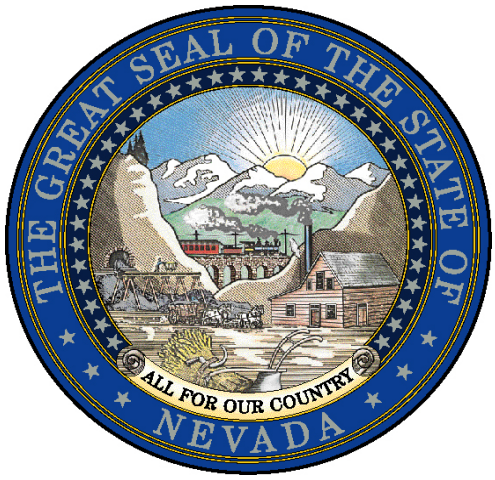

Division of Health Care Financing and Policy
Nevada Medicaid Managed Care

State Fiscal Year 2021 External Quality Review Technical Report

October 2021

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Purpose and Overview of Report

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

DHCFP administers and oversees the Nevada Managed Care Program, which provides Medicaid and Children's Health Insurance Program (CHIP, also referred to as Nevada Check Up in Nevada) benefits to members residing in Clark and Washoe counties. The Nevada Managed Care Program's MCEs include three managed care organizations (MCOs) contracted with DHCFP to provide physical health and behavioral health services to Medicaid and Nevada Check Up members. DHCFP also contracted with one prepaid ambulatory health plan (PAHP), also known as the dental benefits administrator, to provide dental benefits for Medicaid and Nevada Check Up members. The MCOs and PAHP contracted with DHCFP during state fiscal year (SFY) 2021 are displayed in Table 1-1.

Table 1-1—MCEs in Nevada

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

Scope of External Quality Review Activities

To conduct the annual assessment, HSAG used the results of mandatory and optional external quality review (EQR) activities, as described in 42 CFR §438.358. The EQR activities included as part of this assessment were conducted consistent with the associated EQR protocols developed by the Centers for Medicare & Medicaid Services (CMS).[1-1] The purpose of these activities, in general, is to improve states' ability to oversee and manage MCEs they contract with for services, and help MCEs improve

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols,* October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Oct 6, 2021.

their performance with respect to quality of, timeliness of, and access to care. Effective implementation of the EQR-related activities will facilitate State efforts to purchase high-value care and to achieve higher performing healthcare delivery systems for their Medicaid and CHIP members. For the SFY 2021 assessment, HSAG used findings from the mandatory and optional EQR activities displayed in Table 1-2 to derive conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by each MCE. Detailed information about each activity methodology is provided in Appendix A of this report.

Table 1-2—EQR Activities

Activity	Description	CMS Protocol
Validation of Performance Improvement Projects (PIPs)	This activity verifies whether a PIP conducted by an MCE used sound methodology in its design, implementation, analysis, and reporting.	Protocol 1. Validation of Performance Improvement Projects
Performance Measure Validation (PMV)	This activity assesses whether the performance measures calculated by an MCE are accurate based on the measure specifications and State reporting requirements.	Protocol 2. Validation of Performance Measures
Compliance Review	This activity determines the extent to which a Medicaid and CHIP MCE is in compliance with federal standards and associated state-specific requirements, when applicable.	Protocol 3. Review of Compliance with Medicaid and CHIP Managed Care Regulations
Network Adequacy Validation (NAV)	This activity assesses the extent to which an MCE has adequate provider networks in coverage areas to deliver healthcare services to its managed care members.	Protocol 4. Validation of Network Adequacy*
Encounter Data Validation‡ (EDV)	The activity validates the accuracy and completeness of encounter data submitted by an MCE.	Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan
Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1-2] Analysis	This activity assesses member experience with an MCE and its providers and the quality of care members receive.	Protocol 6. Administration or Validation of Quality of Care Surveys

* This activity will be mandatory effective no later than one year from the issuance of the associated EQR protocol.

‡ The EDV study was initiated prior to the conclusion of SFY 2021; however, the activity was ongoing at the time of this report and, therefore, the results of the study will be presented in the SFY 2022 EQR technical report.

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

Nevada Managed Care Program Findings and Conclusions

HSAG used its analyses and evaluations of EQR activity findings from SFY 2021 to comprehensively assess the MCEs' performance in providing quality, timely, and accessible healthcare services to DHCFP Medicaid and CHIP members. For each MCE reviewed, HSAG provides a summary of its overall key findings, conclusions, and recommendations based on the MCEs' performance, which can be found in Section 3 and Section 4 of this report. The overall findings and conclusions for all MCEs were also compared and analyzed to develop overarching conclusions and recommendations for the Nevada Managed Care Program. Table 1-3 highlights substantive findings and actionable state-specific recommendations, when applicable, for DHCFP to target specific goals and objectives in its quality strategy to further promote improvement in the quality, timeliness, and access to healthcare services furnished to its Medicaid managed care members. Refer to Section 8 for more details.

Table 1-3—Nevada Managed Care Program Substantive Findings

Program Strengths
• **Quality** – Through the PIP activities, the Nevada Managed Care Program is focusing its efforts on reducing the prevalence of uncontrolled diabetes through interventions aimed at reducing members' hemoglobin A1c (HbA1c), thereby reducing members' risks for serious diabetic-related health problems, including heart disease, kidney disease, and nerve damage. Additionally, through the *Total of Eligible Enrollees Receiving a Sealant on a Permanent Molar Tooth* PIP, the Nevada Managed Care Program is implementing initiatives to protect its child members from getting cavities that may lead to severe toothache, infection, and tooth loss, as well as problems with eating, speaking, and learning. – As demonstrated through performance measure results in comparison to both State and national benchmarks, overall, Nevada Medicaid's contracted primary care providers (PCPs) are assessing children and adolescents' body mass index and counseling for nutrition and physical activity in order to lower the risk of becoming obese and developing related diseases later in life, including cardiovascular disease and diabetes. Additionally, contracted providers are appropriately managing children and adolescents who are prescribed antipsychotic medications by conducting metabolic testing to assess for and mitigate the risks for developing serious metabolic health complications, such as diabetes and elevated blood pressure. Further, as indicated through high performing results for the *Immunizations for Adolescents* Healthcare Effectiveness Data and Information Set (HEDIS®)[1-3] measure, children who are 13 years of age are being vaccinated against meningitis, tetanus, diphtheria, and pertussis, reducing the risk for contracting these potentially life-threatening diseases. Finally, contracted network providers, pharmacies, and the Nevada Managed Care Program are mitigating the risks for adverse health outcomes related to overuse and misuse of prescribed opioids by members who received prescriptions from multiple prescribers and/or were filled through multiple pharmacies. • **Timeliness** – Through the state-mandated PIP topic, *Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care*, the Nevada Managed Care Program has implemented interventions to quickly identify pregnant women so they can be educated on and encouraged to seek timely prenatal care. Pregnant women who

[1-3] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Program Strengths

do not receive early and adequate prenatal care are at risk for complications that may either be undetected or treated too late in pregnancy, increasing the possibility of adverse outcomes for both mother and baby.

- Performance measure results for *Follow-Up Care for Children Prescribed ADHD Medication* demonstrated children prescribed an attention-deficit/hyperactivity disorder (ADHD) medication followed up timely with their providers to ensure prescribed medications were appropriate and effectively managed their symptoms caused by their behavioral health disorder. When managed appropriately, medication controls symptoms of hyperactivity, impulsiveness, and the inability to concentrate.

- **Access**
  - The dental-focused PIP, *Total of Eligible Enrollees Who Received Preventive Dental Services*, was implemented to increase the percentage of members (between the ages of 2 and 20) who are accessing preventive dental care. Tooth decay, gum disease, and dental caries are mostly preventable through a combination of good oral health hygiene and early and routine preventive dental services.
  - As demonstrated through high performance in the Availability of Services and Assurances of Adequate Capacity and Services standards reviewed through the Compliance Review activity, the Nevada Managed Care Program is maintaining and monitoring an adequate provider network that is sufficient to provide adequate access to all services (e.g., primary care, specialty care, hospital and emergency services, behavioral health services, and dental care) for the Medicaid managed care population.
  - Results from the NAV activity indicated the Nevada Managed Care Program has an adequate geographic distribution of PCPs and dentists for members to access services near their residences and a sufficient number of contracted PCPs and dentists to render services to Medicaid managed care members.

Program Weaknesses

- **Quality**
  - Although immunization compliance for adolescents was identified as a strength, the *Childhood Immunization Status* HEDIS measure indicator rates at the aggregate level did not meet the Nevada Managed Care Program's minimum performance benchmark and the majority of the MCO-specific immunization-related rates did not meet the national Medicaid 50th percentile benchmark, indicating members enrolled in the Medicaid managed care program are not getting the recommended vaccines to reduce risks for contracting preventable diseases.
  - The *Breast Cancer Screening* HEDIS measure results indicated women are not getting mammograms for early detection of breast cancer, as indicated through lower performance rates.
  - Although a state-mandated PIP was implemented to reduce the prevalence of uncontrolled diabetes through interventions aimed at reducing members' HbA1c, performance measure results suggested the implemented interventions may not be effectively impacting health outcomes for members with diabetes, as indicated by significant decreases in HbA1c testing and only minimal program improvement in the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measure indicator rate. Additionally, none of the aggregated performance rates under the *Comprehensive Diabetes Care* measure met the DHCFP-established minimum performance benchmark.
  - As indicated through an aggregated performance score of 81 percent in the Coordination and Continuity of Care standard, the Nevada Managed Care Program may not be providing care

Program Weaknesses
coordination and care management activities to effectively support members in achieving their individualized health goals in coordination with their providers. • **Timeliness** – Although the *Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care* PIP was initiated to improve the prevalence of timely prenatal care, lower aggregated performance in comparison to State and national benchmarks in the *Prenatal and Postpartum Care* measure rates indicated members are not receiving timely prenatal and postpartum care to prevent adverse health outcomes for the mother and baby. • **Access** – Although NAV activity results indicated the Medicaid and Nevada Check Up populations have a sufficient network of primary care and specialty providers to meet the needs of its enrolled members, lower overall aggregated performance in the Access to Care, Children's Preventive Care, Women's Health and Maternity Care, Care for Chronic Conditions, and Behavioral Health domains in comparison to State minimum performance standards (MPS) and national benchmarks indicated members are experiencing barriers to obtaining services unrelated to the capacity of the provider network. This was also a significant finding from the SFY 2020 EQR.

Program Recommendations	
Recommendation	**Associated Quality Strategy Goal to Target for Improvement**
• **Access to Care PIP—**For SFY 2022, DHCFP should select an overarching PIP topic that focuses on improving members' access to care. – To ensure meaningful results at the MCE level, DHCFP should require the MCOs and the PAHP to identify one access-related performance measure (e.g., *Adults' Access to Preventive/Ambulatory Health Services, Annual Dental Visit*) that fell below the national Medicaid 50th percentile and did not meet the DHCFP-established MPS in SFY 2021, or the performance measure rate is not expected to meet the national Medicaid 50th percentile or MPS in SFY 2022. – Further, DHCFP should require the MCOs and PAHP to identify healthcare disparities within their access-related performance measure data to focus its PIP on a disparate population (e.g., Hispanic members).	**Goal 1:** Improve the Health and Wellness of Nevada's Medicaid Population by Increasing Access to and the Use of Preventive Services **Goal 6:** Reduce and/or Eliminate Health Care Disparities for Medicaid Recipients

Program Recommendations	
Recommendation	**Associated Quality Strategy Goal to Target for Improvement**
• **Prenatal Care Focus Group**—DHCFP should lead a program-wide focus group of women on Medicaid who have recently given birth or are pregnant to determine potential barriers to timely access to prenatal care. – Each MCO should identify and outreach to women who are pregnant or have delivered while enrolled in the MCO to participate in the focus group. – The MCO should identify disparate populations and prioritize outreach to those members for inclusion in the focus group. – DHCFP and/or the MCOs should offer an incentive for the women to attend the focus group discussion. – DHCFP and/or the MCOs should assign a moderator to ask a predefined set of questions that focus on member experience while pregnant, including experiences with obtaining timely appointments, barriers to receiving care, perception of member/provider relationship, etc. – DHCFP and/or the MCOs should leverage the information gained from the focus group to identify potential barriers women are experiencing when seeking prenatal care and develop interventions to eliminate those barriers and support program improvement.	**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 **Goal 6:** Reduce and/or Eliminate Health Care Disparities for Medicaid Recipients

2. Overview of the Nevada Managed Care Program

Managed Care in Nevada

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

Table 2-1 presents the gender and age bands of Nevada Medicaid and Nevada Check Up members enrolled in the managed care catchment areas as of June 2021.

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

Gender/Age Band	June 2021 Members
Nevada Medicaid Data	
Males and Females <1 Year of Age‡	16,404
Males and Females 1–2 Years of Age	34,031
Males and Females 3–14 Years of Age	178,861
Females 15–18 Years of Age[1]	23,481
Males 15–18 Years of Age[1]	23,512
Females 19–34 Years of Age	99,392
Males 19–34 Years of Age	63,066
Females 35+ Years of Age	96,193
Males 35+ Years of Age	79,055
Total Medicaid*	**613,995**
Nevada Check Up Data	
Males and Females <1 Year of Age‡	127
Males and Females 1–2 Years of Age	971
Males and Females 3–14 Years of Age	15,792
Females 15–19 Years of Age[1]	2,823
Males 15–19 Years of Age[1]	2,759
Total CHIP*	**22,472**

Gender/Age Band	June 2021 Members
Nevada Medicaid Data	
Total Medicaid and CHIP*	636,467

* Totals reflect the whole Medicaid managed care population using the current county of residence at the time of the data pull on July 30, 2021. This includes members that may have moved outside of a managed care covered service area in the month of July. Data for 2021 are preliminary and subject to change.

ǂ Medicaid dataset for Males and Females <1 Year of Age includes members with unidentified gender.

[1] Nevada Medicaid includes members between the ages of 15 through 18, while CHIP includes members ages 15 through 19.

Overview of Managed Care Entities

During the SFY 2021 review period, DHCFP contracted with three MCOs and one PAHP. These MCEs are responsible for the provision of services to Nevada Managed Care Program members. Table 2-2 and Table 2-3 provide a profile for each MCO. As Nevada has only one PAHP, the eligible population is inclusive of all Medicaid and Nevada Check Up members and therefore is not displayed in the tables below.

Table 2-2—Nevada MCO Medicaid Managed Care Members

MCO	Total Eligible Clark County	Total Eligible Washoe County
HPN	255,885	31,160
Anthem	220,129	30,077
SilverSummit	65,831	8,363
Total*	**541,845**	**69,600**

* Table 2-2 reflects only Medicaid managed care members residing in Clark and Washoe counties as of June 2021.

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

MCO	Total Eligible Clark County	Total Eligible Washoe County
HPN	9,610	2,189
Anthem	7,015	1,443
SilverSummit	1,788	361
Total*	**18,413**	**3,993**

* Table 2-3 reflects only Nevada Check Up members residing in Clark and Washoe counties as of June 2021.

Quality Strategy

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

DHCFP's mission is to purchase and ensure the provision of quality healthcare services, including Medicaid services, to low-income Nevadans in the most efficient manner. DHCFP also seeks to promote equal access to healthcare at an affordable cost to Nevada taxpayers, to restrain the growth of healthcare costs, and to review Medicaid and other State healthcare programs to determine the potential to maximize federal revenue opportunities. The Nevada Department of Health and Human Services (DHHS) director has identified three priority focus areas for the Nevada Managed Care Program: prevention, early intervention, and quality treatment. Consistent with the State's mission and DHHS priority areas, the purpose of DHCFP's Quality Assessment and Performance Improvement Strategy (Quality Strategy) is to:

- Establish a comprehensive quality improvement system that is consistent with the Triple Aim adopted by CMS to achieve better care for patients, better health for communities, and lower costs through improvement in the healthcare system.
- Provide a framework for DHCFP to design and implement a coordinated and comprehensive system to proactively drive quality throughout the Nevada Medicaid and Nevada Check Up system. The Quality Strategy promotes the identification of creative initiatives to continually monitor; assess; and improve access to care, clinical quality of care, and health outcomes of the population served.
- Identify opportunities to improve the health status of the enrolled population and improve health and wellness through preventive care services, chronic disease and special needs management, and health promotion.
- Identify opportunities to improve quality of care and quality of service and implement improvement strategies to ensure Nevada Medicaid and Nevada Check Up members have access to high-quality and culturally appropriate care.
- Identify creative and efficient models of care delivery that are steeped in best practice and make healthcare more affordable for individuals, families, and the State government.
- Improve member satisfaction with care and services.
- Ensure that individuals transitioning to managed care from fee-for-service and individuals transitioning between MCOs receive appropriate therapeutic, medical, and behavioral health services as part of the transition of care policy noted in the *Medicaid Services Manual*, Chapter 3603.17.

To support the priorities of the Quality Strategy, DHCFP established quality goals and objectives to improve the health and wellness of Nevada Medicaid and Nevada Check Up members. The goals and objectives of DHCFP's Quality Strategy are summarized in Table 2-4, and performance is currently evaluated primarily through audited HEDIS data and performance measure validation results.

DHCFP has established an MPS for each objective. Further, DHCFP established additional performance tiers that serve as "stretch goals" for each objective. The purpose of establishing the MPS and performance tiers for each objective was to create a set of reasonable targets that MCEs could achieve through continuous focus and improvement for each of the indicators that represent an objective.

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

Goal 1:	Improve the Health and Wellness of Nevada's Medicaid Population by Increasing Access to and the Use of Preventive Services
Objective #	**Objective Description**
Objective 1.1a:	Increase children and adolescents' access to PCPs (CAP)—12–24 months †
Objective 1.1b:	Increase children and adolescents' access to PCPs (CAP)—25 months–6 years†
Objective 1.1c:	Increase children and adolescents' access to PCPs (CAP)—7–11 years†
Objective 1.1d:	Increase children and adolescents' access to PCPs (CAP)—12–19 years†
Objective 1.2:	Increase well-child visits (W15)—0–15 months +
Objective 1.3:	Increase well-child visits (W34)—3–6 years +
Objective 1.4a:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—body mass index (BMI) percentile
Objective 1.4b:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—counseling for nutrition
Objective 1.4c:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—counseling for physical activity
Objective 1.5a:	Increase immunizations for adolescents (IMA)—Meningococcal, Tdap
Objective 1.5b:	Increase immunizations for adolescents (IMA)—Meningococcal, Tdap, HPV
Objective 1.6a:	Increase childhood immunization status (CIS)—Combination 2
Objective 1.6b:	Increase childhood immunization status (CIS)—Combination 3
Objective 1.6c:	Increase childhood immunization status (CIS)—Combination 4
Objective 1.6d:	Increase childhood immunization status (CIS)—Combination 5
Objective 1.6e:	Increase childhood immunization status (CIS)—Combination 6
Objective 1.6f:	Increase childhood immunization status (CIS)—Combination 7
Objective 1.6g:	Increase childhood immunization status (CIS)—Combination 8
Objective 1.6h:	Increase childhood immunization status (CIS)—Combination 9
Objective 1.6i:	Increase childhood immunization status (CIS)—Combination 10
Objective 1.7:	Increase adolescent well-care visits (AWC) †
Objective 1.8:	Increase breast cancer screening (BCS)
Objective 1.9a:	Increase adults' access to preventive/ambulatory health services (AAP)—20–44 years
Objective 1.9b:	Increase adults' access to preventive/ambulatory health services (AAP)—45–64 years

Goal 1:	Improve the Health and Wellness of Nevada's Medicaid Population by Increasing Access to and the Use of Preventive Services
Objective #	**Objective Description**
Objective 1.9c:	Increase adults' access to preventive/ambulatory health services (AAP)—65 years and older
Objective 1.9d:	Increase adults' access to preventive/ambulatory health services (AAP)—Total
Objective 2.0:	Decrease rate of adult acute inpatient stays that were followed by an unplanned readmission for any diagnosis within 30 days after discharge (PCR)*

Goal 2:	Increase Use of Evidence-Based Practices for Members With Chronic Conditions
Objective #	**Objective Description**
Objective 2.1a:	Increase rate of HbA1c testing for members with diabetes (CDC)
Objective 2.1b:	Decrease rate of HbA1c poor control (>9.0%) for members with diabetes (CDC)*
Objective 2.1c:	Increase rate of HbA1c good control (<8.0%) for members with diabetes (CDC)
Objective 2.1d:	Increase rate of eye exams performed for members with diabetes (CDC)
Objective 2.1e:	Increase medical attention for nephropathy for members with diabetes (CDC) †
Objective 2.1f:	Increase blood pressure control (<140/90 mm Hg) for members with diabetes (CDC)
Objective 2.2a:	Increase medication management for people with asthma (MMA)—medication compliance 50 percent†
Objective 2.2b:	Increase medication management for people with asthma (MMA)—medication compliance 75 percent†
Objective 2.3	Increase rate of controlling high blood pressure (CBP)
Objective 2.X♦	Increase kidney health evaluation for people with diabetes (KED)

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

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

Goal 5:	Increase Use of Evidence-Based Practices for Members With Behavioral Health Conditions
Objective #	**Objective Description**
Objective 5.1a:	Increase follow-up care for children prescribed ADHD medication (ADD)—initiation phase
Objective 5.1b:	Increase follow-up care for children prescribed ADHD medication (ADD)—continuation and maintenance phase
Objective 5.2:	Reduce use of multiple concurrent antipsychotics in children and adolescents (APC)*,†
Objective 5.3:	Increase adherence to antipsychotic medications for individuals with schizophrenia (SAA)
Objective 5.4:	Increase follow-up after hospitalization for mental illness (FUH)—7-day
Objective 5.5:	Increase follow-up after hospitalization for mental illness (FUH)—30-day
Objective 5.6:	Increase diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications (SSD)
Objective 5.7a:	Increase follow-up after emergency department (ED) visit for alcohol and other drug (AOD) abuse or dependence (FUA)—7-day
Objective 5.7b:	Increase follow-up after ED visit for AOD abuse or dependence (FUA)—30-day
Objective 5.8a:	Increase follow-up after ED visit for mental illness (FUM)—7-day
Objective 5.8b:	Increase follow-up after ED visit for mental illness (FUM)—30-day
Objective 5.9a:	Increase initiation and engagement of AOD abuse or dependence treatment (IET)—initiation of treatment
Objective 5.9b:	Increase initiation and engagement of AOD abuse or dependence treatment (IET)—engagement of treatment
Objective 5.10:	Increase metabolic monitoring for children and adolescents on antipsychotics (APM)—blood glucose and cholesterol testing
Goal 6:	**Reduce and/or Eliminate Health Care Disparities for Medicaid Recipients**
Objective #	**Objective Description**
Objective 6.1:	Ensure that health plans maintain, submit for review, and annually revise cultural competency plans.
Objective 6.2:	Stratify data for performance measures by race and ethnicity to determine where disparities exist. Continually identify, organize, and target interventions to reduce disparities and improve access to appropriate services for the Medicaid and Nevada Check Up population.
Objective 6.3:	Ensure that each MCO submits an annual evaluation of its cultural competency programs to the DHCFP. The MCOs must receive a 100 percent *Met* compliance score for all criteria listed in the MCO contract for cultural competency program development, maintenance, and evaluation.

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

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

† Indicates that this measure was retired by the National Committee for Quality Assurance (NCQA) and was not reported in SFY 2021. This measure will be removed from the SFY 2022 Quality Strategy revision.

+ Indicates this is a revised objective due to HEDIS measure changes for SFY 2021. Objective numbering and measure names will be updated in the SFY 2022 Quality Strategy revision in accordance with Appendix B.

♦ New objective to be included in the SFY 2022 Quality Strategy revision. HEDIS measurement year (MY) 2020 rates provided for informational purposes only.

State Directed Payment Initiative

In SFY 2021, DHCFP received approval from CMS to implement a delivery system and provider payment initiative in accordance with 42 CFR §438.6(c) for public hospital systems in Nevada in counties in which the population is 700,000 or more, the licensed professionals working in those public hospital systems, and/or the licensed professionals affiliated with accredited public medical schools in those largely populated counties. DHCFP implemented the payment initiative to help ensure the financial viability of these hospitals and licensed professionals, and to support them in maintaining and enhancing the high quality of care they provide to Medicaid members in Nevada. To evaluate the effectiveness of the state-directed payment initiative related to inpatient services, DHCFP added a performance measure (Objective 2) to its Quality Strategy under Goal 1 to *decrease rate of adult acute inpatient stays that were followed by an unplanned readmission for any diagnosis within 30 days after discharge (PCR)*. For outpatient services, effectiveness of the payment initiative aligns with the revised Quality Strategy Goal 1 to *improve the health and wellness of Nevada's Medicaid population* with a focus on performance measures related to weight assessments and nutrition and physical activity counseling for children and adolescents, and comprehensive diabetes care and controlling high blood pressure for adults. Specifically, performance will be evaluated in accordance with objectives 1.4a, 1.4b, 1.4c, 2.1a, 2.1b, and 2.3 within the Quality Strategy. The MCOs are annually required to calculate the performance of the providers eligible for the payment increase based on the utilization and delivery of services to Medicaid managed care members using state-directed payment measure specifications and HEDIS data results.

In accordance with the CMS-approved Section 438.6(c) Preprint, calendar year 2020 served as the baseline year for measuring whether the payment initiative supported improvement in the services being provided by Nevada public hospitals and licensed professionals meeting the eligibility requirements for the payment increase initiative. Table 2-5 and Table 2-6 includes baseline data provided by the MCOs and aggregated by HSAG for each of the performance measures that DHCFP will use in future years to determine the hospitals' performance and the State's progress on advancing the Quality Strategy goals and objectives due to implementation of the payment initiative.

Table 2-5—State-Directed Payment Initiative Baseline Data—Nevada Medicaid

Performance Measure	Quality Strategy Objective	Baseline (CY 2020)*
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—BMI Percentile—Total	Objective 1.4.a: Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—BMI percentile	40.29%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Counseling for Nutrition—Total	Objective 1.4.b: Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—counseling for nutrition	31.31%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Counseling for Physical Activity—Total	Objective 1.4.c: Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—counseling for physical activity	28.18%
Comprehensive Diabetes Care (CDC)—Hemoglobin A1c (HbA1c) Testing	Objective 2.1.a: Increase rate of HbA1c testing for members with diabetes (CDC)	40.78%
Comprehensive Diabetes Care (CDC)—HbA1c Poor Control (>9.0%)	Objective 2.1.b: Decrease rate of HbA1c poor control (>9.0%) for members with diabetes (CDC)	21.97%
Controlling High Blood Pressure (CBP)	Objective 2.3: Increase rate of controlling high blood pressure (CBP)	11.95%
Plan All-Cause Readmissions (PCR)	Objective 2.0: Decrease rate of adult acute inpatient stays that were followed by an unplanned readmission for any diagnosis within 30 days after discharge (PCR)	11.81%

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

Table 2-6—State-Directed Payment Initiative Baseline Data—Nevada Check Up

Performance Measure	Quality Strategy Objective	Baseline (CY 2020)*
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—BMI Percentile—Total	Objective 1.4.a: Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—BMI percentile	49.68%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Counseling for Nutrition—Total	Objective 1.4.b: Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—counseling for nutrition	38.92%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Counseling for Physical Activity—Total	Objective 1.4.c: Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—counseling for physical activity	35.76%
Comprehensive Diabetes Care (CDC)—HbA1c Testing	Objective 2.1.a: Increase rate of HbA1c testing for members with diabetes (CDC)	NA‡
Comprehensive Diabetes Care (CDC)—HbA1c Poor Control (>9.0%)	Objective 2.1.b: Decrease rate of HbA1c poor control (>9.0%) for members with diabetes (CDC)	NA‡
Controlling High Blood Pressure (CBP)	Objective 2.3: Increase rate of controlling high blood pressure (CBP)	NA‡
Plan All-Cause Readmissions (PCR)	Objective 2.0: Decrease rate of adult acute inpatient stays that were followed by an unplanned readmission for any diagnosis within 30 days after discharge (PCR)	

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

‡ NA indicates that the MCO did not have any members who met the eligibility for the measure.

Indicates that the measure does not apply to the population.

Evaluation of Quality Strategy Effectiveness

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

Table 2-7 and Table 2-8 show the number of rates reported by the MCO or PAHP; the number of reported rates that achieved the MPS; and of those rates achieving MPS, how many reached the highest performance threshold under Tier 1, Tier 2, or Tier 3. Of note, Goal 6: Reduce and/or Eliminate Health Care Disparities for Medicaid Recipients is not evaluated through a performance measure rate and overall performance is determined as either a *Met* or *Not Met* score based on DHCFP's assessment. Therefore, this information is not included in the following tables. For additional details, please see Appendix B of this report.

Table 2-7—2021 Quality Strategy Goals and Objectives Summary of Performance by the MCOs

	Anthem Medicaid	HPN Medicaid	SilverSummit Medicaid	Anthem Check Up	HPN Check Up	SilverSummit Check Up
Number of Rates Reported	53	54	52	23	24	20
Rates With an Established MPS	43	43	42	17	18	14
Rates Achieving the MPS	**9**	**22**	**7**	**1**	**3**	**5**
Rates With Highest Achievement in Tier 1	1	6	0	0	0	1
Rates With Highest Achievement in Tier 2	2	4	0	0	1	0
Rates With Highest Achievement in Tier 3	2	1	4	1	1	0

Table 2-8—2021 Quality Strategy Goals and Objectives Summary of Performance by the PAHP

	LIBERTY Medicaid	LIBERTY Check Up
Number of Rates Reported	2	2
Rates With an Established MPS	2	2
Rates Achieving the MPS	**0**	**0**
Rates With Highest Achievement in Tier 1	0	0
Rates With Highest Achievement in Tier 2	0	0
Rates With Highest Achievement in Tier 3	0	0

DHCFP compares the baseline data for each measure along with the results from the Quality Strategy Tracking Table, as well as performance results from other initiatives outlined in the Quality Strategy and reported through each annual EQR-related deliverable (i.e., PIPs, compliance review, NAV) and the annual EQR, to evaluate the quality of the managed care services offered to Nevada Medicaid managed care members and, subsequently, the overall effectiveness the existing Quality Strategy goals and objectives. Specifically, related to program performance as indicated through performance measures tied to the Quality Strategy goals and objectives, fewer of the MCOs' objectives met the MPS or reached Tier 1, Tier 2, or Tier 3 in MY 2020 than during the previous measurement as reported in the *State Fiscal Year 2019–2020 External Quality Review Technical Report*. This suggests that a stronger focus is needed, such as implementation of PIPs, on specific objectives not meeting the MPS, where applicable.

As indicated by general stability or increased performance for Nevada Medicaid in the areas of improving appropriate use of opioids and increasing use of evidence-based practices for members with behavioral health conditions, DHCFP and its MCOs are meeting or making significant progress toward meeting the Quality Strategy goals and objectives. Additionally, all of the MCOs met the objectives for reducing and/or eliminating healthcare disparities for Nevada Medicaid members. However, as demonstrated by lower performance for Nevada Medicaid and Nevada Check Up in improving the health and wellness of Nevada's Medicaid and Check Up populations by increasing access to and the use of preventive services, it is apparent that these objectives need a stronger focus in future years. Further, the objectives for increasing the utilization of dental services were not met, indicating a need for a stronger focus on these objectives in future years as well. It is noted that because of the coronavirus disease 2019 (COVID-19) pandemic during MY 2020, many preventive services, including dental services, were negatively affected across the country as states followed orders to reduce the use of non-emergent services in order to slow the spread of COVID-19.

In the Nevada Check Up population, due to low denominators, measures for behavioral health-related objectives were not consistently reported across the MCOs. Additionally, none of the chronic condition objectives apply to this population, indicating a potential need to include new objectives within the Quality Strategy for the behavioral health and chronic conditions domains in future years. For the performance objectives related to the access to and use of preventive services, there has been some demonstrated improvement in the prevalence of immunizations; however, DHCFP and the MCOs should continue to focus efforts on increasing vaccine compliance. DHCFP could consider an opportunity to add a state-driven initiative specific to these efforts in the next Quality Strategy revision.

In response to its ongoing evaluation of the Nevada Managed Care Program's performance and to support alignment with federal initiatives, DHCFP is in the process of revising the existing goals and objectives within the Quality Strategy to align more closely with the CMS Child and Adult Core Set measures and NCQA's revised HEDIS measures. DHCFP will also revisit the established benchmarks to determine if any revisions are necessary to further promote positive performance related to the quality of, and access to quality care and services provided by its MCEs. Additionally, DHCFP will mandate new clinical and non-clinical PIP topics for SFY 2022 to support areas of the program requiring focused efforts.

3. Assessment of Managed Care Organization (MCO) Performance

HSAG used findings across mandatory and optional EQR activities conducted during the SFY 2021 review period to evaluate the performance of the MCOs on providing quality, timely, and accessible healthcare services to Nevada Managed Care Program members. Quality, as it pertains to EQR, means the degree to which the MCOs increased the likelihood of members' desired health outcomes through structural and operational characteristics; the provision of services that were consistent with current professional, evidenced-based knowledge; and interventions for performance improvement. Access relates to members' timely use of services to achieve optimal health outcomes, as evidenced by how effective the MCOs were at successfully demonstrating and reporting on outcomes for the availability and timeliness of services.

To identify significant strengths and weaknesses and draw conclusions for each MCO, HSAG analyzed and evaluated each EQR activity and its resulting findings related to the provision of healthcare services across the Nevada Managed Care Program. The composite findings for each MCO were analyzed and aggregated to identify overarching conclusions and focus areas for the MCO in alignment with the priorities of DHCFP.

Objectives of External Quality Review Activities

This section of the report provides the objectives and a brief overview of each EQR activity conducted in SFY 2021 to provide context for the resulting findings of each EQR activity. For more details about each EQR activity's objectives and the comprehensive methodology, including the technical methods for data collection and analysis, refer to Appendix A.

Validation of Performance Improvement Projects

For SFY 2021, all three MCOs continued the two DHCFP-mandated PIP topics, *Comprehensive Diabetes Care (CDC) Hemoglobin A1c (HbA1c) Poor Control >9.0%* and *Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care*. For each of these topics, the MCOs defined a Global Aim and a specific, measurable, attainable, relevant, and timebound (SMART) Aim. The SMART Aim statement includes the narrowed population, the baseline percentage, a set goal for the project, and the project's end date.

Table 3-1 outlines the SMART Aim statement for each topic for all MCOs.

Table 3-1—PIP Topic and SMART Aim Statement

Plan Name	PIP Topic	SMART Aim Statement
Anthem	*Comprehensive Diabetes Care (CDC) Hemoglobin A1c (HbA1c) Poor Control >9.0%*	By June 30, 2021, **Anthem** will decrease the percentage of CDC HbA1c poor control > 9.0% among eligible members 18–75 years of age, residing in Clark County, assigned to [health center*], from 60.95% to 51.43%.
Anthem	*Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care*	By June 30, 2021, **Anthem** will increase the percentage of prenatal visits among pregnant women who delivered, from 46.8% to 53.93%, residing in Clark County assigned to [provider*] by 5.13%.
HPN	*Comprehensive Diabetes Care (CDC) Hemoglobin A1c (HbA1c) Poor Control >9.0%*	By June 30, 2021, **HPN** aims to decrease the rate of HbA1c tests greater than 9% or missing HbA1c test results among diabetic members assigned to [medical center*] from 45.63% to 34.78%.
HPN	*Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care*	By June 30, 2021, **HPN** aims to increase the rate of Medicaid deliveries completed by [OB/GYN† provider*] that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization, from 66.41% to 77.52%.
SilverSummit	*Comprehensive Diabetes Care (CDC) Hemoglobin A1c (HbA1c) Poor Control >9.0%*	By June 30, 2021, **SilverSummit** aims to decrease the percentage of male diabetic members aged 18–75 who have had a reported HbA1c level of > 9.0% from 83% to 63%.
SilverSummit	*Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care*	By June 30, 2021, **SilverSummit**'s aim is to increase the percentage of pregnant members who have a live birth delivery planned at [hospitals*] to obtain a prenatal care visit within the first trimester of pregnancy from 5% to 25%.

* Provider names were redacted for privacy purposes.

† Obstetrics/Gynecologist

Performance Measure Validation

For SFY 2021, HSAG conducted an independent audit of each MCO in alignment with NCQA's HEDIS Compliance Audit™,[3-1] standards, policies, and procedures to assess the validity of the DHCFP-selected performance measures for the Medicaid and Nevada Check Up populations. The PMV activity included

[3-1] HEDIS Compliance Audit™ is a trademark of NCQA.

a comprehensive evaluation of the MCOs' information systems (IS) capabilities and processes used to collect and report data for the performance measures selected by DHCFP for validation.

Table 3-2 lists the performance measures selected by DHCFP for HEDIS MY 2020 reporting of the Medicaid and Nevada Check Up populations. The reported measures are divided into performance domains of care as demonstrated in the table below.

Table 3-2—HEDIS Measures

HEDIS Measures	Medicaid	Nevada Check Up
Access to Care		
Adults' Access to Preventive/Ambulatory Health Services (AAP)	✓	
Children's Preventive Care		
Child and Adolescent Well-Care Visits (WCV)	✓	✓
Childhood Immunization Status (CIS)	✓	✓
Immunizations for Adolescents (IMA)	✓	✓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	✓	✓
Well-Child Visits in the First 30 Months of Life (W30)	✓	✓
Women's Health and Maternity Care		
Breast Cancer Screening (BCS)	✓	
Prenatal and Postpartum Care (PPC)	✓	
Care for Chronic Conditions		
Comprehensive Diabetes Care (CDC)	✓	
Controlling High Blood Pressure (CBP)	✓	
Kidney Health Evaluation for Patients With Diabetes (KED)	✓	
Behavioral Health		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	✓	
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	✓	
Follow-Up After ED Visit for AOD Abuse or Dependence (FUA)	✓	✓
Follow-Up After ED Visit for Mental Illness (FUM)	✓	✓
Follow-Up After Hospitalization for Mental Illness (FUH)	✓	✓
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	✓	✓
Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)	✓	✓
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	✓	✓
Utilization		
Ambulatory Care—Total (Per 1,000 Member Months) (AMB)	✓	✓

HEDIS Measures	Medicaid	Nevada Check Up
Mental Health Utilization—Total (MPT)	✓	✓
Plan All-Cause Readmissions (PCR)	✓	
Overuse/Appropriateness		
Use of Opioids at High Dosage (HDO)	✓	
Use of Opioids From Multiple Providers (UOP)	✓	

Compliance Review

SFY 2021 commenced a new three-year cycle of compliance reviews. The compliance reviews for the DHCFP-contracted MCOs comprise 14 program areas, referred to as standards, that correlate to the federal standards and requirements identified in 42 CFR §438.358(b)(1)(iii). These standards also include applicable state-specific contract requirements and areas of focus identified by DHCFP. For SFY 2021, HSAG conducted a review of seven standards as identified in Table 3-3 under Year One. Table 3-3 also delineates the compliance review activities, and standards that will be reviewed, in Year Two and Year Three of the three-year cycle.

Table 3-3—Compliance Review Standards

	Year One (SFY 2021)	Year Two (SFY 2022)	Year Three (SFY 2023)
Standard	**Review of Standards**		**CAP Review**
Standard I—Disenrollment: Requirements and Limitations	✓		Review of Standards/Elements that received a *Not Met* score during the SFY 2021 and 2022 reviews.
Standard II—Member Rights and Member Information	✓		
Standard III—Emergency and Poststabilization Services	✓		
Standard IV—Availability of Services	✓		
Standard V—Assurances of Adequate Capacity and Services	✓		
Standard VI—Coordination and Continuity of Care	✓		
Standard VII—Coverage and Authorization of Services	✓		
Standard VIII—Provider Selection		✓	
Standard IX—Confidentiality		✓	
Standard X—Grievance and Appeal Systems		✓	

	Year One (SFY 2021)	Year Two (SFY 2022)	Year Three (SFY 2023)
Standard	**Review of Standards**		**CAP Review**
Standard XI—Subcontractual Relationships and Delegation		✓	
Standard XII—Practice Guidelines		✓	
Standard XIII—Health Information Systems		✓	
Standard XIV—Quality Assessment and Performance Improvement Program		✓	

Network Adequacy Validation

The NAV activity for SFY 2021 included network capacity and geographic distribution analyses conducted after the MCOs identified provider categories by using the provider crosswalk HSAG developed in conjunction with DHCFP. HSAG developed the provider crosswalks in collaboration with DCHFP in SFY 2019 to serve as a reference to ensure consistent classification of all ordering, referring, and servicing providers across the MCOs. To assess the capacity of each MCO's provider network, HSAG calculated the ratio of the number of providers by provider category (e.g., PCPs, cardiologists) to the number of members. The provider ratio represents a summary statistic used to highlight the overall capacity of an MCO's provider network to deliver services to Medicaid members. A larger number for providers for a given number of members suggested greater network access since more providers were available to render services to individuals. Provider counts for this analysis were based on counts of distinct providers and not distinct provider locations.

Table 3-4 shows the provider categories used to assess the MCOs' compliance with the provider ratio standards in the MCO contracts with DHCFP.

Table 3-4—Provider Categories and Provider Ratio Standards

Provider Category	Provider to Member Ratio Standard
Primary Care Providers	1:1,500*
Physician Specialists	1:1,500

* If the PCP practices in conjunction with a healthcare professional, the ratio is increased to one (1) full-time equivalent PCP for every 1,800 members.

The second component of the NAV activity, the geographic network distribution analysis, evaluated whether the number of provider locations in an MCO's provider network was appropriately distributed for the MCO's Medicaid population.

To provide a comprehensive view of geographic access, HSAG calculated the following two spatially derived metrics for the provider categories identified in the provider crosswalks:

- Percentage of members within access standards listed in the MCO contracts: A higher percentage of members meeting access standards indicates a better geographic distribution of MCO providers relative to Medicaid members.
- Average travel distances (driving distances in miles) and travel times (driving times in minutes) to the nearest three providers: A shorter driving distance or travel time indicates greater accessibility to providers since members must travel fewer miles or minutes to access care.

Table 3-5 shows the provider categories used to assess the MCOs' network adequacy and the associated time-distance standards. Additional provider types outlined in the provider crosswalk were included in the provider ratio analyses and average travel time analyses.

Table 3-5—Provider Categories, Member Criteria, and Time-Distance Standards

Provider Category	Member Criteria	Time-Distance Access Standard
Primary Care Providers		
Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC)	Adults	30 minutes or 20 miles
Family Practice	Adults	30 minutes or 20 miles
Internal Medicine	Adults	30 minutes or 20 miles
General Practitioner	Adults	30 minutes or 20 miles
Nurse Practitioner (NP)	Adults	30 minutes or 20 miles
Physician Assistant (PA)	Adults	30 minutes or 20 miles
OB/GYN	Adult Females	30 minutes or 20 miles
Pediatrician	Children	30 minutes or 20 miles
Specialty Providers		
Endocrinologists	Adults	100 minutes or 75 miles
Endocrinologists, Pediatric	Children	100 minutes or 75 miles
Infectious Disease	Adults	100 minutes or 75 miles
Infectious Disease, Pediatric	Children	100 minutes or 75 miles
Rheumatologist	Adults	100 minutes or 75 miles
Rheumatologist, Pediatric	Children	100 minutes or 75 miles
Oncologist/Hematologist	Adults	100 minutes or 75 miles
Oncologist/Hematologist, Pediatric	Children	100 minutes or 75 miles
Oncologist/Radiologist*	Adults	100 minutes or 75 miles

Provider Category	Member Criteria	Time-Distance Access Standard
Behavioral Health Providers		
Psychologist	Adults	60 minutes or 45 miles
Pediatric Psychologist	Children	60 minutes or 45 miles
Psychiatrist	Adults	60 minutes or 45 miles
Pediatric Psychiatrist	Children	60 minutes or 45 miles
Licensed Clinical Social Worker (LCSW)	Adults	60 minutes or 45 miles
Facility-Level Providers		
Inpatient Hospital	Adults	80 minutes or 60 miles
Psychiatry Inpatient Hospital	Adults	80 minutes or 60 miles
Pediatric Hospital	Children	80 minutes or 60 miles
Dialysis/End Stage Renal Disease (ESRD) Facility	Adults	80 minutes or 60 miles

* Note: The Oncologist/Radiologist provider category was not included in the provider crosswalk, and providers in this group were identified using taxonomy codes 2085R0001X—Radiation Oncology and 261QX0203X—Oncology, Radiation.

Consumer Assessment of Healthcare Providers and Systems Analysis

The CAHPS surveys ask members to report on and evaluate their experiences with healthcare. These surveys cover topics that are important to members, such as the communication skills of providers and the accessibility of services. The MCOs were responsible for obtaining a CAHPS vendor to administer the CAHPS surveys on their behalf. The primary objective of the CAHPS surveys was to effectively and efficiently obtain information on members' experiences with their healthcare and health plan. HSAG presents top-box scores, which indicate the percentage of members who responded to the survey with positive experiences in a particular aspect of their healthcare. Table 3-6 displays the various measures of member experience.

Table 3-6—CAHPS Measures of Member Experience

CAHPS Measures
Composite Measures
Getting Needed Care
Getting Care Quickly
How Well Doctors Communicate
Customer Service

CAHPS Measures
Global Ratings
Rating of All Health Care
Rating of Personal Doctor
Rating of Specialist Seen Most Often
Rating of Health Plan
Effectiveness of Care
Advising Smokers and Tobacco Users to Quit
Discussing Cessation Medications
Discussing Cessation Strategies
CCC Composite Measures/Items
Access to Specialized Services
Family Centered Care (FCC): Personal Doctor Who Knows Child
Coordination of Care for Children With Chronic Conditions
Access to Prescription Medicines
FCC: Getting Needed Information

Encounter Data Validation

In SFY 2021, an EDV study was initiated by HSAG at the request of DHCFP using three evaluation activities designed to evaluate the completeness and accuracy of DHCFP's encounter data. Together, the different activities for the specific MCOs provide a comprehensive assessment of DHCFP's encounter data submitted by each MCO. The three activities include:

- IS review—assessment of DHCFP's and/or MCOs' IS and processes.
- Comparative analysis—analysis of DHCFP's electronic encounter data completeness and accuracy through a comparison between DHCFP's electronic encounter data and the data extracted from the MCOs' data systems.
- Medical records review—analysis of DHCFP's electronic encounter data completeness and accuracy through a comparison between DHCFP's electronic encounter data and the medical records. Of note, conducting a medical record review will be contingent upon whether the IS review and comparative analysis indicate that the completeness and accuracy of DHCFP's encounter data are sufficient.

Table 3-7 illustrates the core evaluation activities for each MCO.

Table 3-7—Core Evaluation Activities for Each MCO

MCO	IS Review*	Comparative Analysis	Medical Record Review
Anthem	No	Yes	Yes
HPN	No	Yes	Yes
SilverSummit	Yes	Yes	Contingent upon whether the IS review and comparative analysis indicate that the completeness and accuracy of DHCFP's encounter data are sufficient

* IS review will not be conducted for Anthem and HPN as it was previously completed for these two MCOs in SFY 2018. SilverSummit joined the Medicaid managed care program after SFY 2018 and has yet to undergo an EDV IS review. Therefore, an IS review will be conducted for SilverSummit during the SFY 2022 activity.

The EDV study was ongoing at the time of this report; therefore, the results of the study will be presented in the SFY 2022 EQR technical report.

EQR Activity Results

Anthem Blue Cross and Blue Shield Healthcare Solutions

Validation of Performance Improvement Projects

Performance Results

Table 3-8 summarizes the progress Anthem made in completing the four PIP modules during SFY 2021.

Table 3-8—Overall Validation Rating for Anthem

PIP Topic	Module	Status
Comprehensive Diabetes Care (CDC) Hemoglobin A1c (HbA1c) Poor Control >9.0%	1. PIP Initiation	Completed and achieved all validation criteria.
	2. Intervention Determination	Completed and achieved all validation criteria.
	3. Intervention Testing	Module 3 documentation submitted to date have achieved all validation criteria. The MCO tested interventions until 6/30/2021.
	4. PIP Conclusions	Submission targeted for October 2021.
Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care	1. PIP Initiation	Completed and achieved all validation criteria.
	2. Intervention Determination	Completed and achieved all validation criteria.
	3. Intervention Testing	Module 3 documentation submitted to date have achieved all validation criteria. The MCO tested interventions until 6/30/2021.
	4. PIP Conclusions	Submission targeted for October 2021.

Anthem passed Module 3—Intervention Testing submitted for each implemented intervention and achieved all validation criteria for both PIPs. **Anthem** concluded its intervention testing on June 30, 2021. The validation findings for additional Module 3 submissions and Module 4 (PIP Conclusions) with SMART Aim measure outcomes will be reported in the next annual EQR technical report.

Interventions

During SFY 2021, **Anthem** tested one intervention per topic. The intervention description, impact, and status are described in Table 3-9 and Table 3-10 below.

Table 3-9—Intervention for Comprehensive Diabetes Care (CDC) Hemoglobin A1c (HbA1c) Poor Control >9.0%

Intervention 1#	
Intervention Description	Obtained CDC HbA1c results from targeted providers' electronic medical records (EMRs).
Intervention Impact	Initial intervention testing results indicated that receiving standard lab supplemental data files from the targeted providers who perform in-house point of care HbA1c testing increased the number of HbA1c lab test results the MCO received.
Intervention Status	The intervention testing has concluded; however, the final results will be presented in the final Plan-Do-Study-Act (PDSA) worksheet that will be submitted with Module 4.

Table 3-10—Intervention for Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care

Intervention #1	
Intervention Description	Targeted provider and office staff Current Procedural Terminology (CPT) code training.
Intervention Impact	Initial intervention testing results indicated that scheduling trainings around the providers' already full schedules was challenging, holding Webex trainings was more challenging than in-person trainings, and providers participating in the training would not complete the pre- and post-tests. The MCO created an online pre/post-test with the same questions, and this proved to be successful as it allowed the participants to complete the online test quickly and with less burden.
Intervention Status	The MCO adapted the intervention and continued testing. The testing is now concluded and the final PDSA worksheet with results will be submitted with Module 4.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: Anthem used quality improvement tools to identify and prioritize opportunities for improvement within its current processes. These tools, and the results they produced, assisted the MCO in selecting the first interventions to test using PDSA cycles. **[Quality]**

Strength #2: Anthem developed methodologically sound intervention effectiveness measures and tested interventions using PDSA cycles. The MCO made adaptations to the interventions based on lessons learned identified in Cycle 1, which should support improvements in the documentation of members' HbA1c laboratory results and timely access to prenatal care. **[Quality, Timeliness,** and **Access]**

Weaknesses and Recommendations

Weakness #1: Anthem's PDSA testing cycles were too long, which prevented the MCO from quickly revising its interventions to support process improvement. **[Quality, Timeliness,** and **Access]**

Why the weakness exists: The MCO's intervention testing time frames were between two and five months, which may have slowed process improvements implemented to support effective member care.

Recommendation: Anthem should consider shorter testing periods. The testing methodology should allow the MCO to quickly gather data and make data-driven revisions to facilitate achievement of the SMART Aim goal.

Weakness #2: Anthem limited the number of interventions tested for each topic to just one process improvement intervention. **[Quality, Timeliness,** and **Access]**

Why the weakness exists: Anthem's process included one intervention per PIP, which may have limited the opportunity for the MCO to make notable improvements in the reduction of uncontrolled diabetes and untimely access to prenatal care.

Recommendation: Anthem should consider testing more than one intervention during the intervention testing phase of the PIP. This will help the MCO address additional identified opportunities for improvement from the process map and failure mode and effects analysis (FMEA), and increase the likelihood of achieving the SMART Aim goal and desired outcomes for the PIP projects. By achieving the desired goals for the PIPs, the MCO will positively impact the timeliness and quality of care for its members.

Performance Measure Validation

Performance Results

Anthem's Medicaid and Nevada Check Up HEDIS MY 2018, MY 2019, and MY 2020 performance measure results are presented in Table 3-11 and Table 3-12, along with year-to-year rate comparisons and performance target ratings. Measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, a decrease in the rate from MY 2019 to MY 2020 represents performance improvement and an increase in the rate from MY 2019 to MY 2020 represents performance decline. The arrows (↑ or ↓) indicate whether the HEDIS MY 2020 rate was above or below the national Medicaid 50th percentile benchmark. Green and red shading is used to indicate a 5 percentage point performance improvement or performance decline from the prior year's performance, while **bolded** rates indicate the MPS was achieved. Please note that the arrows do not necessarily correlate to shading and bolded font.

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

Table 3-11—Medicaid HEDIS Performance Measure Results for Anthem

HEDIS Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	MY 2019–MY 2020 Rate Comparison
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services (AAP)				
Ages 20–44 Years	73.27%	73.11%	64.55%↓	-8.56
Ages 45–64 Years	80.05%	79.43%	72.29%↓	-7.14
Ages 65 Years and Older	NA	NA	**76.32%**↓	NC
Total	75.38%	75.11%	66.81%↓	-8.30
Children's Preventive Care				
Childhood Immunization Status (CIS)				
Combination 2	72.99%	71.29%	66.67%↓	-4.62
Combination 3	69.83%	68.13%	61.80%↓	-6.33
Combination 4	69.34%	67.64%	61.80%↓	-5.84
Combination 5	59.85%	58.64%	53.53%↓	-5.11
Combination 6	34.79%	38.93%	34.31%↓	-4.62

HEDIS Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	MY 2019–MY 2020 Rate Comparison
Combination 7	59.37%	58.15%	53.53%↓	-4.62
Combination 8	34.79%	38.93%	34.31%↓	-4.62
Combination 9	30.41%	33.82%	30.90%↓	-2.92
Combination 10	30.41%	33.82%	30.90%↓	-2.92
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	89.29%	89.29%	**85.16%**↑	-4.13
Combination 2 (Meningococcal, Tdap, HPV)	41.12%	41.12%	39.42%↑	-1.70
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile—Total[1]	82.73%	82.73%	82.24%↑	-0.49
Counseling for Nutrition—Total	74.21%	74.21%	**74.21%**↑	0.00
Counseling for Physical Activity—Total	67.88%	67.88%	69.34%↑	1.46
Well-Child Visits in the First 30 Months of Life (W30)^				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits[2]	—	—	58.52%	NC
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	—	—	65.15%	NC
Child and Adolescent Well-Care Visits (WCV)[2,^]				
3–11 Years	—	—	46.99%	NC
12–17 Years	—	—	39.02%	NC
18–21 Years	—	—	19.63%	NC
Total	—	—	41.29%	NC
Women's Health and Maternity Care				
Breast Cancer Screening (BCS)[1]				
Breast Cancer Screening	51.93%	51.64%	44.67%↓	-6.97
Prenatal and Postpartum Care (PPC)[1]				
Timeliness of Prenatal Care	—	80.78%	81.75%↓	0.97
Postpartum Care	—	59.37%	66.18%↓	6.81

HEDIS Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	MY 2019–MY 2020 Rate Comparison
Care for Chronic Conditions				
Comprehensive Diabetes Care (CDC)				
HbA1c Testing[1]	77.37%	79.08%	73.72%↓	-5.36
HbA1c Poor Control (>9.0%)[1,*]	45.01%	51.58%	51.09%↓	-0.49
HbA1c Control (<8.0%)[1]	47.45%	40.15%	40.63%↓	0.48
Eye Exam (Retinal) Performed[1]	52.31%	53.04%	50.85%↓	-2.19
Blood Pressure Control (<140/90 mm Hg)[2,^]	—	—	50.61%	NC
Controlling High Blood Pressure (CBP)[2,^]				
Controlling High Blood Pressure	—	—	51.09%	NC
Kidney Health Evaluation for Patients With Diabetes (KED)[^]				
18–64 Years	—	—	27.43%	NC
65–74 Years	—	—	NA	NC
75–84 Years	—	—	NA	NC
Total	—	—	27.55%	NC
Behavioral Health				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	35.32%	45.71%	34.72%↓	-10.99
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	80.48%	83.30%	76.62%↓	-6.68
Follow-Up After ED Visit for AOD Abuse or Dependence (FUA)[1]				
7-Day Follow-Up—Total	9.25%	10.62%	12.29%↓	1.67
30-Day Follow-Up—Total	13.99%	15.55%	17.12%↓	1.57
Follow-Up After ED Visit for Mental Illness (FUM)[1]				
7-Day Follow-Up—Total	28.77%	30.27%	29.55%↓	-0.72
30-Day Follow-Up—Total	41.41%	41.84%	40.89%↓	-0.95

HEDIS Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	MY 2019–MY 2020 Rate Comparison
Follow-Up After Hospitalization for Mental Illness (FUH)[1]				
7-Day Follow-Up—Total	33.52%	34.61%	32.49%↓	-2.12
30-Day Follow-Up—Total	50.33%	50.75%	48.72%↓	-2.03
Follow-Up Care for Children Prescribed ADHD Medication (ADD)[1]				
Initiation Phase	46.77%	41.55%	47.06%↑	5.51
Continuation and Maintenance Phase	66.10%	59.38%	**68.66%**↑	9.28
Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)[1]				
Initiation of AOD—Total	49.65%	48.53%	**45.91%**↑	-2.62
Engagement of AOD—Total	14.78%	15.87%	14.73%↑	-1.14
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)				
Blood Glucose and Cholesterol Testing–Total	23.18%	31.71%	**31.27%**↓	-0.44
Utilization				
Ambulatory Care—Total (per 1,000 Member Months) (AMB)^				
*ED Visits—Total**	56.03	59.89	42.98	-16.91
Outpatient Visits—Total	288.52	291.03	246.46	-44.57
Mental Health Utilization—Total (MPT)[1,^]				
Inpatient—Total	1.39%	1.46%	1.27%	-0.19
Intensive Outpatient or Partial Hospitalization—Total	0.61%	0.77%	0.47%	-0.30
Outpatient—Total	10.14%	11.05%	9.13%	-1.92
ED—Total	0.50%	0.41%	0.26%	-0.15
Telehealth—Total	0.03%	0.09%	4.76%	4.67
Any Service—Total	10.68%	11.60%	10.84%	-0.76
Plan All-Cause Readmissions (PCR)				
Observed Readmissions—Total	—	13.42%	14.42%	1.00
*Expected Readmissions—Total^*	—	9.60%	9.83%	0.23
*O/E Ratio—Total^*	—	1.40	1.47	0.07

HEDIS Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	MY 2019–MY 2020 Rate Comparison
Overuse/Appropriateness of Care				
Use of Opioids at High Dosage (HDO)[1,*]				
Use of Opioids at High Dosage	—	9.18%	8.90%↓	-0.28
Use of Opioids From Multiple Providers (UOP)[1,*]				
Multiple Prescribers	21.55%	21.52%	**15.90%**↑	-5.62
Multiple Pharmacies	1.61%	1.60%	**1.15%**↑	-0.45
Multiple Prescribers and Multiple Pharmacies	0.83%	0.84%	**0.57%**↑	-0.27

[1] Due to changes in the technical specifications for this measure, NCQA recommends that trending between HEDIS MY 2020 and prior years be considered with caution.
[2] Due to significant changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS MY 2020 and prior years; therefore, prior years' rates are not displayed, and rate comparisons are not performed for this measure.
↑ Indicates the HEDIS MY 2020 rate was above NCQA's Quality Compass®,[3-2] HEDIS 2020 Medicaid health maintenance organization (HMO) 50th percentile benchmark.
↓ Indicates the HEDIS MY 2020 rate was below NCQA's Quality Compass HEDIS 2020 Medicaid HMO 50th percentile benchmark.
* A lower rate indicates better performances for this measure.
— Indicates that the MCO was not previously required to report this measure or that the rate is not appropriate to display due to changes in the technical specifications resulting in a break in trending.
^ Indicates HEDIS MY 2020 Quality Improvement System for Managed Care (QISMC) goals are unavailable for this measure.
NC indicates the MY 2019–MY 2020 Rate Comparison could not be calculated because data are not available for both years.
NA indicates that the MCO followed the specifications, but the denominator was too small (i.e., <30) to report a valid rate.
Bolded rates indicate that the HEDIS MY 2020 performance measure rate was at or above the MPS.

Indicates that the HEDIS MY 2020 rate declined by 5 percentage points or more from HEDIS MY 2019.

Indicates that the HEDIS MY 2020 rate improved by 5 percentage points or more from HEDIS MY 2019.

[3-2] Quality Compass® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Table 3-12—Nevada Check Up HEDIS Performance Measure Results for Anthem

HEDIS Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	MY 2019–MY 2020 Rate Comparison
Children's Preventive Care				
Childhood Immunization Status (CIS)				
Combination 2	87.21%	85.27%	81.82%↑	-3.45
Combination 3	84.02%	83.48%	78.79%↑	-4.69
Combination 4	84.02%	83.04%	78.79%↑	-4.25
Combination 5	74.43%	77.23%	69.70%↑	-7.53
Combination 6	47.95%	50.45%	45.96%↑	-4.49
Combination 7	74.43%	76.79%	69.70%↑	-7.09
Combination 8	47.95%	50.45%	45.96%↑	-4.49
Combination 9	42.47%	47.77%	42.42%↑	-5.35
Combination 10	42.47%	47.77%	42.42%↑	-5.35
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	93.63%	93.63%	**92.94%**↑	-0.69
Combination 2 (Meningococcal, Tdap, HPV)	51.96%	51.96%	57.18%↑	5.22
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile—Total[1]	87.83%	87.83%	81.75%↑	-6.08
Counseling for Nutrition—Total	79.56%	79.56%	74.94%↑	-4.62
Counseling for Physical Activity—Total	73.48%	73.48%	69.10%↑	-4.38
Well-Child Visits in the First 30 Months of Life (W30)^				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits[2]	—	—	71.23%	NC
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	—	—	77.27%	NC
Child and Adolescent Well-Care Visits (WCV)[2,^]				
3–11 Years	—	—	55.51%	NC
12–17 Years	—	—	48.50%	NC
18–21 Years	—	—	30.90%	NC
Total	—	—	51.37%	NC

HEDIS Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	MY 2019–MY 2020 Rate Comparison
Behavioral Health				
Follow-Up After ED Visit for AOD Abuse or Dependence (FUA)[1,^]				
7-Day Follow-Up—Total	NA	NA	NA	NC
30-Day Follow-Up—Total	NA	NA	NA	NC
Follow-Up After ED Visit for Mental Illness (FUM)[1]				
7-Day Follow-Up—Total	NA	NA	NA	NC
30-Day Follow-Up—Total	NA	NA	NA	NC
Follow-Up After Hospitalization for Mental Illness (FUH)[1]				
7-Day Follow-Up—Total	NA	37.14%	47.50%↑	10.36
30-Day Follow-Up—Total	NA	60.00%	67.50%↑	7.50
Follow-Up Care for Children Prescribed ADHD Medication (ADD)[1]				
Initiation Phase	42.42%	60.00%	43.59%↑	-16.41
*Continuation and Maintenance Phase^*	NA	NA	NA	NC
Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)[1]				
Initiation of AOD—Total	NA	NA	NA	NC
Engagement of AOD—Total	NA	NA	NA	NC
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)				
Blood Glucose and Cholesterol Testing–Total	NA	48.39%	NA	NC
Utilization				
Ambulatory Care—Total (per 1,000 Member Months) (AMB)^				
*ED Visits—Total**	25.74	30.27	15.63	-14.64
Outpatient Visits—Total	242.04	253.13	185.80	-67.33
Mental Health Utilization—Total (MPT)[1,^]				
Inpatient—Total	0.26%	0.40%	0.52%	0.12
Intensive Outpatient or Partial Hospitalization—Total	0.34%	0.21%	0.19%	-0.02
Outpatient—Total	6.96%	7.15%	6.12%	-1.03
ED—Total	0.14%	0.00%	0.04%	0.04

HEDIS Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	MY 2019–MY 2020 Rate Comparison
Telehealth—Total	0.00%	0.02%	3.17%	3.15
Any Service—Total	7.02%	7.20%	7.03%	-0.17

[1] Due to changes in the technical specifications for this measure, NCQA recommends that trending between HEDIS MY 2020 and prior years be considered with caution.
[2] Due to significant changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS MY 2020 and prior years; therefore, prior years' rates are not displayed, and rate comparisons are not performed for this measure.
↑ Indicates the HEDIS MY 2020 rate was above NCQA's Quality Compass HEDIS 2020 Medicaid HMO 50th percentile benchmark.
↓ Indicates the HEDIS MY 2020 rate was below NCQA's Quality Compass HEDIS 2020 Medicaid HMO 50th percentile benchmark.
* A lower rate indicates better performances for this measure.
— Indicates that the MCO was not previously required to report this measure or that the rate is not appropriate to display due to changes in the technical specifications resulting in a break in trending.
^ Indicates HEDIS MY 2020 QISMC goals are unavailable for this measure.
NC indicates the MY 2019–MY 2020 Rate Comparison could not be calculated because data are not available for both years.
NA indicates that the MCO followed the specifications, but the denominator was too small (i.e., <30) to report a valid rate.
Bolded rates indicate that the HEDIS MY 2020 performance measure rate was at or above the MPS.

Indicates that the HEDIS MY 2020 rate declined by 5 percentage points or more from HEDIS MY 2019.

Indicates that the HEDIS MY 2020 rate improved by 5 percentage points or more from HEDIS MY 2019.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: Within the Children's Preventive Care domain, **Anthem**'s Nevada Check Up performance for the *Childhood Immunization Status* and *Immunizations for Adolescents* measures ranked above NCQA's Quality Compass HEDIS 2020 Medicaid HMO 50th percentile benchmark. **Anthem**'s Medicaid rates for both *Immunizations for Adolescents* measure indicators ranked above NCQA's Quality Compass HEDIS 2020 Medicaid HMO 50th percentile benchmark. In addition, the MCO met the MPS for the *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* measure indicator for Nevada Check Up and Medicaid, indicating adolescents 13 years of age were receiving the meningococcal and tetanus, diphtheria, and pertussis (Tdap) immunizations, which are important for avoidance of vaccine-preventable diseases. **[Quality, Timeliness,** and **Access]**

Strength #2: Within the Overuse/Appropriateness of Care domain for Medicaid, **Anthem** met the MPS for all *Use of Opioids From Multiple Providers* measure rates, indicating that the MCO was managing the frequency of its members' use of multiple prescribers and pharmacies for opioid medications and,

therefore, reducing potential risk for overdoses. In addition, two of the three indicator rates for the *Use of Opioids for Multiple Providers* measure achieved the Tier 3 QISMC goal. **[Quality]**

Strength #3: For **Anthem**'s Medicaid population, the *Adults' Access to Preventive/Ambulatory Health Services—Ages 65 Years and Older* measure indicator rate met the MPS and surpassed the Tier 2 QISMC goal, which is important for receiving preventive services, addressing acute issues, and managing chronic conditions. **[Quality, Timeliness,** and **Access]**

Strength #4: For **Anthem**'s Medicaid population, the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total* measure indicator rate met the MPS and ranked above NCQA's Quality Compass HEDIS 2020 Medicaid HMO 50th percentile benchmark. This measure indicator is important for encouraging healthy lifestyle habits, which can lower the risk of becoming obese and developing related diseases. **[Quality]**

Strength #5: Within the Behavioral Health domain, **Anthem**'s Medicaid performance for the *Follow-Up Care for Children Prescribed ADHD Medication* measure increased by more than 5 percentage points from the prior year and ranked above NCQA's Quality Compass HEDIS 2020 Medicaid HMO 50th percentile benchmark. Follow-up care is important to ensure that medication is prescribed and managed correctly, and that children are monitored by a pediatrician with prescribing authority. **[Quality, Timeliness,** and **Access]**

Strength #6: Within the Behavioral Health domain for Nevada Check Up, **Anthem**'s performance for the *Follow-Up After Hospitalization for Mental Illness* measure demonstrated an increase of more than 5 percentage points from the prior year and ranked above NCQA's Quality Compass HEDIS 2020 Medicaid HMO 50th percentile benchmark. This indicates **Anthem** was appropriately managing care for patients hospitalized for mental health issues, as they are vulnerable after discharge. Follow-up care by trained mental health clinicians is critical for successful transition out of an inpatient setting as well as preventing readmissions. **[Timeliness** and **Access]**

Strength #7: For **Anthem**'s Nevada Check Up population, all reported rates that were comparable to NCQA's Quality Compass HEDIS 2020 Medicaid HMO 50th percentile benchmark ranked above the 50th percentile, demonstrating consistent performance compared to the national average. **[Quality, Timeliness,** and **Access]**

Weaknesses and Recommendations

Weakness #1: Although one of four rates for the *Adults' Access to Preventive/Ambulatory Health Services* measure within the Access to Care domain for Medicaid met the MPS, the remaining three rates demonstrated a decline in performance of more than 5 percentage points from the previous year, and all four measure indicator rates ranked below NCQA's Quality Compass HEDIS 2020 Medicaid HMO 50th percentile benchmark. **[Quality, Timeliness,** and **Access]**

Why the weakness exists: Although adults appear to have access to PCPs for preventive and ambulatory services, these members were not consistently utilizing preventive and ambulatory services, which can significantly reduce non-urgent ED visits.

Recommendation: HSAG recommends **Anthem** conduct a root cause analysis or focused study to determine why its members are not consistently accessing preventive and ambulatory services. Upon identification of a root cause, **Anthem** should implement appropriate interventions to improve the performance related to Access to Care measures. If COVID-19 was a factor, HSAG recommends **Anthem** work with its members to increase the use of telehealth services, when appropriate.

Weakness #2: Anthem's performance for the *Breast Cancer Screening* measure within the Women's Health and Maternity Care domain for Medicaid decreased by more than 5 percentage points from the prior year, indicating women were not getting breast cancer screenings for early detection of breast cancer, which may result in less effective treatment and higher healthcare costs. **[Quality, Timeliness,** and **Access]**

Why the weakness exists: Screening declines may have coincided with the rapid increase of COVID-19 cases in 2020. Factors that may have contributed to the declines during this time include screening site closures and the temporary suspension of non-urgent services due to COVID-19. The requirement or recommendation to stay at home and the fear of contracting COVID-19 also likely deterred individuals from seeking healthcare services, including breast cancer screening.

Recommendation: HSAG recommends **Anthem** conduct a root cause analysis or focused study to determine why its female members are not receiving preventive screenings for breast cancer. **Anthem** could consider if there are disparities within its populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, **Anthem** should implement appropriate interventions to improve the performance related to Women's Health and Maternity Care.

Weakness #3: Although **Anthem**'s Medicaid performance for the *Childhood Immunization Status* measure was consistent overall, performance for *Combination 3*, *Combination 4*, and *Combination 5* experienced a decline of more than 5 percentage points, suggesting that children were not receiving these immunizations, which are a critical aspect of preventable care for children. **Anthem**'s Nevada Check Up performance for the *Childhood Immunization Status—Combination 5*, *Combination 7*, *Combination 9*, and *Combination 10* rates decreased by more than 5 percentage points from the prior year; however, of note, these rates ranked above NCQA's Quality Compass HEDIS 2020 Medicaid HMO 50th percentile benchmark. **[Quality, Timeliness,** and **Access]**

Why the weakness exists: Screening declines may have coincided with the rapid increase of COVID-19 cases in 2020. Factors that may have contributed to the declines during this time include site closures and the temporary suspension of non-urgent services due to COVID-19. The requirement or recommendation to stay at home and the fear of contracting COVID-19 also likely deterred individuals from seeking healthcare services, including immunizations.

Recommendation: HSAG recommends **Anthem** conduct a root cause analysis or focused study to determine why its child members are not receiving all recommended vaccines. **Anthem** could consider if there are disparities within its populations that contribute to lower performance in a

particular race or ethnicity, age group, ZIP Code, etc. **Anthem** could also consider if a particular vaccine or vaccines within the vaccine combinations were missed more often than others, contributing to lower rates within these measures. Upon identification of a root cause, **Anthem** should implement appropriate interventions to improve the performance related to the *Childhood Immunization Status* measure.

Weakness #4: Within the Behavioral Health domain for Medicaid, the majority of **Anthem**'s rates ranked below NCQA's Quality Compass HEDIS 2020 Medicaid HMO 50th percentile benchmark, with the exception of the *Follow-Up Care for Children Prescribed ADHD Medication* and *Initiation and Engagement of AOD Abuse or Dependence Treatment* measures. Of note, **Anthem**'s performance for the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* measure decreased by more than 10 percentage points from HEDIS MY 2019 to HEDIS MY 2020. **[Quality, Timeliness,** and **Access]**

Why the weakness exists: Decreased performance may potentially be due to low appointment availability for qualified mental healthcare professionals to meet the demand, lack of transportation, or perceived social stigma related to seeking mental health services.

Recommendation: HSAG recommends **Anthem** conduct a root cause analysis or focused study to determine why its members needing mental health and substance abuse services are not receiving the needed follow-up care or initiating treatment for services. **Anthem** could consider if there are disparities within its populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, **Anthem** should implement appropriate interventions to improve the performance related to these measures.

Weakness #5: Within the Care for Chronic Conditions domain for Medicaid, **Anthem**'s rates for the *Comprehensive Diabetes Care—HbA1c Testing, HbA1c Poor Control (>9.0%), HbA1c Control (<8.0%), and Eye Exam (Retinal) Performed* measure indicators were below the MPS and NCQA's Quality Compass HEDIS 2020 Medicaid HMO 50th percentile benchmark. Additionally, the *Comprehensive Diabetes Care—HbA1c Testing* rate decreased more than 5 percentage points from the prior year. Of note, **Anthem**'s performance for the *Comprehensive Diabetes Care—HbA1c Control (<8.0%)* and *HbA1c Poor Control (>9.0%)* measure indicators did not experience the same decline and maintained similar rates over the prior year. HbA1c testing and retinal eye exams are critical for effective monitoring and treatment of diabetes, and HbA1c levels are an indicator of disease progression. In addition, low levels of HbA1c testing can lead to underreporting of the *Comprehensive Diabetes Care—HbA1c Control (<8.0%)* and *HbA1c Poor Control (>9.0%)* measure indicators. **[Quality, Timeliness,** and **Access]**

Why the weakness exists: Declines in rates for the *Comprehensive Diabetes Care—HbA1c Testing (<8.0%)* and *Eye Exam (Retinal) Performed* measure indicators may have coincided with the rapid increase of COVID-19 cases in 2020. Factors that may have contributed to the declines during this time include site closures and temporary suspension of non-urgent services due to COVID-19. The requirement or recommendation to stay at home and the fear of contracting COVID-19 also likely deterred individuals from seeking healthcare services, including diabetic testing.

Recommendation: HSAG recommends **Anthem** conduct a root cause analysis or focused study to determine how its diabetic members could receive additional HbA1c testing and retinal eye exams, as well as improve HbA1c levels. **Anthem** could consider if there are disparities within its populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, **Anthem** should implement appropriate interventions to improve the performance related to these measures.

Compliance Review

The SFY 2021 Compliance Review activity demonstrated how successful **Anthem** was at interpreting specific standards under 42 CFR Part 438—Managed Care and the associated requirements under its managed care contract with DHCFP.

Performance Results

Table 3-13 presents **Anthem**'s scores for each standard evaluated in the SFY 2021 Compliance Review activity. Each element within a standard was scored as *Met* or *Not Met* based on evidence found in **Anthem**'s written documents, including policies, procedures, reports, and meeting minutes; and interviews with MCO staff members.

Table 3-13—Summary of Standard Compliance Scores for Anthem

Compliance Monitoring Standard		Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	*NM*	*NA*	
I	Disenrollment: Requirements and Limitations	7	7	7	0	0	**100%**
II	Member Rights and Member Information	22	22	21	1	0	**95%**
III	Emergency and Poststabilization Services	10	10	10	0	0	**100%**
IV	Availability of Services	10	10	10	0	0	**100%**
V	Assurances of Adequate Capacity and Services	2	2	2	0	0	**100%**
VI	Coordination and Continuity of Care	17	17	16	1	0	**94%**
VII	Coverage and Authorization of Services	15	15	13	2	0	**87%**
Total		**83**	**83**	**79**	**4**	**0**	**95%**

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

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: Anthem achieved full compliance for the Disenrollment: Requirements and Limitations program area, demonstrating that the MCO had appropriate processes in place related to member and MCO requests for disenrollment, procedures for disenrollment, and use of the MCO's grievance system when receiving a member's disenrollment request. **[Quality]**

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

Strength #3: Anthem achieved full compliance in the Availability of Services and Assurances of Adequate Capacity and Services program areas, demonstrating that the MCO maintained and monitored an adequate provider network that was sufficient to provide timely and adequate access to all services (e.g., primary care, specialty care, hospital and emergency services, behavioral health, and prenatal care) for its membership. **[Timeliness** and **Access]**

Weaknesses and Recommendations

Weakness #1: Anthem achieved compliance scores of 87 percent or above in all program areas reviewed, indicating no significant weaknesses were identified and the MCO had appropriate processes, procedures, and plans in place to promote members' access to timely and quality care. **[Quality**, **Timeliness,** and **Access]**

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

Recommendation: Although no significant weaknesses were identified, **Anthem** should continually evaluate its processes, procedures, and monitoring efforts to ensure it maintains compliance with all federal and State obligations.

Network Adequacy Validation

Performance Results

Table 3-14 presents **Anthem**'s provider ratio analysis results compared to the provider ratio standards. For the provider categories assessed according to the standards in Table 3-4, the percentage of members with access to the provider within the time-distance standard is shown in red if they did not comply with the standard. The time-distance results are displayed in Table 3-15.

Table 3-14—Summary of Ratio Analysis Results for PCPs and Specialty Care Providers for Anthem

Provider Category	Anthem	
	Providers	Ratio
Primary Care Providers (1:1,500)	1,173	1:201
PCP Extenders (1:1,800)	1,266	1:186
Physician Specialist Providers (1:1,500)	1,300	1:181

Table 3-15—Percentage of Members Residing Within the Access Standard Areas for Anthem

Provider Category	Time-Distance Standard	Anthem
Primary Care Providers		
Primary Care (Adult Total)	20 miles/30 mins	96.9%
OB/GYN	20 miles/30 mins	99.8%
Pediatrician	20 miles/30 mins	99.9%
Specialty Providers		
Endocrinologists	75 miles/100 mins	99.9%
Endocrinologists, Pediatric	75 miles/100 mins	99.9%
Infectious Disease	75 miles/100 mins	99.9%
Infectious Disease, Pediatric	75 miles/100 mins	99.9%
Oncologist/Hematologist	75 miles/100 mins	99.9%
Oncologist/Hematologist, Pediatric	75 miles/100 mins	99.9%
Oncologist/Radiologist	75 miles/100 mins	99.9%
Rheumatologist	75 miles/100 mins	99.9%
Rheumatologist, Pediatric	75 miles/100 mins	88.9%
Facility-Level Providers		
Hospital (Total)	60 miles/80 mins	95.0%
Psychiatry Inpatient Hospital	60 miles/80 mins	99.9%
Dialysis/ESRD Facility	60 miles/80 mins	99.9%
Behavioral Health Providers		
Psychologist	45 miles/60 mins	99.9%
Pediatric Psychologist	45 miles/60 mins	88.9%
LCSW	45 miles/60 mins	99.9%
Psychiatrist	45 miles/60 mins	99.9%
Pediatric Psychiatrist	45 miles/60 mins	99.9%

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: Anthem met the required provider ratio requirements for primary care providers, PCP extenders, and physician specialist providers, indicating **Anthem** has a sufficient provider network for its members to access services. **[Access]**

Strength #2: Anthem met the time-distance contract standards for all primary care provider categories (primary care [adult total], OB/GYN, and pediatrician) and the assessed facility-level provider categories, indicating members had access to a provider within an adequate distance from their residence. **[Access]**

Strength #3: Anthem met the time-distance contract standards for eight of the nine specialty provider categories, indicating members had access to specialty providers within an adequate distance from their residence. **[Access]**

Strength #4: Anthem met the time-distance contract standards for four of the five behavioral health provider categories, indicating members had access to a behavioral health provider within an adequate distance from their residence. **[Access]**

Weaknesses and Recommendations

Weakness #1: Anthem did not meet the time-distance contract standards for pediatric rheumatologists and pediatric psychologists, indicating child members may experience challenges accessing these provider types within an adequate distance from their residence. **[Access]**

Why the weakness exists: The lack of identified providers may result from either a lack of contracted pediatric specialty providers in those specialties or from an inability to identify those pediatric specialists in the data. While **Anthem** indicated in its follow-up on prior EQR recommendations responses in Section 5 that the lack of availability of providers in the region limits the ability of **Anthem** to recruit additional physicians into the network, another MCO met network adequacy standards for pediatric psychologists, suggesting **Anthem**'s inability to meet the access standard for this provider type may not be due to a lack of available providers. For pediatric rheumatologists, all three MCOs did not meet the network adequacy standards, suggesting a possible lack of this provider type within the counties served.

Recommendation: HSAG recommends **Anthem** continue to conduct an in-depth review of provider categories in which it did not meet the time-distance contract standards, with the goal of determining whether or not the failure of the MCO to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results

Table 3-16 presents **Anthem**'s 2021 adult Medicaid, general child Medicaid, and children with chronic conditions (CCC) Medicaid CAHPS top-box scores. Table 3-16 also includes **Anthem**'s 2021 Nevada Check Up general child and CCC top-box scores. Arrows (↓ or ↑) indicate 2021 scores that were at least 5 percentage points higher or lower than the 2020 national average.

Table 3-16—Summary of 2021 CAHPS Top-Box Scores for Anthem

	2021 Adult Medicaid	2021 General Child Medicaid	2021 CCC Medicaid Supplemental	2021 Nevada Check Up General Child	2021 Nevada Check Up CCC Supplemental
Composite Measures					
Getting Needed Care	80.5%	88.8%	88.6%	NA	NA
Getting Care Quickly	NA	87.9%	NA	NA	NA
How Well Doctors Communicate	88.2%	92.5%	92.9%	93.9%	NA
Customer Service	NA	91.6%	NA	NA	NA
Global Ratings					
Rating of All Health Care	55.1%	78.0% ↑	73.1%	76.5%	NA
Rating of Personal Doctor	60.5% ↓	74.4%	76.6%	74.5%	NA
Rating of Specialist Seen Most Often	NA	NA	NA	NA	NA
Rating of Health Plan	59.2%	71.6%	65.7%	76.8%	NA
Effectiveness of Care*					
Advising Smokers and Tobacco Users to Quit	NA				
Discussing Cessation Medications	NA				
Discussing Cessation Strategies	NA				
CCC Composite Measures/Items					
Access to Specialized Services			NA		NA
Family Centered Care (FCC): Personal Doctor Who Knows Child			86.8%		NA
Coordination of Care for Children With Chronic Conditions			NA		NA

	2021 Adult Medicaid	2021 General Child Medicaid	2021 CCC Medicaid Supplemental	2021 Nevada Check Up General Child	2021 Nevada Check Up CCC Supplemental
Access to Prescription Medicines			87.1%		NA
FCC: Getting Needed Information			88.8%		NA

A minimum of 100 responses is required for a measure to be reported as a CAHPS survey results. 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 2021 score is at least 5 percentage points higher than the 2020 national average.

↓ Indicates the 2021 score is at least 5 percentage points lower than the 2020 national average.

Indicates that the measure does not apply to the population.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: Parents/caretakers of general child Medicaid members had positive experiences with their overall healthcare since the score for this measure was at least 5 percentage points higher than the 2020 NCQA Medicaid national average. **[Quality, Timeliness,** and **Access]**

Weaknesses and Recommendations

Weakness #1: Adult members had less positive overall experiences with their personal doctor since the score for this measure was at least 5 percentage points lower than the 2020 NCQA Medicaid national average. **[Quality, Timeliness,** and **Access]**

Why the weakness exists: Members may have a difficult time getting an appointment with their provider. Members may have to talk to more than one provider, and **Anthem**'s providers may not be aware of all the needs of their members and, as a result, may not be providing the consultative care required. Additionally, providers may not be spending enough quality time with members or not satisfactorily addressing members' needs.

Recommendation: HSAG recommends that **Anthem** prioritize improving members' overall experiences with their personal doctor and determine a root cause for the lower performance. As part of this analysis, **Anthem** could determine if any outliers were identified within the data, identify primary areas of focus, and develop appropriate strategies to improve the performance. Additionally, HSAG recommends widely promoting the results of its member experiences with its contracted providers and staff members and soliciting feedback and recommendations to improve members' overall satisfaction with both **Anthem** and its contracted providers.

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

To identify strengths and weaknesses and draw conclusions for **Anthem** about the quality, timeliness, and access to care for its members, HSAG analyzed and evaluated performance related to the provision of healthcare services by **Anthem** across all EQR activities to identify common themes within **Anthem** that impacted, or will have the likelihood to impact, member health outcomes. The overarching aggregated findings show that, while **Anthem** had an adequate network for members to access providers for services as determined through the NAV activity, and the processes, procedures, and monitoring efforts in place to continually evaluate the network for necessary network enhancements as determined through the Compliance Review activity, adult and child members were not always accessing services timely to obtain the preventive and/or condition-specific care they needed to maintain optimal health; this was indicated through lower performing HEDIS rates in the Access to Care, Children's Preventive Care, Women's Health and Maternity Care, Care for Chronic Conditions and Behavioral Health domains, both in comparison to its own historical performance and the national Medicaid 50th percentile. **Anthem** should evaluate through a root cause analysis whether the significant decline in member experience with their personal doctors, as indicated through CAHPS, demonstrates a potential concern with the quality of care being provided by **Anthem** contracted providers. Additionally, while specific efforts were initiated to improve member outcomes related to diabetes care and timeliness of prenatal care as demonstrated through the PIP activity, and although there was a slight improvement in the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measure indicator rate, there was a significant decline in the *Comprehensive Diabetes Care—HbA1c Testing* HEDIS measure indicator rate, indicating members were not having tests completed in order to show a controlled HbA1c. Additionally, **Anthem** demonstrated a slight decline in year-over-year performance in the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* HEDIS measure, indicating **Anthem** should evaluate whether its quality improvement initiatives were effective to support improvements in the PIP focus areas and put new interventions in place as necessary to promote better health outcomes for pregnant women and their babies and members with diabetes. **Anthem** should analyze performance in higher performing measure rates to determine if initiatives were implemented that supported the improved outcomes, and determine whether similar initiatives or interventions would be appropriate to support improvement in other care domains. Further, **Anthem** demonstrated success in appropriately managing members through its care management program, as indicated through a Compliance Review score of 94 percent in the Coordination and Continuity of Care standard. **Anthem** could leverage those processes and collaborate with its members to better understand the barriers members may experience when accessing care, including whether there are challenges accessing certain provider types; whether there are delays to getting timely appointments; and/or whether the quality of providers and the care being received are not sufficient.

Of note, due to the COVID-19 pandemic during HEDIS MY 2020 and SFY 2021, many preventive services were negatively affected across the country as states followed orders to reduce the use of non-emergent services in order to slow the spread of COVID-19. Additionally, due to fear of contracting the virus, members may have chosen to not access routine care, which may have impacted performance outcomes in SFY 2021.

Health Plan of Nevada

Validation of Performance Improvement Projects

Performance Results

Table 3-17 summarizes the progress HPN made in completing the four PIP modules during SFY 2021.

Table 3-17—Overall Validation Rating for HPN

PIP Topic	Module	Status
Comprehensive Diabetes Care (CDC) Hemoglobin A1c (HbA1c) Poor Control >9.0%	1. PIP Initiation	Completed and achieved all validation criteria.
	2. Intervention Determination	Completed and achieved all validation criteria.
	3. Intervention Testing	Module 3 documentation submitted to date have achieved all validation criteria. The MCO tested interventions until 6/30/2021.
	4. PIP Conclusions	Submission targeted for October 2021.
Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care	1. PIP Initiation	Completed and achieved all validation criteria.
	2. Intervention Determination	Completed and achieved all validation criteria.
	3. Intervention Testing	Module 3 documentation submitted to date have achieved all validation criteria. The MCO tested interventions until 6/30/2021.
	4. PIP Conclusions	Submission targeted for October 2021.

HPN passed Module 3—Intervention Testing submitted for each implemented intervention and achieved all validation criteria for both PIPs. HPN concluded its intervention testing on June 30, 2021. The validation findings for additional Module 3 submissions and Module 4 (PIP Conclusions) with SMART Aim measure outcomes will be reported in the next annual EQR technical report.

Interventions

During SFY 2021, HPN tested one intervention per topic. The intervention description, impact, and status are described in Table 3-18 and Table 3-19 below.

Table 3-18—Intervention for Comprehensive Diabetes Care (CDC) Hemoglobin A1c (HbA1c) Poor Control >9.0%

Intervention #1	
Intervention Description	In-home HbA1c Test Kits
Intervention Impact	The MCO reported that the targeted members did not return the completed testing kits as expected and they experienced many challenges. Despite the challenges, HPN determined they would continue testing the intervention.
Intervention Status	The intervention testing period has concluded; however, the final results will be presented in the final PDSA worksheet that will be submitted with Module 4.

Table 3-19—Intervention for Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care

Intervention #1	
Intervention Description	Provider CPT Coding Education
Intervention Impact	HPN predicted that it would see an increase in the number of correctly coded prenatal care visits by the targeted providers following the education and it did. The MCO reported an increase in claim submissions with accurate coding for identifying new positive pregnancies and initiating early prenatal care.
Intervention Status	The intervention testing period has concluded; however, the final results will be presented in the final PDSA worksheet that will be submitted with Module 4.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: HPN used quality improvement tools to identify and prioritize opportunities for improvement within its current processes. These tools, and the results they produced, assisted the MCO in selecting the first interventions to test using PDSA cycles. **[Quality]**

Strength #2: HPN developed methodologically sound intervention effectiveness measures and tested interventions using thoughtful PDSA cycles, which should support improvements in the documentation of members' HbA1c testing results and timely access to prenatal care. **[Quality, Timeliness,** and **Access]**

Weaknesses and Recommendations

Weakness #1: HPN's PDSA testing cycles were too long, which prevented the MCO from quickly revising its interventions to support process improvement. **[Quality, Timeliness,** and **Access]**

Why the weakness exists: The MCO's intervention testing time frames were six months, which may have slowed process improvements implemented to support effective member care.

Recommendation: HPN should consider shorter testing periods. The testing methodology should allow the MCO to quickly gather data and make data-driven revisions to facilitate achievement of the SMART Aim goal.

Weakness #2: HPN limited the number of interventions tested for each topic to just one process improvement intervention. **[Quality, Timeliness,** and **Access]**

Why the weakness exists: HPN's process included one intervention per PIP, which may have limited the opportunity for the MCO to make notable improvements in the reduction of uncontrolled diabetes and untimely access to prenatal care.

Recommendation: HPN should consider testing more than one intervention during the intervention testing phase of the PIP. This will help the MCO address additional identified opportunities for improvement from the process map and FMEA and increase the likelihood of achieving the SMART Aim goal and desired outcomes for the project. By achieving the desired goals for the PIPs, the MCO will positively impact the timeliness and quality of care for its members.

Performance Measure Validation

Performance Results

HPN's Medicaid and Nevada Check Up HEDIS MY 2018, MY 2019, and MY 2020 performance measure results are presented in Table 3-20 and Table 3-21, along with year-to-year rate comparisons and performance target ratings. Measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, a decrease in the rate from MY 2019 to MY 2020 represents performance improvement and an increase in the rate from MY 2019 to MY 2020 represents performance decline. The arrows (↑ or ↓) indicate whether the HEDIS MY 2020 rate was above or below the national Medicaid 50th percentile benchmark. Green and red shading is used to indicate a 5 percentage point performance improvement or performance decline from the prior year's performance, while **bolded** rates indicate the MPS was achieved. Please note that the arrows do not necessarily correlate to shading and bolded font.

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

Table 3-20—Medicaid HEDIS Performance Measure Results for HPN

HEDIS Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	MY 2019–MY 2020 Rate Comparison
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services (AAP)				
Ages 20–44 Years	73.09%	75.70%	69.80%↓	-5.90
Ages 45–64 Years	78.58%	81.68%	76.29%↓	-5.39
Ages 65 Years and Older	33.08%	NA	**81.41%**↓	NC
Total	74.92%	77.81%	71.93%↓	-5.88
Children's Preventive Care				
Childhood Immunization Status (CIS)				
Combination 2	72.02%	72.02%	71.53%↓	-0.49
Combination 3	68.37%	68.37%	**69.34%**↓	0.97
Combination 4	67.64%	67.64%	**69.10%**↑	1.46
Combination 5	60.10%	60.10%	**62.77%**↑	2.67
Combination 6	39.42%	39.42%	35.04%↓	-4.38
Combination 7	59.61%	59.61%	**62.53%**↑	2.92
Combination 8	39.42%	39.42%	35.04%↓	-4.38
Combination 9	35.52%	35.52%	33.09%↓	-2.43
Combination 10	35.52%	35.52%	33.09%↓	-2.43
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	89.05%	90.51%	**88.56%**↑	-1.95
Combination 2 (Meningococcal, Tdap, HPV)	43.55%	48.42%	47.45%↑	-0.97
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile—Total[1]	78.59%	83.45%	**86.44%**↑	2.99
Counseling for Nutrition—Total	68.37%	71.05%	**76.55%**↑	5.50
Counseling for Physical Activity—Total	64.96%	69.34%	**75.14%**↑	5.80
Well-Child Visits in the First 30 Months of Life (W30)^				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits[2]	—	—	59.89%	NC

HEDIS Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	MY 2019–MY 2020 Rate Comparison
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	—	—	68.83%	NC
Child and Adolescent Well-Care Visits (WCV)[2,^]				
3–11 Years	—	—	48.62%	NC
12–17 Years	—	—	41.59%	NC
18–21 Years	—	—	24.50%	NC
Total	—	—	43.00%	NC
Women's Health and Maternity Care				
Breast Cancer Screening (BCS)[1]				
Breast Cancer Screening	54.13%	55.08%	52.01%↓	-3.07
Prenatal and Postpartum Care (PPC)[1]				
Timeliness of Prenatal Care	—	90.02%	**87.59%**↓	-2.43
Postpartum Care	—	81.51%	**78.83%**↑	-2.68
Care for Chronic Conditions				
Comprehensive Diabetes Care (CDC)				
HbA1c Testing[1]	81.02%	84.91%	79.81%↓	-5.10
HbA1c Poor Control (>9.0%)[1,]*	43.31%	41.36%	**38.69%**↓	-2.67
HbA1c Control (<8.0%)[1]	49.64%	49.64%	50.12%↓	0.48
Eye Exam (Retinal) Performed[1]	62.77%	62.04%	**63.02%**↑	0.98
Blood Pressure Control (<140/90 mm Hg)[2,^]	—	—	63.75%	NC
Controlling High Blood Pressure (CBP)[2,^]				
Controlling High Blood Pressure	—	—	60.34%	NC
Kidney Health Evaluation for Patients With Diabetes (KED)[^]				
18–64 Years	—	—	42.02%	NC
65–74 Years	—	—	42.42%	NC
75–84 Years	—	—	NA	NC
Total	—	—	42.02%	NC

HEDIS Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	MY 2019–MY 2020 Rate Comparison
Behavioral Health				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	41.95%	44.00%	44.73%↓	0.73
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	76.38%	78.86%	74.58%↓	-4.28
Follow-Up After ED Visit for AOD Abuse or Dependence (FUA)[1]				
7-Day Follow-Up—Total	15.48%	14.52%	16.03%↑	1.51
30-Day Follow-Up—Total	21.02%	18.92%	20.92%↑	2.00
Follow-Up After ED Visit for Mental Illness (FUM)[1]				
7-Day Follow-Up—Total	47.82%	56.53%	**52.34%**↑	-4.19
30-Day Follow-Up—Total	57.48%	63.92%	**60.81%**↑	-3.11
Follow-Up After Hospitalization for Mental Illness (FUH)[1]				
7-Day Follow-Up—Total	29.11%	36.88%	38.58%↑	1.70
30-Day Follow-Up—Total	49.80%	53.80%	**56.65%**↓	2.85
Follow-Up Care for Children Prescribed ADHD Medication (ADD)[1]				
Initiation Phase	52.29%	49.90%	**54.10%**↑	4.20
Continuation and Maintenance Phase	69.77%	68.29%	**68.82%**↑	0.53
Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)[1]				
Initiation of AOD—Total	40.22%	42.24%	37.81%↓	-4.43
Engagement of AOD—Total	10.01%	10.88%	11.56%↓	0.68
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)				
Blood Glucose and Cholesterol Testing–Total	20.00%	35.71%	**33.89%**↓	-1.82
Utilization				
Ambulatory Care—Total (per 1,000 Member Months) (AMB)^				
*ED Visits—Total**	54.66	58.85	41.60	-17.25

HEDIS Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	MY 2019–MY 2020 Rate Comparison
Outpatient Visits—Total	297.98	318.88	280.22	-38.66
Mental Health Utilization—Total (MPT)[1,^]				
Inpatient—Total	0.82%	0.70%	0.66%	-0.04
Intensive Outpatient or Partial Hospitalization—Total	0.22%	0.39%	0.24%	-0.15
Outpatient—Total	8.13%	9.30%	6.95%	-2.35
ED—Total	0.03%	0.02%	0.02%	0.00
Telehealth—Total	0.00%	0.02%	3.72%	3.70
Any Service—Total	8.30%	9.44%	8.53%	-0.91
Plan All-Cause Readmissions (PCR)				
Observed Readmissions—Total	—	14.87%	**11.13%**	-3.74
*Expected Readmissions—Total^*	—	9.50%	9.08%	-0.42
*O/E Ratio—Total^*	—	1.56	1.23	-0.33
Overuse/Appropriateness of Care				
Use of Opioids at High Dosage (HDO)[1,*]				
Use of Opioids at High Dosage	—	10.36%	10.00%↓	-0.36
Use of Opioids From Multiple Providers (UOP)[1,*]				
Multiple Prescribers	26.56%	25.31%	29.47%↓	4.16
Multiple Pharmacies	4.26%	3.00%	**2.12%**↑	-0.88
Multiple Prescribers and Multiple Pharmacies	2.12%	1.73%	**1.23%**↑	-0.50

[1] Due to changes in the technical specifications for this measure, NCQA recommends that trending between HEDIS MY 2020 and prior years be considered with caution.
[2] Due to significant changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS MY 2020 and prior years; therefore, prior years' rates are not displayed, and rate comparisons are not performed for this measure.
↑ Indicates the HEDIS MY 2020 rate was above NCQA's Quality Compass HEDIS 2020 Medicaid HMO 50th percentile benchmark.
↓ Indicates the HEDIS MY 2020 rate was below NCQA's Quality Compass HEDIS 2020 Medicaid HMO 50th percentile benchmark.
* A lower rate indicates better performances for this measure.
— Indicates that the MCO was not previously required to report this measure or that the rate is not appropriate to display due to changes in the technical specifications resulting in a break in trending.
^ Indicates HEDIS MY 2020 QISMC goals are unavailable for this measure.
NC indicates the MY 2019–MY 2020 Rate Comparison could not be calculated because data are not available for both years.
NA indicates that the MCO followed the specifications, but the denominator was too small (i.e., <30) to report a valid rate.

Bolded rates indicate that the HEDIS MY 2020 performance measure rate was at or above the MPS.

Indicates that the HEDIS MY 2020 rate declined by 5 percentage points or more from HEDIS MY 2019.

Indicates that the HEDIS MY 2020 rate improved by 5 percentage points or more from HEDIS MY 2019.

Table 3-21—Nevada Check Up HEDIS Performance Measure Results for HPN

HEDIS Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	MY 2019–MY 2020 Rate Comparison
Children's Preventive Care				
Childhood Immunization Status (CIS)				
Combination 2	87.57%	85.62%	84.19%↑	-1.43
Combination 3	84.32%	83.56%	81.29%↑	-2.27
Combination 4	83.73%	83.56%	81.29%↑	-2.27
Combination 5	76.63%	75.34%	75.81%↑	0.47
Combination 6	46.15%	48.63%	44.52%↑	-4.11
Combination 7	76.33%	75.34%	75.81%↑	0.47
Combination 8	46.15%	48.63%	44.52%↑	-4.11
Combination 9	42.01%	45.21%	41.94%↑	-3.27
Combination 10	42.01%	45.21%	41.94%↑	-3.27
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	93.92%	97.32%	**94.07%**↑	-3.25
Combination 2 (Meningococcal, Tdap, HPV)	56.20%	56.69%	50.62%↑	-6.07
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile—Total[1]	83.45%	88.81%	**85.97%**↑	-2.84
Counseling for Nutrition—Total	74.70%	73.24%	74.93%↑	1.69
Counseling for Physical Activity—Total	72.02%	72.75%	72.84%↑	0.09
Well-Child Visits in the First 30 Months of Life (W30)^				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits[2]	—	—	72.45%	NC
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	—	—	82.76%	NC

HEDIS Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	MY 2019–MY 2020 Rate Comparison
Child and Adolescent Well-Care Visits (WCV)[2,^]				
3–11 Years	—	—	55.57%	NC
12–17 Years	—	—	50.91%	NC
18–21 Years	—	—	33.50%	NC
Total	—	—	52.09%	NC
Behavioral Health				
Follow-Up After ED Visit for AOD Abuse or Dependence (FUA)[1,^]				
7-Day Follow-Up—Total	NA	NA	NA	NC
30-Day Follow-Up—Total	NA	NA	NA	NC
Follow-Up After ED Visit for Mental Illness (FUM)[1]				
7-Day Follow-Up—Total	66.67%	NA	NA	NC
30-Day Follow-Up—Total	80.00%	NA	NA	NC
Follow-Up After Hospitalization for Mental Illness (FUH)[1]				
7-Day Follow-Up—Total	NA	NA	NA	NC
30-Day Follow-Up—Total	NA	NA	NA	NC
Follow-Up Care for Children Prescribed ADHD Medication (ADD)[1]				
Initiation Phase	58.11%	55.38%	46.55%↑	-8.83
*Continuation and Maintenance Phase^*	NA	NA	NA	NC
Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)[1]				
Initiation of AOD—Total	NA	25.71%	12.50%↓	-13.21
Engagement of AOD—Total	NA	8.57%	0.00%↓	-8.57
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)				
Blood Glucose and Cholesterol Testing–Total	25.58%	21.95%	**44.90%↑**	22.95
Utilization				
Ambulatory Care—Total (per 1,000 Member Months) (AMB)^				
*ED Visits—Total**	22.99	25.99	13.71	-12.28
Outpatient Visits—Total	246.47	265.66	195.10	-70.56

HEDIS Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	MY 2019–MY 2020 Rate Comparison
Mental Health Utilization—Total (MPT)[1,^]				
Inpatient—Total	0.18%	0.20%	0.18%	-0.02
Intensive Outpatient or Partial Hospitalization—Total	0.14%	0.03%	0.03%	0.00
Outpatient—Total	6.55%	7.46%	5.02%	-2.44
ED—Total	0.03%	0.01%	0.01%	0.00
Telehealth—Total	0.00%	0.00%	3.62%	3.62
Any Service—Total	6.60%	7.52%	6.40%	-1.12

[1] Due to changes in the technical specifications for this measure, NCQA recommends that trending between HEDIS MY 2020 and prior years be considered with caution.
[2] Due to significant changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS MY 2020 and prior years; therefore, prior years' rates are not displayed, and rate comparisons are not performed for this measure.
↑ Indicates the HEDIS MY 2020 rate was above NCQA's Quality Compass HEDIS 2020 Medicaid HMO 50th percentile benchmark.
↓ Indicates the HEDIS MY 2020 rate was below NCQA's Quality Compass HEDIS 2020 Medicaid HMO 50th percentile benchmark.
* A lower rate indicates better performances for this measure.
— Indicates that the MCO was not previously required to report this measure or that the rate is not appropriate to display due to changes in the technical specifications resulting in a break in trending.
^ Indicates HEDIS MY 2020 QISMC goals are unavailable for this measure.
NC indicates the MY 2019–MY 2020 Rate Comparison could not be calculated because data are not available for both years.
NA indicates that the MCO followed the specifications, but the denominator was too small (i.e., <30) to report a valid rate.
Bolded rates indicate that the HEDIS MY 2020 performance measure rate was at or above the MPS.

Indicates that the HEDIS MY 2020 rate declined by 5 percentage points or more from HEDIS MY 2019.

Indicates that the HEDIS MY 2020 rate improved by 5 percentage points or more from HEDIS MY 2019.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: Within the Children's Preventive Care domain for Nevada Check Up, although **HPN**'s performance for the *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total* measure indicators decreased slightly from the prior year, **HPN** met the MPS and ranked above NCQA's Quality Compass HEDIS 2020 Medicaid HMO 50th percentile benchmark. This performance demonstrates HPN's commitment to reducing vaccine-preventable disease and obesity in its Nevada Check Up membership. **[Quality]**

Strength #2: Within the Children's Preventive Care domain for Medicaid, **HPN**'s performance for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure met the MPS and ranked above NCQA's Quality Compass HEDIS 2020 Medicaid HMO 50th percentile benchmark for all three indicators. It was also noted that two of the three indicator rates improved by over 5 percentage points from the prior year. This performance demonstrates HPN's commitment to reducing obesity in its Medicaid membership. **[Quality]**

Strength #3: Within the Children's Preventive Care domain for Nevada Check Up, **HPN**'s rates for the *Childhood Immunization Status* and *Immunizations for Adolescents* measures ranked above NCQA's Quality Compass HEDIS 2020 Medicaid HMO 50th percentile benchmark, indicating children are avoiding vaccine-preventable diseases. In addition, **HPN**'s Medicaid rates for the *Immunizations for Adolescents* measure indicators ranked above NCQA's Quality Compass HEDIS 2020 Medicaid HMO 50th percentile benchmark. **[Quality, Timeliness,** and **Access]**

Strength #4: Within the Behavioral Health domain for Nevada Check Up, **HPN**'s performance for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total* rate increased by more than 20 percentage points from the prior year and ranked above NCQA's Quality Compass HEDIS 2020 Medicaid HMO 50th percentile benchmark. This performance improvement demonstrates **HPN** and its contracted providers prioritized members' behavioral healthcare and ensured members were being treated in a timely manner for behavioral health conditions. **[Quality, Timeliness,** and **Access]**

Weaknesses and Recommendations

Weakness #1: Although **HPN**'s Medicaid performance for *Adults' Access to Preventive/Ambulatory Health Services* in the Access to Care domain met the MPS in the *Ages 65 Years and Older* stratification, the *Ages 20–44 Years*, *Ages 45–64 Years*, and overall *Total* stratifications demonstrated a decline in performance of more than 5 percentage points from the prior year. This indicates **HPN** needs to prioritize member access to providers to ensure they are able to get their healthcare needs met in a timely manner and potentially avoid overuse of the ED. **[Quality, Timeliness,** and **Access]**

Why the weakness exists: Although adults appear to have access to PCPs for preventive and ambulatory services, these members were not consistently utilizing preventive and ambulatory services, which can significantly reduce non-urgent ED visits.

Recommendation: HSAG recommends **HPN** conduct a root cause analysis or focused study to determine why its members are not accessing their PCPs routinely. Upon identification of a root cause, **HPN** should implement appropriate interventions to improve performance related to Access to Care measures.

Weakness #2: Within the Behavioral Health domain for Nevada Check Up, performance for the *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*, and *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD—Total* and *Engagement of AOD—Total* rates declined by more than 8 percentage points from the prior year. Of note, although performance for the *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* measure declined, the rate was above NCQA's Quality Compass HEDIS 2020 Medicaid HMO 50th percentile benchmark. **[Quality, Timeliness,** and **Access]**

Why the weakness exists: Decreased performance may be due to low appointment availability for qualified mental healthcare professionals to meet the demand, lack of transportation, or perceived social stigma related to seeking mental health services.

Recommendation: HSAG recommends **HPN** conduct a root cause analysis or focused study to determine why its members needing mental health and substance abuse services are not receiving the needed follow-up care or initiating treatment for services. **HPN** could consider if there are disparities within its populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, **HPN** should implement appropriate interventions to improve the performance related to these measures.

Weakness #3: Within the Care for Chronic Conditions domain for Medicaid, **HPN**'s *Comprehensive Diabetes Care—HbA1c Testing* rate decreased more than 5 percentage points. HbA1c testing is critical for effective monitoring and treatment of diabetes. In addition, reduced testing can lead to underreporting of the *Comprehensive Diabetes Care—HbA1c Control (<8.0%)* and *HbA1c Poor Control (>9.0%)* measure indicators. **[Quality, Timeliness,** and **Access]**

Why the weakness exists: Testing declines may have coincided with the rapid increase of COVID-19 cases in 2020. Factors that may have contributed to the declines during this time include site closures and temporary suspension of non-urgent services due to COVID-19. The requirement or recommendation to stay at home and the fear of contracting COVID-19 also likely deterred individuals from seeking healthcare services, including HbA1c testing.

Recommendation: HSAG recommends **HPN** conduct a root cause analysis or focused study to determine why its diabetic members are receiving less HbA1c testing in comparison to MY 2019. **HPN** could consider if there are disparities within its populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, **HPN** should implement appropriate interventions to improve the performance related to these measures.

Compliance Review

The SFY 2021 Compliance Review activity demonstrated how successful **HPN** was at interpreting specific standards under 42 CFR Part 438—Managed Care and the associated requirements under its managed care contract with DHCFP.

Performance Results

Table 3-22 presents **HPN**'s scores for each standard evaluated in the SFY 2021 compliance review. Each element within a standard was scored as *Met* or *Not Met* based on evidence found in **HPN**'s written documents, including policies, procedures, reports, and meeting minutes; and interviews with MCO staff members.

Table 3-22—Summary of Standard Compliance Scores for HPN

Compliance Monitoring Standard		Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	*NM*	*NA*	
I	Disenrollment: Requirements and Limitations	7	7	7	0	0	**100%**
II	Member Rights and Member Information	22	22	20	2	0	**91%**
III	Emergency and Poststabilization Services	10	10	10	0	0	**100%**
IV	Availability of Services	10	10	10	0	0	**100%**
V	Assurances of Adequate Capacity and Services	2	2	2	0	0	**100%**
VI	Coordination and Continuity of Care	17	17	14	3	0	**82%**
VII	Coverage and Authorization of Services	15	15	14	1	0	**93%**
Total		**83**	**83**	**77**	**6**	**0**	**93%**

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

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

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

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

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: HPN achieved full compliance for the Disenrollment: Requirements and Limitations program area, demonstrating that the MCO had appropriate processes in place related to member and MCO requests for disenrollment, procedures for disenrollment, and use of the MCO's grievance system when receiving a member's disenrollment request. **[Quality]**

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

Strength #3: HPN achieved full compliance in the Availability of Services and Assurances of Adequate Capacity and Services program areas, demonstrating the MCO maintained and monitored an adequate provider network that was sufficient to provide timely and adequate access to all services (e.g., primary care, specialty care, hospital and emergency services, behavioral health) for its membership. **[Timeliness** and **Access]**

Weaknesses and Recommendations

Weakness #1: HPN achieved compliance scores of 82 percent or above in all program areas reviewed, indicating no significant weaknesses were identified and the MCO had appropriate processes, procedures, and plans in place to promote members' access to timely and quality care. **[Quality**, **Timeliness,** and **Access]**

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

Recommendation: Although no significant weaknesses were identified, **HPN** should continually evaluate its processes, procedures, and monitoring efforts to ensure it maintains compliance with all federal and State obligations.

Network Adequacy Validation

Performance Results

Table 3-23 presents **HPN**'s provider ratio analysis results compared to the provider ratio standards. For the provider categories assessed according to the standards in Table 3-4, the percentage of members with access to the provider within the time-distance standard is shown in red if they did not comply with the standard. The time-distance results are displayed in Table 3-24.

Table 3-23—Summary of Ratio Analysis Results for PCPs and Specialty Care Providers for HPN

Provider Category	HPN	
	Providers	Ratio
Primary Care Providers		
Primary Care Providers (1:1,500)	1,801	1:152
PCP Extenders (1:1,800)	1,020	1:269
Physician Specialist Providers (1:1,500)	1,973	1:139

Table 3-24—Percentage of Members Residing Within the Access Standard Areas for HPN

Provider Category	Time-Distance Standard	HPN
Primary Care Providers		
Primary Care (Adult Total)	20 miles/30 mins	98.3%
OB/GYN	20 miles/30 mins	99.9%
Pediatrician	20 miles/30 mins	99.9%
Specialty Providers		
Endocrinologists	75 miles/100 mins	99.9%
Endocrinologists, Pediatric	75 miles/100 mins	99.9%
Infectious Disease	75 miles/100 mins	99.9%
Infectious Disease, Pediatric	75 miles/100 mins	99.9%
Oncologist/Hematologist	75 miles/100 mins	99.9%
Oncologist/Hematologist, Pediatric	75 miles/100 mins	99.9%
Oncologist/Radiologist	75 miles/100 mins	NA
Rheumatologist	75 miles/100 mins	99.9%
Rheumatologist, Pediatric	75 miles/100 mins	87.8%
Facility-Level Providers		
Hospital (Total)	60 miles/80 mins	94.4%
Psychiatry Inpatient Hospital	60 miles/80 mins	99.9%
Dialysis/ESRD Facility	60 miles/80 mins	99.9%
Behavioral Health Providers		
Psychologist	45 miles/60 mins	99.9%
Pediatric Psychologist	45 miles/60 mins	99.9%
LCSW	45 miles/60 mins	99.9%
Psychiatrist	45 miles/60 mins	99.9%
Pediatric Psychiatrist	45 miles/60 mins	99.9%

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: HPN met the required provider ratio requirements for primary care providers and physician specialist providers, indicating **HPN** has a sufficient provider network for its members to access services. **[Access]**

Strength #2: HPN met the time-distance contract standards for all primary care provider categories (primary care [adult total], OB/GYN, and pediatrician), facility-level provider categories, and all reported behavioral health provider categories, indicating that members had access to PCPs within an adequate distance from their residence. **[Access]**

Strength #3: HPN met the time-distance contract standards for eight of the nine specialty provider categories, indicating members had access to specialty providers within an adequate distance from their residence. **[Access]**

Weaknesses and Recommendations

Weakness #1: HPN did not meet the time-distance contract standards for pediatric rheumatologists, indicating child members may experience challenges accessing this provider type within an adequate distance from their residence. **[Access]**

Why the weakness exists: The lack of identified providers may result from either a lack of contracted pediatric specialty providers in this specialty or from an inability to identify those pediatric specialists in the data. All three MCOs did not meet the network adequacy standard for pediatric rheumatologists, suggesting a potential lack of this provider type within the counties served.

Recommendation: HSAG recommends **HPN** continue to conduct an in-depth review of the provider category in which it did not meet the time-distance contract standard, with the goal of determining whether or not the failure of the MCO to meet the contract standard was the result of a lack of providers or an inability to contract providers in the geographic area.

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results

Table 3-25 presents **HPN**'s 2021 adult Medicaid, general child Medicaid, and CCC Medicaid CAHPS top-box scores. Table 3-25 also includes **HPN**'s 2021 Nevada Check Up general child and CCC top-box scores. Arrows (↓ or ↑) indicate 2021 scores that were at least 5 percentage points higher or lower than the 2020 national average.

Table 3-25—Summary of 2021 CAHPS Top-Box Scores for HPN

	2021 Adult Medicaid	2021 General Child Medicaid	2021 CCC Medicaid Supplemental	2021 Nevada Check Up General Child	2021 Nevada Check Up CCC Supplemental
Composite Measures					
Getting Needed Care	82.8%	NA	NA	NA	NA
Getting Care Quickly	82.7%	NA	NA	NA	NA
How Well Doctors Communicate	92.4%	93.6%	96.2%	NA	NA
Customer Service	NA	NA	NA	NA	NA
Global Ratings					
Rating of All Health Care	56.4%	73.3%	77.5% ↑	NA	NA
Rating of Personal Doctor	67.0%	74.5%	81.8%	76.8%	78.9%
Rating of Specialist Seen Most Often	63.4% ↓	NA	NA	NA	NA
Rating of Health Plan	68.0% ↑	74.2%	71.9%	71.5%	66.2%
Effectiveness of Care*					
Advising Smokers and Tobacco Users to Quit	64.5% ↓				
Discussing Cessation Medications	39.9% ↓				
Discussing Cessation Strategies	38.4% ↓				
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			93.0%		NA
FCC: Getting Needed Information			91.9%		NA

A minimum of 100 responses is required for a measure to be reported as a CAHPS survey results. Measures that do not meet the minimum number of responses are denoted as *NA*.

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

↑ Indicates the 2021 score is at least 5 percentage points higher than the 2020 national average.

↓ Indicates the 2021 score is at least 5 percentage points lower than the 2020 national average.

Indicates that the measure does not apply to the population.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: Adult members had positive overall experiences with their health plan since the score for this measure was at least 5 percentage points higher than the 2020 NCQA Medicaid national average. **[Quality, Timeliness,** and **Access]**

Strength #2: Parents/caretakers of child members with chronic conditions had positive experiences with their child's overall healthcare since the score for this measure was at least 5 percentage points higher than the 2020 NCQA Medicaid national average. **[Quality, Timeliness,** and **Access]**

Weaknesses and Recommendations

Weakness #1: Adult members had less positive overall experiences with the specialist they talked to most often since the score for this measure was at least 5 percentage points lower than the 2020 NCQA Medicaid national average. **[Quality, Timeliness,** and **Access]**

Why the weakness exists: Adult members reported a more negative experience with the specialist they talked to most often, which could be because members had a difficult time getting an appointment with their specialist. Members may have to talk to more than one specialist, and **HPN**'s specialists may not be aware of all the needs of their members and, as a result, may not be providing the consultative care required.

Recommendation: HSAG recommends that **HPN** focus on improving members' overall experiences with the specialist they talk to most often by performing a root cause analysis, which could determine if there are any outliers within the data so that **HPN** can identify the primary areas of focus and develop appropriate strategies to improve the performance.

Weakness #2: The Effectiveness of Care scores were at least 5 percentage points lower than the 2020 NCQA Medicaid national averages. **[Quality]**

Why the weakness exists: **HPN**'s providers may not be advising members who smoke or use tobacco to quit and may not be discussing cessation medications and strategies with their adult members as much as other providers compared to national benchmarks.

Recommendation: HSAG recommends that **HPN** focus on quality improvement initiatives to provide medical assistance with smoking and tobacco use cessation and continue to develop efforts to promote its Health Education & Wellness smoking cessation program.

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

To identify strengths and weaknesses and draw conclusions for **HPN** about the quality, timeliness, and access to care for its members, HSAG analyzed and evaluated performance related to the provision of healthcare services by **HPN** across all EQR activities to identify common themes within **HPN** that impacted, or will have the likelihood to impact, member health outcomes. The overarching aggregated findings show that, while **HPN** had an adequate network for members to access providers for services, as determined through the NAV activity, and the processes, procedures, and monitoring efforts in place to

continually evaluate the network for necessary network enhancements as determined through the Compliance Review activity, adult and child members were not always accessing services timely to obtain the preventive and/or condition-specific care they needed to maintain optimal health; this was indicated through lower performing or declining HEDIS rates particularly in the Access to Care, Women's Health and Maternity Care, and Care for Chronic Conditions domains, both in comparison to its own historical performance and the national Medicaid 50th percentile. **HPN** should evaluate through a root cause analysis whether the significant decline in member experience with their specialty providers, as indicated through CAHPS, demonstrates a potential concern with the quality of diabetes care and other specialty care being provided by **HPN** contracted providers. Additionally, while specific efforts were initiated to improve member outcomes related to diabetes care and timeliness of prenatal care as demonstrated through the PIP activity, and although there was a slight improvement in the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* HEDIS measure indicator rate and the MPS was met, there was a significant decline in the *Comprehensive Diabetes Care—HbA1c Testing* HEDIS measure, indicating members were not having tests completed in order to show a controlled HbA1c. Additionally, **HPN** demonstrated a slight decline in year-over-year performance in the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* HEDIS measure (although this measure did meet the MPS), indicating **HPN** should evaluate whether its quality improvement initiatives were effective to support improvements in those focus areas and put new interventions in place as necessary to promote better health outcomes for pregnant women and their babies and members with diabetes. **HPN** performed above the national Medicaid 50th percentile in most follow-up to ED visits and hospitalization-related care measures within the Behavioral Health domain, indicating **HPN** had effective mechanisms in place to ensure members with behavioral health needs were able to access providers timely for follow-up services after behavioral health crises or diagnoses. **HPN** also demonstrated generally stable performance in most Children's Preventive Care measures related to immunization compliance, and performed above the national Medicaid 50th percentile and met the MPS in three immunization combinations for its Medicaid population, while the immunization-related measures for the Nevada Check Up population were all above the national Medicaid 50th percentile, indicating Nevada CHIP members were getting immunized more frequently than the national average. **HPN** should evaluate its strong performance in the Behavioral Health and Children's Preventive Care domains to determine if initiatives were implemented that supported the improved outcomes, and assess whether similar initiatives or interventions would be appropriate to support improvement in other care domains, such as the Access to Care and Care for Chronic Conditions domains. Additionally, although **HPN** had opportunities to enhance performance related to care coordination, specifically its processes for managing members through the care management program as demonstrated through a Compliance Review score of 82 percent in the Coordination and Continuity of Care standard, care management staff members could leverage their experience working directly with members to better understand the barriers members may experience when accessing care, including whether there are challenges accessing certain provider types; whether there are delays to getting timely appointments; and/or whether the quality of providers and the care being received are not sufficient.

Of note, due to the COVID-19 pandemic during HEDIS MY 2020 and SFY 2021, many preventive services were negatively affected across the country as states followed orders to reduce the use of non-emergent services in order to slow the spread of COVID-19. Additionally, due to fear of contracting the virus, members may have chosen to not access routine care, which may have impacted performance outcomes in SFY 2021.

SilverSummit Healthplan, Inc.

Validation of Performance Improvement Projects

Performance Results

Table 3-26 summarizes the progress **SilverSummit** made in completing the four PIP modules during SFY 2021.

Table 3-26—Overall Validation Rating for SilverSummit

PIP Topic	Module	Status
Comprehensive Diabetes Care (CDC) Hemoglobin A1c (HbA1c) Poor Control >9.0%	1. PIP Initiation	Completed and achieved all validation criteria.
	2. Intervention Determination	Completed and achieved all validation criteria.
	3. Intervention Testing	Module 3 documentation submitted to date have achieved all validation criteria. The MCO tested interventions until 6/30/2021.
	4. PIP Conclusions	Submission targeted for October 2021.
Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care	1. PIP Initiation	Completed and achieved all validation criteria.
	2. Intervention Determination	Completed and achieved all validation criteria.
	3. Intervention Testing	Module 3 documentation submitted to date have achieved all validation criteria. The MCO tested interventions until 6/30/2021.
	4. PIP Conclusions	Submission targeted for October 2021.

SilverSummit passed Module 3—Intervention Testing submitted for each implemented intervention and achieved all validation criteria for both PIPs. **SilverSummit** concluded its intervention testing on June 30, 2021. The validation findings for additional Module 3 submissions and Module 4 (PIP Conclusions) with SMART Aim measure outcomes will be reported in the next annual EQR technical report.

Interventions

During this SFY, **SilverSummit** tested two interventions for the *Comprehensive Diabetes Care (CDC) Hemoglobin A1c (HbA1c) Poor Control >9.0%* PIP and one intervention for the *Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care* PIP. The intervention description, impact, and status are described in Table 3-27 and Table 3-28 below.

Table 3-27—Intervention for Comprehensive Diabetes Care (CDC) Hemoglobin A1c (HbA1c) Poor Control >9.0%

Intervention #1	
Intervention Description	Targeted Member Outreach Using Emergency Room Demographic Information
Intervention Impact	The MCO reported that it was only able to access four hospitals' EMR systems, which limited the number of members for possible outreach during the testing period. The MCO elected to abandon this intervention because there was only one member who met the criteria for the PIP population, and that member was not successfully contacted.
Intervention Status	Abandoned
Intervention #2	
Intervention Description	Targeted Member Outreach Using Demographic Information Obtained from Provider Claims Data or Medical Records
Intervention Impact	The MCO was able to obtain the necessary demographic information for only 12 members through medical records and no demographic information from provider claims data. Despite the results, the MCO documented that the intervention would be adopted, and it would continue to use medical record reviews to obtain updated member demographic information so outreach could be conducted.
Intervention Status	Adopted

Table 3-28—Intervention for Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care

Intervention #1	
Intervention Description	Targeted Member Outreach Using 587 Report (The 587 report is generated on a weekly basis and includes names, addresses, and phone numbers of all newly enrolled pregnant members)
Intervention Impact	**SilverSummit** had planned to move this outreach to an automated call; however, due to coronavirus disease 2019 (COVID-19) restraints, the MCO had staff continue the outreach calls. The MCO reported that 87 percent of newly enrolled pregnant members were successfully contacted using the monthly 587 report. **SilverSummit** concluded that even though they had phone numbers, members were not always open to case management; however, the MCO was able to provide education on the importance of a prenatal visit within 42 days of enrollment.
Intervention Status	Adopted

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: SilverSummit used quality improvement tools to identify and prioritize opportunities for improvement within its current processes. These tools and the results they produced assisted the MCO in selecting the first interventions to test using PDSA cycles. **[Quality]**

Strength #2: SilverSummit developed methodologically sound intervention effectiveness measures and tested interventions using thoughtful PDSA cycles, which, when effective, should support improvements in diabetes care and timely access to prenatal care. **[Quality, Timeliness,** and **Access]**

Weaknesses and Recommendations

Weakness #1: SilverSummit's PDSA testing cycles were too long, which prevented the MCO from quickly revising its interventions to support process improvement. **[Quality, Timeliness,** and **Access]**

Why the weakness exists: The MCO's intervention testing time frames were six months, which may have slowed process improvements and member-focused initiatives implemented to support effective member care.

Recommendation: SilverSummit should consider shorter testing periods. The testing methodology should allow the MCO to quickly gather data and make data-driven revisions to facilitate achievement of the SMART Aim goal.

Weakness #2: SilverSummit limited the number of interventions tested for the *Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care* PIP. **[Quality, Timeliness, and Access]**

Why the weakness exists: The MCO's process included one intervention for the *Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care* PIP, which may have limited the opportunity for the MCO to make notable improvements in pregnant members' timely access to prenatal care.

Recommendation: SilverSummit should consider testing more than one intervention during the intervention testing phase of the PIP. This will help the MCO address additional identified opportunities for improvement from the process map and FMEA and increase the likelihood of achieving the SMART Aim goal and desired outcomes for the project. By achieving the desired goals for the PIPs, the MCO will positively impact the timeliness and quality of care for its members.

Performance Measure Validation

Performance Results

SilverSummit's Medicaid and Nevada Check Up HEDIS MY 2018, MY 2019, and MY 2020 performance measure results are presented in Table 3-29 and Table 3-30, along with year-to-year rate

comparisons and performance target ratings. Measures for which lower rates suggest better performance are indicated by an asterisk (*). The arrows (↑ or ↓) indicate whether the HEDIS MY 2020 rate was above or below the national Medicaid 50th percentile benchmark. Green and red shading is used to indicate a 5 percentage point performance improvement or performance decline from the prior year's performance, while **bolded** rates indicate the MPS was achieved. Please note that the arrows do not necessarily correlate to shading and bolded font.

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

Table 3-29—Medicaid HEDIS Performance Measure Results for SilverSummit

HEDIS Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	MY 2019–MY 2020 Rate Comparison
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services (AAP)				
Ages 20–44 Years	62.35%	66.35%	58.20%↓	-8.15
Ages 45–64 Years	72.28%	75.54%	69.12%↓	-6.42
Ages 65 Years and Older	NA	NA	**79.41%**↓	NC
Total	65.40%	69.38%	61.54%↓	-7.84
Children's Preventive Care				
Childhood Immunization Status (CIS)				
Combination 2	46.25%	66.42%	66.18%↓	-0.24
Combination 3	43.13%	60.34%	62.29%↓	1.95
Combination 4	43.13%	60.10%	62.04%↓	1.94
Combination 5	34.38%	49.39%	54.01%↓	4.62
Combination 6	16.25%	33.09%	33.82%↓	0.73
Combination 7	34.38%	49.15%	53.77%↓	4.62
Combination 8	16.25%	33.09%	33.82%↓	0.73
Combination 9	13.13%	28.95%	29.20%↓	0.25
Combination 10	13.13%	28.95%	29.20%↓	0.25
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	67.70%	82.00%	78.59%↓	-3.41

HEDIS Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	MY 2019–MY 2020 Rate Comparison
Combination 2 (Meningococcal, Tdap, HPV)	19.25%	31.14%	33.58%↓	2.44
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile—Total[1]	70.56%	78.59%	78.83%↓	0.24
Counseling for Nutrition—Total	66.42%	65.69%	70.56%↓	4.87
Counseling for Physical Activity—Total	60.58%	59.12%	66.91%↑	7.79
Well-Child Visits in the First 30 Months of Life (W30)[^]				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits[2]	—	—	54.96%	NC
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	—	—	68.08%	NC
Child and Adolescent Well-Care Visits (WCV)[2,^]				
3–11 Years	—	—	39.99%	NC
12–17 Years	—	—	32.03%	NC
18–21 Years	—	—	16.64%	NC
Total	—	—	33.70%	NC
Women's Health and Maternity Care				
Breast Cancer Screening (BCS)[1]				
Breast Cancer Screening	NA	47.54%	44.68%↓	-2.86
Prenatal and Postpartum Care (PPC)[1]				
Timeliness of Prenatal Care	—	75.91%	71.53%↓	-4.38
Postpartum Care	—	54.74%	58.64%↓	3.90
Care for Chronic Conditions				
Comprehensive Diabetes Care (CDC)				
HbA1c Testing[1]	79.08%	74.70%	70.56%↓	-4.14
HbA1c Poor Control (>9.0%)[1,*]	57.66%	53.04%	56.45%↓	3.41
HbA1c Control (<8.0%)[1]	34.55%	37.71%	37.47%↓	-0.24
Eye Exam (Retinal) Performed[1]	46.47%	52.55%	50.36%↓	-2.19
Blood Pressure Control (<140/90 mm Hg)[2,^]	—	—	36.50%	NC

HEDIS Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	MY 2019–MY 2020 Rate Comparison
Controlling High Blood Pressure (CBP)[2,^]				
Controlling High Blood Pressure	—	—	32.85%	NC
Kidney Health Evaluation for Patients With Diabetes (KED)[^]				
18–64 Years	—	—	27.22%	NC
65–74 Years	—	—	NA	NC
75–84 Years	—	—	NA	NC
Total	—	—	27.40%	NC
Behavioral Health				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	35.06%	44.05%	39.32%↓	-4.73
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	78.06%	76.77%	69.19%↓	-7.58
Follow-Up After ED Visit for AOD Abuse or Dependence (FUA)[1]				
7-Day Follow-Up—Total	11.93%	14.20%	**19.70%**↑	5.50
30-Day Follow-Up—Total	15.33%	19.05%	**26.57%**↑	7.52
Follow-Up After ED Visit for Mental Illness (FUM)[1]				
7-Day Follow-Up—Total	26.19%	22.97%	42.96%↑	19.99
30-Day Follow-Up—Total	35.46%	32.43%	53.66%↓	21.23
Follow-Up After Hospitalization for Mental Illness (FUH)[1]				
7-Day Follow-Up—Total	22.40%	28.10%	36.69%↑	8.59
30-Day Follow-Up—Total	36.72%	44.59%	54.62%↓	10.03
Follow-Up Care for Children Prescribed ADHD Medication (ADD)[1]				
Initiation Phase	NA	49.40%	47.71%↑	-1.69
Continuation and Maintenance Phase	NA	NA	NA	NC

HEDIS Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	MY 2019–MY 2020 Rate Comparison
Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)[1]				
Initiation of AOD—Total	46.30%	45.43%	41.27%↓	-4.16
Engagement of AOD—Total	13.37%	12.84%	10.78%↓	-2.06
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)				
Blood Glucose and Cholesterol Testing–Total	23.08%	21.24%	**25.41%**↓	4.17
Utilization				
Ambulatory Care—Total (per 1,000 Member Months) (AMB)^				
*ED Visits—Total**	61.33	66.17	48.01	-18.16
Outpatient Visits—Total	258.11	286.69	250.67	-36.02
Mental Health Utilization—Total (MPT)[1,^]				
Inpatient—Total	1.63%	1.43%	1.13%	-0.30
Intensive Outpatient or Partial Hospitalization—Total	0.16%	0.18%	0.12%	-0.06
Outpatient—Total	12.14%	14.46%	10.43%	-4.03
ED—Total	0.10%	0.06%	0.04%	-0.02
Telehealth—Total	0.06%	0.17%	5.26%	5.09
Any Service—Total	12.80%	14.99%	12.18%	-2.81
Plan All-Cause Readmissions (PCR)				
Observed Readmissions—Total	—	13.42%	13.58%	0.16
*Expected Readmissions—Total^*	—	9.73%	10.30%	0.57
*O/E Ratio—Total^*	—	1.38	1.32	-0.06
Overuse/Appropriateness of Care				
Use of Opioids at High Dosage (HDO)[1,*]				
Use of Opioids at High Dosage	—	5.42%	**4.50%**↑	-0.92
Use of Opioids From Multiple Providers (UOP)[1,*]				
Multiple Prescribers	23.52%	32.45%	24.93%↓	-7.52
Multiple Pharmacies	4.37%	2.65%	**0.62%**↑	-2.03
Multiple Prescribers and Multiple Pharmacies	2.81%	1.86%	**0.18%**↑	-1.68

[1] Due to changes in the technical specifications for this measure, NCQA recommends that trending between HEDIS MY 2020 and prior years be considered with caution.

[2] Due to significant changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS MY 2020 and prior years; therefore, prior years' rates are not displayed, and rate comparisons are not performed for this measure.
↑ Indicates the HEDIS MY 2020 rate was above NCQA's Quality Compass HEDIS 2020 Medicaid HMO 50th percentile benchmark.
↓ Indicates the HEDIS MY 2020 rate was below NCQA's Quality Compass HEDIS 2020 Medicaid HMO 50th percentile benchmark.
* A lower rate indicates better performances for this measure.
— Indicates that the MCO was not previously required to report this measure or that the rate is not appropriate to display due to changes in the technical specifications resulting in a break in trending.
^ Indicates HEDIS MY 2020 QISMC goals are unavailable for this measure.
NC indicates the MY 2019–MY 2020 Rate Comparison could not be calculated because data are not available for both years.
NA indicates that the MCO followed the specifications, but the denominator was too small (i.e., <30) to report a valid rate.
Bolded rates indicate that the HEDIS MY 2020 performance measure rate was at or above the MPS.

Indicates that the HEDIS MY 2020 rate declined by 5 percentage points or more from HEDIS MY 2019.

Indicates that the HEDIS MY 2020 rate improved by 5 percentage points or more from HEDIS MY 2019.

Table 3-30—Nevada Check Up HEDIS Performance Measure Results for SilverSummit

HEDIS Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	MY 2019–MY 2020 Rate Comparison
Children's Preventive Care				
Childhood Immunization Status (CIS)				
Combination 2	NA	88.24%	81.40%↑	-6.84
Combination 3	NA	84.31%	81.40%↑	-2.91
Combination 4	NA	84.31%	81.40%↑	-2.91
Combination 5	NA	68.63%	74.42%↑	5.79
Combination 6	NA	47.06%	**51.16%**↑	4.10
Combination 7	NA	68.63%	74.42%↑	5.79
Combination 8	NA	47.06%	**51.16%**↑	4.10
Combination 9	NA	41.18%	**46.51%**↑	5.33
Combination 10	NA	41.18%	**46.51%**↑	5.33
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	NA	86.36%	**90.63%**↑	4.27
Combination 2 (Meningococcal, Tdap, HPV)	NA	33.33%	43.75%↑	10.42

HEDIS Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	MY 2019–MY 2020 Rate Comparison
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile—Total[1]	76.16%	73.48%	76.64%↓	3.16
Counseling for Nutrition—Total	69.59%	66.42%	67.88%↓	1.46
Counseling for Physical Activity—Total	64.72%	62.04%	66.42%↓	4.38
Well-Child Visits in the First 30 Months of Life (W30)^				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits[2]	—	—	56.25%	NC
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	—	—	85.42%	NC
Child and Adolescent Well-Care Visits (WCV)[2,^]				
3–11 Years	—	—	44.81%	NC
12–17 Years	—	—	40.76%	NC
18–21 Years	—	—	21.84%	NC
Total	—	—	41.56%	NC
Behavioral Health				
Follow-Up After ED Visit for AOD Abuse or Dependence (FUA)[1,^]				
7-Day Follow-Up—Total	NA	NA	NA	NC
30-Day Follow-Up—Total	NA	NA	NA	NC
Follow-Up After ED Visit for Mental Illness (FUM)[1]				
7-Day Follow-Up—Total	NA	NA	NA	NC
30-Day Follow-Up—Total	NA	NA	NA	NC
Follow-Up After Hospitalization for Mental Illness (FUH)[1]				
7-Day Follow-Up—Total	NA	NA	NA	NC
30-Day Follow-Up—Total	NA	NA	NA	NC
Follow-Up Care for Children Prescribed ADHD Medication (ADD)[1]				
Initiation Phase	NA	NA	NA	NC
Continuation and Maintenance Phase^	NA	NA	NA	NC
Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)[1]				
Initiation of AOD—Total	NA	NA	NA	NC

HEDIS Measure	HEDIS MY 2018 Rate	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	MY 2019–MY 2020 Rate Comparison
Engagement of AOD—Total	NA	NA	NA	NC
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)				
Blood Glucose and Cholesterol Testing–Total	NA	NA	NA	NC
Utilization				
Ambulatory Care—Total (per 1,000 Member Months) (AMB) ^				
*ED Visits—Total**	26.36	30.68	15.41	-15.27
Outpatient Visits—Total	192.98	237.83	168.42	-69.41
Mental Health Utilization—Total (MPT) [1,^]				
Inpatient—Total	0.73%	0.23%	0.61%	0.38
Intensive Outpatient or Partial Hospitalization—Total	0.05%	0.14%	0.06%	-0.08
Outpatient—Total	7.14%	9.79%	6.39%	-3.40
ED—Total	0.00%	0.00%	0.00%	0.00
Telehealth—Total	0.00%	0.09%	3.61%	3.52
Any Service—Total	7.30%	9.84%	7.55%	-2.29

[1] Due to changes in the technical specifications for this measure, NCQA recommends that trending between HEDIS MY 2020 and prior years be considered with caution.
[2] Due to significant changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS MY 2020 and prior years; therefore, prior years' rates are not displayed, and rate comparisons are not performed for this measure.
↑ Indicates the HEDIS MY 2020 rate was above NCQA's Quality Compass HEDIS 2020 Medicaid HMO 50th percentile benchmark.
↓ Indicates the HEDIS MY 2020 rate was below NCQA's Quality Compass HEDIS 2020 Medicaid HMO 50th percentile benchmark.
* A lower rate indicates better performances for this measure.
— Indicates that the MCO was not previously required to report this measure or that the rate is not appropriate to display due to changes in the technical specifications resulting in a break in trending.
^ Indicates HEDIS MY 2020 QISMC goals are unavailable for this measure.
NC indicates the MY 2019–MY 2020 Rate Comparison could not be calculated because data are not available for both years.
NA indicates that the MCO followed the specifications, but the denominator was too small (i.e., <30) to report a valid rate.
Bolded rates indicate that the HEDIS MY 2020 performance measure rate was at or above the MPS.

Indicates that the HEDIS MY 2020 rate declined by 5 percentage points or more from HEDIS MY 2019.

Indicates that the HEDIS MY 2020 rate improved by 5 percentage points or more from HEDIS MY 2019.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: Within the Behavioral Health domain, **SilverSummit**'s Medicaid performance for the *Follow-Up After ED Visit for AOD Abuse or Dependence*, *Follow-Up After ED Visit for Mental Illness*, and *Follow-Up After Hospitalization for Mental Illness* measures increased by more than 5 percentage points from the prior year and both rates for the *Follow-Up After ED Visit for AOD Abuse or Dependence* measure indicators met the MPS. This indicates that **SilverSummit** is appropriately managing care for patients hospitalized for mental health issues, as they are vulnerable after discharge. Follow-up care by trained mental health clinicians is critical for their successful transition out of an inpatient or ED setting as well as preventing future admissions and readmissions. **[Quality, Timeliness,** and **Access]**

Strength #2: For **SilverSummit**'s Nevada Check Up population, performance for four out of nine combination rates for *Childhood Immunization Status* increased by more than 5 percentage points from the prior year. Although one of the nine rates decreased by more than 5 percentage points, all nine rates ranked above NCQA's Quality Compass HEDIS 2020 Medicaid HMO 50th percentile benchmark. This suggests that children are receiving the needed vaccines to avoid vaccine-preventable diseases. **[Quality, Timeliness,** and **Access]**

Strength #3: For **SilverSummit**'s Nevada Check Up population, performance rates for both *Immunizations for Adolescents* measure indicators ranked above NCQA's Quality Compass HEDIS 2020 Medicaid HMO 50th percentile. In addition, one indicator also met the MPS and the other improved by over 10 percentage points from the prior year. This suggests that adolescents are receiving the needed vaccines to avoid vaccine-preventable diseases. **[Quality, Timeliness,** and **Access]**

Strength #4: Within the Children's Preventive Care domain, **SilverSummit**'s Medicaid performance for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total* measure indicator increased by over 7 percentage points from the prior year and ranked above NCQA's Quality Compass HEDIS 2020 Medicaid HMO 50th percentile benchmark. Counseling for physical activity is an important component in reducing childhood obesity. **[Quality]**

Weaknesses and Recommendations

Weakness #1: SilverSummit's Medicaid performance for *Adults' Access to Preventive/Ambulatory Health Services* decreased by more than 5 percentage points for three of the four indicators; however, the *Ages 65 Years and Older* stratification met the MPS. All four rates ranked below NCQA's Quality Compass HEDIS 2020 Medicaid HMO 50th percentile benchmark. The low overall performance in the Access to Care domain indicates members may be experiencing issues accessing providers for services. **[Quality, Timeliness,** and **Access]**

Why the weakness exists: The Access to Care measure rates for adult Medicaid members performed below the MPS, suggesting that members are not always able to access providers for preventive services in a timely manner. Additionally, adults are not visiting PCPs as needed to maintain optimal health. These members may have difficulties finding a provider that accepts Medicaid or may be choosing to not go to the doctor.

Recommendation: HSAG recommends **SilverSummit** conduct a root cause analysis or focused study to determine why its members are not accessing contracted providers for services. **SilverSummit** could consider if there are disparities within its populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, **SilverSummit** should implement appropriate interventions to improve performance related to the Access to Care domain. If COVID-19 was a factor, HSAG recommends **SilverSummit** work with its members to increase the use of telehealth services, when appropriate.

Weakness #2: For the Medicaid population, **SilverSummit**'s performance for the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure declined by more than 5 percentage points from the prior year and ranked below NCQA's Quality Compass HEDIS 2020 Medicaid HMO 50th percentile benchmark. Low performance suggests there is a lack of appropriate care for diabetes for people with schizophrenia or bipolar disorder who use antipsychotic medications, which can lead to worsening health. Addressing these physical health needs is an important way to improve health, quality of life, and economic outcomes downstream. **[Quality** and **Access]**

Why the weakness exists: Decreased performance may potentially be due to low appointment availability for qualified mental healthcare professionals to meet the demand, lack of transportation, or perceived social stigma related to seeking mental health services.

Recommendation: HSAG recommends **SilverSummit** conduct a root cause analysis or focused study to determine why its members with schizophrenia or bipolar disorder are not being screened for diabetes. Upon identification of a root cause, **SilverSummit** should implement appropriate interventions to improve performance related to this measure.

Weakness #3: For **SilverSummit**'s Medicaid population, performance for all nine combination rates for *Childhood Immunization Status* remained below the MPS and below NCQA's Quality Compass HEDIS 2020 Medicaid HMO 50th percentile benchmark. Low performance suggests there is a lack of appropriate immunizations, which are a critical aspect of preventable care for children. **[Quality, Timeliness,** and **Access]**

Why the weakness exists: Immunization declines may have coincided with the rapid increase of COVID-19 cases in 2020. Factors that may have contributed to the declines during this time include screening site closures and the temporary suspension of non-urgent services due to COVID-19. The requirement or recommendation to stay at home and the fear of contracting COVID-19 also likely deterred individuals from seeking healthcare services, including immunizations.

Recommendation: HSAG recommends **SilverSummit** conduct a root cause analysis or focused study to determine why its child members are not receiving all recommended vaccines. **SilverSummit** could consider if there are disparities within its populations that contribute to lower

performance in a particular race or ethnicity, age group, ZIP Code, etc. **SilverSummit** could also consider if a particular vaccine or vaccines within the vaccine combinations were missed more often than others, contributing to lower rates within these measures. Upon identification of a root cause, **SilverSummit** should implement appropriate interventions to improve performance related to the *Childhood Immunization Status* measure.

Weakness #4: Within the Care for Chronic Conditions domain for Medicaid, **SilverSummit**'s rates for the *Comprehensive Diabetes Care—HbA1c Testing*, *HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, and *Eye Exam (Retinal) Performed* measure indicators remained below the MPS and below NCQA's Quality Compass HEDIS 2020 Medicaid HMO 50th percentile benchmark. HbA1c testing and retinal eye exams are critical for effective monitoring and treatment of diabetes and HbA1c levels are an indicator of disease progression. In addition, low levels of HbA1c testing can lead to underreporting of the *HbA1c Control (<8.0%)* and *HbA1c Poor Control (>9.0%)* measure indicators. **[Quality, Timeliness,** and **Access]**

Why the weakness exists: Declines in HbA1c testing and retinal eye exams may have coincided with the rapid increase of COVID-19 cases in 2020. Factors that may have contributed to the declines during this time include site closures and temporary suspension of non-urgent services due to COVID-19. The requirement or recommendation to stay at home and the fear of contracting COVID-19 also likely deterred individuals from seeking healthcare services, including diabetic testing.

Recommendation: HSAG recommends **SilverSummit** conduct a root cause analysis or focused study to determine how its diabetic members could receive additional HbA1c testing and retinal eye exams, as well as improve HbA1c levels. **SilverSummit** could consider if there are disparities within its populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, **SilverSummit** should implement appropriate interventions to improve performance related to these measures.

Compliance Review

The SFY 2021 Compliance Review activity demonstrated how successful **SilverSummit** was at interpreting specific standards under 42 CFR Part 438—Managed Care and the associated requirements under its managed care contract with DHCFP.

Performance Results

Table 3-31 presents **SilverSummit**'s scores for each standard evaluated in the SFY 2021 compliance review. Each element within a standard was scored as *Met* or *Not Met* based on evidence found in **SilverSummit**'s written documents, including policies, procedures, reports, and meeting minutes; and interviews with MCO staff members.

Table 3-31—Summary of Standard Compliance Scores for SilverSummit

Compliance Monitoring Standard		Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	*NM*	*NA*	
I	Disenrollment: Requirements and Limitations	7	7	7	0	0	**100%**
II	Member Rights and Member Information	22	22	17	5	0	**77%**
III	Emergency and Poststabilization Services	10	10	10	0	0	**100%**
IV	Availability of Services	10	10	9	1	0	**90%**
V	Assurances of Adequate Capacity and Services	2	2	2	0	0	**100%**
VI	Coordination and Continuity of Care	17	17	12	5	0	**71%**
VII	Coverage and Authorization of Services	15	15	10	5	0	**67%**
Total		**83**	**83**	**67**	**16**	**0**	**81%**

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

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

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

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

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: SilverSummit achieved full compliance for the Disenrollment: Requirements and Limitations program area, demonstrating that the MCO had appropriate processes in place related to member and MCO requests for disenrollment, procedures for disenrollment, and use of the MCO's grievance system when receiving a member's disenrollment request. **[Quality]**

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

Strength #3: SilverSummit achieved full compliance in the Assurances of Adequate Capacity and Services program area, demonstrating that the MCO maintained and monitored an adequate provider network that was sufficient to provide adequate access to all services (e.g., primary care, specialty care, hospital and emergency services, behavioral health) for its membership. **[Access]**

Weaknesses and Recommendations

Weakness #1: SilverSummit received a score of 77 percent in the Member Rights and Member Information program area, indicating members may not receive timely and adequate access to information that can assist them in accessing care and services. **[Quality**, **Timeliness**, and **Access]**

Why the weakness exists: SilverSummit's member materials critical to obtaining services did not comply with language requirements, the member handbook did not contain all mandatory components, and there was no documentation available to support timely notice to members would occur due to a significant change impacting members' access to services and information about the managed care program.

Recommendation: In addition to developing a corrective action plan to mitigate the gaps within its processes and documentation, **SilverSummit** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to member information.

Weakness #2: SilverSummit received a score of 71 percent in the Coordination and Continuity of Care program area, indicating members' care may not be effectively coordinated through the care management program. **[Quality**, **Timeliness**, and **Access]**

Why the weakness exists: SilverSummit did not consistently complete health risk screenings for its members to assess their healthcare needs; provide information to members and their PCPs regarding member eligibility for and/or enrollment into care management; include the members' PCP in the development of member care plans, or consistently include individualized goals and interventions within the care plans; or consistently conduct timely outreach to members to monitor progress and reevaluate members' care needs.

Recommendation: In addition to developing a corrective action plan to mitigate the gaps within its member assessment and care management processes, **SilverSummit** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to care coordination and care management of members. These efforts should support improved member health outcomes.

Weakness #3: SilverSummit received a score of 67 percent in the Coverage and Authorization of Services program area, indicating members may not consistently receive timely and adequate notice of prior authorization decisions, including decisions that result in an adverse benefit determination to the member. **[Quality** and **Timeliness]**

Why the weakness exists: SilverSummit did not consistently adhere to requirements related to the timing of decisions and the timing and content of notices of adverse benefit determination.

Recommendation: In addition to developing a corrective action plan to mitigate the gaps within its coverage and authorization of services processes, **SilverSummit** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to coverage and authorization of services.

Network Adequacy Validation

Performance Results

Table 3-32 presents **SilverSummit**'s provider ratio analysis results compared to the provider ratio standards. For the provider categories assessed according to the standards in Table 3-4, the percentage of members with access to the provider within the time-distance standard is shown in red if they did not comply with the standard. The time-distance results are displayed in Table 3-33.

Table 3-32—Summary of Ratio Analysis Results for PCPs and Specialty Care Providers for SilverSummit

Provider Category	SilverSummit	
	Providers	Ratio
Primary Care Providers		
Primary Care Providers (1:1,500)	1,620	1:42
PCP Extenders (1:1,800)	1,217	1:56
Physician Specialist Providers (1:1,500)	1,171	1:58

Table 3-33—Percentage of Members Residing Within the Access Standard Areas for SilverSummit

Provider Category	Time-Distance Standard	SilverSummit
Primary Care Providers		
Primary Care (Adult Total)	20 miles/30 mins	99.9%
OB/GYN	20 miles/30 mins	99.8%
Pediatrician	20 miles/30 mins	99.9%
Specialty Providers		
Endocrinologists	75 miles/100 mins	99.9%
Endocrinologists, Pediatric	75 miles/100 mins	99.9%
Infectious Disease	75 miles/100 mins	99.9%
Infectious Disease, Pediatric	75 miles/100 mins	99.9%
Oncologist/Hematologist	75 miles/100 mins	99.9%
Oncologist/Hematologist, Pediatric	75 miles/100 mins	99.9%
Oncologist/Radiologist	75 miles/100 mins	99.9%
Rheumatologist	75 miles/100 mins	99.9%
Rheumatologist, Pediatric	75 miles/100 mins	88.1%

Provider Category	Time-Distance Standard	SilverSummit
Facility-Level Providers		
Hospital (Total)	60 miles/80 mins	95.7%
Psychiatry Inpatient Hospital	60 miles/80 mins	99.9%
Dialysis/ESRD Facility	60 miles/80 mins	99.9%
Behavioral Health Providers		
Psychologist	45 miles/60 mins	99.9%
Pediatric Psychologist	45 miles/60 mins	88.1%
LCSW	45 miles/60 mins	99.9%
Psychiatrist	45 miles/60 mins	99.9%
Pediatric Psychiatrist	45 miles/60 mins	99.9%

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: SilverSummit met the required provider ratio requirements for primary care providers, PCP extenders, and physician specialist providers, indicating **SilverSummit** has a sufficient provider network for its members to access services. **[Access]**

Strength #2: SilverSummit met the time-distance contract standards for all primary care provider categories (primary care [adult total], OB/GYN, and pediatrician) and the assessed facility-level provider categories, indicating members had access to a provider within an adequate distance from their residence. **[Access]**

Strength #3: SilverSummit met the time-distance contract standards for eight of the nine specialty provider categories, indicating members had access to specialty providers within an adequate distance from their residence. **[Access]**

Strength #4: SilverSummit met the time-distance contract standards for four of the five behavioral health provider categories, indicating members had access to a provider within an adequate distance from their residence. **[Access]**

Weaknesses and Recommendations

Weakness #1: SilverSummit did not meet the time-distance contract standards for pediatric rheumatologists and pediatric psychologists, indicating child members may experience challenges accessing these provider types within an adequate distance from their residence.

Why the weakness exists: The lack of identified providers may result from either a lack of contracted pediatric specialty providers in those specialties or from an inability to identify those

pediatric specialists in the data. **SilverSummit**'s responses to the follow-up on prior EQR recommendations in Section 5 confirmed the lack of pediatric rheumatologists within its service area. Additionally, while **SilverSummit** increased the number of pediatric psychologists from five to eight, another MCO met network adequacy standards for pediatric psychologists, suggesting **SilverSummit**'s inability to meet the access standard for this provider type may not be due to a lack of available providers and other providers may be available to contract with.

Recommendation: HSAG recommends **SilverSummit** continue to conduct an in-depth review of provider categories in which it did not meet the time-distance contract standards with the goal of determining whether or not the failure of the MCO to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results

Table 3-34 presents **SilverSummit**'s 2021 adult Medicaid, general child Medicaid, and CCC Medicaid CAHPS top-box scores. Table 3-34 also includes **SilverSummit**'s 2021 Nevada Check Up general child and CCC top-box scores. Arrows (↓ or ↑) indicate 2021 scores that were at least 5 percentage points higher or lower than the 2020 national average.

Table 3-34—Summary of 2021 CAHPS Top-Box Scores for SilverSummit

	2021 Adult Medicaid	2021 General Child Medicaid	2021 CCC Medicaid Supplemental	2021 Nevada Check Up General Child	2021 Nevada Check Up CCC Supplemental
Composite Measures					
Getting Needed Care	75.9% ↓	NA	NA	NA	NA
Getting Care Quickly	77.7%	NA	NA	NA	NA
How Well Doctors Communicate	89.8%	NA	NA	NA	NA
Customer Service	88.4%	NA	NA	NA	NA
Global Ratings					
Rating of All Health Care	50.6% ↓	NA	NA	NA	NA
Rating of Personal Doctor	65.5%	NA	NA	NA	NA
Rating of Specialist Seen Most Often	67.4%	NA	NA	NA	NA
Rating of Health Plan	54.5% ↓	67.8%	NA	NA	NA
Effectiveness of Care*					
Advising Smokers and Tobacco Users to Quit	58.0% ↓				

	2021 Adult Medicaid	2021 General Child Medicaid	2021 CCC Medicaid Supplemental	2021 Nevada Check Up General Child	2021 Nevada Check Up CCC Supplemental
Discussing Cessation Medications	36.6% ↓				
Discussing Cessation Strategies	36.0% ↓				
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		NA
FCC: Getting Needed Information			NA		NA

A minimum of 100 responses is required for a measure to be reported as a CAHPS survey results. Measures that do not meet the minimum number of responses are denoted as *NA*.

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

↑ Indicates the 2021 score is at least 5 percentage points higher than the 2020 national average.

↓ Indicates the 2021 score is at least 5 percentage points lower than the 2020 national average.

Indicates that the measure does not apply to the population.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: HSAG did not identify any strengths for **SilverSummit** for the CAHPS surveys.

Weaknesses and Recommendations

Weakness #1: Adult members had less positive overall experiences getting the care they needed since the score for this measure was at least 5 percentage points lower than the 2020 NCQA Medicaid national average. **[Timeliness** and **Access]**

Why the weakness exists: Adult members are reporting a more negative experience getting the care they need, which could be due to the inability to obtain the care, tests, or treatments they need, as well as the inability to obtain an appointment with a specialist as soon as needed.

Recommendation: HSAG recommends **SilverSummit** conduct a root cause analysis or focused study to determine why its members are not getting the care they need. **SilverSummit** could consider if there are disparities within its populations that contribute to this lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause,

SilverSummit should implement appropriate interventions to improve the performance related to getting the care members need. Additionally, HSAG recommends **SilverSummit** determine if there is a shortage of specialists in the area or an unwillingness of the specialists to contract with the MCO.

Weakness #2: Adult members had less positive experiences with their overall healthcare since the score for this measure was at least 5 percentage points lower than the 2020 NCQA Medicaid national average. **[Quality, Timeliness** and **Access]**

Why the weakness exists: Adult members are reporting a more negative experience with their overall healthcare, which could be due to a perceived lack of ability to get the care they need.

Recommendation: HSAG recommends that **SilverSummit** focus on improving members' overall experiences with their healthcare by performing a root cause analysis, which could determine if there are any outliers within the data so that **SilverSummit** can identify the primary areas of focus and develop appropriate strategies to improve the performance.

Weakness #3: Adult members had less positive overall experiences with their health plan since the score for this measure was at least 5 percentage points lower than the 2020 NCQA Medicaid national average. **[Quality, Timeliness,** and **Access]**

Why the weakness exists: Adult members are reporting a more negative experience with their health plan, which could be due to a perceived lack of communication or satisfactory resolution of members' concerns.

Recommendation: HSAG recommends that **SilverSummit** focus on improving members' overall experiences with their health plan through continued initiatives such as improved prior authorization processes, promotion of urgent care and after-hours clinics, implementation of the member concierge program, provider education, and grievance analyses.

Weakness #4: The Effectiveness of Care scores were at least 5 percentage points lower than the 2020 NCQA Medicaid national averages. **[Quality]**

Why the weakness exists: SilverSummit's providers may not be advising members who smoke or use tobacco to quit and may not be discussing cessation medications and strategies with their adult members as much as other providers compared to national benchmarks.

Recommendation: HSAG recommends that **SilverSummit** focus on quality improvement initiatives to provide medical assistance with smoking and tobacco use cessation and continue to develop efforts to promote its Health Education & Wellness smoking cessation program.

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

To identify strengths and weaknesses and draw conclusions for **SilverSummit** about the quality, timeliness, and access to care for its members, HSAG analyzed and evaluated performance related to the provision of healthcare services by **SilverSummit** across all EQR activities to identify common themes within **SilverSummit** that impacted, or will have the likelihood to impact, member health outcomes. The overarching aggregated findings show that, while **SilverSummit** had an adequate network for

members to access providers for services, as determined through the NAV activity, and the processes, procedures, and monitoring efforts in place to continually evaluate the network for necessary network enhancements, as determined through the Compliance Review activity, adult and child members were not always accessing services timely to obtain the preventive and/or condition-specific care they needed to maintain optimal health; this was indicated through lower performing or declining HEDIS rates particularly in the Access to Care, Women's Health and Maternity Care, and Care for Chronic Conditions care domains, both in comparison to its own historical performance and the national Medicaid 50th percentile. **SilverSummit** should evaluate through a root cause analysis whether the significant decline in member experience related to getting needed care and rating of all healthcare, as indicated through CAHPS, demonstrates a potential concern with the quality, timeliness, and access to care being provided by **SilverSummit** contracted providers. Additionally, while specific efforts were initiated to improve member outcomes related to diabetes care and timeliness of prenatal care as demonstrated through the PIP activity, there was a slight decline in the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measure indicator rate, and a substantial decline in the *Comprehensive Diabetes Care—HbA1c Testing* HEDIS measure, indicating members were not having tests completed in order to show a controlled HbA1c. Additionally, **SilverSummit** demonstrated a slight decline in year-over-year performance in the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* HEDIS measure, indicating **SilverSummit** should evaluate whether its quality improvement initiatives were effective to support improvements in the PIP focus areas and put new interventions in place as necessary to promote better health outcomes for pregnant women and their babies and members with diabetes. **SilverSummit** performed above the national Medicaid 50th percentile and demonstrated significant improvements in several follow-up to ED visits and hospitalization-related care measures within the Behavioral Health domain, indicating **SilverSummit** had effective mechanisms in place to ensure members with behavioral health needs were able to access providers timely for follow-up services after behavioral health crises or diagnoses. **SilverSummit** also demonstrated generally stable performance in most Children's Preventive Care measures related to immunization compliance, but performed below the national Medicaid 50th percentile in all immunization combinations for its Medicaid population, while the immunization-related measures for the Nevada Check Up population were all above the national Medicaid 50th percentile, indicating Nevada CHIP members were getting immunized more frequently than the national average. **SilverSummit** should evaluate its strong performance in the Behavioral Health and Children's Preventive Care domains to determine if initiatives were implemented that supported the improved outcomes, and assess whether similar initiatives or interventions would be appropriate to support improvement in other care domains, such as the Access to Care and Care for Chronic Conditions domains. Additionally, although **SilverSummit** had opportunities to enhance performance related to care coordination, specifically its processes for managing members through the care management program as demonstrated through a compliance review score of 71 percent in the Coordination and Continuity of Care standard, care management staff members could leverage their experience working directly with members to better understand the barriers members may experience when accessing care, including whether there are challenges accessing certain provider types; whether there are delays to getting timely appointments; and/or whether the quality of providers and the care being received are not sufficient.

Of note, due to the COVID-19 pandemic during HEDIS MY 2020 and SFY 2021, many preventive services were negatively affected across the country as states followed orders to reduce the use of non-

emergent services in order to slow the spread of COVID-19. Additionally, due to fear of contracting the virus, members may have chosen to not access routine care, which may have impacted performance outcomes in SFY 2021.

4. Assessment of Prepaid Ambulatory Health Plan (PAHP) Performance

HSAG used findings across mandatory EQR activities conducted during the SFY 2021 review period to evaluate the performance of the PAHP on providing quality, timely, and accessible healthcare services to Nevada Managed Care Program members. Quality, as it pertains to EQR, means the degree to which the PAHPs increased the likelihood of members' desired outcomes through structural and operational characteristics; the provision of services that were consistent with current professional, evidenced-based knowledge; and interventions for performance improvement. Access relates to members' timely use of services to achieve optimal outcomes, as evidenced by how effective the PAHPs were at successfully demonstrating and reporting on outcomes for the availability and timeliness of services.

To identify significant strengths and weaknesses and draw conclusions for the PAHP, HSAG analyzed and evaluated each EQR activity and its resulting findings related to the provision of healthcare services across the Nevada Managed Care Program. The composite findings for the PAHP were analyzed and aggregated to identify overarching conclusions and focus areas for the PAHP in alignment with the priorities of DHCFP.

Objectives of External Quality Review Activities

This section of the report provides the objectives and a brief overview of each EQR activity conducted in SFY 2021 to provide context for the resulting findings of each EQR activity. For more details about each EQR activity's objectives and the comprehensive methodology, including the technical methods for data collection and analysis, refer to Appendix A.

Validation of Performance Improvement Projects

For SFY 2021, **LIBERTY** initiated two new DHCFP-mandated PIP topics, *Total of Eligible Enrollees Receiving a Sealant on a Permanent Molar Tooth* and *Total of Eligible Enrollees Who Received Preventive Dental Services*. For each of these topics, the PAHP defined a Global Aim and a specific, measurable, attainable, relevant, and timebound (SMART) Aim. The SMART Aim statement includes the narrowed population, the baseline percentage, a set goal for the project, and the project's end date.

Table 4-1 outlines the SMART Aim statement for each topic.

Table 4-1—PIP Topic and SMART Aim Statement

PIP Title	SMART Aim Statement
Total of Eligible Enrollees Receiving a Sealant on a Permanent Molar Tooth	By December 31, 2021, **LIBERTY**'s goal is to increase the percentage of sealant procedures completed among the identified population, living in zip code 89148, 89178, or 89052, who were at least 6 years old and under age 14 as of July 1, 2019 from the baseline rate of 22.03% to 27.03% by using key driver interventions.
Total of Eligible Enrollees Who Received Preventive Dental Services	By December 31, 2021, **LIBERTY**'s goal is to increase the overall percentage of preventive procedures completed among the identified population of enrollees aged 2 through 20 as of July 1st, 2019, who are assigned to [dental center 1*] and [dental center 2*], from the baseline rate of 39.5% to 49.5% by using key driver interventions.

* Provider names were redacted for privacy purposes.

Performance Measure Validation

The 2021 PMV activity included a comprehensive evaluation of the processes used by **LIBERTY** to collect and report data for two performance measures selected by DHCFP for **LIBERTY**'s Medicaid and Nevada Check Up populations. Table 4-2 lists the performance measures that HSAG validated and the measure specifications **LIBERTY** was required to use for calculating the performance measure results.

Table 4-2—Performance Measures for LIBERTY

Performance Measures	Measure Specifications
Annual Dental Visit (ADV)	HEDIS MY 2020
Percentage of Eligibles Who Received Preventive Dental Services (PDENT)	CMS Federal Fiscal Year (FFY) 2020 Child Core Set

Compliance Review

SFY 2021 commenced a new three-year cycle of compliance reviews. The review focused on standards identified in 42 CFR §438.358(b)(1)(iii) and applicable State contract requirements. The compliance reviews in Nevada consist of 14 standards or program areas. DHCFP requested that HSAG conduct a review of the first seven standards in Year One (SFY 2021), identified in Table 4-3, which lists the standards reviewed to determine compliance with State and federal standards. Table 4-3 also delineates the compliance review activities, and standards that will be reviewed, in Year Two and Year Three of the three-year cycle.

Table 4-3—Compliance Review Standards

	Year One (SFY 2021)	Year Two (SFY 2022)	Year Three (SFY 2023)
Standard	**Review of Standards**		**CAP Review**
Standard I—Disenrollment: Requirements and Limitations	✓		Review of Standards/Elements that received a *Not Met* score during the SFY 2021 and 2022 reviews.
Standard II—Member Rights and Member Information	✓		
Standard III—Emergency and Poststabilization Services	✓		
Standard IV—Availability of Services	✓		
Standard V—Assurances of Adequate Capacity and Services	✓		
Standard VI—Coordination and Continuity of Care	✓		
Standard VII—Coverage and Authorization of Services	✓		
Standard VIII—Provider Selection		✓	
Standard IX—Confidentiality		✓	
Standard X—Grievance and Appeal Systems		✓	
Standard XI—Subcontractual Relationships and Delegation		✓	
Standard XII—Practice Guidelines		✓	
Standard XIII—Health Information Systems		✓	
Standard XIV—Quality Assessment and Performance Improvement Program		✓	

Network Adequacy Validation

The NAV activity for SFY 2021 included network capacity and geographic distribution analyses conducted after the PAHP identified provider categories by using the provider crosswalk HSAG developed in conjunction with DHCFP. HSAG developed the provider crosswalks in collaboration with DCHFP in SFY 2019 to serve as a reference to ensure consistent classification of all ordering, referring, and servicing providers for the PAHP.

To assess the capacity of the PAHP's provider network, HSAG calculated the ratio of the number of providers by provider category (e.g., general dentists, endodontists) to the number of members. The provider ratio represents a summary statistic used to highlight the overall capacity of the PAHP's provider network to deliver services to Medicaid members. A larger number for providers for a given

number of members suggests greater network access since more providers are available to render services to individuals. Provider counts for this analysis were based on counts of distinct providers and not distinct provider locations.

Table 4-4 shows the provider categories used to assess the PAHP's compliance with the provider ratio standards in the PAHP contract with DHCFP.

Table 4-4—Provider Categories and Provider Ratio Standards

Provider Category	Provider to Member Ratio Standard
Dental Primary Care	1:1,500
Dental Specialists	1:1,500

The second dimension of the NAV activity evaluated the geographic distribution of providers relative to MCO or PAHP members. While the previously described provider capacity analysis identified the degree to which the PAHP's provider network infrastructure was sufficient in the number of providers across a variety of specialties, the geographic network distribution analysis evaluated whether the number of provider locations in the PAHP's provider network was appropriately distributed for the PAHP's Medicaid population.

To provide a comprehensive view of geographic access, HSAG calculated the following two spatially derived metrics for the provider categories identified in the provider crosswalks:

- Percentage of members within access standards listed in the PAHP contracts: A higher percentage of members meeting access standards indicates a better geographic distribution of PAHP providers relative to Medicaid members.
- Average travel distances (driving distances in miles) and travel times (driving times in minutes) to the nearest three providers: A shorter driving distance or travel time indicates greater accessibility to providers since members must travel fewer miles or minutes to access care.

Table 4-5 shows the provider categories used to assess the PAHP's network adequacy and the associated time-distance standards. Additional provider types outlined in the provider crosswalk were included in the provider ratio analyses and average travel time analyses.

Table 4-5—Provider Categories, Member Criteria, and Time-Distance Standards

Provider Category	Member Criteria	Time-Distance Access Standard
Dental Providers		
General Dentist	Adults	30 minutes or 20 miles
Pediatric Dentist	Children	30 minutes or 20 miles
Endodontist	Adults	30 minutes or 20 miles
Periodontist	Adults	30 minutes or 20 miles
Prosthodontist	Adults	30 minutes or 20 miles

Provider Category	Member Criteria	Time-Distance Access Standard
Oral Surgeon	Adults	30 minutes or 20 miles
Orthodontist	Adults	30 minutes or 20 miles
Dental Hygienist	Adults	30 minutes or 20 miles
Dental Therapist	Adults	30 minutes or 20 miles

Member Satisfaction Survey

In SFY 2021, the PAHP conducted a member satisfaction survey to assess members' experience with their dental appointments and dental providers. The questionnaire used for the survey was adapted from CAHPS. The survey was conducted by member services representatives through direct dial to members obtained through a sampling process. Any member dissatisfaction discovered through the survey was attempted to be resolved on the call and any unresolved dissatisfaction was forwarded to the PAHP's Grievance and Appeals department. The survey was conducted between June 2020 and May 2021. Table 4-6 displays the categories included in the survey, along with the PAHP's performance benchmarks.

Table 4-6—Member Experience Survey Categories and Benchmarks

Category	Benchmark
Appointment Availability	≥ 90%
Wait Time	≥ 90%
Appearance and Cleanliness	≥ 90%
Language Availability	≥ 90%
Staff Professionalism	≥ 90%
Amount of Time With Doctor	≥ 90%
Treatment Explanation	≥ 90%
Treatment	≥ 90%
Recommend Office	≥ 90%
Overall Satisfaction	≥ 90%
Overall Health of Teeth and Gums	None Identified

Encounter Data Validation

In SFY 2021, an EDV study was initiated by HSAG at the request of DHCFP, using three evaluation activities designed to evaluate the completeness and accuracy of DHCFP's encounter data. Together, the different activities for the specific MCOs provide a comprehensive assessment of DHCFP's encounter data submitted by the PAHP. The three activities include:

- IS review—assessment of DHCFP's and/or PAHP's IS and processes.

- Comparative analysis—analysis of DHCFP's electronic encounter data completeness and accuracy through a comparison between DHCFP's electronic encounter data and the data extracted from the PAHP's data systems.
- Dental records review—analysis of DHCFP's electronic encounter data completeness and accuracy through a comparison between DHCFP's electronic encounter data and the dental records. Of note, conducting a dental record review will be contingent upon whether the IS review and comparative analysis indicate that the completeness and accuracy of DHCFP's encounter data are sufficient.

The EDV study was ongoing at the time of this report; therefore, the results of the study will be presented in the SFY 2022 EQR technical report.

EQR Activity Results

LIBERTY Dental Plan of Nevada, Inc.

Validation of Performance Improvement Projects

Performance Results

Table 4-7 summarizes the PIP topics and the progress made in completing the four PIP modules.

Table 4-7—PIP Topics and Module Status

PIP Topic	Module	Status
Total of Eligible Enrollees Receiving a Sealant on a Permanent Molar Tooth	1. PIP Initiation	Completed and achieved all validation criteria.
	2. Intervention Determination	Completed and achieved all validation criteria.
	3. Intervention Testing	In progress. The Module submitted to date achieved all validation criteria. The PAHP will continue testing interventions until 12/31/2021 and submit Module 3 for validation at the initiation of each new intervention.
	4. PIP Conclusions	Submission targeted for 2022.
Total of Eligible Enrollees Who Received Preventive Dental Services	1. PIP Initiation	Completed and achieved all validation criteria.
	2. Intervention Determination	Completed and achieved all validation criteria.
	3. Intervention Testing	In progress. The Module submitted to date achieved all validation criteria. The PAHP will continue testing interventions until 12/31/2021 and submit Module 3 for validation at the initiation of each new intervention.
	4. PIP Conclusions	Submission targeted for 2022.

LIBERTY passed Module 1 (PIP Initiation), Module 2 (Intervention Determination), and the first Module 3 (Intervention Testing) submitted for each topic. **LIBERTY** is currently testing the first interventions and the results from the testing and validation findings for any additional Module submissions will be reported in the next annual EQR technical report.

Interventions

LIBERTY selected the first intervention to be tested for each topic. The intervention description, impact, and status are described in the tables below.

Table 4-8—Intervention for Total of Eligible Enrollees Receiving a Sealant on a Permanent Molar Tooth

Intervention #1	
Intervention Description	Educational Text Message Campaign to Targeted Members
Intervention Impact	The impact of the intervention is pending testing outcomes.
Intervention Status	The testing is in process and results will be available in the next annual EQR technical report.

Table 4-9—Intervention for Total of Eligible Enrollees Who Received Preventive Dental Services

Intervention #2	
Intervention Measure Title	Educational Text Message Campaign to Targeted Members
Intervention Impact	The impact of the intervention is pending testing outcomes.
Intervention Status	The testing is in process and results will be available in the next annual EQR technical report.

By achieving the desired goals for the PIPs, the PAHP will positively impact the timeliness and quality of care for its members.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: LIBERTY successfully completed the design and initiation of two new PIP topics and achieved all validation criteria. The SMART Aim measures for both new topics were found to be methodologically sound. **[Quality]**

Strength #2: LIBERTY used quality improvement tools to identify and prioritize opportunities for improvement within its current processes. These tools, and the results they produced, assisted the PAHP in selecting the first interventions to test using PDSA cycles. **[Quality]**

Strength #3: LIBERTY developed methodologically sound intervention effectiveness measures and tested interventions using PDSA cycles, which should support improvement in the prevalence of dental care. **[Quality, Timeliness,** and **Access]**

Weaknesses and Recommendations

Weakness #1: There were no substantial weaknesses identified through the completed PIP modules.

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

Recommendation: Although no substantial weaknesses were identified, as **LIBERTY** is currently in the process of testing its interventions, it should consider short testing periods that allow the PAHP to quickly gather data and make data-driven revisions to facilitate achievement of the SMART Aim goal.

Recommendation: LIBERTY should ensure it tests more than one intervention during the intervention testing phase of the PIP. This will help the PAHP address additional identified opportunities for improvement from the process map and FMEA and increase the likelihood of achieving the SMART Aim goal and desired outcomes for the project.

Performance Measure Validation

Performance Results

The 2019, 2020, and 2021 performance measure results for **LIBERTY**'s Medicaid and Nevada Check Up populations are presented in Table 4-10 and Table 4-11, along with year-to-year rate comparisons. The arrows (↑ or ↓) indicate whether the PMV 2021 rate was above or below the national Medicaid 50th percentile benchmark. Green and red shading is used to indicate a 5 percentage point performance improvement or performance decline from the prior year's performance, while **bolded** rates indicate the MPS was achieved. Please note that the arrows do not necessarily correlate to shading and bolded font.

Table 4-10—Medicaid Performance Measure Results for LIBERTY

Performance Measure	PMV 2019 Rate	PMV 2020 Rate	PMV 2021 Rate	PMV 2020–PMV 2021 Rate Comparison
Annual Dental Visit (ADV)				
Ages 2–3 Years	36.27%	37.49%	29.62%↓	-7.87
Ages 4–6 Years	53.43%	55.40%	45.75%↓	-9.65
Ages 7–10 Years	59.78%	62.06%	52.20%↓	-9.86
Ages 11–14 Years	55.21%	57.50%	48.06%↓	-9.44
Ages 15–18 Years	46.44%	48.83%	40.72%↓	-8.11

Performance Measure	PMV 2019 Rate	PMV 2020 Rate	PMV 2021 Rate	PMV 2020–PMV 2021 Rate Comparison
Ages 19–20 Years	30.98%	32.81%	26.65%↓	-6.16
Total (Ages 2–20 Years)	50.67%	52.79%	43.55%↓	-9.24
Percentage of Eligibles Who Received Preventive Dental Services (PDENT)*				
Total (Ages 1–20 Years)	39.76%	39.30%	34.07%	-5.23

↓ Indicates the 2021 rate was below NCQA's Quality Compass HEDIS 2020 Medicaid HMO 50th percentile benchmark.
↑ Indicates the 2021 rate was above NCQA's Quality Compass HEDIS 2020 Medicaid HMO 50th percentile benchmark.
* The PDENT measure is a CMS Child Core Set measure; therefore, performance was not assessed against the NCQA Quality Compass benchmark.

Indicates that the 2021 rate declined by 5 percentage points or more from 2020.

Indicates that the 2021 rate improved by 5 percentage points or more from 2020.

Table 4-11—Nevada Check Up Performance Measure Results for LIBERTY

Performance Measure	PMV 2019 Rate	PMV 2020 Rate	PMV 2021 Rate	PMV 2020–PMV 2021 Rate Comparison
Annual Dental Visit (ADV)				
Ages 2–3 Years	46.96%	49.65%	39.37%↓	-10.28
Ages 4–6 Years	68.23%	70.04%	57.17%↓	-12.87
Ages 7–10 Years	73.60%	77.04%	65.83%↓	-11.21
Ages 11–14 Years	69.44%	72.05%	61.16%↓	-10.89
Ages 15–18 Years	59.33%	62.32%	51.52%↓	-10.80
Ages 19–20 Years	43.35%	51.55%	38.36%↓	-13.19
Total (Ages 2–20 Years)	66.33%	69.42%	57.97%↓	-11.45
Percentage of Eligibles Who Received Preventive Dental Services (PDENT)*				
Total (Ages 1–20 Years)	54.01%	56.69%	50.92%	-5.77

↓ Indicates the 2021 rate was below NCQA's Quality Compass HEDIS 2020 Medicaid HMO 50th percentile benchmark.
↑ Indicates the 2021 rate was above NCQA's Quality Compass HEDIS 2020 Medicaid HMO 50th percentile benchmark.
*The PDENT measure is a CMS Child Core Set measure; therefore, performance was not assessed against the NCQA Quality Compass benchmark.

Indicates that the 2021 rate declined by 5 percentage points or more from 2020.

Indicates that the 2021 rate improved by 5 percentage points or more from 2020.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: No strengths were identified.

Weaknesses and Recommendations

Weakness #1: LIBERTY's Medicaid and Nevada Check Up performance declined for both required measures by more than 5 percentage points from the prior year, indicating members were not receiving preventive dental services, which may lead to overall health issues as dental diseases can have a negative effect on quality of life in childhood and in older age. **[Quality, Timeliness,** and **Access]**

Why the weakness exists: Performance declines for the dental measures likely coincided with the rapid increase of COVID-19 cases in 2020. Factors that may have contributed to the declines during this time include screening site closures and the temporary reduction of non-emergent services. The requirement or recommendation to stay at home and the fear of contracting COVID-19 also likely deterred individuals from seeking healthcare services, including preventive dental services.

Recommendation: HSAG recommends **LIBERTY** conduct a root cause analysis or focused study to determine why its members are not receiving preventive dental screenings. **LIBERTY** could consider if there are disparities within its populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, **LIBERTY** should implement appropriate interventions to improve the performance related to preventive dental services.

Compliance Review

Performance Results

The SFY 2021 Compliance Review activity demonstrated how successful **LIBERTY** was at interpreting specific standards under 42 CFR Part 438—Managed Care and the associated requirements under its managed care contract with DHCFP.

Table 4-12 presents **LIBERTY**'s scores for each standard evaluated in the SFY 2021 compliance review. Each element within a standard was scored as *Met* or *Not Met* based on evidence found in **LIBERTY**'s written documents, including policies, procedures, reports, and meeting minutes; and interviews with MCO staff members.

Table 4-12—Summary of Standard Compliance Scores for LIBERTY

Compliance Monitoring Standard		Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	*NM*	*NA*	
I	Disenrollment: Requirements and Limitations	5	5	5	0	0	**100%**
II	Member Rights and Member Information	18	18	17	1	0	**94%**
III	Emergency and Poststabilization Services	10	10	10	0	0	**100%**
IV	Availability of Services	7	7	7	0	0	**100%**
V	Assurances of Adequate Capacity and Services	4	4	4	0	0	**100%**
VI	Coordination and Continuity of Care	11	11	8	3	0	**73%**
VII	Coverage and Authorization of Services	15	15	12	3	0	**80%**
	Total	**70**	**70**	**63**	**7**	**0**	**90%**

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

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

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

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

Strengths, Weaknesses, and Recommendations

Strengths

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

Strength #2: LIBERTY achieved full compliance in the Emergency and Postabilization Services program area, demonstrating the PAHP had sufficient processes in place to ensure members' access to, the coverage of, and payment for emergency and poststabilization care services. **[Access]**

Strength #3: LIBERTY achieved full compliance in the Availability of Services and Assurances of Adequate Capacity and Services program areas, demonstrating the PAHP maintained and monitored its provider network was sufficient to provide timely and adequate access to dental services for enrolled members. **[Access and Timeliness]**

Weaknesses and Recommendations

Weakness #1: LIBERTY received a score of 73 percent in the Coordination and Continuity of Care program area, indicating members may experience barriers to accessing needed dental services and/or receiving necessary dental services timely. **[Timeliness and Access]**

Why the weakness exists: LIBERTY did not consistently conduct timely outreach to members to complete the initial oral health screen and lacked standardized processes to complete comprehensive assessments and develop individualized care plans for members identified as having special health care needs.

Recommendation: In addition to developing a corrective action plan to mitigated the deficiencies related to its coordination of care and care management processes, **LIBERTY** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to coordination of care and care management processes. Implementation of these efforts should support improved member outcomes.

Weakness #2: LIBERTY received a score of 80 percent in the Coverage and Authorization of Services program area, indicating opportunities for improvement related to the PAHP's prior authorization decision time frames and the notices of adverse benefit determination sent to members. **[Quality** and **Timeliness]**

Why the weakness exists: LIBERTY did not have an adequate process related to the extension of authorization time frames and the notices of adverse benefit determination did not contain all required content.

Recommendation: In addition to developing a corrective action plan to mitigate the gaps within its coverage and authorization of services processes, **LIBERTY** should continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to coverage and authorization of services.

Network Adequacy Validation

Performance Results

Table 4-13 presents **LIBERTY**'s provider ratio analysis results compared to the provider ratio standards. For the provider categories assessed according to the standards in Table 4-4, the percentage of members with access to the provider within the time-distance standard is shown in red if they did not comply with the standard. The time-distance results are displayed in Table 4-14.

Table 4-13—Summary of Ratio Analysis Results for Dental Care Providers for LIBERTY

Provider Category	LIBERTY	
	Providers	Ratio
Dental Primary Care Providers (1:1,500)	413	1:1,399
Dental Specialists Providers (1:1,500)	22	1:26,261

Table 4-14—Percentage of Members Residing Within the Access Standard Areas for LIBERTY

Provider Category	Time-Distance Standard	LIBERTY
General Dental Providers		
General Dentists	20 miles/30 mins	99.9%
Pediatric Dentists	20 miles/30 mins	99.9%
Specialty Dental Providers		
Endodontists	20 miles/30 mins	98.6%
Periodontists	20 miles/30 mins	86.9%
Prosthodontists	20 miles/30 mins	86.9%
Oral Surgeons	20 miles/30 mins	99.8%
Orthodontists	20 miles/30 mins	NA

NA indicates that the PAHP did not report providers in the provider category.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: LIBERTY met the overall provider ratio requirements for dental primary care providers, indicating **LIBERTY** has an adequate network of dentists to provide dental services to its members. **[Access]**

Strength #2: LIBERTY met the time-distance contract standards for all general dentists, pediatric dentists, endodontists, and oral surgeons, indicating members were able to access these dental provider types within an adequate distance from their residence. **[Access]**

Weaknesses and Recommendations

Weakness #1: LIBERTY did not meet the provider ratio requirements for dental specialists providers, indicating members may have challenges accessing specialty dental care. **[Access]**

Why the weakness exists: LIBERTY only contracts with 22 dental specialists. The lack of identified dental specialists may result from either a lack of contracted dental specialists or from an inability to identify those dental specialists in the data, due to data mapping and/or data submission issues. **LIBERTY**'s responses to the follow-up on prior EQR recommendations in Section 6 indicated that, upon an analysis of specialists, it was concluded that there was a gap in periodontics. Review of the active state provider file listed eight periodontists with Medicaid IDs. Of those not contracted, outreach was made to have providers become in network. Due to fee schedules and member demographics, the providers declined to join **LIBERTY**'s network. **LIBERTY** also suggested that there are a limited number of periodontists in Clark and Washoe counties with Medicaid IDs.

Recommendation: LIBERTY should continue to conduct an in-depth review of the dental specialist categories, with the goal of determining whether or not the failure of the PAHP to meet the contract standards was the result of a lack of available providers or an inability to contract providers in the geographic area.

Weakness #2: LIBERTY did not meet the time-distance contract standards for periodontists and prosthodontists, indicating members were unable to access these provider types within an adequate distance from their residence. **[Access]**

Why the weakness exists: The lack of identified dental providers may result from either a lack of contracted specialty dental providers or from an inability to identify those dental specialists in the data, due to data mapping and/or data submission issues. **LIBERTY**'s responses to the follow-up on prior EQR recommendations in Section 6 indicated that, upon an analysis of specialists, it was concluded that there was a gap in periodontics. Review of the active state provider file listed eight periodontists with Medicaid IDs. Of those not contracted, outreach was made to have providers become in network. Due to fees and member demographics, the providers declined to join **LIBERTY**'s network. **LIBERTY** also suggested that there are a limited number of periodontists in Clark and Washoe counties with Medicaid IDs.

Recommendation: LIBERTY should conduct an in-depth review of dental specialist categories in which **LIBERTY** did not meet the time-distance contract standards, with the goal of determining whether or not the failure of the PAHP to meet the contract standard(s) was the result of a lack of available providers or an inability to contract providers in the geographic area.

Member Satisfaction Survey

Performance Results

The SFY 2021 Member Satisfaction Survey included outreach attempts to 7,869 members with 391 members being successfully reached (4.9 percent success rate). The benchmark of 90 percent was achieved, as indicated by green shading, with an overall satisfaction for the members surveyed resulting in a 95 percent overall satisfaction rate.

Table 4-15 and Table 4-16 present **LIBERTY**'s SFY 2021 survey results as provided by **LIBERTY** to DHCFP.

Table 4-15—Member Satisfaction Survey Results for LIBERTY—Metrics

Metric	June 2020–May 2021	Benchmark
# Members Reached	391	
# Members Satisfied	363	
% Members Satisfied	92.8%	≥ 90%

Table 4-16—Member Satisfaction Survey Results for LIBERTY—Category

Category	June 2020–May 2021	Benchmark
Appointment Availability	97.0%	≥ 90%
Wait Time	97.8%	≥ 90%
Appearance and Cleanliness	98.7%	≥ 90%
Language Availability	100%	≥ 90%
Staff Professionalism	97.9%	≥ 90%
Amount of Time With Doctor	97.3%	≥ 90%
Treatment Explanation	96.4%	≥ 90%
Treatment	97.7%	≥ 90%
Recommend Office	91.3%	≥ 90%
Overall Satisfaction	95.0%	≥ 90%
Overall Health of Teeth and Gums	93.4%	

Indicates a benchmark was not applicable or was not established.

Indicates the category met or exceeded the benchmark.

Strengths, Weaknesses, and Recommendations

Strengths

Strength #1: LIBERTY exceeded the 90 percent benchmark in each of the 10 applicable categories, indicating that, overall, members surveyed had good experiences and were satisfied with their dental providers and the dental offices. **[Quality, Access,** and **Timeliness]**

Weaknesses and Recommendations

Weakness #1: Although **LIBERTY** attempted outreach to 7,869 members, only 4.9 percent of those members were successfully reached (391 members), which indicates a low percentage of members provided feedback about their dental experiences and their dental providers/offices and satisfaction results may not be reflective of the entire membership. **[Quality, Access,** and **Timeliness]**

Why the weakness exists: LIBERTY was using "robocalls" but recently transitioned to live outbound calls. Members may not be answering the calls due to being an unknown call number.

Recommendation: LIBERTY indicated it was considering text messaging as an option for outreaching to members. HSAG recommends **LIBERTY** proceed with this initiative to increase the rate of members completing the surveys. **LIBERTY** could also consider member incentives to complete the Member Satisfaction Survey activity.

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

To identify strengths and weaknesses and draw conclusions for **LIBERTY** about the quality, timeliness, and access to care for its members, HSAG analyzed and evaluated performance related to the provision of healthcare services by **LIBERTY** across all EQR activities to identify common themes within **LIBERTY** that impacted, or will have the likelihood to impact, member health outcomes. The overarching aggregated findings show that **LIBERTY** received 100 percent compliance scores in the areas of Availability of Services and Assurances of Adequate Capacity and Services during the Compliance Review activity, and high satisfaction rates, as indicated through the Member Satisfaction Survey specific to appointment availability. However, **LIBERTY** did not have an adequate network for members to access specialty dentists for services, as determined through the NAV activity, and adult and child members were not always accessing dental providers to obtain the preventive dental care they needed to maintain optimal dental health, as indicated through low performing rates in the *Annual Dental Visit* HEDIS measure, both in comparison to its own historical performance and national benchmarks, as well as low performance in the *Percentage of Eligibles Who Received Preventive Dental Services* CMS Child Core Set measure. While **LIBERTY** demonstrated satisfaction with the quality of care provided by **LIBERTY** dental providers, as indicated through a small sample of members completing the Member Experience Survey, **LIBERTY** exhibited an opportunity to improve the quality of services provided to proactively identify and assess members with special health care needs who may benefit from care management, as suggested through a Compliance Review score of 73 percent in the Coordination and Continuity of Care standard. **LIBERTY** could improve its care management program through standardized processes to complete comprehensive assessments and develop individualized care plans for members and use those processes to collaborate with its members to better understand the barriers members may experience when accessing care, including whether there are challenges accessing certain dental specialists or dental offices; whether there are delays to getting timely appointments; and/or whether the quality of providers and the care being received are not sufficient. Additionally, as **LIBERTY** initiated two new PIPs in SFY 2021, *Total of Eligible Enrollees Receiving a Sealant on a Permanent Molar Tooth* and *Total of Eligible Enrollees Who Received Preventive Dental Services*, **LIBERTY** should continually evaluate the interventions implemented as part of these PIPs and quickly make revisions to those initiatives, as necessary, to support timely improvement in the prevalence of members obtaining preventive care.

Of note, due to the COVID-19 pandemic during HEDIS MY 2020 and SFY 2021, many preventive services, including dental services, were negatively affected across the country as states followed orders to reduce the use of non-emergent services in order to slow the spread of COVID-19. Additionally, due to fear of contracting the virus, members may have chosen to not access preventative and routine care, which may have impacted performance outcomes in SFY 2021.

5. Follow-Up on Prior EQR Recommendations for MCOs

From the findings of each MCO's performance for the SFY 2020 EQR activities, HSAG made recommendations for improving the quality of healthcare services furnished to members enrolled in the Nevada Managed Care Program. The recommendations provided to each MCO for the EQR activities in the *State Fiscal Year 2019–2020 External Quality Review Technical Report* are summarized in Table 5-1, Table 5-2, and Table 5-3. The MCO's summary of the activities that were implemented to support performance improvement are also provided in Table 5-1, Table 5-2, and Table 5-3.

Anthem Blue Cross and Blue Shield Healthcare Solutions

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

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG recommended the following: • As **Anthem** determines interventions to test, the MCO should consider the end date specified in the SMART Aim statement and work backward when planning intervention testing. Careful planning is critical to allow enough time to test and refine interventions that will result in meaningful and sustained improvement. When determining interventions to test, **Anthem** should revisit the third fundamental question of the Model for Improvement, "What changes can we make that will result in improvement?" and ensure interventions tested have the potential to positively impact the quality of, timeliness of, and access to care for its members.
MCE's Response ***(Note—The narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Anthem reviewed its SMART Aim data for performance improvement projects and consulted internally with the data analyst team and made revisions. The revised SMART Aim goals were reviewed by the data analyst and statistics team to ensure the goals set from the baseline data were statistically significant so the plan would know that the results obtained are meaningful and supported sustained improvement. The PIP Team will regularly utilize statistical significance when setting SMART Aim goals in all current and future performance improvement projects where applicable.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Setting SMART Aim goals using statistically significant goals allows for the plan to monitor and measure outcomes and their ability to impact intervention effectiveness. Currently aggregating data for the 2019-2021 PIPs for achievement to SMART Aim goal and if statistical significance was achieved. Performance data will be reviewed for increase in performance and summarized in Module 4 which is due October 15, 2021.
c. Identify any barriers to implementing initiatives: • The statistical significance has been approved for all RCI [rapid cycle improvement] PIPs; however, for the initial goal that was set, the analyst utilized an 87.5% confidence level and was later revised

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
using a 95% confidence interval. The data analyst team will continue using the 95% confidence interval in all future goal setting for statistical significance.
HSAG Assessment: HSAG has determined that **Anthem** addressed the prior recommendations.

2. Prior Year Recommendation from the EQR Technical Report for Validation of Performance Measures–NCQA HEDIS Compliance Audit (Medicaid):

HSAG recommended the following:

- **Anthem** should conduct a root cause analysis or focused study to determine why its members are not getting all recommended immunizations as suggested by national organizations, such as the CDC [Centers for Disease Control and Prevention]. Upon identification of a root cause, **Anthem** should implement appropriate interventions to improve the performance related to Children's Preventive Care measures.
- **Anthem** should conduct a root cause analysis or focused study to determine why its women members are not getting preventive screenings for breast cancer. **Anthem** could consider if there are disparities within its populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, **Anthem** should implement appropriate interventions to improve the performance related to Women's Health and Maternity Care.
- **Anthem** should continue its *Comprehensive Diabetes Care HbA1c Poor Control > 9.0%* PIP and proceed with the development and implementation of interventions to address declining diabetes outcomes. Additionally, **Anthem** should evaluate whether lessons learned from this PIP identify the possible cause or causes attributing to the sharp decline in the *Blood Pressure Control (<140/90 mm Hg)* rate. At a minimum, **Anthem** should investigate factors that impact blood pressure control among this population.
- Performance measures in the Behavioral Health domain generally exhibited an increase in rates with this exception of the *ADD* [*Follow-Up Care for Children Prescribed ADHD Medication*] measure. **Anthem** should review numerator negative cases to identify the reason for the decline in the *ADD* measure rates and implement an intervention to improve performance.

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

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

- 1.The CHIP HEDIS measure is hybrid in that the data is pulled administratively as well as through medical record review. The 2020 denominator is based on the number of members registered in the plan who fall within the parameters of the measure. The numerator consists of both administrative and medical record review.

  Anthem completed a root cause analysis of the previous data and found the following:

  The largest population served by Medicaid in Nevada are those in the Hispanic population

  The largest compliant group for Combo 3 and well child visits (WCV) were the Hispanic population
  The Asian population were the most compliant for Combo 10
  There are 26 fewer members in the denominator between 2019 and 2020; members may have unenrolled or no longer eligible for services.

2. Prior Year Recommendation from the EQR Technical Report for Validation of Performance Measures–NCQA HEDIS Compliance Audit (Medicaid):

The number of individuals in the numerator represents the number of members the HEDIS team were able to confirm in receipt of the required vaccinations either through claims data, WEBIZ [Nevada Statewide Immunization Information System] or medical record documentation.

The fall in the number of members immunized for Combo 2 fell by 3.45%, Combo 3 by 4.69% and Combo 10 by 5.35%.

As the state was in full lock down with limited access to services for most of 2020, the fall in the number of children immunized was wholly expected. Many pediatric, general and internal medicine offices were limited to emergent care for the duration of 2020.

The largest population served by Medicaid in Nevada are those in the Hispanic population. The largest compliant group for Combo 3 and well child visits (WCV) were the Hispanic population. The Asian population were the most compliant for Combo 10.

- 2.Anthem formed a work group consisting of leadership in the Anthem HCMS [internal department]to complete the analysis. The work group conducted a Root Cause Analysis focused on female members and breast cancer screening.

  HEDIS data was utilized to focus on members with a gap in care for breast cancer screening. It was found that African American females were not receiving or completing breast cancer screenings as frequently as other women in similar age cohorts of other ethnicities.

  The data was drilled down further to determine the communities most affected by zip code. It was found that large numbers without screening resided in or immediately adjacent to the 89106 zip code. The zip code also houses the largest number of women with mammogram deficiencies, and women 39-40 years; a population shown to have the most significant prevalence of newly diagnosed breast cancer cases.

  The African American population was chosen to drive early testing within suggested time periods. Early intervention may mitigate the effect of more aggressive types of breast cancer which are often diagnosed at later stages in the disease process.

  Anthem is holding the first "Mammo-palooza", the event will be attended by the Anthem Medical Director as well as the Director of Health Care Services among others. Anthem Associates will speak with members and provide education regarding breast cancer, the importance of preventative screenings, and dispel inaccurate information or beliefs about mammograms and breast cancer in general.

  The event will include onsite mammograms and a DJ [disc jockey] and is scheduled to be held at a Senior Center within the 89106 zip code.

- 3. The observed population in the [*Comprehensive Diabetes Care*] CDC diabetes cohort is the same population in the CDC Blood Pressure measure.

  The A1c [hemoglobin A1c (HbA1c) test for diabetes] measure in 2020 fell by 3.16% year over year ending at 47.45%, which we believe is a correlation to the COVID pandemic.

  A deep dive of the data was completed with the largest noncompliant populations by zip code reviewed.

  For the HbA1c, the areas most affected reside in Washoe county where travel to a provider may be hindered by the remote nature of the area.

2. Prior Year Recommendation from the EQR Technical Report for Validation of Performance Measures–NCQA HEDIS Compliance Audit (Medicaid):
Completion of this measure requires a blood draw with presumably, an office visit to obtain laboratory orders. During the pandemic in 2020, Nevada had a shelter in place issued by state governance. As an already remote area, the members residing in Washoe would have been unable to obtain appointments as physician offices were closed to all but emergent care for much of the year. As the pandemic has broadened with the spread of the Delta variant, interventions are on hold until a time where Anthem is able to complete outreach activities to include clinic days and health festivals. Individuals may have been educated in the use of an automated blood pressure cuff, visited a kiosk where blood pressure readings are recorded or completed a virtual visit which would all serve to improve this measure. Comparing the two populations by measure and zip code, very little correlation exists between the two groups. Individuals in the rural areas are less likely to be compliant with a measure which requires more than one visit. This includes the HbA1c measure. The largest blood pressure non-compliance rates fall into areas of high concentration of members as well as high poverty. A further drill down shows the African American and American Indian populations represent 61.6% and 63.4% of members in the HbA1c measure. For the Blood Pressure measure, Hispanics and Hawaiian or Pacific Islander are the most affected at 20.7% and 20.2%.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • 1.There are 26 fewer members in the denominator between 2019 and 2020; members may have unenrolled or no longer eligible for services. The number of individuals in the numerator represents the number of members the HEDIS team were able to confirm in receipt of the required vaccinations either through claims data, WEBIZ or medical record documentation. The fall in the number of members immunized for Combo 2 fell by 3.45%, Combo 3 by 4.69% and Combo 10 by 5.35%. • 2.Improvements will be continued to be tracked but expectation is that we will see in increase in Breast Cancer Screening after the event. • 3.The data shows a marked improvement year over year for the blood pressure measure ending 2020 with a rate of 50.12%.
c. Identify any barriers to implementing initiatives: • COVID hesitancy • Hesitancy of general public attending large gatherings • Hesitancy of general public to visit medical facilities for care • As the state was in full lock down with limited access to services for most of 2020, the fall in the number of children immunized was wholly expected. Many pediatric, general and internal medicine offices were limited to emergent care for the duration of 2020.

2. Prior Year Recommendation from the EQR Technical Report for Validation of Performance Measures–NCQA HEDIS Compliance Audit (Medicaid):

HSAG Assessment: HSAG has determined that **Anthem** addressed the prior recommendations; however, the MCO should continue to prioritize low areas of performance through implemented interventions aimed at reducing all noted barriers.

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

HSAG recommended the following:

- **Anthem** should enhance oversight of its IQAP [internal quality assurance program] through quarterly Board of Directors and Quality Management Committee meetings. Further, **Anthem** should solicit input from the Board of Directors and the Quality Management Committee on the selection and implementation of three additional PIPs required to meet contract provisions. These PIPs should be added to **Anthem**'s IQAP program description and workplan.

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

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

- In 2021 Anthem enhanced our Quality Management Committee meeting structure. This committee will focus on clinical quality and service quality. This committee will be compromised of the functional leaders from many departments that either has direct accountability or shared accountability to many Quality Improvement initiatives and metrics. The Quality Management Committee will now have four subcommittees which include the clinical services committee, service quality committee, consumer advisory committee, and the medical advisory committee. These committees will be responsible for reviewing data, forming workgroups to analyze data and conduct Root Cause analysis, formulate interventions, and report back to the committees with recommendations for improvement after discussing root causes and barriers. This committee will report up to the Board of Directors. The Quality Management Committee is chaired by the Quality Management Director and has executive sponsorship of the Plan President and Medical Director. All meetings are to occur 4 times a year, and will have additional meetings, as warranted. Tracking of the PIPs has been added to the Annual Reporting Scheduler to occur at the applicable committees, dependent on the focus of the PIP. Additionally, there will be at least a quarterly update provided on each PIP and has been added to Anthem's IQAP Work Plan. In 2022, a section will be added to the 2022 Anthem Medicaid Quality Management Program Description, that will outline the focus of the PIP, the Measure(s) of Success, Planned or ongoing interventions, and timeframes for each of the PIPs. This will be a high-level overview and will direct the reviewer to the PIP itself for specific additional information.
- We will continue the existing annual Board of Directors meeting to ensure IQAP discussion and ensure that any recommended actions are clearly documented in the minutes. Anthem will initiate an additional written report to the Board of Directors related to any IQAP actions taken and improvements made and include a request for review of those materials by the Board. Thus, engagement of the Board will shift to twice yearly (once through the annual meeting and one additional written report) in 2021. In the event of review findings and related concerns regarding the quality process, those findings and concerns shall be considered by the Board to determine what actions, or modifications to documents, if any, are appropriate to address the review findings. Board input and any resulting actions or improvements will be clearly documented by Quality Management. Note that two of four members of

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review:
the Board are also active participants in Anthem's local Nevada Quality Management Committee which provides oversight of the IQAP.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The addition of the committees within the QM [quality management] structure is slated to occur in Q3 2021. Anthem will continue to refine the committees and associated documents to meet the recommendations listed above.
c. Identify any barriers to implementing initiatives: • None
HSAG Assessment: HSAG has determined that **Anthem** has addressed the prior recommendations.

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation:
HSAG recommended the following: • **Anthem** should review its provider data and contracted provider list to identify if the inability to identify providers in the data is a result of a lack of contracted providers or if the providers are not appropriately identified in the data due to data mapping and/or submission issues. If a lack of contracted providers is identified, HSAG recommends **Anthem** determine if the lack of contracted providers is due to a shortage of providers in the area or an unwillingness of the providers to contract with the MCO. • **Anthem** should conduct an in-depth review of provider categories in which it did not meet either the time-distance contract standards, with the goal of determining whether or not the failure of the MCO to meet the contract standard(s) was the result of a lack of providers or an inability to contract providers in the geographic area.
MCE's Response ***(Note—The narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • After review of last year's recommendations, Anthem continues to meet the parameters set by the State. Currently we receive a Monthly Active Provider Report from DHCFP that Anthem reviews and initiates contact with provider for contracting purposes when appropriate or applicable. We continue to monitor our data sources in efforts to reduce results that could potentially underrepresent data as it relates to our network adequacy. Anthem also works to ensure that if access is limited, we coordinate care of our members' needs so that they are met timely.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Anthem has improved on all measures for most practitioner types year over year which can be seen in our data.
c. Identify any barriers to implementing initiatives: • The lack of availability of providers in the region limits the ability of Anthem to recruit additional physicians into the network.

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation:
HSAG Assessment: HSAG has determined that **Anthem** has addressed the prior recommendations; however, since similar findings were noted in SFY 2021, **Anthem** should continue its efforts to contract with any new providers in the region as they become available.

5. Prior Year Recommendation from the EQR Technical Report for CAHPS Analysis:
HSAG recommended the following: • **Anthem** should 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** may need to consider adding other data collection survey modes, such as telephone follow-up and/or the Internet, for the CAHPS surveys to increase response rates. HSAG also recommends **Anthem** continue texting and emailing member reminders and determine if there are other initiatives that could be implemented to increase member response rates. • **Anthem** should focus on improving members' overall experiences with their health plan, personal doctor, and healthcare and on quality improvement initiatives to provide medical assistance with smoking and tobacco use cessation. HSAG recommends that **Anthem** prioritize two of its lowest performing measures and determine a root cause for the lower performance. As part of this analysis, **Anthem** could determine if any outliers were identified within the data, identify primary areas of focus, and develop appropriate strategies to improve the performance. **Anthem** should also continue its current initiatives, such as its partnership with National Jewish Health for smoking cessation efforts and provider training on how providers can help improve member experience.
MCE's Response ***(Note—The narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Anthem has worked closely with our vendor and has worked extensively with all Medicaid markets to ensure that a sufficient number of completed surveys are collected. Anthem does significantly oversample for both the Adult (80% oversample) and Child (145%) surveys and augment in up to an additional 1,600 S-CHIP members. For Measurement Year 2021, Anthem has taken the following actions: – All materials are being sent in English and Spanish, a change from sending duplexed letters with English only surveys – Increased levels of oversampling and augmenting to reach the targeted number of completed surveys. – Mixed methodology using letters mailed with surveys, mailed reminder postcards, and phone follow ups are continuing, in an effort to increase number of returned surveys. One major barrier that Anthem has encountered is that NCQA is not yet allowing CAHPS surveys to be conducted electronically for Medicaid plans. • Anthem has conducted analysis of the CAHPS data through workgroups and targeted studies. The current initiative with the National Jewish Health partnership for smoking cessation efforts will continue and efforts to evaluate the effects of the intervention will also continue. Anthem has identified

5. Prior Year Recommendation from the EQR Technical Report for CAHPS Analysis:
that Flu Vaccinations for Adults Ages 18-64 is low at 31.47%. We have determined that there is a wide variety of issues contributing to the lower vaccination rates including: – Vaccine hesitancy – Ineffective understanding of vaccines and side effects – Decreased understanding of vaccine administration timing • As a part of Anthem's Clinical Initiatives, the plan will utilize Health Crowd to deliver targeted messaging in regard to Flu Shots, Availability of Flu Shots, and Reminders to get vaccinated. Anthem will continue to monitor member's overall experiences with the plan, personal doctor, and healthcare in order to develop innovative interventions and execute on these interventions to increase satisfaction.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Anthem is continuing to work with our vendor to ensure an adequate sample is returned for the CAHPS survey. Interventions will continue to occur in a best effort to get to the identified 411 returned survey count. • Anthem will continue to evaluate the Flu Vaccine numbers and monitor compliance via HEDIS workgroups. Rates will be discussed, and additional interventions will be implements if improvement is not noted year over year (YOY).
c. Identify any barriers to implementing initiatives: • One major barrier that Anthem has encountered is that NCQA is not yet allowing CAHPS surveys to be conducted electronically for Medicaid plans. • Public hesitancy in receiving vaccinations due to inaccurate information about vaccine efficacy and purpose.
HSAG Assessment: HSAG has determined that **Anthem** has addressed the prior recommendations; however, the MCO should continue to think "outside of the box" to determine initiatives to increase response rates.

Health Plan of Nevada

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

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG recommended the following: • As **HPN** determines interventions to test, the MCO should consider the end date specified in the SMART Aim statement and work backward when planning intervention testing. Careful planning is critical to allow enough time to test and refine interventions that will result in meaningful and sustained improvement. When determining interventions to test, **HPN** should revisit the third fundamental question of the Model for Improvement, "What changes can we make that will result in improvement?" and ensure interventions tested have the potential to positively impact the quality of, timeliness of, and access to care for its members.
MCE's Response ***(Note—The narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented and any activities still underway to address the finding that resulted in the recommendation)***: • Health Plan of Nevada (HPN) has made significant efforts to review the end date specified in the SMART Aim statement and develop interventions that address the third tenant of the Model for Improvement. HPNs intervention to mail A1c [blood sugar level testing] kits to the member's home was crafted with the goal to reduce the structural barriers such as transportation and provider access.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • No notable performance improvements have resulted.
c. Identify any barriers to implementing initiatives: • Members did not return the kits as expected.
HSAG Assessment: HSAG has determined that **HPN** has addressed the prior recommendations; however, the MCO should continue to implement interventions aimed at improving member outcomes.

2. Prior Year Recommendation from the EQR Technical Report for Validation of Performance Measures–NCQA HEDIS Compliance Audit (Medicaid):
HSAG recommended the following: • **HPN** should conduct a root cause analysis or focused study to determine why its members are not accessing their [primary care physician] PCPs on a routine basis. Upon identification of a root cause, **HPN** should implement appropriate interventions to improve the performance related to Access to Care measures. • **HPN** should conduct a root cause analysis or focused study to determine why its members are not getting all recommended preventive care services as suggested by national organizations, such as the CDC. Upon identification of a root cause, **HPN** should implement appropriate interventions to improve the performance related to Children's Preventive Care measures. • **HPN** should conduct a root cause analysis or focused study to determine why its women members are not getting preventive screenings for breast cancer. **HPN** could consider if there are disparities within its populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc.

2. Prior Year Recommendation from the EQR Technical Report for Validation of Performance Measures–NCQA HEDIS Compliance Audit (Medicaid):
Upon identification of a root cause, **HPN** should implement appropriate interventions to improve the performance related to the *Breast Cancer Screening* measure under the Women's Health and Maternity Care domain. • **HPN** should conduct a root cause analysis or focused study to determine why members with chronic conditions are not getting all recommended services or medications to manage their conditions and improve their overall wellness. Upon identification of a root cause, **HPN** should implement appropriate interventions to improve the performance related to Care for Chronic Conditions measures.
MCE's Response *(Note—The narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • HPN selected to focus on four measures and subsequent interventions: 1. *Adults' Access to Preventive/Ambulatory Health Services* (AAP) -Ages 65+: Implemented partnership with paramedicine provider (provider) to conduct home visits to members in AAP 65+ measure. 2. *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* (WCC)- Body Mass Index (BMI) percentile: Implemented a provider initiative to measure height during non-well visits. 3. *Breast Cancer Screening* (BCS): Expanded radiology providers by contracting with [provider]. 4. *Hemoglobin A1c (HbA1c) Poor Control (>9.0%)*: Implemented home meal delivery program with [home-delivered meals provider]. The target population included members with HbA1C >9.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): 1. AAP [*Adults' Access to Preventative/Ambulatory Services*] 65+ improved by 2.84% from 2020 to 2021. Intervention to conduct home visits proved successful. 2. WCC [*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*] - BMI percentile improved by 2.99% from 2020 to 2021.Intervention to incentive providers to assess height during non-well visit appointments proved to be successful in obtaining BMI percentile. 3. BCS [*Breast Cancer Screening*]: Improved performance has yet to be demonstrated, contract effective 8/1/2021. 4. CDC [*Comprehensive Diabetes Care*] HbA1c Poor Control: Demonstrated a -2.67% decrease from 41.36% to 38.69% from 2020 to 2021.
c. Identify any barriers to implementing initiatives: 1. AAP 65+: The fear of COVID-19 exposure resulted in member hesitancy in accepting home visiting service. 2. WCC-BMI percentile: The COVID-19 pandemic forced many Primary Care Providers (PCPs) to close their doors or significantly reduce staffing and thereby reduced access to in person services.
HSAG Assessment: HSAG has determined that **HPN** has addressed the prior recommendations; however, the MCO should continue to prioritize low performing areas and implement interventions to improve member outcomes.

3. Prior Year Recommendation from the EQR Technical Report for Compliance:
HSAG recommended the following: • No recommendations were identified for program improvement.

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation:
HSAG recommended the following: • **HPN** should review its provider data and contracted provider list to identify if the inability to identify providers in the data is a result of a lack of contracted providers or if the providers are not appropriately identified in the data. If a lack of contracted providers is identified, HSAG recommends **HPN** determine if the lack of contracted providers is due to a shortage of providers in the area or an unwillingness of the providers to contract with the MCO. • **HPN** should conduct an in-depth review of provider categories in which **HPN** did not meet the time-distance contract standards, with the goal of determining whether or not the failure of the MCO to meet the contract standard(s) was the result of a lack of providers or an inability to contract providers in the geographic area.
MCE's Response ***(Note—The narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • HPN's Network Development Department continues to review the integrity of our data through network adequacy reporting and file audits. With the implementation of our new provider database in 2020, our Data Integrity team spent time reviewing and scrubbing data to ensure that providers are identified accurately. Our Contracting team reviews our access and availability report quarterly and coordinates with our utilization management team to discuss barriers and recruitment projects. Our team reviews new applications weekly and is currently in the process of recruiting providers in areas of need.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • We are continuing to gain providers through our current recruitment process, including working with more providers who are integrating medical and behavioral services within the same office.
c. Identify any barriers to implementing initiatives: • Some providers are limiting their hours or panel size due to the Public Health Emergency.
HSAG Assessment: HSAG has determined that **HPN** has addressed the prior recommendations; however, since similar findings were determined in SFY 2021, the MCO should continue its current recruitment process and initiatives focused on increasing its network.

5. Prior Year Recommendation from the EQR Technical Report for CAHPS Analysis:
HSAG recommended the following: • **HPN** should 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. **HPN** may need to consider adding other data collection survey modes, such as the Internet, for the CAHPS surveys to increase response rates.

5. Prior Year Recommendation from the EQR Technical Report for CAHPS Analysis:
• **HPN** should focus on quality improvement initiatives to provide medical assistance with smoking and tobacco use cessation and continue to develop efforts to promote its Health Education & Wellness smoking cessation program.
MCE's Response ***(Note—The narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***

a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:
• HPN worked with CAHPS workgroup to increase the *response rate* by:
  • Mailing branded member letters to potential participants explaining the purpose of the survey.
  • Conducting CAHPS education for all internal member-facing teams.
• HPN worked with the internal Health Education & Wellness (HEW) department to increase awareness of the *smoking cessation program* by:
  • Educating providers on how to refer to the smoking cessation program.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The interventions to increase CAHPS response rate did not demonstrate performance improvement. • Member engagement in smoking cessation program improved from 27.04% to 38.10% from 2020 to 2021.
c. Identify any barriers to implementing initiatives: • The CAHPS survey was hindered by incorrect member demographics. As result, a significant decline in surveys completed by mail was noted in all surveys.
HSAG Assessment: HSAG has determined that **HPN** has addressed the prior recommendations; however, since survey responses remain low in some areas, the MCO should continue to think "outside of the box" to determine initiatives to increase response rates.

SilverSummit Healthplan, Inc.

Table 5-3—Prior Year Recommendations and Responses for SilverSummit

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG recommended the following: • **SilverSummit** should identify mechanisms to improve its ability to successfully outreach to members, such as looking at claims data for more current contact information. Further, **SilverSummit** should consider other provider engagement strategies, which may include financial incentives, to increase collaboration and partnerships, leading to better care coordination and services for its members. • As **SilverSummit** determines interventions to test for its new PIPs, the MCO should consider the end date specified in the SMART Aim statement and work backward when planning intervention testing. Careful planning is critical to allow enough time to test and refine interventions that will result in meaningful and sustained improvement. When determining interventions to test, **SilverSummit** should revisit the third fundamental question of the Model for Improvement, "What changes can we make that will result in improvement?" and ensure interventions tested have the potential to positively impact the quality of, timeliness of, and access to care for its members.
MCE's Response ***(Note—The narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • In 2021, SilverSummit Healthplan (SSHP) implemented a process to view the actual CMS 1500 or UB claim form to view member demographic information and determine if it was different from what is included in the member state demographic file for the member. • In 2021, SSHP updated our Pay for Performance measures and targets to include the Minimum Performance Standard (MPS) from the State Quality Strategy as one of the target areas for payout, as well as making the other two targeted payout rates of 25% and 50% of the 2020 Quality Compass. • In 2021, SSHP provided a monthly scorecard to our top providers with empaneled members, showing details on member care gaps and supporting the provider in member outreach.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Updated/accurate member demographic information was noted on some of the claims being reviewed and resulted in positive outreach to members. • Providers are appreciative of the scorecard and have indicated on monthly calls that this helps them target members with multiple care gaps, enabling them to close as many of those gaps during one visit as needed, especially during COVID, when member may only have one visit a year.
c. Identify any barriers to implementing initiatives: • SSHP's biggest challenge has been COVID 19 and providers not seeing members for preventive services and/or members reluctant to go to providers' offices for preventive visits. • Our next challenge has been not being able to meet with providers in person and having to meet virtually, which decreases/impacts effective communication and brainstorming.

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG Assessment: HSAG has determined that **SilverSummit** has addressed the prior recommendations; however, the MCO should continue to focus its interventions on reducing the barriers determined through the PIP process.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures–NCQA HEDIS Compliance Audit (Medicaid):
HSAG recommended the following: • **SilverSummit** should conduct a root cause analysis or focused study to determine why its members are not accessing contracted providers for services. **SilverSummit** could consider if there are disparities within its populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, **SilverSummit** should implement appropriate interventions to improve the performance related to the Access to Care domain. • **SilverSummit** should conduct a root cause analysis or focused study to determine why its women members are not getting preventive screenings for breast cancer. **SilverSummit** could consider if there are disparities within its populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, **SilverSummit** should implement appropriate interventions to improve the performance related to Women's Health and Maternity Care. • **SilverSummit** should conduct a root cause analysis to determine why its members with diabetes are not getting the appropriate care to manage their diabetes. Upon identification of a root cause, **SilverSummit** should implement at least two interventions to improve performance related to diabetes management. • **SilverSummit** should conduct a focused review to determine if there is a correlation between members who are denominator positive who also may be experiencing barriers to receiving coordinated benefits due to discharge practices or inaccurate contact information. Based on these results, **SilverSummit** could implement interventions to mitigate the barriers. • **SilverSummit** should conduct a targeted review of members receiving opioids from four or more providers and identify prescription patterns and patient profiles driving measure rates. Once identified, exploratory root cause analyses can be performed to identify systemic or member or provider issues that contribute to increased prescriptions by multiple providers and/or processes to identify and disrupt the pattern.
MCE's Response *(Note—The narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)*
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • *For members not accessing contracted providers for services*, SSHP reviewed why members are not accessing contracted providers. One reason is that requests are made for services that are not available in Nevada (e.g., SSHP issued 40 Single Case Agreements during the review period for out of state providers). SSHP also identified that African American women (post-partum care), Asian women (pre-natal care), and homeless men (PCP and preventative care) were disproportionally not accessing services. For African-American women, SSHP investigated the opportunity to utilize Doula services, which might be more culturally acceptable. For Asian women wary of the healthcare system, SSHP provided a grant to Access Health network to assist uninsured members with their prenatal care; we are exploring how to similarly assist our Medicaid members. To address concerns associated with homeless men and other

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures–NCQA HEDIS Compliance Audit (Medicaid):
members with healthcare disparities (who are concerned about being marginalized and discriminated against), SSHP implemented a Social Determinant of Health committee to, in part, conduct regular health needs assessments to design, implement, and evaluate policies, practices, and services to address SDoH-related factors. • *For women not getting preventive screenings for breast cancer*, SSHP conducted a focused study on disparities related to African American not getting breast cancer screening in the State of Nevada. Results did not show a significant health disparity related to African American women getting breast cancer screening. SSHP hosted two walk in clinic days with [radiology provider] for two weekends in October 2020, where members could go in on a Saturday, no appointment needed, and have mammogram done. SSHP posted flyers in provider offices, [radiology provider] clinics, on social media, and our member and provider websites. • *For members with diabetes not getting the appropriate care*, SSHP conducted a focused study on males ages 18 to 65 who are diabetics and whose HgbA1c is out of control at 9 or greater. SSHP developed two interventions to improve performance related to diabetes management. In addition, SSHP partnered with four difference providers/groups to conduct a pilot project for Diabetes Management Classes. • *For members potentially experiencing barriers to receiving coordinated benefits due to discharge practices or inaccurate contact information*, SSHP focused on determining what barriers our members may be experiencing with not receiving coordinated benefits. SSHP's largest barrier when interacting and assisting members is absent/inaccurate/outdated contact information. This is a barrier with all aspects of member communication and is experienced by our providers as well. SSHP conducted one focused study to see if we can obtain updated contact information through claims or the discharge and admission reports from hospitals via their EMR [electronic medical record] systems. • *For members receiving opioids from four or more providers*, SSHP implemented a process to request and review a monthly chronic user report which provides details of members who are receiving opioids from multiple prescribers. In addition, the identified members who receive controlled substances at two or more pharmacies per month, five or more pharmacies in a year, three or more controlled substances per month, and members whose number of controlled substances exceed 10 percent of their total number of prescriptions. Once members are identified, they are placed in our lock-in program by SSHP's Pharmacy department.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • *For members not accessing contracted providers for services*, for African American women and post-partum care, the Nevada Legislature enacted AB256, which provides for Medicaid coverage of doula services; SSHP will monitor utilization trends as this legislative requirement is implemented. For Asian women (pre-natal care), the impacted population was the uninsured, and we have not yet explored how to similarly impact our Medicaid enrollees. For our homeless population, we are assessing how we can best positively impact this population. • *For women not getting preventive screenings for breast cancer*, the walk-in clinic days were unfortunately scheduled at the height of COVID and no members showed for screenings. For 2021, we have partnered with [provider], a FQHC, to conduct mammogram screenings using the mammogram van; the first event occurred 07/13/2021 and we are presently awaiting results from this event. • *For members with diabetes not getting the appropriate care*, SSHP saw a slight improvement in these members' HgbA1c with the Diabetes Education Programs, including members taking ownership of

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures–NCQA HEDIS Compliance Audit (Medicaid):
their disease process to address diet, stop smoking, exercise, and to see their provider every six months for follow-up and medication adherence. • *For members potentially experiencing barriers to receiving coordinated benefits due to discharge practices or inaccurate contact information*, we are continuing to evaluate the effectiveness of the two activities we conducted and are in the process of "brainstorming" on a Performance Improvement Project (PIP) to identify a narrow focus to improve contact information. • *For members receiving opioids from four or more providers*, since implementation, SSHP has made 195 *Patient Safety Concerns for Narcotic Analgesic* outreaches to providers. The intent of the outreach is to assist providers with coordination of care, to promote communication among providers in an effort to optimize pharmacotherapeutic management, and to reduce narcotic abuse and potential drug-drug interactions.
c. Identify any barriers to implementing initiatives: • Across all performance measures, the COVID-19 pandemic was a barrier to care as members delayed or avoided care due to fear of exposure, changes in transportation options, a desire not to overwhelm the healthcare system, unawareness of telehealth options, etc. • *For members are not accessing contracted providers for services* specifically, the primary barrier when members go out of network is that there is no in-network provider who can deliver the needed services. • *For members receiving opioids from four or more providers* specifically, a barrier that SSHP has encountered is that the member is not always seen by the same provider at each visit; they are often seen by a Nurse Practitioner, Physician Assistant, or other Physician in the office. This leads to the member being incorrectly identified as receiving opioids from multiple prescribers based on the practitioner's unique National Provider Identification (NPI) number when actually, looking at the provider address, the member's prescriptions are all written from the same provider address.
HSAG Assessment: HSAG has determined that **SilverSummit** has addressed the prior recommendations; however, the MCO should continue its efforts to reduce noted barriers and improve member outcomes.

3. Prior Year Recommendation from the EQR Technical Report for Compliance:
HSAG recommended the following: • **SilverSummit** should review all member informational materials to ensure that adequate and correct information regarding the disenrollment process is provided to members.
MCE's Response ***(Note—The narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • SSHP's Director of Customer Service, in collaboration with SSHP's Compliance and Grievance & Appeals departments, reviewed and updated the *NV.ELIG.02 Disenrollment* policy to clearly document the disenrollment process flow, which includes redress through our Grievance & Appeals system. The updated policy includes the process for member disenrollment requests within 90 days of becoming a SSHP member, disenrollment during open enrollment, and good cause disenrollment, all in accordance with the requirements in contract Section 3.5.7 *Disenrollment Requirements and Limitations*.

3. Prior Year Recommendation from the EQR Technical Report for Compliance:
• Subsequently, the Director of Customer Service, in collaboration with the Marketing department, updated the *Disenrollment* section of the SSHP Member Handbook to specifically outline the steps members can take to request a disenrollment, and informed members that they can contact SSHP orally or in writing to request disenrollment, and included the address and telephone number members should use when making these requests. • Lastly, the Director of Customer Service, in collaboration with the Marketing department, facilitated the mailing of postcards to our existing Medicaid membership to make them aware of the updated disenrollment process in our online Member Handbook.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Since implementation, all members requesting good cause disenrollment are also referred to SSHP's Grievances & Appeals team, so that they can seek redress through the grievance system before SSHP makes a determination on the member's request.
c. Identify any barriers to implementing initiatives: • There were no barriers to implementation.
HSAG Assessment: HSAG has determined that **SilverSummit** has addressed the prior recommendations.

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation:
HSAG recommended the following: • **SilverSummit** should review its provider data and contracted provider list to identify if the inability to identify providers in the data is a result of a lack of contracted providers or if the providers are not appropriately identified in the data. If a lack of contracted providers is identified, HSAG recommends **SilverSummit** determine if the lack of contracted providers is due to a shortage of providers in the area or an unwillingness of providers to contract with the MCO. • **SilverSummit** should conduct an in-depth review of provider categories in which **SilverSummit** did not meet either the time-distance contract standards, with the goal of determining whether or not the failure of the MCO to meet the contract standard(s) was the result of a lack of providers or an inability to contract providers in the geographic area.
MCE's Response ***(Note—The narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • SSHP reviewed its provider data and contracted provider list to identify provider specialties which were not reflecting providers in the SSHP network. As noted in the follow up response to HSAG dated 09/24/2020, SSHP reviewed and provided updated contracted provider counts for specialties which were inadvertently underreported based on the original assumptions of only reporting a single specialty for each provider. For all other specialties, SSHP verified that the data accurately reflected the network provider counts and that the lack of contracted providers was a result of a shortage of providers in the area. • SSHP found that the specialty of Pediatric Rheumatology reflected a lack of contracted providers as there are no available Pediatric Rheumatology providers within the service area.

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation:
• SSHP reviewed the results of the geographic network distribution analysis and found that Pediatric Psychology fell below the contract standards. Based on these results, SSHP worked with our Behavioral Health partner, Summit Behavioral Health, to add access for this specialty. • To monitor adequacy, SSHP developed additional reporting to routinely compare our contracted provider network to the NV Medicaid Active Provider roster and identify if a provider is added for specialties which have been identified as not having providers.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • As a result of SSHP's collaboration with [behavioral health provider] to increase access for Pediatric Psychology, SSHP's contracted providers increased from 5 to 8.
c. Identify any barriers to implementing initiatives: • The lack of providers within the service area remains the primary barrier to fill these gaps or to implement initiatives to contract with providers.
HSAG Assessment: HSAG has determined that **SilverSummit** has addressed the prior recommendations; however, the MCO should continue its efforts to contract with any new specialty providers in the region who may be able to fill any network gaps.

5. Prior Year Recommendation from the EQR Technical Report for CAHPS Analysis:
HSAG recommended the following: • **SilverSummit** should 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. **SilverSummit** may need to consider adding other data collection survey modes, such as the Internet, for the CAHPS surveys to increase response rates. **SilverSummit** should also determine if its previous initiatives, such as using colored envelopes, increasing the number of oversampling, and conducting extra member calls, improved the rate of respondents and if those methods should continue for the next survey. • **SilverSummit** should focus on improving members' overall experiences with their health plan and parents/caretakers of child members' overall experiences with children's personal doctors through continued initiatives such as improved prior authorization processes, promotion of urgent care and after-hours clinics, implementation of the member concierge program, provider education, and grievance analyses. • HSAG recommends widely promoting the results of its member experiences with its contracted providers and staff members and soliciting feedback and recommendations to improve members' overall satisfaction with both **SilverSummit** and its contracted providers.
MCE's Response ***(Note—The narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • SSHP had an analysis conducted to determine oversampling number that would increase member response rate and increased the oversampling number for adult Medicaid and Child Medicaid surveys for 2021. However, due to limited size of our CHIP population, oversampling was not recommended.

5. Prior Year Recommendation from the EQR Technical Report for CAHPS Analysis:
SSHP determined the use of colored envelopes did not make a difference in response rate, so this was not utilized in 2021. SSHP does not have member email addresses to be able to conduct internet surveys, however, SSHP changed its process to allow members to complete survey via phone for our Spanish-speaking population. Analysis of the 2021 CAHPS survey is underway at this time to determine what methods to continue or improve on for 2022. • Unfortunately, COVID impacted SSHP's planned initiatives to increase members overall experience with the health plan and children's personal doctor due to an inability to get providers to focus and engage in activities to increase members' experience. Provider focus in 2021 has been on COVID and trying to reestablish "normal" office activities. SSHP conducted a grievance analysis but no trends or actionable items identified in this analysis. Provider education was developed and distributed electronically, due to our inability to have in-person meetings. A CAHPS Provider Summit was planned but, due to COVID, has been postponed. In October 2021, mock surveys will be conducted with the ability to identify specific providers and determine what actions, if needed, are to be taken with providers that are not scoring well by the members.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • 2021 CAHPS survey showed an increase in response rate and sufficient number of completed surveys.
c. Identify any barriers to implementing initiatives: • As noted, the COVID-19 pandemic was a barrier to our ability to engage providers and their patients, as well as a barrier to performing the CAHPS Provider Summit.
HSAG Assessment: HSAG has determined that **SilverSummit** has addressed the prior recommendations; however, the MCO should continue thinking "outside of the box" to increase survey response rates.

6. Follow-Up on Prior EQR Recommendations for PAHP

From the findings of the PAHP performance for the SFY 2020 EQR activities, HSAG made recommendations for improving the quality of healthcare services furnished to members enrolled in the Nevada Managed Care Program. The recommendations provided to the PAHP for the EQR activities in the *State Fiscal Year 2019–2020 External Quality Review Technical Report* are summarized in Table 6-1. The PAHP's summary of the activities that were implemented to support performance improvement are also provided in Table 6-1.

LIBERTY Dental Plan of Nevada, Inc.

Table 6-1—Prior Year Recommendations and Responses for LIBERTY

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG recommended the following: • **LIBERTY** should leverage claims data to identify updated member contact information and maintain the information within its health information system since contact information is overlaid with each uploaded enrollment file. **LIBERTY** should also continue to apply the lessons learned and knowledge gained from its efforts and HSAG's feedback throughout the PIP process to future PIPs and other quality improvement activities.
MCE's Response ***(Note—The narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • LIBERTY can update member contact phone numbers as a secondary phone number in its Member Information System (MIS) should the member provide an updated contact phone number directly; however, LIBERTY does not have the capability to pull updated member contact information from claims in the system at this time. LIBERTY is looking into other avenues for collecting more real time member contact information. • We continue to apply the lessons learned and knowledge gained from the HSAG PIP team and request technical assistance calls as needed.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • LIBERTY is looking into other avenues for collecting more real time member contact information and determine how the data can be leveraged for performance improvement. • LIBERTY has achieved validation and continues to progress through the current PIP modules and requirements.
c. Identify any barriers to implementing initiatives: • LIBERTY's system processes do not allow extraction of member demographics from the claim.

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG Assessment: HSAG has determined that **LIBERTY** has addressed the prior recommendations. However, HSAG recommends that **LIBERTY** prioritize and continue to make enhancements to collect additional real-time member contact information to support its quality and performance improvement activities.

2. Prior Year Recommendation from the EQR Technical Report for Validation of Performance Measures–NCQA HEDIS Compliance Audit (Medicaid and Nevada Check Up):
HSAG recommended the following: • **LIBERTY** should conduct a root cause analysis or focused study to determine whether barriers exist to members obtaining regular dental care. Further, HSAG recommends that **LIBERTY** conduct a grievance analysis to identify any systemic issues or challenges that may be impacting access to care.
MCE's Response ***(Note—The narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • LIBERTY identified several key barriers impacting our members access to preventive and medically necessary dental care. Many of the barriers identified, whether direct or indirect, were byproducts of the COVID-19 Pandemic. LIBERTY began developing various programs and efforts to help deliver much needed care and outreach to the NV Medicaid Population.

b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
• LIBERTY developed several performance improvement programs that were aimed at improving access to care, utilization, and preventive services. Some of the programs are listed below:
  • Community Smiles: One of LIBERTY's intervention programs that is focused on identifying social determinants of health for our members. Our community smiles program was introduced previously and is a referral program to connect our members to free and low-cost community resources to address needs such as food insecurity, housing, lack of transportation. On a recent 90-day lookback, LIBERTY found that there was 2000+ unique searches conducted in NV for health services and oral health services.
  • Early Preventive Services: LIBERTY partnered with various Providers to conduct drive thru oral health services for early preventive screenings for children and adults. Additionally, fluoride varnish applications and dental home kits were given to Medicaid children.
  • HEDIS Bonus and 1st Tooth 1st Birthday Program: LIBERTY partnered with our Providers to increase utilization among our Child Nevada Medicaid population. Providers are encouraged to outreach and schedule these members to come into their dental homes. Providers are paid a bonus on top of their normal reimbursement for providing services.

c. Identify any barriers to implementing initiatives: • School Closures. LIBERTY recognizes that some of the most vulnerable members depend on schools to provide oral health education, dental kits, preventive dental service programs and other critical services. Elementary schools, frequented by our community outreach team as well as many other community programs, were heavily impaired. • Long-lasting Effects of COVID-19. Anxiety, fear, stress and loneliness are among the many emotions that people are experiencing as a result of the COVID-19 pandemic and its effects. SDOH have been

2. Prior Year Recommendation from the EQR Technical Report for Validation of Performance Measures–NCQA HEDIS Compliance Audit (Medicaid and Nevada Check Up):
exasperated by the pandemic and members are dealing with many internal/external influences, making non-emergent care low on their priority list. • Office Closures/ Limited Scheduling. Throughout the previous 12 months, there were varying directives and guidance provided by state and local authorities, the CDC and ADA regarding increased safety measures, required closures and limited practices for dental facilities. Separately, many offices experienced a direct impact to both administrative and clinical staff, as well economic hardships forcing closures or reduced office hours.
HSAG Assessment: HSAG has determined that **LIBERTY** partially addressed the prior recommendations. HSAG continues to recommend that **LIBERTY** conduct a grievance analysis to identify any systemic issues or challenges that may be impacting access to care as it is unclear if such analysis has been completed.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review:
HSAG recommended the following: • **LIBERTY** should maintain thorough meeting minutes of discussions with members of the governing body pertaining the IQAP. **LIBERTY** should also implement a mechanism of providing performance and outcome data to its provider network. For example, it should provide an annual summary of **LIBERTY**'s IQAP evaluation.
MCE's Response ***(Note—The narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • In Q4 2020, LIBERTY ensured the Board of Director summary report included more comprehensive and detailed NV reports and analysis discussed in LIBERTY's Quality Management Committee. The NV Dental Director, who conducts monthly NV market meetings and represents the NV region in the Committees, attends each meeting/committee to ensure trends and process improvements are discussed within the NV state requirements on a quarterly basis. LIBERTY communicates and shares performance and outcome data with its provider network through the NV Dental Advisory Committee and Peer Review Committee. These detailed summaries are reported to the Board of Directors in which the Nevada State Dental Director participates and presents details.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • LIBERTY included more comprehensive and detailed NV reports and analysis discussed in its Quality Management Committee.
c. Identify any barriers to implementing initiatives: • No barriers were identified.
HSAG Assessment: HSAG has determined that **LIBERTY** has addressed the prior recommendations; however, HSAG further recommends **LIBERTY** ensure that the annual IQAP evaluation is clearly and thoroughly notated in the Quality Management Committee minutes.

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation:
HSAG recommended the following: • **LIBERTY** should conduct an in-depth review of dental specialist categories, with the goal of determining whether or not the failure of the PAHP to meet the contract standard(s) was the result of a lack of available providers or an inability to contract providers in the geographic area. • **LIBERTY** should continue to monitor the member's access to dental hygienists and dental therapists as more dental therapy programs become accredited and dental therapists are available to provide services to the member. • **LIBERTY** should conduct an in-depth review of dental specialist categories in which **LIBERTY** did not meet the time-distance contract standards, with the goal of determining whether or not the failure of the PAHP to meet the contract standard(s) was the result of a lack of available providers or an inability to contract providers in the geographic area.
MCE's Response ***(Note—The narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)***
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Provider Relations (PR) monitors access and availability on a quarterly basis. If there are any gaps noted, recruitment is initiated. Upon analysis of specialists, it was concluded that there was a gap in Periodontics. Review of the active state provider file lists 8 Periodontists with Medicaid ID's. Of those not contracted, outreach was made by PR to have providers become in network. Due to fees and member demographics the providers declined to join our network. • There are currently no Dental Therapists licensed in Nevada with a Medicaid ID.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • LIBERTY added a Periodontist in Clark County July 2021.
c. Identify any barriers to implementing initiatives: • Providers are not willing to join the network due to reimbursement. There is also a limited number of Periodontists in Clark and Washoe Counties with Medicaid ID's.
HSAG Assessment: HSAG has determined that **LIBERTY** has partially addressed the prior recommendations. However, HSAG further recommends that **LIBERTY** continue to assess gaps in the provider network and determine if additional interventions could be employed to educate and recruit providers.

7. MCE Comparative Information

In addition to performing a comprehensive assessment of the performance of each MCE, HSAG compared the findings and conclusions established for each MCE, when results were comparable, to assess the Nevada Managed Care Program. The overall findings of the MCEs were used to identify the overall strengths and weaknesses of the Nevada Managed Care Program and to identify areas in which DHCFP could leverage or modify the State's Quality Strategy to promote improvement.

EQR Activity Results

This section provides the summarized results for the mandatory EQR activities across the MCEs, when the activity methodologies and resulting findings were comparable.

Validation of Performance Improvement Projects

For this state fiscal year's validation, the MCOs completed and submitted Module 3 for validation for each intervention tested for the two ongoing PIPs. The PAHP completed and submitted modules 1 and 2 for validation of the design and initiation of two new PIP topics. Table 7-1 below provides a comparison of the validation scores, by MCE.

Table 7-1—Comparison of Validation by MCE

PIP Title	Anthem PIP Module Results	HPN PIP Module Results	SilverSummit PIP Module Results	LIBERTY PIP Module Results
Comprehensive Diabetes Care (CDC) Hemoglobin A1c (HbA1c) Poor Control >9.0%	Module 3: All validation criterion *Achieved*	Module 3: All validation criterion *Achieved*	Module 3: All validation criterion *Achieved*	
Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care	Module 3: All validation criterion *Achieved*	Module 3: All validation criterion *Achieved*	Module 3: All validation criterion *Achieved*	
Total of Eligible Enrollees Receiving a Sealant on a Permanent Molar Tooth				Modules 1 and 2: All validation criterion *Achieved*
Total of Eligible Enrollees Who Received Preventive Dental Services				Modules 1 and 2: All validation criterion *Achieved*

Performance Measure Validation

Medicaid Findings

Table 7-2 and Table 7-3 show the HEDIS MY 2020 Medicaid and Nevada Check Up performance measure results for **Anthem**, **HPN**, and **SilverSummit**, along with the MPS for each performance measure and the Medicaid and Nevada Check Up aggregate, which represents the average of all three MCOs' performance measure rates weighted by the eligible population. Measures for which lower rates suggest better performance are indicated by an asterisk (*). The arrows (↑ or ↓) indicate whether the HEDIS MY 2020 rate was above or below the national Medicaid 50th percentile benchmark. **Bolded** rates indicate the HEDIS MY 2020 performance measure rate was at or above the MPS, while **green** and **red** shading indicate the rate improved or declined by 5 percentage points or more from the prior year. Additionally, **yellow** shading indicates the Medicaid aggregate rate was at or above the MPS.

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

LIBERTY's performance measures were dental focused and not comparable to the MCOs' performance measures and resulting rates. Therefore, **LIBERTY**'s results are not included in the below tables.

Table 7-2—HEDIS MY 2020 Medicaid Results

HEDIS Measure	Anthem	HPN	SilverSummit	MPS	Medicaid Aggregate†
Access to Care					
Adults' Access to Preventive/Ambulatory Health Services (AAP)					
Ages 20–44 Years	64.55%↓	69.80%↓	58.20%↓	75.55%	66.31%
Ages 45–64 Years	72.29%↓	76.29%↓	69.12%↓	81.82%	73.99%
Ages 65 Years and Older	**76.32%↓**	**81.41%↓**	**79.41%↓**	67.19%	79.28%
Total	66.81%↓	71.93%↓	61.54%↓	77.67%	68.71%
Children's Preventive Care					
Childhood Immunization Status (CIS)					
Combination 2	66.67%↓	71.53%↓	66.18%↓	73.55%	68.95%
Combination 3	61.80%↓	**69.34%↓**	62.29%↓	68.86%	65.50%
Combination 4	61.80%↓	**69.10%↑**	62.04%↓	68.45%	65.35%
Combination 5	53.53%↓	**62.77%↑**	54.01%↓	59.46%	58.04%
Combination 6	34.31%↓	35.04%↓	33.82%↓	38.58%	34.60%

HEDIS Measure	Anthem	HPN	SilverSummit	MPS	Medicaid Aggregate†
Combination 7	53.53%↓	**62.53%↑**	53.77%↓	59.15%	57.90%
Combination 8	34.31%↓	35.04%↓	33.82%↓	38.48%	34.60%
Combination 9	30.90%↓	33.09%↓	29.20%↓	34.42%	31.75%
Combination 10	30.90%↓	33.09%↓	29.20%↓	34.32%	31.75%
Immunizations for Adolescents (IMA)					
Combination 1 (Meningococcal, Tdap)	**85.16%↑**	**88.56%↑**	78.59%↓	84.85%	86.45%
Combination 2 (Meningococcal, Tdap, HPV)	39.42%↑	47.45%↑	33.58%↓	47.65%	43.23%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)					
BMI Percentile—Total	82.24%↑	**86.44%↑**	78.83%↓	82.70%	84.18%
Counseling for Nutrition—Total	**74.21%↑**	**76.55%↑**	70.56%↓	72.63%	75.17%
Counseling for Physical Activity—Total	69.34%↑	**75.14%↑**	66.91%↑	69.60%	72.18%
Well-Child Visits in the First 30 Months of Life (W30)					
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	58.52%	59.89%	54.96%	MNA	58.75%
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	65.15%	68.83%	68.08%	MNA	67.29%
Child and Adolescent Well-Care Visits (WCV)					
3–11 Years	46.99%	48.62%	39.99%	MNA	47.22%
12–17 Years	39.02%	41.59%	32.03%	MNA	39.83%
18–21 Years	19.63%	24.50%	16.64%	MNA	21.87%
Total	41.29%	43.00%	33.70%	MNA	41.52%
Women's Health and Maternity Care					
Breast Cancer Screening (BCS)					
Breast Cancer Screening	44.67%↓	52.01%↓	44.68%↓	58.90%	49.19%
Prenatal and Postpartum Care (PPC)					
Timeliness of Prenatal Care	81.75%↓	**87.59%↓**	71.53%↓	86.26%	83.36%
Postpartum Care	66.18%↓	**78.83%↑**	58.64%↓	72.66%	71.25%
Care for Chronic Conditions					
Comprehensive Diabetes Care (CDC)					
HbA1c Testing	73.72%↓	79.81%↓	70.56%↓	81.98%	76.64%

HEDIS Measure	Anthem	HPN	SilverSummit	MPS	Medicaid Aggregate†
*HbA1c Poor Control (>9.0%)**	51.09%↓	**38.69%↓**	56.45%↓	39.28%	45.02%
HbA1c Control (<8.0%)	40.63%↓	50.12%↓	37.47%↓	53.14%	45.38%
Eye Exam (Retinal) Performed	50.85%↓	**63.02%↑**	50.36%↓	61.47%	57.32%
Blood Pressure Control (<140/90 mm Hg)[2,^]	50.61%	63.75%	36.50%	MNA	56.12%
Controlling High Blood Pressure (CBP)					
Controlling High Blood Pressure	51.09%	60.34%	32.85%	MNA	54.23%
Kidney Health Evaluation for Patients With Diabetes (KED)					
18–64 Years	27.43%	42.02%	27.22%	MNA	35.21%
65–74 Years	NA	42.42%	NA	MNA	47.95%
75–84 Years	NA	NA	NA	MNA	NA
Total	27.55%	42.02%	27.40%	MNA	35.27%
Behavioral Health					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	34.72%↓	44.73%↓	39.32%↓	46.08%	39.13%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	76.62%↓	74.58%↓	69.19%↓	81.43%	74.77%
Follow-Up After ED Visit for AOD Abuse or Dependence (FUA)					
7-Day Follow-Up—Total	12.29%↓	16.03%↑	**19.70%↑**	18.21%	15.10%
30-Day Follow-Up—Total	17.12%↓	20.92%↑	**26.57%↑**	21.60%	20.29%
Follow-Up After ED Visit for Mental Illness (FUM)					
7-Day Follow-Up—Total	29.55%↓	**52.34%↑**	42.96%↑	47.67%	42.06%
30-Day Follow-Up—Total	40.89%↓	**60.81%↑**	53.66%↓	55.92%	52.02%
Follow-Up After Hospitalization for Mental Illness (FUH)					
7-Day Follow-Up—Total	32.49%↓	38.58%↑	36.69%↑	39.45%	34.86%
30-Day Follow-Up—Total	48.72%↓	**56.65%↓**	54.62%↓	54.86%	51.86%
Follow-Up Care for Children Prescribed ADHD Medication (ADD) ♦					
Initiation Phase	47.06%↑	**54.10%↑**	47.71%↑	50.09%	50.75%
Continuation and Maintenance Phase	**68.66%↑**	**68.82%↑**	NA	60.00%	69.49%

HEDIS Measure	Anthem	HPN	SilverSummit	MPS	Medicaid Aggregate†
Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)					
Initiation of AOD—Total	**45.91%↑**	37.81%↓	41.27%↓	45.24%	41.81%
Engagement of AOD—Total	14.73%↑	11.56%↓	10.78%↓	18.94%	12.82%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)					
Blood Glucose and Cholesterol Testing–Total	**31.27%↓**	**33.89%↓**	**25.41%↓**	25.33%	31.57%
Utilization					
Ambulatory Care—Total (per 1,000 Member Months) (AMB)					
*ED Visits—Total**	42.98	41.60	48.01	MNA	42.91
Outpatient Visits—Total	246.46	280.22	250.67	MNA	263.12
Mental Health Utilization—Total (MPT)					
Inpatient—Total	1.27%	0.66%	1.13%	MNA	0.96%
Intensive Outpatient or Partial Hospitalization—Total	0.47%	0.24%	0.12%	MNA	0.32%
Outpatient—Total	9.13%	6.95%	10.43%	MNA	8.23%
ED—Total	0.26%	0.02%	0.04%	MNA	0.12%
Telehealth—Total	4.76%	3.72%	5.26%	MNA	4.32%
Any Service—Total	10.84%	8.53%	12.18%	MNA	9.89%
Plan All-Cause Readmissions (PCR)					
Observed Readmissions—Total	14.42%	**11.13%**	13.58%	MNA	12.53%
Expected Readmissions—Total	9.83%	9.08%	10.30%	MNA	9.47%
O/E Ratio—Total	1.47	1.23	1.32	MNA	1.32
Overuse/Appropriateness of Care					
Use of Opioids at High Dosage (HDO)*					
Use of Opioids at High Dosage	8.90%↓	10.00%↓	**4.50%↑**	8.63%	9.14%
Use of Opioids From Multiple Providers (UOP)*					
Multiple Prescribers	**15.90%↑**	29.47%↓	24.93%↓	22.43%	24.60%
Multiple Pharmacies	**1.15%↑**	**2.12%↑**	**0.62%↑**	3.16%	1.66%
Multiple Prescribers and Multiple Pharmacies	**0.57%↑**	**1.23%↑**	**0.18%↑**	1.62%	0.92%

♦ Individual plan denominators for this indicator were less than 30 resulting in an "NA" audit designation; however, when the MCO rates were combined to generate the statewide aggregate rate, the denominator was large enough to be reported and subsequently compared to the MPS.

† Represents performance under the Medicaid managed care program.

* A lower rate indicates better performance for this measure.

↑ Indicates the HEDIS MY 2020 rate was above NCQA's Quality Compass HEDIS 2020 Medicaid HMO 50th percentile benchmark.

↓ Indicates the HEDIS MY 2020 rate was below NCQA's Quality Compass HEDIS 2020 Medicaid HMO 50th percentile benchmark.

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

MNA indicates HEDIS MY 2020 QISMC goals are unavailable for this measure.

Bolded rates indicate that the HEDIS MY 2020 performance measure rate was at or above the MPS.

Indicates that the HEDIS MY 2020 rate declined by 5 percentage points or more from HEDIS MY 2019.

Indicates that the HEDIS MY 2020 rate improved by 5 percentage points or more from HEDIS MY 2019.

Indicates that the Medicaid Aggregate rate was at or above the MPS.

Table 7-3—HEDIS MY 2020 Nevada Check Up Results

HEDIS Measure	Anthem	HPN	SilverSummit	MPS	NV Check Up Aggregate†
Children's Preventive Care					
Childhood Immunization Status (CIS)					
Combination 2	81.82%↑	84.19%↑	81.40%↑	89.07%	83.12%
Combination 3	78.79%↑	81.29%↑	81.40%↑	83.46%	80.40%
Combination 4	78.79%↑	81.29%↑	81.40%↑	83.46%	80.40%
Combination 5	69.70%↑	75.81%↑	74.42%↑	77.33%	73.50%
Combination 6	45.96%↑	44.52%↑	**51.16%**↑	47.40%	45.55%
Combination 7	69.70%↑	75.81%↑	74.42%↑	77.33%	73.50%
Combination 8	45.96%↑	44.52%↑	**51.16%**↑	47.40%	45.55%
Combination 9	42.42%↑	41.94%↑	**46.51%**↑	44.91%	42.47%
Combination 10	42.42%↑	41.94%↑	**46.51%**↑	44.91%	42.47%
Immunizations for Adolescents (IMA)					
Combination 1 (Meningococcal, Tdap)	**92.94%**↑	**94.07%**↑	**90.63%**↑	89.03%	93.52%
Combination 2 (Meningococcal, Tdap, HPV)	57.18%↑	50.62%↑	43.75%↑	57.54%	52.56%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)					
BMI Percentile—Total	81.75%↑	**85.97%**↑	76.64%↓	85.65%	84.02%
Counseling for Nutrition—Total	74.94%↑	74.93%↑	67.88%↓	76.13%	74.53%
Counseling for Physical Activity—Total	69.10%↑	72.84%↑	66.42%↓	73.04%	71.21%

HEDIS Measure	Anthem	HPN	SilverSummit	MPS	NV Check Up Aggregate†
Well-Child Visits in the First 30 Months of Life (W30)					
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	71.23%	72.45%	56.25%	MNA	70.00%
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	77.27%	82.76%	85.42%	MNA	81.06%
Child and Adolescent Well-Care Visits (WCV)					
3–11 Years	55.51%	55.57%	44.81%	MNA	54.85%
12–17 Years	48.50%	50.91%	40.76%	MNA	49.52%
18–21 Years	30.90%	33.50%	21.84%	MNA	31.91%
Total	51.37%	52.09%	41.56%	MNA	51.18%
Behavioral Health					
Follow-Up After ED Visit for AOD Abuse or Dependence (FUA)					
7-Day Follow-Up—Total	NA	NA	NA	MNA	NA
30-Day Follow-Up—Total	NA	NA	NA	MNA	NA
Follow-Up After ED Visit for Mental Illness (FUM) ♦					
7-Day Follow-Up—Total	NA	NA	NA	79.47%	75.00%
30-Day Follow-Up—Total	NA	NA	NA	82.63%	75.00%
Follow-Up After Hospitalization for Mental Illness (FUH) ♦					
7-Day Follow-Up—Total	47.50%↑	NA	NA	63.01%	46.67%
30-Day Follow-Up—Total	67.50%↑	NA	NA	75.34%	61.33%
Follow-Up Care for Children Prescribed ADHD Medication (ADD) ♦					
Initiation Phase	43.59%↑	46.55%↑	NA	56.00%	45.28%
Continuation and Maintenance Phase	NA	NA	NA	MNA	NA
Initiation and Engagement of AOD Abuse or Dependence Treatment (IET) ♦					
Initiation of AOD—Total	NA	12.50%↓	NA	38.33%	30.77%
Engagement of AOD—Total	NA	0.00%↓	NA	18.33%	3.08%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) ♦					
Blood Glucose and Cholesterol Testing–Total	NA	**44.90%↑**	NA	28.87%	39.29%

HEDIS Measure	Anthem	HPN	SilverSummit	MPS	NV Check Up Aggregate†
Utilization					
Ambulatory Care—Total (per 1,000 Member Months) (AMB)					
*ED Visits—Total**	15.63	13.71	15.41	MNA	14.53
Outpatient Visits—Total	185.80	195.10	168.42	MNA	189.80
Mental Health Utilization—Total (MPT)					
Inpatient—Total	0.52%	0.18%	0.61%	MNA	0.33%
Intensive Outpatient or Partial Hospitalization—Total	0.19%	0.03%	0.06%	MNA	0.09%
Outpatient—Total	6.12%	5.02%	6.39%	MNA	5.52%
ED—Total	0.04%	0.01%	0.00%	MNA	0.02%
Telehealth—Total	3.17%	3.62%	3.61%	MNA	3.46%
Any Service—Total	7.03%	6.40%	7.55%	MNA	6.71%

♦ Individual plan denominators for this indicator were less than 30 resulting in an "NA" audit designation; however, when the MCO rates were combined to generate the statewide aggregate rate, the denominator was large enough to be reported and subsequently compared to the MPS.

† Represents performance under the Medicaid managed care program.

* A lower rate indicates better performance for this measure.

↑ Indicates the HEDIS MY 2020 rate was above NCQA's Quality Compass HEDIS 2020 Medicaid HMO 50th percentile benchmark.

↓ Indicates the HEDIS MY 2020 rate was below NCQA's Quality Compass HEDIS 2020 Medicaid HMO 50th percentile benchmark.

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

MNA indicates HEDIS MY 2020 QISMC goals are unavailable for this measure.

Bolded rates indicate that the HEDIS MY 2020 performance measure rate was at or above the MPS.

Indicates that the HEDIS MY 2020 rate declined by 5 percentage points or more from HEDIS MY 2019.

Indicates that the HEDIS MY 2020 rate improved by 5 percentage points or more from HEDIS MY 2019.

Indicates that the Medicaid Aggregate rate was at or above the MPS.

Compliance Review

HSAG calculated the Nevada Managed Care Program overall performance in each of the seven performance areas. Table 7-4 compares the program average compliance score in each of the seven performance areas with the compliance score achieved by each MCE.

Table 7-4—Summary of SFY 2021 Compliance Review Results

Standard	Anthem	HPN	SilverSummit	LIBERTY	Nevada Managed Care Program
Standard I—Disenrollment: Requirements and Limitations	100%	100%	100%	100%	100%
Standard II—Member Rights and Member Information	95%	91%	77%	94%	89%
Standard III—Emergency and Poststabilization of Services	100%	100%	100%	100%	100%
Standard IV—Availability of Services	100%	100%	90%	100%	97%
Standard V—Assurances of Adequate Capacity and Services	100%	100%	100%	100%	100%
Standard VI—Coordination and Continuity of Care	94%	82%	71%	73%	81%
Standard VII—Coverage and Authorization of Services	87%	93%	67%	80%	82%
Total Compliance Score	**95%**	**93%**	**81%**	**90%**	**90%**

Total Compliance Score—Elements scored *Met* were given full value (1 point each). The point values were then totaled, and the sum was divided by the number of applicable elements to derive percentage scores for each MCE's standards and for the Nevada Managed Care Program.

Network Adequacy Validation

Table 7-5 presents a summary of the provider ratio analysis results compared to the provider ratio standards for all MCOs. For the provider categories assessed according to the standards in Table 3-5, the percentage of members with access to the provider within the time-distance standard is shown in red if they did not comply with the standard. These MCO comparative time-distance standard results for each provider type are documented in Table 7-6. The provider ratio and time-distance analyses for **LIBERTY** was not comparable to the MCOs; therefore, the results are not included in the below table.

Table 7-5—Summary of Ratio Analysis Results for PCPs and Specialty Care Providers for All MCOs

Provider Category	Anthem		HPN		SilverSummit	
	Providers	Ratio	Providers	Ratio	Providers	Ratio
Primary Care Providers						
Primary Care Providers (1:1,500)	1,173	1:201	1,801	1:152	1,620	1:42
PCP Extenders (1:1,800)	1,266	1:186	1,020	1:269	1,217	1:56
Physician Specialist Providers (1:1,500)	1,300	1:181	1,973	1:139	1,171	1:58

Table 7-6—Percentage of Members Residing Within the Access Standard Areas for All MCOs

Provider Category	Time-Distance Standard	Anthem	HPN	SilverSummit
Primary Care Providers				
Primary Care (Adult Total)	20 miles/30 mins	96.9%	98.3%	99.9%
OB/GYN	20 miles/30 mins	99.8%	99.9%	99.8%
Pediatrician	20 miles/30 mins	99.9%	99.9%	99.9%
Specialty Providers				
Endocrinologists	75 miles/100 mins	99.9%	99.9%	99.9%
Endocrinologists, Pediatric	75 miles/100 mins	99.9%	99.9%	99.9%
Infectious Disease	75 miles/100 mins	99.9%	99.9%	99.9%
Infectious Disease, Pediatric	75 miles/100 mins	99.9%	99.9%	99.9%
Oncologist/Hematologist	75 miles/100 mins	99.9%	99.9%	99.9%
Oncologist/Hematologist, Pediatric	75 miles/100 mins	99.9%	99.9%	99.9%
Oncologist/Radiologist	75 miles/100 mins	99.9%	NA	99.9%
Rheumatologist	75 miles/100 mins	99.9%	99.9%	99.9%
Rheumatologist, Pediatric	75 miles/100 mins	88.9%	87.8%	88.1%
Facility-Level Providers				
Hospital (Total)	60 miles/80 mins	95.0%	94.4%	95.7%
Psychiatry Inpatient Hospital	60 miles/80 mins	99.9%	99.9%	99.9%
Dialysis/ESRD Facility	60 miles/80 mins	99.9%	99.9%	99.9%
Behavioral Health Providers				
Psychologist	45 miles/60 mins	99.9%	99.9%	99.9%
Pediatric Psychologist	45 miles/60 mins	88.9%	99.9%	88.1%
LCSW	45 miles/60 mins	99.9%	99.9%	99.9%

Provider Category	Time-Distance Standard	Anthem	HPN	SilverSummit
Primary Care Providers				
Psychiatrist	45 miles/60 mins	99.9%	99.9%	99.9%
Pediatric Psychiatrist	45 miles/60 mins	99.9%	99.9%	99.9%

Consumer Assessment of Healthcare Providers and Systems Analysis

A comparative analysis identified whether one MCO performed statistically and significantly higher or lower on each measure compared to the program average. Table 7-7 shows a summary of the statistically significant findings (noted with arrows) from the plan comparisons of the adult Medicaid, child Medicaid, and Nevada Check Up populations for **Anthem**, **HPN**, and **SilverSummit**. Please note, no measures had a statistically significantly higher or lower score than the program average for **Anthem**; therefore, this MCO is not included in Table 7-7. **LIBERTY**'s Member Satisfaction Survey results are not included in the below table, as the methodology for the survey was not consistent with CAHPS.

Table 7-7—Summary of Plan Comparisons

2021 Adult Medicaid	2021 General Child Medicaid	2021 CCC Medicaid Supplemental	2021 Nevada Check Up General Child	2021 Nevada Check Up CCC Supplemental
HPN				
		↑ *How Well Doctors Communicate*		
↑ *Rating of Health Plan*				
SilverSummit				
↓ *Rating of Health Plan*				

↑ Indicates the 2021 score is statistically significantly higher than the program average.
↓ Indicates the 2021 score is statistically significantly lower than the program average.
Indicates no measures for the population were statistically significantly higher or lower than the program average.

8. Program-Wide Conclusions and Recommendations

HSAG performed a comprehensive assessment of the performance of each MCE and of the overall strengths and weaknesses of the Nevada Managed Care Program related to the provision of healthcare services. All components of each EQR activity and the resulting findings were thoroughly analyzed and reviewed across the continuum of program areas and activities that comprise the Nevada Managed Care Program.

Strengths

Through this all-inclusive assessment of aggregated performance, HSAG identified areas of strength in the program related to quality of, timeliness of, and access to care and services.

- **Quality**
  - Through the PIP activities, the Nevada Managed Care Program is focusing its efforts on reducing the prevalence of uncontrolled diabetes through interventions aimed at reducing members' HbA1c, thereby reducing members' risks for serious diabetic-related health problems, including heart disease, kidney disease, and nerve damage. Additionally, through the *Total of Eligible Enrollees Receiving a Sealant on a Permanent Molar Tooth* PIP, the Nevada Managed Care Program is implementing initiatives to protect its child members from getting cavities that may lead to severe toothache, infection, and tooth loss, as well as problems with eating, speaking, and learning.
  - As demonstrated through performance measure results in comparison to both State and national benchmarks, overall, Nevada Medicaid's contracted PCPs are assessing children and adolescents' body mass index and counseling for nutrition and physical activity in order to lower the risk of becoming obese and developing related diseases later in life, including cardiovascular disease and diabetes. Additionally, contracted providers are appropriately managing children and adolescents who are prescribed antipsychotic medications by conducting metabolic testing to assess for and mitigate the risks for developing serious metabolic health complications, such as diabetes and elevated blood pressure. Further, as indicated through high performing results for the *Immunizations for Adolescents* HEDIS measure, children who are 13 years of age are being vaccinated against meningitis, tetanus, diphtheria, and pertussis, reducing the risk for contracting these potentially life-threatening diseases. Finally, contracted network providers, pharmacies, and the Nevada Managed Care Program are mitigating the risks for adverse health outcomes related to overuse and misuse of prescribed opioids by members who received prescriptions from multiple prescribers and/or were filled through multiple pharmacies.
- **Timeliness**
  - Through the state-mandated PIP topic, *Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care*, the Nevada Managed Care Program has implemented interventions to quickly identify pregnant women so they can be educated on and encouraged to seek timely prenatal care. Pregnant women who do not receive early and adequate prenatal care are at risk for

complications that may either be undetected or treated too late in pregnancy, increasing the possibility of adverse outcomes for both mother and baby.
  - Performance measure results for *Follow-Up Care for Children Prescribed ADHD Medication* demonstrated children prescribed an ADHD medication followed up timely with their providers to ensure prescribed medications were appropriate and effectively managed their symptoms caused by their behavioral health disorder. When managed appropriately, ADHD medication controls symptoms of hyperactivity, impulsiveness, and the inability to concentrate.
- **Access**
  - The dental-focused PIP, *Total of Eligible Enrollees Who Received Preventive Dental Services*, was implemented to increase the percentage of members (between the ages of 2 and 20) who are accessing preventive dental care. Tooth decay, gum disease, and dental caries are mostly preventable through a combination of good oral health hygiene and early and routine preventive dental services.
  - As demonstrated through high performance in the Availability of Services and Assurances of Adequate Capacity and Services standards reviewed through the Compliance Review activity, the Nevada Managed Care Program is maintaining and monitoring an adequate provider network that is sufficient to provide adequate access to all services (e.g., primary care, specialty care, hospital and emergency services, behavioral health services, and dental care) for the Medicaid managed care population.
  - Results from the NAV activity indicated the Nevada Managed Care Program has an adequate geographic distribution of PCPs and dentists for members to access services near their residences and a sufficient number of contracted PCPs and dentists to render services to Medicaid managed care members.

Weaknesses

HSAG's comprehensive assessment of the MCEs and the Nevada Managed Care Program also identified areas of focus that represent significant opportunities for improvement within the program related to quality of, timeliness of, and access to care and services.

- **Quality**
  - Although immunization compliance for adolescents was identified as a strength, the *Childhood Immunization Status* HEDIS measure indicator rates at the aggregate level did not meet the Nevada Managed Care Program's minimum performance benchmark and the majority of the MCO-specific immunization-related rates did not meet the national Medicaid 50th percentile benchmark, indicating members enrolled in the Medicaid managed care program are not getting the recommended vaccines to reduce risks for contracting preventable diseases.
  - The *Breast Cancer Screening* HEDIS measure results indicated women are not getting mammograms for early detection of breast cancer, as indicated through lower performance rates.
  - Although a state-mandated PIP was implemented to reduce the prevalence of uncontrolled diabetes through interventions aimed at reducing members' HbA1c, performance measure results

suggested the implemented interventions may not be effectively impacting health outcomes for members with diabetes, as indicated by significant decreases in HbA1c testing and only minimal program improvement in the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measure indicator rate. Additionally, none of the aggregated performance rates under the *Comprehensive Diabetes Care* measure met the DHCFP-established minimum performance benchmark.

  - As indicated through an aggregated performance score of 81 percent in the Coordination and Continuity of Care standard, the Nevada Managed Care Program may not be providing care coordination and care management activities to effectively support members in achieving their individualized health goals in coordination with their providers.

- **Timeliness**
  - Although the *Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care* PIP was initiated to improve the prevalence of timely prenatal care, lower aggregated performance in comparison to State and national benchmarks in the *Prenatal and Postpartum Care* measure rates indicated members are not receiving timely prenatal and postpartum care to prevent adverse health outcomes for the mother and baby.
- **Access**
  - Although NAV activity results indicated the Medicaid and Nevada Check Up populations have a sufficient network of primary care and specialty providers to meet the needs of its enrolled members, lower overall aggregated performance in the Access to Care, Children's Preventive Care, Women's Health and Maternity Care, Care for Chronic Conditions, and Behavioral Health domains in comparison to State MPS and national benchmarks indicated members are experiencing barriers to obtaining services unrelated to the capacity of the provider network. This was also a significant finding from the SFY 2020 EQR.

Quality Strategy Recommendations for the Nevada Managed Care Program

The Nevada Quality Assessment and Performance Improvement Strategy (Quality Strategy) is designed to improve the health outcomes of its Medicaid members by continually improving the delivery of quality healthcare to all Medicaid and Nevada Check Up members served by the Nevada Medicaid managed care programs. DHCFP's Quality Strategy provides the framework to accomplish DHCFP's overarching goal of designing and implementing a coordinated and comprehensive system to proactively drive quality throughout the Nevada Medicaid and Check Up system. In consideration of the goals of the Quality Strategy and the comparative review of findings for all activities, HSAG recommends the following quality improvement initiatives, which target the identified specific goals within DHCFP's Quality Strategy.

Goal 1: Improve the Health and Wellness of Nevada's Medicaid Population by Increasing Access to and the Use of Preventive Services

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

Goal 6: Reduce and/or Eliminate Health Care Disparities for Medicaid Recipients

To improve program-wide performance in support of **Goal 1** and **Goal 6** and mitigate the barriers members are experiencing related to accessing care, HSAG recommends the following:

- **Access to Care PIP—**For SFY 2022, DHCFP should select an overarching PIP topic that focuses on improving members' access to care.
  - To ensure meaningful results at the MCE level, DHCFP should require the MCOs and the PAHP to identify one access-related performance measure (e.g., *Adults' Access to Preventive/Ambulatory Health Services, Annual Dental Visit*) that fell below the national Medicaid 50th percentile and did not meet the DHCFP-established MPS in SFY 2021, or the performance measure rate is not expected to meet the national Medicaid 50th percentile or MPS in SFY 2022.
  - Further, DHCFP should require the MCOs and PAHP to identify healthcare disparities within their access-related performance measure data to focus its PIP on a disparate population (e.g., Hispanic members).

To improve program-wide performance in support of **Goal 4** and **Goal 6** and further identify and understand the barriers to accessing timely prenatal care, HSAG recommends the following:

- **Prenatal Care Focus Group—**DHCFP should lead a program-wide focus group of women on Medicaid who have recently given birth or are pregnant to determine potential barriers to timely access to prenatal care.
  - Each MCO should identify and outreach to women who are pregnant or have delivered while enrolled in the MCO to participate in the focus group.
  - The MCO should identify disparate populations and prioritize outreach to those members for inclusion in the focus group.
  - DHCFP and/or the MCOs should offer an incentive for the women to attend the focus group discussion.
  - DHCFP and/or the MCOs should assign a moderator to ask a predefined set of questions that focus on member experience while pregnant, including experiences with obtaining timely appointments, barriers to receiving care, perception of member/provider relationship, etc.
  - DHCFP and/or the MCOs should leverage the information gained from the focus group to identify potential barriers women are experiencing when seeking prenatal care and develop interventions to eliminate those barriers and support program improvement.

Appendix A. External Quality Review Activity Methodologies

Methods for Conducting EQR Activities

Validation of Performance Improvement Projects

Activity Objectives

The objective of HSAG's PIP validation is to ensure that DHCFP and key stakeholders can have confidence that any reported improvement is related and can be reasonably linked to the quality improvement strategies and activities the MCE conducted during the PIP activity. HSAG's scoring methodology evaluates whether the MCE executed a methodologically sound improvement project and confirmed that any achieved improvement could be clearly linked to the quality improvement strategies implemented by the MCE.

DHCFP requires its MCEs to conduct PIPs annually. The topics for the SFY 2021 PIP validation cycle were:

MCOs

- *Comprehensive Diabetes Care (CDC) Hemoglobin A1c (HbA1c) Poor Control >9.0%*
- *Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care*

PAHP

- *Total of Eligible Enrollees Receiving a Sealant on a Permanent Molar Tooth*
- *Total of Eligible Enrollees Who Received Preventive Dental Services*

The topics selected by DHCFP and interventions identified and tested by each MCE addressed CMS requirements related to quality outcomes—specifically, the quality and timeliness of and access to care and services.

For each PIP topic, the MCEs 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.

Technical Methods of Data Collection and Analysis

HSAG developed four modules with an accompanying reference guide and supporting tools in which to collect data from the MCEs and conduct the PIP validation activity. Prior to issuing each module, HSAG held technical assistance sessions with the MCOs to educate about the application of the modules. The four modules are defined as:

- **Module 1—PIP Initiation:** Module 1 outlines the framework for the project. The framework includes the topic and narrowed focus description and rationale, supporting baseline data, description of baseline data collection methodology, setting Aims (Global and SMART), and setting up a run chart for the SMART Aim measure.
- **Module 2—Intervention Determination:** In Module 2, the MCE uses specific quality improvement tools to determine interventions that have the potential to impact the SMART Aim. The MCE will use a step-by-step process to identify and prioritize interventions that will be tested using PDSA cycle(s).
- **Module 3—Intervention Testing:** In Module 3, the MCE defines the Intervention Plan for the intervention to be tested. The MCE will test interventions using thoughtful incremental PDSA cycles and complete PDSA worksheets.
- **Module 4—PIP Conclusions:** In Module 4, key findings, comparisons of successful and unsuccessful interventions, and outcomes achieved are summarized. The MCE will synthesize all data collection, information gathered, and lessons learned to document the impact of the PIP and to consider how demonstrated improvement can be shared and used as a foundation for further improvement going forward.

Approach to PIP Validation

HSAG obtained the data needed to conduct the PIP validation from each MCE's module submission forms. These forms provided detailed information about each of the PIPs and the activities completed.

The MCE submitted each module according to the approved timeline. After the initial validation of each module, the MCE 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 MCE progressed to the next phase of the PIP.

During validation, HSAG determined if criteria for each module were *Achieved*. Any validation criteria not applicable (*NA*) were not scored. As the PIP progressed, and at the completion of Module 4, HSAG uses the validation findings from across all modules completed and validated to determine a level of confidence representing the validity and reliability of the PIP. Using a standardized scoring methodology, HSAG assigned a level of confidence and reported the overall validity and reliability of the findings as one of the following:

- ***High confidence*** = The PIP was methodologically sound, the SMART Aim goal was achieved, the demonstrated improvement was clearly linked to at least one intervention tested, and the MCE accurately summarized the key findings.
- ***Confidence*** = The PIP was methodologically sound, the SMART Aim goal was achieved, the demonstrated improvement was clearly linked to at least one intervention tested; however, the MCE did not accurately summarize the key findings.
- ***Low confidence*** = The PIP was methodologically sound; however, one the following occurred: the SMART Aim goal was not achieved or statistically significant improvement over the narrowed focus baseline percentage was not achieved, or the SMART Aim goal was achieved or statistically significant improvement over the narrowed focus baseline percentage was achieved; however, the demonstrated improvement could not be reasonably linked to any of the tested interventions.
- ***Reported PIP results were not credible*** = The SMART Aim measure and/or approved rapid-cycle PIP process was not followed through the SMART Aim end date.

Description of Data Obtained and Related Time Period

MCOs

Data Collection Methods for Module 3 (Intervention Testing)

Table A-1—PIP Topic, Intervention Name, and Data Source for Each MCO

Anthem PIP Topics	Intervention	Data Source
Comprehensive Diabetes Care (CDC) Hemoglobin A1c (HbA1c) Poor Control >9.0%	Obtaining CDC HbA1c Results From Targeted Providers' Electronic Health Records	Standard lab supplemental data files
Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care	Targeted Provider and Office Staff CPT Code Training	Pre- and post- test provider/office staff results
HPN PIP Topics	**Intervention**	**Data Source**
Comprehensive Diabetes Care (CDC) Hemoglobin A1c (HbA1c) Poor Control >9.0%	In-home HbA1c Test Kits From BioIQ	MCO tracking sheet and report Member survey data
Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care	CPT Provider Coding Education	Administrative: Obstetrics claims from targeted provider office
SilverSummit PIP Topics	**Intervention**	**Data Source**
Comprehensive Diabetes Care (CDC) Hemoglobin A1c (HbA1c) Poor Control >9.0%	Targeted Member Outreach Using Updated Demographic Information from Emergency Room Visit Documentation	Administrative: Claims data Emergency room member record review
Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care	Targeted Member Outreach Using Updated Demographic Information from Provider Claims Data and Member Medical Records	Administrative: Claims data Member Medical record review

PAHP

Data Collection Methods for Module 1 (PIP Initiation), Module 2 (Intervention Determination), Module 3 (Intervention Testing)

Table A-2—PIP Topic, SMART Aim Statement, and Data Source(s)

PIP Topics	SMART Aim Statement	Data Source
Total of Eligible Enrollees Receiving a Sealant on a Permanent Molar Tooth	By December 31, 2021, **LIBERTY**'s goal is to increase the percentage of sealant procedures completed among the identified population, living in zip code 89148, 89178, or 89052, who were at least 6 years old and under age 14 as of July 1, 2019 from the baseline rate of 22.03% to 27.03% by using key driver interventions.	Claims data with a query applied to identify the eligible and targeted population for the rolling 12-month measurement period. Using the SMART Aim denominator, the PAHP will run a query to identify the enrollees that had at least one sealant on the first or second permanent molars. The PAHP reported that the claims lag for the data to be used for this PIP has a 14-day average turnaround time. The results will be displayed on the SMART Aim run chart.
Total of Eligible Enrollees Who Received Preventive Dental Services	By December 31, 2021, **LIBERTY**'s goal is to increase the overall percentage of preventive procedures completed among the identified population of enrollees aged 2 through 20 as of July 1st, 2019, who are assigned to [dental provider 1] and [dental provider 2], from the baseline rate of 39.5% to 49.5% by using key driver interventions.	Claims data with a query applied to identify the eligible and targeted population for the rolling 12-month measurement period. Using the SMART Aim denominator, the PAHP will run a query to identify the enrollees that had at least one preventive dental service. The PAHP reported that the claims lag for the data to be used for this PIP has a 14-day average turnaround time. The results will be displayed on the SMART Aim run chart.

Table A-3—PIP Topic, Intervention, and Data Source(s)

PIP Topic	Intervention	Data Source
Total of Eligible Enrollees Receiving a Sealant on a Permanent Molar Tooth	*Educational Text Message Campaign to Targeted Enrollees*	*Claims and enrollment data*
Total of Eligible Enrollees Who Received Preventive Dental Services	*Educational Text Message Campaign to Targeted Enrollees*	*Claims and enrollment data*

HSAG obtained the data needed to conduct the PIP validation from each MCE's module submission forms. These forms provided detailed information about each of the PIPs and the activities completed, including validated performance measurement data used to support the PIPs.

The MCE submitted each module according to the approved timeline. After the initial validation of each module, the MCE received HSAG's feedback and technical assistance and resubmitted the modules until all validation criteria were achieved. This process ensured that the methodology was sound before the MCE progressed to the next step of the PIP.

Performance Measure Validation

Activity Objectives

The objective of the PMV activity is to ensure the MCEs are collecting and subsequently reporting accurate and reliable data.

DHCFP requires its MCEs to undergo a PMV audit annually. In order to meet the PMV requirements, HSAG, as the EQRO for DHCFP, conducts an NCQA HEDIS Compliance Audit for each MCO. HSAG adheres to National Committee for Quality Assurance's (NCQA's) *HEDIS Compliance Audit Standards, Policies, and Procedures, Volume 5*,[A-1] which outlines the accepted approach for auditors to use when conducting an IS capabilities assessment and an evaluation of the MCOs' ability to process medical, member, and practitioner information and measure production processes to determine compliance with HEDIS measure specifications.

For the PAHP, HSAG conducted the validation activities in accordance with CMS EQR *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity,* October 2019,[A-2] which outlines the accepted approach for auditors to use when conducting an IS capabilities assessment and an evaluation of the PAHP's ability to process medical, member, and practitioner information and measure production processes to determine compliance with performance measure specifications.

Technical Methods of Data Collection and Analysis

MCOs

HSAG performed an audit of the MCOs' HEDIS reporting processes for their Medicaid and Nevada Check Up populations. PMV involved three phases: audit validation, audit review, and follow-up and reporting. The following provides a summary of HSAG's activities with the MCOs within each of the phases. Throughout all audit phases, HSAG actively engages with the MCOs to ensure all audit

[A-1] National Committee for Quality Assurance. *HEDIS Compliance Audit Standards, Policies, and Procedures, Volume 5*. Washington D.C.; 2020.

[A-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity,* October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Oct 6, 2021.

requirements are met, providing technical assistance and guidance as needed. The audit process is iterative to support the MCOs in understanding all audit requirements and in being able to report valid rates for all required performance measures.

Audit Validation Phase (October 2020 through May 2021)

- Forwarded HEDIS MY 2020 Record of Administration, Data Management, and Processes (Roadmap) upon release from NCQA.
- Conducted annual HEDIS updates webinar to review the audit timeline and discuss any changes to the measures, technical specifications, and processes.
- Scheduled virtual audit review dates.
- Conducted kick-off calls to introduce the audit team, discuss the audit review agenda, provide guidance on HEDIS Compliance Audit and PMV processes, and ensure that the MCOs were aware of important deadlines.
- Conducted survey sample frame validation for the MCOs and provided the final survey sample frame validation results report that indicated if the sample frames were approved for reporting.
- Reviewed completed HEDIS Roadmaps to assess compliance with the audit standards and provided the IS standard tracking report that listed outstanding items and areas that required additional clarification.
- Reviewed source code used for calculating the HEDIS performance measure rates to ensure compliance with the technical specifications, unless the MCO used a vendor with HEDIS Certified Measures[SM,A-3]
- Conducted validation for all supplemental data sources intended for reporting and provided a final supplemental data validation report that listed the types of supplemental data reviewed and the validation results.
- Conducted preliminary rate review to assess data completeness and accuracy early in the audit process to allow time for making corrections, if needed, prior to final rate submission.
- Conducted medical record review validation to ensure the integrity of medical record review processes for performance measures that required medical record data for HEDIS reporting.

Audit Review Phase (January 2021 through April 2021)

- Conducted virtual audit reviews to assess capabilities to collect and integrate data from internal and external sources and produce reliable performance measure results.
- Provided preliminary audit findings.

[A-3] HEDIS Certified Measures[SM] is a service mark of the National Committee for Quality Assurance (NCQA).

Follow-Up and Reporting Phase (May 2021 through July 2021)

- Worked collaboratively to resolve any outstanding items and corrective actions, if applicable, and provided a final IS standard tracking report that documented the resolution of each item.
- Conducted final rate review and provided a rate analysis report that included a comparison to the preliminary rate submission and prior two years' rates (if available) and showed how the rates compared to the NCQA HEDIS MY 2019 Audit Means, Percentiles, and Ratios. The report also included requests for clarification on any notable changes in rates, eligible populations, and measures with rates that remained the same from year to year.
- Approved the final rates and assigned a final, audited result to each selected measure.
- Produced and provided final audit reports containing a summary of all audit activities.

PAHP

HSAG performed an audit of the PAHP's reporting processes for its Medicaid and Nevada Check Up populations. PMV involved three phases: audit validation, audit review, and follow-up and reporting. The following provides a summary of HSAG's activities with the PAHP within each phase. Throughout all audit phases, HSAG actively engages with the PAHP to ensure all audit requirements are met, providing technical assistance and guidance as needed. The audit process is iterative to support the PAHP in understanding all audit requirements and in being able to report valid rates for all required performance measures.

Audit Validation Phase (October 2020 through May 2021)

- Forwarded Information Systems Capabilities Assessment Tool (ISCAT) to PAHP.
- Scheduled virtual audit review date.
- Conducted kick-off call to introduce the audit team, discuss the virtual audit review agenda, provide guidance on PMV processes, and ensure that the PAHP was aware of important deadlines.
- Reviewed completed ISCAT to assess the PAHP's IS.
- Reviewed source code used for calculating the performance measure rates to ensure compliance with the technical specifications.
- Conducted validation for all supplemental data sources intended for reporting and provided a final supplemental data validation report that listed the types of supplemental data reviewed and the validation results.
- Conducted preliminary rate review to assess data completeness and accuracy early in the audit process to allow time for making corrections, if needed, prior to final rate submission.

Audit Review Phase (January 2021 through April 2021)

- Conducted virtual audit review to assess the PAHP's capabilities to collect and integrate data from internal and external sources and produce reliable performance measure results.
- Provided preliminary audit findings.

Follow-Up and Reporting Phase (May 2021 through July 2021)

- Worked collaboratively to resolve any outstanding items and corrective actions, if applicable.
- Conducted final rate review and provided a rate analysis report that included a comparison to the preliminary rate submission and prior years' rates (if available). The report also included requests for clarification on any notable changes in rates, eligible populations, and measures with rates that remained the same from year to year.
- Approved the final rates and assigned a final, audited result to each selected measure.
- Produced and provided a final audit report containing a summary of all audit activities.

Description of Data Obtained and Related Time Period

The PMV for the MCOs and PAHP and the data collected through the PMV activities spanned a time period between October 2020 and July 2021.

Through the PMV methodology, HSAG obtained a number of different information sources to conduct the PMV according to NCQA's established HEDIS deadlines or the DHCFP-approved timeline. For the MCOs, these included:

- HEDIS Roadmap.
- Source code, computer programming, and query language (if applicable) used to calculate the selected performance measure rates.
- Supporting documentation such as file layouts, system flow diagrams, system log files, and policies and procedures.
- Re-abstraction of a sample of medical records selected by HSAG auditors.

For the PAHP, these included:

- ISCAT.
- Source code, computer programming, and query language (if applicable) used to calculate the selected measures.
- Supporting documentation such as file layouts, system flow diagrams, system log files, and policies and procedures.

For both the MCOs and the PAHP, HSAG also obtained information through interaction, discussion, and formal interviews with key PAHP staff members, as well as through observing system demonstrations and data processing.

Compliance Review

Activity Objectives

The objective of the SFY 2021 Compliance Review was to assess each MCE's compliance with the federal compliance review standards outlined in 42 CFR §438.358(b)(1)(iii) and related State contract requirements.

SFY 2021 began a new three-year review cycle, in which HSAG reviewed seven standards for compliance. The remaining seven standards will be reviewed in SFY 2022. In SFY 2023, HSAG will perform a comprehensive review of the MCEs' implementation of corrective actions taken to remediate any elements that received a *Not Met* score during SFYs 2021 and 2022. As demonstrated in Table A-4, HSAG will complete a comprehensive review of compliance with all federal requirements as stipulated in 42 CFR §438.358.

Table A-4—Nevada Compliance Review Three-Year Cycle for the MCEs

	Year One (SFY 2021)	Year Two (SFY 2022)	Year Three (SFY 2023)
Standard	**Review of Standards**		**CAP Review**
Standard I—Disenrollment: Requirements and Limitations	✓		Review of Standards/Elements that received a *Not Met* score during the SFY 2021 and 2022 reviews.
Standard II—Member Rights and Member Information	✓		
Standard III—Emergency and Poststabilization Services	✓		
Standard IV—Availability of Services	✓		
Standard V—Assurances of Adequate Capacity and Services	✓		
Standard VI—Coordination and Continuity of Care	✓		
Standard VII—Coverage and Authorization of Services	✓		
Standard VIII—Provider Selection		✓	
Standard IX—Confidentiality		✓	
Standard X—Grievance and Appeal Systems		✓	
Standard XI—Subcontractual Relationships and Delegation		✓	
Standard XII—Practice Guidelines		✓	
Standard XIII—Health Information Systems		✓	
Standard XIV—Quality Assessment and Performance Improvement Program		✓	

Technical Methods of Data Collection and Analysis

Before beginning the compliance review, HSAG developed data collection tools to document the review findings. The requirements in the tools were selected based on applicable federal and State regulations and requirements outlined in the contract between DHCFP and the MCEs. HSAG conducted the following activities as part of the compliance review:

Pre-review activities included:

- Developing the compliance review tools.
- Preparing and forwarding to each MCE a customized desk review form, instructions for completing the form, and instructions for submitting the requested documentation to HSAG for its desk review.
- Conducting a technical assistance session to assist the MCE in preparing for the compliance review.
- Scheduling the review.
- Developing the agenda for the review.
- Providing the detailed agenda and the data collection (compliance review) tool to each MCE to facilitate preparation for HSAG's review.
- Conducting a desk review of documents. HSAG conducted a desk review of key documents and other information obtained from DHCFP and of documents that each MCE submitted to HSAG. The desk review enabled HSAG reviewers to increase their knowledge and understanding of each MCE's operations, identify areas needing clarification, and begin compiling information before the site review.

Site review activities included:[A-4]

- An opening conference with introductions and a review of the agenda and logistics for HSAG's review activities.
- A review of the data systems that each MCE used in its operations, which included, but was not limited to, enrollment, utilization management, and care management systems.
- Interviews conducted with each MCE'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 tool (compliance standards), which serves as a comprehensive record of HSAG's findings; performance scores assigned to each requirement; and actions required to bring each MCE's performance into compliance for those requirements that HSAG assessed as less than fully compliant. HSAG also provided relevant recommendations to enhance program performance.

Post-review activities: HSAG reviewers aggregated findings to produce a comprehensive compliance review report. HSAG used scores of *Met* and *Not Met* to indicate the degree to which each MCE's performance complied with the requirements. A designation of *NA* was used when a requirement was

[A-4] Due to COVID-19, the on-site review was conducted virtually through a Webex session.

not applicable to an MCE during the period covered by HSAG's review. This scoring methodology is consistent with CMS' final protocol, *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity,* October 2019.[A-5] The protocol describes the scoring as follows:

- ***Met*** indicates full compliance defined as *both* of the following:
  - All documentation and data sources reviewed, including MCE data and documentation, case file reviews, and systems demonstrations for a regulatory provision, or component thereof, are present and provide supportive evidence of congruence.
  - Staff members are able to provide responses to reviewers that are consistent with each other, with the data and documentation reviewed, and with the regulatory provision.
- ***Not Met*** indicates noncompliance defined as *either* of the following:
  - Documentation and data sources are not present and/or do not provide supportive evidence of congruence with the regulatory provision.
  - Staff members have little or no knowledge of processes or issues addressed by the regulatory provisions.
  - For those provisions with multiple components, key components of the provision could not be identified and/or do not provide sufficient evidence of congruence with the regulatory provision. Any findings of *Not Met* for these components would result in an overall provision 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 standard and an overall percentage-of-compliance score across the standards. HSAG calculated the total score for each standard by adding the score for each requirement in the standard receiving a score of *Met* (value: 1 point) or *Not Met* (0 points), then dividing the summed 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 values of the scores, then dividing the result by the total number of applicable requirements).

Additionally, HSAG created a corrective action plan (CAP) template that contained the findings and required actions for each element scored *Not Met*. When submitting its CAP to DHCFP, the MCE must use this template to propose its plan to bring all elements scored as *Not Met* into compliance with the applicable standard(s).

[A-5] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Oct 6, 2021.

Aggregating the Scores

To draw conclusions about the quality and timeliness of, and access to, care and services that the MCE provided to members, HSAG aggregated and analyzed the data resulting from desk and site review activities. The data that HSAG aggregated and analyzed included the following:

- Documented findings describing the MCE's performance in complying with each standard requirement.
- Scores assigned to the MCE's performance for each requirement.
- The total percentage-of-compliance score calculated for each standard.
- The overall percentage-of-compliance score calculated across the standards.
- Documentation of the actions required to bring performance into compliance with the requirements for which HSAG assigned scores of *Not Met*.
- Recommendations for program enhancements.

Based on the results of the data aggregation and analysis, HSAG prepared and forwarded draft reports to DHCFP staff members for their review and comment prior to issuing final reports.

Description of Data Obtained and Related Time Period

To assess each MCE's compliance with federal regulations, State rules, and contract requirements, HSAG obtained information from a wide range of written documents produced by the MCEs, including, but not limited to:

- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.
- The provider manual and other MCE communication to providers and subcontractors.
- Member informational materials such as the member handbook and provider directory.
- 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, and care management.

HSAG obtained additional information for the compliance review through interaction, discussions, and interviews with each MCE's key staff members. Table A-5 lists the major data sources HSAG used to determine the MCE's performance in complying with requirements and the time period to which the data applied.

Table A-5—Description of MCE Data Sources

Data Obtained	Time Period to Which the Data Applied
Documentation submitted for HSAG's desk review and additional documentation available to HSAG during the site review	November 1, 2020–May 31, 2021
Information obtained through interviews	September 13–16, 2021
Information obtained from a review of a sample of service authorization denial records for file reviews	Listing of all denials (excluding denials of payment and concurrent reviews) between November 1, 2020–May 31, 2021
Information obtained from a review of a sample of care management records for file reviews	Listing of members newly enrolled into care management on or after September 1, 2020 [MCOs only]

Network Adequacy Validation

Activity Objectives

The objective of the NAV activity was to determine the sufficiency of each MCE's provider network to adequately provide all required services to its enrolled membership.

Under the contract for EQR, DHCFP requested that HSAG conduct a baseline NAV of the Medicaid provider network for all MCOs and the PAHP during SFY 2021. As part of this NAV analysis, HSAG focused on two components of network adequacy validation:

- **Network Capacity Analysis:** Assessment of the capacity of the provider network relative to the number of enrolled members.
- **Geographic Network Distribution Analysis:** Evaluation of the geographic distribution of the providers relative to member populations.

Technical Methods of Data Collection and Analysis

To prepare the data for the NAV analysis, HSAG cleaned, processed, and defined the unique lists of providers, provider locations, and members for inclusion in the analysis. HSAG standardized and geo-coded all Medicaid member and provider files using Quest Analytics Suite software. For all analyses, adults were defined as those members ages 18 years or older, and children were defined as members younger than 18 years of age. Analyses for OB/GYN providers were limited to female members ages 18 years and older.

Similarly, provider networks were restricted based on the type of analysis. Ratio analyses were based on unique providers, deduplicated by National Provider Identifier (NPI) and restricted to provider offices located in the State of Nevada or within Nevada Managed Care Program catchment areas. Each MCE's

full provider network was included in time-distance analyses regardless of provider office location. Individual providers with multiple practice locations were only counted once in the ratio analysis; however, each individual office location was counted in the time-distance analysis.

Provider Capacity Analysis: To assess the capacity of each MCE's provider network, HSAG calculated the member-to-provider ratio (provider ratio) by provider category (e.g., PCPs, cardiologists) relative to the number of members. The provider ratio represents a summary statistic used to highlight the overall capacity of an MCE's provider network to deliver services to Medicaid members. A lower provider ratio suggests the potential for greater network access since a larger pool of providers is available to render services to individuals. Provider counts for this analysis were based on unique providers and not provider locations.

Geographic Network Distribution Analysis: The second dimension of this study evaluated the geographic distribution of providers relative to MCE members. While the previously described provider capacity analysis identified the degree to which each MCE's provider network infrastructure was sufficient in both number of providers and variety of specialties, the geographic network distribution analysis evaluated whether or not the number of provider locations in an MCE's provider network was appropriately distributed for the Medicaid population.

To provide a comprehensive view of geographic access, HSAG calculated the following two spatially derived metrics for the provider categories identified in the provider crosswalks:

- Percentage of members within predefined access standards: A higher percentage of members meeting access standards indicates a better geographic distribution of the MCE providers relative to Medicaid members.
- Average travel distances (driving distances in miles) and travel times (driving times in minutes) to the nearest three providers: A shorter driving distance or travel time indicates greater accessibility to providers since members must travel fewer miles or minutes to access care.

HSAG used Quest Analytics software to calculate the duration of travel time or physical distance between the addresses of specific members and their nearest one-to-three providers for all provider categories identified in the provider crosswalks. All study results were stratified by MCE.

Description of Data Obtained and Related Time Period

DHCFP and the MCEs provided Medicaid member demographic information and provider network files, respectively, to HSAG for use in the baseline NAV analysis. HSAG provided detailed data requirements documents to DHCFP and the MCEs for the requested data, in alignment with the following criteria:

- Member Files
  - Member enrollment and demographic files including all members served by one or more MCEs as of February 1, 2021.

- Provider Data
  - Provider data for providers actively enrolled in an MCE as of February 1, 2021. The MCEs classified providers to selected provider categories in alignment with the provider crosswalk, which detailed the methods for classifying each provider category.

Consumer Assessment of Healthcare Providers and Systems Analysis/Member Satisfaction Survey

MCOs

Activity Objectives

The CAHPS activity assesses member experience with an MCO and its providers, and the quality of care they receive. The goal of the CAHPS Health Plan Surveys is to provide feedback that is actionable and will aid in improving members' overall experiences.

Technical Methods of Data Collection and Analysis

Three populations were surveyed for **Anthem**, **HPN**, and **SilverSummit**: adult Medicaid, child Medicaid, and Nevada Check Up. Center for the Study of Services, an NCQA-certified vendor, administered the 2021 CAHPS surveys for **Anthem**. SPH Analytics, an NCQA-certified vendor, administered the 2021 CAHPS surveys for **SilverSummit** and **HPN**.

The technical method of data collection was through the CAHPS 5.1H Adult Medicaid Health Plan Survey to the adult population and the CAHPS 5.1H Child Medicaid Health Plan Survey (with the CCC measurement set) to the child Medicaid and Nevada Check Up populations. **Anthem**, **HPN**, and **SilverSummit** used a mixed-mode methodology for data collection (i.e., mailed surveys followed by telephone interviews of non-respondents to the mailed surveys). For **Anthem**, **HPN**, and **SilverSummit**, all members selected in the sample received both an English and Spanish mail survey and had the option to complete the survey over the telephone in Spanish. For **HPN**, respondents were also given the option of completing the survey via Internet in English or Spanish.

CAHPS Measures

The survey questions were categorized into various measures of member experience. These measures included four global ratings, four 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 member experience with their personal doctor, specialist, health plan, and all healthcare. The composite measures were derived from sets of questions to address different aspects of care (e.g., getting needed care and how well doctors communicate). The CCC composite measures/items evaluated the experience of families with children with chronic conditions accessing various services (e.g., specialized services, prescription medications). The

Effectiveness of Care measures assessed the various aspects of providing assistance with smoking and tobacco use cessation.

Top-Box Score Calculations

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

For each of the composite measures and CCC composite measures/items, the percentage of respondents who chose a positive response was calculated. CAHPS composite question response choices fell into one of two categories: (1) "Never," "Sometimes," "Usually," or "Always" or (2) "No" or "Yes." A positive or top-box response for the composite measures and CCC composites/items was defined as a response of "Usually/Always" or "Yes." The percentage of top-box responses is referred to as a global proportion for the composite measures and CCC composite measures/items. For the Effectiveness of Care measures, responses of "Always/Usually/Sometimes" were used to determine if the respondent qualified for inclusion in the numerator. The scores presented follow NCQA's methodology of calculating a rolling average using the current and prior year results. When a minimum of 100 responses for a measure was not achieved, the result of the measure was denoted as *Not Applicable (NA)*.

NCQA National Average Comparisons

A substantial difference was denoted by a difference of 5 percentage points or more. Colors and arrows were used to note substantial differences. An MCO that performed at least 5 percentage points higher than the 2020 NCQA national average was denoted with an upward green (↑) arrow.[A-6] Conversely, an MCO that performed at least 5 percentage points lower than the 2020 NCQA national average was denoted with a downward red (↓) arrow. An MCO that was not at least 5 percentage points higher or lower than the 2020 NCQA national average was not denoted with an arrow. Since NCQA does not publish separate rates for CHIP, national comparisons could not be made for the Nevada Check Up program.

Plan Comparisons

Statistically significant differences between the 2021 top-box scores for the adult Medicaid, child Medicaid (general child and CCC), and Nevada Check Up populations for **Anthem**, **HPN**, and **SilverSummit** were noted with colors and arrows. An MCO that performed statistically significantly higher than the program average was denoted with an upward green (↑) arrow. Conversely, an MCO that performed statistically significantly lower than the program average was denoted with a downward red

[A-6] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2020.* Washington, DC: NCQA, September 2020.

(↓) arrow. An MCO that was not statistically significantly different than the program average was not denoted with an arrow.

Description of Data Obtained and Related Time Period

Based on NCQA protocol, adult members included as eligible for the survey were 18 years of age or older as of December 31, 2020, and child members included as eligible for the survey were 17 years of age or younger as of December 31, 2020. Adult members and parents or caretakers of child members completed the surveys from February to May 2021.

PAHP

Activity Objectives

The Member Satisfaction Survey's objective was to assess all areas of a dental appointment experience with providers for quality and member satisfaction, including an assessment of access to care, satisfaction of care, and overall satisfaction with network providers. The survey also assessed prior experience with the PAHP customer service and overall PAHP satisfaction. The Member Satisfaction Survey questionnaire was adapted from the CAHPS Dental Plan Survey.

Technical Methods of Data Collection and Analysis

Members with claims utilization from the most recent 90 days were selected from the PAHP's claims database. Multiple claims by members within 90 days were excluded to prevent multiple call attempts. Multiple members from the same phone number were narrowed down to one member per household to prevent multiple call attempts.

Member services representatives utilized a list compiled from the aforementioned sample and dialed out to those members to solicit feedback. The representative input the survey data directly into the core database under the member's account for reporting. Any member dissatisfaction discovered through the survey was attempted to be resolved on the call and any unresolved dissatisfaction was forwarded to the PAHP's Grievance and Appeals department.

Surveys for providers scoring less than 90 percent were referred to the Director of Professional Relations or designee for review of the deficiency to determine appropriate corrective action. Overall results of the Member Satisfaction Survey were reported to the Quality Management and Improvement Committee, and regulatory and contracted plans, as required.

Description of Data Obtained and Related Time Period

The results of each survey were recorded into the PAHP's core database under the applicable member's account for reporting. Noted dissatisfaction was also recorded through the Grievance and Appeals department. Member Satisfaction Survey results were compiled between June 2020 through May 2021 and reported to the Quality Management and Improvement Committee on June 24, 2021.

Nevada 2021 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 Access to and the Use of Preventive Services.							
Objective	**QISMC Objective**	**Anthem MY 2020**	**HPN MY 2020**	**SilverSummit MY 2020**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
1.1a:	Increase children and adolescents' access to PCPs (CAP)–12–24 months[#]	—	—	—	MNA	MNA	MNA	MNA
1.1b:	Increase children and adolescents' access to PCPs (CAP)–25 months–6 years[#]	—	—	—	MNA	MNA	MNA	MNA
1.1c:	Increase children and adolescents' access to PCPs (CAP)–7–11 years[#]	—	—	—	MNA	MNA	MNA	MNA
1.1d:	Increase children and adolescents' access to PCPs (CAP)–12–19 years[#]	—	—	—	MNA	MNA	MNA	MNA
1.2a:	Increase well-child visits in the first 30 months of life (W30)–0–15 months	58.52%	59.89%	54.96%	MNA	MNA	MNA	MNA
1.2b:	Increase well-child visits in the first 30 months of life (W30)–15–30 months	65.15%	68.83%	68.08%	MNA	MNA	MNA	MNA
1.3a:	Increase child and adolescent well-care visits (WCV)–3–11 years	46.99%	48.62%	39.99%	MNA	MNA	MNA	MNA
1.3b:	Increase child and adolescent well-care visits (WCV)–12–17 years	39.02%	41.59%	32.03%	MNA	MNA	MNA	MNA

Goal 1:	Improve the Health and Wellness of Nevada's Medicaid Population by Increasing Access to and the Use of Preventive Services.							
Objective	**QISMC Objective**	**Anthem MY 2020**	**HPN MY 2020**	**SilverSummit MY 2020**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
1.3c:	Increase child and adolescent well-care visits (WCV)–18–21 years	19.63%	24.50%	16.64%	MNA	MNA	MNA	MNA
1.3d:	Increase child and adolescent well-care visits (WCV)–total	41.29%	43.00%	33.70%	MNA	MNA	MNA	MNA
1.4a:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)–BMI percentile[1]	82.24%	**86.44%**	78.83%	82.70%	84.62%	86.55%	88.47%
1.4b:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)–counseling for nutrition	**74.21%**	**76.55%**	70.56%	72.63%	75.67%	78.71%	81.75%
1.4c:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)–counseling for physical activity	69.34%	**75.14%**	66.91%	69.60%	72.98%	76.35%	79.73%
1.5a:	Increase immunizations for adolescents (IMA)–Meningococcal, Tdap	**85.16%**	**88.56%**	78.59%	84.85%	86.54%	88.22%	89.90%
1.5b:	Increase immunizations for adolescents (IMA)–Meningococcal, Tdap, HPV	39.42%	47.45%	33.58%	47.65%	53.46%	59.28%	65.10%
1.6a:	Increase childhood immunization status (CIS)–Combination 2	66.67%	71.53%	66.18%	73.55%	76.49%	79.43%	82.37%
1.6b:	Increase childhood immunization status (CIS)–Combination 3	61.80%	**69.34%**	62.29%	68.86%	72.32%	75.78%	79.24%
1.6c:	Increase childhood immunization status (CIS)–Combination 4	61.80%	**69.10%**	62.04%	68.45%	71.95%	75.46%	78.96%
1.6d:	Increase childhood immunization status (CIS)–Combination 5	53.53%	**62.77%**	54.01%	59.46%	63.97%	68.47%	72.98%
1.6e:	Increase childhood immunization status (CIS)–Combination 6	34.31%	35.04%	33.82%	38.58%	45.40%	52.23%	59.05%
1.6f:	Increase childhood immunization status (CIS)–Combination 7	53.53%	**62.53%**	53.77%	59.15%	63.69%	68.23%	72.77%
1.6g:	Increase childhood immunization status (CIS)–Combination 8	34.31%	35.04%	33.82%	38.48%	45.31%	52.15%	58.98%

Goal 1:	Improve the Health and Wellness of Nevada's Medicaid Population by Increasing Access to and the Use of Preventive Services.							
Objective	**QISMC Objective**	**Anthem MY 2020**	**HPN MY 2020**	**SilverSummit MY 2020**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
1.6h:	Increase childhood immunization status (CIS)–Combination 9	30.90%	33.09%	29.20%	34.42%	41.70%	48.99%	56.28%
1.6i:	Increase childhood immunization status (CIS)–Combination 10	30.90%	33.09%	29.20%	34.32%	41.62%	48.91%	56.21%
1.7:	Increase adolescent well-care visits (AWC)[#]	—	—	—	MNA	MNA	MNA	MNA
1.8:	Increase breast cancer screening (BCS)[1]	44.67%	52.01%	44.68%	58.90%	63.46%	68.03%	72.60%
1.9a:	Increase adults' access to preventive/ambulatory health services (AAP)–20–44 years	64.55%	69.80%	58.20%	75.55%	78.26%	80.98%	83.70%
1.9b:	Increase adults' access to preventive/ambulatory health services (AAP)–45–64 years	72.29%	76.29%	69.12%	81.82%	83.84%	85.86%	87.88%
1.9c:	Increase adults' access to preventive/ambulatory health services (AAP)–65 years and older	**76.32%**	**81.41%**	**79.41%**	67.19%	70.83%	74.48%	78.12%
1.9d:	Increase adults' access to preventive/ambulatory health services (AAP)–total	66.81%	71.93%	61.54%	77.67%	80.15%	82.63%	85.11%
2.0	Decrease rate of adult acute inpatient stays that were followed by an unplanned readmission for any diagnosis within 30 days after discharge (PCR)*	14.42%	**11.13%**	13.58%	12.72%	11.30%	9.89%	8.48%

Goal 2:	Increase Use of Evidence-Based Practices for Members With Chronic Conditions.							
Objective	**QISMC Objective**	**Anthem MY 2020**	**HPN MY 2020**	**SilverSummit MY 2020**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
2.1a:	Increase rate of HbA1c testing for members with diabetes (CDC)[1]	73.72%	79.81%	70.56%	81.98%	83.98%	85.99%	87.99%
2.1b:	Decrease rate of HbA1c poor control (>9.0%) for members with diabetes (CDC)[*,1]	51.09%	**38.69%**	56.45%	39.28%	34.91%	30.55%	26.18%

Goal 2:	Increase Use of Evidence-Based Practices for Members With Chronic Conditions.							
Objective	**QISMC Objective**	**Anthem MY 2020**	**HPN MY 2020**	**SilverSummit MY 2020**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
2.1c:	Increase rate of HbA1c good control (<8.0%) for members with diabetes (CDC)[1]	40.63%	50.12%	37.47%	53.14%	58.34%	63.55%	68.76%
2.1d:	Increase rate of eye exams performed for members with diabetes (CDC)[1]	50.85%	**63.02%**	50.36%	61.47%	65.75%	70.03%	74.31%
2.1e:	Increase medical attention for nephropathy for members with diabetes (CDC)[#]	—	—	—	MNA	MNA	MNA	MNA
2.1f:	Increase blood pressure control (<140/90 mm Hg) for members with diabetes (CDC)[2]	50.61%	63.75%	36.50%	MNA	MNA	MNA	MNA
2.2a:	Increase medication management for people with asthma (MMA)—medication compliance 50 percent[#]	—	—	—	MNA	MNA	MNA	MNA
2.2b:	Increase medication management for people with asthma (MMA)—medication compliance 75 percent[#]	—	—	—	MNA	MNA	MNA	MNA
2.3:	Increase rate of controlling high blood pressure (CBP)[†]	51.09%	60.34%	32.85%	MNA	MNA	MNA	MNA
2.x:	Increase kidney health evaluation for people with diabetes (KED)–18–64 years	27.43%	42.02%	27.22%	MNA	MNA	MNA	MNA
2.x:	Increase kidney health evaluation for people with diabetes (KED)–65–74 years	NA	42.42%	NA	MNA	MNA	MNA	MNA
2.x:	Increase kidney health evaluation for people with diabetes (KED)–75–84 years	NA	NA	NA	MNA	MNA	MNA	MNA
2.x:	Increase kidney health evaluation for people with diabetes (KED)–total	27.55%	42.02%	27.40%	MNA	MNA	MNA	MNA

Goal 3:	Improve Appropriate Use of Opioids.							
Objective	**QISMC Objective**	**Anthem MY 2020**	**HPN MY 2020**	**SilverSummit MY 2020**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
3.1:	Reduce use of opioids at high dosage (HDO)[*,3]	8.90%	10.00%	**4.50%**	8.63%	7.67%	6.71%	5.75%
3.2a:	Reduce use of opioids from multiple providers (UOP)—multiple prescribers[*,1]	**15.90%**	29.47%	24.93%	22.43%	19.94%	17.44%	14.95%
3.2b:	Reduce use of opioids from multiple providers (UOP)—multiple pharmacies[*,1]	**1.15%**	**2.12%**	**0.62%**	3.16%	2.81%	2.46%	2.11%
3.2c:	Reduce use of opioids from multiple providers (UOP)—multiple prescribers and multiple pharmacies[*,1]	**0.57%**	**1.23%**	**0.18%**	1.62%	1.44%	1.26%	1.08%

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 MY 2020**	**HPN MY 2020**	**SilverSummit MY 2020**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
4.1:	Increase timeliness of prenatal care (PPC)[3]	81.75%	**87.59%**	71.53%	86.26%	87.78%	89.31%	90.84%
4.2:	Increase the rate of postpartum visits (PPC)[3]	66.18%	**78.83%**	58.64%	72.66%	75.70%	78.73%	81.77%

Goal 5:	Increase Use of Evidence-Based Practices for Members With Behavioral Health Conditions.							
Objective	**QISMC Objective**	**Anthem MY 2020**	**HPN MY 2020**	**SilverSummit MY 2020**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
5.1a:	Increase follow-up care for children prescribed ADHD medication (ADD)—initiation phase[1]	47.06%	**54.10%**	47.71%	50.09%	55.63%	61.18%	66.72%
5.1b:	Increase follow-up care for children prescribed ADHD medication (ADD)—continuation and maintenance phase[1]	**68.66%**	**68.82%**	NA	60.00%	64.45%	68.89%	73.34%
5.3:	Increase adherence to antipsychotic medications for individuals with schizophrenia (SAA)	34.72%	44.73%	39.32%	46.08%	52.07%	58.06%	64.05%

Goal 5:	Increase Use of Evidence-Based Practices for Members With Behavioral Health Conditions.							
Objective	**QISMC Objective**	**Anthem MY 2020**	**HPN MY 2020**	**SilverSummit MY 2020**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
5.4:	Increase follow-up after hospitalization for mental illness (FUH)—7-day[1]	32.49%	38.58%	36.69%	39.45%	46.18%	52.90%	59.63%
5.5:	Increase follow-up after hospitalization for mental illness (FUH)—30-day[1]	48.72%	**56.65%**	54.62%	54.86%	59.87%	64.89%	69.90%
5.6:	Increase diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications (SSD)	76.62%	74.58%	69.19%	81.43%	83.50%	85.56%	87.62%
5.7a:	Increase follow-up after ED visit for AOD abuse or dependence (FUA)—7-day[1]	12.29%	16.03%	**19.70%**	18.21%	27.30%	36.38%	45.47%
5.7b:	Increase follow-up after ED visit for AOD abuse or dependence (FUA)—30-day[1]	17.12%	20.92%	**26.57%**	21.60%	30.31%	39.02%	47.73%
5.8a:	Increase follow-up after ED visit for mental illness (FUM)—7-day[1]	29.55%	**52.34%**	42.96%	47.67%	53.49%	59.30%	65.12%
5.8b:	Increase follow-up after ED visit for mental illness (FUM)—30-day[1]	40.89%	**60.81%**	53.66%	55.92%	60.82%	65.71%	70.61%
5.9a:	Increase initiation and engagement of AOD abuse or dependence treatment (IET)—initiation of treatment[1]	**45.91%**	37.81%	41.27%	45.24%	51.33%	57.41%	63.50%
5.9b:	Increase initiation and engagement of AOD abuse or dependence treatment (IET)—engagement of treatment[1]	14.73%	11.56%	10.78%	18.94%	27.94%	36.95%	45.96%
5.10:	Increase metabolic monitoring for children and adolescents on antipsychotics (APM)	**31.27%**	**33.89%**	**25.41%**	25.33%	33.62%	41.92%	50.22%

Goal 6:	Reduce and/or Eliminate Health Care Disparities for Medicaid Recipients				
Objective	**Objective Description**	**Anthem**	**HPN**	**SilverSummit**	**MPS**
6.1:	Ensure that health plans maintain, submit for review, and annually revise cultural competency plans.	Met	Met	Met	Met
6.2:	Stratify data for performance measures by race and ethnicity to determine where disparities exist. Continually identify, organize, and target interventions to reduce disparities and improve access to appropriate services for the Medicaid and Nevada Check Up populations.	Met	Met	Met	Met
6.3:	Ensure that each MCO submits an annual evaluation of its cultural competency programs to the DHCFP. The MCOs must receive a 100 percent *Met* compliance score for all criteria listed in the MCO contract for cultural competency program development, maintenance, and evaluation.	Met	Met	Met	Met

[1] Due to changes in the technical specifications for this measure, NCQA recommends that trending between HEDIS MY 2020 and prior years be considered with caution.
[2] Due to significant changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS MY 2020 and prior years. Due to the QISMC goals being based on HEDIS MY 2019 statewide aggregate rates, where applicable, comparisons to QISMC goals should be considered with caution.
[3] Due to changes in the technical specifications for this measure, NCQA recommends that trending between HEDIS MY 2020 and prior years be considered with caution. As a result, the QISMIC goals were updated based on the prior year's aggregated rate.
* A lower rate indicates better performances for this measure.
[#] This measure is retired for HEDIS MY 2020.
— Indicates that the MCO was not required to report this measure.
MNA indicates the HEDIS MY 2020 QISMC goals are unavailable for this measure.
NA indicates that the MCO followed the specifications, but the denominator was too small (<30) to report a valid rate.
Bolded rates indicate that the performance measure rate for HEDIS MY 2020 was at or above the MPS.
Indicates that the HEDIS MY 2020 rate surpassed the Tier 3 QISMC goal.

Nevada 2021 Quality Strategy
Goals and Objectives for Nevada Check Up

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

Goal 1:	Improve the Health and Wellness of Nevada's Nevada Check Up Population by Increasing Access to and the Use of Preventive Services.							
Objective	**QISMC Objective**	**Anthem MY 2020**	**HPN MY 2020**	**SilverSummit MY 2020**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
1.1a:	Increase children and adolescents' access to PCPs (CAP)–12–24 months[#]	—	—	—	MNA	MNA	MNA	MNA
1.1b:	Increase children and adolescents' access to PCPs (CAP)–25 months–6 years[#]	—	—	—	MNA	MNA	MNA	MNA
1.1c:	Increase children and adolescents' access to PCPs (CAP)–7–11 years[#]	—	—	—	MNA	MNA	MNA	MNA
1.1d:	Increase children and adolescents' access to PCPs (CAP)–12–19 years[#]	—	—	—	MNA	MNA	MNA	MNA
1.2a:	Increase well-child visits in the first 30 months of life (W30)–0–15 months	71.23%	72.45%	56.25%	MNA	MNA	MNA	MNA
1.2b:	Increase well-child visits in the first 30 months of life (W30)–15–30 months	77.27%	82.76%	85.42%	MNA	MNA	MNA	MNA
1.3a:	Increase child and adolescent well-care visits (WCV)–3–11 years	55.51%	55.57%	44.81%	MNA	MNA	MNA	MNA
1.3b:	Increase child and adolescent well-care visits (WCV)–12–17 years	48.50%	50.91%	40.76%	MNA	MNA	MNA	MNA
1.3c:	Increase child and adolescent well-care visits (WCV)–18–21 years	30.90%	33.50%	21.84%	MNA	MNA	MNA	MNA

Goal 1:	Improve the Health and Wellness of Nevada's Nevada Check Up Population by Increasing Access to and the Use of Preventive Services.							
Objective	**QISMC Objective**	**Anthem MY 2020**	**HPN MY 2020**	**SilverSummit MY 2020**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
1.3d:	Increase child and adolescent well-care visits (WCV)–total	51.37%	52.09%	41.56%	MNA	MNA	MNA	MNA
1.4a:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)–BMI percentile	81.75%	**85.97%**	76.64%	85.65%	87.25%	88.84%	90.44%
1.4b:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)–counseling for nutrition	74.94%	74.93%	67.88%	76.13%	78.78%	81.44%	84.09%
1.4c:	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)–counseling for physical activity	69.10%	72.84%	66.42%	73.04%	76.03%	79.03%	82.02%
1.5a:	Increase immunizations for adolescents (IMA)–Meningococcal, Tdap	**92.94%**	**94.07%**	**90.63%**	89.03%	90.25%	91.47%	92.69%
1.5b:	Increase immunizations for adolescents (IMA)–Meningococcal, Tdap, HPV	57.18%	50.62%	43.75%	57.54%	62.26%	66.97%	71.69%
1.6a:	Increase childhood immunization status (CIS)–Combination 2	81.82%	84.19%	81.40%	89.07%	90.29%	91.50%	92.72%
1.6b:	Increase childhood immunization status (CIS)–Combination 3	78.79%	81.29%	81.40%	83.46%	85.30%	87.13%	88.97%
1.6c:	Increase childhood immunization status (CIS)–Combination 4	78.79%	81.29%	81.40%	83.46%	85.30%	87.13%	88.97%
1.6d:	Increase childhood immunization status (CIS)–Combination 5	69.70%	75.81%	74.42%	77.33%	79.85%	82.37%	84.89%
1.6e:	Increase childhood immunization status (CIS)–Combination 6	45.96%	44.52%	**51.16%**	47.40%	53.24%	59.09%	64.93%
1.6f:	Increase childhood immunization status (CIS)–Combination 7	69.70%	75.81%	74.42%	77.33%	79.85%	82.37%	84.89%
1.6g:	Increase childhood immunization status (CIS)–Combination 8	45.96%	44.52%	**51.16%**	47.40%	53.24%	59.09%	64.93%
1.6h:	Increase childhood immunization status (CIS)–Combination 9	42.42%	41.94%	**46.51%**	44.91%	51.03%	57.15%	63.27%

Goal 1:	Improve the Health and Wellness of Nevada's Nevada Check Up Population by Increasing Access to and the Use of Preventive Services.							
Objective	**QISMC Objective**	**Anthem MY 2020**	**HPN MY 2020**	**SilverSummit MY 2020**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
1.6i:	Increase childhood immunization status (CIS)–Combination 10	42.42%	41.94%	**46.51%**	44.91%	51.03%	57.15%	63.27%
1.7:	Increase adolescent well-care visits (AWC)[#]	—	—	—	MNA	MNA	MNA	MNA
1.8:	Increase breast cancer screening (BCS)	—	—	—	MNA	MNA	MNA	MNA
1.9a:	Increase adults' access to preventive/ambulatory health services (AAP)–20–44 years	—	—	—	MNA	MNA	MNA	MNA
1.9b:	Increase adults' access to preventive/ambulatory health services (AAP)–45–64 years	—	—	—	MNA	MNA	MNA	MNA
1.9c:	Increase adults' access to preventive/ambulatory health services (AAP)–65 years and older	—	—	—	MNA	MNA	MNA	MNA
1.9d:	Increase adults' access to preventive/ambulatory health services (AAP)–total	—	—	—	MNA	MNA	MNA	MNA

Goal 2:	Increase Use of Evidence-Based Practices for Members With Chronic Conditions.							
Objective	**QISMC Objective**	**Anthem MY 2020**	**HPN MY 2020**	**SilverSummit MY 2020**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
2.1a:	Increase rate of HbA1c testing for members with diabetes (CDC)	—	—	—	MNA	MNA	MNA	MNA
2.1b:	Decrease rate of HbA1c poor control (>9.0%) for members with diabetes (CDC)*	—	—	—	MNA	MNA	MNA	MNA
2.1c:	Increase rate of HbA1c good control (<8.0%) for members with diabetes (CDC)	—	—	—	MNA	MNA	MNA	MNA
2.1d:	Increase rate of eye exams performed for members with diabetes (CDC)	—	—	—	MNA	MNA	MNA	MNA

Goal 2:	Increase Use of Evidence-Based Practices for Members With Chronic Conditions.							
Objective	**QISMC Objective**	**Anthem MY 2020**	**HPN MY 2020**	**SilverSummit MY 2020**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
2.1e:	Increase medical attention for nephropathy for members with diabetes (CDC)[#]	—	—	—	MNA	MNA	MNA	MNA
2.1f:	Increase blood pressure control (<140/90 mm Hg) for members with diabetes (CDC)[†]	—	—	—	MNA	MNA	MNA	MNA
2.2a:	Increase medication management for people with asthma (MMA)—medication compliance 50 percent[#]	—	—	—	MNA	MNA	MNA	MNA
2.2b:	Increase medication management for people with asthma (MMA)—medication compliance 75 percent[#]	—	—	—	MNA	MNA	MNA	MNA
2.3:	Increase rate of controlling high blood pressure (CBP)[†]	—	—	—	MNA	MNA	MNA	MNA
2.x:	Increase kidney health evaluation for people with diabetes (KED)–18–64 years	—	—	—	MNA	MNA	MNA	MNA
2.x:	Increase kidney health evaluation for people with diabetes (KED)–65–74 years	—	—	—	MNA	MNA	MNA	MNA
2.x:	Increase kidney health evaluation for people with diabetes (KED)–75–84 years	—	—	—	MNA	MNA	MNA	MNA
2.x:	Increase kidney health evaluation for people with diabetes (KED)–total	—	—	—	MNA	MNA	MNA	MNA

Goal 3:	Improve Appropriate Use of Opioids.							
Objective	**QISMC Objective**	**Anthem MY 2020**	**HPN MY 2020**	**SilverSummit MY 2020**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
3.1:	Reduce use of opioids at high dosage (HDO)*	—	—	—	MNA	MNA	MNA	MNA
3.2a:	Reduce use of opioids from multiple providers (UOP)—multiple prescribers*	—	—	—	MNA	MNA	MNA	MNA

Goal 3:	Improve Appropriate Use of Opioids.							
Objective	**QISMC Objective**	**Anthem MY 2020**	**HPN MY 2020**	**SilverSummit MY 2020**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
3.2b:	Reduce use of opioids from multiple providers (UOP)—multiple pharmacies*	—	—	—	MNA	MNA	MNA	MNA
3.2c:	Reduce use of opioids from multiple providers (UOP)—multiple prescribers and multiple pharmacies*	—	—	—	MNA	MNA	MNA	MNA

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 MY 2020**	**HPN MY 2020**	**SilverSummit MY 2020**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
4.1:	Increase timeliness of prenatal care (PPC)	—	—	—	MNA	MNA	MNA	MNA
4.2:	Increase the rate of postpartum visits (PPC)	—	—	—	MNA	MNA	MNA	MNA

Goal 5:	Increase Use of Evidence-Based Practices for Members With Behavioral Health Conditions.							
Objective	**QISMC Objective**	**Anthem MY 2020**	**HPN MY 2020**	**SilverSummit MY 2020**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
5.1a:	Increase follow-up care for children prescribed ADHD medication (ADD)—initiation phase	43.59%	46.55%	NA	56.00%	60.89%	65.78%	70.67%
5.1b:	Increase follow-up care for children prescribed ADHD medication (ADD)—continuation and maintenance phase	NA	NA	NA	MNA	MNA	MNA	MNA
5.3:	Increase adherence to antipsychotic medications for individuals with schizophrenia (SAA)	—	—	—	MNA	MNA	MNA	MNA
5.4:	Increase follow-up after hospitalization for mental illness (FUH)—7-day	47.50%	NA	NA	63.01%	67.12%	71.23%	75.34%
5.5:	Increase follow-up after hospitalization for mental illness (FUH)—30-day	67.50%	NA	NA	75.34%	78.08%	80.82%	83.56%

Goal 5:	Increase Use of Evidence-Based Practices for Members With Behavioral Health Conditions.							
Objective	**QISMC Objective**	**Anthem MY 2020**	**HPN MY 2020**	**SilverSummit MY 2020**	**MPS (QISMC 10%)**	**Tier 1 (QISMC 20%)**	**Tier 2 (QISMC 30%)**	**Tier 3 (QISMC 40%)**
5.6:	Increase diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications (SSD)	—	—	—	MNA	MNA	MNA	MNA
5.7a:	Increase follow-up after ED visit for AOD abuse or dependence (FUA)—7-day	NA	NA	NA	MNA	MNA	MNA	MNA
5.7b:	Increase follow-up after ED visit for AOD abuse or dependence (FUA)—30-day	NA	NA	NA	MNA	MNA	MNA	MNA
5.8a:	Increase follow-up after ED visit for mental illness (FUM)—7-day	NA	NA	NA	79.47%	81.75%	84.03%	86.31%
5.8b:	Increase follow-up after ED visit for mental illness (FUM)—30-day	NA	NA	NA	82.63%	84.56%	86.49%	88.42%
5.9a:	Increase initiation and engagement of AOD abuse or dependence treatment (IET)—initiation of treatment	NA	12.50%	NA	38.33%	45.18%	52.04%	58.89%
5.9b:	Increase initiation and engagement of AOD abuse or dependence treatment (IET)—engagement of treatment	NA	0.00%	NA	18.33%	27.41%	36.48%	45.56%
5.10:	Increase metabolic monitoring for children and adolescents on antipsychotics (APM)	NA	**44.90%**	NA	28.87%	36.78%	44.68%	52.58%

Goal 6:	Reduce and/or Eliminate Health Care Disparities for Medicaid Recipients.				
Objective	**Objective Description**	**Anthem**	**HPN**	**SilverSummit**	**MPS**
6.1:	Ensure that health plans maintain, submit for review, and annually revise cultural competency plans.	Met	Met	Met	Met
6.2:	Stratify data for performance measures by race and ethnicity to determine where disparities exist. Continually identify, organize, and target interventions to reduce disparities and improve access to appropriate services for the Medicaid and Nevada Check Up populations.	Met	Met	Met	Met

Goal 6:	Reduce and/or Eliminate Health Care Disparities for Medicaid Recipients.				
Objective	**Objective Description**	**Anthem**	**HPN**	**SilverSummit**	**MPS**
6.3:	Ensure that each MCO submits an annual evaluation of its cultural competency programs to the DHCFP. The MCOs must receive a 100 percent *Met* compliance score for all criteria listed in the MCO contract for cultural competency program development, maintenance, and evaluation.	Met	Met	Met	Met

* A lower rate indicates better performances for this measure.

This measure is retired for HEDIS MY 2020.

† Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between HEDIS MY 2020 and prior years. Due to the QISMC goals being based on HEDIS MY 2020 statewide aggregate rates, where applicable, comparisons to QISMC goals should be considered with caution.

— Indicates that the health plan was not required to report this measure.

MNA indicates the HEDIS MY 2020 QISMC goals are unavailable for this measure.

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

Bolded rates indicate that the performance measure rate for HEDIS MY 2020 was at or above the MPS.

Indicates that the HEDIS MY 2020 rate surpassed the Tier 3 QISMC goal.

Nevada 2021 Quality Strategy
Goals and Objectives for LIBERTY Dental

Medicaid

Goal 7:	Increase Utilization of Dental Services.					
Objective	QISMC Objective	LIBERTY MY 2020	MPS (QISMC 10%)	Tier 1 (QISMC 20%)	Tier 2 (QISMC 30%)	Tier 3 (QISMC 40%)
7.1	Increase annual dental visits (ADV)	43.55%	57.62%	62.33%	67.04%	71.75%
7.2	Increase percentage of eligible members who received preventive dental services	34.07%	45.78%	51.81%	57.83%	63.86%

Nevada Check Up

Goal 7:	Increase Utilization of Dental Services.					
Objective	QISMC Objective	LIBERTY MY 2020	MPS (QISMC 10%)	Tier 1 (QISMC 20%)	Tier 2 (QISMC 30%)	Tier 3 (QISMC 40%)
7.1	Increase annual dental visits (ADV)	57.97%	71.63%	74.78%	77.94%	81.09%
7.2	Increase percentage of eligible members who received preventive dental services	50.92%	58.61%	63.21%	67.81%	72.41%