverSummit** was also successful in building internal and external quality improvement teams and developing collaborative partnerships with its targeted providers and facilities.

Summary of Recommendations

HSAG offers the following recommendations to each MCO:

- 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 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.
- When planning for and testing changes, the MCO should:
  - Be proactive with changes (i.e., scaling/ramping up to build confidence in the change and eventually implementing 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 in 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.

In addition, as **SilverSummit** moves through the next phase of the PIP to determine interventions to test, it should consider completing process maps both at the MCO and provider levels for both PIPs.

7. CAHPS Surveys—SFY 2017–2018

Objectives

The CAHPS surveys ask members to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers, such as the communication skills of providers and the accessibility of services. **HPN** and **Anthem** 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.

Technical Methods of Data Collection and Analysis

Three populations were surveyed for **HPN** and **Anthem**: adult Medicaid, child Medicaid, and Nevada Check Up. DSS Research, an NCQA-certified vendor, administered the 2018 CAHPS surveys for both **HPN** and **Anthem**.

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

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 the CCC eligible population. The global ratings reflected patients' overall satisfaction with their personal doctor, specialist, health plan, and all health care. The composite scores were derived from sets of questions to address different aspects of care (e.g., getting needed care and how well doctors communicate). 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 Rate 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 rate).

For each of the five composite scores 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 composites 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 scores 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 rates presented follow NCQA's methodology of calculating a rolling average using the current and prior years' results. When a minimum of 100 responses for a measure was not achieved, the result was denoted as Not Applicable (NA).

NCQA National Average Comparisons

A substantial increase or decrease is denoted when a change of 5 percentage points or more occurs. Colors in the tables note substantial differences. Red indicates a top-box rate that was at least 5 percentage points less than the 2017 NCQA national average.

Plan Comparisons

Statistically significant differences between the 2018 top-box rates for the adult Medicaid, child Medicaid (general child and CCC), and Nevada Check Up populations for **Anthem** and **HPN** are noted with arrows. Top-box rates for one population statistically and significantly higher than top-box rates for the other population are noted with upward (↑) arrows. Conversely, top-box rates for one population statistically and significantly lower than top-box rates for the other population are noted with downward (↓) arrows. Top-box rates for one population not statistically and significantly different from the other population are not noted with arrows. If it is true that one population's top-box rate was statistically and significantly higher (↑) than that of the other population, it follows that the other population's top-box rate was statistically and significantly lower (↓). Therefore, in the tables presented in the Plan Comparisons section, a pair of arrows (↑ and ↓) to the right of the top-box rate is indicative of a single statistical test. For example, if it is true that a top-box rate of **Anthem**'s adult Medicaid respondents was statistically significantly lower than that of **HPN**'s adult Medicaid respondents, then it must be true that a top-box rate of **HPN**'s adult Medicaid respondents was statistically and significantly higher than that of **Anthem**'s adult Medicaid respondents.

MCO-Specific Results—Anthem

Table 7-1 shows **Anthem**'s 2018 adult Medicaid CAHPS top-box rates. In 2018, a total of 2,430 adult members were administered a survey, of whom 281 completed a survey. After ineligible members were excluded, the response rate was 11.7 percent. In 2017, the average NCQA response rate for the adult Medicaid population was 23.3 percent, higher than **Anthem**'s response rate.[7-1]

Table 7-1—Anthem Adult Medicaid CAHPS Results

	2018 Top-Box Rates
Composite Measures	
Getting Needed Care	81.2%
Getting Care Quickly	79.0%
How Well Doctors Communicate	87.4%
Customer Service	NA
Shared Decision Making	NA
Global Ratings	
Rating of All Health Care	46.9%
Rating of Personal Doctor	58.5%
Rating of Specialist Seen Most Often	64.7%
Rating of Health Plan	51.9%
Effectiveness of Care*	
Advising Smokers and Tobacco Users to Quit	64.9%
Discussing Cessation Medications	30.9%
Discussing Cessation Strategies	24.7%

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).

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

Indicates the 2018 rate is at least 5 percentage points less than the 2017 national average.

[7-1] 2018 NCQA national response rate information for the CAHPS 5.0 Adult Medicaid Survey was not available at the time this report was produced.

Anthem's 2018 top-box rates for the adult Medicaid population were lower than the 2017 NCQA adult Medicaid national averages for all reportable 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, six measure rates were at least 5 percentage points less than the 2017 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*
- *Discussing Cessation Strategies*

Table 7-2 shows **Anthem**'s 2018 general child Medicaid CAHPS top-box rates.[7-2] In 2018, a total of 4,042 general child members were administered a survey, of whom 345 completed a survey.[7-3] After ineligible members were excluded, the response rate was 8.7 percent. In 2017, the average NCQA response rate for the child Medicaid population was 22.3 percent, higher than **Anthem**'s response rate.[7-4]

Table 7-2—Anthem General Child Medicaid CAHPS Results

	2018 General Child Top-Box Rates
Composite Measures	
Getting Needed Care	79.5%
Getting Care Quickly	89.9%
How Well Doctors Communicate	89.1%
Customer Service	NA
Shared Decision Making	NA
Global Ratings	
Rating of All Health Care	72.5%
Rating of Personal Doctor	74.0%
Rating of Specialist Seen Most Often	NA
Rating of Health Plan	69.9%

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).

Anthem's 2018 top-box rates for the general child Medicaid population were lower than the 2017 NCQA general child Medicaid national averages for four reportable measures:

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

Anthem's 2018 top-box rates for the general child Medicaid population were higher than the 2017

[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] 2018 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.

NCQA general child Medicaid national averages for two reportable measures:

- *Getting Care Quickly*
- *Rating of All Health Care*

None of these measures, however, was at least 5 percentage points less or greater than the 2017 national averages.

Table 7-3 shows **Anthem**'s 2018 CCC Medicaid CAHPS top-box rates.[7-5] In 2018, a total of 179 child members with a chronic condition completed a survey.[7-6]

Table 7-3—Anthem CCC Medicaid CAHPS Results

	2018 CCC Supplemental Top-Box Rates
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	56.9%
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).
Indicates the 2018 rate is at least 5 percentage points less than the 2017 national average.

Anthem's 2018 top-box rates for the CCC population were lower than the 2017 NCQA CCC Medicaid national averages for one reportable measure:

- *Rating of Health Plan*

In addition, this measure rate was at least 5 percentage points less than the 2017 national average.

[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.

Table 7-4 shows **Anthem**'s 2018 Nevada Check Up CAHPS top-box rates.[7-7] Since NCQA does not publish separate rates for the Children's Health Insurance Program (CHIP), national comparisons could not be made. In 2018, a total of 1,600 Nevada Check Up general child members were administered a survey, of whom 208 completed a survey.[7-8] After ineligible members were excluded, the response rate was 13.3 percent.

Table 7-4—Anthem Nevada Check Up CAHPS Results

	2018 General Child Top-Box Rates
Composite Measures	
Getting Needed Care	NA
Getting Care Quickly	NA
How Well Doctors Communicate	89.8%
Customer Service	NA
Shared Decision Making	NA
Global Ratings	
Rating of All Health Care	63.9%
Rating of Personal Doctor	68.9%
Rating of Specialist Seen Most Often	NA
Rating of Health Plan	71.8%

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 2018 Nevada Check Up CAHPS top-box rates for the CCC population.[7-9] Since NCQA does not publish separate rates for the CHIP program, national comparisons could not be made. In 2018, a total of 39 Nevada Check Up child members with a chronic condition completed a survey.[7-10]

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

	2018 CCC Supplemental Top-Box Rates
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 2018 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 2018 adult Medicaid CAHPS top-box rates. In 2018, a total of 1,890 members were administered a survey, of whom 282 completed a survey. After ineligible members were excluded, the response rate was 15.1 percent. In 2017, the average NCQA response rate for the adult Medicaid population was 23.3 percent, higher than **HPN**'s response rate.[7-11]

Table 7-6—HPN Adult Medicaid CAHPS Results

	2018 Top-Box Rates
Composite Measures	
Getting Needed Care	75.2%
Getting Care Quickly	75.7%
How Well Doctors Communicate	86.7%
Customer Service	NA
Shared Decision Making	NA
Global Ratings	
Rating of All Health Care	50.5%
Rating of Personal Doctor	60.5%
Rating of Specialist Seen Most Often	64.5%
Rating of Health Plan	56.5%
Effectiveness of Care*	
Advising Smokers and Tobacco Users to Quit	57.5%
Discussing Cessation Medications	26.3%
Discussing Cessation Strategies	17.6%

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 2018 rate is at least 5 percentage points less than the 2017 national average.

HPN's 2018 top-box rates for the adult Medicaid population were lower than the 2017 NCQA adult Medicaid national averages for all reportable measures:

[7-11] 2017 NCQA national response rate information for the CAHPS 5.0 Adult Medicaid Survey was not available at the time this report was produced.

- *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, six measure rates were at least 5 percentage points less than the 2017 national averages:

- *Getting Needed Care*
- *Getting Care Quickly*
- *Rating of Personal Doctor*
- *Advising Smokers and Tobacco Users to Quit*
- *Discussing Cessation Medications*
- *Discussing Cessation Strategies*

Table 7-7 shows **HPN**'s 2018 child Medicaid CAHPS top-box rates.[7-12] In 2018, a total of 2,310 general child members were administered a survey, of whom 333 completed a survey.[7-13] After ineligible members were excluded, the response rate was 14.5 percent. In 2017, the average NCQA response rate for the child Medicaid population was 22.3 percent, higher than **HPN**'s response rate.[7-14]

Table 7-7—HPN General Child Medicaid CAHPS Results

	2018 General Child Top-Box Rates
Composite Measures	
Getting Needed Care	79.9%
Getting Care Quickly	86.4%
How Well Doctors Communicate	91.8%
Customer Service	NA
Shared Decision Making	NA
Global Ratings	
Rating of All Health Care	68.1%
Rating of Personal Doctor	75.9%
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 2018 top-box rates for the general child Medicaid population were lower than the 2017 NCQA general child Medicaid national averages for five reportable measures:

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

[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] 2018 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.

HPN's 2018 top-box rates for the general child Medicaid population were higher than the 2017 NCQA general child Medicaid national averages for one reportable measure:

- *Rating of Health Plan*

None of these measures, however, was at least 5 percentage points less or greater than the 2017 national averages.

Table 7-8 shows **HPN**'s 2018 CCC Medicaid CAHPS top-box rates.[7-15] In 2018, a total of 158 child members with a chronic condition completed a survey.[7-16]

Table 7-8—HPN CCC Medicaid CAHPS Results

	2018 CCC Supplemental Top-Box Rates
Composite Measures	
Getting Needed Care	86.9%
Getting Care Quickly	90.8%
How Well Doctors Communicate	93.8%
Customer Service	NA
Shared Decision Making	NA
Global Ratings	
Rating of All Health Care	60.6%
Rating of Personal Doctor	72.6%
Rating of Specialist Seen Most Often	NA
Rating of Health Plan	68.1%
CCC Composite Measures/Items	
Access to Specialized Services	NA
Family Centered Care (FCC): Personal Doctor Who Knows Child	84.9%
Coordination of Care for Children with Chronic Conditions	NA
Access to Prescription Medicines	92.8%
FCC: Getting Needed Information	91.0%

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 2018 rate is at least 5 percentage points less than the 2017 national average.

HPN's 2018 top-box rates for the CCC population were lower than the 2017 NCQA CCC Medicaid national averages for six reportable measures:

- *Getting Care Quickly*
- *How Well Doctors Communicate*

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

Of these, two measure rates were at least 5 percentage points less than the 2017 national averages:

- *Rating of All Health Care*
- *Family Centered Care (FCC): Personal Doctor Who Knows Child*

HPN's 2018 top-box rates for the CCC population were higher than the 2017 NCQA CCC Medicaid national averages for three reportable measures:

- *Getting Needed Care*
- *Rating of Health Plan*
- *Access to Prescription Medicines*

Table 7-9 shows **HPN**'s 2018 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 2018, a total of 1,650 Nevada Check Up general child members were surveyed and 492 completed a survey.[7-18] After ineligible members were excluded, the response rate was 21.7 percent.

Table 7-9—HPN Nevada Check Up CAHPS Results

	2018 General Child Top-Box Rates
Composite Measures	
Getting Needed Care	81.8%
Getting Care Quickly	87.4%
How Well Doctors Communicate	91.7%
Customer Service	92.3%
Shared Decision Making	NA
Global Ratings	
Rating of All Health Care	73.7%
Rating of Personal Doctor	76.3%
Rating of Specialist Seen Most Often	NA
Rating of Health Plan	78.7%

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).

[7-17] 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 2018 Nevada Check Up CAHPS top-box rates for the CCC population.[7-19] Since NCQA does not publish separate rates for CHIP, national comparisons could not be made. In 2018, 158 Nevada Check Up child members with a chronic condition completed a survey.[7-20]

Table 7-10—HPN CCC Nevada Check Up CAHPS

	2018 CCC Supplemental Top-Box Rates
Composite Measures	
Getting Needed Care	85.2%
Getting Care Quickly	NA
How Well Doctors Communicate	90.4%
Customer Service	NA
Shared Decision Making	NA
Global Ratings	
Rating of All Health Care	66.7%
Rating of Personal Doctor	80.6%
Rating of Specialist Seen Most Often	NA
Rating of Health Plan	71.0%
CCC Composite Measures/Items	
Access to Specialized Services	NA
Family Centered Care (FCC): Personal Doctor	NA
Coordination of Care for Children with Chronic	NA
Access to Prescription Medicines	93.4%
FCC: Getting Needed Information	91.5%

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).

[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.

Plan Comparisons

This section presents a comparative analysis of survey results.

Response Rates

Table 7-11 shows **Anthem**'s and **HPN**'s 2018 response rates for the adult Medicaid, child Medicaid, and Nevada Check Up populations. In addition, the 2017 NCQA national average response rate is displayed for comparison purposes, where applicable.

Table 7-11–Plan Comparisons: Response Rates

Population	Anthem Response Rate	HPN Response Rate	2017 NCQA National Average Response Rate
Adult Medicaid	11.68%	15.08%	23.3%
Child Medicaid	8.65%	14.54%	22.3%
Nevada Check Up	13.28%	21.74%	NA*

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

Comparative Analysis

A population-to-population comparative analysis identified whether one population performed statistically and significantly higher, the same, or lower on each measure. Table 7-12 through 7-16 show the plan comparisons of the following populations for **Anthem** and **HPN**: adult Medicaid, child Medicaid, and Nevada Check Up. Statistically significant differences between the top-box rates for **Anthem** and **HPN** are noted with arrows.

Table 7-12–Plan Comparisons: Adult Medicaid

	Anthem Adult	HPN Adult
Composite Measures		
Getting Needed Care	81.2%	75.2%
Getting Care Quickly	79.0%	75.7%
How Well Doctors Communicate	87.4%	86.7%
Customer Service	NA	NA
Shared Decision Making	NA	NA
Global Ratings		
Rating of All Health Care	46.9%	50.5%
Rating of Personal Doctor	58.5%	60.5%
Rating of Specialist Seen Most Often	64.7%	64.5%
Rating of Health Plan	51.9%	56.5%
Effectiveness of Care*		
Advising Smokers and Tobacco Users to Quit	64.9%	57.5%
Discussing Cessation Medications	30.9%	26.3%
Discussing Cessation Strategies	24.7%	17.6%

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 2018 rate is statistically significantly higher than the other MCO's population.

↓ Indicates the 2018 rate is statistically significantly lower than the other MCO's population.

Table 7-13–Plan Comparisons: General Child

	Anthem General Child	HPN General Child
Composite Measures		
Getting Needed Care	79.5%	79.9%
Getting Care Quickly	89.9%	86.4%
How Well Doctors Communicate	89.1%	91.8%
Customer Service	NA	NA
Shared Decision Making	NA	NA
Global Ratings		
Rating of All Health Care	72.5%	68.1%
Rating of Personal Doctor	74.0%	75.9%
Rating of Specialist Seen Most Often	NA	NA
Rating of Health Plan	69.9%	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).
↑ Indicates the 2018 rate is statistically significantly higher than the other MCO's population.
↓ Indicates the 2018 rate is statistically significantly lower than the other MCO's population.

Table 7-14–Plan Comparisons: Nevada Check Up General Child

	Anthem Nevada Check Up General Child	HPN Nevada Check Up General Child
Composite Measures		
Getting Needed Care	NA	81.8%
Getting Care Quickly	NA	87.4%
How Well Doctors Communicate	89.8%	91.7%
Customer Service	NA	92.3%
Shared Decision Making	NA	NA
Global Ratings		
Rating of All Health Care	63.9%	73.7%
Rating of Personal Doctor	68.9%	76.3%
Rating of Specialist Seen Most Often	NA	NA
Rating of Health Plan	71.8%	78.7%

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).
↑ Indicates the 2018 rate is statistically significantly higher than the other MCO's population.
↓ Indicates the 2018 rate is statistically significantly lower than the other MCO's population.

Table 7-15–Plan Comparisons: Children with Chronic Conditions

	Anthem CCC	HPN CCC
Composite Measures		
Getting Needed Care	NA	86.9%
Getting Care Quickly	NA	90.8%
How Well Doctors Communicate	NA	93.8%
Customer Service	NA	NA
Shared Decision Making	NA	NA
Global Ratings		
Rating of All Health Care	NA	60.6%
Rating of Personal Doctor	NA	72.6%
Rating of Specialist Seen Most Often	NA	NA
Rating of Health Plan	56.9%	68.1%
CCC Composite Measures/Items		
Access to Specialized Services	NA	NA
Family Centered Care (FCC): Personal Doctor Who Knows Child	NA	84.9%
Coordination of Care for Children with Chronic Conditions	NA	NA
Access to Prescription Medicines	NA	92.8%
FCC: Getting Needed Information	NA	91.0%

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 2018 rate is statistically significantly higher than the other MCO's population.

↓ Indicates the 2018 rate is statistically significantly lower than the other MCO's population.

Table 7-16–Plan Comparisons: Nevada Check Up Children with Chronic Conditions

	Anthem Nevada Check Up CCC	HPN Nevada Check Up CCC
Composite Measures		
Getting Needed Care	NA	85.2%
Getting Care Quickly	NA	NA
How Well Doctors Communicate	NA	90.4%
Customer Service	NA	NA
Shared Decision Making	NA	NA
Global Ratings		
Rating of All Health Care	NA	66.7%
Rating of Personal Doctor	NA	80.6%
Rating of Specialist Seen Most Often	NA	NA
Rating of Health Plan	NA	71.0%
CCC Composite Measures/Items		
Access to Specialized Services	NA	NA
Family Centered Care (FCC): Personal Doctor Who Knows Child	NA	NA
Coordination of Care for Children with Chronic Conditions	NA	NA
Access to Prescription Medicines	NA	93.4%
FCC: Getting Needed Information	NA	91.5%

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).

↑ Indicates the 2018 rate is statistically significantly higher than the other MCO's population.

↓ Indicates the 2018 rate is statistically significantly lower than the other MCO's population.

Conclusions and Recommendations

Anthem

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 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 less 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*.

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 less than the 2017 NCQA CCC Medicaid national average.

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 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.

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 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.

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 less 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 averaged. For the CCC Medicaid population, **HPN** should focus on improving *Rating of All Health Care* and *FCC: Personal Doctor Who Knows Child*, since the rates for these measures were at least 5 percentage points less than the 2017 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 as well as the top-box rates for CAHPS measures. Section 9 contains more information.

8. Health Care Guidance Program (HCGP) Performance Measure Validation

Background

In February 2012, the State of Nevada Department of Health and Human Services, Division of Health Care Financing and Policy (the DHCFP), issued a request for proposal to contract with a care management organization (CMO) to administer care management services to Nevada Comprehensive Care Waiver (NCCW) program enrollees. The NCCW program mandates care management services throughout the state for a subset of high-cost, high-need beneficiaries not served by the existing managed care organizations.

The DHCFP awarded a contract to **McKesson Health Solutions**, which later changed its name to **McKesson Technologies, Inc**. (**McKesson**), to serve as the State's CMO. The contract took effect November 12, 2013, and **McKesson** implemented the Nevada Health Care Guidance Program (HCGP) with a program start date of June 1, 2014. The first day of **McKesson**'s operations, however, was Monday June 2, 2014. On June 2, 2015, **Comvest Partners** purchased **McKesson Technologies, Inc.**'s care management business, which is now doing business as **APH** (**APH**).

The DHCFP sought to verify that **APH** collected and reported complete and accurate performance measure data annually for contractually required performance measures. To that end, the DHCFP contracted with Health Services Advisory Group, Inc. (HSAG), the State's external quality review organization (EQRO), to validate the performance measure rates that **APH** calculated and reported. HSAG validated **APH**'s performance measures using the Centers for Medicare and Medicaid Services (CMS) external quality review (EQR) Protocol 2[8-1] as its guide to ensure the performance measure validation (PMV) activity was performed in accordance with industry standards of practice. HSAG's PMV activity focused on the following objectives:

1. Assess the accuracy of the required performance measures that **APH** reported.
2. Determine the extent to which the measures that **APH** calculated followed the DHCFP's specifications and reporting requirements.

Performance Measures Validated

HSAG validated a set of performance measures selected by the DHCFP for validation. The measures primarily consisted of performance measures that were contractually required by the DHCFP, but not

[8-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 1, 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Sept 26, 2018.

part of the HCGP pay-for-performance (P4P) program. These measures are herein referred to as the non-P4P measures.

Validation Results

Several aspects involved in the calculation of performance measures are crucial to the validation process. These include data retrieval, integration, data control, and source code development and documentation of performance measure calculations. A description for each of these activities is provided below.

Data Retrieval

HSAG reviewed the processes **APH** used to receive, transfer, and store the source data used for calculating the measures, which included staff interview and discussion of the data flow for the various sources of data. Overall, HSAG determined that the data processes in place at **APH** were adequate.

Data Integration

HSAG reviewed the **APH** data integration process, which included a review of file consolidations or extracts, data integration documentation, source code, and linking mechanisms. Overall, HSAG determined that the data integration processes in place at **APH** were adequate.

Data Control

HSAG reviewed the data control processes used by **APH**, which included a review of the data flow process, disaster recovery procedures, data backup protocols, and related policies and procedures. Overall, the audit team determined that the data control processes in place at **APH** were adequate.

Source Code Development and Performance Measure Documentation

HSAG conducted a line-by-line source code review for all measures and reviewed related documentation, which included the completed Information Systems Capabilities Assessment Tool, computer programming code, output files, work flow diagrams, and narrative descriptions of performance measure calculations. All applicable source code was approved prior to the on-site visit. HSAG also determined that the documentation of performance measure calculations by **APH** was adequate.

Performance Measure Validation Results

On September 8, 2017, HSAG received the final performance measure results generated by **APH** based on the latest receipt of all applicable monthly operational files. Table 8-1 shows the measure-specific

validation results for **APH** for program period 2 (June 1, 2015, through May 30, 2016) that included a 12-month claims run-out.

Table 8-1—Measure-Specific Validation Results for APH

Measure ID	Measure	Program Period 2 (June 1, 2015–May 30, 2016)			Audit Validation Results
		Num	Den	Rate	
CCHU.1	*Ambulatory Care-Sensitive Condition Hospital Admission (per 100,000 population)*	2794	39333	7103.45	**Reportable**
CCHU.2	*"Avoidable" ER Visits*	16800	55891	30.1%	**Reportable**
FUP	*Follow-Up with PCP After Hospitalization (within 30 days of discharge)*	3326	5630	59.1%	**Reportable**
FUP	*Follow-Up with PCP After Hospitalization (within 7 days of discharge)*	1887	5630	33.5%	**Reportable**
MRP	*Medication Reconciliation Post-Discharge*	61	5617	1.1%	**Reportable**
DEM	*Cognitive Assessment for Dementia*	6	280	2.1%	**Reportable**
NEUR	*Stroke and Stroke Rehabilitations—Discharged on Antithrombotic Therapy*	24	229	10.5%	**Reportable**
CKD	*Adult Kidney Disease—Laboratory Testing (Lipid Profile)*	507	894	56.7%	**Reportable**
RA	*Disease-modifying Anti-Rheumatic Drug (DMARD) Therapy for Rheumatoid Arthritis*	120	179	67.0%	**Reportable**
OST	*Osteoporosis—Pharmacologic therapy for men and women aged 50 years and older*	NR	NR	NR	**Not Reportable**
OBS.1	*Percentage of members whose BMI calculation is documented, and counseling for nutrition and physical activity is provided during the measurement year (3–11 Years)* ***BMI total***	262	3551	7.4%	**Reportable**
OBS.2	*Percentage of members whose BMI calculation is documented, and counseling for nutrition and physical activity is provided during the measurement year. (12–17 Years)* ***BMI total***	240	3151	7.6%	**Reportable**
OBS.3	*Percentage of members whose BMI calculation is documented, and counseling for nutrition and physical activity is provided during the measurement year (3–11 Years)* ***Counseling for Nutrition Total***	112	3551	3.2%	**Reportable**
OBS.4	*Percentage of members whose BMI calculation is documented, and counseling for nutrition and physical activity is provided during the measurement year (12–17 Years)* ***Counseling for Nutrition Total***	98	3151	3.1%	**Reportable**
OBS.5	*Percentage of members whose BMI calculation is documented, and counseling for nutrition and physical activity is provided during the measurement year (3–11 Years)* ***Counseling for Physical Activity Total***	23	3551	0.6%	**Reportable**

Measure ID	Measure	Program Period 2 (June 1, 2015–May 30, 2016)			Audit Validation Results
		Num	Den	Rate	
OBS.6	*Percentage of members whose BMI calculation is documented, and counseling for nutrition and physical activity is provided during the measurement year (12–17 Years)* ***Counseling for Physical Activity Total***	26	3151	0.8%	**Reportable**
CAP.1	*Children and Adolescents' Access to Primary Care Practitioners (12–24 months)*	93	97	95.9%	**Reportable**
CAP.2	*Children and Adolescents' Access to Primary Care Practitioners (25 months–6 years)*	1177	1314	89.6%	**Reportable**
CAP.3	*Children and Adolescents' Access to Primary Care Practitioners (7–11 years)*	2167	2319	93.4%	**Reportable**
CAP.4	*Children and Adolescents' Access to Primary Care Practitioners (12–19 years)*	3442	3690	93.3%	**Reportable**
W15.1	*Well-Child Visits in the First 15 Months of Life (0 Visits)*	2	68	2.9%	**Reportable**
W15.2	*Well-Child Visits in the First 15 Months of Life (1 Visit)*	4	68	5.9%	**Reportable**
W15.3	*Well-Child Visits in the First 15 Months of Life (2 Visits)*	3	68	4.4%	**Reportable**
W15.4	*Well-Child Visits in the First 15 Months of Life (3 Visits)*	6	68	8.8%	**Reportable**
W15.5	*Well-Child Visits in the First 15 Months of Life (4 Visits)*	9	68	13.2%	**Reportable**
W15.6	*Well-Child Visits in the First 15 Months of Life (5 Visits)*	12	68	17.6%	**Reportable**
W15.7	*Well-Child Visits in the First 15 Months of Life (6 or more visits)*	32	68	47.1%	**Reportable**
W34	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*	662	1197	55.3%	**Reportable**
AWC	*Adolescent Well-Care Visits*	1778	5145	34.6%	**Reportable**
CIS.1	*Childhood Immunization Status (Dtap)*	63	122	51.6%	**Reportable**
CIS.2	*Childhood Immunization Status (IPV)*	97	122	79.5%	**Reportable**
CIS.3	*Childhood Immunization Status (MMR)*	91	122	74.6%	**Reportable**
CIS.4	*Childhood Immunization Status (HiB)*	91	122	74.6%	**Reportable**
CIS.5	*Childhood Immunization Status (HepB)*	95	122	77.9%	**Reportable**
CIS.6	*Childhood Immunization Status (VZV)*	92	122	75.4%	**Reportable**
CIS.7	*Childhood Immunization Status (PCV)*	72	122	59.0%	**Reportable**
CIS.8.	*Childhood Immunization Status (HepA)*	96	122	78.7%	**Reportable**
CIS.9	*Childhood Immunization Status (Rotavirus)*	55	122	45.1%	**Reportable**
CIS.10	*Childhood Immunization Status (Influenza)*	45	122	36.9%	**Reportable**

Measure ID	Measure	Program Period 2 (June 1, 2015–May 30, 2016)			Audit Validation Results
		Num	Den	Rate	
CIS.11	*Childhood Immunization Status (Combination #2)*	60	122	49.2%	**Reportable**
CIS.12	*Childhood Immunization Status (Combination #3)*	59	122	48.4%	**Reportable**
CIS.13	*Childhood Immunization Status (Combination #4)*	59	122	48.4%	**Reportable**
CIS.14	*Childhood Immunization Status (Combination #5)*	32	122	26.2%	**Reportable**
CIS.15	*Childhood Immunization Status (Combination #6)*	33	122	27.0%	**Reportable**
CIS.16	*Childhood Immunization Status (Combination #7)*	32	122	26.2%	**Reportable**
CIS.17	*Childhood Immunization Status (Combination #8)*	33	122	27.0%	**Reportable**
CIS.18	*Childhood Immunization Status (Combination #9)*	18	122	14.8%	**Reportable**
CIS.19	*Childhood Immunization Status (Combination #10)*	18	122	14.8%	**Reportable**
PPC.1	*Timeliness of Prenatal Care*	50	210	23.8%	**Reportable**
PPC.2	*Postpartum Care*	31	210	14.8%	**Reportable**
FPC.1	*Frequency of Ongoing Prenatal Care, <21 percent of expected visits*	147	210	70.0%	**Reportable**
FPC.2	*Frequency of Ongoing Prenatal Care, 21 percent–40 percent of expected visits*	45	210	21.4%	**Reportable**
FPC.3	*Frequency of Ongoing Prenatal Care, 41 percent–60 percent of expected visits*	11	210	5.2%	**Reportable**
FPC.4	*Frequency of Ongoing Prenatal Care, 61 percent–80 percent of expected visits*	3	210	1.4%	**Reportable**
FPC.5	*Frequency of Ongoing Prenatal Care, ≥81 percent of expected visits*	4	210	1.9%	**Reportable**
ABA	*Adult BMI Assessment*	1431	9362	15.3%	**Reportable**
BCS	*Breast Cancer Screening*	1175	2632	44.6%	**Reportable**
CCS	*Cervical Cancer Screening*	2536	6850	37.0%	**Reportable**
COL	*Colorectal Cancer Screening*	1406	5003	28.1%	**Reportable**
WOP	*Percentage of women who delivered a live birth during the measurement year by the weeks of pregnancy at the time of their enrollment in the organization. 1–12 weeks (279–196 days prior to delivery)*	31	265	11.7%	**Reportable**
WOP	*Percentage of women who delivered a live birth during the measurement year by the weeks of pregnancy at the time of their enrollment in the organization. 13–27 weeks (195–91 days prior to delivery)*	43	265	16.2%	**Reportable**
WOP	*Percentage of women who delivered a live birth during the measurement year by the weeks of pregnancy at the time of their enrollment in the organization. 28 or more weeks of pregnancy (<=90 days prior to delivery)*	48	265	18.1%	**Reportable**

Measure ID	Measure	Program Period 2 (June 1, 2015–May 30, 2016)			Audit Validation Results
		Num	Den	Rate	
WOP	*Percentage of women who delivered a live birth during the measurement year by the weeks of pregnancy at the time of their enrollment in the organization. <=0 weeks (280 days or more prior to delivery)*	133	265	50.2%	**Reportable**
WOP	*Percentage of women who delivered a live birth during the measurement year by the weeks of pregnancy at the time of their enrollment in the organization. Unknown*	10	265	3.8%	**Reportable**

Summary of Findings

At the time of the performance measure validation audit, **APH** had an enrollment of approximately 37,000 members and provided active case management to approximately 3,000 of them. The audit examined 22 non-P4P measures for **APH**. The rates for the performance measures appear to be appropriately calculated. **APH** determined all but one as reportable for the year; however, there were issues identified during the on-site audit.

APH received operations and reconciliation claims files from DXC to calculate the measures. DXC produced the monthly operational files and the quarterly reconciliation files and provided them to **APH** through a file transfer protocol (FTP) site. The auditor identified differences in the calculated rates submitted that used data from the operational files and those calculated from the reconciliation files. Rate differences also were identified in the rates calculated in 2016 with a three-month claims run-out and the rates calculated in 2017 for the same measurement period with a 12-month claims run-out. **APH** stated that 98 percent of claims were included in the files received from DXC with a three-month claims run-out.

APH was asked to describe its process to analyze and identify the cause of the rate differences and the resulting impact to the rates. During follow-up from the on-site visit, HSAG also reviewed the data from the monthly operational files and the quarterly reconciliation files for the CKD measure submitted by **APH**. In one case reviewed, the monthly operational file did not include a diagnosis code that was included in the quarterly reconciliation file. **APH** was unable to describe the cause of the file differences or the resulting impact to the measure rates. For future performance measure reporting, further discussion with the DHCFP may be needed regarding the differences in the DXC operations and reconciliation files provided to **APH**.

Based on the audit findings, HSAG recommends the DHCFP work with DXC and **APH** to identify the root cause of the data differences in the claims monthly operational files and the quarterly reconciliation files. **APH** should use the information from the analysis to determine impacts to the measure rates.

Program Update

The NCCW program, HCGP, concluded on June 30, 2018. The DHCFP phased out the HCGP in accordance with the Special Terms and Conditions set by CMS. The DHCFP currently is researching other care management models that will meet the needs of Nevada Medicaid recipients.

9. Follow-Up on Recommendations

Introduction

As the EQRO for the Nevada DHCFP, HSAG conducted the following EQR activities for the Nevada MCOs during SFY 2016–2017.

- Validation of HEDIS performance measures
- Validation of PIPs
- Analysis of each MCO's 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. Annually, the EQRO must report the MCO-specific results and the degree to which each MCO followed up to address any recommendations the EQRO made. This section presents an assessment of how effectively the MCOs addressed the recommendations that HSAG made based on the results of the previous year's EQR activities. Since compliance review activities were not performed in SFY 2016–2017, there were no recommendations related to compliance.

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 2017 Technical Specifications* and to review the MCOs' performance on the HEDIS measures. For HEDIS 2017, the MCOs were required to report 17 measures yielding a total of 45 rates for the

Medicaid population and 14 measures yielding a total of 35 rates for the Nevada Check Up population. HSAG validated all measures the MCOs reported.

Anthem's Response to HSAG's Recommendations

Table 9-1 and 9-2 detail HSAG's recommendations related to validation of performance measures for **Anthem**, as well as **Anthem**'s response.

Table 9-1—Validation of Performance Measures—Recommendation and Anthem Response 1

HSAG HEDIS Recommendation 1
Anthem's HEDIS 2017 Medicaid population rates indicated areas for improvement related to access to care for children/adolescents. While all four children/adolescent access to care indicators have shown slight improvement from HEDIS 2015 to HEDIS 2017, the rates demonstrate opportunities for improvement when compared to the national Medicaid percentiles. In conducting a causal barrier analysis to determine causes impacting CAHPS rates, **Anthem** staff members reported that the expansion of Medicaid eligibility in 2014 may have strained the provider network and, as a result, negatively impacted the availability of appointments. For HEDIS 2017, the denominators in each of the children's access to primary care indicators increased, which was expected with Medicaid expansion. In 2016, **Anthem** hired additional provider relations consultants to review the network and contract with additional providers to fill network gaps. It is possible that the timing of these efforts may not have been early enough to positively impact the availability of appointments to such a degree that it would improve children's and adolescents access to care. Since *Children and Adolescents' Access to Primary Care Practitioners* is an access-related measure, HSAG recommends that **Anthem** continue to evaluate the adequacy of its provider network for children's services, including capacity and geographic locations, to determine if a sufficient number of providers have been added to improve capacity and accessibility. Further, **Anthem** should evaluate the provider appointment availability for children and adolescents as part of its secret shopper survey activities. This is one of the new contract requirements for the MCOs operating in the Nevada managed care program.
Anthem HEDIS Response to HSAG Recommendation 1
Anthem provided the following update in response to HSAG recommendation. **Geo Access for Pediatricians** • 2017 Geo Access: 1 PCP within 25 miles of member home • 100 percent of members have at least 1 Pediatrician PCP provider within 25 miles **Access and Availability Survey for Pediatricians** • In 2017, **Anthem** completed the following surveys to monitor pediatrics appointment availability and access. – Appointment Availability Survey—completed by vendor – After Hour Appointment Survey—completed by vendor – Secret shopper calls—completed by internal provider relations team

Table 9-2—Validation of Performance Measures—Recommendation and Anthem Response 2

HSAG HEDIS Recommendation 2
Anthem's HEDIS 2017 Medicaid population rates also indicated areas for improvement related to HbA1c testing for diabetic members. In its 2016 annual quality evaluation, **Anthem** reported an increase in enrollment in the disease management program for diabetics. Of the 3,673 members enrolled in disease management for diabetes, 96.8 percent received "passive management" which, according to the **Anthem** quality evaluation, meant that members were "considered lower risk and received non-interactive interventions, including condition-specific educational mailings." According to **Anthem**'s quality evaluation, members enrolled in active management had "complex, comorbid conditions and worked collaboratively with a nurse case manager by phone to establish holistic goals, develop a plan of care, and track progress toward meeting goals." HSAG recommends that **Anthem** evaluate the effectiveness of active disease management compared to passive disease management to determine if active management with a care manager, or components of it, is more effective in meeting numerator compliance for the *Comprehensive Diabetes Care* indicators. By evaluating the effectiveness of its interventions, **Anthem** will be able to discern the most effective interventions and spread them across the population.
Anthem HEDIS Response to HSAG Recommendation 2
Anthem provided the following response to HSAG's recommendation: "**Anthem** compared members in Passive Disease Management (DM) versus members in Active DM program for compliance with CDC measure. Using the measurement year (MY) 2017 data, a total of 4,093 members with Diabetes who were enrolled in either Passive DM or Active DM were evaluated for compliance with A1c Testing, Eye Exam Test, Nephropathy test, A1c >9, A1c <8. Of the total (4,093) members included in the analysis, 3154 (77 percent) were in Active DM program while 939 (23 percent) were in Passive DM program. Overall, Members in Passive DM program had a higher compliance rate compared to members in Active DM program. Various CDC sub measures were compared between the Passive and the Active DM groups. **Anthem** was able to discern that both Passive and Active DM programs are effective interventions for our members. **Anthem** continues to identify and increase member participation in the DM program."

HPN's Response to HSAG's Recommendations

Table 9-3 through 9-7 detail HSAG's recommendations related to validation of performance measures for **HPN,** as well as **HPN**'s response.

Table 9-3—Validation of Performance Measures—Recommendation and HPN Response 1

HSAG HEDIS Recommendation 1
HPN's HEDIS 2017 Medicaid population rates indicated areas for improvement for access to care for children/adolescents when compared to national Medicaid percentiles, even though all of the indicators have shown improvement, based on performance, from HEDIS 2015 to HEDIS 2017. The **HPN** 2016 Quality Improvement Program evaluation contained a subgroup analysis performed at **HPN** for the access to care for children/adolescent indicators, which included an analysis by race/ethnicity for all four indicators. The annual evaluation did not show, however, an analysis of numerator compliance by geographic location. Since access to primary care for children and adolescents is an access-related measure, HSAG recommends that **HPN** evaluate the numerator compliance by geographic location to determine if disparities exist. Further, **HPN** should continue to evaluate the adequacy of its provider network by geographic location to determine if the network has a

HSAG HEDIS Recommendation 1
sufficient number of available pediatric providers to serve the population. When completing its contractually required secret shopper survey to determine appointment availability, **HPN** should ensure that pediatricians are included in the sample to determine if network pediatricians are accepting new patients and if appointments are available.

HPN HEDIS Response to HSAG Recommendation 1
In addition to the analysis included in the 2016 Quality Improvement Program evaluation, **Health Plan of Nevada** (**HPN**) conducted an analysis of the Children and Adolescents' Access to Primary Care Practitioners (PCP) HEDIS measure, which included county, ZIP code, race, age, and gender to determine any disparities. The results of the county and ZIP code analysis were shared with **HPN**'s Provider Services. A further evaluation of the number of providers within the top-rated noncompliant ZIP codes was conducted to ensure this was not a cause for noncompliance. **HPN** also conducts monthly analysis to ensure that all contractual requirements regarding access to care for primary care practitioners, which include pediatricians, are met and sustained, including: • **HPN** must have at least one (1) full-time equivalent (FTE) primary care provider for every one thousand five hundred (1,500) enrollees per service area. However, if the PCP practices in conjunction with a health care professional, the ratio is increased to one (1) FTE PCP for every one thousand eight hundred (1,800) recipients per service area. • **HPN** must provide access to all types of physician specialists for PCP referrals, and it must employ or contract with specialists or arrange for access to specialty care outside of **HPN**'s network, if necessary, in sufficient numbers to ensure specialty services are available in a timely manner. The minimum ratio for across-the-board specialists (i.e., those who are not PCPs) is one (1) specialist per one thousand five hundred recipients per service area (1:1,500). • **HPN** must offer every enrolled recipient a PCP located within a reasonable distance from the enrolled recipient's place of residence, but the PCP may not be more than twenty-five (25) miles from the enrolled recipient's place of residence. **HPN** has and will continue to conduct Secret Shopper Surveys of the pediatricians in the **HPN** network. All pediatricians who hold a panel receive a secret shopper audit by the **HPN** provider advocates. Additionally, claims volume and empanelment size are reviewed to ensure the high-volume pediatricians receive a secret shopper audit more frequently. If a provider fails to meet the appointment standards set forth in the contract, provider advocates contact the provider to discuss the contractual standards. As a result of continuing education with providers, the 2018 secret shopper audit results to date reflect that 95 percent of the pediatricians are scheduling within the access standards. During the secret shopper audit the advocate also confirms the provider is accepting new patients. For 2018 to date, 99 percent of the providers indicated they had an open panel. **HPN** has taken the following steps to assist with increasing compliance with the Children and Adolescents' Access to Primary Care Practitioners HEDIS measure: • Offering an incentive program for members who are noncompliant for all age categories of this HEDIS measure. Members receive a mailer alerting them of their noncompliance, educating them on the importance of seeing a PCP every year and on how to receive the gift card, and providing a member service phone number for any necessary assistance scheduling of an appointment or attending an appointment. The dollar amount of the gift card was increased for 2018. • Members receive a live telephone call alerting them of their noncompliance, educating them on the importance of seeing a PCP every year, and offering to schedule appointments and address any concerns with

HPN HEDIS Response to HSAG Recommendation 1
attending an appointment. Reminder calls and follow-up calls are made where rescheduling is completed, if needed. • Fostering the increase in providers offering additional after hours service or urgent care clinics for their members who need after hours care and ensuring these visits are HEDIS-compliant. • Increasing member awareness of the NOW Clinic, **HPN**'s telehealth program, and ensuring visits are HEDIS-compliant. • Increasing the number of Medicine on the Move events in noncompliant ZIP codes to encourage members to receive an annual visit with a PCP. Members receive a mailer and a live call notifying them of the event and inviting them to schedule an appointment. • Clinical practice consultants visit providers each month to review HEDIS requirements, provide a list of noncompliant members, evaluate barriers to members receiving care, and help address and offer best practices to ensure compliance with HEDIS measures. • Offering an incentive program for providers with members who are noncompliant with this HEDIS measure. Providers receive a list of members who are noncompliant, with demographic information included. Providers are encouraged to reach out to members to schedule appointments for noncompliant members. • Providers are offered co-branded postcards to mail to members who are noncompliant with HEDIS measures. • Members without contact information or incorrect contact information are processed through a vendor's system to determine if there is any additional contact information available. The health plan collects members' email addresses, which seems to be a more reliable source for member contact. **HPN** will continue to investigate additional opportunities to encourage members to see their PCPs each year and for opportunities to reach out to members to help schedule and address any barriers to completing an appointment.

Table 9-4—Validation of Performance Measures—Recommendation and HPN Response 2

HSAG HEDIS Recommendation 2
HPN's rates indicated improvement in the frequency of prenatal care from HEDIS 2015 to HEDIS 2017. This suggests that once pregnant women are identified in **HPN**'s population, the MCO's strategies to increase the number of prenatal care visits for women have been successful. The decline in performance for **HPN**'s rate for timeliness of prenatal care, however, suggests that pregnant women either have not been identified early enough in the pregnancy or enrollment in the MCO, or once identified they are not receiving prenatal services as quickly as they should. This could indicate an access to care issue. HSAG recommends that **HPN** evaluate the availability of prenatal care appointments within its provider network to determine if providers are accepting new patients and if earlier appointments may be established for members. The secret shopper survey, which the MCOs are required to complete as part of the MCO contract 3260, will be helpful in determining appointment availability for pregnant members.
HPN HEDIS Response to HSAG Recommendation 2
In the past, **HPN** relied on the eligibility file from the DHCFP as notification of a pregnant member. However, it was determined there was incorrect information in the files and the notification was not timely enough to meet HEDIS compliance for the Timeliness of Prenatal Care measure. Today **HPN** identifies pregnant members through various sources including but not limited to: • Positive Pregnancy Test Lab Claims

HPN HEDIS Response to HSAG Recommendation 2
• Prenatal Vitamin Prescriptions • Inpatient admissions • ER visits • Outpatient claims • Prior Authorization requests • **HPN** Case Management, Utilization Management, Member Services, 24-hour Nurse Line, Community Health Workers and other Internal Departments • Health risk assessments completed by new members • Maternity Risk Assessment Forms completed by OBs With the change in the identification source, **HPN** also changed our OB Case Management program to include an Outreach team, RN team, Community Health Worker and Clinical Practice Consultants. Each member of the team has a specific responsibility. The Outreach team contacts all of the members from the referral sources to determine the risk level and assist with scheduling OB appointments and offer any assistance with barriers to attending the appointments. The Outreach team maintains contact with the mothers who are low to medium risk throughout their pregnancy and after delivery. The RN team establishes contact with mothers who are high risk and it maintains contact through the pregnancy and until the baby is the age of two years. The Community Health Worker provides assistance with locating hard to reach mothers and visits with mothers in the community. The Outreach team, RN team and Community Health Worker all help to address not only a mother's medical care but also her social needs to ensure a healthy pregnancy and baby. The Clinical Practice Consultants works closely with our OBs to provide education around the timelines for the HEDIS measures and provides a list of members who were compliant and non-compliant with the measures to help address barriers and partner to ensure mothers receive timely, appropriate care. Through our Clinical Practice Consultant program we have seen an increase in the submission of the Maternity Risk Assessment Form completed by the providers for enrollment into our OB Outreach and Case Management Program. This relationship has also enabled us to have direct contact with clinics that will see members within the same day or within 24 hours for their initial prenatal appointment. We have also assisted in developing an Urgent Care Clinic for our mothers and ensuring these visits are HEDIS compliant. **HPN** has and will continue to conduct secret shop audits on the **HPN** Medicaid OB providers. All OB providers have always been included in the secret shop audit. **HPN** will continue to work with the providers and educate them on the importance of scheduling these members to ensure they meet the contractual time frames. **HPN** has taken the following steps to assist with increasing compliance with the Timeliness of Prenatal Care HEDIS measure: • Offering an incentive program for mothers who are compliant for the previous HEDIS Frequency of Prenatal Care measure. Members receive information in the mailed prenatal packet and their outreach or case manager educates on the importance of seeing their OB and educates on how to receive the gift card and provides any necessary assistance scheduling an appointment or attending an appointment. The program was updated from providing cribs to providing a gift card in 2017.

HPN HEDIS Response to HSAG Recommendation 2
• Members without contact information or incorrect contact information are processed through a vendor's system to determine if there is any additional contact information available. Members' email addresses are collected by the health plan, as this seems to be a more reliable source to contact members. • Offering an incentive program for providers who are compliant with initial prenatal appointment and the Maternity Risk Assessment Form. We are ensuring visits are HEDIS compliant. • **HPN** is collaborating with multiple community organizations whose mission is to educate all Nevada women on the importance of seeing an OB immediately for prenatal care and continuing care throughout the pregnancy and past delivery. • Encouraging providers to complete an initial prenatal appointment when the mother comes in for a pregnancy test instead of scheduling for a later date. To date, **HPN** has seen an almost 5 percent year-over-year increase in this HEDIS measure and will continue to investigate additional opportunities to encourage mothers to receive timely care, ensure OB providers schedule mothers appointment immediately especially for their initial appointment, and opportunities to reach out to mothers to help schedule and address any barriers to completing an appointment.

Table 9-5—Validation of Performance Measures—Recommendation and HPN Response 3

HSAG HEDIS Recommendation 3
HPN's HEDIS 2017 Medicaid population rates indicated areas for improvement related to HbA1c testing and blood pressure control for members with diabetes when compared to national Medicaid percentiles. The **HPN** 2016 Quality Improvement Program evaluation showed an evaluation and analysis of comprehensive diabetes care indicators (e.g., race and ethnicity analysis); however, HbA1c testing was not included as one of the indicators. Further, the **HPN** 2017 Quality Improvement Work Plan did not include diabetes care goals for the Medicaid population. HSAG recommends that **HPN** conduct detailed analyses to determine the factors that are impacting performance in these areas. Further, HSAG recommends that **HPN** establish performance goals for HbA1c testing and blood pressure control for Medicaid members with diabetes, and that it evaluates interventions to determine which have the greatest impact on the Medicaid population. The prioritization to study and improve HbA1c testing for Medicaid members with diabetes has the potential to earn **HPN** a performance award since it is one of the pay-for-performance indicators identified by the DHCFP.
HPN HEDIS Response to HSAG Recommendation 3
In addition to the analysis included in the 2016 Quality Improvement Program Evaluation, **Health Plan of Nevada** (**HPN**) conducted analysis of the Comprehensive Diabetes Care (CDC) Hemoglobin A1c (HbA1c) testing and Blood Pressure Control (<140-90 mm Hg) HEDIS measure, which included county, ZIP code, race, age and gender to determine any disparities. Strategies and goals were created to address the identified disparities. **HPN** has taken the following steps to assist with increasing compliance with the Comprehensive Diabetes Care HbA1c test and Blood Pressure HEDIS measure: • Offering an incentive program for members who are non-compliant for HbA1c testing HEDIS measure that will also assist with compliance with the Blood Pressure HEDIS measure. Members receive a mailer alerting them of their non-compliance, educating on the importance of seeing a PCP every year and getting tested, educating on how to receive the gift card, and it provides a member service phone number for any necessary

HPN HEDIS Response to HSAG Recommendation 3
assistance scheduling an appointment or attending an appointment. Dollar amount of gift card was increased for 2018. • Members receive a live telephone call alerting them of their non-compliance, educating on the importance of seeing a PCP and being tested every year and offering to schedule appointments and address any concerns with attending an appointment. Reminder calls and follow-up calls are made where rescheduling is completed if needed. • Promoting the increase in providers utilizing point of care machines in their offices for HbA1c testing instead of referring members to an off-site lab for testing and ensuring these tests are HEDIS compliant. • Fostering relationships with **HPN** preferred lab provider and PCP offices to determine opportunities to have a lab provider in the office or the ability to pick up lab samples from PCP office. • Increasing the number of Medicine on the Move events in non-compliant ZIP codes to encourage members to receive an annual visit with a PCP, including a blood pressure reading, HbA1c testing and diabetic eye exam. Members receive a mailer and a live call inviting them to schedule an appointment. • Clinical Practice Consultants visit providers on a monthly basis to review HEDIS requirements, provide a list of non-compliant members, evaluate with providers barriers to members receiving care and help to address and offer best practices to ensure compliance with HEDIS measures. • Clinical Practice Consultants conduct medical record reviews to determine areas of opportunity to increase provider compliance with Blood Pressure HEDIS measure. • Clinical Practice Consultants conducted on-site education at provider offices regarding the American Diabetes Association's (ADA) *Standards of Medical Care in Diabetes*. In addition, extensive education regarding coding efficiency via the utilization of Current Procedural Terminology II (CPT II) codes was conducted. Detailed reports that reflected the health status of members was shared with primary care providers. Furthermore, providers were instructed to review the member's plan of care and refer to endocrinology, health education and wellness and disease management as needed. • Clinical Practice Consultants conducted on-site education at provider offices regarding the American Heart Association's (AHA) *2017 Guideline for The Prevention, Detection, Evaluation and Management of High Blood Pressure in Adult*. The utilization of CPT II codes to track BP measurement at every visit enabled the health plan to identify members based on BP measurement and thus facilitated early interventions. • Offering an incentive program for providers who have members who are non-compliant with this HEDIS measure. Providers receive a list of members who are non-compliant, with demographic information included. Providers are encouraged to reach out to members to schedule appointments for non-compliant members. • Providers are offered co-branded postcards to mail to members who are non-compliant with HEDIS measures. • Members without contact information or incorrect contact information are processed through a vendor's system to determine if there is any additional contact information available. Members' email addresses are collected by the health plan, as it seems to be a more reliable source to contact members. • The results of the county and ZIP code analysis were shared with **HPN**'s Provider Services. A further evaluation was conducted of the number of providers within the top rated non-compliant ZIP codes to ensure this was not a cause for non-compliance. **HPN** will continue to investigate additional opportunities to encourage members to have their HbA1c tested each year and for opportunities to reach out to members to help schedule and address any barriers to completing the test.

Table 9-6—Validation of Performance Measures—Recommendation and HPN Response 4

HSAG HEDIS Recommendation 4
HPN's rates presented opportunities for improvement for follow-up care for children on ADHD medication, where both indicators demonstrated a decline in performance from HEDIS 2016 to HEDIS 2017 and the continuation and maintenance phase indicator fell below the 50th national Medicaid percentile. HSAG noted that the **HPN** 2016 Quality Improvement Program evaluation did not include an analysis of the measure *Follow-Up Care for Children Prescribed ADHD Medication,* as it did for other Medicaid performance measures. Further, the **HPN** 2017 Quality Improvement Work Plan did not include any goals for the performance measure. HSAG recommends that to identify interventions that may improve rates, **HPN** monitor performance related to care for children on ADHD medication in a manner similar to that performed for other Medicaid performance measures.
HPN HEDIS Response to HSAG Recommendation 4
In addition to the analysis included in the 2016 Quality Improvement Program Evaluation, **Health Plan of Nevada** (**HPN**) conducted analysis of the Follow-Up Care for Children Prescribed ADHD Medication (6-12 years) the Initiation Phase and the Continuation and Maintenance Phase (ADD) HEDIS measure which included county, ZIP code, race, age and gender to determine any disparities. An additional analysis was completed to determine if the actual prescriber was a behavioral health provider or a PCP. Strategies and goals were created to address the identified disparities. **HPN** has taken the following steps to assist with increasing compliance with the Follow-up Care for Children Prescribed ADHD Medication the initiation Phase and the Continuation and Maintenance Phase HEDIS measure: • The prescribing providers receive a letter alerting them of their members included in the eligible population, and education on the importance of completing the appropriate visits within the HEDIS guidelines to meet compliance. • Clinical Practice Consultants visit providers on a monthly basis to review HEDIS requirements, provide a list of non-compliant members, evaluate with providers barriers to members receiving care, and help to address and offer best practices to ensure compliance with HEDIS measures. • Encouraging providers to schedule follow-appointments at the appointment when medication is prescribed and encouraging providers to utilize the telephonic visit as an alternative to the member coming into the office. • Providers are offered co-branded postcards to mail to members who are non-compliant with HEDIS measures. • Members without contact information or incorrect contact information are processed through a vendor's system to determine if there is any additional contact information available. Members' email addresses are collected by the health plan, as it seems to be a more reliable source to contact members. • The results of the county and ZIP code analysis were shared with **HPN**'s Provider Services. A further evaluation was conducted of the number of providers within the top rated non-compliant ZIP codes to ensure this was not a cause for non-compliance. To date, **HPN** has seen an almost 5 percent year-over-year increase in this HEDIS measure and will continue to investigate additional opportunities to encourage members to see their PCPs after they are prescribed ADHD medication and opportunities to reach out to members to help schedule and address any barriers to completing an appointment.

Table 9-7—Validation of Performance Measures—Recommendation and HPN Response 5

HSAG HEDIS Recommendation 5
For the Nevada Check Up population performance measure evaluation, **HPN**'s rates demonstrated mixed performance for immunizations for children, with select vaccination rates improving from the previous year and others declining. Those that declined were combinations 6, 8, 9, and 10. This same trend existed for both Medicaid and Nevada Check Up populations. These combination vaccines are the only ones that include the influenza antigen, which may have been the missing antigen that caused the decline in rates. For example, the only difference between combinations 3 and 6 is the inclusion of the influenza antigen in combination 6. All other antigens are the same between the two combinations and the combination 3 vaccine demonstrated a 4.97 percentage point increase from HEDIS 2015 to HEDIS 2017 for the Nevada Check Up population. HSAG recommends that **HPN** conduct a root cause analysis to determine the factors that may be impacting the immunization rates containing the influenza antigen, such as failure of the provider offices to administer the recommended vaccines; failure to report the vaccines to WebIZ, which is Nevada's immunization registry; or failure of a provider, who is not the child's primary care provider, to report to WebIZ in the event the child received the vaccine at a flu clinic or pharmacy, for example. **HPN** might benefit from hosting a focused discussion with parents of children who were not numerator-compliant to determine if there are other factors that might impede immunizations that contain the influenza antigen. Since the Medicaid pay-for-performance incentive for MCOs includes the measure *Childhood Immunization Status—Combination 10*, **HPN** will be rewarded for improving this measure beyond the minimum performance standard for the Medicaid population.
HPN HEDIS Response to HSAG Recommendation 5
Health Plan of Nevada (**HPN**) conducted analysis of the Childhood Immunization Status (CIS) HEDIS measure, which included county, ZIP code, race, age and gender to determine any disparities. An analysis was completed to determine the reason for non-compliance for the 411 members included in the annual HEDIS audit. In addition, **HPN**'s Member Advisory Committee, which includes **HPN** members, physicians and community stakeholders, reviewed reasons for non-compliance with all of the immunizations in the CIS Combination 10, which includes the flu vaccinations. Strategies and goals were created to address the identified disparities. **HPN** has taken the following steps to assist with increasing compliance with the Childhood Immunization Status HEDIS measure: • **HPN** continues to obtain monthly feeds of the immunizations records from WebIZ, as it has been determined that this is the primary source of immunizations a child receives in a PCP office, at any community immunization events, or any other places outside of the PCP office. • Offering an incentive program for members who are non-compliant with the Combination 10 of the CIS HEDIS measure. Members receive a mailer alerting them of their non-compliance, educating on the importance of receiving all immunizations including the Flu vaccinations, educating on how to receive the gift card and provides member service phone number for any necessary assistance, and scheduling an appointment or attending an appointment. Dollar amount of gift card was increased for 2018. • Members receive a live telephone call alerting them of their non-compliance, educating on the importance of receiving all immunizations, including the flu vaccination, and offering to schedule appointments and address any concerns with attending an appointment. Reminder calls and follow-up calls are made where rescheduling is completed, if needed. • Increasing the number of Medicine on the Move events in non-compliant ZIP codes to encourage members to receive all of their immunizations, including the flu vaccination. Members receive a mailer and a live call notifying them of the event and inviting them to schedule an appointment.

HPN HEDIS Response to HSAG Recommendation 5
• Clinical Practice Consultants visit providers on a monthly basis to review HEDIS requirements, provide a list of non-compliant members, evaluate with providers barriers to members receiving care, and help to address and offer best practices to ensure compliance with HEDIS measures. • Offering an incentive program for providers who have members who are non-compliant with this HEDIS measure. Providers receive a list of members who are non-compliant with demographic information included. Providers are encouraged to reach out to members to schedule appointments for non-compliant members. • Providers are offered co-branded postcards to mail to members who are non-compliant with HEDIS measures. • Members without contact information or incorrect contact information are processed through a vendor's system to determine if there is any additional contact information available. Members' email addresses are collected by the health plan, as it seems to be a more reliable source to contact members. • OB Case Managers are continuing to work with mothers after delivery until the child is two years old. They educate mothers on the importance of receiving all immunizations, including the flu vaccination, and offer to schedule appointments and address any concerns with attending an appointment. To date, **HPN** has seen more than a 5 percent year-over-year increase in this HEDIS measure and will continue to investigate additional opportunities to encourage members to see complete their immunizations before the age of two and opportunities to reach out to members to help schedule and address any barriers to completing an appointment.

Performance Improvement Projects

HSAG validated the PIPs submitted by each MCO. In SFY 2016–2017, the MCOs continued using the rapid-cycle PIP approach for the two DHCFP-selected PIP topics: *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents*, and *Behavioral Health Hospital Readmissions*. 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 9-8 details HSAG's recommendations related to PIP validation for **Anthem** as well as **Anthem**'s response.

Table 9-8—PIP Validation—Recommendations and Anthem Responses

HSAG PIP Recommendations
Based on the validation and outcome findings, HSAG offers the following recommendations: • MCOs should execute improvement projects according to the approved methodology outlined in Module 2. If changes to the methodology are necessary, the MCO must contact HSAG to discuss the changes. • MCOs should apply to future PIPs and quality improvement activities the identified lessons learned and knowledge gained from HSAG's feedback throughout the life of the PIP. • MCOs should ensure that their core PIP teams include data analytical staff members who are involved in all data-related PIP processes for the life of the PIP. • MCOs should complete an upfront analysis before testing an intervention. The MCOs should be able to gauge current performance, compare it to improved performance, and have a method of measuring the difference. By completing the upfront analysis, both objectives can be accomplished. • MCOs should conduct a series of thoughtful and incremental PDSA cycles to accelerate the rate of improvement. Each PDSA cycle should be initiated with a methodologically sound evaluation plan using a clearly defined testing measure to ensure meaningful and actionable testing results.
Anthem PIP Responses to HSAG Recommendations
All recommendations have been acknowledged and incorporated in the current PIP cycle. • **Anthem** continues to seek HSAG Technical Assistance on an ongoing basis to review progress, when making major decision and changes to the PIP to ensure we are maintaining a sound methodology for the PIP process. • The core PIP workgroup includes a data analyst required to be involved in all workgroup and TA sessions. • **Anthem** completed an upfront analysis before testing an intervention for the current PIPs. **Anthem** will maintain this process for any future PIPs. • **Anthem** is conducting a series of thoughtful and incremental PDSA cycles to accelerate the rate of improvement. Each PDSA cycle will be initiated with a methodologically sound evaluation plan using a clearly defined testing measure to ensure meaningful and actionable testing results.

Anthem PIP Responses to HSAG Recommendations
• **Anthem** will apply to future PIPs and quality improvement activities the identified lessons learned and knowledge gained from HSAG's feedback throughout the life of the PIP.

HPN's Response to HSAG's Recommendations

Table 9-9 details HSAG's recommendations related to performance improvement project validation for **HPN** as well as **HPN**'s response.

Table 9-9—PIP Validation—Recommendations and HPN Responses

HSAG PIP Recommendations
Based on the validation and outcome findings, HSAG offers the following recommendations: • MCOs should execute improvement projects according to the approved methodology outlined in Module 2. If changes to the methodology are necessary, the MCO must contact HSAG to discuss the changes. • MCOs should apply to future PIPs and quality improvement activities the identified lessons learned and knowledge gained from HSAG's feedback throughout the life of the PIP. • MCOs should ensure that their core PIP teams include data analytical staff members who are involved in all data-related PIP processes for the life of the PIP. • MCOs should complete an upfront analysis before testing an intervention. The MCOs should be able to gauge current performance, compare it to improved performance, and have a method of measuring the difference. By completing the upfront analysis, both objectives can be accomplished. • MCOs should conduct a series of thoughtful and incremental PDSA cycles to accelerate the rate of improvement. Each PDSA cycle should be initiated with a methodologically sound evaluation plan using a clearly defined testing measure to ensure meaningful and actionable testing results.
HPN PIP Responses to HSAG Recommendations
For the 2017 PIP topics of Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life and Follow-Up After Emergency Department Visit for Mental Illness HEDIS measures, **HPN** attended the HSAG PIP Module Training Sessions in August 2017 and utilized the HSAG Rapid Cycle Performance Improvement Project Reference Guide to ensure all methodologies met HSAG requirements and all modules were accurately submitted. To ensure compliance, **HPN** continues to request frequent technical assistance calls with HSAG to review data, methodologies, and module drafts to ensure HSAG is aware and approves all of **HPN**'s activities. Following each technical assistance call, HSAG sends an email with a summary of the call with **HPN**'s questions and HSAG's answers, along with any action items discussed during the call. **HPN** has applied all of the previous feedback that was received from the 2016 PIP module submissions and all of the current feedback HSAG provides on the 2017 PIP from the technical calls and draft submissions. **HPN** has also included the UnitedHealthcare Clinical Quality Consultant who oversees all UnitedHealthcare Medicaid health plans' PIPs and who also works with HSAG and other EQROs to provide direction, review submissions and provide feedback. The other UnitedHealthcare Medicaid health plans that work with HSAG have also provided guidance and feedback on draft submissions for **HPN**. **HPN** has included internal members from the EPSDT department, Quality department (data analytical staff), Health Care Informatics department (data analytical staff), Compliance department, Operations department,

HPN PIP Responses to HSAG Recommendations
Maternity Health department, Project Management department, Behavioral Health department and several external partners in the PIP team to ensure that all aspects of the PIP and modules are appropriately addressed by the correct subject matter experts. **HPN** completed extensive upfront analysis for both of the PIP HEDIS measures. This analysis was shared with HSAG during the technical assistance calls. Any questions or concerns about the source of the data, the processes for collecting data, or the analysis of the data were shared during the technical assistance calls. **HPN** received approval from HSAG on the method of measuring the difference between the current performance and the performance during and after the intervention. **HPN** will notify HSAG and ask for a technical assistance call if there are any challenges that might arise with regard to the measurement to review the challenges and propose possible resolutions. **HPN** has received approval from HSAG for the Intervention Plan section of module 4. **HPN** has completed modules one to four based on the information received during the original training in August of 2017, the HSAG Rapid Cycle Performance Improvement Project Reference Guide and HSAG's feedback to draft modules submitted and information shared during the technical assistance calls. **HPN** has outlined an evaluation plan for both PIP HEDIS measures that utilizes defined measures to ensure testing results are both meaningful and actionable.

CAHPS Surveys

The CAHPS surveys ask members to report on and evaluate their experiences with healthcare. These surveys cover topics 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 healthcare experiences. HSAG analyzed and reported the CAHPS survey results that each MCO provided. Table 9-10 through Table 9-16 detail HSAG's specific recommendation for each MCO and the MCO's response.

Anthem's Response to HSAG's Recommendations

Table 9-10 through Table 9-13 detail HSAG's recommendations related to CAHPS for **Anthem** as well as **Anthem**'s response.

Table 9-10—CAHPS—Recommendation and Anthem Response 1

HSAG CAHPS Recommendation 1
HSAG recommends that **Anthem** 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. **Anthem** had measures that did not meet the minimum 100 responses for the CCC Medicaid population, Nevada Check Up general child population, and Nevada Check Up CCC population.
Anthem CAHPS Response to HSAG Recommendation 1
To increase the response rate, **Anthem** includes a 145 percent oversample to the Child population. In 2017, the Child Medicaid with CCC sample standard size was 3,490. An oversample of 145 percent (2,393) was included. Target total sample was 5,882. **Anthem** employs other strategies to improve response rate for all CAHPS, including the child population: • Member education and reminders—this is completed through: • Postcards reminders • Due to rebranding of the Health plan as of 1st Feb 2018, all **Anthem** members were mailed Pre-CAHPS letters in November 2017 to remind them of the name change and the upcoming CAHPS. This was also an effort to increase response rate. • Member website CAHPS reminder notices. • Member newsletters—CAHPS information included in member newsletters. • Consumer Advocate committees (CAC) meetings—members are invited to this meeting where CAHPS information is shared and members are encouraged to complete survey if they receive from vendor.

Table 9-11—CAHPS—Recommendation and Anthem Response 2

HSAG CAHPS Recommendation 2
For the adult population, HSAG recommends that **Anthem** focus quality improvement initiatives on enhancing members' experiences with *Getting Needed Care*, *How Well Doctors Communicate*, *Shared Decision Making*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Discussing Cessation Strategies*, since these rates were lower than the 2016 adult CAHPS results and fell below NCQA's 2016 CAHPS adult Medicaid national averages.
Anthem CAHPS Response to HSAG Recommendation 2
Anthem Quality improvement initiatives to enhance member experience with Getting Needed Care, How Well Doctors Communicate, Shared Decision Making, Rating of Personal Doctor, Rating of Specialist Seen Most Often, and Discussing Cessation Strategies, include but are not limited to: **Improving Access** Within the past two years (2016 and 2017), **Anthem** contracted an additional 337 providers to the network. **Provider education** • **Anthem** developed a flier highlighting the CAHPS questions that members receive to promote provider awareness. • **Anthem** has developed a provider CME program focusing on member experience. This training is available to all providers and their office staff. The provider CME program is available at www.patientexptraining.com. **Member initiatives** • **Anthem** uses an outreach team to review and assist members to get needed care on an ongoing basis by assisting members to schedule appointment, calling members to remind them to attend the scheduled appointments, and educating members about their care benefit. • **Anthem** collaborates with providers to organize Clinic days for our members. Among the benefits of a clinic days include education to provider on member needs. **Anthem** prepares a checklist to help guide appointments. Clinic days help block provider schedule to attend to **Anthem** members only during the allotted time. • PCP change—**Anthem** members are educated on the option to change their PCP at any time to fit their needs. Information on PCP change can be found in member newsletters, member handbooks, and new member letter and member websites. **Pay for Performance** • Approximately 60 percent of **Anthem** members are empaneled to a pay for quality program (PQIP) provider. PQIP providers receive incentives to promote quality care through improvement of quality measures and member access. **Medical Records Review** • Reviews are conducted by an **Anthem** Clinical Quality Nurse. During the review, the **Anthem** clinical quality nurse assesses for correct documentation, referrals, treatment plan. Provider is then educated by the reviewer on the findings. A corrective action plan is put in place by provider if the 80 percent pass rate set by **Anthem** is not met.

Table 9-12—CAHPS—Recommendation and Anthem Response 3

HSAG CAHPS Recommendation 3
For the general child Medicaid population, **Anthem** should focus on improving *Rating of Specialist Seen Most Often*, since the rate for this measure was substantially lower than the 2016 general child CAHPS results and fell slightly below NCQA's 2016 CAHPS child Medicaid national averages. Interventions targeted at the provider level for this measure likely will have the greatest impact on the measure. Additionally, efforts should focus on improving *Getting Needed Care* and *Getting Care Quickly*, since these rates were substantially lower than the NCQA's 2016 CAHPS child Medicaid national averages. For the CCC Medicaid population, **Anthem** should focus on improving *FCC: Personal Doctor Who Knows Child*, since the rate for this reportable measure was lower than the 2016 CCC child CAHPS results and fell below NCQA's 2016 CAHPS CCC child Medicaid national average. In addition, **Anthem** should look to improve *Getting Needed Care*, *Getting Care Quickly*, and *Access to Prescription Medicines*, since the rates for these measures were substantially lower than the 2016 NCQA CCC child Medicaid national averages. For the Nevada Check Up population, HSAG recommends that **Anthem** focus quality improvement initiatives on enhancing members' experiences with *Rating of Health Plan*, since the 2017 rate for this reportable measure was lower than the 2016 rate.
Anthem CAHPS Response to HSAG Recommendation 3
Anthem focused on improving the following measures: Getting Needed Care, Getting Care Quickly, and Access to Prescription Medicines, Health Plan rating for Child members including children with chronic conditions. **Surveys** Annual Appointment Availability (AA) Survey together with Secret shopper calls assess the provider's gaps in appointments for the members. Both 2016 and 2017 Pediatrics results for AA survey shows relatively similar compliance rate, with most of the Appointment types scoring between 94 percent compliance to 100 percent compliance rate. **Improving Access** • **Anthem** network Pediatric specialist (Pediatrics and Pediatric Nurse practitioner) increased by 77 between 2016 to 2017. • **Anthem** contracted the 337 new providers contracted in 2016 through 2017. This included PCPs, Specialists who see Child members as well. One hundred and eighty-two (54 percent) of the new providers were in in the hot ZIP codes (have highest member concentration) including: 89502, 89109, 89106, 89104, 89102, 89030, and 89146. • **Anthem** completed secret shopper calls in 2017. • Results were analyzed as follows: 87 percent (2,245/2,580) of new pediatric and adult patients had access to appointments within two weeks during the reporting period (N/A responses excluded). 100 percent had access within 30 days. The pediatric only sample was small (n=13), and 100 percent of patients had access to appointments within 30 days. **For Existing patients:** Appointment Availability for established Pediatric and/or Adult patients was 94 percent (2,498/2,650). • Appointment availability survey **CAHPS review** • As per the 2017 CAHPS, 80.73 percent: Child received care as soon as needed when care was needed right away, 80.71 percent received an appointment for a check-up or routine care for their child at a doctor's office or clinic, 75.59 percent received an appointment for their child to see a specialist as soon as they needed.

Anthem CAHPS Response to HSAG Recommendation 3
• **Anthem** pharmacy team works closely with member services team to address any prescription issues identified. In 2017, **Anthem** hired a local pharmacy coordinator to improve customer service at a local level. **Anthem** thoroughly investigates all complaints, focusing on remediation of access issues including prescriptions. Other **Anthem** initiatives to improve and evaluate access in the network and appointments availability include: • **Anthem** member outreach and assistance with appointment scheduling • Urgent care • Live Health Online—Telehealth is available in both English and Spanish • 24 hours Nurseline • Outreach for member and provider education • Increase quality management resources working on various initiatives, including Health Promotion and education outreach, provider in office education **Health Plan rating** **Anthem**'s focus is to improve member experience in all areas of service, including customer service, experience in provider offices, access to services, and appointment availability. **Anthem** employs multiple interventions, including internal training for customer service, assisting members to make appointments to meet their needs, resolving appeals and grievances in a timely manner, educating providers on member experience through in-office training and CME training, improving our network to meet member needs, value added benefits to members, member education on available benefits etc. are all efforts to improve the Health Plan rating. Rating of Health Plan from the Child CAHPS® survey has shown an improvement. Similarly, the Customer Service rating has improved.

	2015	2016	2017
Customer Service	85.95 percent	84.54 percent	88.16 percent
Health Plan Rating	66.75 percent	81.55 percent	85.00 percent

Table 9-13—CAHPS—Recommendation 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. **Anthem**'s 2016 Annual Quality Evaluation described the efforts the MCO employed to expand the network to include additional providers and provider relations consultants. 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*, *Shared Decision Making*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, 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 to HSAG Recommendation 4
Provider education to address: How Well Doctors Communicate, Shared Decision Making, Rating of Personal Doctor, Rating of Specialist Seen Most Often, and Discussing Cessation Strategies).

Anthem CAHPS Response to HSAG Recommendation 4
• **Anthem** developed a flier highlighting the CAHPS questions that members receive to promote provider awareness **Provider CME Training on member experience** • **Anthem** developed a provider CME program focusing on member experience. This training is available to all providers and their office staff. The provider CME program is available at www.patientexptraining.com. **Pay for Quality (PQIP)** • In 2017, **Anthem** launched a Community Transformation department dedicated to member and provider relations. The overarching goal is to improve provider relationships, provide educational resources and address issues as they arise. Over 60 percent of all **Anthem** Medicaid members are empaneled to a PQIP provider. Providers receive incentives for improving quality of care measured through quality measures and member access. **Grievance process** • Complaints on provider attitude and the level of service provided are reviewed and investigated on an ongoing basis and appropriate education is provided to the providers. **Anthem** strives to improve cultural consciousness in the provider network. Cultural Competency training is part of the new provider onboarding training and is available to all providers on the Provider website and provided as needed.

HPN's Response to HSAG's Recommendations

Table 9-14 through Table 9-16 detail HSAG's recommendations related to CAHPS for **HPN** as well as **HPN**'s response.

Table 9-14—CAHPS—Recommendation 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 are 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 the CCC Nevada Check Up population. 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 to HSAG Recommendation 1
In 2017, **HPN** created a Medicaid specific CAHPS workgroup that included members from Member Services department, Provider Services department, Member Outreach department, Coordination of Care and Medical Management department, Behavioral Health department, Quality department, EPSDT department, Maternity Health department, Project Management department and our national UnitedHealthcare Associate Director of CAHPS who oversees all UnitedHealthcare CAHPS surveys for all lines of business. The focus of the workgroup was to increase response rates as well as overall rates.

HPN CAHPS Response to HSAG Recommendation 1
The workgroup reached out to other UnitedHealthcare plans to determine best practices to increase response rates and instituted several initiatives to educate members on the what the CAHPS survey is, what their role is in the CAHPS survey, how the health plan responds to the results, and to encourage them to complete the survey. Some of these initiatives include: • Sending members a personalized letter from our Health Plan Medicaid Vice President encouraging members to complete the CAHPS survey • Included CAHPS article in the member newsletter • CAHPS messaging posted to the member website • CAHPS messaging included in member appreciation events • CAHPS messaging included in community outreach events • All **HPN** member facing staff received training on CAHPS and how the health plan responds to the results to encourage members to complete the survey if they should receive one • CAHPS messaging included in employee website • Included CAHPS article in the provider newsletter • CAHPS messaging posted to the provider website • Clinical Practice Consultants and Provider Advocates provided face-to-face training on the CAHPS survey to providers and asked the providers to encourage members to complete the survey • Clinical Practice Consultants distributed posters with CAHPS messaging to the provider office In addition to the preliminary initiatives that **HPN** implemented to encourage members to complete the CAHPS survey, **HPN** continues to utilize the more robust administrative option allowed by NCQA, which includes the following: • First questionnaire mailing • First reminder postcard/letter • Second questionnaire mailing • Second reminder postcard/letter • Initiate telephone interviewing – members are called six times Respondents are given the option of the completing the survey in English and/or Spanish. In addition to the CAHPS survey, **HPN** also conducts monthly surveys related to the health plan's Net Promoter Score (NPS). The NPS measures loyalty that exists between a company and the customers it serves. Each month a random sample of members is contacted and asked (on a scale of 1-10), "How likely are you to recommend Health Plan of Nevada to a friend or colleague?" The NPS is calculated by assigning the following categories: 0-6= Detractors, 7-8=Passives, 9-10=Promoters. The percentage of Detractors is subtracted from the number of Promoters. In addition, the members are asked "Why?" they scored the way they did. This information reveals the reason for high or low ratings and can guide improvements or best practices to increase Promoters and decrease Detractors. The Net Promoter System is built upon an interactive process of continuous feedback, learning and improvement.

HPN CAHPS Response to HSAG Recommendation 1
Nevada's current NPS is 56, with monthly scores ranging from 42-68. Nationally UnitedHealthcare Medicaid health plans' NPS is 62. In 2017, Nevada's NPS was 59 and nationally the NPS was 61. The 2018 goal for Nevada and all UnitedHealthcare Medicaid health plans are 65. Age, gender, member tenure data is analyzed to determine any disparities that might exist. Nevada scores higher with members under the age of 18 years and lowest with ages 36-64 years. Nevada scores higher with females than males. Nevada members with three or more year's tenure score the highest while members with 1-3 years tenure score the lowest. Nevada receives the actual member comments in addition to the overall score. These comments are categorized to determine areas of opportunity. The 2018 most frequent comment category is general satisfaction and doctor access challenges is the second most frequent comment category. The Medicaid specific CAHPS workgroup is evaluating the NPS data, including the comments in addition to the CAHPS results, to recognize common areas of opportunities and determine possible improvement initiatives. **HPN** will continue to evaluate opportunities to increase the response rate. The Medicaid specific workgroup is now reviewing the 2018 CAHPS results and will determine new initiatives for 2019.

Table 9-15—CAHPS—Recommendation and HPN Response 2

HSAG CAHPS Recommendation 2
HSAG recommends that **HPN** focus quality improvement initiatives on enhancing members' experiences with *How Well Doctors Communicate*, *Rating of Health Plan*, *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 lower than the NCQA's 2016 CAHPS adult Medicaid national averages. For the general child Medicaid population, **HPN** should focus on improving *Rating of All Health Care*, since the rate was lower than the 2016 child CAHPS result and fell below NCQA's 2016 CAHPS child Medicaid national average. For the CCC child Medicaid population, **HPN** should focus on improving *Getting Needed Care* and *Rating of All Health Care*, since the rates for these measures were substantially lower than the 2016 NCQA CCC child Medicaid national averages. In addition, **HPN** should look to improve on *How Well Doctors Communicate* and *FCC: Personal Doctor Who Knows Child*, since the rates were lower than the 2016 CCC child Medicaid results and fell below the 2016 NCQA CCC child Medicaid national averages. For the Nevada Check Up population, **HPN** should focus quality improvement efforts on *Getting Needed Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*, since these measures showed a slight decrease from 2016 to 2017. For the CCC Nevada Check Up population, **HPN** should improve on *Getting Needed Care*, *Rating of All Health Care*, and *Rating of Health Plan*, since the rates for these measures decreased from 2016 to 2017.
HPN CAHPS Response to HSAG Recommendation 2
In 2017 **HPN**'s Medicaid specific CAHPS workgroup was created with the focus of increasing overall rates. The workgroup reviewed the 2017 CAHPS results, reached out to other UnitedHealthcare plans to determine best practices to achieve higher ratings, and instituted several initiatives, including: • Increasing marketing of **HPN**'s Tobacco Cessation Program – Included information in the member handbook with information/registration information provided – Included information on the member website with information/registration information provided – Included information on the provider website with information/registration information provided

HPN CAHPS Response to HSAG Recommendation 2
– Clinical Practice Consultants reviewed with the providers the importance of advising tobacco users to quit, educated providers on **HPN**'s Tobacco Cessation Program and how to refer members to the program and provided brochures and signage for their **HPN** members. • 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 communication, encouraging providers to make personal connections, and ways to reduce wait times and ensure members are seen timely. • All **HPN** member facing staff received training on CAHPS and how each of their interactions with members influence response to CAHPS. • Completed member appreciation events throughout the year. • Initiated member advisory groups in Clark and Washoe counties. This committee was expanded to include providers and community stakeholders as well as members. Several different topics are reviewed throughout the year. • Increased the number of community events **HPN** participates in to increase awareness and assist with any areas of concerns members or community stakeholders might have. • Sending members a personalized letter from our Health Plan Medicaid Vice President educating members on the actions taken from the CAHPS survey results. • Included CAHPS article in the member newsletter educating members on the actions taken from the CAHPS survey results. • CAHPS messaging posted to the member website educating members on the actions taken from the CAHPS survey results. • **HPN** conducts monthly analysis to ensure that all contractual requirements regarding access to care for Primary Care Practitioners, which include Pediatricians, are met and sustained. • **HPN** conducts frequent Secret Shop surveys and if a provider fails to meet the appointment standards set forth in the contract provider advocates contact the provider to discuss the contractual standards. • **HPN** increased education of the availability of the NOW Clinic, **HPN**'s telehealth program, as an alternative to an office visit. • **HPN** increased the number of Medicine on the Move, **HPN**'s mobile medical clinic, events as an alternative to an office visit. • Fostering the increase in providers offering additional after hours or Urgent Care Clinics to meet members' needs. **HPN** did see increases in some of the CHAPS ratings and will continue to evaluate opportunities to increase the overall rates. The Medicaid specific workgroup is no reviewing the 2018 CAHPS results and will determine new initiatives for 2019.

Table 9-16—CAHPS—Recommendation and HPN Response 3

HSAG CAHPS Recommendation 3
The **HPN** 2016 Quality Improvement Evaluation described several interventions the MCO deployed to improve CAHPS rates. Those included expanding the Medicaid network and encouraging providers to use the automated referral application to reduce the turnaround time for referrals to specialists. These interventions have the greatest likelihood of impacting access-related CAHPS measures like *Getting Needed Care* and *Getting Care Quickly*.

HSAG CAHPS Recommendation 3
CAHPS measures like *How Well Doctors Communicate*, *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, *Discussing Cessation Strategies,* and *Rating of Personal Doctor* would be most affected by targeting interventions at the provider level. The **HPN** 2016 Quality Improvement Evaluation described **HPN**'s intervention to conduct monthly patient satisfaction surveys to identify poor-performing providers who may be referred to the health plan's Credentialing Committee. HSAG encourages **HPN** to evaluate the effectiveness of the intervention and use survey data collected from monthly surveys to advise and educate providers on ways to improve interactions with Medicaid members.

HPN CAHPS Response to HSAG Recommendation 3
Recently **HPN** evaluated the patient satisfaction surveys and several changes were made. The timing between the member's office visit and the survey mailing to the member was decreased. Each of the questions on the survey was reviewed and the survey was reduced to one page. The results of the survey are shared with **HPN**'s provider services department, which addresses concerns with the provider and works to resolve issues. The results are also sent to the Credentialing Committee to review and determine appropriate steps. **HPN** will continue to evaluate the survey and process to ensure it is viable information. In addition to the patient satisfaction surveys, **HPN** also conducts an analysis of all grievances regarding providers. The results are shared with **HPN**'s provider service department, which addresses concerns with the providers and works to resolve issues. The results are also sent to the Credentialing Committee to review and determine appropriate steps. **HPN**'s Provider Advocates conduct quarterly site visits and Clinical Practice Consultants conduct monthly site visits. Visits include: • Education on benefits, policies and procedures unique to **HPN** • Providing training to incorporate changes in the administration of the Medicaid and Nevada Check Up Program • Provide current best practices to improve the management of chronic diseases and increase uptake of preventive services • Advocate for the implementation of best practices and evidence-based practice related to clinical guidelines • Troubleshoots barriers such as claims denials, and referrals to specialist providers between internal health plan departments and network providers • Assist practice managers to identify high risk members and connect them to health plan wrap-around services including: case management, social workers, health education and wellness and behavioral health • Assist Health Plan with all provider education initiatives; for example, CAHPS, pharmacy changes and Health Plan member programs • Provided face-to-face training on the CAHPS survey to providers and reviewed best practices and tips to increase patient experience by addressing concerns regarding members overall satisfaction with their provider, providers' communication, scheduling times and wait times and encouraged providers to make personal connections with their patients. **HPN** will continue to evaluate opportunities to increase the overall rates. The Medicaid specific workgroup is now reviewing the 2018 CAHPS results and will determine new initiatives for 2019.

10. Dental Benefits Administrator Readiness Review

Overview

In March 2017, the State of Nevada, Purchasing Division, on behalf of the DHCFP, solicited responses from qualified vendors to provide risk-based capitated prepaid ambulatory health plan (PAHP) services designed in support of the Title XIX (Medicaid) and Title XXI Child Health Insurance Program (CHIP, also known as "Nevada Check Up") dental assistance programs. In response to request for proposal (RFP) 3425, one PAHP was selected by the DHCFP to provide dental benefits administrator (DBA) services to Medicaid and Nevada Check Up recipients. The new DBA vendor was **LIBERTY Dental Plan of Nevada, Inc.** (**LIBERTY**).

According to the 42nd Code of Federal Regulations (CFR) §438.66(d)(1)(ii), which describes the activities related to state monitoring requirements, the state must assess the readiness of each PAHP entity with which it contracts when the specific PAHP has not previously contracted with the State. In SFY 2017–2018, the DHCFP requested that Health Services Advisory Group, Inc. (HSAG), conduct a readiness review of **LIBERTY**.

The review consisted of two components: (1) Operational Readiness Review, and (2) Information Systems (IS) Readiness Review. The purpose of the Operational Readiness Review was to determine if the DBA had the structural and operational capacity to perform the Medicaid managed care functions described in the DHCFP's contract 3425 to ensure appropriate and timely access to quality healthcare services for Medicaid enrollees. The purpose of the IS Readiness Review was to evaluate the DBA's ability to adjudicate a set of test claims to pay providers and subsequently prepare encounters based on the adjudicated test cases. The DHCFP maintained authority to validate the sufficiency of the DBA's provider network in accordance with the DHCFP's contract 3425.

Operational Readiness Review Results

Table 10-1 through Table 10-3 detail the overall scores for the operational readiness review. Table 10-1 details the scores for all elements contained in each of the 15 operational review standards. Table 10-2 details the results of the credentialing file review. Table 10-3 details the scores of the file reviews for the checklists.

Table 10-1—Summary of Scores for the Operational Readiness Review Standards: LIBERTY

Standard Number	Readiness Review Standard	Total Applicable Elements	Total Critical Elements	Number of Elements		
				Complete	Incomplete	Incomplete—Critical*
I	Internal Quality Assurance Program	19	12	19	0	**0**
II	Credentialing and Recredentialing	13	9	13	0	**0**
III	Member Rights and Responsibilities	7	4	7	0	**0**

Standard Number	Readiness Review Standard	Total Applicable Elements	Total Critical Elements	Number of Elements		
				Complete	Incomplete	Incomplete—Critical*
IV	Member Information	6	4	5	0	**1**
V	Availability and Accessibility of Services	18	10	18	0	**0**
VI	Continuity and Coordination of Care	2	2	2	0	**0**
VII	Grievances and Appeals	30	15	27	1	**2**
VIII	Subcontracts and Delegation	9	5	8	0	**1**
IX	Cultural Competency Program	5	4	5	0	**0**
X	Coverage and Authorization of Services	18	6	17	0	**1**
XI	Provider Dispute and Complaint Resolution	6	4	6	0	**0**
XII	Confidentiality and Recordkeeping	7	4	3	2	**2**
XIII	Provider Information	1	1	0	0	**1**
XIV	Enrollment and Disenrollment	0	0	0	0	**0**
XV	Program Integrity	24	12	23	1	**0**
Total Readiness Review Elements		**165**	**92**	**153**	**4**	**8**
Percent Complete (No Action Required)				**92.7% (153/165)**		
Percent Incomplete (Action Required)				**2.4% (4/165)**		
Percent Incomplete-Critical (Action Required*)				**4.8% (8/165)**		

Totals rounded to the nearest tenth of a percent.
* Incomplete—Critical elements should be prioritized and resolved before enrolling members.
Total Elements: The total number of elements in each standard.
Total Critical Elements: The total number of elements designated as critical within the standard.

Of the 15 standard areas reviewed, **LIBERTY** demonstrated sufficient ability and capacity to satisfactorily perform the required functions and operational activities outlined in the DHCFP Medicaid managed care contract 3425. **LIBERTY** achieved 100 percent *Complete* on seven standards, demonstrating readiness to perform the applicable requirements in the following areas: Internal Quality Assurance Program, Credentialing and Recredentialing, Member Rights and Responsibilities, Availability and Accessibility of Services, Continuity and Coordination of Care, Cultural Competency Program, and Provider Dispute and Complaint Resolution. **LIBERTY** received a score of *Incomplete* for at least one element in the standards, Grievances and Appeals, Confidentiality and Recordkeeping, and Program Integrity. **LIBERTY** received a score of *Incomplete—Critical* for at least one element in each of the following standards: Member Information, Grievances and Appeals, Subcontracts and Delegation, Coverage and Authorization of Services, Confidentiality and Recordkeeping, and Provider Information. Appendix A of the 2017 Operational Readiness Review report includes the detailed findings and applicable recommendations associated with each element reviewed. **LIBERTY** must use

the template provided in Appendix F of the 2017 Operational Readiness Review report to submit its remediation plan to the DHCFP to propose its plan to remediate all elements scored *Incomplete* or *Incomplete—Critical.*

Table 10-2—Summary of Results for File Reviews: LIBERTY

Associated Standard	File Review Name	# of Records Reviewed	# of Applicable Elements	# of Compliant Elements	% of Compliant Elements
III	Credentialing	15	238	229	**96.2%**
	File Review Totals	**15**	**238**	**229**	**96.2%**

Of the 238 applicable elements reviewed across 15 files, **LIBERTY** achieved 96.2 percent compliance, showing that the DBA missed nine of 238 elements reviewed. **LIBERTY** completed site visits; however, there was no documentation of a review of dental record-keeping practices for primary dental care practitioners.

Table 10-3—Summary of Checklist Results: LIBERTY

Associated RR Standard	Checklist Name (Associated Standard)	# of Applicable Elements	# of Compliant Elements	% of Compliant Elements
III	Member Rights and Responsibilities	14	14	**100%**
IV	Member Handbook	26	25	**96.2%**
XII	Dental Record Standards	23	23	**100%**
XIII	Provider Manual	10	9	**90%**
	Checklist Total	**73**	**71**	**97.3%**

LIBERTY demonstrated 100 percent compliance with all elements contained in the Member Rights and Responsibilities checklist and the Dental Record Standards checklist. **LIBERTY** missed one element for each of the following checklists: Member Handbook and Provider Manual.

Information System Readiness Review Results

In accordance with 42 CFR §438.66(d)(3), the 2017 IS readiness review included both a desk review of documents and a web conference and on-site reviews to interview key staff members and leadership testing the DBA's claims systems. HSAG also evaluated the DBA's processes for creating encounter data files in accordance with the State's technical specifications. HSAG developed data collection tools to document the review. The IS review tools included assessment of standards based on the requirements of the contract between the DHCFP and the DBA and key areas noted in 42 CFR §438.66(d)(4).

Table 10-4 details the scores for all elements contained in each of the three IS readiness review standards using the *Complete*, *Incomplete*, and *Incomplete—Critical* rating methodology established for the systems desk review evaluation tools.

Table 10-4—Summary of Scores for the Information Systems Readiness Review Standards: LIBERTY

Standard Number	Readiness Review Standard	Total Applicable Elements	Total Critical Elements	Number of Elements		
				Complete	Incomplete	Incomplete—Critical*
I	Enrollment Systems	4	2	2	2	0
II	Claims Systems	3	1	2	1	0
III	Encounter Systems	3	1	0	2	1
Total Readiness Review Elements		**10**	**4**	**4**	**5**	**1**
Percent Complete (No Action Required)				**40.0% (4/10)**		
Percent Incomplete (Action Required)				**50.0% (5/10)**		
Percent Incomplete—Critical (Action Required*)				**10.0% (1/10)**		

Totals rounded to the nearest tenth of a percent.
* Incomplete—Critical elements must be completed prior to enrolling members.
Total Elements: The total number of elements in each standard.
Total Critical Elements: The total number of elements designated as critical within the standard.

Table 10-5 displays the scores for the claims systems testing.

Table 10-5—Summary of Scores for the Claims Systems Testing: LIBERTY

Claim Type	# of Scenarios	# of Claims Scored as *Met*	# of Claims Scored as *Partially Met*	# of Claims Scored as *Not Met*	% of Compliant Claims*
Prior Authorization	6	6	0	0	100%
Claim	32	32	0	0	100%
Claim Scenarios Total (38)		**38**	**0**	**0**	**100%**

*Totals rounded to the nearest tenth of a percent.

Table 10-6 displays the scores for encounter data validation testing.

Table 10-6—Summary of Scores for the Encounter Data Validation: LIBERTY

Claim Type	Number of Applicable Claim Lines	Number of Claim Lines Submitted	File Transmission Size Threshold	Claim Lines Contained the Required Elements	Encounter File Aligned With Companion Guide	Overall Encounter Data Compliance
Dental	70	76*	***Met***	***Met***	***Met***	**100%**

*Test Encounter Data File included 6 claim lines not related to testing scenarios provided.

LIBERTY submitted the test encounter data files on time and within expectations regarding file formatting requirements.

Conclusion

While several items were found to be incomplete during **LIBERTY**'s readiness review, for which a remediation plan was submitted to and approved by the DHCFP to remedy deficient elements, there did not appear to be operational, structural, or system deficiencies to gravely impede the DBA's ability or capacity to satisfactorily perform the managed care responsibilities outlined in its contract with the DHCFP. None of the incomplete elements that resulted from HSAG's operational readiness review and IS readiness review required a delay in implementation.

Appendix A. Technical Methods of Data Collection and Analysis

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, requires states to prepare an annual technical report that describes the manner in which data were aggregated and analyzed and how conclusions were drawn as to the quality and timeliness of, and access to, care and services furnished by the states' managed care organizations (MCOs). The data come from activities conducted in accordance with the Code of Federal Regulations (CFR) at 42 CFR §438.358. To meet these requirements, the State of Nevada, Department of Health and Human Resources, Division of Health Care Financing and Policy (the DHCFP), contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO). HSAG has served as the EQRO for the DHCFP since 2000.

From all of the data collected, HSAG summarizes each MCO's strengths and weaknesses and provides an overall assessment and evaluation of the quality, timeliness of, and access to, care and services that each MCO 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, PIHP, PAHP, or 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."[A-1]

- ***Timeliness***—NCQA defines "timeliness" relative to utilization decisions as follows:

  "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[A-2] It further discusses the intent of this standard to minimize any disruption in the provision of health care. HSAG extends this definition of timeliness to include other managed care provisions that impact services to 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

[A-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.

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

elements defined under §438.68 (Network adequacy standards) and §438.206 (Availability of services)." [A-3]

This appendix describes the technical methods for data collection and analysis for each of the following activities: Internal Quality Assurance Program compliance review, performance measure validation, validation of performance improvement projects, CAHPS surveys, Health Care Guidance Program (HCGP) compliance review follow up, HCGP performance measure validation (PMV), and dental benefits administrator (DBA) Readiness Review. The objectives for each of these activities are described in the respective sections of this report.

Internal Quality Assurance Program (IQAP)

The purpose of the SFY 2017–2018 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, 2017, through December 31, 2017.

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, 2017, through December 31, 2017. 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[A-4] to create the process, tools, and interview questions used for the SFY 2017–2018 IQAP Compliance Review.

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.

[A-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: September 26, 2018.

[A-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: Sept 26, 2018.

- Preparing and forwarding to each MCO a customized desk review form, instructions for completing the form, and instructions for submitting the requested documentation to HSAG for its desk review.
- Scheduling the on-site reviews.
- Developing the agenda for the on-site review.
- Providing the detailed agenda and the data collection (compliance review) tool 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 key documents and other information obtained from the DHCFP, and 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 cases plus an oversample of five cases for the credentialing and recredentialing file reviews and reviewing all delegated subcontractor contracts.

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 member cases that HSAG requested from each MCO.
- 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, quality improvement tracking, and quality measure reporting.
- 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. The results for the IQAP standards are noted in Table A-1 of this report. The results for checklists and file reviews are summarized in Table A-2 and Table A-3, respectively, in the pages that follow.

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 provider manual and other MCO 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, credentialing, cultural competency, delegation and contracting, and member education.
- MCO-maintained files for practitioner credentialing and recredentialing.
- 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 A-1 through Table A-3 list the standards reviewed, provider manual checklist, and files reviewed to determine compliance with State and federal standards.

Table A-1—IQAP Standards

IQAP Standard #	IQAP Standard Name	Number of Elements
I	Credentialing and Recredentialing	15
II	Availability and Accessibility of Services	26
III	Subcontracts and Delegation	13
IV	Provider Dispute and Complaint Resolution	7
V	Provider Information	3
	Total Number of IQAP Elements	**64**

Table A-2—Provider Manual Checklist

Associated IQAP Standard #	Checklist Name	Number of Elements
V	Provider Manual	10
	Total Number of Checklist Elements	**10**

Table A-3—File Reviews

Associated IQAP Standard #	File Review Name	Number of Elements
I	Initial Credentialing	160
I	Recredentialing	199
III	Delegated Subcontracts	33
	Total Number of File Review Elements	**392**

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).

Provider Manual Checklist

For the checklist 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 credentialing, recredentialing, and delegated subcontractor oversight to verify that the MCO had put into practice what the MCO had documented in its policy. For credentialing and recredentialing, 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 delegated subcontractor file review, HSAG reviewed the delegated subcontractor files for all delegated subcontractors.

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 **HPN** and **Anthem** 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 A-4.

Table A-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 2017–2018 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 2017–2018, HSAG obtained the data needed to conduct the PIP validation from the MCO's module submission forms. These forms provided detailed information about each of the PIPs and the activities completed in Modules 1 through 3.

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 testing interventions.

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 life of 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 **HPN** and **Anthem**: adult Medicaid, child Medicaid, and Nevada Check Up. DSS Research, an NCQA-certified vendor, administered the 2018 CAHPS surveys for **HPN** and **Anthem**.

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.

HPN and **Anthem** 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 **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 **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.

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 health care. The composite scores were derived from sets of questions to address different aspects of care (e.g., getting needed care and how well doctors communicate). 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 Rate 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 rate).

For each of the five composite scores 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 composites 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 scores 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 rates 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 rate that was at least 5 percentage points

greater than the 2017 NCQA national average. Red indicates a top-box rate that was at least 5 percentage points less than the 2017 NCQA national average.

Plan Comparisons

Statistically significant differences between the 2018 top-box rates for the adult Medicaid, child Medicaid (general child and CCC), and Nevada Check Up populations for **Anthem** and **HPN** are noted with arrows. Top-box rates that were statistically and significantly higher for one population than top-box rates for the other population are noted with upward (↑) arrows. Conversely, top-box rates for one population that were statistically and significantly lower than top-box rates for the other population are noted with downward (↓) arrows. Top-box rates for one population that were not statistically and significantly different from the other population are not noted with arrows. If it is true that one population's top-box rate was statistically and significantly higher (↑) than that of the other population's, then it follows that the other population's top-box rate was statistically and significantly lower (↓). Therefore, in the tables presented in the Plan Comparisons section, a pair of arrows (↑ and ↓) to the right of the top-box rate is indicative of a single statistical test. For example, if it is true that a top-box rate of **Anthem**'s adult Medicaid respondents was statistically and significantly lower than that of **HPN**'s adult Medicaid respondents, then it must be true that a top-box rate of **HPN**'s adult Medicaid respondents was statistically and significantly higher than that of **Anthem**'s adult Medicaid respondents.

Health Care Guidance Program (HCGP) Performance Measure Validation

In September of 2017, HSAG conducted a performance measure validation (PMV) audit of **APH** to verify the accuracy of the its reported rates. HSAG validated **APH**'s performance measures using the external quality review (EQR) Protocol 2[A-5] developed by CMS as its guide. HSAG's **APH** activity focused on the following objectives:

1. Assess the accuracy of the required performance measures reported by **APH**.
2. Determine the extent to which the measures calculated by **APH** follow the DHCFP specifications and reporting requirements.

HSAG validated a set of performance measures selected by the DHCFP for validation. The measures primarily consisted of performance measures that the DHCFP required contractually but were not part of the HCGP pay-for-performance (P4P) program. These measures are herein referred to as the non-P4P measures. In Attachment II of the **APH** contract (RFP/Contract #1958), the DHCFP provided the specifications **APH** was required to use to calculate the performance measures. Table A-5 lists the performance measures that HSAG validated under the scope of this audit. The measurement period for

[A-5] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 1, 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Sept 26, 2018.

which the PMV was conducted was identified as program period 2 (i.e., June 1, 2015, through May 30, 2016).

Table A-5—List of Performance Measures

	Measure ID	Non-P4P Measure Name
1	*CCHU.1*	*Ambulatory Care—Sensitive Condition Hospital Admission*
2	*CCHU.2*	*Avoidable Emergency Room Visits*
3	*FUP*	*Follow-Up With Primary Care Physician After Hospitalization*
4	*MRP*	*Medication Reconciliation Post-Discharge*
5	*DEM*	*Cognitive Assessment for Dementia*
6	*NEUR*	*Stroke and Stroke Rehabilitations—Discharged on Antithrombotic Therapy*
7	*CKD*	*Adult Kidney Disease—Laboratory Testing (Lipid Profile)*
8	*RA*	*Disease-modifying Anti-Rheumatic Drug (DMARD) Therapy for Rheumatoid Arthritis*
9	*OST*	*Osteoporosis—Pharmacologic Therapy for Men and Women Aged 50 Years and Older*
10	*OBS*	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
11	*CAP*	*Children and Adolescents' Access to Primary Care Practitioners*
12	*W15*	*Well-Child Visits in the First 15 Months of Life*
13	*W34*	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
14	*AWC*	*Adolescent Well-Care Visits*
15	*CIS*	*Childhood Immunization Status*
16	*PPC*	*Prenatal and Postpartum Care*
17	*WOP*	*Weeks of Pregnancy at Time of Enrollment*
18	*FPC*	*Frequency of Ongoing Prenatal Care*
19	*ABA*	*Adult BMI [Body Mass Index] Assessment*
20	*BCS*	*Breast Cancer Screening*
21	*CCS*	*Cervical Cancer Screening*
22	*COL*	*Colorectal Cancer Screening*

Pre-audit Strategy

To assist with the validation process, HSAG provided technical assistance to **APH**'s staff throughout the audit process.

HSAG prepared and sent a documentation request letter to **APH**, which outlined the steps in the PMV process. The letter included a request for source code for each performance measure, a completed

Information Systems Capabilities Assessment Tool (ISCAT), any additional supporting documentation necessary to complete the audit, and a timetable for completion and instructions for submission. The ISCAT was customized to collect information regarding the necessary data that were consistent with the Nevada HCGP and the Nevada Comprehensive Care Waiver (NCCW) special terms and conditions (STCs). HSAG responded to ISCAT-related questions received directly from **APH** during the pre-on-site phase.

Upon receiving the completed ISCAT and requested supporting documents, HSAG conducted a desk review of all the materials and noted any issues or items that required further follow-up. Before the on-site visit, HSAG also conducted an extensive review of **APH**'s source code used to calculate the non-P4P measures. HSAG's source code reviewers performed a line-by-line review of the source codes to assess whether the codes were developed according to the non-P4P measure specifications detailed in **APH**'s contract with the DHCFP. Findings of the source code review were provided to **APH**, and all issues were resolved prior to the on-site audit. After approval of the source code, the preliminary rates were calculated by **APH** and provided to HSAG. This strategy allowed HSAG to review numerators, denominators, and rates to tailor the on-site review around any potential issues identified with the calculations.

On-Site Activities

HSAG conducted the on-site visit with **APH** on September 20, 2017. HSAG auditors collected information from **APH** staff members using several methods, which included interviews, system demonstration, review of data output files, primary source verification, observation of data processing, and review of data reports. The on-site activities included the following:

- Opening session
- Evaluation of system compliance
- Overview of data integration and control procedures
- Closing conference

HSAG also conducted several interviews with key **APH** staff members who were involved with any aspect of performance measure reporting.

Post-On-Site Activities

During the on-site visit, HSAG auditors identified several items that required follow-up from **APH,** including documentation explaining processes used to ensure that the files received from DXC were fully and accurately loaded into the internal data warehouse, submission of the PLD file for the CIS measure for administered vaccinations, submission of the PLD file for verification of the denominator and numerator counts, documentation explaining the rate variances for measures reviewed during the 2016 and the 2017 performance measure validation audits, and documentation explaining the different challenges faced when calculating rates for several of the measures. **APH** submitted the requested

documentation for HSAG review. Upon resolving all outstanding items, HSAG auditors reviewed the rates provided by **APH** before issuing the report.

Dental Benefits Administrator Readiness Review

The DBA readiness review conducted by HSAG consisted of two components: (1) Operational Readiness Review, and (2) IS Readiness Review. The purpose of the Operational Readiness Review was to determine if the DBA had the structural and operational capacity to perform the Medicaid managed care functions described in the DHCFP's contract 3425 to ensure appropriate and timely access to quality healthcare services for Medicaid enrollees. The purpose of the IS Readiness Review was to evaluate the DBA's ability to adjudicate a set of test claims to pay providers and subsequently prepare encounters based on the adjudicated test cases. The DHCFP maintained authority to validate the sufficiency of the DBA's provider network in accordance with the DHCFP's contract 3425.

Operational Review Readiness Review Process

In accordance with 42 CFR §438.66(d)(3), the 2017 Readiness Review included both a desk review of documents and an on-site review of the DBA for the purposes of interviewing key staff and leadership who manage the operational areas for the DBA. HSAG also conducted live system demonstrations of multiple systems used by the DBA to support activities related to enrollee and provider communications and outreach, grievance and appeal processing and tracking, provider network management, utilization review, and quality improvement.

The operational readiness review included an assessment of 15 standards based on the requirements of the contract. These standards incorporated the key areas noted in 42 CFR §438.66(d)(4) and are presented in Table A-6 below.

Table A-6—Crosswalk of Nevada Readiness Review Standards to Federal Readiness Review Areas

Operational Readiness Review Standards	Federal Readiness Review Areas 42 CFR §438.66(d)(4)*
Standard I: Internal Quality Assurance Program	Quality improvement
Standard II: Credentialing and Recredentialing	Provider network management
Standard III: Member Rights and Responsibilities	Enrollee and provider communications
Standard IV: Member Information	Member services and outreach
Standard V: Availability and Accessibility of Services	Provider network management
Standard VI: Continuity and Coordination of Care	Case management/care coordination/service planning
Standard VII: Grievances and Appeals	Grievance and appeals
Standard VIII: Subcontracts and Delegation	Delegation and oversight of DBA responsibilities
Standard IX: Cultural Competency Program	Provider network management

Operational Readiness Review Standards	Federal Readiness Review Areas 42 CFR §438.66(d)(4)*
Standard X: Coverage and Authorization of Services	Utilization review
Standard XI: Provider Dispute and Complaint Resolution	Grievance and appeals
Standard XII: Confidentiality and Recordkeeping	Delegation and oversight of DBA responsibilities
Standard XIII: Provider Information	Provider network management
Standard XIV: Enrollment and Disenrollment	Member services and outreach
Standard XV: Program Integrity	Program integrity/compliance

* An assessment of the DBA's financial reporting and monitoring, and financial solvency, was performed by the DHCFP and was not part of the readiness review performed by HSAG.

Methods for Data Collection

Before beginning the readiness reviews, HSAG developed data collection tools to document the review. The requirements in the tools were based on applicable federal and State regulations and laws and on the requirements set forth in the contract between the DHCFP and the DBA. In August 2017, HSAG initiated the systems readiness review activities by providing a cover letter to the DBA that described the activities and critical dates associated with the systems readiness review. The cover letter included the review tools associated with the systems readiness review.

Description of Data Obtained

To assess the DBA's ability and capacity to perform managed care activities consistent with federal regulations, State rules, and contract requirements, HSAG obtained information from a wide range of written documents produced by the DBA. The written documents included but were not limited to:

- Policies and procedures
- Committee charters and descriptions
- Provider manual and other DBA communication to providers/subcontractors
- Member handbook and other written materials to members
- Narrative and/or reporting templates
- DBA-maintained files for practitioner contracting and credentialing
- DBA questionnaire

HSAG obtained additional information for the readiness review through interactive discussions and interviews with the DBA's key staff members and information system demonstrations provided by the DBA's staff members.

Operational Readiness Review Evaluation Tool

The Operational Readiness Review Evaluation Tool contained 15 standards that were organized based on the requirements of the DHCFP managed care contract 3425. A total of 165 applicable elements within the 15 standards were reviewed as part of the operational readiness review. Other elements included in the Operational Readiness Review Evaluation Tool were marked Not Applicable (N/A). Elements marked as N/A were for informational purposes only because they involved requirements that can only be evaluated once the DBA is operational and serving enrollees. These elements will be reviewed during the FY 2018–2019 Compliance Review but were not reviewed as part of the readiness review. HSAG included the N/A elements to familiarize the new DBA with all the operational elements included in the DBA contract to be reviewed as part of the future comprehensive compliance review.

Certain elements were considered more critical to the successful launch of a managed care program, such as the ability to notify individuals of the services available and how to obtain those services, processing grievances and appeals, and contracting with providers. The DHCFP and HSAG designated those elements as "critical" elements with the expectation that the DBA prioritize the functions associated with those elements as part of its remediation strategy. Table A-7 lists the total number of applicable elements reviewed within each of the operational readiness review standards and the subset of critical elements within each standard.

Table A-7—Operational Readiness Review Evaluation Tool—Total Elements Reviewed

Standard Number	Readiness Review Standard	Total Applicable Elements	Total Critical Elements
I	Internal Quality Assurance Program	19	12
II	Credentialing and Recredentialing	13	9
III	Member Rights and Responsibilities	7	4
IV	Member Information	6	4
V	Availability and Accessibility of Services	18	10
VI	Continuity and Coordination of Care	2	2
VII	Grievances and Appeals	30	15
VIII	Subcontracts and Delegation	9	5
IX	Cultural Competency Program	5	4
X	Coverage and Authorization of Services	18	6
XI	Provider Dispute and Complaint Resolution	6	4
XII	Confidentiality and Recordkeeping	7	4
XIII	Provider Information	1	1
XIV	Enrollment and Disenrollment	0	0
XV	Program Integrity	24	12
Total Operational Readiness Review Elements		**165**	**92**

Readiness Review Checklists

Readiness review checklists were used to review sub-elements within four of the 15 standards. HSAG used the checklists to determine the DBA's compliance with the respective documentation requirements. The total elements associated with each checklist are listed in Table A-8.

Table A-8—Operational Readiness Review Checklists—Total Elements Reviewed

Associated Standard #	Checklist Name	Total Applicable Elements
III	Recipient Rights and Responsibilities	14
IV	Member Handbook	26
XII	Dental Record Standards	23
XIII	Provider Manual	10
	Total Checklist Elements	**73**

Credentialing File Review Tool

While on-site, HSAG reviewed a sampling of credentialing files to evaluate the DBA's compliance with the credentialing and primary source verification requirements in the Nevada DBA contract. Table A-9 shows the total applicable elements for the credentialing file review.

Table A-9—Credentialing File Review—Total Elements Reviewed

Associated Standard #	File Review	Total Applicable Elements
II	Credentialing	238
	Total File Review Elements	**238**

Readiness Review Activities

To complete the readiness review, HSAG conducted pre-on-site, on-site, and post-on-site review activities.

Pre-on-site and desk review activities included:

- Developing the readiness review tools: Operational Readiness Review Evaluation Tool, Operational Readiness Review Checklists, and Initial Credentialing File Review Tool.
- Preparing and forwarding to the DBA a customized desk review form with instructions for completing it and for submitting the requested documentation to HSAG for its desk review.
- Scheduling the on-site reviews.
- Developing agendas for the on-site review.

- Providing a cover letter with detailed instructions about the readiness review, key dates for the readiness review, and data collection tools to the DBA to facilitate their preparation for HSAG's review.
- Conducting a readiness review preparation webinar.
- Conducting a pre-on-site desk review of documents. HSAG conducted a desk review of the information obtained from the DBA. The desk review enabled HSAG reviewers to increase their knowledge and understanding of the DBA' operations, identify areas needing clarification, and begin compiling information before the on-site and system demonstration reviews.
- Generating a list of 15 sample cases plus an oversample of five cases for the credentialing file review.

On-site review activities included:

- Facilitating an opening conference, with introductions and a review of the agenda and logistics for HSAG's on-site review activities.
- Reviewing the documents HSAG requested that the DBA have available on-site.
- Reviewing the credentialing files HSAG requested from the DBA and completing the credentialing file review tool.
- Reviewing the DBA's data systems used in its operations, which included:
  - Enrollee and provider communications and outreach.
  - Grievance and appeal processing and tracking.
  - Provider network management.
  - Utilization review.
  - Quality improvement.
  - Ad hoc reporting from claims.
- Interviewing the DBA's key administrative and program staff members.
- Facilitating a closing conference during which HSAG reviewers summarized their preliminary findings.

HSAG documented its findings in the data collection tools, which now serve as the comprehensive records of HSAG's findings, completeness scores assigned to each requirement, and the actions required by the DBA to remedy deficiencies noted in the tools.

Post-on-site review activities: HSAG reviewers aggregated findings to produce this comprehensive readiness review report. In addition, HSAG created a template for the DBA to detail its plan to remedy the deficiencies noted. The remediation plan template, , contains the findings and recommendation for each element found to be incomplete during the readiness review. The DBA must use the template to submit its remediation plan to the DHCFP to propose its plan to remediate all elements scored *Incomplete* or *Incomplete—Critical.* The DHCFP maintained ultimate authority for critical element designation and approving remediation plans submitted in response to the readiness review.

Data Aggregation and Analysis

From a review of documents, observations, and interviews with key staff during the on-site readiness review, the HSAG surveyors assigned a score for each element and an aggregate score for each standard for the Operational Readiness Review Evaluation tool. Certain elements were considered more critical to the successful launch of a managed care program, such as the ability to notify individuals of the services available and how to obtain those services, processing grievances and appeals, and contracting with providers. Each element was given a score of *Complete, Incomplete,* or *Incomplete—Critical*.

HSAG's scoring included the following:

- ***Complete*** indicates full compliance defined as *both* of the following:
  - All documentation listed under a regulatory provision, or component thereof, was present.
  - Staff members provided responses to reviewers that were consistent with each other and with the policies and/or processes described in documentation.
- ***Incomplete*** indicates noncompliance defined as *either* of the following:
  - No documentation was present or documentation was unclear or contained conflicting information that did not address the regulatory requirement.
  - 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 *Incomplete* would result in an overall provision finding of incomplete, regardless of the findings noted for the remaining components.
- ***Incomplete—Critical*** indicates noncompliance (defined above) and requires that the DBA prioritize the element in its remediation plan and remedy the deficiency before enrolling members.

From the scores it assigned for each of the requirements, HSAG calculated a total percentage-of-complete score for each of the 15 standards and an overall percentage-of-complete score across the 15 standards. HSAG also calculated scores for each of the checklists reviewed and the credentialing files reviewed.

Information Systems Readiness Review Process

In accordance with 42 CFR §438.66(d)(3), the 2017 Information Systems (IS) Readiness Review included both a desk review of documents and a Web conference for the purposes of interviewing key staff and leadership and testing the DBA's claims systems. HSAG also evaluated the DBA's processes for creating encounter data files in accordance with the State's technical specifications.

The IS readiness review included an assessment of three standards based on the requirements of the contract and key areas noted in 42 CFR §438.66(d)(4). The IS readiness review standards are also included in Table A-10 below.

Table A-10—Crosswalk of Nevada IS Readiness Review Standards to Federal Readiness Review Areas

Information System (IS) Readiness Review Standards	Federal Readiness Review Areas 42 CFR §438.66(d)(4)
IS Review Standard I: Enrollment Systems	Encounter data/enrollment information management Claims management
IS Review Standard II: Claims Systems	Encounter data/enrollment information management Claims management
IS Review Standard III: Encounter Systems	Encounter data/enrollment information management Claims management

Methods for Data Collection

Before beginning the readiness reviews, HSAG developed data collection tools to document the review. The requirements in the tools were based on applicable federal and State regulations and laws and on the requirements set forth in the contract between the DHCFP and the DBA. In August 2017, HSAG initiated the systems readiness review activities by providing a cover letter to the DBA that described the activities and critical dates associated with the systems readiness review. The cover letter included the review tools associated with the systems readiness review.

Description of Data Obtained

To assess the DBA's systems functionality and capacity to support managed care activities consistent with federal regulations, State rules, and contract requirements, HSAG obtained information from written documents and systems information produced by the DBA, including, but not limited to, the following:

- Technical documents and workflow diagrams
- Written policies and procedures
- Systems manuals
- Real-time review of systems

HSAG obtained additional information for the readiness review through interactive discussions and interviews with the DBA's key staff members.

Data Collection Tools

HSAG used the IS Readiness Desk Review tool to document its evaluation of the DBA's key policies, procedures, and processes related to the enrollment, claims, and encounter systems. Table A-11 shows the total applicable elements for the IS readiness desk review.

Table A-11—IS Readiness Desk Review Tool—Total Elements Reviewed

Standard Number	Readiness Review Standard	Total Applicable Elements
I	Enrollment Systems	**4**
II	Claims Systems	**3**
III	Encounter Data Systems	**3**
	Total IS Readiness Review Elements	**10**

IS Claims and Encounters Systems Testing Tools

The IS Claims and Encounters Systems Testing tool was used to document the findings from the remote systems claims testing and encounter file validation conducted in November 2017. The test scenarios included a range of dental claims designed to encompass Nevada Medicaid and Check Up dental benefits and billing requirements. The DBA was provided test recipients, providers, and claim files to load into the DBA's test systems to review with HSAG via WebEx. One week after the systems testing, the DBA was required to submit the test claim encounter files in accordance with the DHCFP's encounter submission file formats. The IS Claims and Encounters Systems Testing tools provide a record of HSAG's findings regarding the DBA's ability to process claims and submit encounters according to the scenarios.

Readiness Review Activities

To complete the readiness review, HSAG conducted pre-systems testing, remote IS and claims testing, and post-systems testing review activities.

Pre-systems testing and desk review activities included:

- Developing the readiness review tools: IS Readiness Desk Review Tool, and IS Claims and Encounters Systems Testing Tool.
- Scheduling the Web conference for claims testing.
- Developing an agenda for the remote claims systems testing.
- Providing a cover letter with detailed instructions about the readiness review, key dates for the readiness review, and data collection tools to facilitate the DBA's preparation for HSAG's systems review.
- Conducting a systems readiness review preparation webinar.
- Conducting a desk review of documents. HSAG conducted a desk review of the information obtained from the DBA. The desk review enabled HSAG reviewers to increase their knowledge and understanding of the DBA's operational areas that support enrollment, claims, and encounter data processing and the corresponding systems.
- Responding to the DBA's questions regarding systems testing and the DHCFP's data requirements.

Information systems and claims testing activities included:

- Facilitating an opening conference, with introductions and a review of the agenda and systems testing activities.
- Interviewing DBA staff members to clarify HSAG's understanding of the policies and procedures provided by the DBA as part of the desk review.
- Processing test claims in a live claims adjudication environment using dental scenarios provided by HSAG.
- Reviewing claims monitoring and audit controls.
- Reviewing DBA's encounter data processes and systems.

HSAG documented its findings in the data collection tools, which now serve as the comprehensive records of HSAG's findings.

Post-systems testing activities: HSAG reviewers aggregated findings to produce this IS Readiness Review report. In addition, HSAG created a template for the DBA to detail its plan to remedy the deficiencies noted. The remediation plan template, contains the findings and recommendations for each element found to be incomplete during the readiness review. The DBA used the template to submit a remediation plan to the DHCFP to propose its plan to remediate all elements scored *Incomplete* or *Incomplete—Critical.* The DHCFP maintained ultimate authority for applying critical element designation and approving remediation plans submitted in response to the readiness review.

Data Aggregation and Analysis

From a review of documents, observations, and interviews with key staff during the systems testing, the HSAG reviewers assigned a score for each element and an aggregate score for each standard for the Systems Readiness Review Evaluation tools. Certain elements were considered more critical to the successful launch of a managed care program, such as the DBA's ability to process eligibility and enrollment files and create encounter data files in accordance with the DHCFP's specifications. Each element was given a score of *Complete, Incomplete,* or *Incomplete—Critical*, in the same manner that was used for the operational readiness review.

From the scores assigned for each of the requirements, HSAG calculated a total percentage-of-complete score for each of the three standards and an overall percentage-of-complete score across the three standards. HSAG also calculated scores for the IS claims and encounter systems testing.

Appendix B. Goals and Objectives Tracking

Nevada 2017–2018 Quality Strategy
Goals and Objectives for Medicaid

Unless otherwise indicated, all objectives will follow the 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 2017**	**QISMC Goal**	**Anthem 2018**	**HPN 2017**	**QISMC Goal**	**HPN 2018**
Objective 1.1a:	Increase children and adolescents' access to PCPs (12–24 months).	93.83%	92.03%	94.89%	95.17%	92.28%	93.95%
Objective 1.1b:	Increase children and adolescents' access to PCPs (25 months–6 years).	82.25%	83.17%	83.97%	83.81%	81.32%	84.16%
Objective 1.1c:	Increase children and adolescents' access to PCPs (7–11 years).	86.59%	87.04%	85.98%	87.57%	85.54%	86.59%
Objective 1.1d:	Increase children and adolescents' access to PCPs (12–19 years).	82.95%	83.38%	83.53%	85.51%	82.72%	84.58%
Objective 1.2:	Increase well-child visits (0–15 months).	62.50%	55.52%	68.04%	62.77%	56.42%	61.31%
Objective 1.3:	Increase well-child visits (3–6 years).	68.72%	69.09%	73.24%	65.21%	64.75%	70.07%
Objective 1.4a:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (BMI percentile).	70.14%	67.71%†	77.37%	71.78%	73.29%†	83.21%
Objective 1.4b:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (counseling for nutrition).	62.73%	58.96%†	71.29%	62.29%	62.12%†	68.37%
Objective 1.4c:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (counseling for physical activity).	56.48%	49.38%†	67.64%	59.61%	56.86%†	65.21%
Objective 1.5:	Increase immunizations for adolescents.	79.40%	74.74%†	84.67%	80.78%	81.83%†	82.24%
Objective 1.8:	Increase adolescent well-care visits.	47.69%	47.92%	51.09%	44.77%	43.72%	46.72%
Objective 1.9a:	Increase childhood immunization status (Combination 2).	72.92%	69.58%	70.07%	73.72%	73.72%	71.05%
Objective 1.9b:	Increase childhood immunization status (Combination 3).	67.13%	64.79%	65.94%	71.05%	69.56%	64.96%

Goal 1:	Improve the Health and Wellness of Nevada's Medicaid Population by Increasing the Use of Preventive Services.						
Objective	**QISMC Objective**	**Anthem 2017**	**QISMC Goal**	**Anthem 2018**	**HPN 2017**	**QISMC Goal**	**HPN 2018**
Objective 1.9c:	Increase childhood immunization status (Combination 4).	66.67%	62.92%	65.21%	71.05%	69.56%	64.72%
Objective 1.9d:	Increase childhood immunization status (Combination 5).	56.71%	55.21%	55.23%	61.07%	57.74%	54.74%
Objective 1.9e:	Increase childhood immunization status (Combination 6).	36.11%	40.00%	33.09%	34.79%	45.48%	30.66%
Objective 1.9f:	Increase childhood immunization status (Combination 7).	56.25%	53.54%	54.74%	61.07%	57.74%	54.50%
Objective 1.9g:	Increase childhood immunization status (Combination 8).	36.11%	39.79%	32.85%	34.79%	45.48%	30.66%
Objective 1.9h:	Increase childhood immunization status (Combination 9).	32.18%	35.42%	28.47%	30.41%	39.12%	26.03%
Objective 1.9i:	Increase childhood immunization status (Combination 10).	32.18%	35.21%	28.22%	30.41%	39.12%	26.03%
Goal 2:	**Increase Use of Evidence-Based Practices for Members With Chronic Conditions.**						
Objective	**QISMC Objective**	**Anthem 2017**	**QISMC Goal**	**Anthem 2018**	**HPN 2017**	**QISMC Goal**	**HPN 2018**
Objective 2.1:	Increase rate of HbA1c testing for members with diabetes.	81.02%	83.71%	82.48%	82.73%	85.76%	78.59%
Objective 2.2:	Decrease rate of HbA1c poor control (>9.0%) for members with diabetes.**	46.30%	41.76%	41.61%	42.82%	40.08%	44.77%
Objective 2.3:	Increase rate of HbA1c good control (<8.0%) for members with diabetes.	45.60%	48.84%	50.12%	48.42%	49.42%	46.72%
Objective 2.4:	Increase rate of eye exams performed for members with diabetes.	59.49%	59.91%	53.28%	61.31%	60.36%	59.37%
Objective 2.5:	Increase medical attention for nephropathy for members with diabetes.	90.28%	77.65%	90.27%	90.75%	84.46%	87.35%
Objective 2.6:	Increase blood pressure control (<140/90 mm Hg) for members with diabetes.	61.11%	65.96%	54.26%	50.36%	73.29%	66.18%

Goal 2:	Increase Use of Evidence-Based Practices for Members With Chronic Conditions.						
Objective	**QISMC Objective**	**Anthem 2017**	**QISMC Goal**	**Anthem 2018**	**HPN 2017**	**QISMC Goal**	**HPN 2018**
Objective 2.7a:	Increase medication management for people with asthma—medication compliance 50 percent.	56.19%	55.20%†	55.71%	53.37%	52.26%†	57.39%
Objective 2.7b:	Increase medication management for people with asthma—medication compliance 75 percent.	32.16%	34.16%†	32.70%	32.81%	31.73%†	35.33%

Goal 3:	Reduce and/or Eliminate Health Care Disparities for Medicaid Recipients.						
Objective	**QISMC Objective**	**Anthem 2017**	**QISMC Goal**	**Anthem 2018**	**HPN 2017**	**QISMC Goal**	**HPN 2018**
Objective 3.1:	Ensure that health plans maintain, submit for review, and annually revise cultural competency plans.	Met	Met	Met	Met	Met	Met
Objective 3.2:	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	Met	Met
Objective 3.3:	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	Met	Met

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 2017**	**QISMC Goal**	**Anthem 2018**	**HPN 2017**	**QISMC Goal**	**HPN 2018**
Objective 4.1:	Increase the rate of postpartum visits.	62.50%	52.07%	62.11%	59.12%	62.99%	59.12%
Objective 4.2:	Increase timeliness of prenatal care.	83.33%	72.79%	80.15%	72.75%	79.86%	71.29%

Goal 5:	Increase Use of Evidence-Based Practices for Members With Behavioral Health Conditions.						
Objective	**QISMC Objective**	**Anthem 2017**	**QISMC Goal**	**Anthem 2018**	**HPN 2017**	**QISMC Goal**	**HPN 2018**
Objective 5.1a:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication—initiation phase.	43.51%	43.01%†	39.66%	43.68%	51.99%†	48.28%
Objective 5.1b:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication—continuation and maintenance phase.	64.91%	46.82%†	61.02%	49.28%	62.22%†	51.76%
Objective 5.2:	Reduce use of multiple concurrent antipsychotics in children and adolescents.**	3.74%	0.00%†	1.42%	2.26%	1.62%†	5.29%
Objective 5.4:	Increase follow-up after hospitalization for mental illness within 7 days of discharge.	CS	NC	40.13%	CS	NC	25.04%
Objective 5.5:	Increase follow-up after hospitalization for mental illness within 30 days of discharge.	CS	NC	56.26%	CS	NC	43.18%

Goal 6:	Increase Reporting of CMS Quality Measures for Medicaid.				
Objective	**QISMC Objective**	**DHCFP 2015 Reporting**	**DHCFP 2016 Reporting**	**DHCFP 2017 Reporting**	**DHCFP 2018 Reporting**
Objective 6.1:	Increase number of CMS adult core measures reported to MACPro (non-QISMC).	4	5	5	N/A**
Objective 6.2:	Increase number of CMS child core measures reported to MACPro (non-QISMC).	7	13	15	N/A**

= the QISMC goal was met.

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

N/A** indicates that information was not available at the time of this report.

† indicates that the indicator was not required in 2015; therefore, the QISMC goal was set based on 2016 results.

NC indicates that a QISMC goal could not be calculated based on the prior rate.

CS indicates a change in NCQA HEDIS measure specifications; therefore, current rates are not comparable to prior years.

Nevada 2017–2018 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 Medicaid Population by Increasing the Use of Preventive Services.						
Objective	**QISMC Objective**	**Anthem 2017**	**QISMC Goal**	**Anthem 2018**	**HPN 2017**	**QISMC Goal**	**HPN 2018**
Objective 1.1a:	Increase children and adolescents' access to PCPs (12–24 months).	98.18%	96.25%	99.12%	98.50%	95.23%	96.33%
Objective 1.1b:	Increase children and adolescents' access to PCPs (25 months–6 years).	89.45%	91.43%	91.10%	89.61%	88.48%	88.12%
Objective 1.1c:	Increase children and adolescents' access to PCPs (7–11 years).	91.83%	93.36%	93.08%	92.98%	94.45%	92.25%
Objective 1.1d:	Increase children and adolescents' access to PCPs (12–19 years).	91.08%	92.96%	90.11%	91.29%	91.71%	90.61%
Objective 1.2:	Increase well-child visits (0–15 months).	78.92%	73.33%	83.24%	63.49%	64.00%	68.33%
Objective 1.3:	Increase well-child visits (3–6 years).	76.16%	74.17%	77.37%	67.64%	74.76%	73.48%
Objective 1.4a:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (BMI percentile).	71.30%	65.84%†	84.67%	73.24%	74.82%†	83.70%
Objective 1.4b:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (counseling for nutrition).	65.28%	60.00%†	73.48%	61.07%	64.31%†	73.48%
Objective 1.4c:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (counseling for physical activity).	59.72%	52.92%†	70.80%	58.39%	61.46%†	69.59%
Objective 1.5:	Increase immunizations for adolescents.	83.61%	83.45%†	90.37%	87.59%	88.62%†	86.62%
Objective 1.8:	Increase adolescent well-care visits.	60.88%	60.83%	65.82%	54.74%	59.92%	59.61%
Objective 1.9a:	Increase childhood immunization status (Combination 2).	91.16%	77.10%	90.24%	84.38%	85.11%	85.91%
Objective 1.9b:	Increase childhood immunization status (Combination 3).	82.87%	76.28%	81.71%	82.14%	79.45%	81.54%
Objective 1.9c:	Increase childhood immunization status (Combination 4).	81.22%	76.28%	81.71%	82.14%	78.74%	81.54%
Objective 1.9d:	Increase childhood immunization status (Combination 5).	72.93%	59.10%	75.61%	71.88%	69.53%	74.16%

Goal 1:	Improve the Health and Wellness of Nevada's Medicaid Population by Increasing the Use of Preventive Services.						
Objective	**QISMC Objective**	**Anthem 2017**	**QISMC Goal**	**Anthem 2018**	**HPN 2017**	**QISMC Goal**	**HPN 2018**
Objective 1.9e:	Increase childhood immunization status (Combination 6).	47.51%	50.91%	38.21%	41.52%	53.23%	44.30%
Objective 1.9f:	Increase childhood immunization status (Combination 7).	72.38%	59.10%	75.61%	71.88%	68.82%	74.16%
Objective 1.9g:	Increase childhood immunization status (Combination 8).	47.51%	50.91%	38.21%	41.52%	52.52%	44.30%
Objective 1.9h:	Increase childhood immunization status (Combination 9).	44.75%	39.46%	36.18%	37.50%	48.27%	40.94%
Objective 1.9i:	Increase childhood immunization status (Combination 10).	44.75%	39.46%	36.18%	37.50%	47.56%	40.94%

Goal 2:	Increase Use of Evidence-Based Practices for Members With Chronic Conditions.						
Objective	**QISMC Objective**	**Anthem 2017**	**QISMC Goal**	**Anthem 2018**	**HPN 2017**	**QISMC Goal**	**HPN 2018**
Objective 2.1:	Increase rate of HbA1c testing for members with diabetes.	—	—	—	—	—	—
Objective 2.2:	Decrease rate of HbA1c poor control (>9.0%) for members with diabetes.	—	—	—	—	—	—
Objective 2.3:	Increase rate of HbA1c good control (<8.0%) for members with diabetes.	—	—	—	—	—	—
Objective 2.4:	Increase rate of eye exams performed for members with diabetes.	—	—	—	—	—	—
Objective 2.5:	Increase medical attention for nephropathy for members with diabetes.	—	—	—	—	—	—
Objective 2.6:	Increase blood pressure control (<140/90 mm Hg) for members with diabetes.	—	—	—	—	—	—
Objective 2.7a:	Increase medication management for people with asthma—medication compliance 50 percent.	58.43%	52.98%†	54.84%	51.02%	52.86%†	53.65%
Objective 2.7b:	Increase medication management for people with asthma—medication compliance 75 percent.	24.72%	34.18%†	30.11%	27.89%	34.28%†	34.90%

Goal 3:	Reduce and/or Eliminate Health Care Disparities for Nevada Check Up Recipients.						
Objective	**QISMC Objective**	**Anthem 2017**	**QISMC Goal**	**Anthem 2018**	**HPN 2017**	**QISMC Goal**	**HPN 2018**
Objective 3.1:	Ensure that health plans maintain, submit for review, and annually revise cultural competency plans.	Met	Met	Met	Met	Met	Met
Objective 3.2:	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	Met	Met
Objective 3.3:	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	Met	Met

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 2017**	**QISMC Goal**	**Anthem 2018**	**HPN 2017**	**QISMC Goal**	**HPN 2018**
Objective 4.1:	Increase the rate of postpartum visits.	—	—	—	—	—	—
Objective 4.2:	Increase timeliness of prenatal care.	—	—	—	—	—	—

Goal 5:	Increase Use of Evidence-Based Practices for Members With Behavioral Health Conditions.						
Objective	**QISMC Objective**	**Anthem 2017**	**QISMC Goal**	**Anthem 2018**	**HPN 2017**	**QISMC Goal**	**HPN 2018**
Objective 5.1a:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication—initiation phase.	41.67%	NC	44.12%	48.89%	45.58%†	55.36%
Objective 5.1b:	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication—continuation and maintenance phase.	NA	NC	NA	NA	NC	NA
Objective 5.2:	Reduce use of multiple concurrent antipsychotics in children and adolescents.**	NA	NC	NA	NA	NC	NA
Objective 5.4:	Increase follow-up after hospitalization for mental illness within 7 days of discharge.	CS	NC	50.00%	CS	NC	68.57%
Objective 5.5:	Increase follow-up after hospitalization for mental illness within 30 days of discharge.	CS	NC	65.79%	CS	NC	80.00%

Goal 6:	Increase Reporting of CMS Quality Measures.				
Objective	**QISMC Objective**	**DHCFP 2015 Reporting**	**DHCFP 2016 Reporting**	**DHCFP 2017 Reporting**	**DHCFP 2018 Reporting**
Objective 6.1:	Increase number of CMS child core measures reported to MACPro (non-QISMC).	7	13	13	N/A**

= the QISMC goal was met.

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

N/A** indicates that information was not available at the time of this report.

—indicates that the measure was not required for the Nevada Check Up population; therefore, no rate is provided.

NA indicates that no rate was reported.

† indicates that the indicator was not required in 2015; therefore, the QISMC goal was set based on 2016 results.

NC indicates that a QISMC goal could not be calculated based on the prior rate.

CS indicates a change in NCQA HEDIS measure specifications; therefore, current rates are not comparable to prior years.