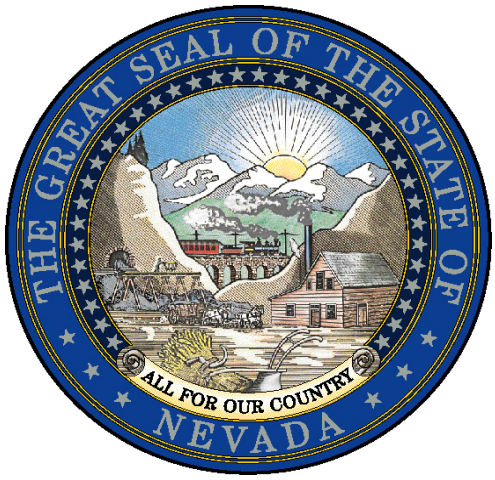

Division of Health Care Financing and Policy
Nevada Managed Care Program

State Fiscal Year 2022 External Quality Review Technical Report

February 2023

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Purpose and Overview of Report

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

DHCFP administers and oversees the Nevada Managed Care Program, which provides Medicaid and Children's Health Insurance Program (CHIP, also referred to as Nevada Check Up in Nevada) benefits to members residing in Clark and Washoe counties. The Nevada Managed Care Program's MCEs include four managed care organizations (MCOs) contracted with DHCFP to provide physical health and behavioral health services to Medicaid and Nevada Check Up members. DHCFP also contracted with one prepaid ambulatory health plan (PAHP), also known as the dental benefits administrator, to provide dental benefits for Medicaid and Nevada Check Up members. The MCOs and PAHP contracted with DHCFP during state fiscal year (SFY) 2022 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
Molina Healthcare of Nevada, Inc.[1-1]	Molina
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

[1-1] Molina began providing coverage to Medicaid and Nevada Check Up members effective January 1, 2022.

Medicare & Medicaid Services (CMS).[1-2] 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 their performance with respect to the quality, timeliness, and accessibility of care. Effective implementation of the EQR-related activities will facilitate State efforts to purchase high-value care and to achieve higher performing healthcare delivery systems for their Medicaid and CHIP members. For the SFY 2022 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, timeliness, and accessibility of care and services provided by each MCE. Detailed information about each activity methodology is provided in Appendix A of this report.

Table 1-2—EQR Activities

Activity	Description	CMS Protocol
Validation of Performance Improvement Projects (PIPs)	This activity verifies whether a PIP conducted by an MCE used sound methodology in its design, implementation, analysis, and reporting.	Protocol 1. Validation of Performance Improvement Projects
Performance Measure Validation (PMV)	This activity assesses whether the performance measures calculated by an MCE are accurate based on the measure specifications and State reporting requirements.	Protocol 2. Validation of Performance Measures
Compliance Review	This activity determines the extent to which a Medicaid and CHIP MCE is in compliance with federal standards and associated state-specific requirements, when applicable.	Protocol 3. Review of Compliance with Medicaid and CHIP Managed Care Regulations
Network Adequacy Validation (NAV)	This activity assesses the 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®)[1-3] 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.

[1-2] 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: Dec 16, 2022.

[1-3] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Nevada Managed Care Program Conclusions and Recommendations

HSAG used its analyses and evaluations of EQR activity findings from SFY 2022 activities 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 conclusions and actionable state-specific recommendations, when applicable, for DHCFP to drive progress toward achieving the goals of the Nevada Quality Strategy and support improvement in the quality, timeliness, and access to healthcare services furnished to Medicaid members.

Table 1-3—Programwide Conclusions and Recommendations

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Goal 1—Improve the health and wellness of Nevada's Medicaid population by increasing the use of preventive services by December 31, 2024	**Conclusions:** The Nevada Managed Care Program overall had adequate practices for ensuring its providers were aware of its adopted practice guidelines including guidelines for preventive care. The network adequacy standards were also met for primary care providers (PCPs) and pediatricians statewide, indicating the MCOs appeared to have a sufficient number of providers to render preventive services to children and adults. However, over the past three-year period (measurement year [MY] 2019–MY 2021), there has been a steady decline in the percentage of adult members accessing preventive services, and an even higher rate of decline in members 65 years and older. While there has been improvement in the percentage of Medicaid children and adolescents ages 3 to 17 who received one or more well-care visits with a PCP or an obstetrics and gynecology (OB/GYN) provider during the year, there has been a decline in the associated rates for the *Well-Child Visits in the First 30 Months of Life* performance measure for both the Medicaid and Nevada Check Up populations. There was also a decline in the prevalence of immunizations for children and adolescents over the past three years and no objectives under Goal 1 met the minimum performance standard (MPS). **Recommendations:** For SFY 2023, DHCFP has mandated that the MCOs implement a PIP to increase rates of child and adolescent well-care visits among members eligible for these services. To ensure interventions are actionable and will support performance improvement for this PIP, HSAG recommends that DHCFP review the MCOs' planned interventions prior to MCO implementation and provide feedback on any planned interventions based on DHCFP's knowledge of the environment in the State of Nevada. DHCFP	☒ Quality ☒ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	could also consider whether state-required interventions would be appropriate for the MCOs to implement for the PIP mandated by DHCFP for SFY 2023. Further, to gain a better understanding of the potential barriers to members seeking preventive care, HSAG also recommends that DHCFP collaborate with the MCOs to identify strategies to improve the CAHPS response rates so that the information obtained through the surveys provide enough data to make meaningful conclusions.	
Goal 2—Increase use of evidence-based practices for members with chronic conditions by December 31, 2024	**Conclusions:** All MCOs demonstrated an improvement in performance over the past three MYs in the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measure indicator, and the programwide aggregated rate also demonstrated improvement over time. Additionally, programwide, the percentage of diabetic members obtaining hemoglobin A1c (HbA1c) tests, having HbA1c levels less than 8 percent, and having their blood pressure under control improved over the past SFY, indicating the Nevada Managed Care Program focused efforts on diabetes management and members were gaining better control over their diabetes. However, MPS at the program level have not been met for SFY 2022 for Quality Strategy Objectives 2.1a and b, 2.2, and 2.3 related to comprehensive diabetes care. Additionally, the *Controlling High Blood Pressure* measure demonstrated a slight increase from MY 2019. Further the *Kidney Health Evaluation for Patients With Diabetes* measure rates demonstrated minimal change overall. Under Goal 2 and the associated objectives (2.1a-b, 2.2, 2.3, 2.4, 2.6), no programwide MPS were attained. **Recommendations:** In SFY 2020, DHCFP mandated that the MCOs initiate the *Comprehensive Diabetes Care (CDC) Hemoglobin A1c (HbA1c) Poor Control >9.0%* PIP. Although there was demonstrated improvement in the *Comprehensive Diabetes Care* measure indicators, including *HbA1c Poor Control (>9.0%)*, as determined through the PMV activity results, only one of the MCO's interventions was attributed to the improved outcomes, suggesting the improvement in the rates was not related to the PIP interventions but was influenced by other factors. To ensure interventions are actionable and will support performance improvement for future PIPs, HSAG recommends that DHCFP review the MCOs' planned interventions prior to MCO implementation and provide feedback on any planned interventions based on DHCFP's knowledge of the environment in the State of Nevada. DHCFP could also consider whether state-required interventions would be appropriate for the MCOs to implement for the PIPs mandated by DHCFP for SFY 2023. DHCFP could consult	☒ Quality ☐ Timeliness ☐ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	with HSAG through these processes. Additionally, while the aggregate compliance review score for the Practice Guidelines standard was 94 percent, HSAG recommends that the MCOs ensure their list of adopted clinical practice guidelines are inclusive of guidelines to support the Quality Strategy objectives under Goal 2 and ensure their contracted providers are informed of the expectations for treating chronic conditions.	
Goal 3—Reduce misuse of opioids by December 31, 2024	**Conclusions:** For the *Use of Opioids at High Dosage* and *Use of Opioids From Multiple Providers* measures, the Medicaid aggregate rates were above the MPS, indicating the Nevada Managed Care Program achieved Objectives 3.1 and 3.2 under Goal 3. **Recommendations:** In SFY 2022, DHCFP added two new objectives to its Quality Strategy to support continued improvement of Goal 3. HSAG recommends that DHCFP and its MCOs monitor network providers' prescribing practices of opioids related to the new objectives (3.3a-b) and implement interventions, as necessary, to support achievement of the established MPS once available.	☒ Quality ☐ Timeliness ☐ Access
Goal 4—Improve the health and wellness of pregnant women and infants by December 31, 2024	**Conclusions:** While the *Postpartum Care* measure indicator at the programwide level improved slightly over a three-year period, the aggregated rate for the *Timeliness of Prenatal Care* measure indicator declined over a three-year period; and the associated Quality Strategy objectives (4.1a-b) did not meet the established MPS for both of these measures. From the findings of the NAV activity, three of the four MCOs did not meet the access standard statewide for the OB/GYN provider type and none of the four MCOs met the standard for Washoe County. These findings indicate pregnant women may experience challenges accessing prenatal care timely due to the lack of OB/GYN providers contracted with the MCOs and available to provide services to pregnant women or women who have recently delivered. **Recommendations:** In SFY 2020, DHCFP mandated that the MCOs initiate the *Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care* PIP. While a PIP was implemented to support improved outcomes for pregnant women, two of three MCOs' PIPs were not successful and the *Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care* performance measure declined programwide over a three-year period, indicating overall that the PIPs did not support achievement of the objectives under Quality Strategy Goal 4. To ensure the newly DHCFP-mandated PIPs for improving rates for prenatal and postpartum care for pregnant women in Medicaid managed care are successful, HSAG recommends that DHCFP review the MCOs' planned interventions	☒ Quality ☒ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	prior to MCO implementation and provide feedback on any planned interventions to ensure the interventions will support a reduction in health disparities and overall improvement in the timeliness of prenatal and postpartum care. In SFY 2022, DHCFP added five new objectives (4.2a-b, 4.3a-b, 4.4) to its Quality Strategy to support improvement in the health and wellness of pregnant women and their babies. HSAG recommends that DHCFP and its MCOs monitor the associated performance measures and identify strategies to improve member access to OB/GYN providers.	
Goal 5—Increase use of evidence-based practices for members with behavioral health conditions by December 31, 2024	**Conclusions:** At the program wide level, none of the behavioral health objectives under Goal 5 met the MPS for the Medicaid population, when an MPS was available. Additionally, while three objectives (5.3b, 5.6a-b) for the Nevada Check Up population met the programwide MPS, the remaining objectives with an established MPS did not. These findings indicate substantial opportunities for DHCFP and its contracted MCOs to ensure all members diagnosed with a mental illness and/or substance use disorder (SUD) are receiving timely follow-up appointments after emergency department (ED) visits and inpatient hospitalization, and are receiving adequate screenings, treatment, and medication management. With the exception of pediatric psychologists for two MCOs, the Nevada Managed Care Program had a sufficient network of behavioral health providers to render necessary services. **Recommendations:** For SFY 2023, DHCFP mandated that the MCOs initiate PIPs related to increasing rates of follow up after ED visit for adults and children who received a follow-up visit for mental illness, and improving access to care for Medicaid members with SUD. DHCFP is also requiring the MCOs to initiate and test at least one intervention focused on network adequacy and coordination of care initiatives around these two topics. Further, DHCFP added additional objectives (5.9, 5.11a-b, 5.12, 5.13a-b) to its Quality Strategy to support health outcomes in members with behavioral health conditions. As DHCFP has targeted initiatives to promote the achievement of Quality Strategy Goal 5, HSAG has no additional recommendations at this time.	☒ Quality ☒ Timeliness ☒ Access
Goal 6—Increase utilization of dental services by December 31, 2024	**Conclusions:** Based on the NAV activity, there appeared to be an adequate network of primary dental providers and most specialists, and for all age groups under the *Annual Dental Visit* measure, the Nevada Managed Care Program demonstrated an increase in all performance measures rates. However, no objectives under Goal 6 met the MPS for both the Medicaid and Nevada Check Up populations.	☒ Quality ☒ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	Recommendations: DHCFP added three objectives (6.2, 6.3, 6.4) to its Quality Strategy to support health outcomes and increase the rate of children receiving a comprehensive or periodic oral evaluation, topical fluoride applications, and sealants. HSAG recommends that DHCFP monitor the results of the associated new performance measures and identify additional strategies (e.g., new PIP topics), as necessary, to continue its progress toward achieving Quality Strategy Goal 6 and improving oral health outcomes for its members.	
Goal 7—Reduce and/or eliminate health care disparities for Medicaid members by December 31, 2024	**Conclusions:** The aggregated findings from each of the EQR activities did not produce sufficient data for HSAG to assess the impact the EQR activities had on reducing and/or eliminating healthcare disparities for Medicaid members other than by geographic area or by gender (i.e., through the PIP and/or NAV activities). **Recommendations:** Through its contract with the MCEs, DHCFP requires that each MCE initiate several activities focused on eliminating healthcare disparities such as mandated PIPs (e.g., addressing maternal and infant health disparities within the African-American population, interventions addressing health disparities in dental services); implementation of cultural competency programs and plans; and the development of population health programs, including the requirement to target clinical programs to reduce healthcare disparities based on race and ethnicity. DHCFP also encourages each MCO to obtain the Multicultural Health Care Distinction from the National Committee for Quality Assurance (NCQA) as a way to build a strong cultural competency program, reduce health disparities, and develop culturally and linguistically appropriate member communication strategies. In addition to the initiatives already underway, HSAG recommends DHCFP consider requiring the MCEs to stratify the Healthcare Effectiveness Data and Information Set (HEDIS®)[1-4] and other performance measure data by race and ethnicity and use the data to drive future quality improvement efforts and develop targeted interventions.	☒ Quality ☒ Timeliness ☒ Access

[1-4] HEDIS is a registered trademark of NCQA.

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 2022.

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

Gender/Age Band	June 2022 Members
Nevada Medicaid Data	
Males and Females <1 Year of Age	16,581
Males and Females 1–2 Years of Age	35,060
Males and Females 3–14 Years of Age	187,116
Females 15–18 Years of Age	24,548
Males 15–18 Years of Age	23,937
Females 19–34 Years of Age	110,065
Males 19–34 Years of Age	73,002
Females 35+ Years of Age	101,759
Males 35+ Years of Age	86,610
Total Medicaid	**658,678**
Nevada Check Up Data	
Males and Females <1 Year of Age	345
Males and Females 1–2 Years of Age	888

[2-1] Please note that Medicaid has the age range of 15–18, while Nevada Check Up has the range of 15–19. The Medicaid dataset for males and females <1 year of age include members with unidentified gender. Totals for Table 2-1 reflect the whole Medicaid managed care population using the current county of residence at the time of the data pull on August 1, 2022. This includes members that may have moved outside of a Medicaid managed care covered service area in the month of March. Table 2-2 and Table 2-3 reflect only Medicaid managed care enrollees in Clark and Washoe counties. Data for 2022 are preliminary and subject to change.

Gender/Age Band	June 2022 Members
Nevada Medicaid Data	
Males and Females 3–14 Years of Age	13,933
Females 15–19 Years of Age	1,899
Males 15–19 Years of Age	1,886
Total CHIP	**18,951**
Total Medicaid and CHIP	**677,629**

Overview of Managed Care Entities

During the SFY 2022 review period, DHCFP contracted with four MCOs and one PAHP. These MCEs are responsible for the provision of services to Nevada Managed Care Program members. Table 2-2 and Table 2-3 provide a profile for each MCO. As Nevada has only one PAHP, the eligible population is inclusive of all Medicaid and Nevada Check Up members and therefore is not displayed in the tables below.

Table 2-2—Nevada MCO Medicaid Managed Care Members[2-1]

MCO	Total Eligible Clark County	Total Eligible Washoe County
Anthem	168,638	24,796
HPN	190,237	21,415
Molina	100,240	14,048
SilverSummit	120,547	15,001
Total	**579,662**	**75,260**

Table 2-3—Nevada MCO Nevada Check Up Managed Care Members[2-1]

MCO	Total Eligible Clark County	Total Eligible Washoe County
Anthem	4,266	852
HPN	5,507	1,125
Molina	2,900	699
SilverSummit	2,995	578
Total	**15,668**	**3,254**

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. Consistent with its mission and the Nevada DHCFP Strategic Plan[2-2], the purpose of DHCFP's Quality Strategy is to:

- Establish a comprehensive quality improvement system that is consistent with the Triple Aim adopted by CMS to achieve better care for patients, better health for communities, and lower costs through improvement in the 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 3603.21 (A)(25).

[2-2] Nevada Department of Health and Human Services Division of Health Care Financing and Policy. Strategic Plan. July 2019–June 2021. Available at: https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/About/ExternalStrategicPlanOnePager.pdf. Accessed on: Dec 8, 2022.

Quality Strategy Goals

In alignment with the purpose of the Quality Strategy, DHCFP established quality goals that are supported by specific objectives to continuously improve the health and wellness of Nevada Medicaid and Nevada Check Up members. The goals and supporting objectives are measurable and take into consideration the health status of all populations served by the Nevada Managed Care Program. The overarching Quality Strategy goals and applicable program are displayed in Table 2-4. Refer to Appendix B for a detailed description of the objectives and performance measures used to support each goal.

Table 2-4—Quality Strategy Goals and Applicable Program

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

Payment Initiative Programs

Certified Community Behavioral Health Centers

The Certified Community Behavioral Health Centers (CCBHCs) provide outpatient behavioral health services and primary care screenings and monitoring to individuals in Nevada for mental illness and SUD regardless of their ability to pay, including Nevada Medicaid and Nevada Check Up members. The Quality Incentive Payment (QIP) program for CCBHCs uses clinic-led and state-led quality measures, listed in Table 2-5, to determine quality payments that will be granted to each CCBHC based on performance year over year. CCBHCs can receive up to 5 percent of annual prospective payment system (PPS) payments for reporting the appropriate data for the two clinic-led measures and five state-led measures on a quarterly basis. Additionally, CCBHCs can receive up to 10 percent of annual PPS payments by achieving the appropriate performance for all six required measures and one optional

measure. The CCBHCs must reach the target goal or achieve gap improvement on the measure (improvement target goal minus prior year performance times 10 percent).

Table 2-5—CCBHC Performance Measures

Performance Measure	Clinic/State-Led	Source[1]	Target Goal
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	Clinic-led	CMS	90%
Major Depressive Disorder: Suicide Risk Assessment	Clinic-led	CMS	90%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	State-led	NCQA	60.1%
Follow-Up After Hospitalization for Mental Illness, Ages 21+	State-led	NCQA	7 Days–43.9% 30 days–63%
Follow-Up After Hospitalization for Mental Illness, Ages 6–21	State-led	NCQA	7 Days–43.9% 30 days–63%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	State-led	NCQA	Initiation–38.3% Engagement–11.3%
Plan All-Cause Readmission Rate*	State-led	NCQA	15.2%

* Not a federally required measure for quality improvement incentive payment

[1] Measure stewards include CMS and NCQA

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

Patient-Centered Opioid Addiction Treatment (P-COAT) Model

The P-COAT Model is an alternative payment model designed by the American Medical Association and the American Society of Addiction Medicine. The P-COAT Model was developed to expand access and utilization of medication-assisted treatment (MAT) while also ensuring that providers are appropriately reimbursed for the services they provide. Under the current models of MAT, there are several key issues that the P-COAT Model seeks to resolve:

- Underutilization of MAT services
- Barriers to care coordination/separation in billing for medical and behavioral services
- Reimbursement may not cover all costs of providing treatment
- Administrative barriers

The goals of the P-COAT Model include:

- Create a reimbursement structure to support the full range of services physicians/clinicians provide to treat opioid use disorder (OUD)
- Expand the network of providers who treat OUD
- Encourage coordinated delivery of services
- Reduce/eliminate spending for ineffective or unnecessarily expensive treatments
- Utilize evidence-based care practices that lead to improved outcomes

Nevada Medicaid is one of 15 states awarded a planning grant under the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act to fund implementation of the P-COAT Model. The planning grant phase lasts 18 months.

DHCFP will evaluate the results of the implemented P-COAT Model using a series of treatment and utilization performance measures, including the following:

- Treatment Measure #1: Percentage of patients who filled and used prescribed medications throughout the month
- Treatment Measure #2: Percentage of patients who demonstrated compliance by only taking medications that are part of the written treatment plan at the end of the month
- Utilization Services Measure #1: Percentage of patients whose opioid and other drug-related lab testing during initiation of treatment is consistent with evidence-based practices
- Utilization of Services Measure #2: Risk-adjusted average number of opioid-related ED visits per patient

This initiative supports Quality Strategy Goal 3 to *reduce misuse of opioids*. Implementation of this initiative should result in an expanded network of providers who treat opioid use disorder while leading to improved outcomes through the use of evidence-based care practices.

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 to the Quality Strategy under Goal 2 to *decrease rate of adult acute inpatient stays that were followed by an unplanned readmission for any diagnosis within 30 days after discharge*. For

outpatient services, effectiveness of the payment initiative aligns with Quality Strategy Goal 1—*Improve the health and wellness of Nevada's Medicaid population by increasing the use of preventive services by December 31, 2024*. 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.

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

Table 2-6 and Table 2-7 identify the Quality Strategy objectives identified in the CMS-approved Section 438.6(c) Preprint to evaluate performance of the state-directed payment initiative and the baseline rate, CY 2021 rate, and CY 2021 target for UMC. Rates listed in green font indicate that UMC met the target for CY 2021. Rates listed in red font indicate that UMC did not meet the target for CY 2021. UMC met the targets for CY 2021 for four of the eight measures for the Nevada Medicaid population. However, none of the three measures for the Nevada Check Up population were met and all seven measures not meeting the target also demonstrated a decline from the baseline rate. Based on these results, the payment initiative did not support that significant progress was made toward achieving the related Quality Strategy goals and continued efforts should be implemented to support improvement in the associated measures.

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

Measure	Objective Alignment	UMC Baseline[1]	UMC CY 2021 Rate	UMC CY 2021 Target[2]
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—BMI Percentile	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—BMI percentile	40.29%	35.90%	41.10%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Counseling for Nutrition	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—counseling for nutrition	31.31%	27.33%	31.94%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Counseling for Physical Activity	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—counseling for physical activity	28.18%	29.25%	28.74%

Measure	Objective Alignment	UMC Baseline[1]	UMC CY 2021 Rate	UMC CY 2021 Target[2]
Comprehensive Diabetes Care (CDC)—Hemoglobin A1c (HbA1c) Testing	Increase rate of HbA1c testing for members with diabetes (CDC)	40.78%	47.23%	41.60%
Comprehensive Diabetes Care (CDC)—HbA1c Poor Control (>9.0%)[3]	Decrease rate of HbA1c poor control (>9.0%) for members with diabetes (CDC)	21.97%	25.62%	21.53%
Controlling High Blood Pressure (CBP)	Increase rate of controlling high blood pressure (CBP)	11.95%	11.56%	12.19%
Plan All-Cause Readmissions (PCR)—Observed Readmissions[3]	Decrease rate of adult acute inpatient stays that were followed by an unplanned readmission for any diagnosis within 30 days after discharge (PCR)—Observed readmissions	11.81%	9.86%	11.57%

BMI: body mass index
* Rates in this table were derived from validated HEDIS measure rates; however, these rates were a subset of the validated measures and were not validated through the HEDIS audit process.
[1] The baseline year for UMC was CY 2020.
[2] Year-over-year targets were set at 2 percent improvement over the baseline year. Overall targets for full five-year period of state-directed payment initiative is 10 percent.
[3] A lower rate indicates better performance for this measure.
Green font indicates UMC met the target for CY 2021.
Red font indicates UMC did not meet the target for CY 2021.

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

Measure	Objective Alignment	UMC Baseline[1]	UMC CY 2021 Rate	UMC Target[2]
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—BMI Percentile	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—BMI percentile	49.68%	37.36%	50.67%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Counseling for Nutrition	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—counseling for nutrition	38.92%	32.60%	39.70%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Counseling for Physical Activity	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—counseling for physical activity	35.76%	30.04%	36.48%

Measure	Objective Alignment	UMC Baseline[1]	UMC CY 2021 Rate	UMC Target[2]
Comprehensive Diabetes Care (CDC)—Hemoglobin A1c (HbA1c) Testing	Increase rate of HbA1c testing for members with diabetes (CDC)	NA	NA	NA
Comprehensive Diabetes Care (CDC)—HbA1c Poor Control (>9.0%)[3]	Decrease rate of HbA1c poor control (>9.0%) for members with diabetes (CDC)	NA	NA	NA
Controlling High Blood Pressure (CBP)	Increase rate of controlling high blood pressure (CBP)	NA	NA	NA
Plan All-Cause Readmissions (PCR)—Observed Readmissions[3]	Decrease rate of adult acute inpatient stays that were followed by an unplanned readmission for any diagnosis within 30 days after discharge (PCR)—Observed readmissions	NA	NA	NA

* Rates in this table were derived from validated HEDIS measure rates; however, these rates were a subset of the validated measures and were not validated through the HEDIS audit process.
[1] The baseline year for UMC was CY 2020.
[2] Year-over-year targets were set at 2 percent improvement over the baseline year. Overall targets for the full five-year period of state-directed payment initiative is 10 percent.
[3] A lower rate indicates better performance for this measure.
NA (Not Applicable) indicates the performance measure is not applicable to the Nevada Check Up population.
Green font indicates UMC met the target for CY 2021.
Red font indicates UMC did not meet the target for CY 2021.

Table 2-8 and Table 2-9 identify the Quality Strategy objectives identified in the CMS-approved Section 438.6(c) Preprint to evaluate performance of the state-directed payment initiative and the CY 2022 target for UNR. UNR's performance will be evaluated in the SFY 2023 EQR technical report.

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

Measure	Objective Alignment	UNR Baseline[1]	UNR Target[2]
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—BMI Percentile	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—BMI percentile	10.44%	10.65%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Counseling for Nutrition	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—counseling for nutrition	10.88%	11.10%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Counseling for Physical Activity	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—counseling for physical activity	11.99%	12.23%

Measure	Objective Alignment	UNR Baseline[1]	UNR Target[2]
Comprehensive Diabetes Care (CDC)—Hemoglobin A1c (HbA1c) Testing	Increase rate of HbA1c testing for members with diabetes (CDC)	53.49%	54.56%
Comprehensive Diabetes Care (CDC)—HbA1c Poor Control (>9.0%)[3]	Decrease rate of HbA1c poor control (>9.0%) for members with diabetes (CDC)	53.49%	52.42%
Controlling High Blood Pressure (CBP)	Increase rate of controlling high blood pressure (CBP)	2.36%	2.41%

* 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.
[1] The baseline year for UNR was CY 2021.
[2] Year-over-year targets were set at 2 percent improvement over the baseline year. Overall targets for the full five-year period of state-directed payment initiative is 10 percent.
[3] A lower rate indicates better performance for this measure.

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

Measure	Objective Alignment	UNR Baseline[1]	UNR Target[2]
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—BMI Percentile	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—BMI percentile	17.65%	18.00%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Counseling for Nutrition	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—counseling for nutrition	14.71%	15.00%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)—Counseling for Physical Activity	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—counseling for physical activity	14.71%	15.00%
Comprehensive Diabetes Care (CDC)—Hemoglobin A1c (HbA1c) Testing	Increase rate of HbA1c testing for members with diabetes (CDC)	NA	NA
Comprehensive Diabetes Care (CDC)—HbA1c Poor Control (>9.0%)[3]	Decrease rate of HbA1c poor control (>9.0%) for members with diabetes (CDC)	NA	NA
Controlling High Blood Pressure (CBP)	Increase rate of controlling high blood pressure (CBP)	NA	NA

* Rates in this table were derived from validated HEDIS measure rates; however, these rates were a subset of the validated measures and were not validated through the HEDIS audit process.
[1] The baseline year for UNR was CY 2021.
[2] Year-over-year targets were set at 2 percent improvement over the baseline year. Overall targets for the full five-year period of state-directed payment initiative is 10 percent.
[3] A lower rate indicates better performance for this measure.
NA (Not Applicable) indicates the performance measure is not applicable to the Nevada Check Up 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 Goals and Objectives Tracking Table, as shown in Appendix B. The Goals and Objectives Tracking Table lists each of the seven goals and the objectives used to measure achievement of those goals.

Table 2-10 and Table 2-11 show the number of rates reported by the MCO or PAHP and the number and percentage of reported rates that achieved the DHCFP-established MPS. Of note, Goal 7—*Reduce and/or eliminate health care disparities for Medicaid members by December 31, 2024* is not evaluated through a performance measure rate and overall performance is determined as either a *Met* or *Not Met* score based on DHCFP's assessment. Therefore, this information is not included in the following tables. For additional details, please see Appendix B of this report.

Table 2-10—SFY 2022 Quality Strategy Goals and Objectives Summary of Performance by the MCOs

	Anthem Medicaid	HPN Medicaid	Molina Medicaid*	SilverSummit Medicaid	Anthem Check Up	HPN Check Up	Molina Check Up*	SilverSummit Check Up
Number of Rates Reported	71	71		69	30	31		23
Rates With an Established MPS	40	40		40	21	21		21
Rates Achieving the MPS	**4**	**16**		**4**	**0**	**3**		**0**
Percentage of Rates Achieving the MPS	**10%**	**40%**		**10%**	**0%**	**14%**		**0%**

* **Molina** entered the Nevada Managed Care Program on January 1, 2022; therefore, the MCO did not report data for these measures.

Table 2-11—SFY 2022 Quality Strategy Goals and Objectives Summary of Performance by the PAHP

	LIBERTY Medicaid	LIBERTY Check Up
Number of Rates Reported	8	8
Rates With an Established MPS	6	6
Rates Achieving the MPS	**0**	**0**
Percentage of Rates Achieving the MPS	**0%**	**0%**

In response to its ongoing evaluation of the Nevada Managed Care Program's performance and to support the appropriateness of the program structure, processes, and objectives in alignment with federal initiatives, in SFY 2022, DHCFP revised the goals and objectives within its Quality Strategy to align more closely with the CMS Child and Adult Core Set measures and NCQA's revised HEDIS measures.

DHCFP also revised the MPS, when data were available, to further promote positive performance related to the quality, timeliness, and accessibility of care and services provided by its MCEs.

At the conclusion of SFY 2022, DHCFP, in collaboration with HSAG, evaluated the quality of the managed care services offered to Nevada Managed Care Program members and, subsequently, the overall effectiveness of the Quality Strategy goals through EQR-related performance results and year-over-year trending of performance measure data, when a comparison of data was appropriate. Based on this evaluation, the Nevada Managed Care Program has made significant progress toward achieving Goal 3—*Reduce misuse of opioids by December 31, 2024*, as aggregated performance results indicated that the established MPS were achieved. In SFY 2022, DHCFP added two new objectives to its Quality Strategy to further support continued improvement in this program area. The Nevada Managed Care Program also demonstrated some improvement for the Nevada Check Up population in achieving Goal 5—*Increase use of evidence-based practices for members with behavioral health conditions by December 31, 2024*, as the aggregated performance tied to three related objectives (i.e., increase follow-up after ED visit for mental illness [7-day and 30-day follow-up] and increase follow-up after hospitalization for mental illness [30-day follow-up]) met the established MPS. However, continued opportunities exist for the Nevada Managed Care Program to improve in this program area as several other objectives' MPS were not achieved.

The Nevada Managed Care Program has demonstrated limited progress toward achieving Goal 1—*Improve the health and wellness of Nevada's Medicaid population by increasing the use of preventive services by December 31, 2024*, Goal 2—*Increase use of evidence-based practices for members with chronic conditions by December 31, 2024*, Goal 4—*Improve the health and wellness of pregnant women and infants by December 31, 2024*, and Goal 6—*Increase utilization of dental services by December 31, 2024*, as none of the associated objectives' MPS, when MPS were established, were achieved. The MCEs continue to report that the coronavirus disease 2019 (COVID-19) public health emergency (PHE) impacted members' access to timely services due to staffing shortages and limited office hours, and incorrect member demographic and contact information resulted in the decreased ability to provide education to members. However, the MCEs should continue to focus efforts on reducing all barriers to care in these related program areas. In addition to mandating contract requirements to help support Goal 7—*Reduce and/or eliminate health care disparities for Medicaid members by December 31, 2024*, DHCFP has also mandated that the MCOs implement six new PIPs to help support progress toward achieving the Quality Strategy goals and objectives and ultimately improve the health outcomes of Nevada's Medicaid managed care members.

3. Assessment of Managed Care Organization Performance

HSAG used findings across mandatory and optional EQR activities conducted during the SFY 2022 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.

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

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

Objectives of External Quality Review Activities

This section of the report provides the objectives and a brief overview of each EQR activity conducted in SFY 2022 to provide context for the resulting findings of each EQR activity. For more details about each EQR activity's objectives and the comprehensive methodology, including the technical methods for data collection and analysis, a description of the data obtained, and the process for drawing conclusions from the data, refer to Appendix A.

Validation of Performance Improvement Projects

For SFY 2022, three MCOs[3-1] concluded 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 SMART (Specific, Measurable, Attainable, Relevant, and Timebound) 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.

[3-1] **Molina** began providing coverage to Medicaid and Nevada Check Up members effective January 1, 2022; therefore, no data were available to display in Table 3-1. **Molina**'s PIPs will be reported in the SFY 2023 EQR technical report.

Performance Measure Validation

For SFY 2022, HSAG conducted an independent audit of three MCOs[3-2] in alignment with NCQA's HEDIS Compliance Audit™[3-3] 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 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 2021 reporting of the Medicaid and Nevada Check Up populations. The reported measures are divided into performance domains of care as demonstrated in the following table.

Table 3-2—HEDIS Performance Measures

HEDIS Performance Measure	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)	✓	
Chlamydia Screening in Women (CHL)	✓	✓
Prenatal and Postpartum Care (PPC)	✓	
Care for Chronic Conditions		
Asthma Medication Ratio (AMR)	✓	✓
Comprehensive Diabetes Care (CDC)	✓	
Controlling High Blood Pressure (CBP)	✓	
Kidney Health Evaluation for Patients With Diabetes (KED)	✓	

3-2 **Molina** began providing coverage to Medicaid and Nevada Check Up members effective January 1, 2022; therefore, no performance measure data were available for the SFY 2021 PMV activity. **Molina**'s PMV will be reported in the SFY 2023 EQR technical report.

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

HEDIS Performance Measure	Medicaid	Nevada Check Up
Behavioral Health		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	✓	
Antidepressant Medication Management (AMM)	✓	
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	✓	
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)	✓	✓
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	✓	✓
Utilization		
Ambulatory Care—Total (Per 1,000 Member Months) (AMB)	✓	✓
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)	✓	

ADHD: attention-deficit/hyperactivity disorder; AOD: alcohol and other drug; ED: emergency department

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. HSAG conducted a review of the first seven standards in Year One (SFY 2021). For SFY 2022, the remaining seven standards were reviewed (Year Two of the cycle). In Year Three (SFY 2023), a comprehensive review will be conducted on each element scored as *Not Met* during the SFY 2021 and SFY 2022 compliance reviews. Table 3-3 outlines the standards reviewed over the three-year compliance review cycle.

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

Standards	Associated Federal Citation[1]	Year One (SFY 2021)	Year Two (SFY 2022)	Year Three (SFY 2023)[3]
Standard I—Disenrollment: Requirements and Limitations	§438.56	✓		Review of the MCOs' implementation of Year One and Year Two corrective action plans (CAPs)
Standard II—Member Rights and Member Information	§438.10 §438.100	✓		
Standard III—Emergency and Poststabilization Services	§438.114	✓		
Standard IV—Availability of Services	§438.206	✓		
Standard V—Assurances of Adequate Capacity and Services	§438.207	✓		
Standard VI—Coordination and Continuity of Care	§438.208	✓		
Standard VII—Coverage and Authorization of Services	§438.210	✓		
Standard VIII—Provider Selection	§438.214		✓	
Standard IX—Confidentiality	§438.224		✓	
Standard X—Grievance and Appeal Systems	§438.228		✓	
Standard XI—Subcontractual Relationships and Delegation	§438.230		✓	
Standard XII—Practice Guidelines	§438.236		✓	
Standard XIII—Health Information Systems[2]	§438.242		✓	
Standard XIV—Quality Assessment and Performance Improvement Program	§438.330		✓	

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

[2] This standard includes a comprehensive assessment of the MCOs' IS capabilities.

[3] **Molina** joined the Nevada Managed Care Program on January 1, 2022; therefore, in addition to the CAP review, the Year One standards will be included in this MCO's compliance review activity in SFY 2023 and reported in the SFY 2023 EQR technical report.

Network Adequacy Validation

The NAV activity for SFY 2022 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.

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. 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 Provider	1:1,500*
Physician Specialist	1:1,500

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

The second component of the NAV activity evaluated the geographic distribution of providers relative to each of the MCO's members. To provide a comprehensive view of geographic access, HSAG calculated the percentage of members with access within the standards for the provider categories identified in the MCO provider crosswalk. Table 3-5 shows the provider categories used to assess the MCOs' network adequacy and the associated time-distance standards.

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

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

Provider Category	Member Criteria	Time and Distance Access Standard to the Nearest Provider
Facility-Level Providers		
Hospital, All	Adults	45 minutes or 30 miles
Dialysis/End Stage Renal Disease (ESRD) Facility	Adults	45 minutes or 30 miles
Pharmacy	All	15 minutes or 10 miles

Consumer Assessment of Healthcare Providers and Systems Analysis

The 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[3-4] 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
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

[3-4] **Molina** began providing coverage to Medicaid and Nevada Check Up members effective January 1, 2022; therefore, the MCO did not conduct CAHPS during SFY 2022.

CAHPS Measures
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 2022, HSAG conducted and completed EDV activities for three MCOs.[3-5] The EDV activities included:

- 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.

For **Anthem** and **HPN**, HSAG had previously conducted the core activities listed above in SFY 2018. As such, HSAG did not conduct an IS review for **Anthem** and **HPN** in SFY 2022. For **SilverSummit**, since SFY 2022 was the first year HSAG conducted the EDV study, HSAG included the IS review component of the EDV activities. Table 3-7 shows the core evaluation activities for each MCO included as part of the SFY 2022 study.

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	Yes

[3-5] **Molina** began providing coverage to Medicaid and Nevada Check Up members effective January 1, 2022; therefore, this MCO was not included in the EDV study.

External Quality Review Activity Results

Anthem Blue Cross and Blue Shield Healthcare Solutions

Validation of Performance Improvement Projects

Performance Results

Anthem completed and submitted Module 4 (PIP Conclusions) for validation for each topic. HSAG organized and analyzed **Anthem**'s PIP data to draw conclusions about the MCO's quality improvement efforts. Based on its review, HSAG determined the overall methodological validity of the PIP, as well as the overall success in achieving the SMART Aim goal. As part of this determination, HSAG evaluated the appropriateness and validity of the SMART Aim measure, as well as trends in the SMART Aim measurements, in comparison with the reported baseline rate and goal. To represent the validity and reliability of each PIP, HSAG assigned a level of confidence (i.e., *High confidence*, *Confidence*, *Low confidence*, *Reported PIP results were not credible*). Refer to Appendix A for details regarding the scoring methodology for each level of confidence. The validation findings assessed by HSAG, and a description of the interventions implemented by **Anthem** for each PIP, are displayed in Table 3-8 through Table 3-11.

Table 3-8—SMART Aim Measure Results for CDC HbA1c Poor Control >9.0%

SMART Aim	Baseline Rate	SMART Aim Goal Rate	Lowest Rate Achieved	Confidence Level
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%.	60.95%	51.43%	50.80%	*Confidence*

* Provider name has been redacted for privacy purposes.

Table 3-9—Intervention for CDC HbA1c Poor Control >9.0%

Intervention: CDC HbA1c Poor Control >9.0% PIP	
Intervention Description	Obtained CDC HbA1c results from targeted providers' electronic medical records (EMRs)
Intervention Impact	**Anthem** indicated that receiving standard lab supplemental data files from the targeted providers who perform in-house point of care HbA1c testing was effective and increased the number of HbA1c lab test results the MCO received.
Intervention Status	The intervention was adopted.

Table 3-10—SMART Aim Measure Results for Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care

SMART Aim	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
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%.	46.8%	53.93%	87.73%	*Low confidence*

* Provider name has been redacted for privacy purposes.

Table 3-11—Intervention for Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care

Intervention: *Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care* PIP	
Intervention Description	Targeted provider and office staff Current Procedural Terminology (CPT) code training
Intervention Impact	**Anthem** reported intervention testing results were effective at improving the office staff's use of the correct CPT codes.
Intervention Status	**Anthem** indicated that the intervention was effective and chose to adapt it again, considering lessons learned through intervention testing. The MCO will adjust current training materials to match operational processes.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Anthem developed methodologically sound improvement projects that met both State and federal requirements. **[Quality]**

Strength #2: Anthem used quality improvement tools and processes to identify and prioritize opportunities for improvement that led to the development of the intervention tested for each PIP. **[Quality]**

Strength #3: Anthem met its SMART Aim goal to decrease the percentage of members 18 to 75 years of age living with poorly controlled diabetes. **[Quality]**

Strength #4: Anthem achieved its SMART Aim goal to increase the percentage of prenatal care visits among pregnant women residing in Clark County assigned to a specific provider. **[Quality** and **Timeliness]**

Weaknesses and Recommendations

Weakness #1: Anthem limited the number of interventions tested for each topic to just one for the duration of the PIP. **[Quality**, **Timeliness**, and **Access]**

Why the weakness exists: Anthem included one intervention per PIP, which may have limited the opportunity for the MCO to address other opportunities for improvement identified through its quality improvement processes.

Recommendation: Anthem should consider testing more than one intervention during the PIP, which will help the MCO address as many identified opportunities for improvement as possible. The MCO should apply lessons learned and knowledge gained from its efforts and HSAG's feedback throughout the PIP to future PIPs and other quality improvement activities. Lastly, **Anthem** should continue improvement efforts in the PIP topic areas and, for the successful interventions, consider spreading beyond the narrowed focus. The conclusion of a project should be used as a springboard for sustaining the improvement achieved and attaining new improvements.

Weakness #2: Even though the SMART Aim goal was achieved, HSAG identified inaccuracies in **Anthem**'s PIP documentation, which resulted in HSAG assigning a level of *Confidence* to the *CDC HbA1c Poor Control >9.0%* PIP, instead of *High confidence*. **[Quality]**

Why the weakness exists: Anthem documented inaccurate conclusions about not achieving the SMART Aim goal and incorrectly documented percentage point differences.

Recommendations: Anthem should ensure that its data and interpretation of results are accurately documented in its PIP submissions. Additionally, any improvement achieved should be reasonably linked to intervention(s) tested and the outcomes data reported.

Weakness #3: Anthem was unable to determine whether its implemented intervention was linked to achievement of the SMART Aim goal, which resulted in HSAG assigning a *Low confidence* level to the *Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care* PIP. **[Quality]**

Why the weakness exists: Anthem provided rolling 12-month data for the SMART Aim measure from March 2020 through July 2021. The highest result achieved was 87.73 percent in September 2020, and the SMART Aim goal of 53.93 percent was achieved. However, the first four measurement periods reported occurred prior to intervention testing. Additionally, four consecutive rolling 12-month SMART Aim periods decreased by approximately 25 percentage points for February 2021, March 2021, April 2021, and May 2021 but remained above the SMART Aim goal. The decreases occurred after the intervention was initiated. Further, the rolling 12-month SMART Aim measure denominators had large fluctuations and were significantly lower than the baseline denominator of 468, ranging from 135 to 362 births below the baseline.

Recommendations: Anthem should ensure that the intervention(s) tested have the potential to impact the desired outcomes of the PIP and be mindful of the timing of intervention initiation.

Performance Measure Validation

Performance Results

Table 3-12 and Table 3-13 show **Anthem**'s Medicaid and Nevada Check Up performance measure results for HEDIS MY 2019, MY 2020, and MY 2021, along with MY 2020 to MY 2021 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 2020 to MY 2021 represents performance improvement and an increase in the rate from MY 2020 to MY 2021 represents performance decline. The arrows (↑ or ↓) indicate whether the HEDIS MY 2021 rate was above or below NCQA's Quality Compass®[3-6] HEDIS 2021 Medicaid health maintenance organization (HMO) 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 3-12—Medicaid HEDIS MY 2021 Performance Measure Results and Trending for Anthem

HEDIS Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	MY 2020–MY 2021 Rate Comparison
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services (AAP)				
Ages 20–44 Years	73.11%	64.55%	62.89%↓	-1.66
Ages 45–64 Years	79.43%	72.29%	70.45%↓	-1.84
*Ages 65 Years and Older^*	NA	76.32%	68.99%↓	-7.33
*Total^*	75.11%	66.81%	65.03%↓	-1.78
Children's Preventive Care				
Childhood Immunization Status (CIS)				
Combination 3	68.13%	61.80%	57.42%↓	-4.38
Combination 7	58.15%	53.53%	49.15%↓	-4.38
Combination 10	33.82%	30.90%	25.55%↓	-5.35

[3-6] Quality Compass® is a registered trademark of NCQA.

HEDIS Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	MY 2020–MY 2021 Rate Comparison
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	89.29%	85.16%	81.27%↓	-3.89
Combination 2 (Meningococcal, Tdap, HPV)	41.12%	39.42%	30.17%↓	-9.25
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile—Total	82.73%	82.24%	80.05%↑	-2.19
Counseling for Nutrition—Total	74.21%	74.21%	74.94%↑	0.73
Counseling for Physical Activity—Total	67.88%	69.34%	72.26%↑	2.92
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%	58.50%↑	-0.02
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	—	65.15%	60.39%↓	-4.76
Child and Adolescent Well-Care Visits (WCV)				
3–11 Years	—	46.99%	50.14%↓	3.15
12–17 Years	—	39.02%	45.39%↑	6.37
18–21 Years	—	19.63%	20.53%↓	0.90
*Total^*	—	41.29%	44.67%↓	3.38
Women's Health and Maternity Care				
Breast Cancer Screening (BCS)				
Breast Cancer Screening	51.64%	44.67%	39.50%↓	-5.17
Chlamydia Screening in Women (CHL)^				
16–20 Years	—	—	48.04%	NC
21–24 Years	—	—	61.22%	NC
Total	—	—	55.65%	NC
Prenatal and Postpartum Care (PPC)				
Timeliness of Prenatal Care	80.78%	81.75%	81.75%↓	0.00
Postpartum Care	59.37%	66.18%	71.29%↓	5.11
Care for Chronic Conditions				
Asthma Medication Ratio (AMR)^				
5–11 Years	—	—	81.70%	NC
12–18 Years	—	—	68.08%	NC

HEDIS Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	MY 2020–MY 2021 Rate Comparison
19–50 Years	—	—	55.37%	NC
51–64 Years	—	—	54.71%	NC
Total	—	—	63.28%	NC
Comprehensive Diabetes Care (CDC)				
*Hemoglobin A1c (HbA1c) Testing^*	79.08%	73.72%	76.40%↓	2.68
*HbA1c Poor Control (>9.0%)**	51.58%	51.09%	47.45%↓	-3.64
HbA1c Control (<8.0%)	40.15%	40.63%	45.74%↓	5.11
Eye Exam (Retinal) Performed	53.04%	50.85%	49.88%↓	-0.97
Blood Pressure Control (<140/90 mm Hg)	—	50.61%	51.82%↓	1.21
Controlling High Blood Pressure (CBP)				
Controlling High Blood Pressure	—	51.09%	53.04%↓	1.95
Kidney Health Evaluation for Patients With Diabetes (KED)^				
18–64 Years	—	27.43%	28.21%	0.78
65–74 Years	—	NA	32.20%	NC
75–84 Years	—	NA	NA	NC
Total	—	27.55%	28.24%	0.69
Behavioral Health				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	45.71%	34.72%	34.31%↓	-0.41
Antidepressant Medication Management (AMM)^				
Effective Acute Phase Treatment	—	—	52.06%	NC
Effective Continuation Phase Treatment	—	—	35.05%	NC
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	83.30%	76.62%	76.68%↑	0.06
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)				
7-Day Follow-Up—Total	10.62%	12.29%	10.69%↓	-1.60
30-Day Follow-Up—Total	15.55%	17.12%	15.24%↓	-1.88

HEDIS Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	MY 2020–MY 2021 Rate Comparison
Follow-Up After Emergency Department Visit for Mental Illness (FUM)				
7-Day Follow-Up—Total	30.27%	29.55%	35.58%↓	6.03
30-Day Follow-Up—Total	41.84%	40.89%	46.93%↓	6.04
Follow-Up After Hospitalization for Mental Illness (FUH)				
7-Day Follow-Up—Total	34.61%	32.49%	28.87%↓	-3.62
30-Day Follow-Up—Total	50.75%	48.72%	46.60%↓	-2.12
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
Initiation Phase	41.55%	47.06%	49.38%↑	2.32
Continuation and Maintenance Phase	59.38%	68.66%	60.81%↑	-7.85
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)				
Initiation of AOD—Total	48.53%	45.91%	45.52%↑	-0.39
Engagement of AOD—Total	15.87%	14.73%	14.85%↑	0.12
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)				
Blood Glucose and Cholesterol Testing—Total	31.71%	31.27%	31.58%↑	0.31
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)^				
1–11 Years	—	—	53.19%	NC
12–17 Years	—	—	63.41%	NC
Total	—	—	59.69%	NC
Utilization				
Ambulatory Care—Total (per 1,000 Member Months) (AMB)^				
*ED Visits—Total**	59.89	42.98	45.92	2.94
Outpatient Visits—Total	291.03	246.46	251.42	4.96
Mental Health Utilization—Total (MPT)^				
Inpatient—Total	1.46%	1.27%	1.09%	-0.18
Intensive Outpatient or Partial Hospitalization—Total	0.77%	0.47%	0.39%	-0.08
Outpatient—Total	11.05%	9.13%	8.01%	-1.12
ED—Total	0.41%	0.26%	0.29%	0.03
Telehealth—Total	0.09%	4.76%	5.31%	0.55
Any Service—Total	11.60%	10.84%	10.27%	-0.57
Plan All-Cause Readmissions (PCR)				
Observed Readmissions—Total	13.42%	14.42%	13.23%	-1.19

HEDIS Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	MY 2020–MY 2021 Rate Comparison
*Expected Readmissions—Total^*	9.60%	9.83%	9.51%	-0.32
*O/E Ratio—Total^*	1.40	1.47	1.39	-0.08
Overuse/Appropriateness of Care				
Use of Opioids at High Dosage (HDO)*				
Use of Opioids at High Dosage	9.18%	8.90%	**8.15%↓**	-0.75
Use of Opioids From Multiple Providers (UOP)*				
Multiple Prescribers	21.52%	15.90%	**20.68%↓**	4.78
*Multiple Pharmacies^*	1.60%	1.15%	**0.52%↑**	-0.63
*Multiple Prescribers and Multiple Pharmacies^*	0.84%	0.57%	**0.30%↑**	-0.27

HPV: human papillomavirus; Tdap: tetanus, diphtheria toxoids and acellular pertussis
↑ Indicates the HEDIS MY 2021 rate was above NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile benchmark.
↓ Indicates the HEDIS MY 2021 rate was below NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile benchmark.
* A lower rate indicates better performance 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 2021 Quality Improvement System for Managed Care (QISMC) goals are unavailable for this measure or indicator.
NC indicates the MY 2020–MY 2021 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 2021 performance measure rate was at or above the MPS.

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

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

Table 3-13—Nevada Check Up HEDIS MY 2021 Performance Measure Results and Trending for Anthem

HEDIS Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	MY 2020–MY 2021 Rate Comparison
Children's Preventive Care				
Childhood Immunization Status (CIS)				
Combination 3	83.48%	78.79%	71.33%↑	-7.46
Combination 7	76.79%	69.70%	66.67%↑	-3.03
Combination 10	47.77%	42.42%	35.33%↓	-7.09

HEDIS Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	MY 2020–MY 2021 Rate Comparison
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	93.63%	92.94%	91.48%↑	-1.46
Combination 2 (Meningococcal, Tdap, HPV)	51.96%	57.18%	44.28%↑	-12.90
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile—Total	87.83%	81.75%	83.94%↑	2.19
Counseling for Nutrition—Total	79.56%	74.94%	76.64%↑	1.70
Counseling for Physical Activity—Total	73.48%	69.10%	73.24%↑	4.14
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%	66.29%↑	-4.94
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	—	77.27%	72.19%↑	-5.08
Child and Adolescent Well-Care Visits (WCV)				
3–11 Years	—	55.51%	56.17%↑	0.66
12–17 Years	—	48.50%	53.97%↑	5.47
18–21 Years	—	30.90%	33.52%↑	2.62
*Total^*	—	51.37%	53.95%↑	2.58
Women's Health and Maternity Care				
Chlamydia Screening in Women (CHL)^				
16–20 Years	—	—	39.58%	NC
21–24 Years	—	—	NA	NC
Total	—	—	39.58%	NC
Care for Chronic Conditions				
Asthma Medication Ratio (AMR)^				
5–11 Years	—	—	77.14%	NC
12–18 Years	—	—	64.71%	NC
19–50 Years	—	—	NA	NC
51–64 Years	—	—	NA	NC
Total	—	—	71.01%	NC

HEDIS Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	MY 2020–MY 2021 Rate Comparison
Behavioral Health				
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)^				
7-Day Follow-Up—Total	—	NA	NA	NC
30-Day Follow-Up—Total	—	NA	NA	NC
Follow-Up After Emergency Department Visit for Mental Illness (FUM)				
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)				
7-Day Follow-Up—Total	37.14%	47.50%	35.48%↓	-12.02
30-Day Follow-Up—Total	60.00%	67.50%	61.29%↑	-6.21
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
Initiation Phase	60.00%	43.59%	50.00%↑	6.41
*Continuation and Maintenance Phase^*	NA	NA	NA	NC
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)				
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	48.39%	NA	NA	NC
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)^				
1–11 Years	—	—	NA	NC
12–17 Years	—	—	NA	NC
Total	—	—	NA	NC
Utilization				
Ambulatory Care—Total (per 1,000 Member Months) (AMB)^				
*ED Visits—Total**	30.27	15.63	15.94	0.31
Outpatient Visits—Total	253.13	185.80	192.37	6.57
Mental Health Utilization—Total (MPT)^				
Inpatient—Total	0.40%	0.52%	0.45%	-0.07

HEDIS Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	MY 2020–MY 2021 Rate Comparison
Intensive Outpatient or Partial Hospitalization—Total	0.21%	0.19%	0.21%	0.02
Outpatient—Total	7.15%	6.12%	5.23%	-0.89
ED—Total	0.00%	0.04%	0.08%	0.04
Telehealth—Total	0.02%	3.17%	3.33%	0.16
Any Service—Total	7.20%	7.03%	6.75%	-0.28

↑ Indicates the HEDIS MY 2021 rate was above NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile benchmark.

↓ Indicates the HEDIS MY 2021 rate was below NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile benchmark.

* A lower rate indicates better performance 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 2021 QISMC goals are unavailable for this measure or indicator.

NC indicates the MY 2020–MY 2021 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.

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

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

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Within the Children's Preventive Care domain, **Anthem**'s Medicaid and Nevada Check Up performance for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure indicators ranked above NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile benchmarks. Nevada Check Up rates for the *Well-Child Visits in the First 30 Months of Life*, *Child and Adolescent Well-Care Visits*, and *Immunizations for Adolescents* measure indicators also ranked above NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile benchmarks; however, the *Well-Child Visits in the First 30 Months of Life—Two or More Well-Child Visits* measure indicator demonstrated a decline of more than 5 percentage points from the prior year. Of note, the 12 to 17 years age group for *Child*

and Adolescent Well-Care Visits measure demonstrated an increase of more than 5 percentage points from the prior year. The overall increase in performance for these measures suggests that **Anthem**'s child and adolescent members received appropriate well-care visits, providing an opportunity for providers to influence health and development. Assessing physical, emotional, and social development is important at every stage of life, particularly with children and adolescents. **[Quality** and **Timeliness]**

Strength #2: Within the Women's Health and Maternity Care domain for Medicaid, the *Prenatal and Postpartum Care—Postpartum Care* measure indicator showed an increase of more than 5 percentage points from the prior year. Although the rate did not meet the MPS and ranked below NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile, **Anthem** demonstrated an increase of more than 5 percentage points in MY 2020 and MY 2021, indicating **Anthem**'s commitment to providing timely and adequate postpartum care, setting the stage for the long-term health and well-being of new mothers and their infants. **[Quality, Timeliness,** and **Access]**

Strength #3: Within the Care for Chronic Conditions domain, **Anthem**'s Medicaid population showed an increase of more than 5 percentage points for the *Comprehensive Diabetes Care—HbA1c Control (<8.0%)* measure indicator. This is a critical measure for managing members with diabetes, which is essential to control blood glucose, reduce risks for complications, and prolong life. Left unmanaged, diabetes can lead to serious complications, including heart disease, stroke, hypertension, blindness, kidney disease, diseases of the nervous system, amputations, and premature death. **[Quality]**

Strength #4: Within the Overuse/Appropriateness of Care domain for **Anthem**'s Medicaid population, all rates for the *Use of Opioids at High Dosage* and *Use of Opioids From Multiple Providers* measure indicators met the MPS. In addition, the *Use of Opioids From Multiple Providers—Multiple Pharmacies* and *Multiple Prescribers and Multiple Pharmacies* measure indicators ranked above NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile benchmarks. These measures help identify members who may be at high risk for opioid overuse and misuse, potentially decreasing the risk of opioid-related overdose deaths. **[Quality]**

Strength #5: Within the Behavioral Health domain, **Anthem**'s Medicaid performance for the *Follow-Up After Emergency Department Visit for Mental Illness* measure indicators increased by more than 5 percentage points from the prior year. Additionally, although none of the performance measures in this domain met the MPS for **Anthem**'s Medicaid population, all indicators for the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*, *Follow-Up Care for Children Prescribed ADHD Medication*, *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment*, and *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measures ranked above NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile benchmarks. Furthermore, and of note, **Anthem**'s Nevada Check Up performance for the *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* measure indicator increased by more than 5 percentage points from the prior year and ranked above NCQA's HEDIS 2021 Medicaid HMO 50th percentile

benchmark. **Anthem**'s performance shows dedication to its members with mental health diagnoses. **[Quality, Timeliness,** and **Access]**

Strength #6: For **Anthem**'s Nevada Check Up population, with the exception of the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *Childhood Immunization Status—Combination 10* measure indicators, all reported rates that were comparable to NCQA's Quality Compass HEDIS 2021 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: Rates for the *Adults' Access to Preventive/Ambulatory Health Services—Ages 65 Years and Older* measure indicator within the Access to Care domain for Medicaid 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 2021 Medicaid HMO 50th percentile benchmark. Additionally, rates for the two age stratifications with QISMC goals (i.e., *Ages 20–44* and *Ages 45–64*) did not meet the MPS. **[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. **Anthem** also reported that the COVID-19 PHE continues to impact members accessing preventive and ambulatory services.

Recommendation: HSAG recommends **Anthem** continue its promotion of telehealth services and/or seek alternative interventions to mitigate the impacts of COVID-19 and continue to outreach members to schedule preventive and ambulatory services. **Anthem** should also continue to conduct analyses to determine why members ages 65 years and older are not consistently accessing preventive and ambulatory services and implement appropriate interventions to improve the performance related to Access to Care measures.

Weakness #2: **Anthem**'s overall performance for the *Childhood Immunization Status* and *Immunizations for Adolescents* measures within the Children's Preventive Care domain for Medicaid declined. All measure indicator rates for these two measures ranked below NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile benchmark and did not meet the MPS. Of note, the *Childhood Immunization Status—Combination 10* and *Immunizations for Adolescents—Combination 2* measure indicators demonstrated a decline of more than 5 percentage points from the prior year, 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 3* and *Combination 10* and *Immunizations for Adolescents—Combination 2* measure indicators showed a decrease by more than 5 percentage points from the prior year. The decrease in performance was noted in the prior year's findings as well. **[Quality]**

Why the weakness exists: Immunization declines may have been due to lingering effects of the COVID-19 PHE during 2021. Factors that may have contributed to the declines during this time include staffing shortages and the requirement or recommendation to stay at home, while the fear of

contracting COVID-19 also likely continued to deter individuals from seeking healthcare services, including immunizations.

Recommendation: Anthem self-reported that it conducts root cause analyses to determine why its child members are not receiving all recommended vaccines, and that it considers disparities within its populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. **Anthem** also reported that telehealth services are advertised in provider newsletters and provider education materials, and that it also shares member-level detail data with its contracted providers to conduct outreach and reduce member gaps in care. HSAG recommends that these efforts continue, and that **Anthem** also consider additional interventions based on its root cause analyses to improve the performance related to the Children's Preventive Care domain.

Weakness #3: Anthem's Medicaid performance for the *Breast Cancer Screening* measure demonstrated a decline of more than 5 percentage points from the prior year, which was also noted in the prior year. This indicates 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]**

Why the weakness exists: Screening declines may have been due to lingering effects of the COVID-19 PHE during 2021. Factors that may have contributed to the declines during this time include provider staffing shortages and the requirement or recommendation for members to stay at home, while the fear of contracting COVID-19 also likely continued to deter individuals from seeking healthcare services, including immunizations. **Anthem** also indicated that, through its root cause analysis process, it identified radiology desert areas and an intervention is in the planning stages.

Recommendation: Anthem self-reported that it conducts root cause analyses to determine why its female members are not receiving preventive screenings for breast cancer, and that it considers disparities within its populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. In responses to these analyses, **Anthem** reported that it piloted telehealth kits to increase preventive screenings and scheduled events to offer mammograms. **Anthem** also reported that it shares member level detail data with its contracted providers to conduct outreach and reduce member gaps in care. HSAG recommends that these efforts continue, and that **Anthem** also consider additional interventions based on its root cause analyses to improve the performance related to the Women's Health and Maternity Care domain.

Weakness #4: Within the Behavioral Health domain for Medicaid, **Anthem**'s performance for the *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* measure indicator demonstrated a decline of more than 5 percentage points from the prior year, indicating that not all children are being monitored after being prescribed ADHD medication, which is important to assess for the presence or absence of potential adverse effects. Monitoring adverse effects from ADHD medication allows physicians to suggest an optimal, alternative treatment. In addition, rates for the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*, *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence*, *Follow-Up After Emergency Department Visit for Mental Illness*, and *Follow-Up After Hospitalization for Mental Illness* measure indicators ranked below NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile benchmarks. **[Quality, Timeliness,** and **Access]**

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

Recommendation: **Anthem** self-reported that it has increased member and provider awareness of telehealth services through provider newsletters and provider education materials, and that HEDIS member-level detail data including race/ethnicity, age, and demographic information are also shared with its providers to conduct outreach. HSAG recommends **Anthem** continue its existing efforts to determine why its Medicaid child members are not consistently receiving follow-up care after being prescribed ADHD medication and implement appropriate interventions to improve outcomes for its members diagnosed with ADHD. HSAG also recommends that **Anthem** continue to monitor performance for the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*, *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence*, *Follow-Up After Emergency Department Visit for Mental Illness*, and *Follow-Up After Hospitalization for Mental Illness* measures, and implement appropriate interventions to improve the performance related to the Behavioral Health domain.

Weakness #5: Within the Behavioral Health domain for Nevada Check Up, **Anthem**'s performance for the *Follow-Up After Hospitalization for Mental Illness* showed a decline of more than 5 percentage points from the prior year for the *7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* measure indicators, indicating that not all members who were hospitalized for mental health disorders received adequate and timely follow-up care. Providing follow-up care to patients after psychiatric hospitalization can improve patient outcomes, decrease the likelihood of re-hospitalization, and reduce the overall cost of outpatient care. **[Quality, Timeliness,** and **Access]**

Why the weakness exists: Decreased performance in rates for the *Follow-Up After Hospitalization for Mental Illness* measure indicators may potentially be due to low appointment availability for QMHPs to meet the demand, lack of transportation, or perceived social stigma related to seeking mental health services.

Recommendation: HSAG recommends **Anthem** continue its efforts to educate providers on the use of telehealth services and sharing member demographic information with providers for conducting outreach. **Anthem** should also continue conducting root cause analyses or focused studies to determine why its members who were hospitalized for mental health disorders are not receiving adequate follow-up care. **Anthem** should also continue to evaluate whether there are any 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

Performance Results

Table 3-14 presents **Anthem**'s compliance review scores for each standard evaluated during the current three-year compliance review cycle. **Anthem** was required to submit a CAP for all reviewed standards scoring less than 100 percent compliant. **Anthem**'s implementation of the plans of action under each CAP will be assessed during the third year of the three-year compliance review cycle, and a reassessment of compliance will be determined for each standard not meeting the 100 percent compliance threshold.

Table 3-14—Standard Compliance Scores for Anthem

Compliance Review Standard	Associated Federal Citations[1]	Compliance Score
Mandatory Standards		
Year One (SFY 2021)		
Standard I—Disenrollment: Requirements and Limitations	§438.56	**100%**
Standard II—Member Rights and Member Information	§438.10 §438.100	**95%**
Standard III—Emergency and Poststabilization Services	§438.114	**100%**
Standard IV—Availability of Services	§438.206	**100%**
Standard V—Assurances of Adequate Capacity and Services	§438.207	**100%**
Standard VI—Coordination and Continuity of Care	§438.208	**94%**
Standard VII—Coverage and Authorization of Services	§438.210	**87%**
Year Two (SFY 2022)		
Standard VIII—Provider Selection	§438.214	**67%**
Standard IX—Confidentiality	§438.224	**91%**
Standard X—Grievance and Appeal Systems	§438.228	**74%**
Standard XI—Subcontractual Relationships and Delegation	§438.230	**100%**
Standard XII—Practice Guidelines	§438.236	**100%**
Standard XIII—Health Information Systems[2]	§438.242	**100%**
Standard XIV—Quality Assessment and Performance Improvement Program	§438.330	**97%**
Year Three (SFY 2023)		
Review of MCO implementation of Year One and Year Two CAPs		

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

[2] The Health Information Systems standard includes an assessment of the MCO's IS capabilities.

Table 3-15 presents **Anthem**'s scores for each standard evaluated during the SFY 2022 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. The SFY 2022 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.

Table 3-15—SFY 2022 Standard Compliance Scores for Anthem

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard VIII—Provider Selection	12	12	8	4	0	**67%**
Standard IX—Confidentiality	11	11	10	1	0	**91%**
Standard X—Grievance and Appeal Systems	38	38	28	10	0	**74%**
Standard XI—Subcontractual Relationships and Delegation	7	7	7	0	0	**100%**
Standard XII—Practice Guidelines	10	10	10	0	0	**100%**
Standard XIII—Health Information Systems[1]	14	14	14	0	0	**100%**
Standard XIV—Quality Assessment and Performance Improvement Program	42	39	38	1	3	**97%**
Total	**134**	**131**	**115**	**16**	**3**	**88%**

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.

[1] The Health Information Systems standard included an assessment of the MCO's IS capabilities.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Anthem achieved full compliance for the Subcontractual Relationships and Delegation program area, demonstrating that the MCO had appropriate subcontracts in place and had adequate

oversight and monitoring processes to ensure its delegates are meeting their contractual obligations. [**Quality**]

Strength #2: Anthem achieved full compliance for the Practice Guidelines program area, demonstrating that the MCO adopted evidence-based practice guidelines, disseminated its practice guidelines to all affected providers, and rendered utilization management and coverage of services decisions consistent with its practice guidelines. [**Quality** and **Access**]

Strength #3: Anthem achieved full compliance for the Health Information Systems program area, demonstrating that the MCO maintained a health information system that collects, analyzes, integrates, and reports data on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: Anthem received a score of 67 percent in the Provider Selection program area, indicating that providers may not be appropriately credentialed or assessed in accordance with contractual requirements. [**Quality**]

Why the weakness exists: Anthem's policy did not require all providers applying for network status with the MCO to be credentialed, and gaps in the MCO's process for monitoring Medicare and Medicaid sanctions and exclusions were identified.

Recommendation: While **Anthem** was required to develop a CAP, HSAG recommends that the MCO's credentialing committee conduct a thorough review of providers excluded from its credentialing process and ensure credentialing requirements are developed for all providers, practitioners, and organizations, who can apply for network status. **Anthem** should develop a crosswalk of all provider types and the specific licensing requirements required in the State of Nevada. HSAG also recommends that **Anthem** conduct a root cause analysis on the deficiencies identified through the credentialing case files, and determine whether any area found to be out of compliance was the result of an anomaly or if a more serious breach in policy occurred.

Weakness #2: Anthem received a score of 74 percent in the Grievance and Appeal Systems program area, indicating that the MCO had not implemented a member grievance and appeal process that met all federal and contractual requirements. A total of 10 deficiencies were identified. [**Quality**, **Timeliness**, and **Access**]

Why the weakness exists: Anthem did not consistently resolve all grievances, or resolve all grievances timely; include appropriate non-English taglines written in a conspicuously visible font; obtain member written consent for a provider or authorized representative to file an appeal on behalf of the member; provide oral notice of a denied expedited appeal resolution request; provide members with written acknowledgement of an appeal; provide members with oral notice of an expedited appeal resolution; provide members with an appeal resolution notice; or provide members with State fair hearing (SFH) rights or with accurate SFH rights. Additionally, **Anthem**'s grievance and appeal resolution time frame extension process did not meet all federal requirements.

Recommendation: While **Anthem** was required to develop a CAP, given the high volume of deficiencies identified in the MCO's grievance and appeal process, HSAG recommends that the MCO conduct a comprehensive review of all policies, procedures, workflows, letter templates, and all other member grievance and appeal materials to identify any additional opportunities for improvement in this program area. HSAG also recommends that **Anthem** conduct additional staff training once all materials have been reviewed and revised, and enhance management oversight of the grievance and appeal process.

Network Adequacy Validation

Performance Results

Table 3-16 presents **Anthem**'s network capacity analysis results and compares the provider ratios to the standards displayed in Table 3-4. Assessed provider ratios shown in green indicate the provider ratio was in compliance with the access standard, whereas provider ratios shown in red indicate the provider ratio was not in compliance with the access standard.

Table 3-16—Summary of Ratio Analysis Results for PCPs and Specialty Care Providers for Anthem

Provider Category	Providers*	Clark County Ratio	Washoe County Ratio	Statewide Ratio**
PCPs (1:1,500)	1,372	1:122	1:18	1:140
PCP Extenders (1:1,800)	1,795	1:52	1:8	1:59
Physician Specialists (1:1,500)	1,487	1:113	1:17	1:129

Note: results shown in green font indicate the result complies with the access standard; results shown in red font indicate the result does not comply with the access standard; PCP: Primary Care Provider.
* Providers contracted statewide and contracted providers located in the Nevada Medicaid catchment areas were included in provider counts.
** Statewide ratio incorporates all Nevada counties included in the DHCFP member file submission and members enrolled with the MCO as of March 1, 2022.

Table 3-17 presents **Anthem**'s geographic network distribution analysis and compares the percentage of members within the access standard compared to the standards displayed in Table 3-5. Assessed results shown in green indicate that the percentage of members within the access standard was in compliance, and percentages shown in red indicate a result of less than 99.0 percent.

Table 3-17—Percentage of Members Residing Within the Access Standard Areas for Anthem

Provider Category	Clark County	Washoe County	Statewide*
Primary Care Providers			
Primary Care, Adults (10 miles/15 mins)	99.9%	99.5%	99.9%
OB/GYN (10 miles/15 mins)	99.0%	95.3%	98.4%
Pediatrician (10 miles/15 mins)	99.9%	99.4%	99.7%

Provider Category	Clark County	Washoe County	Statewide*
Physician Specialists			
Endocrinologist (40 miles/60 mins)	>99.9%	>99.9%	99.9%
Endocrinologist, Pediatric (40 miles/60 mins)	>99.9%	100%	>99.9%
Infectious Disease (40 miles/60 mins)	>99.9%	>99.9%	99.9%
Infectious Disease, Pediatric (40 miles/60 mins)	>99.9%	100%	99.9%
Oncologist/Radiologist (40 miles/60 mins)	>99.9%	>99.9%	99.9%
Oncologist—Medical/Surgical (30 miles/45 mins)	>99.9%	>99.9%	99.9%
Oncologist—Medical/Surgical, Pediatric (30 miles/45 mins)	>99.9%	>99.9%	99.9%
Rheumatologist (40 miles/60 mins)	>99.9%	>99.9%	99.9%
Rheumatologist, Pediatric (40 miles/60 mins)	>99.9%	0.0%	87.9%
Behavioral Health Providers			
Board Certified Child and Adolescent Psychiatrist (30 miles/45 mins)	>99.9%	>99.9%	99.9%
Psychiatrist (30 miles/45 mins)	>99.9%	>99.9%	99.9%
Psychologist (30 miles/45 mins)	>99.9%	>99.9%	99.9%
Psychologist, Pediatric (30 miles/45 mins)	>99.9%	0.0%	87.9%
QMHP (30 miles/45 mins)	>99.9%	>99.9%	>99.9%
QMHP, Pediatric (30 miles/45 mins)	>99.9%	100%	>99.9%
Facility-Level Providers			
Hospitals, All (30 miles/45 mins)	>99.9%	>99.9%	99.9%
Pharmacy (10 miles/15 mins)	>99.9%	99.6%	99.9%
Psychiatry Inpatient Hospital (30 miles/45 mins)	>99.9%	>99.9%	99.9%
Dialysis/ESRD Facility (30 miles/45 mins)	>99.9%	>99.9%	99.9%

Note: results shown in green font indicate the result complies with the access standard; results shown in red font indicate that less than 99.0 percent of members had access to the provider within the time and distance access standard.

* Statewide results incorporate all Nevada counties included in the DHCFP member file submission and members enrolled with the MCO as of March 1, 2022.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Anthem met the provider ratio requirements for PCPs and physician specialists, indicating **Anthem** had a sufficient provider network for its members to access services. **[Access]**

Weaknesses and Recommendations

Weakness #1: Anthem did not meet the time-distance contract standards for OB/GYN, Pediatric Rheumatologist, or Pediatric Psychologist, indicating members may experience challenges accessing these provider types within an adequate time or distance from their residence. **[Access]**

Why the weakness exists: The lack of identified providers may result from either a lack of contracted providers in these specialties or from an inability to identify those providers in the data. Three of the four MCOs did not meet the contract adequacy standard for OB/GYN, and all four MCOs did not meet the contract standard for Pediatric Rheumatologists, suggesting a potential lack of this provider type within the counties served. Although half of the MCOs did not meet the contract standard for Pediatric Psychologist, two MCOs did meet the contract standard, suggesting that there may not be a lack of available providers and there may be other providers available for contracting. Although **Anthem** reported it has a process for conducting an in-depth review of provider categories in which it did not meet the time-distance contract standards, it reported this process is manual, suggesting there could also be a delay identifying the gaps and subsequently implementing contracting initiatives to fill those gaps.

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. HSAG also recommends **Anthem** continue to collaborate with the network strategy and information technology (IT) reporting teams for assistance implementing a process to identify targeted providers more quickly.

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results

Table 3-18 presents **Anthem**'s 2022 adult Medicaid, general child Medicaid, and children with chronic conditions (CCC) Medicaid CAHPS top-box scores. Table 3-18 also includes **Anthem**'s 2022 Nevada Check Up general child and CCC top-box scores. Arrows (↓ or ↑) indicate 2022 scores that were statistically significantly higher or lower than the 2021 national average.

Table 3-18—Summary of 2022 CAHPS Top-Box Scores for Anthem

	Adult Medicaid	General Child Medicaid	CCC Medicaid	Nevada Check Up General Child	Nevada Check Up CCC
Composite Measures					
Getting Needed Care	NA	NA	NA	NA	NA
Getting Care Quickly	NA	NA	NA	NA	NA
How Well Doctors Communicate	NA	NA	NA	NA	NA
Customer Service	NA	NA	NA	NA	NA
Global Ratings					
Rating of All Health Care	NA	NA	NA	NA	NA
Rating of Personal Doctor	NA	77.9%	NA	68.2% ↓	NA
Rating of Specialist Seen Most Often	NA	NA	NA	NA	NA
Rating of Health Plan	61.3%	76.1%	NA	64.4% ↓	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	—	—	NA	—	NA
Coordination of Care for Children With Chronic Conditions	—	—	NA	—	NA

	Adult Medicaid	General Child Medicaid	CCC Medicaid	Nevada Check Up General Child	Nevada Check Up CCC
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 result. Measures that do not meet the minimum number of responses are denoted as *Not Applicable (NA)*.

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

↑ Indicates the 2022 score is statistically significantly higher than the 2021 national average.

↓ Indicates the 2022 score is statistically significantly lower than the 2021 national average.

— Indicates the measure does not apply to the population.

Strengths, Weaknesses, and Recommendations

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

Strengths

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

Weaknesses and Recommendations

Weakness #1: Parents/caretakers of Nevada Check Up general child members had less positive overall experiences with their child's personal doctor since the score for this measure was statistically significantly lower than the 2021 NCQA Medicaid national average. **[Quality]**

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

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

Weakness #2: Parents/caretakers of Nevada Check Up general child members had fewer positive experiences with their child's health plan since the score for this measure was statistically significantly lower than the 2021 NCQA Medicaid national average. **[Quality]**

Why the weakness exists: Parents/caretakers of Nevada Check Up general child members are reporting a more negative experience with their child's health plan overall, which could be due to a perceived lack of ability to get the care they need.

Recommendation: HSAG recommends that **Anthem** focus on improving parents'/caretakers' of general child members overall experiences with Nevada Check Up by performing a root cause analysis, which could determine if there are any outliers within the data so that **Anthem** can identify the primary areas of focus and develop appropriate strategies to improve the performance.

Weakness #3: There were less than 100 respondents for every measure for the CCC populations and most measures for the adult Medicaid, general child Medicaid, and Nevada Check Up general child populations; therefore, results could not be reported for the other measures and other strengths and weaknesses could not be identified. **[Quality, Timeliness, Access]**

Why the weakness exists: Adult members and parents/caretakers of child members are less likely to respond to the CAHPS survey. **Anthem** also reported that COVID-19 continues to impact the survey response rate, as completion of surveys may be exceptionally low on the list of priorities for members struggling with COVID-19, unemployment, and/or other life-changing events.

Recommendation: HSAG recommends that **Anthem** focus on increasing response rates to the CAHPS survey for all populations so there are greater than 100 respondents for each measure by educating and engaging all employees to increase their knowledge of CAHPS, using customer service techniques, oversampling, and continuing to provide awareness to members and providers during the survey period.

Encounter Data Validation

Performance Results

Comparative Analysis

Table 3-19 displays the percentage of records present in the files submitted by **Anthem** that were not found in DHCFP's files (record omission) and the percentage of records present in DHCFP's files but not present in the files submitted by **Anthem** (record surplus). Lower rates indicate better performance for both record omission and record surplus.

Table 3-19—Record Omission and Surplus by Encounter Type for Anthem

Encounter Data Source	Record Omission	Record Surplus
Professional	10.4%	0.8%
Institutional	21.1%	3.4%
Pharmacy	0.2%	13.6%

Table 3-20 through Table 3-22 display the element omission, surplus, and accuracy results for each key data element by encounter type for **Anthem**. For the element omission and surplus indicators, lower rates indicate better performance; while for the element accuracy indicator, higher rates indicate better performance.

Table 3-20—Element Omission, Surplus, and Accuracy—Professional Encounters for Anthem

Key Data Element	Element Omission	Element Surplus	Element Accuracy
Recipient Identification (ID)	0.0%	0.0%	>99.9%
Header Service From Date	0.0%	0.0%	>99.9%
Header Service To Date	0.0%	0.0%	>99.9%
Detail Service From Date	0.0%	0.0%	>99.9%
Detail Service To Date	0.0%	0.0%	>99.9%
Billing Provider National Provider Identifier (NPI)	4.3%	<0.1%	99.9%
Rendering Provider NPI	2.1%	31.6%	100%
Referring Provider NPI	0.0%	46.1%	NA
Primary Diagnosis Code	0.0%	<0.1%	>99.9%
Secondary Diagnosis Code[1]	<0.1%	20.6%	0.0%
Procedure Code (CPT/Healthcare Common Procedure Coding System [HCPCS]/Current Dental Terminology [CDT])	<0.1%	0.0%	>99.9%
Procedure Code Modifier	<0.1%	<0.1%	>99.9%
National Drug Code (NDC)	<0.1%	<0.1%	>99.9%
Drug Quantity	<0.1%	0.0%	47.0%
Header Paid Amount	0.0%	0.0%	>99.9%
Detail Paid Amount	0.0%	0.0%	>99.9%

[1] Calculated for *Diagnosis Code 2* only.
NA indicates not applicable since no records had values present in both data sources.

Table 3-21—Element Omission, Surplus, and Accuracy—Institutional Encounters for Anthem

Key Data Element	Element Omission	Element Surplus	Element Accuracy
Recipient ID	0.0%	0.0%	>99.9%
Header Service From Date	0.0%	0.0%	>99.9%
Header Service To Date	0.0%	0.0%	100%
Detail Service From Date	0.0%	0.0%	84.4%
Detail Service To Date	0.0%	0.0%	64.7%
Billing Provider NPI	0.5%	0.0%	>99.9%

Key Data Element	Element Omission	Element Surplus	Element Accuracy
Attending Provider NPI	2.0%	0.0%	100%
Referring Provider NPI	0.0%	0.0%	NA
Primary Diagnosis Code	0.0%	0.0%	100%
Secondary Diagnosis Code[1]	0.0%	12.8%	0.0%
Procedure Code (CPT/HCPCS/CDT)	<0.1%	<0.1%	>99.9%
Procedure Code Modifier	<0.1%	<0.1%	>99.9%
Primary Surgical Procedure Code	0.0%	13.3%	NA
Secondary Surgical Procedure Code[2]	0.0%	8.4%	NA
NDC	<0.1%	<0.1%	>99.9%
Drug Quantity	<0.1%	0.0%	48.2%
Revenue Code	<0.1%	0.0%	>99.9%
Header Paid Amount	0.0%	0.0%	>99.9%
Detail Paid Amount	0.0%	0.0%	>99.9%

[1] Calculated for *Diagnosis Code 2* only.
[2] Calculated for *Surgical Procedure Code 2* only.
NA indicates not applicable since no records had values present in both data sources.

Table 3-22—Element Omission, Surplus, and Accuracy—Pharmacy Encounters for Anthem

Key Data Element	Element Omission	Element Surplus	Element Accuracy
Recipient ID	0.0%	0.0%	>99.9%
Date of Service	0.0%	0.0%	100%
Billing Provider NPI	0.1%	0.0%	100%
Prescribing Provider NPI	0.0%	<0.1%	>99.9%
NDC	0.0%	0.0%	>99.9%
Drug Quantity	0.0%	0.0%	99.9%
Paid Amount	0.0%	0.0%	94.6%

Table 3-23 displays the all-element accuracy results for the percentage of records present in both data sources with the same values (missing and non-missing) for all key data elements relevant to each encounter data type for **Anthem**.

Table 3-23—All-Element Accuracy by Encounter Type for Anthem

Indicator	Professional	Institutional	Pharmacy
All-Element Accuracy	13.4%	8.4%	94.5%

Medical Record Review

Table 3-24 presents the percentage of key data elements identified in the encounter data that were not supported by the members' medical records provided by **Anthem** (i.e., medical record omission) and the percentage of key data elements from the members' medical records that were not found in the encounter data provided by **Anthem** (i.e., encounter data omission). Lower rates for each data element indicate better performance.

Table 3-24 also displays the percentage of key data elements associated with validated dates of service from the encounter data that were correctly coded based on the members' medical records. Errors found in the diagnosis coding were separated into two categories: inaccurate coding and specificity error. Errors found in the procedure coding associated with the medical record reviews (MRRs) were separated into three categories: higher level of service in the medical record, lower level of service in the medical record, and inaccurate coding. The errors for the procedure code modifier data element could not be separated into subcategories and therefore are not presented in Table 3-24. Higher accuracy rates for each data element indicate better performance.

Table 3-24—MRR: Encounter Data Completeness and Accuracy for Anthem

Data Element	Medical Record Omission[1]	Encounter Data Omission[2]	Element Accuracy[3]	Error Type
Date of Service	13.4%	4.4%	—	—
Diagnosis Code	17.3%	3.0%	99.6%	Incorrect Code (100%) Specificity Error (0.0%)
Procedure Code	21.8%	24.3%	96.6%	Incorrect Code (84.0%) Lower Level of Services in Medical Records (16.0%) Higher Level of Services in Medical Records (0.0%)
Procedure Code Modifier	31.1%	3.5%	100%	—
All-Element Accuracy[4]			51.3%	—

"—" indicates that the accuracy rate analysis and/or the error type analysis was not applicable to a given data element.

[1] Services documented in the encounter data but not supported by the members' medical records. Lower rate values indicate better performance.

[2] Services documented in the members' medical records but not in the encounter data. Lower rate values indicate better performance.

[3] Services documented in the members' medical records associated with validated dates of service from the encounter data that were correctly coded based on the medical records. Higher rate values indicate better performance.

[4] The all-element accuracy rate describes the percentage of dates of service present in both DHCFP's encounter data and in the medical records with all data elements coded correctly (i.e., not omitted from the medical record; not omitted from the encounter data; and, when populated, have the same values). As such, the gray cells indicate the evaluation for medical record omission or encounter data omission is not applicable.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Pharmacy data element comparison between data extracted from **Anthem**'s claims systems and data extracted from DHCFP's data warehouse showed complete and accurate data. **[Quality]**

Weaknesses and Recommendations

Weakness #1: Errors in data files extracted for the study were observed (e.g., the *Drug Quantity* data element having the same values as the *Units of Service* data element). Consequently, the errors resulted in discrepancies in the comparative analysis. **[Quality]**

Why the weakness exists: Anthem reviewed the findings from the comparative analysis and noted that it discovered a mapping issue in the data extract for the study that resulted in drug quantity being mapped in all lines of the claims instead of the lines that only correlate to a NDC procedure code.

Recommendation: HSAG recommends that **Anthem** implement standard quality controls to ensure accurate data extracts from its respective systems. Through the development of standard data extraction procedures and quality control, the number of errors associated with extracted data could be reduced.

Weakness #2: Anthem was unable to procure all requested medical records from its contracted providers, resulting in a low medical record procurement rate. The low medical record procurement rate consequently impacted the results of the MRRs of key data elements that were evaluated. **[Quality]**

Why the weakness exists: Anthem reported that the main reasons for missing medical records were due to non-responsive providers and providers not responding to the requests for records timely.

Recommendation: To ensure **Anthem**'s contracted provider accountability in addressing submission of medical records for auditing, inspection, and examination related to its members, **Anthem** should consider strengthening and/or enforcing its contract requirements with providers in providing the requested documentation.

Weakness #3: Procedure codes documented in the medical records were either not found in the encounter data or were found in the encounter data but should have been coded with a different procedure code. **[Quality]**

Why the weakness exists: While discrepancies were largely related to medical record non-submission, other reasons may also have contributed to the discrepancies. Some of the potential

reasons include: (1) the provider did not document the services performed in the medical record, and (2) the provider did not provide the service(s) found in the encounter data.

Recommendation: Anthem should consider performing periodic MRRs of submitted claims to verify appropriate coding and data completeness. Any findings from these reviews should then be shared with providers through periodic education and training regarding encounter data submissions, medical record documentation, and coding practices.

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

HSAG performed a comprehensive assessment of **Anthem**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **Anthem** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **Anthem**'s overall performance contributed to the Nevada Managed Care Program's progress in achieving the Quality Strategy goals and objectives. Table 3-25 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **Anthem**'s Medicaid and Nevada Check Up members.

Table 3-25—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Use of Preventive Services	**Quality, Timeliness,** and **Access**—Over the past three-year period (MY 2019–MY 2021), there has been a steady decline in the percentage of **Anthem**'s adult members accessing preventive services, and an even higher rate of decline in members 65 years and older. While there has been improvement in the percentage of children and adolescents between the ages of 3 and 21 years who received one or more well-care visits with a PCP or an OB/GYN provider during the year, there has been a decline in the percentage of well-child visits in the first 30 months of life, particularly in members who turned 30 months old during the year. There was also a decline in the prevalence of immunizations for children and adolescents and a significant decline in breast cancer screenings over the past three years. Accessing preventive care decreases the risk for diseases, disabilities, and death. Children also need regular preventive care visits to monitor their development and find health problems early so they are easier to treat. Although **Anthem** demonstrated through the compliance review activity that it has strong practices for ensuring its providers were aware of its adopted practice guidelines, which should include guidelines for preventive care, and **Anthem** appears to have a sufficient number of PCPs to provide services, as indicated through the NAV activity, parents or guardians of **Anthem**'s child members reported less positive experiences with their providers through the CAHPS activity, which may indicate issues accessing care or may contribute to child members not seeing their providers regularly for preventive care. Based on these findings, **Anthem** has significant opportunities to mitigate any barriers to receiving preventive care, and to implement interventions to support improvement in the use of preventive services for its adult and child members.

Performance Area	Overall Performance Impact
Evidence-Based Practices for Members With Chronic Conditions	**Quality**—Through the PIP activity and its implemented intervention, **Anthem** was able to effectively decrease the percentage of its diabetic members who had an HbA1c level greater than 9 percent at certain points in time. **Anthem** also demonstrated a lower number of diabetic members with HbA1c levels greater than 9 percent (i.e., poor control) from the previous two MYs. Additionally, in MY 2021, **Anthem** also slightly improved the percentage of diabetic members obtaining HbA1c tests, having HbA1c levels less than 8 percent, and having their blood pressure under control, indicating **Anthem** had focused efforts on diabetes management and members were gaining better control over their diabetes.
Health and Wellness of Pregnant Women	**Quality, Timeliness,** and **Access**—Although **Anthem** implemented an intervention to support an improvement in the number of pregnant women receiving prenatal care timelier, the intervention could not be linked to improved performance in this program area. Additionally, the percentage of pregnant women obtaining timely prenatal care stayed stagnant over the last three-year period (MY 2019–MY 2021), which may be due to an inadequate number of OB/GYN providers to support the number of pregnant women needing services as determined through the NAV activity. These findings indicate **Anthem** has continued opportunities to implement interventions that will result in more members seeking and having access to timely prenatal services, thus improving the likelihood of better health outcomes for mothers and their babies.
Evidence-Based Practices for Members With Behavioral Health Conditions	**Quality, Timeliness,** and **Access**—A high prevalence of **Anthem**'s adult and adolescent members with a new episode of alcohol or other drug (AOD) dependence received timely treatment as indicated by performance above the national average, which supports improved member outcomes. However, **Anthem** must target its efforts on coordinating care for its members hospitalized with other behavioral health conditions, as demonstrated by a decline in the percentage of child and adult members hospitalized with a mental illness who did not receive timely follow-up care with a mental health provider after discharge. Per the NAV activity results, **Anthem** did not have any pediatric psychologists in Washoe County, which may contribute to children not accessing care timely; however, **Anthem** did demonstrate significant improvement over the past MY in the percentage of members who accessed timely follow-up care after an ED visit for mental illness. As such, **Anthem** should evaluate its follow-up processes after ED visits to determine whether those same processes could be implemented for members being discharged from the hospital.
Appropriate Prescribing Practices	**Quality**—**Anthem** met the established MPS and demonstrated adequate oversight of its provider network specific to the prescribing and filling of opioids as indicated by a relatively low prevalence of high-risk opioid analgesic prescribing practices, multiple prescribers prescribing opioids, and multiple pharmacies filling the prescriptions, therefore reducing the higher likelihood of opioid-related overdose deaths. Of note, as there was an increase in the percentage of members receiving prescriptions for opioids from four or more different prescribers during the MY, **Anthem** should continue its monitoring efforts and provide education to its providers and contracted pharmacies, as necessary, to maintain an adequate level of performance.

Health Plan of Nevada

Validation of Performance Improvement Projects

Performance Results

HPN completed and submitted Module 4 (PIP Conclusions) for validation for each topic. HSAG organized and analyzed **HPN**'s PIP data to draw conclusions about the MCO's quality improvement efforts. Based on its review, HSAG determined the overall methodological validity of the PIP, as well as the overall success in achieving the SMART Aim goal. As part of this determination, HSAG evaluated the appropriateness and validity of the SMART Aim measure, as well as trends in the SMART Aim measurements, in comparison with the reported baseline rate and goal. To represent the validity and reliability of each PIP, HSAG assigned a level of confidence (i.e., *High confidence*, *Confidence*, *Low confidence*, *Reported PIP results were not credible*). Refer to Appendix A for details regarding the scoring methodology for each level of confidence. The validation findings assessed by HSAG, and a description of the interventions implemented by **HPN** for each PIP, are displayed in Table 3-26 through Table 3-29.

Table 3-26—SMART Aim Measure Results for CDC HbA1c Poor Control >9.0%

SMART Aim	Baseline Rate	SMART Aim Goal Rate	Lowest Rate Achieved	Confidence Level
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%.	45.63%	34.78%	34.09%	*Low confidence*

* Provider name has been redacted for privacy purposes.

Table 3-27—Intervention for CDC HbA1c Poor Control >9.0%

Intervention: CDC HbA1c Poor Control >9.0% PIP	
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 many challenges were encountered.
Intervention Status	The intervention was abandoned.

Table 3-28—SMART Aim Measure Results for Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care

SMART Aim	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
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%.	66.41%	77.52%	85.15%	*High confidence*

* Provider name has been redacted for privacy purposes.

Table 3-29—Intervention for Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care

Intervention: *Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care* PIP	
Intervention Description	Targeted provider and office staff CPT code training
Intervention Impact	The MCO reported intervention testing results were effective at improving the office staff's use of the correct CPT codes.
Intervention Status	The intervention was adopted.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: HPN developed methodologically sound improvement projects that met both State and federal requirements. **[Quality]**

Strength #2: HPN used quality improvement tools and processes to identify and prioritize opportunities for improvement that led to the development of the intervention tested for each PIP. **[Quality]**

Strength #3: HPN achieved its SMART Aim goal to decrease the rate of HbA1c test results greater than 9 percent or missing HbA1c test results among diabetic Medicaid members assigned to a specific medical center. **[Quality]**

Strength #3: HPN met its SMART Aim goal to increase the rate of Medicaid deliveries completed by a specific OB/GYN provider who received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment in the MCO. **[Quality** and **Timeliness]**

Weaknesses and Recommendations

Weakness #1: HPN limited the number of interventions tested for each topic to just one for the duration of the PIP. **[Quality, Timeliness,** and **Access]**

Why the weakness exists: HPN included one intervention per PIP, which may have limited the opportunity for the MCO to address other opportunities for improvement identified through its quality improvement processes.

Recommendation: HPN should consider testing more than one intervention during the PIP, which will help the MCO address as many identified opportunities for improvement as possible. The MCO should apply lessons learned and knowledge gained from its efforts and HSAG's feedback throughout the PIP to future PIPs and other quality improvement activities. Lastly, **HPN** should continue improvement efforts in the PIP topic areas and, for the successful intervention, consider spreading beyond the narrowed focus. The conclusion of a project should be used as a springboard for sustaining the improvement achieved and attaining new improvements.

Weakness #1: Although the SMART Aim goal was achieved for the *CDC HbA1c Poor Control >9.0%* PIP, the outcome was not linked to the implemented intervention, which resulted in HSAG assigning a *Low confidence* level to the PIP. **[Quality]**

Why the weakness exists: HPN provided rolling 12-month data for the SMART Aim measure from February 2020 through June 2021. The SMART Aim goal was achieved for the rolling 12-month SMART Aim measurement period of July 2020, with a rate of 34.09 percent. However, the SMART Aim goal was achieved two months prior to initiating intervention testing, which started in September 2020.

Recommendation: HPN should ensure that the intervention(s) tested have the potential to impact the desired outcomes of the PIP and be mindful of the timing of intervention initiation.

Performance Measure Validation

Performance Results

Table 3-30 and Table 3-31 show **HPN**'s Medicaid and Nevada Check Up performance measure results for HEDIS MY 2019, MY 2020, and MY 2021, along with MY 2020 to MY 2021 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 2020 to MY 2021 represents performance improvement and an increase in the rate from MY 2020 to MY 2021 represents performance decline. The arrows (↑ or ↓) indicate whether the HEDIS MY 2021 rate was above or below NCQA's Quality Compass HEDIS 2021 Medicaid HMO 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 3-30—Medicaid HEDIS MY 2021 Performance Measure Results and Trending for HPN

HEDIS Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	MY 2020–MY 2021 Rate Comparison
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services (AAP)				
Ages 20–44 Years	75.70%	69.80%	66.38%↓	-3.42
Ages 45–64 Years	81.68%	76.29%	74.57%↓	-1.72
*Ages 65 Years and Older^*	NA	81.41%	71.43%↓	-9.98
*Total^*	77.81%	71.93%	68.93%↓	-3.00
Children's Preventive Care				
Childhood Immunization Status (CIS)				
Combination 3	68.37%	69.34%	60.58%↓	-8.76
Combination 7	59.61%	62.53%	52.80%↓	-9.73
Combination 10	35.52%	33.09%	27.25%↓	-5.84
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	90.51%	88.56%	83.21%↑	-5.35
Combination 2 (Meningococcal, Tdap, HPV)	48.42%	47.45%	37.96%↑	-9.49
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile—Total	83.45%	86.44%	**86.58%**↑	0.14
Counseling for Nutrition—Total	71.05%	76.55%	76.68%↑	0.13
Counseling for Physical Activity—Total	69.34%	75.14%	72.84%↑	-2.30
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	—	59.89%	57.43%↑	-2.46
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	—	68.83%	59.91%↓	-8.92
Child and Adolescent Well-Care Visits (WCV)				
3–11 Years	—	48.62%	50.75%↓	2.13

HEDIS Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	MY 2020–MY 2021 Rate Comparison
12–17 Years	—	41.59%	**46.03%**↑	4.44
18–21 Years	—	24.50%	20.86%↓	-3.64
*Total^*	—	43.00%	44.66%↓	1.66
Women's Health and Maternity Care				
Breast Cancer Screening (BCS)				
Breast Cancer Screening	55.08%	52.01%	51.07%↓	-0.94
Chlamydia Screening in Women (CHL)^				
16–20 Years	—	—	57.86%	NC
21–24 Years	—	—	62.11%	NC
Total	—	—	60.02%	NC
Prenatal and Postpartum Care (PPC)				
Timeliness of Prenatal Care	90.02%	87.59%	**86.37%**↑	-1.22
Postpartum Care	81.51%	78.83%	**74.21%**↓	-4.62
Care for Chronic Conditions				
Asthma Medication Ratio (AMR)^				
5–11 Years	—	—	77.84%	NC
12–18 Years	—	—	67.40%	NC
19–50 Years	—	—	50.58%	NC
51–64 Years	—	—	52.41%	NC
Total	—	—	58.78%	NC
Comprehensive Diabetes Care (CDC)				
*Hemoglobin A1c (HbA1c) Testing^*	84.91%	79.81%	**80.78%**↓	0.97
*HbA1c Poor Control (>9.0%)**	41.36%	38.69%	**37.71%**↑	-0.98
HbA1c Control (<8.0%)	49.64%	50.12%	**51.58%**↑	1.46
Eye Exam (Retinal) Performed	62.04%	63.02%	57.91%↑	-5.11
Blood Pressure Control (<140/90 mm Hg)	—	63.75%	**68.37%**↑	4.62
Controlling High Blood Pressure (CBP)				
Controlling High Blood Pressure	—	60.34%	**65.69%**↑	5.35

HEDIS Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	MY 2020–MY 2021 Rate Comparison
Kidney Health Evaluation for Patients With Diabetes (KED)^				
18–64 Years	—	42.02%	**44.36%**	2.34
65–74 Years	—	42.42%	**60.67%**	18.25
75–84 Years	—	NA	NA	NC
Total	—	42.02%	**44.50%**	2.48
Behavioral Health				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	44.00%	44.73%	43.18%↓	-1.55
Antidepressant Medication Management (AMM)^				
Effective Acute Phase Treatment	—	—	54.22%	NC
Effective Continuation Phase Treatment	—	—	36.61%	NC
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	78.86%	74.58%	72.69%↓	-1.89
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)				
7-Day Follow-Up—Total	14.52%	16.03%	10.26%↓	-5.77
30-Day Follow-Up—Total	18.92%	20.92%	13.44%↓	-7.48
Follow-Up After Emergency Department Visit for Mental Illness (FUM)				
7-Day Follow-Up—Total	56.53%	52.34%	44.07%↑	-8.27
30-Day Follow-Up—Total	63.92%	60.81%	53.79%↑	-7.02
Follow-Up After Hospitalization for Mental Illness (FUH)				
7-Day Follow-Up—Total	36.88%	38.58%	35.73%↓	-2.85
30-Day Follow-Up—Total	53.80%	56.65%	51.96%↓	-4.69
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
Initiation Phase	49.90%	54.10%	54.56%↑	0.46
Continuation and Maintenance Phase	68.29%	68.82%	72.15%↑	3.33

HEDIS Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	MY 2020–MY 2021 Rate Comparison
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)				
Initiation of AOD—Total	42.24%	37.81%	40.09%↓	2.28
Engagement of AOD—Total	10.88%	11.56%	11.46%↓	-0.10
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)				
Blood Glucose and Cholesterol Testing—Total	35.71%	33.89%	29.86%↓	-4.03
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)^				
1–11 Years	—	—	56.63%	NC
12–17 Years	—	—	54.70%	NC
Total	—	—	55.50%	NC
Utilization				
Ambulatory Care—Total (per 1,000 Member Months) (AMB)^				
*ED Visits—Total**	58.85	41.60	42.95	1.35
Outpatient Visits—Total	318.88	280.22	269.01	-11.21
Mental Health Utilization—Total (MPT)^				
Inpatient—Total	0.70%	0.66%	0.68%	0.02
Intensive Outpatient or Partial Hospitalization—Total	0.39%	0.24%	0.18%	-0.06
Outpatient—Total	9.30%	6.95%	5.98%	-0.97
ED—Total	0.02%	0.02%	0.02%	0.00
Telehealth—Total	0.02%	3.72%	3.73%	0.01
Any Service—Total	9.44%	8.53%	7.97%	-0.56
Plan All-Cause Readmissions (PCR)				
Observed Readmissions—Total	14.87%	11.13%	**9.99%**	-1.14
*Expected Readmissions—Total^*	9.50%	9.08%	8.85%	-0.23
*O/E Ratio—Total^*	1.56	1.23	1.13	-0.10
Overuse/Appropriateness of Care				
Use of Opioids at High Dosage (HDO)*				
Use of Opioids at High Dosage	10.36%	10.00%	8.83%↓	-1.17

HEDIS Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	MY 2020–MY 2021 Rate Comparison
Use of Opioids From Multiple Providers (UOP)*				
Multiple Prescribers	25.31%	29.47%	**21.57%↓**	-7.90
*Multiple Pharmacies^*	3.00%	2.12%	**1.08%↑**	-1.04
*Multiple Prescribers and Multiple Pharmacies^*	1.73%	1.23%	**0.69%↑**	-0.54

↑ Indicates the HEDIS MY 2021 rate was above NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile benchmark.
↓ Indicates the HEDIS MY 2021 rate was below NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile benchmark.
* A lower rate indicates better performance 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 2021 QISMC goals are unavailable for this measure or indicator.
NC indicates the MY 2020–MY 2021 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 2021 performance measure rate was at or above the MPS.

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

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

Table 3-31—Nevada Check Up HEDIS MY 2021 Performance Measure Results and Trending for HPN

HEDIS Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	MY 2020–MY 2021 Rate Comparison
Children's Preventive Care				
Childhood Immunization Status (CIS)				
Combination 3	83.56%	81.29%	75.78%↑	-5.51
Combination 7	75.34%	75.81%	68.61%↑	-7.20
Combination 10	45.21%	41.94%	43.05%↑	1.11
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	97.32%	94.07%	89.05%↑	-5.02
Combination 2 (Meningococcal, Tdap, HPV)	56.69%	50.62%	47.93%↑	-2.69
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile—Total	88.81%	85.97%	85.07%↑	-0.90

HEDIS Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	MY 2020–MY 2021 Rate Comparison
Counseling for Nutrition—Total	73.24%	74.93%	76.12%↑	1.19
Counseling for Physical Activity—Total	72.75%	72.84%	72.84%↑	0.00
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	—	72.45%	63.03%↑	-9.42
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	—	82.76%	73.96%↑	-8.80
Child and Adolescent Well-Care Visits (WCV)				
3–11 Years	—	55.57%	52.35%↑	-3.22
12–17 Years	—	50.91%	52.87%↑	1.96
18–21 Years	—	33.50%	28.69%↑	-4.81
*Total^*	—	52.09%	50.72%↑	-1.37
Women's Health and Maternity Care				
Chlamydia Screening in Women (CHL)^				
16–20 Years	—	—	59.62%	NC
21–24 Years	—	—	NA	NC
Total	—	—	59.62%	NC
Care for Chronic Conditions				
Asthma Medication Ratio (AMR)^				
5–11 Years	—	—	83.02%	NC
12–18 Years	—	—	69.70%	NC
19–50 Years	—	—	NA	NC
51–64 Years	—	—	NA	NC
Total	—	—	75.63%	NC
Behavioral Health				
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)^				
7-Day Follow-Up—Total	—	NA	NA	NC
30-Day Follow-Up—Total	—	NA	NA	NC

HEDIS Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	MY 2020–MY 2021 Rate Comparison
Follow-Up After Emergency Department Visit for Mental Illness (FUM)				
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)				
7-Day Follow-Up—Total	NA	NA	**57.89%**↑	NC
30-Day Follow-Up—Total	NA	NA	**81.58%**↑	NC
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
Initiation Phase	55.38%	46.55%	**50.85%**↑	4.30
*Continuation and Maintenance Phase^*	NA	NA	NA	NC
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)				
Initiation of AOD—Total	25.71%	12.50%	NA	NC
Engagement of AOD—Total	8.57%	0.00%	NA	NC
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)				
Blood Glucose and Cholesterol Testing—Total	21.95%	44.90%	43.90%↑	-1.00
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)^				
1–11 Years	—	—	NA	NC
12–17 Years	—	—	NA	NC
Total	—	—	NA	NC
Utilization				
Ambulatory Care—Total (per 1,000 Member Months) (AMB)^				
*ED Visits—Total**	25.99	13.71	16.06	2.35
Outpatient Visits—Total	265.66	195.10	191.05	-4.05
Mental Health Utilization—Total (MPT)^				
Inpatient—Total	0.20%	0.18%	0.31%	0.13
Intensive Outpatient or Partial Hospitalization—Total	0.03%	0.03%	0.05%	0.02
Outpatient—Total	7.46%	5.02%	5.48%	0.46
ED—Total	0.01%	0.01%	0.02%	0.01

HEDIS Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	MY 2020–MY 2021 Rate Comparison
Telehealth—Total	0.00%	3.62%	3.39%	-0.23
Any Service—Total	7.52%	6.40%	6.92%	0.52

↑ Indicates the HEDIS MY 2021 rate was above NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile benchmark.
↓ Indicates the HEDIS MY 2021 rate was below NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile benchmark.
* A lower rate indicates better performance 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 2021 QISMC goals are unavailable for this measure or indicator.
NC indicates the MY 2020–MY 2021 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 2021 performance measure rate was at or above the MPS.
Indicates that the HEDIS MY 2021 rate declined by 5 percentage points or more from HEDIS MY 2020.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Within the Children's Preventive Care domain for Medicaid, **HPN** demonstrated performance above NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile benchmarks for the *Immunizations for Adolescents* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure indicators, as well as the *Well-Child Visits in the First 30 Months of Life—Six or More Well-Child Visits* and *Child and Adolescent Well-Care Visits—12–17 Years* measure indicators. In addition, the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total* and *Child and Adolescent Well-Care Visits—12–17 Years* measure indicator rates for **HPN**'s Medicaid population met the MPS. Furthermore, rates for all measure indicators in the Children's Preventive Care domain for **HPN**'s Nevada Check Up population ranked above NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile benchmarks. This performance demonstrates **HPN**'s commitment to influencing health and development in its child and adolescent members, as well as reducing vaccine-preventable disease and obesity. **[Quality]**

Strength #2: Within the Women's Health and Maternity Care domain, **HPN** met the MPS for both *Prenatal and Postpartum Care* measure indicators for its Medicaid population. In addition, the *Timeliness of Prenatal Care* measure indicator ranked above NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile benchmark. This performance demonstrates **HPN**'s commitment to increasing the quality of care and preventing pregnancy-related deaths by providing better access to care for its pregnant Medicaid members. **[Quality, Timeliness** and **Access]**

Strength #3: Within the Care for Chronic Conditions domain for Medicaid, all *Comprehensive Diabetes Care* measure indicators, except *Eye Exam (Retinal) Performed*, met the MPS; in addition, all measure indicators, except *HbA1c Testing*, ranked above NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile benchmarks. Furthermore, **HPN**'s Medicaid rate for the *Controlling High Blood Pressure* measure met the MPS. Of note, the *Controlling High Blood Pressure* and *Kidney Health Evaluation for Patients With Diabetes—65–74 Years* measure indicator demonstrated an increase of more than 5 percentage points from the prior year. **[Quality]**

Strength #4: HPN's Nevada Check Up rates for the *Follow-Up After Hospitalization for Mental Illness* and *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* measure indicators met the MPS and ranked above NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile benchmarks. In addition, the Nevada Check Up rate for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measure ranked above NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile benchmark. This performance within the Behavioral Health domain demonstrates that **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]**

Strength #5: Within the Overuse/Appropriateness of Care domain for **HPN**'s Medicaid population, all three indicators for the *Use of Opioids From Multiple Providers* measure met the MPS, and two indicators (i.e., *Multiple Pharmacies* and *Multiple Prescribers and Multiple Pharmacies)* ranked above NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile benchmarks. **[Quality]**

Weaknesses and Recommendations

Weakness #1: Within the Access to Care domain for **HPN**'s Medicaid population, the two indicators with QISMC goals for the *Adults' Access to Preventive/Ambulatory Health Services* measure (i.e., *Ages 20–44 Years* and *Ages 45–64 Years*) did not meet the MPS, and all indicator rates ranked below NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile benchmarks. In addition, these rates have shown a steady decline when compared to the prior two years' rates. **[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. These visits can also help address acute issues or manage chronic conditions.

Recommendation: HPN reported that it has implemented value-based contracts that include the *Adults' Access to Preventive/Ambulatory Health Services* measure and initiated member outreach

activities to improve adults' access to preventive services. HSAG recommends **HPN** continue with these interventions, but also conduct timely studies to determine whether the interventions are effective. **HPN** should also determine whether additional interventions are necessary and implement, as appropriate, to improve the performance related to Access to Care measures. If COVID-19 continues to be a factor in lower performance, HSAG also recommends **HPN** work with its members to increase the use of telehealth services, when appropriate.

Weakness #2: Within the Children's Preventive Care domain for **HPN**'s Medicaid population, performance for the *Childhood Immunization Status, Immunizations for Adolescents,* and *Well-Child Visits in the First 30 Months of Life—Two or More Well-Child Visits* measure indicators demonstrated a decline of more than 5 percentage points from the prior year, indicating that children are not receiving the recommended immunizations and well-child visits, which are a critical aspect of preventable care for children. **[Quality]**

Why the weakness exists: Immunizations and well-child visit declines may have been due to lingering effects of the COVID-19 PHE during 2021. Factors that may have contributed to the declines during this time include provider staffing shortages and the requirement or recommendation to stay at home, while the fear of contracting COVID-19 also likely continued to deter individuals from seeking healthcare services, including immunizations.

Recommendation: HPN reported that it has implemented a member incentive program that rewards members for the completion of well-child visits. HSAG recommends that **HPN** continue this intervention and, as part of its implementation process, **HPN** should conduct a timely evaluation to determine whether the member rewards program is resulting in increased member well-child visits and timely immunizations. If COVID-19 is still a factor, **HPN** should also determine interventions to reduce any COVID-19-related barriers to members accessing care and obtaining immunizations.

Weakness #3: Within the Children's Preventive Care domain for **HPN**'s Nevada Check Up population, although all measure indicator rates ranked above NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile benchmarks, performance for the *Childhood Immunization Status—Combination 3* and *Combination 7*, *Immunizations for Adolescents—Combination 1*, and *Well-Child Visits in the First 30 Months of Life* measure indicators showed a decline of more than 5 percentage points from the prior year, indicating that fewer of **HPN**'s child and adolescent members are receiving the recommended immunizations and well-child visits, which are a critical aspect of preventable care for children. **[Quality]**

Why the weakness exists: Immunizations and well-child visit declines may have been due to lingering effects of the COVID-19 PHE during 2021. Factors that may have contributed to the declines during this time include provider staffing shortages and the requirement or recommendation to stay at home, while the fear of contracting COVID-19 also likely continued to deter individuals from seeking healthcare services, including immunizations and well-child visits.

Recommendation: HPN reported that it has implemented a member incentive program that rewards members for the completion of well-child visits. HSAG recommends that **HPN** continue this intervention and, as part of its implementation process, **HPN** should conduct a timely evaluation to determine whether the member rewards program is resulting in increased member well-child visits

and timely immunizations. If COVID-19 is still a factor, HPN should also determine interventions to reduce any COVID-19-related barriers to members accessing care and obtaining immunizations.

Weakness #4: HPN's Medicaid performance within the Care for Chronic Conditions domain for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure indicator demonstrated a decrease of more than 5 percentage points from the prior year, suggesting that not all members with diabetes are receiving eye screenings. Eye exams are a critical aspect of care for members with diabetes as, left unmanaged, it can lead to blindness. **[Quality]**

Why the weakness exists: Screening declines may be due to providers not educating their diabetic members on the importance of eye exams or not outreaching to diabetic members to encourage yearly eye exams. The decline may also have been due to the lingering effects of the COVID-19 PHE during 2021. Factors that may have contributed to the declines during this time include provider staffing shortages and the requirement or recommendation to stay at home, while the fear of contracting COVID-19 also likely continued to deter individuals from seeking healthcare services, including eye exams.

Recommendation: HSAG recommends HPN update its provider Gap in Care (GIC) reports to identify diabetic members who are not receiving yearly eye exams. HPN may also consider conducting a root cause analysis or focused study to determine why Medicaid members with diabetes are not all receiving the recommended eye exams. HPN should consider if there are disparities within its populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc.

Compliance Review

Performance Results

Table 3-32 presents HPN's compliance review scores for each standard evaluated during the current three-year compliance review cycle. HPN was required to submit a CAP for all reviewed standards scoring less than 100 percent compliant. HPN's implementation of the plans of action under each CAP will be assessed during the third year of the three-year compliance review cycle, and a reassessment of compliance will be determined for each standard not meeting the 100 percent compliance threshold.

Table 3-32—Standard Compliance Scores for HPN

Compliance Review Standard	Associated Federal Citations[1]	Compliance Score
Mandatory Standards		
Year One (SFY 2021)		
Standard I—Disenrollment: Requirements and Limitations	§438.56	**100%**
Standard II—Member Rights and Member Information	§438.10 §438.100	**91%**

Compliance Review Standard	Associated Federal Citations[1]	Compliance Score
Standard III—Emergency and Poststabilization Services	§438.114	**100%**
Standard IV—Availability of Services	§438.206	**100%**
Standard V—Assurances of Adequate Capacity and Services	§438.207	**100%**
Standard VI—Coordination and Continuity of Care	§438.208	**82%**
Standard VII—Coverage and Authorization of Services	§438.210	**93%**
Year Two (SFY 2022)		
Standard VIII—Provider Selection	§438.214	**83%**
Standard IX—Confidentiality	§438.224	**91%**
Standard X—Grievance and Appeal Systems	§438.228	**87%**
Standard XI—Subcontractual Relationships and Delegation	§438.230	**71%**
Standard XII—Practice Guidelines	§438.236	**70%**
Standard XIII—Health Information Systems[2]	§438.242	**86%**
Standard XIV—Quality Assessment and Performance Improvement Program	§438.330	**95%**
Year Three (SFY 2023)		
Review of MCO implementation of Year One and Year Two CAPs		

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

[2] The Health Information Systems standard includes an assessment of the MCO's IS capabilities.

Table 3-33 presents **HPN**'s scores for each standard evaluated during the SFY 2022 Compliance Review activity. 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. The SFY 2022 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.

Table 3-33—SFY 2022 Standard Compliance Scores for HPN

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard VIII—Provider Selection	12	12	10	2	0	**83%**
Standard IX—Confidentiality	11	11	10	1	0	**91%**

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard X—Grievance and Appeal Systems	38	38	33	5	0	**87%**
Standard XI—Subcontractual Relationships and Delegation	7	7	5	2	0	**71%**
Standard XII—Practice Guidelines	10	10	7	3	0	**70%**
Standard XIII—Health Information Systems[1]	14	14	12	2	0	**86%**
Standard XIV—Quality Assessment and Performance Improvement Program	42	39	37	2	3	**95%**
Total	**134**	**131**	**114**	**17**	**3**	**87%**

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.

[1] The Health Information Systems standard included an assessment of the MCO's IS capabilities.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: HPN did not achieve full compliance in any program area evaluated during the SFY 2022 Compliance Review activity; therefore, no substantial strengths in the MCO's program were identified.

Weaknesses and Recommendations

Weakness #1: HPN received a score of 71 percent in the Subcontractual Relationships and Delegation program area, indicating gaps in the MCO's process for ensuring its contracts or written arrangements with its delegates include all required federal and State contractual provisions. **[Quality]**

Why the weakness exists: Of the delegation agreements reviewed as part of the case file review, **HPN** did not consistently include a provision indicating that the delegate agreed to comply with all applicable Medicaid laws and regulations, including applicable subregulatory guidance and contract provisions related to confidentiality, Health Insurance Portability and Accountability Act of 1996

(HIPAA) requirements, insurance requirements, and record retention requirements. The delegation agreements also did not consistently include the required right to audit provisions.

Recommendation: While **HPN** was required to develop a CAP, HSAG recommends that the MCO conduct a comprehensive review of all written arrangements with its delegates for the Nevada Managed Care Program and ensure they include all provisions required by federal and State contractual requirements. **HPN** should include the provisions verbatim, when appropriate, to ensure no misinterpretation of the requirements.

Weakness #2: HPN received a score of 70 percent in the Practice Guidelines program area, indicating that the MCO had not adopted practice guidelines and protocols in accordance with all federal and State contractual requirements. **[Quality** and **Access]**

Why the weakness exists: HPN was unable to demonstrate that its plan-level chief medical director oversaw the development and revision of the MCO's clinical care standards, and practice guidelines and protocols as required by its contract with DHCFP; or that **HPN** adopted practice guidelines that considered the needs of Nevada Medicaid and Nevada Check Up members and were adopted in consultation with network providers. The review of clinical policies, criteria, and guidelines occurred at the corporate level, and there was a lack of adoption protocols at the local level.

Recommendation: While **HPN** was required to develop a CAP, HSAG recommends that the MCO develop processes for the adoption of practice guidelines specific to the Nevada Managed Care Program and the needs of its members. This should occur at a Nevada-based committee that includes representation of the MCO's provider network.

Network Adequacy Validation

Performance Results

Table 3-34 presents **HPN**'s network capacity analysis results and compares the provider ratios to the standards displayed in Table 3-4. Assessed provider ratios shown in green indicate the provider ratio was in compliance with the access standard, whereas provider ratios shown in red indicate the provider ratio was not in compliance with the access standard.

Table 3-34—Summary of Ratio Analysis Results for PCPs and Specialty Care Providers for HPN

Provider Category	Providers*	Clark County Ratio	Washoe County Ratio	Statewide Ratio**
PCPs (1:1,500)	1,843	1:102	1:12	1:114
PCP Extenders (1:1,800)	1,110	1:93	1:10	1:103
Physician Specialists (1:1,500)	2,152	1:87	1:11	1:97

Note: results shown in green font indicate the result complies with the access standard; results shown in red font indicate the result does not comply with the access standard; PCP: Primary Care Provider.

* Providers contracted statewide and contracted providers located in the Nevada Medicaid catchment areas were included in provider counts.

** Statewide ratio incorporates all Nevada counties included in the DHCFP member file submission and members enrolled with the MCO as of March 1, 2022.

Table 3-35 presents **HPN**'s geographic network distribution analysis and compares the percentage of members within the access standard compared to the standards displayed in Table 3-5. Assessed results shown in green indicate that the percentage of members within the access standard was in compliance, and percentages shown in red indicate a result of less than 99.0 percent.

Table 3-35—Percentage of Members Residing Within the Access Standard Areas for HPN

Provider Category	Clark County	Washoe County	Statewide*
Primary Care Providers			
Primary Care, Adults (10 miles/15 mins)	>99.9%	99.4%	99.9%
OB/GYN (10 miles/15 mins)	99.5%	95.2%	99.0%
Pediatrician (10 miles/15 mins)	>99.9%	98.0%	99.7%
Physician Specialists			
Endocrinologist (40 miles/60 mins)	>99.9%	100%	>99.9%
Endocrinologist, Pediatric (40 miles/60 mins)	>99.9%	100%	>99.9%
Infectious Disease (40 miles/60 mins)	>99.9%	100%	>99.9%
Infectious Disease, Pediatric (40 miles/60 mins)	>99.9%	100%	>99.9%
Oncologist/Radiologist (40 miles/60 mins)	>99.9%	100%	>99.9%
Oncologist—Medical/Surgical (30 miles/45 mins)	>99.9%	>99.9%	>99.9%
Oncologist—Medical/Surgical, Pediatric (30 miles/45 mins)	>99.9%	100%	>99.9%
Rheumatologist (40 miles/60 mins)	>99.9%	100%	99.9%
Rheumatologist, Pediatric (40 miles/60 mins)	>99.9%	0.0%	88.4%
Behavioral Health Providers			
Board Certified Child and Adolescent Psychiatrist (30 miles/45 mins)	100%	100%	100%
Psychiatrist (30 miles/45 mins)	100%	100%	>99.9%
Psychologist (30 miles/45 mins)	>99.9%	>99.9%	>99.9%
Psychologist, Pediatric (30 miles/45 mins)	>99.9%	100%	99.9%
QMHP (30 miles/45 mins)	100%	100%	>99.9%
QMHP, Pediatric (30 miles/45 mins)	100%	100%	100%
Facility-Level Providers			
Hospitals, All (30 miles/45 mins)	>99.9%	>99.9%	>99.9%
Pharmacy (10 miles/15 mins)	>99.9%	99.7%	99.9%
Psychiatry Inpatient Hospital (30 miles/45 mins)	>99.9%	>99.9%	99.9%

Provider Category	Clark County	Washoe County	Statewide*
Dialysis/ESRD Facility (30 miles/45 mins)	>99.9%	100%	99.9%

Note: results shown in green font indicate the result complies with the access standard; results shown in red font indicate that less than 99.0 percent of members had access to the provider within the time and distance access standard.

* Statewide results incorporate all Nevada counties included in the DHCFP member file submission and members enrolled with the MCO as of March 1, 2022.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: HPN met the provider ratio requirements for PCPs and physician specialists, indicating **HPN** had a sufficient provider network for its members to access services. **[Access]**

Strength #2: HPN met the time-distance contract standards for Board Certified Child and Adolescent Psychiatrist and Pediatric QMHP, indicating members had access to physician specialists within an adequate time or distance from their residence. **[Access]**

Weaknesses and Recommendations

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

Why the weakness exists: The lack of identified providers may result from either a lack of contracted providers in these specialties or from an inability to identify those providers in the data. All four MCOs did not meet the contract standard for Pediatric Rheumatologists, suggesting a potential lack of this provider type within the counties served. **HPN** indicated that a lack of specialty providers in Nevada as a whole is an ongoing barrier.

Recommendation: HSAG recommends **HPN** 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. **HPN** should also continue its efforts to contract with providers outside of the service area when there is a lack of providers in a specific county or counties, and expand the option for telehealth services, when appropriate, to reduce barriers to members accessing care.

Weakness #2: HPN did not meet the time-distance contract standards in Washoe County for the OB/GYN and Pediatrician provider types, indicating members may experience challenges accessing these provider types within an adequate time or distance from their residence. **[Access]**

Why the weakness exists: The lack of identified providers may result from a lack of available providers in these specialties in Washoe County, or a lack of providers in this county willing to contract with **HPN**. All four MCOs did not meet the contract standard for the OB/GYN provider type in Washoe County, and three of the four MCOs did not meet the contract standard for the Pediatrician provider type, further suggesting limited providers in this county available for contracting.

Recommendation: HSAG recommends **HPN** continue to review DHCFP's monthly enrolled provider list to determine if new providers are available in Washoe County for contracting.

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results

Table 3-36 presents **HPN**'s 2022 adult Medicaid, general child Medicaid, and CCC Medicaid CAHPS top-box scores. Table 3-36 also includes **HPN**'s 2022 Nevada Check Up general child and CCC top-box scores. Arrows (↓ or ↑) indicate 2022 scores that were statistically significantly higher or lower than the 2021 national average.

Table 3-36—Summary of 2022 CAHPS Top-Box Scores for HPN

	Adult Medicaid	General Child Medicaid	CCC Medicaid	Nevada Check Up General Child	Nevada Check Up CCC
Composite Measures					
Getting Needed Care	NA	NA	NA	NA	NA
Getting Care Quickly	NA	NA	NA	NA	NA
How Well Doctors Communicate	NA	NA	NA	94.9%	NA
Customer Service	NA	NA	NA	NA	NA
Global Ratings					
Rating of All Health Care	NA	NA	NA	73.3%	NA
Rating of Personal Doctor	NA	69.4% ↓	71.4%	79.8%	NA
Rating of Specialist Seen Most Often	NA	NA	NA	NA	NA
Rating of Health Plan	71.5% ↑	75.4%	72.2%	81.5% ↑	NA

	Adult Medicaid	General Child Medicaid	CCC Medicaid	Nevada Check Up General Child	Nevada Check Up CCC
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	—	—	NA	—	NA
Coordination of Care for Children With Chronic Conditions	—	—	NA	—	NA
Access to Prescription Medicines	—	—	94.2%	—	NA
FCC: Getting Needed Information	—	—	NA	—	NA

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

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

↑ Indicates the 2022 score is statistically significantly higher than the 2021 national average.

↓ Indicates the 2022 score is statistically significantly lower than the 2021 national average.

— Indicates the measure does not apply to the population.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Adult members had positive overall experiences with their health plan since the score for this measure was statistically significantly higher than the 2021 NCQA Medicaid national average. **[Quality]**

Strength #2: Parents/caretakers of Nevada Check Up general child members had positive overall experiences with their child's health plan since the score for this measure was statistically significantly higher than the 2021 NCQA Medicaid national average. **[Quality]**

Weaknesses and Recommendations

Weakness #1: Parents/caretakers of general child members had less positive overall experiences with their child's personal doctor since the score for this measure was statistically significantly lower than the 2021 NCQA Medicaid national average. **[Quality]**

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

Recommendation: HSAG recommends that **HPN** prioritize improving parents'/caretakers' overall experiences with their child's personal doctor and determine a root cause for the lower performance. As part of this analysis, **HPN** 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 parents'/caretakers' overall satisfaction with both **HPN** and its contracted pediatric providers.

Weakness #2: There were less than 100 respondents for most measures for all populations; therefore, results could not be reported for the other measures, and other strengths and weaknesses could not be identified. **[Quality, Timeliness, Access]**

Why the weakness exists: Adult members and parents/caretakers of child members are less likely to respond to the CAHPS survey.

Recommendation: HSAG recommends that **HPN** focus on increasing response rates to the CAHPS survey for all populations so there are greater than 100 respondents for each measure by educating and engaging all employees to increase their knowledge of CAHPS, using customer service techniques, oversampling, and providing awareness to members and providers during the survey period.

Encounter Data Validation

Performance Results

Comparative Analysis

Table 3-37 displays the percentage of records present in the files submitted by **HPN** that were not found in DHCFP's files (record omission) and the percentage of records present in DHCFP's files but not

present in the files submitted by **HPN** (record surplus). Lower rates indicate better performance for both record omission and record surplus.

Table 3-37—Record Omission and Surplus by Encounter Type for HPN

Encounter Data Source	Record Omission	Record Surplus
Professional	2.4%	1.6%
Institutional	2.2%	5.6%
Pharmacy	0.0%	12.3%

Table 3-38 through Table 3-40 display the element omission, surplus, and accuracy results for each key data element by encounter type for **HPN**. **For the element omission and surplus indicators, lower rates indicate better performance; while for the element accuracy indicator, higher rates indicate better performance.**

Table 3-38—Element Omission, Surplus, and Accuracy—Professional Encounters for HPN

Key Data Element	Element Omission	Element Surplus	Element Accuracy
Recipient ID	0.0%	<0.1%	>99.9%
Header Service From Date	0.0%	0.0%	>99.9%
Header Service To Date	0.0%	0.0%	>99.9%
Detail Service From Date	0.0%	0.0%	>99.9%
Detail Service To Date	0.0%	0.0%	>99.9%
Billing Provider NPI	3.2%	<0.1%	97.9%
Rendering Provider NPI	0.4%	27.8%	>99.9%
Referring Provider NPI	1.4%	0.0%	100%
Primary Diagnosis Code	0.0%	<0.1%	100%
Secondary Diagnosis Code[1]	0.0%	0.0%	97.1%
Procedure Code (CPT/HCPCS/CDT)	<0.1%	<0.1%	99.7%
Procedure Code Modifier	<0.1%	<0.1%	>99.9%
NDC	0.1%	<0.1%	99.9%
Drug Quantity	0.1%	0.0%	99.8%
Header Paid Amount	0.0%	0.0%	97.5%
Detail Paid Amount	0.0%	0.0%	98.7%

[1] Calculated for *Diagnosis Code 2* only.

Table 3-39—Element Omission, Surplus, and Accuracy—Institutional Encounters for HPN

Key Data Element	Element Omission	Element Surplus	Element Accuracy
Recipient ID	0.0%	<0.1%	>99.9%
Header Service From Date	0.0%	0.0%	99.7%
Header Service To Date	0.0%	0.0%	98.7%
Detail Service From Date	0.0%	0.0%	97.8%
Detail Service To Date	0.0%	0.0%	97.8%
Billing Provider NPI	0.3%	0.0%	>99.9%
Attending Provider NPI	1.7%	0.0%	100%
Referring Provider NPI	0.7%	1.1%	4.4%
Primary Diagnosis Code	0.0%	0.0%	>99.9%
Secondary Diagnosis Code[1]	4.7%	0.0%	90.0%
Procedure Code (CPT/HCPCS/CDT)	0.4%	0.4%	86.9%
Procedure Code Modifier	0.9%	0.9%	98.7%
Primary Surgical Procedure Code	<0.1%	<0.1%	42.8%
Secondary Surgical Procedure Code[2]	<0.1%	0.1%	19.3%
NDC	2.0%	2.0%	98.4%
Drug Quantity	2.0%	0.0%	88.6%
Revenue Code	<0.1%	0.0%	91.4%
Header Paid Amount	0.0%	0.0%	97.8%
Detail Paid Amount	0.0%	0.0%	91.4%

[1] Calculated for *Diagnosis Code 2* only.
[2] Calculated for *Surgical Procedure Code 2* only.

Table 3-40—Element Omission, Surplus, and Accuracy—Pharmacy Encounters for HPN

Key Data Element	Element Omission	Element Surplus	Element Accuracy
Recipient ID	0.0%	0.0%	>99.9%
Date of Service	0.0%	0.0%	100%
Billing Provider NPI	1.0%	0.0%	>99.9%
Prescribing Provider NPI	0.0%	0.0%	100%
NDC	0.0%	0.0%	100%
Drug Quantity	0.0%	0.0%	99.8%
Paid Amount	0.0%	0.0%	99.8%

Table 3-41 displays the all-element accuracy results for the percentage of records present in both data sources with the same values (missing and non-missing) for all key data elements relevant to each encounter data type for **HPN**.

Table 3-41—All-Element Accuracy by Encounter Type for HPN

Indicator	Professional	Institutional	Pharmacy
All-Element Accuracy	62.5%	66.3%	98.9%

Medical Record Review

Table 3-42 presents the percentage of key data elements identified in the encounter data that were not supported by the members' medical records provided by **HPN** (i.e., medical record omission) and the percentage of key data elements from the members' medical records that were not found in the encounter data provided by **HPN** (i.e., encounter data omission). Lower rates for each data element indicate better performance.

Table 3-42 also displays the percentage of key data elements associated with validated dates of service from the encounter data that were correctly coded based on the members' medical records. Errors found in the diagnosis coding were separated into two categories: inaccurate coding and specificity error. Errors found in the procedure coding associated with the MRRs were separated into three categories: higher level of service in the medical record, lower level of service in the medical record, and inaccurate coding. The errors for the procedure code modifier data element could not be separated into subcategories and therefore are not presented in Table 3-42. Higher accuracy rates for each data element indicate better performance.

Table 3-42—MRR: Encounter Data Completeness and Accuracy for HPN

Data Element	Medical Record Omission[1]	Encounter Data Omission[2]	Element Accuracy[3]	Error Type
Date of Service	0.7%	5.0%	—	—
Diagnosis Code	3.6%	2.8%	99.7%	Incorrect Code (100%) Specificity Error (0.0%)
Procedure Code	13.0%	19.2%	97.2%	Incorrect Code (96.4%) Lower Level of Services in Medical Records (3.6%) Higher Level of Services in Medical Records (0.0%)
Procedure Code Modifier	29.3%	3.3%	99.7%	—
All-Element Accuracy[4]			63.1%	—

"—" indicates that the accuracy rate analysis and/or the error type analysis was not applicable to a given data element.
[1] Services documented in the encounter data but not supported by the members' medical records. Lower rate values indicate better performance.

[2] Services documented in the members' medical records but not in the encounter data. Lower rate values indicate better performance.
[3] Services documented in the members' medical records associated with validated dates of service from the encounter data that were correctly coded based on the medical records. Higher rate values indicate better performance.
[4] The all-element accuracy rate describes the percentage of dates of service present in both DHCFP's encounter data and in the medical records with all data elements coded correctly (i.e., not omitted from the medical record; not omitted from the encounter data; and, when populated, have the same values). As such, the gray cells indicate the evaluation for medical record omission or encounter data omission is not applicable.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: HPN's professional encounter data appeared complete when comparing data extracted from **HPN**'s claims systems to data extracted from DHCFP's data warehouse. Encounter data records from DHCFP-submitted files were highly corroborated in **HPN**-submitted files. **[Quality]**

Strength #2: Professional and pharmacy data element comparison between data extracted from **HPN**'s claims systems and data extracted from DHCFP's data warehouse showed complete and accurate data. **[Quality]**

Strength #3: Based on the MRR, the encounter data dates of service and diagnosis codes were well supported by the members' medical record documentation. Similarly, dates of service and diagnosis codes documented in the medical records were found in the encounter data. **[Quality]**

Weaknesses and Recommendations

Weakness #1: Procedure codes documented in the medical records were either not found in the encounter data or were found in the encounter data but should have been coded with a different procedure code.

Why the weakness exists: While discrepancies may have been due to medical record non-submission, other reasons also may have contributed to the discrepancies. Some of the potential reasons include: (1) the provider did not document the services performed in the medical record, and (2) the provider did not provide the service(s) found in the encounter data.

Recommendation: HPN should consider performing periodic MRRs of submitted claims to verify appropriate coding and data completeness. Any findings from these reviews should then be shared with providers through periodic education and training regarding encounter data submissions, medical record documentation, and coding practices.

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

HSAG performed a comprehensive assessment of **HPN**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **HPN** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **HPN**'s overall performance contributed to the Nevada Managed Care Program's progress in achieving the Quality Strategy goals and objectives. Table 3-43 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **HPN**'s Medicaid and Nevada Check Up members.

Table 3-43—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Use of Preventive Services	**Quality, Timeliness,** and **Access**—Over the past three-year period (MY 2019–MY 2021), there has been a steady decline in the percentage of **HPN**'s adult members accessing preventive services, and an even higher rate of decline in members 65 years and older. There was also an overall decline in the prevalence of immunizations for children and adolescents, and the prevalence of children 30 months old and younger who received the recommended well-care visits. Additionally, fewer children and adolescents within the Nevada Check Up population received recommended well-care visits, with the exception of adolescents between the ages of 12 and 17 years. The Medicaid population showed positive results in the prevalence of children and adolescents receiving the recommended well-care visits, with the exception of members 18 to 21 years of age, which demonstrated a decline. The number of women who received breast cancer screening also declined. Accessing preventive care decreases the risk for diseases, disabilities, and death. Children also need regular preventive care visits to monitor their development and find health problems early so they are easier to treat. While **HPN** had a sufficient number of PCPs to provide services, as indicated through the NAV activity, parents or guardians of **HPN**'s child members reported fewer positive experiences with their providers through the CAHPS activity, which may indicate issues accessing care or may contribute to child members not seeing their providers regularly for preventive care. Further, as demonstrated through the compliance review activity, opportunities exist in enhancing processes related to clinical practice guidelines. **HPN** should ensure its processes include the adoption of clinical practice guidelines related to all relevant preventive services. PCPs in the community should be included in this process who are imperative in identifying the barriers that occur in clinical practice and may lead to actionable interventions for improving adherence to preventive guidelines and protocols. Based on these findings, **HPN** has several opportunities to mitigate any barriers to receiving preventive care, and to implement interventions to support improvement in the use of preventive services for its adult and child members.

Performance Area	Overall Performance Impact
Evidence-Based Practices for Members With Chronic Conditions	**Quality**—Although **HPN** implemented an intervention to decrease the percentage of its diabetic members who had an HbA1c level greater than 9 percent, the intervention could not be linked to the improvement in performance seen through the PIP activity. However, **HPN** did meet the MPS for both HbA1c control measures with both rates demonstrating a small increase in performance over the previous two MYs. The blood pressure control measure also demonstrated marked improvement. These findings indicate that **HPN**'s members are gaining better control over their diabetes and blood pressure. However, the number of members diagnosed with diabetes who had a retinal eye exam and number of members diagnosed with diabetes who received an HbA1c test decreased from MY 2019–MY 2021, which indicated additional opportunities for **HPN** to more effectively manage members diagnosed with diabetes. However, the number of adults with diabetes who received an annual kidney health evaluation increased, and all reportable performance measure rates all met the MPS. Further, the rate for adults ages 65 to 74 years increased by over 18 percentage points. Ongoing monitoring of kidney health is crucial for people with diabetes, as early diagnosis and treatment can prevent or slow chronic kidney disease.
Health and Wellness of Pregnant Women	**Quality, Timeliness,** and **Access**—**HPN** implemented an intervention to support an improvement in the number of pregnant women receiving timely prenatal care which showed some success as evidenced by the results of its PIP activity. However, while meeting its goal for the PIP activity for most reporting periods, **HPN** also demonstrated a marked decline in performance beginning in the December 2020 reporting month. Additionally, while **HPN** met the MPS for the prenatal and postpartum care performance measures, both measure rates declined in performance over the past two MYs. As demonstrated through the NAV activity, an insufficient number of OB/GYN providers in Washoe County to support the number of pregnant women needing services may be a contributing factor to these declines. These findings indicate that **HPN** has continued opportunities to implement interventions that will result in more members seeking and having access to timely prenatal services, thus improving the likelihood of better health outcomes for mothers and their babies.
Evidence-Based Practices for Members With Behavioral Health Conditions	**Quality, Timeliness,** and **Access**—While above the national average, over the past three years (MY 2019–MY 2021), **HPN** showed a marked decline in the number of adolescent and adult members receiving timely follow-up care following an ED visit or hospitalization for AOD dependence or mental illness. The Nevada Check Up population demonstrated higher rates of members receiving timely follow-up care after a hospitalization for a mental illness and met the MPS; however, no prior rates are available for comparison. Some behavioral health performance measures demonstrated improved performance, while several others declined from MY 2019–MY 2021. While the NAV activity demonstrated that **HPN** had an adequate number of behavioral health providers, these findings indicate multiple opportunities for improving the number of members with a behavioral health condition who

Performance Area	Overall Performance Impact
	receive the medications and follow-up care they need. Further, as demonstrated through the compliance review activity, opportunities exist in enhancing processes related to clinical practice guidelines. **HPN** should ensure its processes include the adoption of clinical practice guidelines related to behavioral conditions relevant to its membership. Behavioral health practitioners in the community should be included in this process and are imperative in identifying the barriers that occur in clinical practice and may lead to actionable interventions for improving adherence to behavioral clinical guidelines and protocols.
Appropriate Prescribing Practices	**Quality**—**HPN** met the established MPS for three measure rates related to opioid use. While the fourth measure rate did not meet the MPS, it demonstrated an increase in performance (i.e., a decline in rate). This demonstrates that **HPN** has adequate oversight of its provider network specific to the prescribing and filling of opioids as demonstrated by a lower prevalence of multiple prescribers prescribing opioids and multiple pharmacies filling the prescriptions, therefore reducing the higher likelihood of opioid-related overdose deaths.

Molina Healthcare of Nevada, Inc.

Validation of Performance Improvement Projects

Molina was a new MCO in Nevada effective January 1, 2022; therefore, the MCO did not have sufficient data to conduct PIPs in SFY 2022.

Performance Measure Validation

Molina was a new MCO in Nevada effective January 1, 2022; therefore, an audit was not conducted since the MCO did not have any MY 2021 performance measure data for review.

Compliance Review

Performance Results

Table 3-44 presents **Molina**'s compliance review scores for each standard evaluated during the current three-year compliance review cycle. **Molina** was required to submit a CAP for all reviewed standards scoring less than 100 percent compliant. **Molina**'s implementation of the plans of action under each CAP will be assessed during the third year of the three-year compliance review cycle, and a reassessment of compliance will be determined for each standard not meeting the 100 percent compliance threshold. Of note, **Molina** went through a comprehensive readiness review process in SFY 2022 that included all federal compliance review standards. However, all standards reviewed in Year One of the compliance review cycle for the other MCEs will be reviewed in Year Three for **Molina** to ensure that **Molina** can demonstrate implementation of its policies and procedures related to all federal and state-specific requirements over the three-year compliance review cycle.

Table 3-44—Standard Compliance Scores for Molina

Compliance Review Standard	Associated Federal Citations[1]	Compliance Score
Mandatory Standards		
Year One (SFY 2021)*		
Standard I—Disenrollment: Requirements and Limitations	§438.56	**These standards will be reviewed in SFY 2023.**
Standard II—Member Rights and Member Information	§438.10 §438.100	
Standard III—Emergency and Poststabilization Services	§438.114	
Standard IV—Availability of Services	§438.206	
Standard V—Assurances of Adequate Capacity and Services	§438.207	

Compliance Review Standard	Associated Federal Citations[1]	Compliance Score
Mandatory Standards		
Standard VI—Coordination and Continuity of Care	§438.208	
Standard VII—Coverage and Authorization of Services	§438.210	
Year Two (SFY 2022)		
Standard VIII—Provider Selection	§438.214	**82%**
Standard IX—Confidentiality	§438.224	**100%**
Standard X—Grievance and Appeal Systems	§438.228	**87%**
Standard XI—Subcontractual Relationships and Delegation	§438.230	**100%**
Standard XII—Practice Guidelines	§438.236	**100%**
Standard XIII—Health Information Systems[2]	§438.242	**100%**
Standard XIV—Quality Assessment and Performance Improvement Program	§438.330	**97%**
Year Three (SFY 2023)		
Review of Standard I through Standard VII and the MCO's implementation of the Year Two CAP		

* To ensure the MCO had the ability and capacity to perform satisfactorily in all operations/administration, service delivery, financial management, and systems management program areas, HSAG conducted a comprehensive readiness review of the MCO that included all federally required readiness and compliance review standards. The MCO was determined to be ready to accept Nevada Managed Care Program members effective January 1, 2022. To ensure alignment with Nevada MCEs' current three-year compliance review cycle, DHCFP determined that the Year One compliance review standards will be reviewed in Year Three of the compliance review cycle for **Molina**.

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

[2] The Health Information Systems standard includes an assessment of the MCO's IS capabilities.

Table 3-45 presents **Molina**'s scores for each standard evaluated during the SFY 2022 Compliance Review activity. Each element within a standard was scored as *Met* or *Not Met* based on evidence found in **Molina**'s written documents, including policies, procedures, reports, and meeting minutes; and interviews with MCO staff members. The SFY 2022 Compliance Review activity demonstrated how successful **Molina** was at interpreting specific standards under 42 CFR Part 438—Managed Care and the associated requirements under its managed care contract with DHCFP.

Table 3-45—SFY 2022 Standard Compliance Scores for Molina

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard VIII—Provider Selection	12	11	9	2	1	**82%**

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard IX—Confidentiality	11	11	11	0	0	**100%**
Standard X—Grievance and Appeal Systems	38	38	33	5	0	**87%**
Standard XI—Subcontractual Relationships and Delegation	7	7	7	0	0	**100%**
Standard XII—Practice Guidelines	10	10	10	0	0	**100%**
Standard XIII—Health Information Systems[1]	14	14	14	0	0	**100%**
Standard XIV—Quality Assessment and Performance Improvement Program	42	39	38	1	3	**97%**
Total	**134**	**130**	**122**	**8**	**4**	**94%**

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.
[1] The Health Information Systems standard included an assessment of the MCO's IS capabilities.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Molina achieved full compliance for the Confidentiality program area, demonstrating that the MCO had appropriate policies and processes for the use and disclosure of members' protected health information (PHI) and members' privacy rights, and provided required notices related to privacy practices. [**Quality**]

Strength #2: Molina achieved full compliance for the Subcontractual Relationships and Delegation program area, demonstrating that the MCO had appropriate subcontracts in place and had adequate oversight and monitoring processes to ensure its delegates are meeting their contractual obligations. [**Quality**]

Strength #3: Molina achieved full compliance for the Practice Guidelines program area, demonstrating that the MCO adopted evidence-based practice guidelines, disseminated its practice

guidelines to all affected providers, and rendered utilization management and coverage of services decisions consistent with its practice guidelines. [**Quality** and **Access**]

Strength #4: Molina achieved full compliance for the Health Information Systems program area, demonstrating that the MCO maintained a health information system that collects, analyzes, integrates, and reports data on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollment for other than loss of Medicaid eligibility. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any substantial weaknesses for **Molina** as no program area scored at or below 80 percent compliance.

Why the weakness exists: As no weaknesses were identified, this section is not applicable.

Recommendation: As all remediation plans were successfully on track for implementation, this section is not applicable.

Network Adequacy Validation

Performance Results

Table 3-46 presents **Molina**'s network capacity analysis results and compares the provider ratios to the standards displayed in Table 3-4. Assessed provider ratios shown in green indicate the provider ratio was in compliance with the access standard, whereas provider ratios shown in red indicate the provider ratio was not in compliance with the access standard.

Table 3-46—Summary of Ratio Analysis Results for PCPs and Specialty Care Providers for Molina

Provider Category	Providers*	Clark County Ratio	Washoe County Ratio	Statewide Ratio**
PCPs (1:1,500)	1,191	1:91	1:13	1:104
PCP Extenders (1:1,800)	1,151	1:53	1:8	1:60
Physician Specialists (1:1,500)	1,025	1:105	1:15	1:121

Note: results shown in green font indicate the result complies with the access standard; results shown in red font indicate the result does not comply with the access standard; PCP: Primary Care Provider.

* Providers contracted statewide and contracted providers located in the Nevada Medicaid catchment areas were included in provider counts.

** Statewide ratio incorporates all Nevada counties included in the DHCFP member file submission and members enrolled with the MCO as of March 1, 2022.

Table 3-47 presents **Molina**'s geographic network distribution analysis and compares the percentage of members within the access standard compared to the standards displayed in Table 3-5. Assessed results shown in green indicate that the percentage of members within the access standard was in compliance, and percentages shown in red indicate a result of less than 99.0 percent.

Table 3-47—Percentage of Members Residing Within the Access Standard Areas for Molina

Provider Category	Clark County	Washoe County	Statewide*
Primary Care Providers			
Primary Care, Adults (10 miles/15 mins)	99.9%	99.5%	99.9%
OB/GYN (10 miles/15 mins)	98.9%	95.2%	98.4%
Pediatrician (10 miles/15 mins)	>99.9%	98.0%	99.7%
Physician Specialists			
Endocrinologist (40 miles/60 mins)	>99.9%	>99.9%	>99.9%
Endocrinologist, Pediatric (40 miles/60 mins)	>99.9%	>99.9%	>99.9%
Infectious Disease (40 miles/60 mins)	>99.9%	>99.9%	99.9%
Infectious Disease, Pediatric (40 miles/60 mins)	>99.9%	>99.9%	99.9%
Oncologist/Radiologist (40 miles/60 mins)	>99.9%	>99.9%	99.9%
Oncologist—Medical/Surgical (30 miles/45 mins)	>99.9%	>99.9%	99.9%
Oncologist—Medical/Surgical, Pediatric (30 miles/45 mins)	>99.9%	>99.9%	99.9%
Rheumatologist (40 miles/60 mins)	>99.9%	>99.9%	99.9%
Rheumatologist, Pediatric (40 miles/60 mins)	>99.9%	0.0%	86.9%
Behavioral Health Providers			
Board Certified Child and Adolescent Psychiatrist (30 miles/45 mins)	>99.9%	>99.9%	>99.9%
Psychiatrist (30 miles/45 mins)	>99.9%	>99.9%	>99.9%
Psychologist (30 miles/45 mins)	>99.9%	>99.9%	>99.9%
Psychologist, Pediatric (30 miles/45 mins)	>99.9%	99.9%	99.9%
QMHP (30 miles/45 mins)	>99.9%	>99.9%	>99.9%
QMHP, Pediatric (30 miles/45 mins)	>99.9%	>99.9%	>99.9%
Facility-Level Providers			
Hospitals, All (30 miles/45 mins)	>99.9%	>99.9%	>99.9%
Pharmacy (10 miles/15 mins)	>99.9%	99.7%	99.9%
Psychiatry Inpatient Hospital (30 miles/45 mins)	>99.9%	>99.9%	99.9%
Dialysis/ESRD Facility (30 miles/45 mins)	>99.9%	97.6%	99.6%

Note: results shown in green font indicate the result complies with the access standard; results shown in red font indicate that less than 99.0 percent of members had access to the provider within the time and distance access standard.

* Statewide results incorporate all Nevada counties included in the DHCFP member file submission and members enrolled with the MCO as of March 1, 2022.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Molina met the provider ratio requirements for PCPs and physician specialists in both Clark and Washoe counties, indicating **Molina, Inc.** had a sufficient provider network for its members to access services. **[Access]**

Weaknesses and Recommendations

Weakness #1: Molina did not meet the time-distance contract standards for OB/GYN and Pediatric Rheumatologist, indicating members may experience challenges accessing these provider types within an adequate time or distance from their residence.

Why the weakness exists: The lack of identified providers may result from either a lack of contracted providers in these specialties or from an inability to identify those providers in the data. Three of the four MCOs did not meet the contract adequacy standard for OB/GYN, and all four MCOs did not meet the contract standard for Pediatric Rheumatologists, suggesting a potential lack of these provider types within the counties served.

Recommendation: HSAG recommends **Molina** 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.

Weakness #2: Molina did not meet the time-distance contract standards for the Pediatrician and Dialysis/ESRD Facility provider types in Washoe County, indicating members may experience challenges accessing these provider types within an adequate time or distance from their residence.

Why the weakness exists: The lack of identified Pediatrician providers may result from a lack of this provider type in Washoe County, as three of the four MCOs did not meet the contract standard for the Pediatrician provider type in this county, further suggesting limited providers available for contracting. It is not clear; however, why **Molina** did not meet the time-distance contract standard for Dialysis/ESRD Facility, as all other MCOs were able to meet the standard for this provider type in Washoe County.

Recommendation: HSAG recommends **Molina** review DHCFP's monthly enrolled provider list to determine if new Pediatrician providers are available in Washoe County for contracting. **Molina** should also continue its contracting efforts with Dialysis/ESRD Facility providers in Washoe County to mitigate any access to care barriers for members needing dialysis and other ESRD-related care from this provider type.

Consumer Assessment of Healthcare Providers and Systems Analysis

Molina began providing coverage to Medicaid and Nevada Check Up members effective January 1, 2022; therefore, CAHPS results are not available for SFY 2022.

Encounter Data Validation

Molina began providing services to members enrolled in the Nevada Managed Care Program on January 1, 2022; therefore, since the EDV activity began prior to January 1, 2022, the SFY 2022 EDV activity did not include **Molina** as sufficient encounter data were not available during the period under review.

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

HSAG performed an assessment of **Molina**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **Molina** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **Molina**'s overall performance contributed to the Nevada Managed Care Program's progress in achieving the Quality Strategy goals and objectives. Table 3-48 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **Molina**'s Medicaid and Nevada Check Up members. As **Molina** joined the Nevada Managed Care Program on January 1, 2022, there was limited data available to comprehensively assess performance in all areas.

Table 3-48—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Use of Preventive Services	**Quality, Timeliness,** and **Access**—**Molina** demonstrated through the compliance review activity that it has strong practices for ensuring its providers are aware of its adopted practice guidelines, including guidelines for preventive care, and that it also provides education to members on appropriate preventive services, including immunizations, in alignment with its adopted practice guidelines. Additionally, **Molina** appears to have a sufficient number of PCPs to provide services to its members, as indicated through the NAV activity. **Molina**'s NAV results indicate a gap of pediatricians in Washoe County, which could indicate a barrier to child members in Washoe County being able to receive preventive services near their homes. However, the overarching results indicate that **Molina** has provided the appropriate education to its members and contracted providers regarding preventive care guidelines, and that it has an adequate provider network available to provide preventive care services to most of its child and adult members. **Molina** also demonstrated through the compliance review activity that it has a Health Information System capable of analyzing and reporting claims and utilization data. The results of these analyses and reporting efforts related to the use of preventive services will be included in the SFY 2023 EQR technical report.

Performance Area	Overall Performance Impact
Evidence-Based Practices for Members With Chronic Conditions	**Quality** and **Access**—**Molina** demonstrated through the NAV activity that it has a sufficient network of PCPs and most specialty provider types to provide services to members with chronic conditions. However, **Molina** did not have a sufficient network of dialysis/ESRD facility providers in Washoe County. Therefore, this gap may impact services for members who have been diagnosed with ESRD or other kidney disease requiring dialysis. The results of the analyses and reporting efforts related to evidence-based practices for members with chronic conditions will be included in the SFY 2023 EQR technical report.
Health and Wellness of Pregnant Women	**Quality, Timeliness,** and **Access**—**Molina** demonstrated through the NAV activity that it has a deficit of OB/GYN providers available to provide services to members in both Clark and Washoe counties. Therefore, this may impact the availability of existing OB/GYN providers in these counties to see pregnant members timely. However, **Molina** demonstrated through its readiness review activity that it has contingency plans in place to ensure all members can access services timely, including pregnant members and members who have delivered babies. The results of the analyses and reporting efforts related to the health and wellness of pregnant women will be included in the SFY 2023 EQR technical report.
Evidence-Based Practices for Members With Behavioral Health Conditions	**Quality, Timeliness,** and **Access**—**Molina** demonstrated through the NAV activity that it has an adequate network of behavioral health providers in both Clark and Washoe counties. Therefore, **Molina** should have an appropriate network of providers to provide behavioral health services to its members diagnosed with mental illness and SUD. The results of the analyses and reporting efforts related to evidence-based practices for members with behavioral health conditions will be included in the SFY 2023 EQR technical report.
Appropriate Prescribing Practices	**Quality**—**Molina** demonstrated through the compliance review activity that it has appropriate practices in place for ensuring its providers are aware of its adopted practice guidelines, including guidelines related to the prescribing of opioids. The results of the analyses and reporting efforts related to appropriate prescribing practices will be included in the SFY 2023 EQR technical report.

SilverSummit Healthplan, Inc.

Validation of Performance Improvement Projects

Performance Results

SilverSummit completed and submitted Module 4 (PIP Conclusions) for validation for each topic. HSAG organized and analyzed **SilverSummit**'s PIP data to draw conclusions about the MCO's quality improvement efforts. Based on its review, HSAG determined the overall methodological validity of the PIP, as well as the overall success in achieving the SMART Aim goal. As part of this determination, HSAG evaluated the appropriateness and validity of the SMART Aim measure, as well as trends in the SMART Aim measurements, in comparison with the reported baseline rate and goal. To represent the validity and reliability of each PIP, HSAG assigned a level of confidence (i.e., *High confidence*, *Confidence*, *Low confidence*, *Reported PIP results were not credible*). Refer to Appendix A for details regarding the scoring methodology for each level of confidence. The validation findings assessed by HSAG, and a description of the interventions implemented by **SilverSummit** for each PIP, are displayed in Table 3-49 through Table 3-52.

Table 3-49—SMART Aim Measure Results for CDC HbA1c Poor Control >9.0%

SMART Aim	Baseline Rate	SMART Aim Goal Rate	Lowest Rate Achieved	Confidence Level
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%.	83.0%	63.0%	72.6%	*Low confidence*

Table 3-50—Intervention for CDC HbA1c Poor Control >9.0%

Intervention #1: CDC HbA1c Poor Control >9.0%	
Intervention Description	Targeted Member Outreach Using Emergency Room Demographic Information
Intervention Impact	The MCO reported the intervention was unsuccessful.
Intervention Status	Abandoned
Intervention #2: CDC HbA1c Poor Control >9.0%	
Intervention Description	Targeted Member Outreach Using Demographic Information Obtained from Provider Claims Data or Medical Records
Intervention Impact	The MCO did not provide intervention testing results; therefore, the impact is unknown.
Intervention Status	Unknown

Table 3-51—SMART Aim Measure Results for Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care

SMART Aim	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
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%.	5%	25%	NR	*Reported PIP results were not credible*

* Provider name has been redacted for privacy purposes.

Table 3-52—Intervention for Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care

Intervention: *Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care* PIP	
Intervention Description	Targeted provider and office staff CPT code training
Intervention Impact	Incomplete intervention testing data were provided in the PIP submission and the MCO did not report on outcomes; therefore, the impact is unknown.
Intervention Status	Unknown

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: SilverSummit developed methodologically sound improvement projects that met both State and federal requirements. **[Quality]**

Weaknesses and Recommendations

Weakness #1: SilverSummit did not achieve its goal to decrease the rate of HbA1c test results greater than 9 percent or missing HbA1c test results among male diabetic members ages 18 to 75 who have a reported HbA1c level greater than 9 percent. **[Quality]**

Why the weakness exists: SilverSummit provided the rolling 12-month data for the SMART Aim measure from February 2020 through May 2021. The lowest result achieved was 72.6 percent in December 2020, indicating implemented interventions were not effective.

Recommendation: SilverSummit should apply lessons learned and knowledge gained from its intervention efforts and proceed with implementing new interventions to support quality improvement.

Weakness #2: Incomplete data reporting and interpretation of results resulted in **SilverSummit** receiving a level of *Low confidence* on the *CDC HbA1c Poor Control >9.0%* PIP and a level of *Reported PIP results were not credible* on the *Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care* PIP.

Why the weakness exists: SilverSummit did not provide complete performance measure data for the *CDC HbA1c Poor Control >9.0%* PIP. For the *Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care* PIP, HSAG was unable to determine if **SilverSummit** achieved the SMART Aim goal because the data documented in the SMART Aim run chart appeared to be the monthly intervention testing data and not the rolling 12-month SMART Aim measure data. The rolling 12-month SMART Aim measure denominators were significantly lower as compared to the baseline denominator of 530 births. It was unclear if the approved methodology was followed for the rolling 12-month SMART Aim measurement periods. The June 2021 rolling 12-month SMART Aim measurement period was omitted, and the SMART Aim run chart had data issues. Based on the information provided, HSAG could not determine if the approved methodology was followed through to the end of the *Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care* PIP. The interventions tested for both PIPs were unsuccessful, and the MCO did not provide sufficient data or narrative results for HSAG to make any type of assessment.

Recommendations: SilverSummit should ensure that its data and interpretation of results are complete and accurately documented in its PIP submissions. The MCO should include all intervention testing data and outcomes. **SilverSummit** must follow and report data based on the validated and approved PIP methodology.

Weakness #3: SilverSummit limited the number of interventions tested for the duration of the PIP. **[Quality, Timeliness,** and **Access]**

Why the weakness exists: SilverSummit included one intervention for its *Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care* PIP and two for the *CDC HbA1c Poor Control >9.0%* PIP. Limiting the number of interventions tested may limit the opportunity for the MCO to address other opportunities for improvement identified through its quality improvement processes.

Recommendation: SilverSummit should consider testing more than one or two interventions during the PIP study. Initiating multiple interventions will help **SilverSummit** address as many identified opportunities for improvement as possible. **SilverSummit** should also apply lessons learned and knowledge gained from its efforts and HSAG's feedback throughout the PIP to future PIPs and other quality improvement activities.

Performance Measure Validation

Performance Results

Table 3-53 and Table 3-54 show **SilverSummit**'s Medicaid and Nevada Check Up performance measure results for HEDIS MY 2019, MY 2020, and MY 2021, along with MY 2020 to MY 2021 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 2020 to MY 2021 represents performance improvement and an increase in the rate from MY 2020 to MY 2021 represents performance decline. The arrows (↑ or ↓) indicate whether the HEDIS MY 2021 rate was above or below NCQA's Quality Compass HEDIS 2021 Medicaid HMO 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 3-53—Medicaid HEDIS MY 2021 Performance Measure Results and Trending for SilverSummit

HEDIS Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	MY 2020–MY 2021 Rate Comparison
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services (AAP)				
Ages 20–44 Years	66.35%	58.20%	55.38%↓	-2.82
Ages 45–64 Years	75.54%	69.12%	66.42%↓	-2.70
Ages 65 Years and Older^	NA	79.41%	59.23%↓	-20.18
Total^	69.38%	61.54%	58.64%↓	-2.90
Children's Preventive Care				
Childhood Immunization Status (CIS)				
Combination 3	60.34%	62.29%	57.42%↓	-4.87
Combination 7	49.15%	53.77%	51.58%↓	-2.19
Combination 10	28.95%	29.20%	27.49%↓	-1.71
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	82.00%	78.59%	76.64%↓	-1.95

HEDIS Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	MY 2020–MY 2021 Rate Comparison
Combination 2 (Meningococcal, Tdap, HPV)	31.14%	33.58%	27.74%↓	-5.84
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile—Total	78.59%	78.83%	73.24%↓	-5.59
Counseling for Nutrition—Total	65.69%	70.56%	66.91%↓	-3.65
Counseling for Physical Activity—Total	59.12%	66.91%	61.07%↓	-5.84
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	—	54.96%	56.31%↑	1.35
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	—	68.08%	60.53%↓	-7.55
Child and Adolescent Well-Care Visits (WCV)				
3–11 Years	—	39.99%	43.66%↓	3.67
12–17 Years	—	32.03%	35.55%↓	3.52
18–21 Years	—	16.64%	16.80%↓	0.16
*Total^*	—	33.70%	36.57%↓	2.87
Women's Health and Maternity Care				
Breast Cancer Screening (BCS)				
Breast Cancer Screening	47.54%	44.68%	40.99%↓	-3.69
Chlamydia Screening in Women (CHL)^				
16–20 Years	—	—	46.84%	NC
21–24 Years	—	—	56.73%	NC
Total	—	—	53.07%	NC
Prenatal and Postpartum Care (PPC)				
Timeliness of Prenatal Care	75.91%	71.53%	73.24%↓	1.71
Postpartum Care	54.74%	58.64%	62.77%↓	4.13
Care for Chronic Conditions				
Asthma Medication Ratio (AMR)^				
5–11 Years	—	—	72.58%	NC
12–18 Years	—	—	53.19%	NC

HEDIS Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	MY 2020–MY 2021 Rate Comparison
19–50 Years	—	—	34.09%	NC
51–64 Years	—	—	37.66%	NC
Total	—	—	42.00%	NC
Comprehensive Diabetes Care (CDC)				
*Hemoglobin A1c (HbA1c) Testing^*	74.70%	70.56%	75.67%↓	5.11
*HbA1c Poor Control (>9.0%)**	53.04%	56.45%	52.07%↓	-4.38
HbA1c Control (<8.0%)	37.71%	37.47%	42.82%↓	5.35
Eye Exam (Retinal) Performed	52.55%	50.36%	49.39%↓	-0.97
Blood Pressure Control (<140/90 mm Hg)	—	36.50%	44.28%↓	7.78
Controlling High Blood Pressure (CBP)				
Controlling High Blood Pressure	—	32.85%	40.88%↓	8.03
Kidney Health Evaluation for Patients With Diabetes (KED)^				
18–64 Years	—	27.22%	28.89%	1.67
65–74 Years	—	NA	41.18%	NC
75–84 Years	—	NA	NA	NC
Total	—	27.40%	29.05%	1.65
Behavioral Health				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	44.05%	39.32%	41.14%↓	1.82
Antidepressant Medication Management (AMM)^				
Effective Acute Phase Treatment	—	—	54.56%	NC
Effective Continuation Phase Treatment	—	—	39.57%	NC
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	76.77%	69.19%	71.56%↓	2.37
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)				
7-Day Follow-Up—Total	14.20%	19.70%	14.12%↑	-5.58

HEDIS Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	MY 2020–MY 2021 Rate Comparison
30-Day Follow-Up—Total	19.05%	26.57%	20.05%↓	-6.52
Follow-Up After Emergency Department Visit for Mental Illness (FUM)				
7-Day Follow-Up—Total	22.97%	42.96%	40.19%↑	-2.77
30-Day Follow-Up—Total	32.43%	53.66%	48.43%↓	-5.23
Follow-Up After Hospitalization for Mental Illness (FUH)				
7-Day Follow-Up—Total	28.10%	36.69%	31.07%↓	-5.62
30-Day Follow-Up—Total	44.59%	54.62%	45.99%↓	-8.63
Follow-Up Care for Children Prescribed ADHD Medication (ADD)				
Initiation Phase	49.40%	47.71%	49.02%↑	1.31
Continuation and Maintenance Phase	NA	NA	NA	NC
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)				
Initiation of AOD—Total	45.43%	41.27%	42.27%↓	1.00
Engagement of AOD—Total	12.84%	10.78%	11.31%↓	0.53
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)				
Blood Glucose and Cholesterol Testing—Total	21.24%	25.41%	34.17%↑	8.76
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)^				
1–11 Years	—	—	NA	NC
12–17 Years	—	—	51.61%	NC
Total	—	—	53.06%	NC
Utilization				
Ambulatory Care—Total (per 1,000 Member Months) (AMB)^				
*ED Visits—Total**	66.17	48.01	45.76	-2.25
Outpatient Visits—Total	286.69	250.67	237.62	-13.05
Mental Health Utilization—Total (MPT)^				
Inpatient—Total	1.43%	1.13%	1.10%	-0.03
Intensive Outpatient or Partial Hospitalization—Total	0.18%	0.12%	0.15%	0.03
Outpatient—Total	14.46%	10.43%	7.06%	-3.37
ED—Total	0.06%	0.04%	0.04%	0.00
Telehealth—Total	0.17%	5.26%	4.47%	-0.79

HEDIS Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	MY 2020–MY 2021 Rate Comparison
Any Service—Total	14.99%	12.18%	9.51%	-2.67
Plan All-Cause Readmissions (PCR)				
Observed Readmissions—Total	13.42%	13.58%	12.58%	-1.00
*Expected Readmissions—Total^*	9.73%	10.30%	9.59%	-0.71
*O/E Ratio—Total^*	1.38	1.32	1.31	-0.01
Overuse/Appropriateness of Care				
Use of Opioids at High Dosage (HDO)*				
Use of Opioids at High Dosage	5.42%	4.50%	**4.14%**↑	-0.36
Use of Opioids From Multiple Providers (UOP)*				
Multiple Prescribers	32.45%	24.93%	**17.52%**↑	-7.41
*Multiple Pharmacies^*	2.65%	0.62%	**0.39%**↑	-0.23
*Multiple Prescribers and Multiple Pharmacies^*	1.86%	0.18%	**0.08%**↑	-0.10

↑ Indicates the HEDIS MY 2021 rate was above NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile benchmark.
↓ Indicates the HEDIS MY 2021 rate was below NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile benchmark.
* A lower rate indicates better performance 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 2021 QISMC goals are unavailable for this measure or indicator.
NC indicates the MY 2020–MY 2021 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 2021 performance measure rate was at or above the MPS.

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

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

Table 3-54—Nevada Check Up HEDIS MY 2021 Performance Measure Results and Trending for SilverSummit

HEDIS Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	MY 2020–MY 2021 Rate Comparison
Children's Preventive Care				
Childhood Immunization Status (CIS)				
Combination 3	84.31%	81.40%	75.51%↑	-5.89
Combination 7	68.63%	74.42%	69.39%↑	-5.03
Combination 10	41.18%	46.51%	42.86%↑	-3.65
Immunizations for Adolescents (IMA)				
Combination 1 (Meningococcal, Tdap)	86.36%	90.63%	86.02%↑	-4.61
Combination 2 (Meningococcal, Tdap, HPV)	33.33%	43.75%	26.88%↓	-16.87
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)				
BMI Percentile—Total	73.48%	76.64%	75.43%↓	-1.21
Counseling for Nutrition—Total	66.42%	67.88%	65.45%↓	-2.43
Counseling for Physical Activity—Total	62.04%	66.42%	62.04%↓	-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	—	56.25%	NA	NC
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	—	85.42%	69.77%↓	-15.65
Child and Adolescent Well-Care Visits (WCV)				
3–11 Years	—	44.81%	43.39%↓	-1.42
12–17 Years	—	40.76%	39.79%↓	-0.97
18–21 Years	—	21.84%	29.91%↑	8.07
Total^	—	41.56%	40.95%↓	-0.61
Women's Health and Maternity Care				
Chlamydia Screening in Women (CHL)^				
16–20 Years	—	—	34.15%	NC
21–24 Years	—	—	NA	NC
Total	—	—	34.15%	NC

HEDIS Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	MY 2020–MY 2021 Rate Comparison
Care for Chronic Conditions				
Asthma Medication Ratio (AMR)^				
5–11 Years	—	—	NA	NC
12–18 Years	—	—	NA	NC
19–50 Years	—	—	NA	NC
51–64 Years	—	—	NA	NC
Total	—	—	NA	NC
Behavioral Health				
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)^				
7-Day Follow-Up—Total	—	NA	NA	NC
30-Day Follow-Up—Total	—	NA	NA	NC
Follow-Up After Emergency Department Visit for Mental Illness (FUM)				
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)				
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)				
Initiation Phase	NA	NA	NA	NC
*Continuation and Maintenance Phase^*	NA	NA	NA	NC
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)				
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	NA	NA	NC
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)^				
1–11 Years	—	—	NA	NC
12–17 Years	—	—	NA	NC

HEDIS Measure	HEDIS MY 2019 Rate	HEDIS MY 2020 Rate	HEDIS MY 2021 Rate	MY 2020–MY 2021 Rate Comparison
Total	—	—	NA	NC
Utilization				
Ambulatory Care—Total (per 1,000 Member Months) (AMB)^				
*ED Visits—Total**	30.68	15.41	18.02	2.61
Outpatient Visits—Total	237.83	168.42	158.88	-9.54
Mental Health Utilization—Total (MPT)^				
Inpatient—Total	0.23%	0.61%	0.49%	-0.12
Intensive Outpatient or Partial Hospitalization—Total	0.14%	0.06%	0.15%	0.09
Outpatient—Total	9.79%	6.39%	5.73%	-0.66
ED—Total	0.00%	0.00%	0.10%	0.10
Telehealth—Total	0.09%	3.61%	2.96%	-0.65
Any Service—Total	9.84%	7.55%	7.10%	-0.45

↑ Indicates the HEDIS MY 2021 rate was above NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile benchmark.

↓ Indicates the HEDIS MY 2021 rate was below NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile benchmark.

* A lower rate indicates better performance 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 2021 QISMC goals are unavailable for this measure or indicator.

NC indicates the MY 2020–MY 2021 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.

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

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

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: Within the Care for Chronic Conditions domain, **SilverSummit**'s Medicaid population demonstrated an increase of more than 5 percentage points for the *Controlling High Blood Pressure* measure and the *Comprehensive Diabetes Care—HbA1c Testing*, *HbA1c Control (<8.0%)*, and *Blood Pressure Control (<140/90 mm Hg)* measure indicators. This performance suggests **SilverSummit**'s Medicaid members are receiving appropriate screenings and treatment for managing blood pressure and diabetes, which is essential to prevent heart disease, stroke, and premature death. **[Quality]**

Strength #2: Within the Children's Preventive Care domain for **SilverSummit**'s Nevada Check Up population, performance for the *Child and Adolescent Well-Care Visits—18–21 Years* measure indicator increased by more than 5 percentage points from the prior year and ranked above NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile benchmarks. This performance suggests **SilverSummit**'s Nevada Check Up members ages 18–21 years are receiving the recommended amount of well-care visits, which provide an opportunity for providers to influence health and development, and they are a critical opportunity for screening and counseling. **[Quality]**

Strength #3: Within the Behavioral Health domain for **SilverSummit**'s Medicaid population, performance for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total* measure indicator rate increased by more than 5 percentage points from the prior year and ranked above NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile benchmarks. This improved performance indicates **SilverSummit**'s dedication to ensuring appropriate management of its child and adolescent members on antipsychotic medications, which may potentially lower the risk for developing serious metabolic health conditions. **[Quality]**

Strength #4: Within the Overuse/Appropriateness of Care domain for **SilverSummit**'s Medicaid population, performance for the *Use of Opioids at High Dosage* measure and *Use of Opioids From Multiple Providers* measure indicators met the MPS and ranked above NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile benchmarks. This performance indicates **SilverSummit** is appropriately monitoring its Medicaid members who are taking opioid medications and identifying members who may be at high risk for opioid overuse and misuse. This oversight is critical in preventing fatal and non-fatal overdoses. **[Quality]**

Weaknesses and Recommendations

Weakness #1: Within the Access to Care domain for **SilverSummit**'s Medicaid population, all measure indicator rates for *Adults' Access to Preventive/Ambulatory Health Services* ranked below NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile benchmarks and did not meet the MPS. In addition, the *Ages 65 Years and Older* measure indicator demonstrated a significant decline of more than 20 percentage points. Preventive and ambulatory visits are an opportunity for members to receive preventive services and counseling on topics such as diet and exercise, as well as help address acute issues or manage chronic conditions. **[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, especially for the *Ages 65 Years and Older* age group. These members may have difficulties finding a provider that accepts Medicaid or may be choosing to not go to the doctor. Declines in rates may also coincide with the continued increase of COVID-19 cases in 2021. As reported by **SilverSummit**, the COVID-19 PHE resulted in provider office closures, restricted hours, and provider staffing issues, which impacted providers' ability to see members and outreach for educational purposes. Additionally, members' fear of contracting COVID-19 also likely impacted individuals from seeking healthcare services.

Recommendation: **SilverSummit** should continue its initiatives to mitigate the barriers caused by the COVID-19 PHE, including promoting and encouraging telehealth services and conducting member outreach through member newsletters, flyers, and the website. **SilverSummit** should also continue its efforts to evaluate network adequacy and implement interventions in those ZIP Codes in which there are disparities in service utilization.

Weakness #2: With the exception of *Well-Child Visits in the First 30 Months of Life—Six or More Well-Child Visits* measure indicator, all measure rates within the Children's Preventive Care domain for **SilverSummit**'s Medicaid population ranked below NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile benchmarks. In addition, a decline in performance of more than 5 percentage points was shown for the *Immunizations for Adolescents—Combination 2*, *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total* and *Counseling for Physical Activity—Total*, and *Well-Child Visits in the First 30 Months of Life—Two or More Well-Child Visits* measure indicators. Within **SilverSummit**'s Nevada Check Up population, a decline in performance of more than 5 percentage points was shown for the *Childhood Immunization Status—Combination 3* and *Combination 7*, *Immunizations for Adolescents—Combination 2*, and *Well-Child Visits in the First 30 Months of Life—Two or More Well-Child Visits* measure indicators. This performance suggests that not all of **SilverSummit**'s Medicaid and Nevada Check Up child and adolescent members are receiving the recommended immunizations and well-care visits, which are important for avoiding vaccine-preventable diseases, as well as screening and counseling, which are important at every stage of life. **[Quality]**

Why the weakness exists: Immunization and well-care visit declines may have been due to lingering effects of the COVID-19 PHE during 2021. Factors that may have contributed to the declines during this time include provider staffing shortages and the requirement or recommendation to stay at home, while the fear of contracting COVID-19 also likely continued to deter individuals from seeking healthcare services, including immunizations and well-care visits. As reported by **SilverSummit**, there was an overall hesitancy for members to get vaccinations during the period they were not attending school in person due to COVID-19, particularly with the Latino population.

Recommendation: HSAG recommends **SilverSummit** continue its "Project Neighborhood Health" initiative that was implemented to promote screenings and vaccinations in specific ZIP Codes where there are disparities in service utilization. As part of this initiative, **SilverSummit** should conduct ongoing analyses to confirm that the initiative is successful at increasing the prevalence of well-care

visits and immunizations. If the intervention is not successful, **SilverSummit** should implement new interventions to improve performance in the Children's Preventive Care domain.

Weakness #3: SilverSummit did not meet the MPS for any performance measure rates for its Nevada Check Up population. Furthermore, **SilverSummit** did not meet the MPS for any performance measure rates for its Medicaid population other than the *Use of Opioids at High Dosage* and *Use of Opioids From Multiple Providers* measures. **[Quality, Timeliness,** and **Access]**

Why the weakness exists: As reported by **SilverSummit,** lingering effects of the COVID-19 PHE may have contributed to lower service utilization. However, it is likely that other factors also contributed to members not seeking services, such as access issues or lack of transportation.

Recommendation: SilverSummit should continue to conduct analyses on all performance measure rates that did not meet the MPS for the Medicaid and Nevada Check Up populations. HSAG recommends that **SilverSummit** monitor rates regularly and consider whether there are disparities within its populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, **SilverSummit** should implement appropriate interventions to improve performance. **SilverSummit** should also conduct a comprehensive review of all member grievances reported over the past 12 months to determine other factors that may have contributed to members not accessing services and implement interventions to mitigate any noted barriers.

Compliance Review

Performance Results

Table 3-55 presents **SilverSummit**'s compliance review scores for each standard evaluated during the current three-year compliance review cycle. **SilverSummit** was required to submit a CAP for all reviewed standards scoring less than 100 percent compliant. **SilverSummit**'s implementation of the plans of action under each CAP will be assessed during the third year of the three-year compliance review cycle, and a reassessment of compliance will be determined for each standard not meeting the 100 percent compliance threshold.

Table 3-55—Standard Compliance Scores for SilverSummit

Compliance Review Standard	Associated Federal Citations[1]	Compliance Score
Mandatory Standards		
Year One (SFY 2021)		
Standard I—Disenrollment: Requirements and Limitations	§438.56	**100%**
Standard II—Member Rights and Member Information	§438.10 §438.100	**77%**

Compliance Review Standard	Associated Federal Citations[1]	Compliance Score
Mandatory Standards		
Standard III—Emergency and Poststabilization Services	§438.114	**100%**
Standard IV—Availability of Services	§438.206	**90%**
Standard V—Assurances of Adequate Capacity and Services	§438.207	**100%**
Standard VI—Coordination and Continuity of Care	§438.208	**71%**
Standard VII—Coverage and Authorization of Services	§438.210	**67%**
Year Two (SFY 2022)		
Standard VIII—Provider Selection	§438.214	**83%**
Standard IX—Confidentiality	§438.224	**100%**
Standard X—Grievance and Appeal Systems	§438.228	**76%**
Standard XI—Subcontractual Relationships and Delegation	§438.230	**71%**
Standard XII—Practice Guidelines	§438.236	**100%**
Standard XIII—Health Information Systems[2]	§438.242	**100%**
Standard XIV—Quality Assessment and Performance Improvement Program	§438.330	**97%**
Year Three (SFY 2023)		
Review of MCO implementation of Year One and Year Two CAPs		

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

Table 3-56 presents **SilverSummit**'s scores for each standard evaluated during the SFY 2022 Compliance Review activity. 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. The SFY 2022 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.

Table 3-56—SFY 2022 Standard Compliance Scores for SilverSummit

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard VIII—Provider Selection	12	12	10	2	0	**83%**

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard IX—Confidentiality	11	11	11	0	0	**100%**
Standard X—Grievance and Appeal Systems	38	38	29	9	0	**76%**
Standard XI—Subcontractual Relationships and Delegation	7	7	5	2	0	**71%**
Standard XII—Practice Guidelines	10	10	10	0	0	**100%**
Standard XIII—Health Information Systems[1]	14	14	14	0	0	**100%**
Standard XIV—Quality Assessment and Performance Improvement Program	42	39	38	1	3	**97%**
Total	**134**	**131**	**117**	**14**	**3**	**89%**

M = Met*; *NM = Not Met*; *NA = Not Applicable
Total Elements: The total number of elements within each standard.
Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.
Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.
[1] The Health Information Systems standard included an assessment of the MCO's IS capabilities.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: SilverSummit achieved full compliance for the Confidentiality program area, demonstrating that the MCO had appropriate policies and processes for the use and disclosure of members' PHI and members' privacy rights, and provided required notices related to privacy practices. [**Quality**]

Strength #2: SilverSummit achieved full compliance for the Practice Guidelines program area, demonstrating that the MCO adopted evidence-based practice guidelines, disseminated its practice guidelines to all affected providers, and rendered utilization management and coverage of services decisions consistent with its practice guidelines. [**Quality** and **Access**]

Strength #2: SilverSummit achieved full compliance for the Health Information Systems program area, demonstrating that the MCO maintained a health information system that collects, analyzes,

integrates, and reports data on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollment for other than loss of Medicaid eligibility. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: SilverSummit received a score of 76 percent in the Grievance and Appeal Systems program area, indicating that the MCO had not implemented a member grievance and appeal process that met all federal and contractual requirements. A total of nine deficiencies were identified. [**Quality**, **Timeliness**, **Access**]

Why the weakness exists: SilverSummit did not demonstrate that reasonable efforts were made to provide oral notice to the member of the grievance resolution, resolution letters inappropriately included appeal rights, the MCO did not include in policy or demonstrate in practice that the MCO would inform members of their grievance rights should the member disagree with the decision to extend the grievance resolution time frame, written consent from the member was not consistently obtained when an appeal was filed by someone else on behalf of the member, reasonable efforts to give members prompt oral notice of the delay when appeal resolution time frames were extended was not demonstrated, adverse benefit determination notices incorrectly informed members that a signed written appeal must be provided to the MCO for oral appeals, members were not informed about the opportunity to present evidence as part of the appeal process, and the MCO lacked a documented process for when an appeal is not resolved timely.

Recommendation: While **SilverSummit** was required to develop a CAP, given the high volume of deficiencies identified in the MCO's grievance and appeal process, HSAG recommends that the MCO conduct a comprehensive review of all policies, procedures, workflows, letter templates, and all other member grievance and appeal materials to identify any additional opportunities for improvement in this program area. HSAG also recommends that **SilverSummit** conduct additional staff training once all materials have been reviewed and revised, and enhance management oversight of the grievance and appeal process.

Weakness #2: SilverSummit received a score of 71 percent in the Subcontractual Relationships and Delegation program area, indicating gaps in the MCO's process for ensuring its delegation agreements include all required federal and State contractual provisions.

Why the weakness exists: Of the delegation agreements reviewed as part of the case file review, **HPN**'s right to audit provisions within the agreements did not fully align with the federally required language, or were located under a Medicare-specific addendum that did not support the Nevada Managed Care Program. Further, the MCO did not effectively demonstrate that when deficiencies or areas for improvement are noted during its auditing and monitoring processes of the delegate, corrective action is taken.

Recommendation: While **SilverSummit** was required to develop a CAP, HSAG recommends that the MCO conduct a comprehensive review of all written arrangements with its delegates for the Nevada Managed Care Program and ensure they include all provisions required by federal and State contractual requirements. **SilverSummit** should include the provisions verbatim, when appropriate, to ensure no misinterpretation of the requirements. Additionally, the MCO should update its formal

auditing process, specifically the scoring methodology for determining when a CAP is or is not required from a delegate, to ensure deficiencies identified during the auditing process are remedied appropriately.

Network Adequacy Validation

Performance Results

Table 3-57 presents **SilverSummit**'s network capacity analysis results and compares the provider ratios to the standards displayed in Table 3-4. Assessed provider ratios shown in green indicate the provider ratio was in compliance with the access standard, whereas provider ratios shown in red indicate the provider ratio was not in compliance with the access standard.

Table 3-57—Summary of Ratio Analysis Results for PCPs and Specialty Care Providers for SilverSummit

Provider Category	Providers*	Clark County Ratio	Washoe County Ratio	Statewide Ratio**
PCPs (1:1,500)	1,695	1:76	1:10	1:85
PCP Extenders (1:1,800)	1,591	1:49	1:7	1:55
Physician Specialists (1:1,500)	1,675	1:76	1:10	1:86

Note: results shown in green font indicate the result complies with the access standard; results shown in red font indicate the result does not comply with the access standard; PCP: Primary Care Provider.
* Providers contracted statewide and contracted providers located in the Nevada Medicaid catchment areas were included in provider counts.
** Statewide ratio incorporates all Nevada counties included in the DHCFP member file submission and members enrolled with the MCO as of March 1, 2022.

Table 3-58 presents **SilverSummit**'s geographic network distribution analysis and compares the percentage of members within the access standard compared to the standards displayed in Table 3-5. Assessed results shown in green indicate that the percentage of members within the access standard was in compliance, and percentages shown in red indicate a result of less than 99.0 percent.

Table 3-58—Percentage of Members Residing Within the Access Standard Areas for SilverSummit

Provider Category	Clark County	Washoe County	Statewide*
Primary Care Providers			
Primary Care, Adults (10 miles/15 mins)	99.9%	99.3%	99.8%
OB/GYN (10 miles/15 mins)	98.9%	95.2%	98.4%
Pediatrician (10 miles/15 mins)	>99.9%	97.5%	99.6%
Physician Specialists			
Endocrinologist (40 miles/60 mins)	>99.9%	100%	>99.9%

Provider Category	Clark County	Washoe County	Statewide*
Endocrinologist, Pediatric (40 miles/60 mins)	>99.9%	100%	>99.9%
Infectious Disease (40 miles/60 mins)	>99.9%	100%	99.9%
Infectious Disease, Pediatric (40 miles/60 mins)	>99.9%	100%	>99.9%
Oncologist/Radiologist (40 miles/60 mins)	>99.9%	100%	>99.9%
Oncologist—Medical/Surgical (30 miles/45 mins)	>99.9%	99.9%	99.9%
Oncologist—Medical/Surgical, Pediatric (30 miles/45 mins)	>99.9%	99.9%	99.9%
Rheumatologist (40 miles/60 mins)	>99.9%	100%	99.9%
Rheumatologist, Pediatric (40 miles/60 mins)	>99.9%	0.0%	88.6%
Behavioral Health Providers			
Board Certified Child and Adolescent Psychiatrist (30 miles/45 mins)	100%	99.9%	99.9%
Psychiatrist (30 miles/45 mins)	>99.9%	>99.9%	99.9%
Psychologist (30 miles/45 mins)	>99.9%	>99.9%	99.9%
Psychologist, Pediatric (30 miles/45 mins)	>99.9%	0.0%	88.6%
QMHP (30 miles/45 mins)	100%	100%	>99.9%
QMHP, Pediatric (30 miles/45 mins)	100%	99.9%	99.9%
Facility-Level Providers			
Hospitals, All (30 miles/45 mins)	>99.9%	>99.9%	>99.9%
Pharmacy (10 miles/15 mins)	99.9%	99.5%	99.9%
Psychiatry Inpatient Hospital (30 miles/45 mins)	>99.9%	99.9%	99.9%
Dialysis/ESRD Facility (30 miles/45 mins)	>99.9%	>99.9%	>99.9%

Note: results shown in green font indicate the result complies with the access standard; results shown in red font indicate that less than 99.0 percent of members had access to the provider within the time and distance access standard.

* Statewide results incorporate all Nevada counties included in the DHCFP member file submission and members enrolled with the MCO as of March 1, 2022.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: SilverSummit met the provider ratio requirements for PCPs and physician specialists in both Clark and Washoe counties, indicating **SilverSummit** had a sufficient provider network for its members to access services. **[Access]**

Weaknesses and Recommendations

Weakness #1: SilverSummit did not meet the time-distance contract standards for OB/GYN, Pediatric Rheumatologist, and Pediatric Psychologist, indicating members may experience challenges accessing these provider types within an adequate time or distance from their residence. **[Access]**

Why the weakness exists: The lack of identified providers may result from either a lack of contracted providers in these specialties or from an inability to identify those providers in the data. Three of the four MCOs did not meet the contract adequacy standard for OB/GYN, and all four MCOs did not meet the contract standard for Pediatric Rheumatologists, suggesting a potential lack of these provider types within the counties served. Although half of the MCOs did not meet the contract standard for Pediatric Psychologist, two MCOs did meet the contract standard, suggesting that there may not be a lack of available providers and there may be other providers available for contracting. **SilverSummit** reported that it has identified some Medicaid enrolled providers refusing to contract with the MCOs.

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. **SilverSummit** should also continue to review DHCFP's monthly enrolled provider file to identify providers that may be able to fill any network gaps. When providers are not available for contracting, **SilverSummit** should also continue its efforts to promote telehealth services and transportation benefits to mitigate access to care issues.

Weakness #2: SilverSummit did not meet the time-distance contract standard in Washoe County for the Pediatrician provider type, indicating child members may experience challenges accessing pediatricians within an adequate time or distance from their residence. **[Access]**

Why the weakness exists: The lack of identified providers may result from a lack of available Pediatrician providers in Washoe County, or a lack of Pediatrician providers in this county willing to contract with **SilverSummit**. Three of the four MCOs did not meet the contract standard for the Pediatrician provider type in Washoe County, further suggesting limited providers in this county available for contracting.

Recommendation: HSAG recommends **SilverSummit** continue to review DHCFP's monthly enrolled provider list to determine if new providers are available in Washoe County for contracting.

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results

Table 3-59 presents **SilverSummit**'s 2022 adult Medicaid, general child Medicaid, and CCC Medicaid CAHPS top-box scores. Table 3-59 also includes **SilverSummit**'s 2022 Nevada Check Up general child and CCC top-box scores. Arrows (↓ or ↑) indicate 2022 scores that were statistically significantly higher or lower than the 2021 national average.

Table 3-59—Summary of 2022 CAHPS Top-Box Scores for SilverSummit

	Adult Medicaid	General Child Medicaid	CCC Medicaid	Nevada Check Up General Child	Nevada Check Up CCC
Composite Measures					
Getting Needed Care	NA	NA	NA	NA	NA
Getting Care Quickly	NA	NA	NA	NA	NA
How Well Doctors Communicate	NA	NA	NA	NA	NA
Customer Service	NA	NA	NA	NA	NA
Global Ratings					
Rating of All Health Care	53.2%	NA	NA	NA	NA
Rating of Personal Doctor	60.7%	NA	NA	NA	NA
Rating of Specialist Seen Most Often	NA	NA	NA	NA	NA
Rating of Health Plan	52.4% ↓	69.2%	NA	NA	NA
Effectiveness of Care*					
Advising Smokers and Tobacco Users to Quit	61.7% ↓	—	—	—	—
Discussing Cessation Medications	41.0% ↓	—	—	—	—
Discussing Cessation Strategies	37.0% ↓	—	—	—	—
CCC Composite Measures/Items					
Access to Specialized Services	—	—	NA	—	NA
Family Centered Care (FCC): Personal Doctor Who Knows Child	—	—	NA	—	NA

	Adult Medicaid	General Child Medicaid	CCC Medicaid	Nevada Check Up General Child	Nevada Check Up CCC
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 result. 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 2022 score is statistically significantly higher than the 2021 national average.

↓ Indicates the 2022 score is statistically significantly lower than the 2021 national average.

— Indicates the measure does not apply to the population.

Strengths, Weaknesses, and Recommendations

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

Strengths

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

Weaknesses and Recommendations

Weakness #2: Adult members had fewer positive experiences with their health plan since the score for this measure was statistically significantly lower than the 2021 NCQA Medicaid national average. **[Quality]**

Why the weakness exists: Adult members are reporting a more negative experience with their health plan overall, 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 health plan 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. **SilverSummit** should also continue the initiatives it has already implemented based on previous analyses, including the member concierge program, door-to-door visits by community health workers, and the promotion of urgent care and engagement with providers to offer after-hours clinics.

Weakness #2: The Effectiveness of Care scores were statistically significantly lower than the 2021 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. **SilverSummit** also reported that provider offices continue to be impacted by COVID-19, making it difficult to provide education because the offices are either closed or have limited hours, and they lack the human resources necessary to receive the education.

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. **SilverSummit** should also continue with the development of a social media platform and provider materials aimed at promoting smoking cessation and the available options to stop smoking, including medication assistance.

Weakness #3: There were less than 100 respondents for every measure for the CCC populations and Nevada Check Up general child population, several measures for the adult Medicaid population, and every measure except *Rating of Health Plan* for the child Medicaid population; therefore, results could not be reported for the other measures and other strengths and weaknesses could not be identified. **[Quality, Timeliness, Access]**

Why the weakness exists: Adult members and parents/caretakers of child members are less likely to respond to the CAHPS survey.

Recommendation: HSAG recommends that **SilverSummit** focus on increasing response rates to the CAHPS survey for all populations so there are greater than 100 respondents for each measure by educating and engaging all employees to increase their knowledge of CAHPS, using customer service techniques, oversampling, and providing member and provider awareness during the survey period.

Encounter Data Validation

Performance Results

Information Systems Review

The IS review component of the EDV study provided self-reported qualitative information from **SilverSummit** for which HSAG conducted an IS review regarding the encounter data processes related to collection, processing, and transmission of encounter data to DHCFP.

Based on contractual requirements and DHCFP's data submission requirements (e.g., companion guides), **SilverSummit** demonstrated its capability to collect, process, and transmit encounter data to DHCFP, as well as develop data review and correction processes that can respond to quality issues identified by DHCFP. Additionally, **SilverSummit** also described the systems/subcontractor oversight

and data remediation activities in place to ensure the completeness and accuracy of data submitted to **SilverSummit** or processed on its behalf.

Comparative Analysis

Table 3-60 displays the percentage of records present in the files submitted by **SilverSummit** that were not found in DHCFP's files (record omission) and the percentage of records present in DHCFP's files but not present in the files submitted by **SilverSummit** (record surplus). Lower rates indicate better performance for both record omission and record surplus.

Table 3-60—Record Omission and Surplus by Encounter Type for SilverSummit

Encounter Data Source	Record Omission	Record Surplus
Professional	1.7%	1.9%
Institutional	8.4%	1.9%
Pharmacy	0.7%	15.0%

Table 3-61 through Table 3-63 display the element omission, surplus, and accuracy results for each key data element by encounter type for **SilverSummit**. **For the element omission and surplus indicators, lower rates indicate better performance; while for the element accuracy indicator, higher rates indicate better performance.**

Table 3-61—Element Omission, Surplus, and Accuracy—Professional Encounters for SilverSummit

Key Data Element	Element Omission	Element Surplus	Element Accuracy
Recipient ID	0.0%	0.0%	>99.9%
Header Service From Date	0.0%	0.0%	>99.9%
Header Service To Date	0.0%	0.0%	100%
Detail Service From Date	0.0%	0.0%	>99.9%
Detail Service To Date	0.0%	0.0%	>99.9%
Billing Provider NPI	1.5%	0.0%	96.4%
Rendering Provider NPI	0.7%	26.9%	>99.9%
Referring Provider NPI	3.6%	0.0%	100%
Primary Diagnosis Code	0.0%	0.0%	89.4%
Secondary Diagnosis Code[1]	0.0%	12.8%	93.2%
Procedure Code (CPT/HCPCS/CDT)	<0.1%	<0.1%	>99.9%
Procedure Code Modifier	<0.1%	<0.1%	>99.9%
NDC	<0.1%	<0.1%	>99.9%
Drug Quantity	<0.1%	0.0%	57.3%
Header Paid Amount	0.0%	0.0%	99.9%

Key Data Element	Element Omission	Element Surplus	Element Accuracy
Detail Paid Amount	0.0%	0.0%	99.9%

[1] Calculated for *Diagnosis Code 2* only.

Table 3-62—Element Omission, Surplus, and Accuracy—Institutional Encounters for SilverSummit

Key Data Element	Element Omission	Element Surplus	Element Accuracy
Recipient ID	0.0%	0.0%	100%
Header Service From Date	0.0%	0.0%	100%
Header Service To Date	0.0%	0.0%	100%
Detail Service From Date	0.0%	0.0%	98.5%
Detail Service To Date	0.0%	0.0%	98.5%
Billing Provider NPI	0.2%	0.0%	>99.9%
Attending Provider NPI	1.7%	0.0%	100%
Referring Provider NPI	1.0%	0.0%	NA
Primary Diagnosis Code	0.0%	0.0%	100%
Secondary Diagnosis Code[1]	0.0%	<0.1%	100%
Procedure Code (CPT/HCPCS/CDT)	0.1%	0.3%	95.2%
Procedure Code Modifier	0.3%	0.5%	99.6%
Primary Surgical Procedure Code[2]	0.0%	0.0%	100%
Secondary Surgical Procedure Code	0.0%	0.0%	99.8%
NDC	0.3%	0.5%	97.1%
Drug Quantity	0.3%	0.0%	86.9%
Revenue Code	<0.1%	<0.1%	97.6%
Header Paid Amount	0.0%	0.0%	99.9%
Detail Paid Amount	0.0%	0.0%	97.9%

[1] Calculated for *Diagnosis Code 2* only.
[2] Calculated for *Surgical Procedure Code 2* only.
NA indicates not applicable since no records had values present in both data sources.

Table 3-63—Element Omission, Surplus, and Accuracy—Pharmacy Encounters for SilverSummit

Key Data Element	Element Omission	Element Surplus	Element Accuracy
Recipient ID	0.0%	0.0%	>99.9%
Date of Service	0.0%	0.0%	100%
Billing Provider NPI	1.0%	0.0%	100%
Prescribing Provider NPI	0.0%	<0.1%	>99.9%
NDC	0.0%	0.0%	99.8%

Key Data Element	Element Omission	Element Surplus	Element Accuracy
Drug Quantity	0.0%	0.0%	99.8%
Paid Amount	0.0%	0.0%	98.3%

Table 3-64 displays the all-element accuracy results for the percentage of records present in both data sources with the same values (missing and non-missing) for all key data elements relevant to each encounter data type for **SilverSummit**.

Table 3-64—All-Element Accuracy by Encounter Type for SilverSummit

Indicator	Professional	Institutional	Pharmacy
All-Element Accuracy	52.3%	91.5%	97.3%

Medical Record Review

Table 3-65 presents the percentage of key data elements identified in the encounter data that were not supported by the members' medical records provided by **SilverSummit** (i.e., medical record omission) and the percentage of key data elements from the members' medical records that were not found in the encounter data provided by **SilverSummit** (i.e., encounter data omission). Lower rates for each data element indicate better performance.

Table 3-65 also displays the percentage of key data elements associated with validated dates of service from the encounter data that were correctly coded based on the members' medical records. Errors found in the diagnosis coding were separated into two categories: inaccurate coding and specificity error. Errors found in the procedure coding associated with the MRRs were separated into three categories: higher level of service in the medical record, lower level of service in the medical record, and inaccurate coding. The errors for the procedure code modifier data element could not be separated into subcategories and therefore are not presented in Table 3-65. Higher accuracy rates for each data element indicate better performance.

Table 3-65—MRR: Encounter Data Completeness and Accuracy for SilverSummit

Data Element	Medical Record Omission[1]	Encounter Data Omission[2]	Element Accuracy[3]	Error Type
Date of Service	40.7%	0.7%	—	—
Diagnosis Code	42.0%	1.0%	99.7%	Incorrect Code (100%) Specificity Error (0.0%)
Procedure Code	43.3%	12.3%	99.0%	Incorrect Code (100%) Lower Level of Services in Medical Records (0.0%) Higher Level of Services in Medical Records (0.0%)
Procedure Code Modifier	54.0%	1.6%	100%	—

Data Element	Medical Record Omission[1]	Encounter Data Omission[2]	Element Accuracy[3]	Error Type
All-Element Accuracy[4]			66.8%	—

"—" indicates that the accuracy rate analysis and/or the error type analysis was not applicable to a given data element.

[1] Services documented in the encounter data but not supported by the members' medical records. Lower rate values indicate better performance.

[2] Services documented in the members' medical records but not in the encounter data. Lower rate values indicate better performance.

[3] Services documented in the members' medical records associated with validated dates of service from the encounter data that were correctly coded based on the medical records. Higher rate values indicate better performance.

[4] The all-element accuracy rate describes the percentage of dates of service present in both DHCFP's encounter data and in the medical records with all data elements coded correctly (i.e., not omitted from the medical record; not omitted from the encounter data; and, when populated, have the same values). As such, the gray cells indicate the evaluation for medical record omission or encounter data omission is not applicable.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: SilverSummit demonstrated its capability to collect, process, and transmit encounter data to DHCFP, as well as develop data review and correction processes that can promptly respond to quality issues identified by DHCFP. **[Quality and Timeliness]**

Strength #2: SilverSummit's professional encounter data appeared complete when comparing data extracted from **SilverSummit**'s claims system to data extracted from DHCFP's data warehouse. Encounter data records from DHCFP-submitted files were highly corroborated in **SilverSummit**-submitted files. **[Quality]**

Strength #3: Pharmacy data element comparison between data extracted from **SilverSummit**'s claims systems and data extracted from DHCFP's data warehouse also showed complete and accurate data. **[Quality]**

Weaknesses and Recommendations

Weakness #1: SilverSummit had challenges requesting medical records from its contracted providers, resulting in a low medical record procurement rate. The low medical record procurement rate consequently impacted the results of the MRRs of key data elements that were evaluated. **[Quality and Timeliness]**

Why the weakness exists: SilverSummit reported that the main reasons for missing medical records were due to non-responsive providers or providers did not respond in a timely manner.

Recommendation: To ensure **SilverSummit**'s contracted provider accountability in addressing submission of medical records for auditing, inspection, and examination related to its members, **SilverSummit** should consider strengthening and/or enforcing its contract requirements with providers in providing the requested documentation.

Weakness #2: Procedure codes documented in the medical records were either not found in the encounter data or were found in the encounter data but should have been coded with a different procedure code. **[Quality]**

Why the weakness exists: While discrepancies may have been due to medical record non-submission, other reasons may also have contributed to the discrepancies. Some of the potential reasons include: (1) the provider did not document the services performed in the medical record, and (2) the provider did not provide the service(s) found in the encounter data.

Recommendation: **SilverSummit** should consider performing periodic MRRs of submitted claims to verify appropriate coding and data completeness. Any findings from these reviews should then be shared with providers through periodic education and training regarding encounter data submissions, medical record documentation, and coding practices.

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

HSAG performed a comprehensive assessment of **SilverSummit**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services to identify common themes within **SilverSummit** that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **SilverSummit**'s overall performance contributed to the Nevada Managed Care Program's progress in achieving the Quality Strategy goals and objectives. Table 3-66 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **SilverSummit**'s Medicaid and Nevada Check Up members.

Table 3-66—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Use of Preventive Services	**Quality, Timeliness,** and **Access**—Over the past three-year period (MY 2019–MY 2021), there has been a steady decline in the percentage of **SilverSummit**'s adult members accessing preventive services, and an even higher rate of decline in members 65 years and older. While there has been improvement in the percentage of Medicaid children and adolescents between the ages of 3 and 21 years who received one or more well-care visits with a PCP or an OB/GYN provider during the year and well-child visits for members in the first 30 months of life, there was a significant decline in well-child visits for members who turned 30 months old during the year. For the Nevada Check Up population, although there was a significant improvement in the percentage of members between the ages of 18 and 21 getting a well-care visit, there was also a slight decline in the percentage of child members between the ages of 3 and 17 years who received one or more well-care visits as recommended. There was also a decline in the prevalence of immunizations for children and adolescents and a

Performance Area	Overall Performance Impact
	steady decline in breast cancer screenings over the past three years. Accessing preventive care decreases the risk for diseases, disabilities, and death. Children also need regular preventive care visits to monitor their development and find health problems early so they are easier to treat. Although **SilverSummit** demonstrated through the compliance review activity that it had strong practices for ensuring its providers were aware of its adopted practice guidelines, which should include guidelines for preventive care, and **SilverSummit** appears to have a sufficient number of PCPs to provide services as indicated through the NAV activity, child members in Washoe County may experience challenges accessing pediatricians within an adequate time or distance from their residence to obtain preventive care, as **SilverSummit** did not meet the network adequacy standard in this county. Based on these findings, **SilverSummit** has significant opportunities to mitigate any barriers to receiving preventive care, and to implement interventions to support improvement in the use of preventive services for its adult and child members.
Evidence-Based Practices for Members With Chronic Conditions	**Quality**—In MY 2021, **SilverSummit** had a PIP in place with a goal to decrease the percentage of male diabetic members with an HbA1c level greater than 9 percent from 83 percent to 63 percent. Although the targeted member outreach intervention was discontinued, and **SilverSummit** did not achieve the goal, it did demonstrate slight improvement overall from MY 2020. Additionally, in MY 2021, **SilverSummit** also showed significant improvement in the percentage of diabetic members obtaining HbA1c tests, having HbA1c levels less than 8 percent, and having their blood pressure under control, indicating **SilverSummit** had focused some efforts on diabetes management and members were gaining better control over their diabetes. **SilverSummit** also demonstrated significant improvement in the percentage of members diagnosed with hypertension whose blood pressure was adequately controlled, therefore decreasing their risk of heart disease and stroke.
Health and Wellness of Pregnant Women	**Quality, Timeliness,** and **Access**—Although **SilverSummit** demonstrated slight improvement in the prevalence of women getting timely prenatal and postpartum care over the past MY, **SilverSummit** had the lowest rates overall within the Nevada Managed Care Program in the *Timeliness of Prenatal Care* and *Postpartum Care* measure indicators. Having an inadequate number of OB/GYN providers to support the number of pregnant women needing prenatal services potentially contributed to members not being able to access services timely, as determined through the NAV activity. Additionally, although **SilverSummit** implemented a provider education intervention to support an improvement in the number of pregnant women receiving prenatal care timelier, the intervention could not be linked to improved performance in this program area. These findings indicate **SilverSummit** has continued opportunities to implement effective interventions that will result in more members seeking and having access to timely prenatal and postpartum services, thus improving the likelihood of better health outcomes for mothers and their babies.

Performance Area	Overall Performance Impact
Evidence-Based Practices for Members With Behavioral Health Conditions	**Quality, Timeliness,** and **Access**—**SilverSummit** must target its efforts on coordinating care for its members seen in the emergency room for, or hospitalized with, mental health conditions, as demonstrated by a decline in the percentages of child and adult members seen in the emergency room or hospitalized with a mental illness who did not receive timely follow-up care with a mental health provider after discharge. Additionally, although there was a slight improvement in the percentage of **SilverSummit**'s adult and adolescent members with a new episode of AOD dependence receiving timely treatment, there was also a significant decline in follow-up visits with treatment providers after ED visits for members diagnosed with SUD, indicating further that **SilverSummit** must implement effective processes to ensure its members are accessing timely treatment after ED discharge. Per the NAV activity results, **SilverSummit** did not have any pediatric psychologists in Washoe County, which may contribute to children in Washoe County not having access to appropriate mental health treatment providers close to their homes. However, overall, **SilverSummit** demonstrated an adequate network of behavioral health providers, indicating further evaluations should occur to see why members with behavioral health conditions and SUD are not accessing follow-up care timely.
Appropriate Prescribing Practices	**Quality**—**SilverSummit** met the established MPS and performed above the national average for all indicators under the *Use of Opioids at High Dosage* and *Use of Opioids From Multiple Providers* measures, demonstrating adequate oversight of its provider network specific to the prescribing and filling of opioids, therefore reducing the higher likelihood of opioid-related overdose deaths.

4. Assessment of Prepaid Ambulatory Health Plan Performance

HSAG used findings across mandatory EQR activities conducted during the SFY 2022 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.

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

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

Objectives of External Quality Review Activities

This section of the report provides the objectives and a brief overview of each EQR activity conducted in SFY 2022 to provide context for the resulting findings of each EQR activity. For more details about each EQR activity's objectives and the comprehensive methodology, including the technical methods for data collection and analysis, a description of the data obtained, and the process for drawing conclusions from the data, refer to Appendix A.

Validation of Performance Improvement Projects

For SFY 2022, **LIBERTY** concluded its 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 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 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 members aged 2 through 20, 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 2022 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 2021
Percentage of Eligibles Who Received Preventive Dental Services (PDENT)	CMS Federal Fiscal Year (FFY) 2021 Child Core Set

Compliance Review

SFY 2021 commenced a new three-year cycle of compliance reviews. The compliance reviews for the DHCFP-contracted PAHP 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. HSAG conducted a review of the first seven standards in Year One (SFY 2021). For SFY 2022, the remaining seven standards were reviewed (Year Two of the cycle). In Year Three (SFY 2023), a comprehensive review will be conducted on each element scored as *Not Met* during the SFY 2021 and SFY 2022 compliance reviews. Table 4-3 outlines the standards reviewed over the three-year compliance review cycle.

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

Standards	Associated Federal Citation[1]	Year One (CY 2021)	Year Two (CY 2022)	Year Three (CY 2023)
Standard I—Disenrollment: Requirements and Limitations	§438.56	✓		Review of the PAHP's implementation of Year One and Year Two CAPs
Standard II—Member Rights and Member Information	§438.10 §438.100	✓		
Standard III—Emergency and Poststabilization Services	§438.114	✓		
Standard IV—Availability of Services	§438.206	✓		
Standard V—Assurances of Adequate Capacity and Services	§438.207	✓		
Standard VI—Coordination and Continuity of Care	§438.208	✓		
Standard VII—Coverage and Authorization of Services	§438.210	✓		
Standard VIII—Provider Selection	§438.214		✓	
Standard IX—Confidentiality	§438.224		✓	
Standard X—Grievance and Appeal Systems	§438.228		✓	
Standard XI—Subcontractual Relationships and Delegation	§438.230		✓	
Standard XII—Practice Guidelines	§438.236		✓	
Standard XIII—Health Information Systems[2]	§438.242		✓	
Standard XIV—Quality Assessment and Performance Improvement Program	§438.330		✓	

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

[2] This Health Information Systems includes a comprehensive assessment of the PAHP's IS capabilities.

Network Adequacy Validation

The NAV activity for SFY 2022 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.

To assess the capacity 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.

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 Provider	1:1,500
Dental Specialist	1:1,500

The second component of the NAV activity evaluated the geographic distribution of providers relative to each of the PAHP's members. To provide a comprehensive view of geographic access, HSAG calculated the percentage of members with access to a provider within the standards for the provider categories identified in the PAHP provider crosswalk. Table 4-5 shows the provider categories used to assess the PAHP's network adequacy and the associated time-distance standards.

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

Provider Category	Member Criteria	Time and Distance Access Standard to the Nearest Provider
General Dental Providers		
General Dentist	Adults	30 minutes or 20 miles
Dentist, Pediatric	Children	30 minutes or 20 miles
Mid-Level Dental Providers		
Dental Therapist	Adults	30 minutes or 20 miles
Public Health Endorsed Dental Hygienist	Adults	30 minutes or 20 miles
Dental Specialists		
Endodontist	Adults	30 minutes or 20 miles
Periodontist	Adults	30 minutes or 20 miles
Prosthodontist	Adults	30 minutes or 20 miles
Oral Surgeon	Adults	30 minutes or 20 miles

Member Satisfaction Survey

In SFY 2022, 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 2021 and May 2022. 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 2022, HSAG conducted and completed EDV activities for the one PAHP. The EDV activities included:

- IS review—assessment of PAHP's IS and processes.
- Comparative analysis—analysis of DHCFP's electronic encounter data completeness and accuracy through a comparative analysis between DHCFP's electronic encounter data and the data extracted from the PAHP's data systems.
- Dental record review—analysis of DHCFP's electronic encounter data completeness and accuracy through a comparison between DHCFP's electronic encounter data and the dental records.

External Quality Review Activity Results

LIBERTY Dental Plan of Nevada, Inc.

Validation of Performance Improvement Projects

Performance Results

LIBERTY completed and submitted Module 4 (PIP Conclusions) for validation for each topic. HSAG organized and analyzed **LIBERTY**'s PIP data to draw conclusions about the MCO's quality improvement efforts. Based on its review, HSAG determined the overall methodological validity of the PIP, as well as the overall success in achieving the SMART Aim goal. As part of this determination,

HSAG evaluated the appropriateness and validity of the SMART Aim measure, as well as trends in the SMART Aim measurements, in comparison with the reported baseline rate and goal. To represent the validity and reliability of each PIP, HSAG assigned a level of confidence (i.e., *High confidence*, *Confidence*, *Low confidence*, *Reported PIP results were not credible*). Refer to Appendix A for details regarding the scoring methodology for each level of confidence. The validation findings assessed by HSAG, and a description of the interventions implemented by **LIBERTY** for each PIP, are displayed in Table 4-7 through Table 4-10.

Table 4-7—SMART Aim Measure Results for Total of Eligible Enrollees Receiving a Sealant on a Permanent Molar Tooth

SMART Aim	Baseline Rate	SMART Aim Goal Rate	Lowest Rate Achieved	Confidence Level
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 from the baseline rate of 22.03% to 27.03% by using key driver interventions.	22.03%	27.03%	27.98%*	*Confidence*

* Represents statistically significant improvement over the baseline percentage.

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

Intervention: Total of Eligible Enrollees Receiving a Sealant on a Permanent Molar Tooth	
Intervention Description	Educational Text Message Campaign to Targeted Members
Intervention Impact	The PAHP reported the intervention was effective for educating parents/caregivers on the importance of sealants, appointment scheduling, and dental benefits.
Intervention Status	Adopted with plan to spread beyond the scope of the PIP.

Table 4-9—SMART Aim Measure Results for Total of Eligible Enrollees Who Received Preventive Dental Services

SMART Aim	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
By December 31, 2021, **LIBERTY**'s goal is to increase the overall percentage of preventive procedures completed among the identified population of members aged 2 through 20, 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.	39.5%	49.5%	46.2%	*High confidence*

* Provider names were redacted for privacy purposes.

Table 4-10—Intervention for Total of Eligible Enrollees Who Received Preventive Dental Services

Intervention: Total of Eligible Enrollees Who Received Preventive Dental Services	
Intervention Description	Educational Text Message Campaign to Targeted Members
Intervention Impact	The PAHP reported the intervention was effective for educating parents/caregivers on the importance of preventive dental care, appointment scheduling, and dental benefits.
Intervention Status	Adopted with plan to spread beyond the scope of the PIP.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: LIBERTY developed methodologically sound improvement projects that met both State and federal requirements. **[Quality]**

Strength #2: LIBERTY developed an intervention that resulted in statistically significant improvement for both PIPs. **[Quality]**

Weaknesses and Recommendations

Weakness #1: Even though the SMART Aim goal was achieved, HSAG identified calculation errors in the analysis of results, which resulted in HSAG assigning a level of *Confidence* to the *Total of Eligible Enrollees Receiving a Sealant on a Permanent Molar Tooth* PIP instead of *High confidence*. **[Quality]**

Why the weakness exists: LIBERTY inaccurately calculated the percentages for several SMART Aim rolling 12-month measurement periods.

Recommendations: LIBERTY should implement validation processes to ensure its calculations of results are accurately documented in its PIP submissions.

Performance Measure Validation

Performance Results

The 2020, 2021, and 2022 performance measure results for **LIBERTY**'s Medicaid and Nevada Check Up populations are presented in Table 4-11 and Table 4-12, along with 2021 to 2022 rate comparisons. The arrows (↑ or ↓) indicate whether the PMV 2022 rate was above or below NCQA's Quality Compass

HEDIS 2021 Medicaid HMO 50th percentile benchmark. **Bolded** rates indicate the MPS was achieved. Please note that the arrows do not necessarily correlate to bolded font.

Table 4-11—Medicaid Performance Measure Results and Trending for LIBERTY

Performance Measure	PMV 2020 Rate	PMV 2021 Rate	PMV 2022 Rate	2021–2022 Rate Comparison
Annual Dental Visit (ADV)				
Ages 2–3 Years	37.49%	29.62%	33.19%↑	3.57
Ages 4–6 Years	55.40%	45.75%	49.91%↓	4.16
Ages 7–10 Years	62.06%	52.20%	55.85%↑	3.65
Ages 11–14 Years	57.50%	48.06%	51.60%↑	3.54
Ages 15–18 Years	48.83%	40.72%	43.90%↓	3.18
Ages 19–20 Years	32.81%	26.65%	28.25%↓	1.60
*Total (Ages 2–20 Years)^*	52.79%	43.55%	46.86%↑	3.31
Percentage of Eligibles Who Received Preventive Dental Services (PDENT)*^				
Total (Ages 1–20 Years)	39.30%	34.07%	37.81%	3.74

↓ Indicates the 2022 rate was below NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile benchmark.
↑ Indicates the 2022 rate was above NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile benchmark.
^ Indicates 2022 QISMC goals are unavailable for this measure or indicator.
* The *PDENT* measure is a CMS Child Core Set measure; therefore, performance was not assessed against the NCQA Quality Compass benchmark.

Table 4-12—Nevada Check Up Performance Measure Results and Trending for LIBERTY

Performance Measure	PMV 2020 Rate	PMV 2021 Rate	PMV 2022 Rate	2021–2022 Rate Comparison
Annual Dental Visit (ADV)				
Ages 2–3 Years	49.65%	39.37%	39.66%↑	0.29
Ages 4–6 Years	70.04%	57.17%	58.86%↑	1.69
Ages 7–10 Years	77.04%	65.83%	65.76%↑	-0.07
Ages 11–14 Years	72.05%	61.16%	62.31%↑	1.15
Ages 15–18 Years	62.32%	51.52%	53.78%↑	2.26
Ages 19–20 Years	51.55%	38.36%	37.95%↑	-0.41
*Total (Ages 2–20 Years)^*	69.42%	57.97%	59.10%↑	1.13

Performance Measure	PMV 2020 Rate	PMV 2021 Rate	PMV 2022 Rate	2021–2022 Rate Comparison
Percentage of Eligibles Who Received Preventive Dental Services (PDENT)* ^				
Total (Ages 1–20 Years)	56.69%	50.92%	50.99%	0.07

↓ Indicates the 2022 rate was below NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile benchmark.
↑ Indicates the 2022 rate was above NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile benchmark.
^ Indicates 2022 QISMC goals are unavailable for this measure or indicator.
* The *PDENT* measure is a CMS Child Core Set measure; therefore, performance was not assessed against the NCQA Quality Compass benchmark.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: LIBERTY demonstrated consistent performance for both the Medicaid and Nevada Check Up populations. Overall, most rates for both populations have shown a steady increase to pre-PHE rates, indicating **LIBERTY**'s strategies to increase the prevalence of dental services amongst its members are effective. **[Quality, Timeliness,** and **Access]**

Strength #2: For **LIBERTY**'s Nevada Check Up population, all *Annual Dental Visit* measure indicator rates ranked above NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile benchmarks. **[Quality, Timeliness,** and **Access]**

Strength #3: With the exception of the *Ages 4–6 Years*, *Ages 15–18 Years*, and *Ages 19–20 Years* measure indicators, **LIBERTY**'s Medicaid performance for the *Annual Dental Visit* measure ranked above NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile benchmarks, and all indicators showed improvement over the previous year. **[Quality, Timeliness,** and **Access]**

Weaknesses and Recommendations

Weakness #1: For **LIBERTY**'s Medicaid population, the *Annual Dental Visit* rates for the *Ages 4–6 Years*, *Ages 15–18 Years*, and *Ages 19–20 Years* measure indicators ranked below NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile benchmarks indicating additional opportunities for **LIBERTY** to focus on members within these age groups to ensure they are receiving the oral care necessary to reduce the risks of developing oral disease in the future. **[Quality, Timeliness,** and **Access]**

Why the weakness exists: Lower performance may be due to the lingering effects of the COVID-19 PHE during 2021. The requirement or recommendation to stay at home and the fear of contracting COVID-19 also likely continued to deter individuals from seeking healthcare services, including dental visits. **LIBERTY** also reported that the COVID-19 PHE limited school and community-based screening activities and affected the dental delivery system's capacity.

Recommendation: HSAG recommends **LIBERTY** continue its efforts to identify underutilization of dental services among Medicaid and Nevada Check Up members, including any disparities within these populations, and target outreach efforts, education, school-based services, and member and provider incentive programs when and where appropriate. As part of these efforts, **LIBERTY** should regularly evaluate whether the interventions and initiatives are successful, and make revisions as necessary, to support continued improvement in the prevalence of members seeking preventive dental care.

Compliance Review

Performance Results

Table 4-13 presents **LIBERTY**'s compliance review scores for each standard evaluated during the current three-year compliance review cycle. **LIBERTY** was required to submit a CAP for all reviewed standards scoring less than 100 percent compliant. **LIBERTY**'s implementation of the plans of action under each CAP will be assessed during the third year of the three-year compliance review cycle, and a reassessment of compliance will be determined for each standard not meeting the 100 percent compliance threshold.

Table 4-13—Standard Compliance Scores for LIBERTY

Compliance Review Standard	Associated Federal Citations[1]	Compliance Score
Mandatory Standards		
Year One (SFY 2021)		
Standard I—Disenrollment: Requirements and Limitations	§438.56	**100%**
Standard II—Member Rights and Member Information	§438.10 §438.100	**94%**
Standard III—Emergency and Poststabilization Services	§438.114	**100%**
Standard IV—Availability of Services	§438.206	**100%**
Standard V—Assurances of Adequate Capacity and Services	§438.207	**100%**
Standard VI—Coordination and Continuity of Care	§438.208	**73%**
Standard VII—Coverage and Authorization of Services	§438.210	**80%**

Compliance Review Standard	Associated Federal Citations[1]	Compliance Score
Mandatory Standards		
Year Two (SFY 2022)		
Standard VIII—Provider Selection	§438.214	**100%**
Standard IX—Confidentiality	§438.224	**100%**
Standard X—Grievance and Appeal Systems	§438.228	**92%**
Standard XI—Subcontractual Relationships and Delegation	§438.230	**100%**
Standard XII—Practice Guidelines	§438.236	**100%**
Standard XIII—Health Information Systems[2]	§438.242	**83%**
Standard XIV—Quality Assessment and Performance Improvement Program	§438.330	**100%**
Year Three (SFY 2023)		
Review of PAHP implementation of Year One and Year Two CAPs		

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

[2] The Health Information Systems standard includes an assessment of the PAHP's IS capabilities.

Table 4-14 presents **LIBERTY**'s scores for each standard evaluated during the SFY 2022 Compliance Review activity. 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. The SFY 2022 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 4-14—SFY 2022 Standard Compliance Scores for LIBERTY

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard VIII—Provider Selection	12	10	10	0	2	**100%**
Standard IX—Confidentiality	11	11	11	0	0	**100%**
Standard X—Grievance and Appeal Systems	38	38	35	3	0	**92%**
Standard XI—Subcontractual Relationships and Delegation	7	7	7	0	0	**100%**
Standard XII—Practice Guidelines	8	8	8	0	0	**100%**
Standard XIII—Health Information Systems[1]	12	12	10	2	0	**83%**

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard XIV—Quality Assessment and Performance Improvement Program	27	24	24	0	3	**100%**
Total	**115**	**110**	**105**	**5**	**5**	**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.

[1] The Health Information Systems standard included an assessment of the PAHP's IS capabilities.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: LIBERTY achieved full compliance for the Provider Selection program area, demonstrating that the PAHP had appropriate and thorough credentialing and recredentialing policies, procedures, and practices in place for the selection and retention of network providers, which also support that contracted providers met the requirements and standards for participating in the PAHP's provider network. [**Quality**, **Timeliness**, and **Access]**

Strength #2: LIBERTY achieved full compliance for the Confidentiality program area, demonstrating that the PAHP had appropriate policies and processes for the use and disclosure of members' PHI and members' privacy rights, and provided required notices related to privacy practices. [**Quality**]

Strength #3: LIBERTY achieved full compliance for the Subcontractual Relationships and Delegation program area, demonstrating that the PAHP had appropriate subcontracts in place and had adequate oversight and monitoring processes to ensure its delegates were meeting their contractual obligations. [**Quality**]

Strength #4: LIBERTY achieved full compliance for the Practice Guidelines program area, demonstrating that the PAHP adopted evidence-based practice guidelines, disseminated its practice guidelines to all affected providers, and rendered utilization management and coverage of services decisions consistent with its practice guidelines. [**Quality** and **Access**]

Strength #5: LIBERTY achieved full compliance for the Quality Assessment and Performance Improvement Program area, demonstrating that the PAHP established and maintained an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its members that addresses availability, accessibility, coordination, and continuity of care of services through detailed program objectives, performance measures, and monitoring of outcomes. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any substantial weaknesses for **LIBERTY** as no program area scored at or below 80 percent compliance.

Why the weakness exists: As no weaknesses were identified, this section is not applicable.

Recommendation: As all remediation plans were successfully on track for implementation, this section is not applicable.

Network Adequacy Validation

Performance Results

Table 4-15 presents **LIBERTY**'s network capacity analysis results and compares the provider ratios to the standards displayed in Table 4-4. Assessed provider ratios shown in green indicate the provider ratio was in compliance with the access standard, whereas provider ratios shown in red indicate the provider ratio was not in compliance with the access standard.

Table 4-15—Summary of Ratio Analysis Results for Dental Care Providers for LIBERTY

Provider Category	Providers*	Clark County Ratio	Washoe County Ratio	Statewide Ratio**
Dental Primary Care Providers (1:1,500)	450	1:1,308	1:173	1:1,482
Dental Specialists (1:1,500)	36	1:9,189	1:1,193	1:10,403

Note: results shown in green font indicate the result complies with the access standard; results shown in red font indicate the result does not comply with the access standard.

* Providers contracted statewide and contracted providers located in the Nevada Medicaid catchment areas were included in provider counts.

** Statewide ratio incorporates all Nevada counties included in the DHCFP member file submission and members enrolled with the PAHP as of March 1, 2022.

Table 4-16 presents **LIBERTY**'s geographic network distribution analysis and compares the percentage of members within the access standard compared to the standards displayed in Table 4-5. Assessed results shown in green indicate that the percentage of members within the access standard was in compliance, and percentages shown in red indicate a result of less than 99.0 percent.

Table 4-16—Percentage of Members Residing Within the Access Standard Areas for LIBERTY

Provider Category	Clark County	Washoe County	Statewide*
General Dental Providers			
General Dentist (20 miles/30 mins)	>99.9%	99.9%	99.9%
Dentist, Pediatric (20 miles/30 mins)	>99.9%	99.9%	>99.9%
Mid-Level Dental Providers			
Dental Therapist (20 miles/30 mins)	NA	NA	NA
Public Health Endorsed Dental Hygienist (20 miles/30 mins)	99.4%	0.0%	87.8%
Dental Specialists			
Endodontist (20 miles/30 mins)	>99.9%	99.8%	99.8%
Oral Surgeon (20 miles/30 mins)	>99.9%	99.7%	99.8%
Periodontist (20 miles/30 mins)	99.5%	99.7%	99.4%
Prosthodontist (20 miles/30 mins)	99.5%	0.0%	87.9%

Note: results shown in green font indicate the result complies with the access standard; results shown in red font indicate that less than 99.0 percent of members had access to the provider within the time and distance access standard.
NA (Not Applicable) indicates the PAHP did not report providers for the provider category.
* Statewide results incorporate all Nevada counties included in the DHCFP member file submission and members enrolled with the PAHP as of March 1, 2022.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: LIBERTY met the provider ratio requirements for Dental Primary Care Providers, indicating **LIBERTY** had a sufficient provider network for its members to access these services. **[Access]**

Weaknesses and Recommendations

Weakness #1: LIBERTY did not meet the provider ratio requirements for dental specialists, indicating **LIBERTY** may not have a sufficient provider network for its members to access these services. **[Access]**

Why the weakness exists: 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** also reported there are a low number of dental specialists in the state of Nevada and, among those, a reluctance to participate in the Nevada Managed Care Program.

Recommendation: HSAG recommends **LIBERTY** 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 PAHP to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area. **LIBERTY** should continue using DHCFP's monthly provider list to identify new specialty dental providers and, subsequently, outreach and try to recruit those specialists in Clark and Washoe counties.

Weakness #2: LIBERTY did not meet the time-distance contract standards for Public Health Endorsed Dental Hygienist or Prosthodontist, indicating members may experience challenges accessing these provider types within an adequate time or distance from their residence. **[Access]**

Why the weakness exists: The lack of identified providers may result from a lack of available providers in these specialties or from an inability to identify those providers in the data, due to data mapping and/or data submission issues. **LIBERTY** reported there are a low number of dental specialists overall in the state of Nevada; however, the PAHP further indicated that it is currently contracted with all prosthodontists with a Medicaid ID in Washoe and Clark counties.

Recommendation: HSAG recommends **LIBERTY** 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 PAHP to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area. To mitigate access issues, **LIBERTY** should continue its efforts to provide out-of-network providers to serve members when specialty services are not available from a contracted provider near the members' homes.

Member Satisfaction Survey

Performance Results

Table 4-17 and Table 4-18 present **LIBERTY**'s SFY 2022 survey results as provided by **LIBERTY** to DHCFP.

Table 4-17—Member Satisfaction Survey Results for LIBERTY—Metrics

Metric	June 2021–May 2022	Benchmark
# Members Reached	724	
# Members Satisfied	575	
% Members Satisfied	93.5%	≥ 90%

Table 4-18—Member Satisfaction Survey Results for LIBERTY—Category

Category	June 2021–May 2022	Benchmark
Appointment Availability	92.4%	≥ 90%
Wait Time	95.9%	≥ 90%
Appearance and Cleanliness	97.8%	≥ 90%
Language Availability	100%	≥ 90%
Staff Professionalism	94.1%	≥ 90%
Amount of Time With Doctor	95.4%	≥ 90%
Treatment Explanation	93.5%	≥ 90%
Treatment	92.5%	≥ 90%
Recommend Office	89.3%	≥ 90%
Overall Satisfaction	93.5%	≥ 90%
Overall Health of Teeth and Gums	94.2%	

Indicates a benchmark was not applicable or was not established.

Indicates the category met or exceeded the benchmark.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: LIBERTY exceeded the 90 percent benchmark in nine 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 16,655 members, only 4.3 percent of those members were successfully reached (724 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: Members may not be answering the calls since the call number is unknown. Additionally, **LIBERTY** reported that the inaccuracy of members' contact information is a barrier to communicating with Nevada Managed Care Program members.

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

Weakness #2: LIBERTY did not meet the 90 percent benchmark for Recommend Office. **[Quality, Access,** and **Timeliness]**

Why the weakness exists: Members may have had negative experiences with their dental providers or the dental offices that may be related to one of the other nine categories with a benchmark, assessed through the Member Satisfaction Survey.

Recommendation: HSAG recommends that **LIBERTY** perform a root cause analysis to determine if any outliers were identified within the data, especially as it pertains to certain dental offices; identify primary areas of focus; and develop appropriate strategies to improve the performance. Additionally, HSAG recommends **LIBERTY** continue to forward any identified trends in members' negative experiences to Provider Relations for counseling, widely promote these results with its contracted dental providers and staff members, and solicit feedback and recommendations to improve members' overall satisfaction with both **LIBERTY** and its contracted dental providers.

Encounter Data Validation

Performance Results

Information Systems Review

The IS review component of the EDV study provided self-reported qualitative information from **LIBERTY** for which HSAG conducted an IS review regarding the encounter data processes related to collection, processing, and transmission of encounter data to DHCFP.

Based on contractual requirements and DHCFP's data submission requirements (e.g., companion guides), **LIBERTY** demonstrated its capability to collect, process, and transmit encounter data to DHCFP, as well as develop data review and correction processes that can respond to quality issues identified by DHCFP.

Comparative Analysis

Table 4-19 displays the percentage of records present in the files submitted by **LIBERTY** that were not found in DHCFP's files (record omission) and the percentage of records present in DHCFP's files but not present in the files submitted by **LIBERTY** (record surplus). Lower rates indicate better performance for both record omission and record surplus.

Table 4-19—Record Omission and Surplus by Encounter Type for LIBERTY

Encounter Data Source	Record Omission	Record Surplus
Dental	1.8%	1.0%

Table 4-20 display the element omission, surplus, and accuracy results for each key data element by dental encounter for **LIBERTY**. For the element omission and surplus indicators, lower rates indicate better performance for both record omission and record surplus.

Table 4-20—Element Omission, Surplus, and Accuracy—Dental Encounters for LIBERTY

Key Data Element	Element Omission	Element Surplus	Element Accuracy
Recipient ID	0.0%	0.0%	>99.9%
Header Service From Date	0.0%	0.0%	>99.9%
Header Service To Date	0.0%	0.0%	>99.9%
Detail Service From Date	0.0%	0.0%	>99.9%
Detail Service To Date	0.5%	0.0%	>99.9%
Billing Provider NPI	5.2%	0.0%	97.6%
Rendering Provider NPI	0.3%	0.0%	>99.9%
Procedure Code (CPT/HCPCS/CDT)	<0.1%	0.0%	>99.9%
Tooth Number	<0.1%	<0.1%	>99.9%

Key Data Element	Element Omission	Element Surplus	Element Accuracy
Oral Cavity Code	<0.1%	<0.1%	98.7%
Tooth Surface 1	<0.1%	<0.1%	100%
Tooth Surface 2	<0.1%	0.0%	>99.9%
Tooth Surface 3	<0.1%	0.0%	100%
Tooth Surface 4	<0.1%	<0.1%	100%
Tooth Surface 5	<0.1%	0.0%	100%
Header Paid Amount	0.0%	0.0%	99.5%
Detail Paid Amount	0.0%	0.0%	99.7%

Table 4-21 displays the all-element accuracy results for the percentage of records present in both data sources with the same values (missing and non-missing) for all key data elements relevant to dental encounters data type for **LIBERTY**.

Table 4-21—All-Element Accuracy for Dental Encounters for LIBERTY

Indicator	Rate
All-Element Accuracy	91.4%

Dental Record Review

Table 4-22 presents the percentage of key data elements identified in the encounter data that were not supported by the members' dental records provided by **LIBERTY** (i.e., dental record omission) and the percentage of dates of service from the members' dental records that were not found in the encounter data provided by **LIBERTY** (i.e., encounter data omission). Lower rates for each data element indicate better performance.

Table 4-22 also displays the percentage of the procedure code data elements associated with validated dates of service from the encounter data that were correctly coded based on the members' dental records. Errors found in the procedure coding associated with the dental record reviews were only related to inaccurate coding. Higher accuracy rates for each data element indicate better performance.

Table 4-22—Dental Record Review: Encounter Data Completeness and Accuracy for LIBERTY

Data Element	Medical Record Omission[1]	Encounter Data Omission[2]	Element Accuracy[3]
Date of Service	4.3%	4.7%	—
Procedure Code	11.0%	23.5%	88.6%
All-Element Accuracy[4]			19.0%

— Indicates that the accuracy rate analysis was not applicable to a given data element.
[1] Services documented in the encounter data but not supported by the members' dental records. Lower rate values indicate better performance.
[2] Services documented in the members' dental records but not in the encounter data. Lower rate values indicate better performance.

[3] Services documented in the members' dental records associated with validated dates of service from the encounter data that were correctly coded based on the dental records. Higher rate values indicate better performance.

[4] The all-element accuracy rate describes the percentage of dates of service present in both DHCFP's encounter data and in the dental records with *Procedure Code* data elements coded correctly (i.e., not omitted from the dental record; not omitted from the encounter data; and, when populated, have the same values). As such, the gray cells indicate the evaluation for dental record omission or encounter data omission is not applicable.

Strengths, Weaknesses, and Recommendations

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

Strengths

Strength #1: LIBERTY demonstrated its capability to collect, process, and transmit encounter data to DHCFP, as well as develop data review and correction processes that can promptly respond to quality issues identified by DHCFP. **[Quality and Timeliness]**

Strength #2: LIBERTY's dental encounter data appeared complete when comparing data extracted from **LIBERTY**'s claims system to data extracted from DHCFP's data warehouse. Encounter data records from DHCFP-submitted files were highly corroborated in **LIBERTY**-submitted files. **[Quality]**

Strength #3: Data element comparison between the data extracted from **LIBERTY**'s claims systems and data extracted from DHCFP's data warehouse also showed complete and accurate data. **[Quality]**

Weaknesses and Recommendations

Weakness #1: Dental procedure codes documented in the dental records were either not found in the encounter data or were found in the encounter data but should have been coded with a different procedure code. **[Quality]**

Why the weakness exists: While discrepancies may have been due to dental record non-submission, other reasons may also had contributed to the discrepancies. Some of the potential reasons include: (1) the provider did not document the services performed in the medical record, and (2) the provider did not provide the service(s) found in the encounter data.

Recommendation: LIBERTY should consider performing periodic dental record reviews of submitted claims to verify appropriate coding and data completeness. Any findings from these reviews should then be shared with providers through periodic education and training regarding encounter data submissions, dental record documentation, and coding practices.

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

HSAG performed a comprehensive assessment of **LIBERTY**'s aggregated performance and its overall strengths and weaknesses related to the provision of dental services to identify common themes within **LIBERTY** that impacted, or will have the likelihood to impact, member dental health outcomes. HSAG also considered how **LIBERTY**'s overall performance contributed to the Nevada Managed Care Program's progress in achieving the Quality Strategy goals and objectives. Table 4-23 displays each applicable performance area and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to **LIBERTY**'s Medicaid and Nevada Check Up members.

Table 4-23—Overall Performance Impact Related to Quality, Timeliness, and Access

Performance Area	Overall Performance Impact
Use of Preventive Services	**Quality, Timeliness,** and **Access**—Over the past three-year period, the PMV rates have demonstrated a fluctuation in the percentage of **LIBERTY**'s members (ages 1 to 20 years) accessing preventive dental services, although an increase of 3.74 percentage points was shown in the rate comparison between 2021 and 2022. While the SMART Aim goal was not attained for the *Total of Eligible Enrollees Who Received Preventive Dental Services* PIP, there was nearly a 7 percentage point increase from the baseline rate, indicating interventions were effective for educating parents/caregivers on the importance of preventive dental care, appointment scheduling, and accessing dental benefits. **LIBERTY** demonstrated through the compliance review activity that it has strong practices for ensuring its providers are aware of its adopted practice guidelines, which should include guidelines for preventive care, and **LIBERTY** appeared to have a sufficient number of dental primary care providers to deliver services as indicated through the NAV activity. Through the Member Satisfaction Survey activity, **LIBERTY** exceeded the 90 percent benchmark for the Appointment Availability and Wait Time categories, indicating that, overall, members surveyed were satisfied with access to their dental providers and the dental offices.
Increase Utilization of Dental Services	**Quality, Timeliness,** and **Access**—For Nevada Medicaid, the PMV rates increased from 2021 to 2022 for all age groups and in total for the *Annual Dental Visit* (*ADV*) measure, and rates for the *Ages 2–3 Years*, *Ages 7–10 Years*, and *Ages 11–14 Years* measure indicators ranked above NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile benchmarks, indicating these members appear to have access to and utilize necessary dental services to maintain oral health and reduce the risk of future oral disease. **LIBERTY**'s 2022 PMV rates for all measure indicators ranked above NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile for Nevada Check Up, also indicating Nevada Check Up members had access to and utilized necessary dental services.

5. Follow-Up on Prior EQR Recommendations for MCOs

From the findings of each MCO's performance for the SFY 2021 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 2021 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 either completed, or were implemented and still underway, to improve the finding that resulted in the recommendation, and as applicable, identified performance improvement, and/or barriers identified are also provided in Table 5-1, Table 5-2, 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: • **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. • **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.
MCE's Response
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 the testing periods and consulted internally with the data analytics team to identify future intervention testing periods. The cadence of the meetings was modified to allow for discussion of data needs. The quality management team encountered challenges in the 2021 testing period as Covid restrictions were in place. The restrictions resulted in delayed implementation of interventions for both providers and vendors. Provider-facing care delivery consultants were asked to facilitate and increase provider engagement in deliverables and intervention activities. The Provider RACI (Responsible, Accountable, Consulted, Informed) document was modified to include performance improvement projects for the care delivery transformation team as a 'responsible' task in this process for communication and education on interventions to the providers. • Anthem uses both process mapping and failure mode and effects analysis (FMEA) to drive interventions assessed during performance improvement projects. The State has issued an EQRO Rapid Cycle Intervention methodology; the process allows for one intervention assessed at a time. The Process Improvement Team will implement shorter testing periods to increase the possible number of interventions assessed.

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Implementation of shorter testing periods and collaboration with provider consultants improved communication with providers over the course of the PIP. The providers participating were held accountable for deliverables contributing to the success of the initiative during the PIP process. • Provider consultant collaboration will be integrated into the new 2022-2025 PIP process as well as other lessons learned from the prior PIP cycles.
c. Identify any barriers to implementing initiatives: • The annual submissions of validated and non-validated PIPs for 2022-2025 have changed from prior RCI PIP process; the PIP team will implement all recommendations in the new PIP process.
HSAG Assessment: HSAG has determined that **Anthem** addressed the prior year's recommendations.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures
HSAG recommended the following: • **Anthem** should 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, **Anthem** should work with its members to increase the use of telehealth services, when appropriate. • **Anthem** should 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. • **Anthem** should 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. • **Anthem** should 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. • **Anthem** should 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.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures
MCE's Response
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)***: • Telehealth services are advertised in Provider Newsletters and provider education material as a result of continued COVID impact on members accessing preventative and ambulatory services. • A root cause analysis was performed for Mammography. Radiology desert areas were identified. An intervention is in the planning stages based on the success of the same type of event hosted in 2021. • All of Anthem's HEDIS member level detail data includes the member's demographic information including race/ethnicity, age, and zip code to identify disparities and is routinely used to conduct root cause analysis in all HEDIS performance measures during informal workgroup meetings within quality. Anthem's quality department additionally collaborates and meets on a monthly basis with the Health Equity and Whole Health Population workgroups to further perform social determinants of health (SDOH) root cause analysis to create interventions aimed and reducing SDOH barriers to increase members accessing preventative and ambulatory services such as upon identification of decreasing telehealth trends in claims data by Anthem increasing member and provider awareness of telehealth usage and HEDIS measure compliance through member and provider education. Using this same framework Anthem piloted Telehealth Kits to increase preventative screenings and managing chronic conditions such as controlling high blood pressure and diabetes, developing Flu campaigns, creating, and scheduling events to offer mammograms, and implementing Diabetic retinal eye cameras with provider offices. • In addition to partnering with our corporate enterprise teams on HEDIS strategies to reduce gaps in care and improve member outcomes, Anthem's quality department, health equity and whole health strategy continue to meet monthly and ad hoc to analyze identified HEDIS measure data and identify trends to drive intervention ideation within these workgroups. • HEDIS member level detail data including race/ethnicity, age and demographic information is also shared with Anthem providers to conduct outreach and work to reduce member gaps in care to improve health outcomes while improving provider quality metrics.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Anthem's process of performing root cause analysis and using data to identify disparities to drive initiatives allows for more targeted approach to measure improvement, analysis is ongoing for 2022.
c. Identify any barriers to implementing initiatives: • The 2022 state mandated member redistribution may have caused delays or confusion in the members accessing preventative or ambulatory services, Anthem continues to outreach members to schedule preventative and ambulatory service appointments.
HSAG Assessment: HSAG has determined that **Anthem** addressed the prior year's recommendations; however, since similar findings were noted in SFY 2022, the MCO should continue its existing efforts and implement additional interventions to address the continued low performance.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
HSAG recommended the following: • 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.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
MCE's Response
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 updates our policies and procedures on an annual basis with the exception of new contract amendments, legislation updates, and proactive procedure change updates which can occur prior to the yearly review. When any of these for-mentioned items occur, it triggers a review of our processes and procedures by the health plan and our compliance team. During these reviews Anthem will ensure that not only the contract updates are incorporated into our policies and procedures, but we will also be doing a review of the Code of Federal Regulation (CFR), Nevada Administrative Code (NAC) and Nevada Revised Statue (NRS) alongside the policies and procedures update congruently to capture all updates. Applicable sources will be cited for reference in our policy documents to ensure these items can be continuously reviewed, checked, and updated as needed upon each update to a policy and procedure. The federal and state resources have also been linked to our internal compliance page for all business areas within the health plan to access for research and review as needed. Compliance has also shared the CFR link and our internal compliance page link with the health plan for review and encourages the team to outreach if there are question surrounding these regulations as they can be reviewed collaboratively between legal, compliance and the health plan. Any updates captured will be shared through our compliance 360 tool and further discussed in our quarterly compliance meeting. Updates will be shared collaboratively between our compliance and/or government relations leads with the team.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A, this will be a monitoring and sharing of information process to ensure requirements remain up to date with state and federal obligations.
c. Identify any barriers to implementing initiatives: • No barriers identified.
HSAG Assessment: HSAG has determined that **Anthem** addressed the prior year's recommendations.

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation
HSAG recommended the following: • **Anthem** should 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.
MCE's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Anthem has implemented a process for conducting an in-depth review of provider categories in which it did not meet the time-distance contract standards. Upon completion of each quarterly report a full review of the gaps is conducted. Each gap is broken down by county, zip code and specialty. The contracting team utilizes the most recent DHCFP Monthly Active Provider Report, along with Google and team knowledge to identify providers to target for gap closures. Over the past year Anthem has successfully closed many gaps however the process implemented is manual. The contracting team has recently engaged the Anthem network strategy team, along with our IT reporting team to assist in the

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation
implementation of a less manual process which will allow them to identify targeted providers more quickly.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Anthem was able to close a number of gaps in the Mesquite, Logandale, Overton area by adding Mesa View Regional Hospital and its affiliated medical group. Those gap closures will be visible in the Q3 2022 report. Anthem was also able to reduce the gap in Washoe County in the Pediatric category.
c. Identify any barriers to implementing initiatives: • Anthem has not experienced any barriers to implementing these initiatives and is continuing to refine its approach to most accurately identify providers that may close gaps and/or document the zip codes/specialty combinations where the provider community may be deficient.
HSAG Assessment: HSAG has determined that **Anthem** addressed the prior year's recommendations; however, since similar findings were noted in SFY 2022, the MCO 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 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 recommended 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.
MCE's Response
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): • Promotion of results: Anthem issued an article to providers with the CAHPS results; information included a request for input from across the Nevada network. • An additional email was sent to internal associates regarding participation in the CAHPS work group. • CSS [survey vendor] administered the Child Medicaid with CCC Measure version of the CAHPS Health Plan Survey on behalf of Anthem between February 20 and May 13, 2021. During the survey fielding period, 502 general population sample members completed the survey. After final survey eligibility criteria were applied, the resulting NCQA response rate was 14.31 percent. Adult Survey: final sample included 2,430 members. During the survey fielding period, 207 sample members completed the survey. After final survey eligibility criteria were applied, the resulting NCQA response rate was 8.59 percent • A Western Region CAHPS Work Group was implemented to develop interventions based on root cause analysis. In 2021, a reorganization was completed, and the work group was discontinued in Q3. • The workgroup developed a number of interventions across the Western Region • Review/update CAHPS Tips pages based on annual CAHPS performance (customizable to each HP[health plan]) • CAHPS data was included in HEDIS Coding Booklets

5. Prior Year Recommendation from the EQR Technical Report for CAHPS Analysis
• 10/29/2020- combined presentation from MRT [unknown acronym] review on WRWG [unknown acronym] and sent out for each plan to provide approval. 11/6/20 Approvals received, sent to MRT for west region • Provider Engagement: CME [unknown acronym] promotion ran article in August, September, October newsletters. • Refresh file to HealthCrowd; Planned for 2021, texting campaigns are ongoing • Mammorama October 2021, scheduled for 10/2022; the event includes flu and Covid vaccine administration. Overflow members provided contact information and were scheduled by community outreach associates • Anthem members are historically difficult to contact due to the transient nature of the population served. Members are contacted via texting campaigns through the Sydney Health application or HealthCrowd text campaigns. Members are able to opt out of Anthem messaging which provides a variety of information impacting health measures. Sydney Health provides plan information that is easy to navigate.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Child Population: Rating of All Health Care 78.08% vs. 73.60% [+4.48 points] • Adult Population: Satisfaction with Plan Services 61.34% vs. 59.20% [+2.14 points]
c. Identify any barriers to implementing initiatives: • COVID impacted 2020 and 2021 survey completion as evidenced by the low response rates for both the adult and child surveys. Completing a survey may have been exceptionally low on the list of priorities for individuals struggling with Covid, unemployment and other life-changing events. • Nevada state was in full lockdown for much of 2020 with partial opening in 2021. The mask mandate was lifted in March of 2022. Full member engagement activities which would raise awareness of the plan and its benefits was on hiatus until the end of Q1 2022. • For much of 2020 and 2021 provider-facing services were unable to complete on-site visits due to Covid precautions. During provider visits, the representatives engage with the physician and staff, reminding each of the importance of the CAHPS survey. Provider Newsletter Update sent July 2021.
HSAG Assessment: HSAG has determined that **Anthem** addressed the prior year's recommendations.

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: • **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. • **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.
MCE's Response
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) agrees with HSAG recommendations and will shorten the testing periods and modify interventions as needed. The testing period will be shortened by reviewing and analyzing data on a monthly cadence. In addition, HPN will test a minimum of three interventions in the upcoming Performance Improvement Project (PIP) cycle.
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: • No notable performance improvements have resulted.
HSAG Assessment: HSAG has determined that **HPN** addressed the prior year's recommendations.
2. Prior Year Recommendation from the EQR Technical Report for Performance Measures
HSAG recommended the following: • **HPN** should 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. • **HPN** should 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. • **HPN** should 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.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures
MCE's Response
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/metrics and subsequent interventions: – Adults' Access to Preventive/Ambulatory Health Services (AAP)– total: Activities currently underway include the implementation of Value Based Contracts (VBCs) that include AAP in the performance metrics, and member outreach activities. – Child and Adolescent Well-Care Visit (WCV): Implemented a member incentive program that rewards members for the completion of well child visits. – Hemoglobin A1c Control for Patients with Diabetes (HBD): Updated the provider Gap in Care (GIC) reports to identify members who are not adherent to diabetes medication. – HPN conducted a root cause analysis 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 and identified the top four non-compliant zip codes. Consequently, HPN initiated new provider contracts in the four low performing zip codes.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • AAP total: Year over Year (YOY) improvement of 2.92% is currently noted. • WCV: Improved by 1.66% from 2020 to 2021. • HBD: Improved by 1.46% from 2020 to 2021. • BH Access: Improved performance in targeted zip codes has yet to be determined. HPN Behavioral Health team plans to review performance metrics during Q4 of 2022.
c. Identify any barriers to implementing initiatives: • HPN did not identify any barriers to implement the aforementioned initiatives.
HSAG Assessment: HSAG has determined that **HPN** addressed the prior year's recommendations.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
HSAG recommended the following: • 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.
MCE's Response
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 continually evaluates its processes, procedures and monitoring efforts to ensure compliance with federal and state obligations.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A
c. Identify any barriers to implementing initiatives: • HPN did not identify any barriers to implement the aforementioned initiatives.
HSAG Assessment: HSAG has determined that **HPN** addressed the prior year's recommendations.

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation
HSAG recommended the following: • **HPN** should 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.
MCE's Response
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 continually reviews its Medicaid network to ensure time, distance, access and availability standards are met through geo access reporting, secret shopper and provider ratio reviews. We also opened up closed panels and recruited additional providers in areas where we had deficiencies or felt our ratios were low. • In areas where there are a lack of providers, such as with Pediatric Rheumatologists in Washoe County, we have established provider contracts as close as possible, either in Las Vegas or in nearby States. We review the DHCFP's monthly enrolled provider list to determine if new providers are available for outreach. • One last initiative was to expand the option for Telehealth.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • An increased network size and increased utilization of Telehealth has provided additional opportunities for our members to be seen by providers.
c. Identify any barriers to implementing initiatives: • Lack of specialty providers in Nevada as a whole is an ongoing barrier.
HSAG Assessment: HSAG has determined that **HPN** addressed the prior year's recommendations; however, since similar findings were noted in SFY 2022, the MCO 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: • **HPN** should 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. • **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
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 improve the experience with specialist by: – Conducting specialty provider education during quarterly meetings. – Evaluating quarterly member satisfaction surveys relevant to specialty providers.

5. Prior Year Recommendation from the EQR Technical Report for CAHPS Analysis
• 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. – Educating providers on Chantix medication changes.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Rating of Specialist measure increased in all CAHPS surveys by more than 5%.
c. Identify any barriers to implementing initiatives: • HPN did not identify any barriers to implement the aforementioned initiatives.
HSAG Assessment: HSAG has determined that **HPN** addressed the prior year's recommendations.

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 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. • **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.
MCE's Response
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 July 2022, we were provided with a new process for our Performance Improvement Projects (PIPs). We will ensure shorter testing periods are applied based on the new process. Prior to July, as we awaited the new PIPs, we continued to discuss and develop processes to ensure shorter testing periods are established. We also plan on implementing testing of more than one intervention during the intervention testing phase of the PIP.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Not Applicable
c. Identify any barriers to implementing initiatives: • Not Applicable
HSAG Assessment: HSAG has determined that **SilverSummit** addressed the prior year's recommendations.
2. Prior Year Recommendation from the EQR Technical Report for Performance Measures
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 performance related to the Access to Care domain. If COVID-19 was a factor, **SilverSummit** should work with its members to increase the use of telehealth services, when appropriate. • **SilverSummit** should 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. • **SilverSummit** should 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

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures
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. • **SilverSummit** should 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.
MCE's Response
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)***: • A root cause analysis was performed, and we determined there were issues related to the pandemic resulting in provider office closures, restricted hours, and provider staffing issues impacting their ability to see members. In addition, lack of office staff to conduct outreach to and/or see the members, and members' fear of contracting COVID while in provider offices were also factors. Initiatives undertaken included: – Promoting and encouraging telehealth services, such as our platform, Babylon, which is available for appointments 24/7 – Providing a local Federally Qualified Health Center (FQHC) a telehealth grant to improve and increase telehealth capabilities – Promoting telehealth availability on social media – Education to providers during provider visits and/or Joint Operation Committee meetings – Member outreach through newsletters, flyers, and on our website • In addition, we have started conducting disparity reports to target zip codes in Clark and Washoe Counties. The data indicates decreased utilization of services prompting further evaluation of network adequacy and any Social Determinants of Health affecting access to care, such as transportation. • Along with the initiatives described above, activities for members with schizophrenia or bipolar disorder (not being screened for diabetes), also included a promotion of member letters encouraging them to visit their providers, behavioral health telehealth services promotion and Summit Behavioral Health outreach with same day appointment availability. • For children not receiving all recommended vaccines, we identified an overall hesitancy for vaccinations during the period they were not attending school in person, including a delay by parents in getting vaccinations. Along with the activities described above, a disparity analysis was performed, and we identified a disparity in our Latino membership with obtaining vaccinations. Particular zip codes with higher gaps were noted. We have implemented an intervention in these identified zip codes, Project Neighborhood Health, which promotes screenings and the ability to get vaccinations within their neighborhood, partnering with Immunize Nevada to provide vaccinations. • We performed the same activities described in #1 for our diabetic members to help increase HbA1c testing and retinal eye exams, as well as improve HbA1c levels. In addition, narrowing the network for optometrist with performance standards for retinal eye exams and member outreach to close the gap, was also performed. We also engaged a vendor to mail HbA1c test kits to Medicaid members and have arranged for Eye Care to perform eye exams at certain health fair events.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • We have continued to see significant use of telehealth services, but for the other initiatives, it is too soon for the data to show any improvements.
c. Identify any barriers to implementing initiatives: • One barrier has been the inability to obtain correct member demographic and contact information. We have also encountered excessive heat warnings during some of the events, possibly decreasing attendance.
HSAG Assessment: HSAG has determined that **SilverSummit** addressed the prior year's recommendations.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
HSAG recommended the following: • 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. • 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. • 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.
MCE's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • SilverSummit selected to implement corrective action plans for each of the care management process recommendations provided by HSAG. The process for conducting new member initial screening was revised to include three phone attempts over a period of 90 days (for 2021) and now, over a period of 60 days (as of 2022, in accordance with the new contract). In addition to the phone attempts, a postcard is mailed to the member's home address after the second phone attempt. These changes now ensure that outreach efforts are performed throughout the required timeframe the Healthplan has to complete the screening. This remains a current practice. • The process for informing members and their providers that they have been enrolled into care management includes the mailing of the welcome letter. It was previously noted that the letter did not allow for the care manager to include their name and contact information. The letter was updated in the documentation system and now allows for each care manager to include their contact information for both the member and their provider. Additional staff training was also provided to ensure that every member enrolled into case management receives the welcome letter. Ongoing random audits are conducted for compliance and continue to date, with favorable results. • The process for including the member and the member's primary care physician (PCP) involvement in the careplan, was noted to be inconsistent. The process was revised so all members enrolled in care management will have a copy of their careplan mailed to both them and their PCP, and include the contact information for the respective care manager. Ongoing random audits are conducted for

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
compliance and continue to date. Results have been favorable. The process for including specific information on the careplan, such as the primary medical diagnosis, psychological and community support needs and individualized interventions was also found to be inconsistent. Additional staff training took place to emphasize that each careplan needs to include these elements and be member centric. Ongoing random audits are conducted for compliance and continue to date. Results have shown an improvement. • Additionally, the process to continuously monitor the member's progress and reevaluate their care needs was found to be inconsistent and was revised. Retraining took place to ensure the care managers conduct follow-up calls with their members in a timely manner (based on the member's acuity level) and that each attempt, whether successful or not, is documented accordingly and speaks to the reevaluation component. This will also help to close any gaps in care. Ongoing random audits are conducted for compliance and continue to date, with positive results.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • There has been noted performance improvement for each of the findings as described above. The process for conducting the outreach attempts for the new member initial screening is now 100% compliant. Audits are conducted on random case files for each individual care manager. The Healthplan is currently aggregating data regarding the components for the care management files which will be reviewed for performance improvement on a quarterly basis.
c. Identify any barriers to implementing initiatives: • Incomplete or inaccurate member information continues to be a barrier to completing the actual new member screenings. The physician's involvement with developing the member's plan of care is also challenging and often times results with unsuccessful participation. The care managers continue to mail the careplans and continue to attempt outreach despite this barrier. Lastly, a barrier still exists with the members and their participation with care management, especially during follow-up outreach for continuous monitoring, at which time, the members are often not available or do not return calls. The care managers continue to conduct outreach attempts despite this barrier as well before final case closure.
HSAG Assessment: HSAG has determined that **SilverSummit** addressed the prior year's recommendations.

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation
HSAG recommended the following: • **SilverSummit** should 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.
MCE's Response
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)***: • Silver Summit Health Plan (SSHP) monitors the network on an ongoing basis. At least quarterly, the contracting team reviews the adequacy report to determine the root cause of members who do not have access to care. The following is determined. • If a member falls out of the time distance standard, SSHP reviews the state active file to determine if there is a provider enrolled in NV Medicaid that can fill this gap. o SSHP uses Geo Mapping to find the next available provider.

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation
○ If no provider available within the time and distance standards, SSHP has telehealth options and transportation available to assist the member in accessing care. ○ If there is a provider available, SSHP will outreach to the Medicaid enrolled provider and offer them a contract with SSHP. • Additionally, SSHP conducts and monitors Secret Shop reports monthly. The SSHP Provider Relations team outreaches to providers who are not meeting the access standards as set forth in their contract. A follow up letter is sent to the provider for documentation purposes.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Continuous monitoring of the network has improved overall adequacy for SSHP. Monthly reviews have resulted in additional outreach to Medicaid enrolled providers. These outreach activities have resulted in additional providers being added to the SSHP network across PCP and specialty types.
c. Identify any barriers to implementing initiatives: • Through our outreach efforts, SSHP has identified some Medicaid enrolled providers refusing to contract with MCO's. Our research has also found providers are struggling to maintain office staff, creating challenges in meeting access standards stated within the contracts.
HSAG Assessment: HSAG has determined that **SilverSummit** addressed the prior year's recommendations; however, since similar findings were noted in SFY 2022, the MCO 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: • **SilverSummit** should conduct a root cause analysis or focused study to determine why its members are not getting the care they need. **SilverSummit** t 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, **SilverSummit** should determine if there is a shortage of specialists in the area or an unwillingness of the specialists to contract with the MCO. • **SilverSummit** should 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. • **SilverSummit** should 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. • **SilverSummit** 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
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)***: • A root cause analysis was performed and we determined there were issues related to the pandemic resulting in provider office closures, restricted hours, and provider staffing issues impacting their

5. Prior Year Recommendation from the EQR Technical Report for CAHPS Analysis
ability to see members. In addition, lack of office staff to conduct outreach to and/or see the members, and members' fear of contracting COVID while in provider offices were also factors. Initiatives undertaken included: – Promoting and encouraging telehealth services, such as our platform, Babylon, which is available for appointments 24/7 – Providing a local FQHC a telehealth grant to improve and increase telehealth capabilities – Promoting telehealth availability on social media – Education to providers during provider visits and/or Joint Operation Committee meetings – Member outreach through newsletters, flyers and on our website In addition, we have started conducting disparity reports to target zip codes in Clark and Washoe Counties. The data indicates a decreased utilization of services prompting further evaluation of network adequacy and any Social Determinants of Health affecting access to care, such as transportation. The root cause analysis also showed a lack of a perinatologist or Maternal-Fetal Medicine Specialist in one of the Clark County zip code areas that have a concentrated number of SilverSummit members. The Provider Contracting team worked with a perinatologist to join our provider network thus increasing access to members with high-risk pregnancy within their zip code. • SilverSummit began conducting mock surveys, in off period, to obtain information on areas of opportunity for member satisfaction with the health plan and we are using this data to develop a member satisfaction work plan and focus group, to implement activities and address areas of opportunity. • From the mock survey analysis, member follow up calls (after calling member services), and analysis of grievance data, SilverSummit implemented several initiatives to help improve members' overall experience with the health plan. These initiatives include: – A member concierge program – Door to door visits by Community workers to members identified through case management, grievance data, and member services calls – A focused educational initiative promoting urgent care and engaging providers to offer after hours clinics. This also includes promotion on our website, educating providers to re-direct members to urgent care if they are booked or unable to give the member an appointment. • SilverSummit is developing a social media platform for promoting smoking cessation and available options to stop smoking, including medication assistance. Materials are also being developed for provider education around the available options for their patients concerning smoking cessation, including medication assistance.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • It is still too early to determine any performance improvement from these initiatives.
c. Identify any barriers to implementing initiatives: • Provider offices continue to be affected by the pandemic, making it difficult to provide education because they are either closed or have limited hours, and lack the human resources to receive the education. Incorrect member demographic and contact information has resulted in decreased ability to provide education to members, as well.
HSAG Assessment: HSAG has determined that **SilverSummit** addressed the prior year's recommendations.

6. Follow-Up on Prior EQR Recommendations for PAHP

From the findings of the PAHP performance for the SFY 2021 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 2021 External Quality Review Technical Report* are summarized in Table 6-1. The PAHP's summary of the activities that were either completed, or were implemented and still underway, to improve the finding that resulted in the recommendation, and as applicable, identified performance improvement, and/or barriers identified are also provided in Table 6-1.

LIBERTY Dental Plan of Nevada, Inc.

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

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects
HSAG recommended the following: • **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.
MCE's Response
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 successfully implemented two Performance Improvement Projects (PIPs) in SFY2022 to increase preventive services utilization in Nevada: increase the rate of sealant placement on a permanent molar tooth and increase utilization of preventive dental services among the Medicaid population. While only one intervention was tested for each PIP (a targeted intervention education campaign via text message outreach to families), LIBERTY implemented multiple interventions that were not part of the testing phase. These interventions included Member and Provider incentives, school-based education, and on-site screenings, fluoride and sealants. • With the assistance of the Division of Health Care Financing and Policy (DHCFP) and HSAG, LIBERTY is developing the SFY2023 PIPs starting in Q3 2022 to address maternal and infant health disparities that exist within the African American and Latino populations as well as increasing preventive services utilization for children ages 3 through 20 and decreasing emergency department visits for non-emergent dental services. LIBERTY will ensure to test more than one intervention for these PIPs as recommended.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Overall, 33% of the population received oral sealant treatment after outreach intervention, exceeding our SMART Aim goal, and LIBERY achieved a 14.4% increase in utilization, exceeding the average success rate of 5-10%.
c. Identify any barriers to implementing initiatives: • N/A
HSAG Assessment: HSAG has determined that **LIBERTY** addressed the prior year's recommendations.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures
HSAG recommended the following: • **LIBERTY** should 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.
MCE's Response
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 has undertaken a comprehensive, data-driven approach to identify under-utilization among our Nevada Medicaid and Check Up Members. LIBERTY's approach includes both Nevada community-specific analysis as well as input from our national Quality Management Improvement (QMI) Committee and Cultural and Linguistic Competency Committee (CLCC). Our CLCC reviews data across all of LIBERTY's Medicaid programs and designs strategies and best practices aligned with the applicable populations we serve. Based on utilization data analysis and GeoAccess mapping technology, LIBERTY's African American Members in Nevada consistently display lower dental utilization when compared to other populations in Washoe and Clark Counties and there are pockets of disparity among our Latino and Caucasian Members as well. • LIBERTY has implemented a range of strategies to address the disparities revealed through data analysis, including targeted outreach, education, school-based services, and Member and Provider incentives. LIBERTY developed and implemented targeted outreach to specific zip codes and communities, partnered with Community Based Organizations (CBOs) who serve this demographic to identify and assist with Social Determinants of Health (SDOH) needs, and created culturally sensitive education resources. • LIBERTY has engaged with Nevada's medical Managed Care Organizations (MCOs) for care coordination of our common Members to ensure oral health is addressed as part of the Member's care management plan. • Future strategies to improve the use of preventive services include developing PIPs with DHCFP and HSAG to address utilization disparities, improving Member contact information for outreach and educational opportunities; co-locating LIBERTY staff in Nevada Department of Welfare and Supportive Services (DWSS) offices; offering Member and Provider incentives; and Value-Based Performance bonuses to our providers.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Through our interventions in SFY2022. LIBERY achieved a 14.4% increase in utilization, exceeding the average success rate of 5-10%.
c. Identify any barriers to implementing initiatives: • As noted by HSAG in its Technical Report, performance declines for the dental measures coincided with the COVID-19 Public Health Emergency (PHE) that began in 2020 and has been extended as of July 2022. The PHE affected utilization by deterring individuals from seeking healthcare services including preventive dental services, limiting school and community based screening activities, and affecting the dental delivery system's capacity. • Having out of date Member contact information continues to be an issue, which was heightened during the PHE. LIBERTY has made significant efforts and is implementing new initiatives to engage new Members shortly after their enrollment which increases the likelihood of connection.
HSAG Assessment: HSAG has determined that **LIBERTY** addressed the prior year's recommendations.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review
HSAG recommended the following: • In addition to developing a corrective action plan to mitigate 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. • 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.
MCE's Response
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)***: • While LIBERTY maintains a Corporate Compliance staff, a full-time, dedicated Nevada Medicaid and Check Up Compliance Officer was hired in February 2022. This position is responsible for evaluating and monitoring existing and new state and federal regulations as well as contract requirements for each business area and working with staff from those business areas to implement or adjust policies, procedures and documents as needed.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • LIBERTY's Compliance Officer has been involved in the preparation for multiple audits, including but not limited to the conclusion of the 2021 Annual Compliance audit, the 2022 HSAG Annual Compliance audit, and the Encounter Data Validation audit. For these audits, the Compliance Officer has assisted various business units in reviewing their policies, procedures and documents against the current contract and applicable state and federal regulations to ensure compliance. Results of these audits are pending.
c. Identify any barriers to implementing initiatives: • N/A.
HSAG Assessment: HSAG has determined that **LIBERTY** addressed the prior year's recommendations.

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation
HSAG recommended the following: • **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. • **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
a. Describe initiatives implemented based on recommendations (include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation): • LIBERTY maintains a network development strategy which includes our approach to maintaining and growing our network in alignment with DHCFP's goals and vision for care delivery. We receive an

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation
active Medicaid Provider list from DHCFP monthly that is utilized to outreach and recruit specialists in Clark and Washoe Counties, including periodontists, endodontists, oral surgeons, and prosthodontists. Our Provider Network team continuously recruits these specialist Provider types to join our network, identifies out-of-network Providers to serve Members when needed, and identifies General Dentists with the training and willingness to perform Specialty services.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • As a result of our specialist network access efforts during SFY 2022, we increased endodontists within 20 miles/30 minutes more than 11 % to 99.90%, we increased periodontists within 20 miles/30 minutes more than 11% to 99.70%, we maintained oral surgeons within 20 miles/30 minutes at 99.90%, and we increased to 88% prosthodontists within 20 miles and 30 minutes. LIBERTY is currently contracted with 100% of prosthodontists with a Medicaid ID in Washoe and Clark Counties.
c. Identify any barriers to implementing initiatives: • There are a low number of dental specialists in the state of Nevada and among those, a reluctance to participate in the State's Medicaid program.
HSAG Assessment: HSAG has determined that **LIBERTY** addressed the prior year's recommendations; however, since similar findings were noted in SFY 2022, the PAHP 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 Member Satisfaction Survey
HSAG recommended the following: • **LIBERTY** indicated it was considering text messaging as an option for outreaching to members. **LIBERTY** should 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.
MCE's Response
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 has continued to invest in our Member communication tools including our website, secure Member Portal, Smartphone app, and texting platform. These investments increase self-service opportunities and Member engagement. LIBERTY is in the process of implementing our new text message platform, transitioning from a traditional SMS platform to a personalized "feed" experience. • LIBERTY is also improving the quality of Member contact information for mail and telephone engagement by participating in DHCFP's all-MCO Member Contact Information initiative and engaging in other collection methods. • Once these initiatives are completed, LIBERTY will again evaluate the use of texting as a means to administer the Member Satisfaction Survey.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • All efforts related to the new text messaging platform and improving the quality of Member contact information are taking place outside of the SFY 2022 evaluation timeframe, however, using the results of a pilot of this program as a baseline, LIBERTY expects to increase our Nevada Medicaid and Check Up Member engagement (response) rate by at least 200% from the evaluation period.
c. Identify any barriers to implementing initiatives: • The accuracy of Medicaid members' contact information, including accurate telephone numbers to send text messages, is a barrier to communicating with our Nevada Medicaid and Check Up Members.
HSAG Assessment: HSAG has determined that **LIBERTY** addressed the prior year's recommendations.

7. MCE Comparative Information

In addition to performing a comprehensive assessment of each MCE's performance, HSAG uses a step-by-step process methodology to compare the findings and conclusions established for each MCE to assess the Nevada Managed Care Program. Specifically, HSAG identifies any patterns and commonalities that exist across the five MCEs and the Nevada Managed Care Program, draws conclusions about the overall strengths and weaknesses of the program, and identifies areas in which DHCFP could leverage or modify its Quality Strategy to promote improvement.

EQR Activity Results

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

Validation of Performance Improvement Projects

For the SFY 2022 PIP validation, the MCOs and PAHP completed and submitted Module 4 for each PIP conducted. Table 7-1 provides a comparison of each PIP's validation scores, by MCE.

Table 7-1—Comparative Validation Results by PIP

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 4 Validation**: Met all but one evaluation element **Improvement Achieved**: SMART Aim goal achieved **Confidence Level**: *Confidence*	**Module 4 Validation**: Met all but one evaluation element **Improvement Achieved**: SMART Aim goal achieved **Confidence Level**: *Confidence*	**Module 4 Validation**: Did not meet evaluation elements **Improvement Achieved:** SMART Aim goal was not achieved **Confidence Level:** *Low confidence*	
Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care	**Module 4 Validation**: Met all but two evaluation elements **Improvement Achieved:** SMART Aim goal achieved **Confidence Level:** *Low confidence*	**Module 4 Validation**: Met all evaluation elements **Improvement Achieved:** SMART Aim goal achieved **Confidence Level:** *High confidence*	**Module 4 Validation**: Did not meet evaluation elements **Improvement Achieved:** Unknown **Confidence Level:** *Reported PIP results not credible*	

PIP Title	Anthem PIP Module Results	HPN PIP Module Results	SilverSummit PIP Module Results	LIBERTY PIP Module Results
Total of Eligible Enrollees Receiving a Sealant on a Permanent Molar Tooth				**Module 4 Validation**: Met all but one evaluation element **Improvement Achieved**: SMART Aim goal and statistically significant improvement achieved **Confidence Level**: *Confidence*
Total of Eligible Enrollees Who Received Preventive Dental Services				**Module 4 Validation**: Met all evaluation elements **Improvement Achieved**: Statistically significant improvement achieved **Confidence Level**: *High confidence*

Performance Measure Validation

Table 7-2 and Table 7-3 show the HEDIS MY 2021 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 2021 rate was above or below NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile benchmark. **Bolded** rates indicate the HEDIS MY 2021 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.

Molina did not report any rates for MY 2021 as the MCO joined the Nevada Managed Care Program in January 2022; therefore, **Molina** is not included in the following tables. **LIBERTY**'s performance measures were dental focused and not comparable to the MCOs' performance measures and resulting rates; therefore, **LIBERTY**'s results are also not included in the following tables.

Medicaid Findings

Table 7-2—HEDIS MY 2021 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	62.89%↓	66.38%↓	55.38%↓	69.68%	63.48%
Ages 45–64 Years	70.45%↓	74.57%↓	66.42%↓	76.59%	71.92%
*Ages 65 Years and Older^*	68.99%↓	71.43%↓	59.23%↓	81.35%	68.46%
*Total^*	65.03%↓	68.93%↓	58.64%↓	71.84%	65.99%
Children's Preventive Care					
Childhood Immunization Status (CIS)					
Combination 3	57.42%↓	60.58%↓	57.42%↓	68.95%	58.90%
Combination 7	49.15%↓	52.80%↓	51.58%↓	62.11%	51.16%
Combination 10	25.55%↓	27.25%↓	27.49%↓	38.58%	26.59%
Immunizations for Adolescents (IMA)					
Combination 1 (Meningococcal, Tdap)	81.27%↓	83.21%↑	76.64%↓	87.81%	81.84%
Combination 2 (Meningococcal, Tdap, HPV)	30.17%↓	37.96%↑	27.74%↓	48.91%	33.87%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)					
BMI Percentile—Total	80.05%↑	**86.58%**↑	73.24%↓	85.76%	82.70%
Counseling for Nutrition—Total	74.94%↑	76.68%↑	66.91%↓	77.65%	75.12%
Counseling for Physical Activity—Total	72.26%↑	72.84%↑	61.07%↓	74.96%	71.60%
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	58.50%↑	57.43%↑	56.31%↑	62.88%	57.74%
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	60.39%↓	59.91%↓	60.53%↓	70.56%	60.18%
Child and Adolescent Well-Care Visits (WCV)					
3–11 Years	50.14%↓	50.75%↓	43.66%↓	52.50%	49.81%

HEDIS Measure	Anthem	HPN	SilverSummit	MPS	Medicaid Aggregate†
12–17 Years	45.39%↑	**46.03%**↑	35.55%↓	45.85%	44.81%
18–21 Years	20.53%↓	20.86%↓	16.80%↓	29.68%	20.27%
*Total^*	44.67%↓	44.66%↓	36.57%↓	47.37%	43.88%
Women's Health and Maternity Care					
Breast Cancer Screening (BCS)					
Breast Cancer Screening	39.50%↓	51.07%↓	40.99%↓	54.27%	46.13%
Chlamydia Screening in Women (CHL)					
16–20 Years	48.04%	57.86%	46.84%	MNA	53.43%
21–24 Years	61.22%	62.11%	56.73%	MNA	61.06%
*Total^*	55.65%	60.02%	53.07%	MNA	57.61%
Prenatal and Postpartum Care (PPC)					
Timeliness of Prenatal Care	81.75%↓	**86.37%**↑	73.24%↓	85.02%	82.78%
Postpartum Care	71.29%↓	**74.21%**↓	62.77%↓	74.13%	71.56%
Care for Chronic Conditions					
Asthma Medication Ratio (AMR)^					
5–11 Years	81.70%	77.84%	72.58%	MNA	79.07%
12–18 Years	68.08%	67.40%	53.19%	MNA	66.86%
19–50 Years	55.37%	50.58%	34.09%	MNA	50.34%
51–64 Years	54.71%	52.41%	37.66%	MNA	51.82%
Total	63.28%	58.78%	42.00%	MNA	58.86%
Comprehensive Diabetes Care (CDC)					
*Hemoglobin A1c (HbA1c) Testing^*	76.40%↓	**80.78%**↓	75.67%↓	78.98%	78.48%
*HbA1c Poor Control (>9.0%)**	47.45%↓	**37.71%**↑	52.07%↓	40.52%	43.19%
HbA1c Control (<8.0%)	45.74%↓	**51.58%**↑	42.82%↓	50.84%	48.28%
Eye Exam (Retinal) Performed	49.88%↓	57.91%↑	49.39%↓	61.59%	53.80%
Blood Pressure Control (<140/90 mm Hg)	51.82%↓	**68.37%**↑	44.28%↓	60.51%	59.10%
Controlling High Blood Pressure (CBP)					
Controlling High Blood Pressure	53.04%↓	**65.69%**↑	40.88%↓	58.81%	57.94%
Kidney Health Evaluation for Patients With Diabetes (KED)					
18–64 Years	28.21%	**44.36%**	28.89%	41.69%	36.35%

HEDIS Measure	Anthem	HPN	SilverSummit	MPS	Medicaid Aggregate†
*65–74 Years^*	32.20%	**60.67%**	41.18%	53.16%	47.80%
*75–84 Years^*	NA	NA	NA	MNA	NA
*Total^*	28.24%	**44.50%**	29.05%	41.74%	36.45%
Behavioral Health					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	34.31%↓	43.18%↓	41.14%↓	45.22%	38.50%
Antidepressant Medication Management (AMM)					
Effective Acute Phase Treatment	52.06%	54.22%	54.56%	MNA	53.35%
Effective Continuation Phase Treatment	35.05%	36.61%	39.57%	MNA	36.33%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	76.68%↑	72.69%↓	71.56%↓	77.29%	74.37%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)					
7-Day Follow-Up—Total	10.69%↓	10.26%↓	14.12%↑	23.59%	11.07%
30-Day Follow-Up—Total	15.24%↓	13.44%↓	20.05%↓	28.26%	15.29%
Follow-Up After Emergency Department Visit for Mental Illness (FUM)					
7-Day Follow-Up—Total	35.58%↓	44.07%↑	40.19%↑	47.85%	39.65%
30-Day Follow-Up—Total	46.93%↓	53.79%↑	48.43%↓	56.82%	49.87%
Follow-Up After Hospitalization for Mental Illness (FUH)					
7-Day Follow-Up—Total	28.87%↓	35.73%↓	31.07%↓	41.37%	31.55%
30-Day Follow-Up—Total	46.60%↓	51.96%↓	45.99%↓	56.67%	48.34%
Follow-Up Care for Children Prescribed ADHD Medication (ADD)					
Initiation Phase	49.38%↑	54.56%↑	49.02%↑	55.68%	51.88%
Continuation and Maintenance Phase	60.81%↑	72.15%↑	NA	72.54%	65.90%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)					
Initiation of AOD—Total	45.52%↑	40.09%↓	42.27%↓	47.63%	42.85%
Engagement of AOD—Total	14.85%↑	11.46%↓	11.31%↓	21.54%	12.97%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)					
Blood Glucose and Cholesterol Testing—Total	31.58%↑	29.86%↓	34.17%↑	38.41%	31.11%

HEDIS Measure	Anthem	HPN	SilverSummit	MPS	Medicaid Aggregate†
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)					
1–11 Years	53.19%	56.63%	NA	MNA	55.41%
12–17 Years	63.41%	54.70%	51.61%	MNA	57.39%
Total	59.69%	55.50%	53.06%	MNA	56.61%
Utilization					
Ambulatory Care—Total (per 1,000 Member Months) (AMB)					
*ED Visits—Total**	45.92	42.95	45.76	MNA	44.51
Outpatient Visits—Total	251.42	269.01	237.62	MNA	257.94
Mental Health Utilization—Total (MPT)					
Inpatient—Total	1.09%	0.68%	1.10%	MNA	0.90%
Intensive Outpatient or Partial Hospitalization—Total	0.39%	0.18%	0.15%	MNA	0.26%
Outpatient—Total	8.01%	5.98%	7.06%	MNA	6.94%
ED—Total	0.29%	0.02%	0.04%	MNA	0.13%
Telehealth—Total	5.31%	3.73%	4.47%	MNA	4.46%
Any Service—Total	10.27%	7.97%	9.51%	MNA	9.10%
Plan All-Cause Readmissions (PCR)					
Observed Readmissions—Total	13.23%	**9.99%**	12.58%	11.28%	11.51%
Expected Readmissions—Total	9.51%	8.85%	9.59%	MNA	9.18%
O/E Ratio—Total	1.39	1.13	1.31	MNA	1.25
Overuse/Appropriateness of Care					
Use of Opioids at High Dosage (HDO)*					
Use of Opioids at High Dosage	**8.15%↓**	8.83%↓	**4.14%↑**	8.23%	8.14%
Use of Opioids From Multiple Providers (UOP)*					
Multiple Prescribers	**20.68%↓**	**21.57%↓**	**17.52%↑**	22.14%	20.87%
*Multiple Pharmacies^*	**0.52%↑**	**1.08%↑**	**0.39%↑**	1.49%	0.82%
*Multiple Prescribers and Multiple Pharmacies^*	**0.30%↑**	**0.69%↑**	**0.08%↑**	0.83%	0.50%

^ Indicates HSAG calculated the MPS if prior year's data were available; however, the MPS is not tied to a QISMC goal.

† Represents performance under the Medicaid managed care program.

* A lower rate indicates better performance for this measure.

↑ Indicates the HEDIS MY 2021 rate was above NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile benchmark.

↓ Indicates the HEDIS MY 2021 rate was below NCQA's Quality Compass HEDIS 2021 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 2021 QISMC goals are unavailable for this measure or indicator.
Bolded rates indicate that the HEDIS MY 2021 performance measure rate was at or above the MPS.

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

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

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

Nevada Check Up Findings

Table 7-3—HEDIS MY 2021 Nevada Check Up Results

HEDIS Measure	Anthem	HPN	SilverSummit	MPS	NV Check Up Aggregate†
Children's Preventive Care					
Childhood Immunization Status (CIS)					
Combination 3	71.33%↑	75.78%↑	75.51%↑	82.36%	74.17%
Combination 7	66.67%↑	68.61%↑	69.39%↑	76.15%	68.01%
Combination 10	35.33%↓	43.05%↑	42.86%↑	48.22%	40.29%
Immunizations for Adolescents (IMA)					
Combination 1 (Meningococcal, Tdap)	91.48%↑	89.05%↑	86.02%↑	94.17%	89.68%
Combination 2 (Meningococcal, Tdap, HPV)	44.28%↑	47.93%↑	26.88%↓	57.30%	45.18%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)					
BMI Percentile—Total	83.94%↑	85.07%↑	75.43%↓	85.62%	83.88%
Counseling for Nutrition—Total	76.64%↑	76.12%↑	65.45%↓	77.08%	75.51%
Counseling for Physical Activity—Total	73.24%↑	72.84%↑	62.04%↓	74.09%	72.17%
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	66.29%↑	63.03%↑	NA	73.00%	63.79%
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	72.19%↑	73.96%↑	69.77%↓	82.95%	73.00%
Child and Adolescent Well-Care Visits (WCV)					
3–11 Years	56.17%↑	52.35%↑	43.39%↓	59.37%	53.00%
12–17 Years	53.97%↑	52.87%↑	39.79%↓	54.57%	52.22%
18–21 Years	33.52%↑	28.69%↑	29.91%↑	38.72%	30.28%
*Total^*	53.95%↑	50.72%↑	40.95%↓	56.06%	51.06%

HEDIS Measure	Anthem	HPN	SilverSummit	MPS	NV Check Up Aggregate†
Women's Health and Maternity Care					
Chlamydia Screening in Women (CHL)					
16–20 Years	39.58%	59.62%	34.15%	MNA	50.79%
21–24 Years	NA	NA	NA	MNA	NA
Total	39.58%	59.62%	34.15%	MNA	50.79%
Care for Chronic Conditions					
Asthma Medication Ratio (AMR)					
5–11 Years	77.14%	83.02%	NA	MNA	81.52%
12–18 Years	64.71%	69.70%	NA	MNA	67.33%
19–50 Years	NA	NA	NA	MNA	NA
51–64 Years	NA	NA	NA	MNA	NA
Total	71.01%	75.63%	NA	MNA	74.09%
Behavioral Health					
Follow-Up After Emergency Department Visit for Alcohol and Other Drug 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 Emergency Department Visit for Mental Illness (FUM)♦					
7-Day Follow-Up—Total	NA	NA	NA	77.50%	91.89%
30-Day Follow-Up—Total	NA	NA	NA	77.50%	91.89%
Follow-Up After Hospitalization for Mental Illness (FUH)					
7-Day Follow-Up—Total	35.48%↓	**57.89%**↑	NA	52.00%	44.87%
30-Day Follow-Up—Total	61.29%↑	**81.58%**↑	NA	65.20%	69.23%
Follow-Up Care for Children Prescribed ADHD Medication (ADD)					
Initiation Phase	50.00%↑	**50.85%**↑	NA	50.75%	50.00%
Continuation and Maintenance Phase	NA	NA	NA	MNA	NA
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)♦					
Initiation of AOD—Total	NA	NA	NA	37.69%	27.50%
Engagement of AOD—Total	NA	NA	NA	12.77%	7.50%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)					
Blood Glucose and Cholesterol Testing—Total	NA	43.90%↑	NA	45.36%	35.71%

HEDIS Measure	Anthem	HPN	SilverSummit	MPS	NV Check Up Aggregate†
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)					
1–11 Years	NA	NA	NA	MNA	NA
12–17 Years	NA	NA	NA	MNA	NA
Total	NA	NA	NA	MNA	67.57%
Utilization					
Ambulatory Care—Total (per 1,000 Member Months) (AMB)					
*ED Visits—Total**	15.94	16.06	18.02	MNA	16.19
Outpatient Visits—Total	192.37	191.05	158.88	MNA	188.69
Mental Health Utilization—Total (MPT)					
Inpatient—Total	0.45%	0.31%	0.49%	MNA	0.37%
Intensive Outpatient or Partial Hospitalization—Total	0.21%	0.05%	0.15%	MNA	0.12%
Outpatient—Total	5.23%	5.48%	5.73%	MNA	5.41%
ED—Total	0.08%	0.02%	0.10%	MNA	0.05%
Telehealth—Total	3.33%	3.39%	2.96%	MNA	3.33%
Any Service—Total	6.75%	6.92%	7.10%	MNA	6.88%

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

† Represents performance under the Nevada Check Up program.

* A lower rate indicates better performance for this measure.

↑ Indicates the HEDIS MY 2021 rate was above NCQA's Quality Compass HEDIS 2021 Medicaid HMO 50th percentile benchmark.

↓ Indicates the HEDIS MY 2021 rate was below NCQA's Quality Compass HEDIS 2021 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 2021 QISMC goals are unavailable for this measure or indicator.

Bolded rates indicate that the HEDIS MY 2021 performance measure rate was at or above the MPS.

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

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

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

Three-Year Medicaid and Nevada Check Up Aggregate Rate Trending

Table 7-4 and Table 7-5 provide a three-year comparison (i.e., MY 2019, MY 2020, and MY 2021) of the Medicaid and Nevada Check Up aggregate rates and applicable MPS for each performance measure.

Bolded rates indicate the Medicaid or Nevada Check Up aggregate rate was at or above the MPS. The Medicaid and Nevada Check Up aggregate rates represent 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 (*).

Table 7-4—Medicaid Aggregate Three-Year Rate Trending

HEDIS Measure	MY 2019 Medicaid Aggregate†	MY 2019 MPS	MY 2020 Medicaid Aggregate†	MY 2020 MPS	MY 2021 Medicaid Aggregate†	MY 2021 MPS
Access to Care						
Adults' Access to Preventive/Ambulatory Health Services (AAP)						
Ages 20–44 Years	73.74%	75.55%	66.31%	75.55%	63.48%	69.68%
Ages 45–64 Years	80.28%	81.82%	73.99%	81.82%	71.92%	76.59%
Ages 65 Years and Older	**75.00%**	67.19%	**79.28%**	67.19%	68.46%	81.35%
Total	75.95%	77.67%	68.71%	77.67%	65.99%	71.84%
Children's Preventive Care						
Childhood Immunization Status (CIS)						
Combination 3	67.71%	68.86%	65.50%	68.86%	58.90%	68.95%
Combination 7	58.32%	59.15%	57.90%	59.15%	51.16%	62.11%
Combination 10	**34.32%**	34.32%	31.75%	34.32%	26.59%	38.58%
Immunizations for Adolescents (IMA)						
Combination 1 (Meningococcal, Tdap)	89.57%	84.85%	86.45%	84.85%	81.84%	87.81%
Combination 2 (Meningococcal, Tdap, HPV)	44.80%	47.65%	43.23%	47.65%	33.87%	48.91%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)						
BMI Percentile—Total	**82.88%**	82.70%	**84.18%**	82.70%	82.70%	85.76%
Counseling for Nutrition—Total	71.99%	72.63%	**75.17%**	72.63%	75.12%	77.65%
Counseling for Physical Activity—Total	68.16%	69.60%	**72.18%**	69.60%	71.60%	74.96%
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	66.89%	67.99%	58.75%	MNA	57.74%	62.88%
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	—	—	67.29%	MNA	60.18%	70.56%
Child and Adolescent Well-Care Visits (WCV)						
3–11 Years	—	—	47.22%	MNA	49.81%	52.50%

HEDIS Measure	MY 2019 Medicaid Aggregate†	MY 2019 MPS	MY 2020 Medicaid Aggregate†	MY 2020 MPS	MY 2021 Medicaid Aggregate†	MY 2021 MPS
12–17 Years	—	—	39.83%	MNA	44.81%	45.85%
18–21 Years	—	—	21.87%	MNA	20.27%	29.68%
Total	—	—	41.52%	MNA	43.88%	47.37%
Women's Health and Maternity Care						
Breast Cancer Screening (BCS)						
Breast Cancer Screening	53.77%	58.90%	49.19%	58.90%	46.13%	54.27%
Chlamydia Screening in Women (CHL)						
16–20 Years	—	—	—	—	53.43%	MNA
21–24 Years	—	—	—	—	61.06%	MNA
Total	—	—	—	—	57.61%	MNA
Prenatal and Postpartum Care (PPC)						
Timeliness of Prenatal Care	84.73%	MNA	83.36%	86.26%	82.78%	85.02%
Postpartum Care	69.62%	MNA	71.25%	72.66%	71.56%	74.13%
Care for Chronic Conditions						
Asthma Medication Ratio (AMR)						
5–11 Years	—	—	—	—	79.07%	MNA
12–18 Years	—	—	—	—	66.86%	MNA
19–50 Years	—	—	—	—	50.34%	MNA
51–64 Years	—	—	—	—	51.82%	MNA
Total	—	—	—	—	58.86%	MNA
Comprehensive Diabetes Care (CDC)						
Hemoglobin A1c (HbA1c) Testing	81.92%	81.98%	76.64%	81.98%	78.48%	78.98%
*HbA1c Poor Control (>9.0%)**	46.01%	39.28%	45.02%	39.28%	43.19%	40.52%
HbA1c Control (<8.0%)	45.22%	53.14%	45.38%	53.14%	48.28%	50.84%
Eye Exam (Retinal) Performed	58.03%	61.47%	57.32%	61.47%	53.80%	61.59%
Blood Pressure Control (<140/90 mm Hg)	53.16%	65.72%	56.12%	MNA	59.10%	60.51%
Controlling High Blood Pressure (CBP)						
Controlling High Blood Pressure	**57.14%**	55.58%	54.23%	MNA	57.94%	58.81%

HEDIS Measure	MY 2019 Medicaid Aggregate†	MY 2019 MPS	MY 2020 Medicaid Aggregate†	MY 2020 MPS	MY 2021 Medicaid Aggregate†	MY 2021 MPS
Kidney Health Evaluation for Patients With Diabetes (KED)						
18–64 Years	—	—	35.21%	MNA	36.35%	41.69%
65–74 Years	—	—	47.95%	MNA	47.80%	53.16%
75–84 Years	—	—	NA	MNA	NA	MNA
Total	—	—	35.27%	MNA	36.45%	41.74%
Behavioral Health						
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)						
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	44.80%	46.08%	39.13%	46.08%	38.50%	45.22%
Antidepressant Medication Management (AMM)						
Effective Acute Phase Treatment	—	—	—	—	53.35%	MNA
Effective Continuation Phase Treatment	—	—	—	—	36.33%	MNA
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	80.38%	81.43%	74.77%	81.43%	74.37%	77.29%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)						
7-Day Follow-Up—Total	13.00%	18.21%	15.10%	18.21%	11.07%	23.59%
30-Day Follow-Up—Total	17.67%	21.60%	20.29%	21.60%	15.29%	28.26%
Follow-Up After Emergency Department Visit for Mental Illness (FUM)						
7-Day Follow-Up—Total	42.49%	47.67%	42.06%	47.67%	39.65%	47.85%
30-Day Follow-Up—Total	51.59%	55.92%	52.02%	55.92%	49.87%	56.82%
Follow-Up After Hospitalization for Mental Illness (FUH)						
7-Day Follow-Up—Total	34.40%	39.45%	34.86%	39.45%	31.55%	41.37%
30-Day Follow-Up—Total	50.83%	54.86%	51.86%	54.86%	48.34%	56.67%
Follow-Up Care for Children Prescribed ADHD Medication (ADD)						
Initiation Phase	46.63%	50.09%	**50.75%**	50.09%	51.88%	55.68%
Continuation and Maintenance Phase	**62.82%**	60.00%	69.49%	60.00%	65.90%	72.54%
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)						
Initiation of AOD—Total	**45.24%**	45.24%	41.81%	45.24%	42.85%	47.63%

HEDIS Measure	MY 2019 Medicaid Aggregate†	MY 2019 MPS	MY 2020 Medicaid Aggregate†	MY 2020 MPS	MY 2021 Medicaid Aggregate†	MY 2021 MPS
Engagement of AOD—Total	13.19%	18.94%	12.82%	18.94%	12.97%	21.54%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)						
Blood Glucose and Cholesterol Testing—Total	31.92%	25.33%	31.57%	25.33%	31.11%	38.41%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)						
1–11 Years	—	—	—	—	55.41%	MNA
12–17 Years	—	—	—	—	57.39%	MNA
Total	—	—	—	—	56.61%	MNA
Utilization						
Ambulatory Care—Total (per 1,000 Member Months) (AMB)						
*ED Visits—Total**	60.06	MNA	42.91	MNA	44.51	MNA
Outpatient Visits—Total	304.51	MNA	263.12	MNA	257.94	MNA
Mental Health Utilization—Total (MPT)						
Inpatient—Total	1.08%	MNA	0.96%	MNA	0.90%	MNA
Intensive Outpatient or Partial Hospitalization—Total	0.51%	MNA	0.32%	MNA	0.26%	MNA
Outpatient—Total	10.55%	MNA	8.23%	MNA	6.94%	MNA
ED—Total	0.18%	MNA	0.12%	MNA	0.13%	MNA
Telehealth—Total	0.07%	MNA	4.32%	MNA	4.46%	MNA
Any Service—Total	10.89%	MNA	9.89%	MNA	9.10%	MNA
Plan All-Cause Readmissions (PCR)						
Observed Readmissions—Total	14.13%	MNA	12.53%	MNA	11.51%	11.28%
Expected Readmissions—Total	9.57%	MNA	9.47%	MNA	9.18%	MNA
O/E Ratio—Total	1.48	MNA	1.32	MNA	1.25	MNA
Overuse/Appropriateness of Care						
Use of Opioids at High Dosage (HDO)*						
Use of Opioids at High Dosage	9.59%	MNA	9.14%	8.63%	**8.14%**	8.23%
Use of Opioids From Multiple Providers (UOP)*						
Multiple Prescribers	24.78%	22.43%	24.60%	22.43%	**20.87%**	22.14%

HEDIS Measure	MY 2019 Medicaid Aggregate†	MY 2019 MPS	MY 2020 Medicaid Aggregate†	MY 2020 MPS	MY 2021 Medicaid Aggregate†	MY 2021 MPS
Multiple Pharmacies	**2.54%**	3.16%	**1.66%**	3.16%	**0.82%**	1.49%
Multiple Prescribers and Multiple Pharmacies	**1.47%**	1.62%	**0.92%**	1.62%	**0.50%**	0.83%

† Represents performance under the Medicaid managed care program.
* A lower rate indicates better performance for this measure.
— Indicates that the MCOs were not previously required to report this measure or that the rate is not appropriate to display due to changes in the technical specifications resulting in a break in trending.
MNA indicates QISMC goals are unavailable for this measure or indicator.
NA indicates that the MCOs followed the specifications, but the denominator was too small (i.e., <30) to report a valid rate.
Bolded rates indicate that the Medicaid Aggregate performance measure rate was at or above the MPS.

Table 7-5—Nevada Check Up Aggregate Three-Year Rate Trending

HEDIS Measure	MY 2019 NV Check Up Aggregate†	MY 2019 MPS	MY 2020 NV Check Up Aggregate†	MY 2020 MPS	MY 2021 NV Check Up Aggregate†	MY 2021 MPS
Children's Preventive Care						
Childhood Immunization Status (CIS)						
Combination 3	**83.60%**	83.46%	80.40%	83.46%	74.17%	82.36%
Combination 7	75.31%	77.33%	73.50%	77.33%	68.01%	76.15%
Combination 10	**45.86%**	44.91%	42.47	44.91	40.29%	48.22%
Immunizations for Adolescents (IMA)						
Combination 1 (Meningococcal, Tdap)	**95.52%**	89.03%	**93.52%**	89.03%	89.68%	94.17%
Combination 2 (Meningococcal, Tdap, HPV)	53.88%	57.44%	52.56%	57.54%	45.18%	57.30%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)						
BMI Percentile—Total	**87.67%**	85.65%	84.02%	85.65%	83.88%	85.62%
Counseling for Nutrition—Total	75.37%	76.13%	74.53%	76.13%	75.51%	77.08%
Counseling for Physical Activity—Total	72.51%	73.04%	71.21%	73.04%	72.17%	74.09%
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	**80.50**	77.38	70.00%	MNA	63.79%	73.00%
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	—	—	—	—	73.00%	82.95%
Child and Adolescent Well-Care Visits (WCV)						
3–11 Years	—	—	—	—	53.00%	59.37%

HEDIS Measure	MY 2019 NV Check Up Aggregate†	MY 2019 MPS	MY 2020 NV Check Up Aggregate†	MY 2020 MPS	MY 2021 NV Check Up Aggregate†	MY 2021 MPS
12–17 Years	—	—	—	—	52.22%	54.57%
18–21 Years	—	—	—	—	30.28%	38.72%
Total	—	—	—	—	51.06%	56.06%
Women's Health and Maternity Care						
Chlamydia Screening in Women (CHL)						
16–20 Years	—	—	—	—	50.79%	MNA
21–24 Years	—	—	—	—	NA	MNA
Total	—	—	—	—	50.79%	MNA
Care for Chronic Conditions						
Asthma Medication Ratio (AMR)						
5–11 Years	—	—	—	—	81.52%	MNA
12–18 Years	—	—	—	—	67.33%	MNA
19–50 Years	—	—	—	—	NA	MNA
51–64 Years	—	—	—	—	NA	MNA
Total	—	—	—	—	74.09%	MNA
Behavioral Health						
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)						
7-Day Follow-Up—Total	—	—	NA	MNA	NA	MNA
30-Day Follow-Up—Total	—	—	NA	MNA	NA	MNA
Follow-Up After Emergency Department Visit for Mental Illness (FUM)♦						
7-Day Follow-Up—Total	59.26%	79.47%	75.00%	79.47%	**91.89%**	77.50%
30-Day Follow-Up—Total	66.67%	82.63%	75.00%	82.63%	**91.89%**	77.50%
Follow-Up After Hospitalization for Mental Illness (FUH)						
7-Day Follow-Up—Total	41.43%	63.01%	46.67%	63.01%	44.87%	52.00%
30-Day Follow-Up—Total	70.00%	75.34%	61.33%	75.34%	**69.23%**	65.20%
Follow-Up Care for Children Prescribed ADHD Medication (ADD)						
Initiation Phase	**56.10%**	56.00%	45.28%	56.00%	50.00%	50.75%
Continuation and Maintenance Phase	NA	MNA	NA	MNA	NA	MNA

HEDIS Measure	MY 2019 NV Check Up Aggregate†	MY 2019 MPS	MY 2020 NV Check Up Aggregate†	MY 2020 MPS	MY 2021 NV Check Up Aggregate†	MY 2021 MPS
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)						
Initiation of AOD—Total	27.59%	38.33%	30.77%	38.33%	27.50%	37.69%
Engagement of AOD—Total	8.62%	18.33%	3.08%	18.33%	7.50%	12.77%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)						
Blood Glucose and Cholesterol Testing—Total	**32.93%**	28.87%	**39.29%**	28.87%	35.71%	45.36%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)						
1–11 Years	—	—	—	—	NA	MNA
12–17 Years	—	—	—	—	NA	MNA
Total	—	—	—	—	67.57%	MNA
Utilization						
Ambulatory Care—Total (per 1,000 Member Months) (AMB)						
*ED Visits—Total**	27.97	MNA	14.53	MNA	16.19	MNA
Outpatient Visits—Total	258.61	MNA	189.80	MNA	188.69	MNA
Mental Health Utilization—Total (MPT)						
Inpatient—Total	0.28%	MNA	0.33%	MNA	0.37%	MNA
Intensive Outpatient or Partial Hospitalization—Total	0.11%	MNA	0.09%	MNA	0.12%	MNA
Outpatient—Total	7.55%	MNA	5.52%	MNA	5.41%	MNA
ED—Total	0.00%	MNA	0.02%	MNA	0.05%	MNA
Telehealth—Total	0.02%	MNA	3.46%	MNA	3.33%	MNA
Any Service—Total	7.60%	MNA	6.71%	MNA	6.88%	MNA

† Represents performance under the Medicaid managed care program.

♦ Individual MCO denominators reported for MY 2021 for this measure and/or indicator were less than 30 resulting in an "NA" audit designation; however, when the MCO rates were combined to generate the statewide aggregate rate, the denominator was large enough to be reported and subsequently compared to the MPS.

* A lower rate indicates better performance for this measure.

— Indicates that the MCOs were not previously required to report this measure or that the rate is not appropriate to display due to changes in the technical specifications resulting in a break in trending.

MNA indicates QISMC goals are unavailable for this measure or indicator.

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

Bolded rates indicate that the Nevada Check Up Aggregate performance measure rate was at or above the MPS.

Compliance Review

HSAG calculated the Nevada Managed Care Program overall performance in each of the 14 compliance review standards that are reviewed as part of the three-year compliance review cycle. Table 7-6 compares the Nevada Managed Care Program average compliance score in each of the 14 standards with the compliance score achieved by each MCE. As **Molina** was new to the Nevada Managed Care Program effective January 1, 2022, Standard I through Standard VII will be reviewed in 2023.

Table 7-6—Summary of SFY 2021 and SFY 2022 Compliance Review Results

Standard	Anthem	HPN	Molina	SilverSummit	LIBERTY	Nevada Managed Care Program
Standard I—Disenrollment: Requirements and Limitations	100%	100%	TBD	100%	100%	100%
Standard II—Member Rights and Member Information	95%	91%		77%	94%	89%
Standard III—Emergency and Poststabilization 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 for Year One (SFY 2021)	**95%**	**93%**	**NA**	**81%**	**90%**	**90%**
Standard VIII—Provider Selection	67%	83%	82%	83%	100%	82%
Standard IX—Confidentiality	91%	91%	100%	100%	100%	96%
Standard X—Grievance and Appeal Systems	74%	87%	87%	76%	92%	83%
Standard XI—Subcontractual Relationships and Delegation	100%	71%	100%	71%	100%	89%
Standard XII—Practice Guidelines	100%	70%	100%	100%	100%	94%
Standard XIII—Health Information Systems	100%	86%	100%	100%	83%	94%
Standard XIV—Quality Assessment and Performance Improvement Program	97%	97%	97%	97%	100%	98%

Standard	Anthem	HPN	Molina	SilverSummit	LIBERTY	Nevada Managed Care Program
Total Compliance Score for Year Two (SFY 2022)	**88%**	**88%**	**94%**	**89%**	**95%**	**91%**
Combined Compliance Score for Year One (SFY 2021) and Year Two (SFY 2022)	**91%**	**89%**	**TBD**	**86%**	**93%**	**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.

TBD (To Be Determined)—As **Molina** was new to the Nevada Managed Care Program effective January 1, 2022, Standard I through Standard VII will be reviewed in 2023. Therefore, a combined compliance score for Year One and Year Two is not provided for **Molina**.

Network Adequacy Validation

Table 7-7 presents the network capacity analysis results for all MCOs and compares the provider ratios to the standards displayed in Table 3-4. Assessed provider ratios shown in green indicate the provider ratio was in compliance with the access standard, whereas provider ratios shown in red indicate the provider ratio was not in compliance with the access standard. The provider ratio analyses for **LIBERTY** were not comparable to the MCOs; therefore, the results are not included in the following table.

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

Provider Category	Anthem		HPN		Molina		SilverSummit	
	Providers	Ratio	Providers	Ratio	Providers	Ratio	Providers	Ratio
Primary Care Provider (1:1,500)	1,372	1:140	1,843	1:114	1,191	1:104	1,695	1:85
PCP Extender (1:1,800)	1,795	1:59	1,110	1:103	1,151	1:60	1,591	1:55
Physician Specialist (1:1,500)	1,487	1:129	2,152	1:97	1,025	1:121	1,675	1:86

Note: results shown in green font indicate the result complies with the ratio access standard; results shown in red font indicate the result does not comply with the ratio access standard.

* Statewide results incorporate all Nevada counties included in the DHCFP member file submission and members enrolled with the MCO as of March 1, 2022.

Table 7-8 presents the geographic network distribution analysis for all MCOs and compares the percentage of members within the access standard compared to the standards displayed in Table 3-5. Assessed results shown in green indicate that the percentage of members within the access standard was in compliance, and percentages shown in red indicate a result of less than 99.0 percent. The provider time-distance analyses for **LIBERTY** were not comparable to the MCOs; therefore, the results are not included in the following table.

Table 7-8—Percentage of Members Residing Within the Access Standard Areas for All MCOs

Provider Category	Anthem	HPN	Molina	SilverSummit
Primary Care Providers				
Primary Care, Adults (10 miles/15 mins)	99.9%	99.9%	99.9%	99.8%
OB/GYN (10 miles/15 mins)	98.4%	99.0%	98.4%	98.4%
Pediatrician (10 miles/15 mins)	99.7%	99.7%	99.7%	99.6%
Physician Specialists				
Endocrinologist (40 miles/60 mins)	99.9%	>99.9%	>99.9%	>99.9%
Endocrinologist, Pediatric (40 miles/60 mins)	>99.9%	>99.9%	>99.9%	>99.9%
Infectious Disease (40 miles/60 mins)	99.9%	>99.9%	99.9%	99.9%
Infectious Disease, Pediatric (40 miles/60 mins)	99.9%	>99.9%	99.9%	>99.9%
Oncologist/Radiologist (40 miles/60 mins)	99.9%	>99.9%	99.9%	>99.9%
Oncologist—Medical/Surgical (30 miles/45 mins)	99.9%	>99.9%	99.9%	99.9%
Oncologist—Medical/Surgical, Pediatric (30 miles/45 mins)	99.9%	>99.9%	99.9%	99.9%
Rheumatologist (40 miles/60 mins)	99.9%	99.9%	99.9%	99.9%
Rheumatologist, Pediatric (40 miles/60 mins)	87.9%	88.4%	86.9%	88.6%
Behavioral Health Providers				
Board Certified Child and Adolescent Psychiatrist (30 miles/45 mins)	99.9%	100%	>99.9%	99.9%
Psychiatrist (30 miles/45 mins)	99.9%	>99.9%	>99.9%	99.9%
Psychologist (30 miles/45 mins)	99.9%	>99.9%	>99.9%	99.9%
Psychologist, Pediatric (30 miles/45 mins)	87.9%	99.9%	99.9%	88.6%
QMHP (30 miles/45 mins)	>99.9%	>99.9%	>99.9%	>99.9%
QMHP, Pediatric (30 miles/45 mins)	>99.9%	100%	>99.9%	99.9%
Facility-Level Providers				
Hospitals, All (30 miles/45 mins)	99.9%	>99.9%	>99.9%	>99.9%
Pharmacy (10 miles/15 mins)	99.9%	99.9%	99.9%	99.9%
Psychiatry Inpatient Hospital (30 miles/45 mins)	99.9%	99.9%	99.9%	99.9%
Dialysis/ESRD Facility (30 miles/45 mins)	99.9%	99.9%	99.6%	>99.9%

Note: results shown in green font indicate the result complies with the access standard; results shown in red font indicate that less than 99.0 percent of members had access to the provider within the time and distance access standard.

* Statewide results incorporate all Nevada counties included in the DHCFP member file submission and members enrolled with the MCO as of March 1, 2022.

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 7-9 through Table 7-11 show the plan comparison results of the adult Medicaid, child Medicaid, and Nevada Check Up populations for **Anthem**, **HPN**, and **SilverSummit**. **LIBERTY**'s Member Satisfaction Survey results are not included in the following tables, as the methodology for the survey was not consistent with CAHPS.

Table 7-9—Plan Comparisons: Adult Medicaid

	Anthem	HPN	SilverSummit	Program Average
Composite Measures				
Getting Needed Care	NA	NA	NA	78.7%
Getting Care Quickly	NA	NA	NA	76.3%
How Well Doctors Communicate	NA	NA	NA	90.7%
Customer Service	NA	NA	NA	91.7%
Global Ratings				
Rating of All Health Care	NA	NA	53.2%	56.4%
Rating of Personal Doctor	NA	NA	60.7%	64.6%
Rating of Specialist Seen Most Often	NA	NA	NA	61.0%
Rating of Health Plan	61.3%	71.5% ↑	52.4% ↓	60.7%
Effectiveness of Care*				
Advising Smokers and Tobacco Users to Quit	NA	NA	61.7%	59.6%
Discussing Cessation Medications	NA	NA	41.0%	38.4%
Discussing Cessation Strategies	NA	NA	37.0%	33.2%

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

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

↑ Indicates the 2022 score is statistically significantly higher than the program average.

↓ Indicates the 2022 score is statistically significantly lower than the program average.

Table 7-10—Plan Comparisons: Child Medicaid

	Anthem		HPN		SilverSummit		Program Average	
	General Child	CCC	General Child	CCC	General Child	CCC	General Child	CCC
Composite Measures								
Getting Needed Care	NA	NA	NA	NA	NA	NA	78.5%	84.0%
Getting Care Quickly	NA	NA	NA	NA	NA	NA	78.7%	86.2%
How Well Doctors Communicate	NA	NA	NA	NA	NA	NA	90.8%	90.5%
Customer Service	NA	NA	NA	NA	NA	NA	86.8%	NA
Global Ratings								
Rating of All Health Care	NA	NA	NA	NA	NA	NA	73.5%	67.3%
Rating of Personal Doctor	77.9%	NA	69.4%	71.4%	NA	NA	73.5%	72.0%
Rating of Specialist Seen Most Often	NA	NA	NA	NA	NA	NA	NA	75.7%
Rating of Health Plan	76.1%	NA	75.4%	72.2%	69.2%	NA	73.9%	68.2%
CCC Composite Measures/Items								
Access to Specialized Services	—	NA	—	NA	—	NA	—	NA
Family Centered Care (FCC): Personal Doctor Who Knows Child	—	NA	—	NA	—	NA	—	88.4%
Coordination of Care for Children With Chronic Conditions	—	NA	—	NA	—	NA	—	NA
Access to Prescription Medicines	—	NA	—	94.2%	—	NA	—	91.1%
FCC: Getting Needed Information	—	NA	—	NA	—	NA	—	90.9%

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

↑ Indicates the 2022 score is statistically significantly higher than the program average.

↓ Indicates the 2022 score is statistically significantly lower than the program average.

— Indicates the measure does not apply to the population.

Table 7-11—Plan Comparisons: Nevada Check Up

	Anthem		HPN		SilverSummit		Program Average	
	General Child	CCC	General Child	CCC	General Child	CCC	General Child	CCC
Composite Measures								
Getting Needed Care	NA	NA	NA	NA	NA	NA	83.4%	NA
Getting Care Quickly	NA	NA	NA	NA	NA	NA	84.3%	NA
How Well Doctors Communicate	NA	NA	94.9%	NA	NA	NA	93.6%	NA
Customer Service	NA	NA	NA	NA	NA	NA	89.8%	NA
Global Ratings								
Rating of All Health Care	NA	NA	73.3%	NA	NA	NA	73.5%	NA
Rating of Personal Doctor	68.2%	NA	79.8%	NA	NA	NA	74.8%	NA
Rating of Specialist Seen Most Often	NA	NA	NA	NA	NA	NA	NA	NA
Rating of Health Plan	64.4% ↓	NA	81.5% ↑	NA	NA	NA	74.6%	NA
CCC Composite Measures/Items								
Access to Specialized Services	—	NA	—	NA	—	NA	—	NA
Family Centered Care (FCC): Personal Doctor Who Knows Child	—	NA	—	NA	—	NA	—	NA
Coordination of Care for Children With Chronic Conditions	—	NA	—	NA	—	NA	—	NA
Access to Prescription Medicines	—	NA	—	NA	—	NA	—	NA
FCC: Getting Needed Information	—	NA	—	NA	—	NA	—	NA

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

↑ Indicates the 2022 score is statistically significantly higher than the program average.

↓ Indicates the 2022 score is statistically significantly lower than the program average.

— Indicates the measure does not apply to the population.

Encounter Data Validation

Information Systems Review

The IS review component of the EDV study provided self-reported qualitative information from the MCEs for which HSAG conducted an IS review regarding the encounter data processes related to collection, processing, and transmission of encounter data to DHCFP. Since SFY 2022 was the first year HSAG conducted an EDV study for **SilverSummit** and **LIBERTY**, HSAG included the IS review component in the EDV activity. HSAG had already included the IS review in SFY 2018 when conducting the EDV study for **Anthem** and **HPN**. The modular structure of the encounter data processing systems ensures that:

- MCEs can submit data and receive feedback about accuracy, completeness, and timeliness.
- Electronic Data Interchange (EDI) file compliance and validation checks are performed on encounter data (i.e., files are in valid formats, data are checked for HIPAA compliance and prepared for business rules processing).
- Data are validated against the business rules engine.
- Data analyses for program management and decision support are run.

Based on contractual requirements and DHCFP's data submission requirements (e.g., companion guides), both **SilverSummit** and **LIBERTY** demonstrated their capability to collect, process, and transmit encounter data to DHCFP, as well as develop data review and correction processes that can respond to quality issues identified by DHCFP. Additionally, **SilverSummit** also described the systems/subcontractor oversight and data remediation activities in place to ensure the completeness and accuracy of data submitted to **SilverSummit** or processed on its behalf.

Comparative Analysis

Table 7-12 displays the percentage of records present in the files submitted by the MCEs that were not found in DHCFP's files (record omission) and the percentage of records present in DHCFP's files but not present in the files submitted by the MCEs (record surplus). Lower rates indicate better performance for both record omission and record surplus.

Table 7-12—Record Omission and Surplus Rates, by MCE and Encounter Type

MCE	Professional Encounters		Institutional Encounters		Pharmacy Encounters		Dental Encounters	
	Omission	Surplus	Omission	Surplus	Omission	Surplus	Omission	Surplus
Anthem	10.4%	0.8%	21.1%	3.4%	0.2%	13.6%		
HPN	2.4%	1.6%	2.2%	5.6%	0.0%	12.3%		
SilverSummit	1.7%	1.9%	8.4%	1.9%	0.7%	15.0%		
LIBERTY							1.8%	1.0%
Overall	**5.8%**	**1.3%**	**11.6%**	**4.3%**	**0.2%**	**13.3%**	**1.8%**	**1.0%**

Note: Gray cells indicate encounter types that were not applicable for the MCEs.

Table 7-13 displays the element omission and surplus results for each key data element from the professional encounters for the MCOs. **For the element omission and surplus indicators, lower rates indicate better performance.**

Table 7-13—Data Element Omission and Surplus: Professional Encounters

Key Data Element	Element Omission				Element Surplus			
	Overall Rate	Anthem	HPN	SilverSummit	Overall Rate	Anthem	HPN	SilverSummit
Recipient ID	**0.0%**	0.0%	0.0%	0.0%	**<0.1%**	0.0%	<0.1%	0.0%
Header Service From Date	**0.0%**	0.0%	0.0%	0.0%	**0.0%**	0.0%	0.0%	0.0%
Header Service To Date	**0.0%**	0.0%	0.0%	0.0%	**0.0%**	0.0%	0.0%	0.0%
Detail Service From Date	**0.0%**	0.0%	0.0%	0.0%	**0.0%**	0.0%	0.0%	0.0%
Detail Service To Date	**0.0%**	0.0%	0.0%	0.0%	**0.0%**	0.0%	0.0%	0.0%
Billing Provider NPI	**3.4%**	4.3%	3.2%	1.5%	**<0.1%**	<0.1%	<0.1%	0.0%
Rendering Provider NPI	**1.1%**	2.1%	0.4%	0.7%	**29.3%**	31.6%	27.8%	26.9%
Referring Provider NPI	**1.1%**	0.0%	1.4%	3.6%	**19.1%**	46.1%	0.0%	0.0%
Primary Diagnosis Code	**0.0%**	0.0%	0.0%	0.0%	**<0.1%**	<0.1%	<0.1%	0.0%
Secondary Diagnosis Code[1]	**<0.1%**	<0.1%	0.0%	0.0%	**10.1%**	20.6%	0.0%	12.8%
Procedure Code (CPT/HCPCS/CDT)	**<0.1%**	<0.1%	<0.1%	<0.1%	**<0.1%**	0.0%	<0.1%	<0.1%
Procedure Code Modifier	**<0.1%**	<0.1%	<0.1%	<0.1%	**<0.1%**	<0.1%	<0.1%	<0.1%
NDC	**<0.1%**	<0.1%	0.1%	<0.1%	**<0.1%**	<0.1%	<0.1%	<0.1%
Drug Quantity	**<0.1%**	<0.1%	0.1%	<0.1%	**0.0%**	0.0%	0.0%	0.0%
Header Paid Amount	**0.0%**	0.0%	0.0%	0.0%	**0.0%**	0.0%	0.0%	0.0%
Detail Paid Amount	**0.0%**	0.0%	0.0%	0.0%	**0.0%**	0.0%	0.0%	0.0%

Table 7-14 displays the element omission and surplus results for each key data element from institutional encounters for the MCOs. **For this indicator, lower rates indicate better performance.**

Table 7-14—Data Element Omission and Surplus: Institutional Encounters

Key Data Element	Element Omission				Element Surplus			
	Overall Rate	Anthem	HPN	SilverSummit	Overall Rate	Anthem	HPN	SilverSummit
Recipient ID	**0.0%**	0.0%	0.0%	0.0%	**<0.1%**	0.0%	<0.1%	0.0%
Header Service From Date	**0.0%**	0.0%	0.0%	0.0%	**0.0%**	0.0%	0.0%	0.0%
Header Service To Date	**0.0%**	0.0%	0.0%	0.0%	**0.0%**	0.0%	0.0%	0.0%
Detail Service From Date	**0.0%**	0.0%	0.0%	0.0%	**0.0%**	0.0%	0.0%	0.0%
Detail Service To Date	**0.0%**	0.0%	0.0%	0.0%	**0.0%**	0.0%	0.0%	0.0%
Billing Provider NPI	**0.4%**	0.5%	0.3%	0.2%	**0.0%**	0.0%	0.0%	0.0%
Attending Provider NPI	**1.8%**	2.0%	1.7%	1.7%	**0.0%**	0.0%	0.0%	0.0%
Referring Provider NPI	**0.5%**	0.0%	0.7%	1.0%	**0.5%**	0.0%	1.1%	0.0%
Primary Diagnosis Code	**0.0%**	0.0%	0.0%	0.0%	**0.0%**	0.0%	0.0%	0.0%
Secondary Diagnosis Code[1]	**2.2%**	0.0%	4.7%	0.0%	**5.2%**	12.8%	0.0%	<0.1%
Procedure Code (CPT/HCPCS/CDT)	**0.2%**	<0.1%	0.4%	0.1%	**0.2%**	<0.1%	0.4%	0.3%
Procedure Code Modifier	**0.5%**	<0.1%	0.9%	0.3%	**0.5%**	<0.1%	0.9%	0.5%
Primary Surgical Procedure Code	**<0.1%**	0.0%	<0.1%	0.0%	**5.5%**	13.3%	<0.1%	0.0%
Secondary Surgical Procedure Code[2]	**<0.1%**	0.0%	<0.1%	0.0%	**3.5%**	8.4%	0.1%	0.0%
NDC	**1.0%**	<0.1%	2.0%	0.3%	**1.0%**	<0.1%	2.0%	0.5%
Drug Quantity	**1.0%**	<0.1%	2.0%	0.3%	**0.0%**	0.0%	0.0%	0.0%
Revenue Code	**<0.1%**	<0.1%	<0.1%	<0.1%	**<0.1%**	0.0%	0.0%	<0.1%
Header Paid Amount	**0.0%**	0.0%	0.0%	0.0%	**0.0%**	0.0%	0.0%	0.0%
Detail Paid Amount	**0.0%**	0.0%	0.0%	0.0%	**0.0%**	0.0%	0.0%	0.0%

Table 7-15 displays the element omission and surplus results for each key data element from pharmacy encounters for the MCOs. **For this indicator, lower rates indicate better performance.**

Table 7-15—Data Element Omission and Surplus: Pharmacy Encounters

Key Data Element	Element Omission				Element Surplus			
	Overall Rate	Anthem	HPN	SilverSummit	Overall Rate	Anthem	HPN	SilverSummit
Recipient ID	**0.0%**	0.0%	0.0%	0.0%	**0.0%**	0.0%	0.0%	0.0%
Date of Service	**0.0%**	0.0%	0.0%	0.0%	**0.0%**	0.0%	0.0%	0.0%
Billing Provider NPI	**0.6%**	0.1%	1.0%	1.0%	**0.0%**	0.0%	0.0%	0.0%
Prescribing Provider NPI	**0.0%**	0.0%	0.0%	0.0%	**<0.1%**	<0.1%	0.0%	<0.1%
NDC	**0.0%**	0.0%	0.0%	0.0%	**0.0%**	0.0%	0.0%	0.0%
Drug Quantity	**0.0%**	0.0%	0.0%	0.0%	**0.0%**	0.0%	0.0%	0.0%
Paid Amount	**0.0%**	0.0%	0.0%	0.0%	**0.0%**	0.0%	0.0%	0.0%

Table 7-16 displays the element omission and surplus results for each key data element from dental encounters for the PAHP. **For this indicator, lower rates indicate better performance.**

Table 7-16—Data Element Omission and Surplus: Dental Encounters for LIBERTY

Key Data Element	Element Omission	Element Surplus
Recipient ID	0.0%	0.0%
Header Service From Date	0.0%	0.0%
Header Service To Date	0.0%	0.0%
Detail Service From Date	0.0%	0.0%
Detail Service To Date	0.5%	0.0%
Billing Provider NPI	5.2%	0.0%
Rendering Provider NPI	0.3%	0.0%
Procedure Code (CDT)	<0.1%	0.0%
Tooth Number	<0.1%	<0.1%
Oral Cavity Code	<0.1%	<0.1%
Tooth Surface 1	<0.1%	<0.1%
Tooth Surface 2	<0.1%	0.0%
Tooth Surface 3	<0.1%	0.0%
Tooth Surface 4	<0.1%	<0.1%
Tooth Surface 5	<0.1%	0.0%
Header Paid Amount	0.0%	0.0%
Detail Paid Amount	0.0%	0.0%

Table 7-17 displays, for each key data element associated with professional encounters for the MCOs, the percentage of records with the same values in both MCO- and DHCFP-submitted files. **For this indicator, higher rates indicate better performance.**

Table 7-17—Data Element Accuracy: Professional Encounters

Key Data Element	Element Accuracy			
	Overall Rate	Anthem	HPN	SilverSummit
Recipient ID	**>99.9%**	>99.9%	>99.9%	>99.9%
Header Service From Date	**>99.9%**	>99.9%	>99.9%	>99.9%
Header Service To Date	**>99.9%**	>99.9%	>99.9%	100%
Detail Service From Date	**>99.9%**	>99.9%	>99.9%	>99.9%
Detail Service To Date	**>99.9%**	>99.9%	>99.9%	>99.9%
Billing Provider NPI	**98.6%**	99.9%	97.9%	96.4%
Rendering Provider NPI	**>99.9%**	100%	>99.9%	>99.9%
Referring Provider NPI	**100%**	NA	100%	100%
Primary Diagnosis Code	**98.7%**	>99.9%	100%	89.4%
Secondary Diagnosis Code[1]	**66.6%**	0.0%	97.1%	93.2%
Procedure Code (CPT/HCPCS/CDT)	**99.8%**	>99.9%	99.7%	>99.9%
Procedure Code Modifier	**>99.9%**	>99.9%	>99.9%	>99.9%
NDC	**>99.9%**	>99.9%	99.9%	>99.9%
Drug Quantity	**71.9%**	47.0%	99.8%	57.3%
Header Paid Amount	**98.8%**	>99.9%	97.5%	99.9%
Detail Paid Amount	**99.4%**	>99.9%	98.7%	99.9%

[1] Calculated for Diagnosis Code 2 only.

Table 7-18 displays, for each key data element associated with institutional encounters for the MCOs, the percentage of records with the same values in both MCO- and DHCFP-submitted files. **For this indicator, higher rates indicate better performance.**

Table 7-18—Data Element Accuracy: Institutional Encounters

Key Data Element	Element Accuracy			
	Overall Rate	Anthem	HPN	SilverSummit
Recipient ID	**>99.9%**	>99.9%	>99.9%	100%
Header Service From Date	**99.9%**	>99.9%	99.7%	100%
Header Service To Date	**99.4%**	100%	98.7%	100%
Detail Service From Date	**92.4%**	84.4%	97.8%	98.5%
Detail Service To Date	**84.3%**	64.7%	97.8%	98.5%

Key Data Element	Element Accuracy			
	Overall Rate	Anthem	HPN	SilverSummit
Billing Provider NPI	**>99.9%**	>99.9%	>99.9%	>99.9%
Attending Provider NPI	**100%**	100%	100%	100%
Referring Provider NPI	**4.4%**	NA	4.4%	NA
Primary Diagnosis Code	**>99.9%**	100%	>99.9%	100%
Secondary Diagnosis Code[1]	**57.8%**	0.0%	90.0%	100%
Procedure Code (CPT/HCPCS/CDT)	**93.3%**	>99.9%	86.9%	95.2%
Procedure Code Modifier	**99.4%**	>99.9%	98.7%	99.6%
Primary Surgical Procedure Code	**55.2%**	NA	42.8%	100%
Secondary Surgical Procedure Code[2]	**37.0%**	NA	19.3%	99.8%
NDC	**98.9%**	>99.9%	98.4%	97.1%
Drug Quantity	**72.9%**	48.2%	88.6%	86.9%
Revenue Code	**95.7%**	>99.9%	91.4%	97.6%
Header Paid Amount	**99.0%**	>99.9%	97.8%	99.9%
Detail Paid Amount	**95.8%**	>99.9%	91.4%	97.9%

[1] Calculated for Diagnosis Code 2 only.
[2] Calculated for Surgical Procedure Code 2 only.
NA indicates not applicable since no records had values present in both data sources.

Table 7-19 displays, for each key data element associated with pharmacy encounters for the MCOs, the percentage of records with the same values in both MCO- and DHCFP-submitted files. **For this indicator, higher rates indicate better performance.**

Table 7-19—Data Element Accuracy: Pharmacy Encounters

Key Data Element	Element Accuracy			
	Overall Rate	Anthem	HPN	SilverSummit
Recipient ID	>99.9%	>99.9%	>99.9%	>99.9%
Date of Service	100%	100%	100%	100%
Billing Provider NPI	>99.9%	100%	>99.9%	100%
Prescribing Provider NPI	>99.9%	>99.9%	100%	>99.9%
NDC	>99.9%	>99.9%	100%	99.8%
Drug Quantity	99.9%	99.9%	99.8%	99.8%
Paid Amount	97.1%	94.6%	99.8%	98.3%

Table 7-20 displays, for each key data element associated with dental encounters, the percentage of records with the same values in both PAHP- and DHCFP-submitted files. **For this indicator, higher rates indicate better performance.**

Table 7-20—Data Element Accuracy: Dental Encounters for LIBERTY

Key Data Element	Element Accuracy
Recipient ID	>99.9%
Header Service From Date	>99.9%
Header Service To Date	>99.9%
Detail Service From Date	>99.9%
Detail Service To Date	>99.9%
Billing Provider NPI	97.6%
Rendering Provider NPI	>99.9%
Procedure Code (CDT)	>99.9%
Tooth Number	>99.9%
Oral Cavity Code	98.7%
Tooth Surface 1	100%
Tooth Surface 2	>99.9%
Tooth Surface 3	100%
Tooth Surface 4	100%
Tooth Surface 5	100%
Header Paid Amount	99.5%
Detail Paid Amount	99.7%

Table 7-21 displays the all-element accuracy results for the percentage of records present in both data sources with the same values (missing and non-missing) for all key data elements relevant to each encounter data type.

Table 7-21—All-Element Accuracy, by MCE and Encounter Type

MCE	Professional	Institutional	Pharmacy	Dental
Anthem	13.4%	8.4%	94.5%	
HPN	62.5%	66.3%	98.9%	
SilverSummit	52.3%	91.5%	97.3%	
LIBERTY				91.4%
Overall	**40.9%**	**45.7%**	**96.6%**	**91.4%**

Note: Gray cells indicate encounter types that were not applicable for the MCEs.

Medical/Dental Record Review

Table 7-22 displays the medical/dental record omission and encounter data omission rates for each key data element from the medical/dental record review activity.

Table 7-22—Medical/Dental Record Review: Encounter Data Completeness Summary

Data Element	MCO				PAHP
	Statewide	Anthem	HPN	SilverSummit	LIBERTY
Medical Record Omission					
Date of Service	**10.3%**	13.4%	0.7%	40.7%	4.3%
Diagnosis Code	**13.5%**	17.3%	3.6%	42.0%	NA
Procedure Code	**19.9%**	21.8%	13.0%	43.3%	11.0%
Procedure Code Modifier	**32.7%**	31.1%	29.3%	54.0%	NA
Encounter Data Omission					
Date of Service	**4.3%**	4.4%	5.0%	0.7%	4.7%
Diagnosis Code	**2.7%**	3.0%	2.8%	1.0%	NA
Procedure Code	**20.6%**	24.3%	19.2%	12.3%	23.5%
Procedure Code Modifier	**3.2%**	3.5%	3.3%	1.6%	NA

NA indicates that the data element was not applicable for dental record review.

Table 7-23 displays the element accuracy rates for each key data element and the all-element accuracy rates.

Table 7-23—Encounter Data Accuracy Summary

Data Element	MCO				PAHP	Statewide Error Type
	Statewide	Anthem	HPN	SilverSummit	LIBERTY	
Diagnosis Code	**99.7%**	99.6%	99.7%	99.7%	NA	Incorrect Code (100%); Specificity Error[1] (0.0%)
Procedure Code	**97.2%**	96.6%	97.2%	99.0%	88.6%	Incorrect Code (91.6%); Lower Level of Services in Medical Records (8.4%); Higher Level of Services in Medical Records (0.0%)
Procedure Code Modifier	**99.9%**	100%	99.7%	100%	NA	—
All-Element Accuracy	**58.6%**	51.3%	63.1%	66.8%	19.0%	—

NA indicates that the data element was not applicable for dental record review.
"—" denotes that the error type analysis was not applicable to a given data element.
[1] Specificity errors occurred when the documentation supported a more specific code than was listed in DHCFP's encounter data. Specificity errors also include diagnosis codes that do not have the required fourth or fifth digit.

8. Programwide Conclusions and Recommendations

HSAG performed a comprehensive assessment of the performance of the MCEs and identified their strengths and weaknesses related to the provision of healthcare services. The aggregated findings from all EQR activities were thoroughly analyzed and reviewed across the continuum of program areas and the activities that comprise the Nevada Managed Care Program to identify programwide conclusions. HSAG presents these programwide conclusions and corresponding recommendations to DHCFP to drive progress toward achieving the goals of the Nevada Quality Strategy and support improvement in the quality, timeliness, and access to healthcare services furnished to Medicaid members.

Table 8-1—Programwide Conclusions and Recommendations

Quality Strategy Goal	Overall Performance Impact	Performance Domain
Goal 1—Improve the health and wellness of Nevada's Medicaid population by increasing the use of preventive services by December 31, 2024	**Conclusions:** The Nevada Managed Care Program overall had adequate practices for ensuring its providers were aware of its adopted practice guidelines, including guidelines for preventive care. The network adequacy standards were also met for PCPs and pediatricians statewide, indicating the MCOs appeared to have a sufficient number of providers to render preventive services to children and adults. However, over the past three-year period (MY 2019–MY 2021), there has been a steady decline in the percentage of adult members accessing preventive services, and an even higher rate of decline in members 65 years and older. While there has been improvement in the percentage of Medicaid children and adolescents ages 3 to 17 who received one or more well-care visits with a PCP or an OB/GYN provider during the year, there has been a decline in the associated rates for the *Well-Child Visits in the First 30 Months of Life* performance measure for both the Medicaid and Nevada Check Up populations. There was also a decline in the prevalence of immunizations for children and adolescents over the past three years and no objectives under Goal 1 met the MPS. **Recommendations:** For SFY 2023, DHCFP has mandated that the MCOs implement a PIP to increase rates of child and adolescent well-care visits among members eligible for these services. To ensure interventions are actionable and will support performance improvement for this PIP, HSAG recommends that DHCFP review the MCOs' planned interventions prior to MCO implementation and provide feedback on any planned interventions based on DHCFP's knowledge of the environment in the State of Nevada. DHCFP could also consider whether state-required interventions would be appropriate for the MCOs to implement for the PIP mandated by DHCFP for SFY 2023. Further, to gain a better understanding of the potential barriers to members seeking preventive care, HSAG also	☒ Quality ☒ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	recommends that DHCFP collaborate with the MCOs to identify strategies to improve the CAHPS response rates so that the information obtained through the surveys provide enough data to make meaningful conclusions.	
Goal 2—Increase use of evidence-based practices for members with chronic conditions by December 31, 2024	**Conclusions:** All MCOs demonstrated an improvement in performance over the past three MYs in the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* measure, and the programwide aggregated rate also demonstrated improvement over time. Additionally, programwide, the percentage of diabetic members obtaining HbA1c tests, having HbA1c levels less than 8 percent, and having their blood pressure under control improved over the past SFY, indicating the Nevada Managed Care Program focused efforts on diabetes management and members were gaining better control over their diabetes. However, MPS at the program level have not been met for SFY 2022 for Quality Strategy Objectives 2.1a and b, 2.2, and 2.3 related to comprehensive diabetes care. Additionally, the *Controlling High Blood Pressure* measure demonstrated a slight increase from MY 2019. Further the *Kidney Health Evaluation for Patients With Diabetes* measure rates demonstrated minimal change overall. Under Goal 2 and the associated objectives (2.1a-b, 2.2, 2.3, 2.4, 2.6), no programwide MPS were attained. **Recommendations:** In SFY 2020, DHCFP mandated that the MCOs initiate the *Comprehensive Diabetes Care (CDC) Hemoglobin A1c (HbA1c) Poor Control >9.0%* PIP. Although there was demonstrated improvement in the *Comprehensive Diabetes Care* measure indicators, including *HbA1c Poor Control (>9.0%)*, as determined through the PMV activity results, only one of the MCO's interventions was attributed to the improved outcomes, suggesting the improvement in the rates was not related to the PIP interventions but was influenced by other factors. To ensure interventions are actionable and will support performance improvement for future PIPs, HSAG recommends that DHCFP review the MCOs' planned interventions prior to MCO implementation and provide feedback on any planned interventions based on DHCFP's knowledge of the environment in the State of Nevada. DHCFP could also consider whether state-required interventions would be appropriate for the MCOs to implement for the PIPs mandated by DHCFP for SFY 2023. DHCFP could consult with HSAG through these processes. Additionally, while the aggregate compliance review score for the Practice Guidelines standard was 94 percent, HSAG recommends that the MCOs ensure their list of adopted clinical practice guidelines are inclusive of	☒ Quality ☐ Timeliness ☐ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	guidelines to support the Quality Strategy objectives under Goal 2 and ensure their contracted providers are informed of the expectations for treating chronic conditions.	
Goal 3—Reduce misuse of opioids by December 31, 2024	**Conclusions:** For the *Use of Opioids at High Dosage* and *Use of Opioids From Multiple Providers* measures, the Medicaid aggregate rates were above the MPS, indicating the Nevada Managed Care Program achieved Objectives 3.1 and 3.2 under Goal 3. **Recommendations:** In SFY 2022, DHCFP added two new objectives to its Quality Strategy to support continued improvement of Goal 3. HSAG recommends that DHCFP and its MCOs monitor network providers' prescribing practices of opioids related to the new objectives (3.3a-b) and implement interventions, as necessary, to support achievement of the established MPS once available.	☒ Quality ☐ Timeliness ☐ Access
Goal 4—Improve the health and wellness of pregnant women and infants by December 31, 2024	**Conclusions:** While the *Postpartum Care* measure indicator at the programwide level improved slightly over a three-year period, the aggregated rate for the *Timeliness of Prenatal Care* measure indicator declined over a three-year period; and the associated Quality Strategy objectives (4.1a-b) did not meet the established MPS for both of these measures. From the findings of the NAV activity, three of the four MCOs did not meet the access standard statewide for the OB/GYN provider type and none of the four MCOs met the standard for Washoe County. These findings indicate pregnant women may experience challenges accessing prenatal care timely due to the lack of OB/GYN providers contracted with the MCOs and available to provide services to pregnant women or women who have recently delivered. **Recommendations:** In SFY 2020, DHCFP mandated that the MCOs initiate the *Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care* PIP. While a PIP was implemented to support improved outcomes for pregnant women, two of three MCOs' PIPs were not successful and the *Prenatal and Postpartum Care (PPC) Timeliness of Prenatal Care* performance measure declined programwide over a three-year period, indicating overall that the PIPs did not support achievement of the objectives under Quality Strategy Goal 4. To ensure the newly DHCFP-mandated PIPs for improving rates for prenatal and postpartum care for pregnant women in Medicaid managed care are successful, HSAG recommends that DHCFP review the MCOs' planned interventions prior to MCO implementation and provide feedback on any planned interventions to ensure the interventions will support a reduction in	☒ Quality ☒ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	health disparities and overall improvement in the timeliness of prenatal and postpartum care. In SFY 2022, DHCFP added five new objectives (4.2a-b, 4.3a-b, 4.4) to its Quality Strategy to support improvement in the health and wellness of pregnant women and their babies. HSAG recommends that DHCFP and its MCOs monitor the associated performance measures and identify strategies to improve member access to OB/GYN providers.	
Goal 5—Increase use of evidence-based practices for members with behavioral health conditions by December 31, 2024	**Conclusions:** At the programwide level, none of the behavioral health objectives under Goal 5 met the MPS for the Medicaid population, when an MPS was available. Additionally, while three objectives (5.3b, 5.6a-b) for the Nevada Check Up population met the programwide MPS, the remaining objectives with an established MPS did not. These findings indicate substantial opportunities for DHCFP and its contracted MCOs to ensure all members diagnosed with a mental illness and/or SUD are receiving timely follow-up appointments after ED visits and inpatient hospitalization, and are receiving adequate screenings, treatment, and medication management. With the exception of pediatric psychologists for two MCOs, the Nevada Managed Care Program had a sufficient network of behavioral health providers to render necessary services. **Recommendations:** For SFY 2023, DHCFP mandated that the MCOs initiate PIPs related to increasing rates of follow up after ED visit for adults and children who received a follow-up visit for mental illness, and improving access to care for Medicaid members with SUD. DHCFP is also requiring the MCOs to initiate and test at least one intervention focused on network adequacy and coordination of care initiatives around these two topics. Further, DHCFP added additional objectives (5.9, 5.11a-b, 5.12, 5.13a-b) to its Quality Strategy to support health outcomes in members with behavioral health conditions. As DHCFP has targeted initiatives to promote the achievement of Quality Strategy Goal 5, HSAG has no additional recommendations at this time.	☒ Quality ☒ Timeliness ☒ Access
Goal 6—Increase utilization of dental services by December 31, 2024	**Conclusions:** Based on the NAV activity, there appeared to be an adequate network of primary dental providers and most specialists, and for all age groups under the *Annual Dental Visit* measure, the Nevada Managed Care Program demonstrated an increase in all performance measures rates. However, no objectives under Goal 6 met the MPS for both the Medicaid and Nevada Check Up populations.	☒ Quality ☒ Timeliness ☒ Access

Quality Strategy Goal	Overall Performance Impact	Performance Domain
	Recommendations: DHCFP added three objectives (6.2, 6.3, 6.4) to its Quality Strategy to support health outcomes and increase the rate of children receiving a comprehensive or periodic oral evaluation, topical fluoride applications, and sealants. HSAG recommends that DHCFP monitor the results of the associated new performance measures and identify additional strategies (e.g., new PIP topics), as necessary, to continue its progress toward achieving Quality Strategy Goal 6 and improving oral health outcomes for its members.	
Goal 7—Reduce and/or eliminate health care disparities for Medicaid members by December 31, 2024	**Conclusions:** The aggregated findings from each of the EQR activities did not produce sufficient data for HSAG to assess the impact the EQR activities had on reducing and/or eliminating healthcare disparities for Medicaid members other than by geographic area or by gender (i.e., through the PIP and/or NAV activities). **Recommendations:** Through its contract with the MCEs, DHCFP requires that each MCE initiate several activities focused on eliminating healthcare disparities such as mandated PIPs (e.g., addressing maternal and infant health disparities within the African-American population, interventions addressing health disparities in dental services); implementation of cultural competency programs and plans; and the development of population health programs, including the requirement to target clinical programs to reduce healthcare disparities based on race and ethnicity. DHCFP also encourages each MCO to obtain the Multicultural Health Care Distinction from NCQA as a way to build a strong cultural competency program, reduce health disparities, and develop culturally and linguistically appropriate member communication strategies. In addition to the initiatives already underway, HSAG recommends DHCFP consider requiring the MCEs to stratify HEDIS and other performance measure data by race and ethnicity and use the data to drive future quality improvement efforts and develop targeted interventions.	☒ Quality ☒ Timeliness ☒ Access

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 designed, conducted, and reported PIPs in a methodologically sound manner meeting all State and federal requirements.

DHCFP requires its MCEs to conduct PIPs annually. The topics for the SFY 2022 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, timeliness, and accessibility of 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 Plan-Do-Study-Act (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.

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

Table A-1 displays each MCO's PIP topics, implemented interventions, and data sources used for analyzing the results of each PIP. The duration of rapid-cycle PIPs is approximately 18 months, with the MCOs submitting rolling 12-month data per PIP.

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

Table A-2 and Table A-3 display the PAHP's PIP topics, SMART Aim statements, implemented interventions, and data sources used for analyzing the results of each PIP. The duration of rapid-cycle PIPs is approximately 18 months, with the MCOs submitting rolling 12-month data per PIP.

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

PIP Topic	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.

Process for Drawing Conclusions

To draw conclusions about the quality, timeliness, and accessibility of care and services that the MCEs provided to members, HSAG validated the PIPs to ensure that the MCEs used a sound methodology in their design, implementation, analysis, and reporting of the PIP's findings and outcomes. The process assesses the validation findings on the likely validity and reliability of the results by assigning a level of confidence (i.e., *High confidence*, *Confidence*, *Low confidence*, or *Reported PIP results were not credible*). HSAG further analyzed the quantitative results (e.g., SMART Aim measure results) and qualitative results (e.g., technical design of the PIP, data analysis and interpretation of results, initiation of improvement strategies, and intervention testing results) to identify strengths and weaknesses and determine whether each strength and weakness impacted one or more of the domains of quality, timeliness, or access. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to the MCEs' Medicaid members.

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 MCOs to undergo a PMV audit annually. In order to meet the PMV requirements, HSAG, as the EQRO for DHCFP, conducts an NCQA HEDIS Compliance Audit for each MCO. HSAG adheres to NCQA's *HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*,[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 (EQR Protocol 2),[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.

[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: Dec 14, 2022.

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 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 2021 through May 2022)

- Forwarded HEDIS MY 2021 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.
- 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 MRR validation to ensure the integrity of MRR processes for performance measures that required medical record data for HEDIS reporting.

Audit Review Phase (January 2022 through April 2022)

- 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.

Follow-Up and Reporting Phase (May 2022 through July 2022)

- 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 2020 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 2021 through May 2022)

- 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 2022 through April 2022)

- 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 2022 through July 2022)

- 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 2021 and July 2022.

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.
- 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.

Process for Drawing Conclusions

To draw conclusions about the quality, timeliness, and accessibility of care and services that the MCEs provided to members, HSAG determined results for each performance measure at the indicator level and assigned each an audit designation in alignment with the applicable guidelines for each type of audit. For the MCO HEDIS audits, HSAG assigned each performance indicator an audit designation of *Reportable (R)*, *Not Applicable (NA)*, or *Biased Rate (BR)*, according to NCQA's *HEDIS Measurement Year 2021 Volume 5: HEDIS Compliance Audit: Standards, Policies and Procedures.* For the PAHP PMV audit, HSAG assigned each performance measure indicator an audit designation of *Reportable (R)* or *Do Not Report (DNR)*, according to CMS EQR Protocol 2. HSAG further analyzed the quantitative results (e.g., performance indicator results) and qualitative results (e.g., IS data collection and reporting processes) to identify strengths and weaknesses and determine whether each strength and weakness impacted one or more of the domains of quality, timeliness, or access. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to each MCE's Medicaid members.

Compliance Review

Activity Objectives

The objective of the SFY 2022 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 were 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

Prior to beginning the compliance review, HSAG developed data collection tools, referred to as compliance review tools, to document the review. The content of the tools was selected based on applicable federal and State regulations and laws and on the requirements set forth in the contract between DHCFP and the MCE as they related to the scope of the review. The review processes used by HSAG to evaluate each MCE's compliance were consistent with CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019 (EQR Protocol 3).[A-3]

For each MCE, HSAG's compliance review consisted of the following activities:

Pre-Site Review Activities:

- Collaborated with DHCFP to develop the scope of work, compliance review methodology, and compliance review tools.
- Prepared and forwarded to the MCE a timeline, description of the compliance process, pre-site review information packet, a submission requirements checklist, and a post-site review document tracker.
- Scheduled the site review with the MCE.
- Hosted a pre-site review preparation session with all MCEs.
- Generated a list of 10 sample records for practitioner credentialing, organizational credentialing, grievances, appeals, and three sample records for delegate case file reviews.
- Conducted a desk review of supporting documentation the MCE submitted to HSAG.
- Followed up with the MCE, as needed, based on the results of HSAG's preliminary desk review.
- Developed an agenda for the one-day site review interview sessions and provided the agenda to the MCE to facilitate preparation for HSAG's review.

Site Review Activities:

- Conducted an opening conference, with introductions and a review of the agenda and logistics for HSAG's review activities.
- Interviewed MCE key program staff members.
- Conducted a review of practitioner credentialing, organizational credentialing, grievances, appeals, and delegated entities' records.
- Conducted an IS review of the data systems that the MCE used in its operations, applicable to the standards under review.
- Conducted a closing conference during which HSAG reviewers summarized their preliminary findings, as appropriate.

[A-3] 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: Dec 15, 2022.

Post-Site Review Activities:

- Conducted a review of additional documentation submitted by the MCE.
- Documented findings and assigned each element a score of *Met*, *Not Met*, or *NA* (as described in the Data and Aggregation and Analysis section) within the compliance review tool.
- Prepared an MCE-specific report and CAP template for the MCE to develop and submit its remediation plans for each element that received a *Not Met* score.

Data Aggregation and Analysis:

HSAG used scores of *Met* and *Not Met* to indicate the degree to which the MCE's performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to an MCE during the period covered by HSAG's review. This scoring methodology is consistent with CMS EQR Protocol 3. The protocol describes the scoring as follows:

Met indicates full compliance defined as *all* of the following:

- All documentation listed under a regulatory provision, or component thereof, is present.
- Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.
- Documentation, staff responses, case file reviews, and IS reviews confirm implementation of the requirement.

Not Met indicates noncompliance defined as *one or more* of the following:

- There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews.
- Staff members can describe and verify the existence of processes during the interviews, but documentation is incomplete or inconsistent with practice.
- Documentation, staff responses, case file reviews, and IS reviews do not demonstrate adequate implementation of the requirement.
- No documentation is present and staff members have little or no knowledge of processes or issues addressed by the regulatory provisions.
- For those provisions with multiple components, key components of the provision could not be identified and any findings of *Not Met* would result in an overall provision finding of noncompliance, regardless of the findings noted for the remaining components.

From the scores that it assigned for each 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 totaling the number of *Met* (1 point) elements and the number of *Not Met* (0 points) elements, then dividing the summed score by the total number of applicable elements for that standard. Elements not applicable to the MCE were scored *NA* and were not included in the denominator of the total score.

HSAG determined the overall percentage-of-compliance score across the areas of review by following the same method used to calculate the scores for each standard (i.e., by summing the total values of the scores and dividing the result by the total number of applicable elements).

HSAG conducted file reviews of each MCE's records for practitioner credentialing, organizational credentialing, grievances, appeals, and delegated entities to verify that the MCE had put into practice what the MCE had documented in its policy. HSAG selected 10 records each for practitioner and organizational credentialing, grievances, appeals, and three delegated entities from the full universe of records provided by the MCE. The file reviews were not intended to be a statistically significant representation of all the MCE's files. Rather, the file reviews highlighted instances in which practices described in policy were not followed by MCE staff members. Based on the results of the file reviews, the MCE must determine whether any area found to be out of compliance was the result of an anomaly or if a more serious breach in policy occurred. Findings from the file reviews were documented within the applicable standard and element in the compliance review tool.

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.
- Management/monitoring reports and audits.
- Narrative and/or data reports across a broad range of performance and content areas.
- Records for practitioner credentialing, organizational credentialing, grievances, appeals, and delegated entities.

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 and Applicable Time Period

Data Obtained	Time Period to Which the Data Applied
Documentation submitted for HSAG's desk review and additional documentation available to HSAG during or after the site review	January 1, 2022–May 31, 2022
Information obtained through interviews	September 12, 2022–September 16, 2022
Information obtained from a review of a sample of practitioner and organizational credentialing files	Listing of all practitioners and organizations who completed the credentialing process between January 1, 2022–May 31, 2022
Information obtained from a review of a sample of member grievance files	Listing of all closed member grievances between January 1, 2022–May 31, 2022
Information obtained from a review of a sample of member appeal files	Listing of all closed appeals between January 1, 2022–May 31, 2022
Information obtained from a review of a sample of delegated entity files	Listing of all delegates serving the Nevada Managed Care Program between January 1, 2022–May 31, 2022

Process for Drawing Conclusions

To draw conclusions and provide an understanding of the strengths and weaknesses of each MCE individually, HSAG used the results of the comprehensive case file reviews for six program areas. For any program area that was determined to be out of compliance, the MCEs were required to submit a CAP.

HSAG determined each MCE's substantial strengths and weaknesses as follows:

- Strength—Any program area that did not require a CAP (i.e., achieved a compliance score of 100 percent)
- Weakness—Any program area that received a compliance score of less than 80 percent.

HSAG further analyzed the qualitative results of each strength and weakness (i.e., findings that resulted in the strength or weakness) to draw conclusions about the quality, timeliness, and accessibility of care and services that the MCE provided to members by determining whether each strength and weakness impacted one or more of the domains of quality, timeliness, and access. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to the MCE's Medicaid members.

Network Adequacy Validation

Activity Objectives

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 NAV of the Medicaid provider network for all MCOs and the PAHP during SFY 2022. 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 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 provider-to-member 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 percentage of members within access standards for the provider categories identified in the MCE's provider crosswalk. A higher percentage of members meeting access standards indicated a better geographic distribution of the MCE's providers relative to Medicaid members.

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

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 March 1, 2022.

Provider Data

- Provider data for providers actively enrolled in an MCE as of March 1, 2022. The MCEs classified providers to selected provider categories in alignment with the provider crosswalk, which detailed the methods for classifying each provider category.

Process for Drawing Conclusions

To draw conclusions about the quality, timeliness, and accessibility of care and services that each MCE provided to members, HSAG calculated provider-to-member ratios by provider category relative to the number of members for each MCE and the geographic distribution of providers relative to MCE members and then compared these analytic results to DHCFP's minimum network standards and identified the MCEs that failed to meet the minimum network requirements. HSAG determined each MCE's substantial strengths and weaknesses by considering the degree to which the MCE met minimum network requirements for the analyses under review.

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 2022 CAHPS surveys for **Anthem**. SPH Analytics, an NCQA-certified vendor, administered the 2022 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 the 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 Effectiveness of Care measures assessed the various aspects of providing assistance with smoking and tobacco use cessation. The CCC composite measures/items evaluated the experience of families with children with chronic conditions accessing various services (e.g., specialized services, prescription medications).

Top-Box Score Calculations

For each of the global ratings, the percentage of respondents who chose a top experience rating, or top-box response (i.e., a response value of 9 or 10 on a scale of 0 to 10) was calculated.

For each of the composite measures and CCC composite measures/items, the percentage of respondents who chose a positive, or top-box 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." 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

Colors and arrows were used to note substantial differences. An MCO that performed statistically significantly higher than the 2021 NCQA national average was denoted with an upward green (↑) arrow.[A-4] Conversely, an MCO that performed statistically significantly lower than the 2021 NCQA national average was denoted with a downward red (↓) arrow. An MCO that was not statistically significantly higher or lower than the 2021 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 2022 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 (i.e., combined results of **Anthem**, **HPN**, and **SilverSummit**) 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 (↓) 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, 2021, and child members included as eligible for the survey were 17 years of

[A-4] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2020.* Washington, DC: NCQA, September 2020.

age or younger as of December 31, 2021. Adult members and parents or caretakers of child members completed the surveys from February to May 2022.

Process for Drawing Conclusions

To draw conclusions about the quality, timeliness, and accessibility of care and services that each MCO provided to members, HSAG compared each MCO's 2022 survey results to determine if a substantial increase or decrease was denoted by a change of 5 percentage points higher or lower than the 2021 NCQA national averages.

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 2021 through May 2022 and reported to the Quality Management and Improvement Committee on June 20, 2022.

Process for Drawing Conclusions

To draw conclusions about the quality, timeliness, and accessibility of care and services that the PAHP provided to members, HSAG compared each applicable survey category to the established benchmark. Those categories that exceeded the 90 percent benchmark were considered to be a strength, indicating that members reported positive experiences; while those categories that did not meet the established 90 percent benchmark were considered a weakness, indicating that members reported fewer positive experiences.

Encounter Data Validation

MCOs/PAHP

Activity Objectives

Accurate and complete encounter data are critical to the success of any managed care program. State Medicaid agencies rely on the quality of encounter data submissions from contracted MCEs so as to accurately and effectively monitor and improve the program's quality of care, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information.

During SFY 2022, DHCFP contracted HSAG to conduct an EDV study. In alignment with CMS EQR *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity*, October 2019 (EQR Protocol 5),[A-5] HSAG conducted the EDV study based on three evaluation activities designed to evaluate the completeness and accuracy of DHCFP's encounter. The three activities are as follows:

- **IS review**—assessment of DHCFP's and/or the MCE's IS and processes.
- **Comparative analysis**—analysis of DHCFP's electronic encounter data completeness and accuracy through a comparative analysis between DHCFP's electronic encounter data and the data extracted from the MCEs' data systems.
- **Medical/dental records review**—analysis of DHCFP's electronic encounter data completeness and accuracy through a review of a sample of medical/dental records for physician/dental services rendered during the study period. HSAG used data with dates of service from January 1, 2020, through December 31, 2020.

[A-5] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Dec 15, 2022.

Of note, since SFY 2022 was the first year that HSAG conducted the EDV study for **SilverSummit** and **LIBERTY**, HSAG included the IS review component of the activity for these MCEs. Table A-6 illustrates the core evaluation activities for each of the respective MCEs.

Table A-6—Core Evaluation Activities for Each MCE

MCE	IS Review	Comparative Analysis	Record Review	
			Medical	Dental
Anthem	No	Yes	Yes	No
HPN	No	Yes	Yes	No
SilverSummit	Yes	Yes	Yes	No
LIBERTY	Yes	Yes	No	Yes

Information System Review

The IS review seeks to define how each participant in the encounter data process collects and processes encounter data such that the data flow from the MCEs to DHCFP is understood. The IS review is key to understanding whether the IS infrastructures are likely to produce complete and accurate encounter data. This activity corresponds to Activity 2: Review the MCO's Capability in the CMS EQR Protocol 5.

Comparative Analysis

The goal of the comparative analysis is to evaluate the extent to which encounters submitted to DHCFP by the MCEs are complete and accurate, based on corresponding information stored in each MCE's data systems. This step corresponds to another important validation activity described in the CMS EQR Protocol 5 (i.e., analyses of MCO electronic encounter data for accuracy and completeness on reporting).

Medical/Dental Record Review

As outlined in the CMS EQR Protocol 5, medical/dental record review is a complex and resource-intensive process. Medical and clinical records are considered the "gold standard" for documenting Medicaid members' access to and quality of healthcare services. The goal of the medical/dental record review is to evaluate encounter data completeness and accuracy through a review of medical/dental records for physician/dental services rendered from January 1, 2020, through December 31, 2020. This study answered the following question: *Are the data elements in Table A-7 found on the professional/dental encounters complete and accurate when compared to information contained within the medical/dental records?*

Table A-7—Key Data Elements for Medical and Dental Record Review

Medical	Dental
Date of Service	Date of Service
Diagnosis Code	Dental Procedure Code (CDT)
Procedure Code (CPT/HCPCS)	
Procedure Code Modifier	

Technical Methods of Data Collection and Analysis

Information System Review

To ensure the collection of critical information, HSAG employed a three-stage process that included a document review, development and fielding of a customized encounter data assessment, and follow-up with key staff members. Of note, HSAG conducted this activity for **SilverSummit** and **LIBERTY** only, since HSAG conducted the IS review activity for **Anthem** and **HPN** during SFY 2018.

Stage 1—Document Review

HSAG initiated the EDV activity with a desk review of documents related to encounter data initiatives and validation activities currently put forth by DHCFP. Documents reviewed included data dictionaries, process flow charts, data system diagrams, encounter system edits, sample rejection reports, workgroup meeting minutes, and DHCFP's current encounter data submission requirements. The information obtained from this review assisted in the development of a targeted questionnaire to address important topics of interest to DHCFP.

Stage 2—Development and Fielding of Customized Encounter Data Assessment

Based on the information provided by DHCFP, HSAG developed a questionnaire, customized in collaboration with DHCFP, to gather information and specific procedures for data processing, personnel, and data acquisition capabilities. This assessment also included a review of supplemental documentation regarding other data systems, including enrollment and providers. Lastly, this review included specific topics of interest to DHCFP.

Stage 3—Key Staff Member Interviews

After reviewing the completed assessments, HSAG followed up with key IT personnel to clarify any questions that stemmed from questionnaire responses. Overall, the IS reviews allowed HSAG to document current processes and develop a thematic process map identifying critical points that impact the submission of quality encounter data.

Comparative Analysis

HSAG developed a data requirements document requesting claims and encounter data from DHCFP and the MCEs. Follow-up technical assistance meetings occurred approximately one week after distributing the data requirements documents, thereby allowing the MCEs time to review and prepare questions during the meeting.

Once HSAG received and processed the final set of data requested from DHCFP and each MCE, HSAG conducted a series of comparative analyses, which were divided into two analytic sections. First, HSAG assessed record-level data completeness using the following metrics for each encounter data type:

- The number and percentage of records present in the MCEs' submitted files but not in DHCFP's data warehouse (record omission).
- The number and percentage of records present in DHCFP's data warehouse but not in the MCEs' submitted files (record surplus).

Second, based on the number of records present in both data sources, HSAG further examined completeness and accuracy for key data elements listed in Table A-8. The analyses focused on an element-level comparison for each data element.

Table A-8—Key Data Elements for Comparative Analysis

Key Data Element	Professional	Institutional	Pharmacy	Dental
Recipient ID	✓	✓	✓	✓
Header Service From Date	✓	✓	✓	✓
Header Service To Date	✓	✓		✓
Detail Service From Date	✓	✓		✓
Detail Service To Date	✓	✓		✓
Billing Provider Number/NPI	✓	✓	✓	✓
Rendering Provider Number/NPI	✓			✓
Referring/Prescribing/Admitting Provider Number/NPI	✓	✓	✓	✓
Primary Diagnosis Code	✓	✓		
Secondary Diagnosis Code	✓	✓		
Procedure Code (CPT/HCPCS/CDT)	✓	✓		✓
Procedure Code Modifier	✓	✓		
Primary Surgical Procedure Code		✓		
Secondary Surgical Procedure Code		✓		
Tooth Number				✓
Tooth Quadrant				✓
Tooth Surface (1 through 5)				✓
NDC	✓	✓	✓	
Drug Quantity	✓	✓	✓	
Revenue Code		✓		
Header Paid Amount	✓	✓	✓	✓
Detail Paid Amount	✓	✓		✓

HSAG evaluated element-level completeness based on the following metrics:

- The number and percentage of records with values present in the MCEs' submitted files but not in DHCFP's data warehouse (element omission).

- The number and percentage of records with values present in DHCFP's data warehouse but not in the MCEs' submitted files (element surplus).

Element-level accuracy was limited to those records with values present in both the MCEs' submitted files and DHCFP's data warehouse. For each key data element, HSAG determined the number and percentage of records with the same values in both the MCEs' submitted files and DHCFP's data warehouse (element accuracy).

Finally, for records present in both DHCFP's and the MCEs' data, HSAG evaluated the number and percentage of records with the same values for all key data elements relevant to each encounter data type (all-element accuracy).

Medical/Dental Record Review

To answer the study question, HSAG conducted the following activities:

- Identified the eligible population and generated sample cases from data extracted from DHCFP's data warehouse.
- Assisted the MCEs to procure medical/dental records from providers, as appropriate.
- Reviewed medical/dental records against DHCFP's encounter data.
- Calculated study indicators and presented study results to DHCFP.

Study Population

To be eligible for the MRR, a member had to be continuously enrolled in the same MCE during the study period (i.e., from January 1, 2020, through December 31, 2020) and had to have at least one physician/dental visit during the study period. Additionally, members with Medicare and/or other insurance coverage were excluded from the eligible population since these members may have received services that were documented in their medical/dental record but were not represented in DHCFP's encounter data. HSAG also presented and discussed with DHCFP an agreed-upon criteria to determine how to identify physician/dental visits from the encounter data.

Sampling Strategy

HSAG used a two-stage sampling technique to select samples based on the member enrollment and encounter data extracted from the DHCFP data warehouse. HSAG first identified all members who meet the study population eligibility criteria, and random sampling was used to select 411 members[A-6] from the eligible population for each of the MCEs. Then, for each selected sampled member, HSAG used the SURVEYSELECT procedure in SAS®,[A-7] to randomly select one physician/dental visit[A-8] that occurred

[A-6] The sample size of 411 is based on a 95 percent confidence level and a margin of error of 5 percent.

[A-7] SAS and all other SAS Institute Inc. product or service names are registered trademarks or trademarks of SAS Institute Inc. in the USA and other countries. ® indicates USA registration.

[A-8] To ensure that the medical/dental record review includes all services provided on the same date of service, encounters with the same date of service and same rendering provider will be consolidated into one visit for sampling purposes.

in the study period (i.e., between January 1, 2020, and December 31, 2020). Additionally, to evaluate whether any dates of service were omitted from the DHCFP data warehouse, HSAG reviewed a second date of service rendered by the same provider during the review period. The providers selected the second date of service, which was closest to the selected date of service, from the medical/dental records for each sampled member. If a sampled member did not have a second visit with the same provider during the review period, HSAG evaluated only one date of service for that member. As such, the final number of cases reviewed were between 411 and 822 cases in total for each MCE.

Since an equal number of cases was selected from each MCE to ensure an adequate sample size when reporting rates at the MCE level, adjustments were required to calculate the statewide rates to account for population differences among the MCEs. When reporting statewide rates, HSAG weighted each MCE's raw rates based on the volume of physician/dental visits among the eligible population for that MCE. This approach ensured that no MCE was over- or under-represented in the statewide rates.

Medical/Dental Record Procurement

Upon receiving the final sample lists from HSAG, each MCE was responsible for procuring the sampled members' medical/dental records from their contracted providers for services that occurred during the study period and submitting the documentation to HSAG.

All electronic medical/dental records HSAG received were maintained on a secure HSAG network, which allowed HSAG's trained reviewers to validate the cases from a centralized location under supervision and oversight. As with all record reviews and research activities, HSAG implemented a thorough HIPAA compliance and protection program in accordance with federal regulations that included recurring training as well as policies and procedures that address physical security, electronic security, and day-to-day operations.

Review of Medical/Dental Records

HSAG's trained reviewers collected and documented findings in an HSAG-designed electronic data collection tool. The tool was designed with edits to assist in the accuracy of data collection. The validation included a review of specific data elements identified in sample cases and compared to corresponding documentation in the medical/dental record.

HSAG's trained reviewer verified whether the sampled date of service from DHCFP's encounter data could be found in the member's medical/dental record. If so, the reviewer documented that the date of service was valid; if not, the reviewers reported the date of service as a *medical record omission*. Next, the reviewer evaluated the services provided on the selected date of service and validated the data elements listed in Table A-8. The reviewer entered all findings into the electronic tool to ensure data integrity.

If the documentation for a second date of service was available, the reviewers evaluated the services rendered and validated the data elements in Table A-8 associated with the second date of service. If the documentation contained more than one second date of service, the reviewer selected the date closest to the sampled date of service to validate. If the second date of service was missing from DHCFP's data

warehouse, it was reported as an *encounter data omission*. The missing values associated with this visit were listed as an omission for each key data element, respectively.

Study Indicators

Once HSAG's trained reviewers completed the medical/dental record review, HSAG analysts exported information collected from the electronic tool, reviewed the data, and conducted the analysis. HSAG used four study indicators to report the medical/dental record review results:

- *Medical/dental record omission rate*: the percentage of dates of service identified in the electronic encounter data that were not found in the members' medical/dental records. HSAG also calculated this rate for the other key data elements in Table A-8.
- *Encounter data omission rate*: the percentage of dates of service from members' medical/dental records that were not found in the electronic encounter data. HSAG also calculated this rate for the other key data elements in Table A-8.
- *Accuracy rate of coding*: the percentage of diagnosis codes, procedure codes, and procedure code modifiers associated with validated dates of service from the electronic encounter data that were correctly coded based on the members' medical/dental records.
- *Overall accuracy rate:* the percentage of dates of service with all data elements coded correctly among all validated dates of service from the electronic encounter data.

Description of Data Obtained and Related Time Period

Information System Review

Representatives from the MCEs completed the DHCFP-approved questionnaire and then submitted its responses and relevant documents to HSAG for review. Of note, the questionnaire includes an attestation statement from the MCE's chief executive officer or responsible individual to certify that the information provided is complete and accurate.

Comparative Analysis

HSAG used data from both DHCFP and the MCEs with dates of service from January 1, 2020, through December 31, 2020, to evaluate the accuracy and completeness of the encounter data. To ensure that the extracted data from both sources represented the same universe of encounters, the data for the MCO targeted professional, institutional, and pharmacy encounters submitted to DHCFP on or before June 30, 2021. Similarly, the data for the PAHP targeted dental encounters submitted to DHCFP on or before June 30, 2021. This anchor date allowed sufficient time for the CY 2020 encounters to be submitted, processed, and available for evaluation in the DHCFP data warehouse.

Once HSAG received the requested data files from all data sources, the analytic team conducted a preliminary file review to ensure that the data were sufficient to conduct the evaluation. The preliminary file review included the following basic checks:

- Data extraction—Data were extracted based on the data requirements document.

- Percentage present—Required data fields are present in the file and have values assigned in those fields.
- Percentage of valid values—Values included are the expected values (e.g., valid International Classification of Diseases, 10th Revision [ICD-10] codes in the diagnosis field).
- Evaluation of matching claim numbers—The percentage of claim numbers that match between the data extracted from DHCFP's data warehouse and the MCEs' data submitted to HSAG.
- Based on the results of the preliminary file review, HSAG generated a report that highlighted major findings requiring both the MCEs and DHCFP to resubmit data.

Medical/Dental Record Review

HSAG submitted a data requirements document to DHCFP to request member enrollment, provider, and professional/dental encounter data with dates of service from January 1, 2020, through December 31, 2020. Based on these data, HSAG randomly selected sample cases and submitted them to the MCEs for medical/dental record procurement. Once HSAG received medical/dental records from the MCOs/PAHP, HSAG's trained reviewers tracked them into an HSAG-designed electronic data collection tool and conducted the validation. HSAG designed the tool with edits to assist in accuracy and consistency of data collection. Finally, an HSAG analyst exported information collected from the electronic tool, reviewed the data, and calculated study indicators based on the data.

Process for Drawing Conclusions

To draw conclusions about the quality of each MCE's encounter data submissions to DHCFP, HSAG evaluated the results based on the EDV core activities. HSAG calculated the predefined study indicators and/or metrics associated with each of the study components. To identify strengths and weaknesses, HSAG assessed the results based on its experience working with other states in assessing the completeness and accuracy of the MCEs' encounter data submissions to the State. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality of encounter data submitted to DHCFP.

Nevada 2022–2024 Quality Strategy
Goals and Objectives for Medicaid and Nevada Check Up

The Nevada Quality Strategy objectives were developed in alignment with national performance measures, including HEDIS and the Adult and Child Core Sets, to assess the Nevada Managed Care Program's progress in meeting its Quality Strategy goals. Performance is evaluated annually and reported through the annual EQR technical report.

To establish performance targets, DHCFP uses the QISMC methodology developed by the Department of Health & Human Services Health Care Financing Administration. Performance goals (i.e., MPS) are established by reducing by 10 percent the gap between the performance measure baseline rate and 100 percent (or 0 percent for inverse measures [i.e., lower rates indicate better performance]). For example, if the baseline rate was 55 percent, the MCE would be expected to improve the rate by 4.5 percentage points to 59.5 percent. This is calculated as 4.5% = 10% x (100% – 55%). The methodology for calculating performance metrics for initiatives relating to specific provider groups (e.g., CCBHC, State-Directed Payment, and P-COAT) is included in Section 2, and performance rates are not included as part of this tracking table.

Unless otherwise indicated, DHCFP established an MPS for each objective using performance measurement data from MY 2021 Medicaid and Nevada Check Up aggregate performance data. The MPS will remain stagnant over a period of three years, then be reassessed during the triennial review of the Quality Strategy. Each objective that shows improvement equal to or greater than the performance target (i.e., MPS) is considered achieved, and suggests the Nevada Managed Care Program has made progress toward reaching the associated goal. **MPS that were met for SFY 2022 are denoted by green shading.**

Goal 1—Improve the health and wellness of Nevada's Medicaid population by increasing the use of preventive services by December 31, 2024									
Objective #	Objective Description	Measure Steward	Measure Set			Medicaid Aggregate MY 2021	Nevada Check Up Aggregate MY 2021	MPS	
			HEDIS	Adult Core Set	Child Core Set			Medicaid	Nevada Check Up
1.1a	Increase well-child visits in the first 30 months of life (W30)—0–15 months (6 or more well-child visits)	NCQA	✓		✓	57.74%	63.79%	62.88%	73.00%
1.1b	Increase well-child visits in the first 30 months of life (W30)—15–30 months (2 or more well-child visits)	NCQA	✓		✓	60.18%	73.00%	70.56%	82.95%
1.2a	Increase child and adolescent well-care visits (WCV)—3–11 years	NCQA	✓		✓	49.81%	53.00%	52.50%	59.37%
1.2b	Increase child and adolescent well-care visits (WCV)—12–17 years	NCQA	✓		✓	44.81%	52.22%	45.85%	54.57%
1.2c	Increase child and adolescent well-care visits (WCV)—18–21 years	NCQA	✓		✓	20.27%	30.28%	29.68%	38.72%
1.3a	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—BMI percentile	NCQA	✓		✓	82.70%	83.88%	85.76%	85.62%
1.3b	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—Counseling for nutrition	NCQA	✓		✓	75.12%	75.51%	77.65%	77.08%
1.3c	Increase weight assessment and counseling for nutrition and physical activity for children/adolescents (WCC)—Counseling for physical activity	NCQA	✓		✓	71.60%	72.17%	74.96%	74.09%
1.4a	Increase immunizations for adolescents (IMA)—Combination 1	NCQA	✓		✓	81.84%	89.68%	87.81%	94.17%
1.4b	Increase immunizations for adolescents (IMA)—Combination 2	NCQA	✓		✓	33.87%	45.18%	48.91%	57.30%
1.5a	Increase childhood immunization status (CIS)—Combination 3	NCQA	✓		✓	58.90%	74.17%	68.95%	82.36%

Goal 1—Improve the health and wellness of Nevada's Medicaid population by increasing the use of preventive services by December 31, 2024									
Objective #	Objective Description	Measure Steward	Measure Set			Medicaid Aggregate MY 2021	Nevada Check Up Aggregate MY 2021	MPS	
			HEDIS	Adult Core Set	Child Core Set			Medicaid	Nevada Check Up
1.5b	Increase childhood immunization status (CIS)—Combination 7	NCQA	✓		✓	51.16%	68.01%	62.11%	76.15%
1.5c	Increase childhood immunization status (CIS)—Combination 10	NCQA	✓		✓	26.59%	40.29%	38.58%	48.22%
1.6	Increase breast cancer screening (BCS)	NCQA	✓	✓		46.13%	—	54.27%	—
1.7a	Increase adults' access to preventive/ambulatory health services (AAP)—20–44 years	NCQA	✓			63.48%	—	69.68%	—
1.7b	Increase adults' access to preventive/ambulatory health services (AAP)—45–64 years	NCQA	✓			71.92%	—	76.59%	—
1.8a	Increase chlamydia screening in women (CHL)—16–20 years	NCQA	✓		✓	53.43%	50.79%	MNA	MNA
1.8b	Increase chlamydia screening in women (CHL)—21–24 years	NCQA	✓	✓		61.06%	NA	MNA	—

Goal 2—Increase use of evidence-based practices for members with chronic conditions by December 31, 2024									
Objective #	Objective Description	Measure Steward	Measure Set			Medicaid Aggregate MY 2021	Nevada Check Up Aggregate MY 2021	MPS	
			HEDIS	Adult Core Set	Child Core Set			Medicaid	Nevada Check Up
2.1a	Increase rate of HbA1c control (<8.0%) for members with diabetes (CDC) [1]	NCQA	✓			48.28%	—	50.84%	—
2.1b	Reduce rate of HbA1c poor control (>9.0%) for members with diabetes (CDC) [1]*	NCQA	✓	✓		43.19%	—	40.52%	—
2.2	Increase rate of eye exams performed for members with diabetes (CDC) [1]	NCQA	✓			53.80%	—	61.59%	—

Goal 2—Increase use of evidence-based practices for members with chronic conditions by December 31, 2024									
Objective #	Objective Description	Measure Steward	Measure Set			Medicaid Aggregate MY 2021	Nevada Check Up Aggregate MY 2021	MPS	
			HEDIS	Adult Core Set	Child Core Set			Medicaid	Nevada Check Up
2.3	Increase blood pressure control (<140/90 mm Hg) for members with diabetes (CDC) [1]	NCQA	✓			59.10%	—	60.51%	—
2.4	Increase rate of controlling high blood pressure (CBP)	NCQA	✓	✓		57.94%	—	58.81%	—
2.5a	Increase the asthma medication ratio (AMR)—5–18 years	NCQA	✓		✓	—	—	MNA	MNA
2.5b	Increase the asthma medication ratio (AMR)—19–64 years	NCQA	✓	✓		—	—	MNA	—
2.6	Increase kidney health evaluation for people with diabetes (KED)—18–64 years	NCQA	✓			36.35%	—	41.69%	—
2.7	Decrease the rate of adult acute inpatient stays that were followed by an unplanned readmission for any diagnosis within 30 days after discharge (PCR)*—Observed readmissions	NCQA	✓	✓		11.51%	—	11.28%	—

Goal 3—Reduce misuse of opioids by December 31, 2024									
Objective #	Objective Description	Measure Steward	Measure Set			Medicaid Aggregate MY 2021	Nevada Check Up Aggregate MY 2021	MPS	
			HEDIS	Adult Core Set	Child Core Set			Medicaid	Nevada Check Up
3.1	Reduce use of opioids at high dosage (HDO)*	NCQA	✓			8.14%	—	8.23%	—
3.2	Reduce use of opioids from multiple providers (UOP)—Multiple prescribers*	NCQA	✓			20.87%	—	22.14%	—
3.3a	Reduce the rate of adult members with at least 15 days of prescription opioids in a 30–day period (COU)*	NCQA	✓			—	—	MNA	—
3.3b	Reduce the rate of adult members with at least 31 days of prescription opioids in a 62–day period (COU)*	NCQA	✓			—	—	MNA	—

Goal 4—Improve the health and wellness of pregnant women and infants by December 31, 2024									
Objective #	Objective Description	Measure Steward	Measure Set			Medicaid Aggregate MY 2021	Nevada Check Up Aggregate MY 2021	MPS	
			HEDIS	Adult Core Set	Child Core Set			Medicaid	Nevada Check Up
4.1a	Increase timeliness of prenatal care (PPC)	NCQA	✓		✓	82.78%	—	85.02%	—
4.1b	Increase the rate of postpartum visits (PPC)	NCQA	✓	✓		71.56%	—	74.13%	—
4.2a	Increase the rate of deliveries in which members were screened for clinical depression during pregnancy using a standardized instrument (PND)	NCQA	✓			—	—	MNA	—
4.2b	Increase the rate of deliveries in which members received follow-up care within 30 days of a positive depression screen finding (PND)	NCQA	✓			—	—	MNA	—
4.3a	Increase the rate of deliveries in which members were screened for clinical depression using a standardized instrument during the postpartum period (PDS)	NCQA	✓			—	—	MNA	—
4.3b	Increase the rate of deliveries in which members received follow-up care within 30 days of a positive depression screen finding (PDS)	NCQA	✓			—	—	MNA	—
4.4	Increase the rate of deliveries in the measurement period in which women received influenza and tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccinations (PRS-E)	NCQA	✓			—	—	MNA	—

Goal 5—Increase use of evidence-based practices for members with behavioral health conditions by December 31, 2024									
Objective #	Objective Description	Measure Steward	Measure Set			Medicaid Aggregate MY 2021	Nevada Check Up Aggregate MY 2021	MPS	
			HEDIS	Adult Core Set	Child Core Set			Medicaid	Nevada Check Up
5.1a	Increase follow-up care for children prescribed attention-deficit/ hyperactivity (ADHD) medication (ADD)—Initiation phase	NCQA	✓		✓	51.88%	50.00%	55.68%	50.75%

Goal 5—Increase use of evidence-based practices for members with behavioral health conditions by December 31, 2024									
Objective #	Objective Description	Measure Steward	Measure Set			Medicaid Aggregate MY 2021	Nevada Check Up Aggregate MY 2021	MPS	
			HEDIS	Adult Core Set	Child Core Set			Medicaid	Nevada Check Up
5.1b	Increase follow-up care for children prescribed attention-deficit/hyperactivity (ADHD) medication (ADD)—Continuation and maintenance phase	NCQA	✓		✓	65.90%	NA	72.54%	MNA
5.2	Increase adherence to antipsychotic medications for individuals with schizophrenia (SAA)	NCQA	✓	✓		38.50%	—	45.22%	—
5.3a	Increase follow-up after hospitalization for mental illness (FUH)—7–day	NCQA	✓	✓	✓	31.55%	44.87%	41.37%	52.00%
5.3b	Increase follow-up after hospitalization for mental illness (FUH)—30–day♦	NCQA	✓	✓	✓	48.34%	69.23%	56.67%	65.20%
5.4	Increase diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications (SSD)	NCQA	✓	✓		74.37%	—	77.29%	—
5.5a	Increase follow-up after ED visit for AOD abuse or dependence (FUA)—7–day	NCQA	✓	✓	✓	11.07%	NA	23.59%	MNA
5.5b	Increase follow-up after ED visit for AOD abuse or dependence (FUA)—30–day	NCQA	✓	✓	✓	15.29%	NA	28.26%	MNA
5.6a	Increase follow-up after ED visit for mental illness (FUM)—7–day♦	NCQA	✓	✓	✓	39.65%	91.89%	47.85%	77.50%
5.6b	Increase follow-up after ED visit for mental illness (FUM)—30–day♦	NCQA	✓	✓	✓	49.87%	91.89%	56.82%	77.50%
5.7a	Increase initiation and engagement of AOD abuse or dependence treatment (IET)—Initiation of treatment	NCQA	✓	✓		42.85%	27.50%	47.63%	37.69%
5.7b	Increase initiation and engagement of AOD abuse or dependence treatment (IET)—Engagement of treatment	NCQA	✓	✓		12.97%	7.50%	21.54%	12.77%

Goal 5—Increase use of evidence-based practices for members with behavioral health conditions by December 31, 2024									
Objective #	Objective Description	Measure Steward	Measure Set			Medicaid Aggregate MY 2021	Nevada Check Up Aggregate MY 2021	MPS	
			HEDIS	Adult Core Set	Child Core Set			Medicaid	Nevada Check Up
5.8	Increase the rate of children with and adolescents with ongoing antipsychotic medication use who had metabolic testing during the year (APM)	NCQA	✓		✓	31.11%	35.71%	38.41%	45.36%
5.9a	Increase the rate of antidepressant medication management (AMM)—Effective acute phase treatment	NCQA	✓	✓		53.35%	—	MNA	—
5.9b	Increase the rate of antidepressant medication management (AMM)—Effective continuation phase treatment	NCQA	✓	✓		36.33%	—	MNA	—
5.10	Increase the use of first-line psychosocial care for children and adolescents on antipsychotics (APP)	NCQA	✓		✓	56.61%	67.57%	MNA	MNA
5.11a	Increase the rate of inpatient, residential treatment and detoxification visits or discharges for a diagnosis of substance use disorder (SUD) among patients 13 years of age and older that resulted in follow-up care for a diagnosis of SUD within 7 days (FUI)	NCQA	✓			—	—	MNA	MNA
5.11b	Increase the rate of inpatient, residential treatment and detoxification visits or discharges for a diagnosis of substance use disorder (SUD) among patients 13 years of age and older that resulted in follow-up care for a diagnosis of SUD within 30 days (FUI)	NCQA	✓			—	—	MNA	MNA
5.12	Increase the rate of opioid use disorder (OUD) pharmacotherapy treatment events among members ages 16 and older that continue for at least 180 days (6 months) (POD)	NCQA	✓			—	—	MNA	MNA
5.13a	Increase the rate of screening for depression and follow-up plan for members (CDF)—12–17 years	CMS			✓	—	—	MNA	MNA
5.13b	Increase the rate of screening for depression and follow-up plan for members (CDF)—18 years and older	CMS		✓		—	—	MNA	—

Goal 6—Increase utilization of dental services by December 31, 2024[1]									
Objective #	Objective Description	Measure Steward	Measure Set			LIBERTY Medicaid MY 2021	LIBERTY Nevada Check Up MY 2021	MPS	
			HEDIS	Adult Core Set	Child Core Set			Medicaid	Nevada Check Up
6.1a	Increase annual dental visits (ADV)—2–3 years[2]	NCQA	✓			33.19%	39.66%	36.66%	45.43%
6.1b	Increase annual dental visits (ADV)—4–6 years[2]	NCQA	✓			49.91%	58.86%	51.18%	61.45%
6.1c	Increase annual dental visits (ADV)—7–10 years[2]	NCQA	✓			55.85%	65.76%	56.98%	69.25%
6.1d	Increase annual dental visits (ADV)—11–14 years[2]	NCQA	✓			51.60%	62.31%	53.25%	65.04%
6.1e	Increase annual dental visits (ADV)—15–18 years[2]	NCQA	✓			43.90%	53.78%	46.65%	56.37%
6.1f	Increase annual dental visits (ADV)—19–20 years[2]	NCQA	✓			28.25%	37.95%	33.99%	44.52%
6.2	Increase the rate of children under age 21 who received a comprehensive or periodic oral evaluation within the reporting year (OEV)	DQA			✓	—	—	MNA	MNA
6.3	Increase the rate of children aged 1 through 20 years who received at least 2 topical fluoride applications within the reporting year (TFL)	DQA			✓	—	—	MNA	MNA
6.4	Increase the rate of enrolled children, who have ever received sealants on a permanent first molar tooth: (1) at least one sealant and (2) all four molars sealed by 10th birthdate (SFM)	DQA			✓	—	—	MNA	MNA

Goal 7—Reduce and/or eliminate health care disparities for Medicaid members by December 31, 2024		
Objective #	**Objective Description**	**DHCFP Evaluation (Met/Not Met)**
7.1	Ensure that health plans maintain, submit for review, and annually revise cultural competency plans.	**Met**
7.2	Stratify data for performance measures by race and ethnicity to determine where disparities exist. Continually identify, organize, and target interventions to reduce disparities and improve access to appropriate services for the Medicaid and Nevada Check Up population.	**Met**
7.3	Ensure that each MCO submits an annual evaluation of its cultural competency programs to the DHCFP. The MCOs must receive a 100 percent *Met* compliance score for all criteria listed in the MCO contract for cultural competency program development, maintenance, and evaluation.	**Met**

[1] Beginning in MY 2022, the *Comprehensive Diabetes Care (CDC)* measure indicators will be separated into three standalone measures: *Hemoglobin A1c Control for Patients With Diabetes (HBD), Blood Pressure Control for Patients With Diabetes (BPD),* and *Eye Exam for Patients With Diabetes (EED).*

[2] This goal only applies to **LIBERTY**; therefore, the rates displayed are not aggregate rates.

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

* A lower rate indicates better performance for this measure.

Dash (—) indicates that the MCO was not required to report this measure and/or the objective does not apply to the population.

MNA indicates the MPS will be established when the baseline rate is available.

NA (not applicable) indicates that the MCO followed the specifications, but the denominator was too small (i.e., <30) to report a valid rate.

Indicates that the HEDIS MY 2021 Medicaid aggregate or Nevada Check Up aggregate performance measure rate was at or above the MPS.