State of Nevada

Division of Health Care Financing and Policy

2007-2008 External Quality Review Technical Report

for

Managed Care Organizations (MCOs)

October 2008

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Purpose of Report

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

Scope of EQR Activities Conducted

This external quality review (EQR) technical report includes a review of recipients' access to care and the clinical and service quality received by recipients of Title XIX, Medicaid, and Title XXI, the State Child Health Insurance Program (SCHIP), also known as Nevada Check Up.

In addition, this external quality review (EQR) technical report focuses on the three federally mandated EQR activities. As set forth in 42 CFR 438.352, these mandatory activities are:

- **Compliance monitoring evaluation.** This evaluation was designed to determine an MCO's compliance with its contract with the State, federal regulations, and various compliance monitoring standards. Compliance was also determined through review of individual files to evaluate implementation of standards.
- **Validation of performance measures.** HSAG validated each of the performance measures identified by the State to evaluate their accuracy as reported by, or on behalf of, an MCO. The validation was also done to determine the extent to which Medicaid-specific performance measures calculated by an MCO followed specifications established by the State.
- **Validation of performance improvement projects (PIPs).** For each MCO, three PIPs were reviewed to ensure that the MCO designed, conducted, and reported the projects in a methodologically sound manner, allowing real improvements in care and providing confidence in the reported improvements.

The report includes the following information for each activity conducted:

- Activity objectives
- Technical methods of data collection and analysis
- Description of data obtained
- Conclusions drawn from the data

The report also includes an assessment of each plan's strengths and weaknesses and information to compare plan performance (as available). When possible, the report compares findings from the most recent activities to results from previous time periods and discusses the status of improvement activities. The report offers recommendations for improving the quality of health care services provided by each MCO and reviews the technical assistance provided to develop and implement the State's quality strategy. **Anthem** did not report on HEDIS measures for Medicaid prior to 2008, so trended results are not available.

On June 13, 2000, the State of Nevada entered into a contract with HSAG to perform EQR services for DHCFP and to meet the requirements of the Nevada Medicaid Managed Care Contract, Amendment 2, dated April 24, 2003. In 2006–2007 HSAG conducted and analyzed the EQR activities described in the next section and offered conclusions and recommendations for quality improvement and interventions.

EQR Activities, Conclusions, and Recommendations

Quality Assessment and Performance Improvement (QAPI) Program Evaluation

Description

According to 42 CFR 438.358, the State or its EQRO must conduct a review within a three-year period to determine the Medicaid MCOs' compliance with standards established by the State for access to care, structure and operations, and quality measurement and improvement. The objective when evaluating contractual compliance with federal Medicaid managed care regulations was to identify any areas of noncompliance and assist the MCOs in developing corrective actions to achieve compliance with the contractual requirements.

Conclusions and Recommendations

In SFY 2007, HSAG conducted a QAPI and information systems (IS) readiness review for **Anthem** to ensure that the health plan had established and functioning processes and IS capabilities that would accommodate Nevada Medicaid enrollment. HSAG provided specific recommendations that resulted in a CAP in all areas except the 24-hour call center, provider relations, case management, and member services. **Anthem** corrected all recommendations prior to accepting Medicaid managed care enrollment.

HPN continues to achieve a high degree of compliance with the contract and BBA requirements as demonstrated in the scores for the State fiscal year (SFY) 2005 and 2007 QAPI program evaluations. **HPN**'s performance declined slightly in the areas of Continuity of Care and Recipient Rights and Responsibilities for the SFY 2007 review; however, **HPN** has corrected the deficiencies identified in these standards.

HSAG is scheduled to perform a comprehensive QAPI on-site review of the MCOs in SFY 2008–2009.

Validation of Performance Measures—NCQA HEDIS Compliance Audits 2007–2008

Description

HSAG performed an independent audit of the 2008 Healthcare Effectiveness Data and Information Set (HEDIS®[1-1]) data for each MCO consistent with the *2007 NCQA HEDIS Compliance Audit Standards, Policies and Procedures, HEDIS Volume 5*. The NCQA HEDIS Compliance Audit™[1-2] incorporated a detailed assessment of the health plan's information systems (IS) capabilities for collecting, analyzing, and reporting HEDIS information and a review of the specific reporting methods used for HEDIS measures. In addition, HSAG reviewed the performance of each MCO on the HEDIS measures.

Conclusions and Recommendations

The audit findings determined that both MCOs reported accurate rates according to *HEDIS 2008 Technical Specifications* for all of the audited measures. The rates for the performance measures indicated the following:

- Overall, the quality of services provided by both MCOs appears to be relatively good. The Nevada Check Up rates tended to be above the 50th percentile, indicating at least average performance, and several measures were above the 90th percentile. Except for two measures, Nevada Check Up rates were higher than the Medicaid rates.
- Both MCOs showed strong performance for both Medicaid and SCHIP on the HEDIS measures for Childhood Immunizations, Children's and Adolescents' Access to PCPs, and Annual Dental Visits. The MCOs' performance on these measures demonstrates their strength in terms of access to care for children.
- The timeliness of and access to maternity-related care is a statewide concern, as indicated by low performance results for both MCOs on Timeliness of Prenatal Care and Frequency of Ongoing Prenatal Care. These findings may indicate an issue with obtaining appointments in a timely manner, network adequacy for maternity care, obtaining all appropriate encounter data, or member compliance. Both MCOs should explore these issues and determine appropriate corrective action plans.
- DHCFP and the MCOs should consider implementing a collaborative PIP for measures related to maternity care.

Both MCOs were compliant with the HEDIS audit standards and were able to report on all the performance measures. The audits of IS capabilities identified several potential issues and recommended the following corrective actions:

- **Anthem** should implement a "hard" edit to require a diagnosis to process all claims/encounters.
- **Anthem** should implement a mechanism to monitor the data submission patterns of its capitated providers to further support/improve encounter data completeness.

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

[1-2] NCQA HEDIS Compliance Audit™ is a trademark of the NCQA.

- **Anthem** should consider implementing a peer-led source code review process at the front end to identify any source code-related issues, which would reduce the incidence of source code errors and increase reporting efficiencies.
- **Anthem's** processes for production of hybrid measures and medical record review specific to Nevada were not clearly indicated within their baseline assessment tool (BAT). **Anthem** should consider implementing a process for final local review of the BAT prior to submitting the tool to the auditors.
- **HPN** used an internally-built administrative database to supplement its HEDIS data. The process for maintaining this database was not well-documented. **HPN** should formally document each step used to collect and validate data within an internally-built administrative database to ensure data accuracy and validity.

Health Insurance Flexibility and Accountability (HIFA) Waiver Results

At the aggregate level, HIFA rates were based on 90 total eligible cases; therefore, the rates should be viewed with caution and considered in terms of baseline rates. Individual MCO rates should not be used at this time since the individual MCO HIFA populations were too small for this year.

Based on the overall baseline results, the first-year HIFA rates for Timeliness of Prenatal Care and Postpartum Care were below the Nevada Medicaid results and the national Medicaid benchmarks. These baseline rates are likely to improve as more members become eligible for the program and the measures. Both MCOs should include the HIFA population when implementing quality improvement efforts in maternity care for the Medicaid population. A collaborative PIP that includes both HIFA and Medicaid enrollees may be the most cost effective method of improving the performance measures for Perinatal Care.

Validation of Performance Improvement Projects 2007–2008

Description

PIPs are designed to assess health care processes, implement process improvements, and improve outcomes of care. Both **Anthem** and **HPN** conducted two PIPs in 2006–2007. In 2007–2008, both **Anthem** and **HPN** continued two PIPs conducted the previous year, one on childhood immunizations and the other on diabetes management. **Anthem** and **HPN** also began a collaborative *Lead Screening in Children* PIP in 2007–2008. HSAG followed standardized procedures for validating each MCO's PIPs, assessing the degree to which the MCO designed, conducted, and reported the PIPs in a methodologically sound manner. This process facilitates improvement in care and provides confidence that the MCO accomplished the reported improvement.

Conclusions and Recommendations

Anthem completed Activities I–VI for two of its PIPs, *Improving Childhood Immunization Rates* and *Improving Diabetes Screening and Control*. For the collaborative *Lead Screening in Children* PIP, **Anthem** completed Activities I–IV. All three PIPs achieved a *Met* validation status. Because **Anthem** received one *Not Met* score in both the immunization and diabetes PIPs for noncritical elements, HSAG recommends that the plan continue using the publication, *Conducting Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities* (U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, final protocol, Version 1.0, May 1, 2002). This publication provides the MCOs with guidelines for designing, implementing, and reporting on PIPs. Further, **Anthem** should seek technical assistance as needed from HSAG.

HPN completed Activities I–VII for its *Improving Immunization Rates for Children Two Years Old in Medicaid* PIP, all 10 activities for its *Improving Diabetes Management* PIP, and Activities I–IV for its *Lead Screening in Children* PIP. All three PIPs achieved a *Met* validation status and 100 percent scores for all evaluation elements *Met* and critical elements *Met*. The results of the *Improving Diabetes Management* PIP indicate that **HPN** should continue its efforts to improve rates for providing services to members with diabetes. The second remeasurement for HbA1c testing showed a statistically significant improvement over a three-year period; however, the rate was below the goal and substantially below the 2006 HEDIS 90th percentile benchmark. The second remeasurement for LDL-C testing showed a rate below both the goal and the HEDIS benchmark. The rate for monitoring for diabetic nephropathy showed strong performance and exceeded the 2006 HEDIS 90th percentile benchmark. HSAG recommends that **HPN** consider ways to apply lessons learned from monitoring for nephropathy to HbA1c testing and LDL-C screening.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Surveys—Fiscal Year (FY) 2007–2008

Description

The overarching objective of the CAHPS surveys was to effectively and efficiently obtain information on patients' levels of satisfaction with their health care experiences. These surveys cover topics that are important to consumers, such as the communication skills of providers and the accessibility of services. The CAHPS surveys were administered to adult Medicaid, child Medicaid, and child SCHIP members of the **Anthem**, **HPN**, and **Fee-for-Service** (**FFS)** program. **Anthem** and **HPN** were responsible for obtaining a CAHPS vendor to administer the CAHPS surveys on their behalf. DHCFP forwarded **Anthem**'s and **HPN**'s results to HSAG for analysis. HSAG administered the surveys on behalf of DHCFP for the **FFS** program.

This report includes the results of measures of satisfaction. These measures include the following global ratings: Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, and Rating of Specialist Seen Most Often. The report also includes the following composite measures: Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Courteous and Helpful Office Staff (child only), Customer Service, and Shared Decision Making (adult only).

Conclusions and Recommendations

Based on the CAHPS results for **Anthem**, **HPN**, and **FFS**, HSAG recommends that the three organizations focus quality improvement initiatives on the following measures: Getting Needed Care, How Well Doctors Communicate, Courteous and Helpful Office Staff, Rating of All Health Care, Rating of Personal Doctor, and Rating of Health Plan. HSAG recommends the following based on the most up-to-date information in CAHPS literature.

- Getting Needed Care—The organizations should enhance provider directories by ensuring that they are updated and provide patients with information such as descriptions of providers' training, board certification(s), their photograph, background information, specialty, language(s) spoken, and whether they are accepting new patients. The organizations should also streamline the referral process and ensure receipt of care by the appropriate physician.
- How Well Doctors Communicate—The MCOs should work with network providers to develop a system that will send out reminders to patients for routine and preventive care and supply patients with tools such as question lists.
- Courteous and Helpful Office Staff—The organizations should target perceptions of the courtesy and respect shown by office staff and the helpfulness of office staff.
- Rating of All Health Care—The organizations should increase access to care and improve overall satisfaction with patient health care and program experiences.
- Rating of Personal Doctor—The organizations should increase levels of patient-physician communication and decrease wait times by eliminating barriers that may prohibit patients from receiving prompt, adequate care.
- Rating of Health Plan—The organizations should evaluate and modify existing program and physician office operations to ensure that the most effective and efficient processes are in place.

Aged, Blind, and Disabled (ABD) Care Management/Care Coordination of Readiness Review

Description

HSAG conducted a review of **APS Healthcare, Inc. (APS)**, regarding its readiness to provide services to the ABD Medicaid population as described in Scope of Work (SOW) #1—Care Management and SOW #2—Care Coordination for Request for Proposal (RFP) 1629. The readiness review ensures that **APS** is prepared to fulfill all of the Medicaid program's requirements prior to enrolling eligible Medicaid recipients. HSAG developed 2008 Readiness Review Tools for SOW #1—Care Management and SOW #2—Care Coordination. These tools listed the RFP requirements, corresponding documentation required and provided, readiness review findings, and approval status (yes or no). Some requirements were denoted as critical elements. HSAG made recommendations for revisions to policies and procedures and processes when they did not meet the intent of the requirement, and **APS** was required to correct the identified deficiencies.

Conclusions and Recommendations

In July 2008, HSAG completed the readiness reviews of the critical and noncritical elements with the information that **APS** had sent to date. A majority of the critical areas were reviewed and approved. Some of the documentation had not been received in several of the critical areas. However, HSAG and DHCFP determined that the missing documentation should not prevent **APS** from contacting recipients. HSAG will work with DHCFP to ensure that all outstanding critical elements are completed. In addition, HSAG will conduct an on-site review in SFY 2009 to assess **APS**' compliance with contract requirements.

Nevada Quality Strategy and Work Plan

Nevada Medicaid developed a Nevada Medicaid and SCHIP Managed Care Quality Assessment and Performance Improvement Strategy (Strategy), pursuant to 42 CFR 438.200.

Description

The Strategy is in two parts: the 2006–2008 Quality Assessment and Performance Improvement Strategy (April 2008), which is an overriding conceptual program, and the 2006–2008 Quality Assessment and Performance Improvement Strategy Work Plan (April 2008). The Strategy incorporates policies, procedures, contract compliance, and input from the public, stakeholder providers, recipient advocates, and multiple Nevada State departments that hold an interest in the improvement of access to care and of clinical and service quality received by Medicaid and SCHIP recipients.

The Strategy is designed so that services provided to recipients meet established standards for access to care, clinical quality of care, and quality of service, and that opportunities to improve access to care, quality of care, and quality of service are identified and pursued. The Strategy is designed to identify, document, and review access, quality of care, and service issues, and to verify that appropriate corrective actions are taken to address these issues.

In April 2008, the Centers for Medicare & Medicaid Services (CMS) Division of Quality, Evaluation, and Health Outcomes (DQEHO) provided feedback to DHCFP on the Strategy. The DQEHO analysis:

- Indicated that the State had complied with most of the mandatory regulatory requirements.
- Offered feedback and recommendations.
- Requested a response indicating the State's rationale and evidence to support its belief that it has met the regulatory requirements in 42 CFR 438.202 and 42 CFR 438.204 for access to care, structure and operations, quality measurement and improvement, and procedures for race, ethnicity, and primary language spoken.
- Invited the State to inform CMS about any new quality initiatives that might be useful to other states.

DHCFP's response to DQEHO in May 2008 included the requested rationale and evidence, information about additional future revisions and methods to strengthen the State's strategy, and new quality initiatives.

Conclusions and Recommendations

Based on DQEHO's feedback, and with technical assistance from HSAG, DHCFP and the MCOs, stakeholders, and strategic planning groups will work together to revise, implement, and strengthen the Strategy in the areas that did not meet the identified regulatory requirements or topics.

Performance Tracking Tool (PTT)

In 2005, DHCFP and HSAG created a Performance Tracking Tool (PTT) for each MCO. The PTT was initially designed as a mechanism for the State and the MCOs to monitor and trend the results of each performance measure identified in the tool. The PTT was used to record baseline and remeasurement results for each performance measure and to identify how the plan is performing compared to national benchmarks and the calculated goals for the subsequent reporting period. The methodology used to calculate performance goals is based on the Quality Improvement System for Managed Care (QISMC) methodology.

DHCFP and HSAG modified the QISMC method into what is now called the hybrid QISMC method, which is being used in several states. This method is similar to the original QISMC method, but takes into consideration minimum performance levels (MPLs) and high performance levels (HPLs).

DHCFP, HSAG, and the MCOs have continued to enhance the PTT design and functionality. The PTT has evolved into more than just a mechanism for monitoring and trending the results of performance measures. The latest revision in April 2008 facilitates tracking and monitoring all rates and activities, quality improvement efforts, comparisons to benchmarks, setting and achieving goals, and internal and external reporting. The MCOs, DHCFP, and HSAG will use this information. Specifically, DHCFP will use the PTT to enhance reporting to CMS, the State legislature, and other departments, and to determine areas that need attention—for example, areas that might be the topic of collaborative PIPs.

Technical Assistance

HSAG provided technical assistance to DHCFP in the following areas: guidance in strengthening the managed care contract language for race and ethnicity, fraud and abuse prevention, and case management and care coordination, guidance in the evaluation and strengthening of the State quality strategy and work plan goals and objectives, and guidance with the specifications for the pay-for-performance measures and setting performance goals for the HEDIS measures.

HSAG, at the State's direction, provided technical guidance to the MCOs to assist them in conducting activities related to the mandatory and optional activities that provide information for the EQR. The technical assistance provided to the MCOs included: guidance in developing and implementing PIPs as well as implementing a collaborative PIP, tools and information related to cultural competency, and training in the use of the PTT.

Overall Conclusions and Recommendations

HSAG will conduct a comprehensive QAPI on-site review of the MCOs in SFY 2008–2009.

Both **Anthem** and **HPN** are focusing on improving the quality and timeliness of and access to care provided through the Medicaid and SCHIP programs. The MCOs should continue to work closely with DHCFP, with technical assistance from HSAG, to implement the State's quality strategy. The MCOs should also continue to revise and strengthen the Strategy to support service delivery excellence.

Adherence to the *HEDIS 2008 Technical Specifications* resulted in both MCOs reporting on all selected performance measures. Overall, the quality of services provided by **Anthem** and **HPN** appears to be relatively positive, although opportunities for improvement exist in many areas. The timeliness of and access to prenatal care are issues for both MCOs, which should develop appropriate corrective action plans to address deficiencies identified in these areas. HSAG recommends that both plans continue efforts to improve performance on HEDIS measures, with the goal of reaching the national 90th percentile for all measures.

Both MCOs demonstrated strength in children's access to care through solid performance on the HEDIS measures for Childhood Immunizations, Children's and Adolescents' Access to PCPs, and Annual Dental Visits. The Nevada Check Up rates tended to be higher than Medicaid child rates for HEDIS performance measures, blood lead screening rates, and CAHPS scores. HSAG recommends further examination of population differences that may explain disparities in performance and satisfaction levels, and developing interventions that might help improve the delivery of services to the Medicaid population.

The MCOs' understanding of the PIP process appears to be strong, with both plans achieving a *Met* validation status for all PIPs. **Anthem** has an opportunity to further refine its process and ensure that all noncritical as well as critical elements achieve *Met* scores in future PIP validations.

CAHPS results tended to fall below the 2007 national averages for the adult and child Medicaid populations and the SCHIP population for **Anthem**, **HPN**, and the **FFS** program. Although some measures exceeded the national average, the MCOs and the **FFS** program should focus quality improvement initiatives on improving the following measures: *Getting Needed Care*, *How Well Doctors Communicate*, *Courteous and Helpful Office Staff*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*.

In SFY 2009 HSAG will conduct an on-site review of **APS**' compliance with contract and ABD program requirements.

DHCFP will obtain input from the MCOs, stakeholders, and strategic planning groups to revise, strengthen, and implement the quality strategy.

History of State Medicaid

The Welfare Division administered Medicaid when Nevada adopted the program in 1967. The 1997 legislative session created DHCFP to administer two major federal health coverage programs that provide health care to eligible Nevadans, Medicaid, and SCHIP. The mission of DHCFP is to purchase and provide quality health care services to low-income Nevadans in the most efficient manner, promote equal access to health care at an affordable cost to the taxpayers of Nevada, restrain the growth of health care costs, and review Medicaid and other state health care programs to maximize potential federal revenue.

Medicaid provides health care to low-income families and aged, blind, and disabled (ABD) individuals. The Nevada SCHIP program, Nevada Check Up, provides coverage to low-income, uninsured children who are not eligible for Medicaid but whose family income is at or below 200 percent of the federal poverty level (FPL). The mission of the Nevada Check Up program is to provide low-cost, comprehensive health care coverage to low income, uninsured children (from birth to 18 years of age) who are not covered by private insurance or Medicaid while promoting health care coverage for children, encouraging individual responsibility, and working with public and private health care providers and community advocates for children.

Nevada also has a Health Insurance Flexibility and Accountability (HIFA) waiver, a demonstration project authorized under Section 1115 of the Social Security Act and funded under Title XXI (SCHIP). The HIFA waiver program covers uninsured pregnant women who do not quality for Medicaid with family incomes above 133 percent of the FPL, up to and including 185 percent of the FPL through direct coverage. This eligibility group receives pregnancy-related services through the Nevada Medicaid Provider Panel; the Division of Welfare and Supportive Services (DWSS) determines eligibility. The HIFA waiver program also covers parents, caretaker relatives, and legal guardians of Medicaid- or SCHIP-eligible children with family income below 200 percent of the FPL who work for a qualified small employer that has a credible insurance plan. This eligibility group receives a subsidy payment toward any monthly premium for health care insurance. DHCFP determines eligibility for this program.

Nevada Medicaid administers both fee-for-service and managed care programs. Enrollment in an MCO is mandatory for recipients in Temporary Assistance for Needy Families (TANF) (Section 1931) and the Child Health Assurance Program (CHAP)—for poverty-level pregnant women, infants, and children—when recipients have more than one MCO option from which to choose in a geographic area. Enrollment in an MCO is mandatory for all Nevada Check Up recipients when they have at least one MCO option in their geographic service area. MCOs provide medical and dental services. Managed care contracts include an innovative pay-for-performance program, which offers incentives to increase dental and well-child visits and provide best-practice treatments for children with asthma.

The eligibility and aid code determination functions for the Medicaid applicant and eligible population are the responsibility of DWSS. The eligibility function for the Nevada Check Up applicant and eligible population is the responsibility of DHCFP. The enrollment function is the responsibility of the Medicaid Management Information System (MMIS).

Nevada Medicaid operates five Section 1915(c) home and community-based services (HCBS) waivers that offer services to certain individuals throughout the State with mental retardation and related conditions, the frail elderly, elderly in adult residential care, the physically disabled, and elderly in affordable assisted living facilities. Services may include case management, personal care services, respite care services, adult day health services, homemaker/home health aide, habilitation, and other services requested by the State and approved by CMS.

Nevada Medicaid is implementing a new program in 2008 to provide care management and care coordination to the Medicaid-eligible ABD population.

The Nevada Check Up and Medicaid programs offer the same benefit coverage; however, Nevada Check Up recipients have higher survey response rates and report greater satisfaction with MCO performance. DHCFP and HSAG are examining these data to identify any differences in the populations that might provide guidance to ensure timely access to quality care for recipients in both programs. For example, a study of Georgia SCHIP and Medicaid populations found that Medicaid children, controlling for many demographic characteristics, report less use of services and lower satisfaction with services used. Evidence supports three possible explanations for these differences: Medicaid families are less familiar with and supportive of systems requiring use of an assigned primary care physician (PCP), the families face more non-program barriers to using care, and physicians have different responses to the two programs.[2-1] Efforts are under way to investigate possible explanations for differences in Nevada.

[2-1] Edwards JN, Bronstein J, and Rein DB. Do Enrollees in "Look-Alike" Medicaid and SCHIP Programs Really Look Alike? *Health Affairs*, Volume 21, Number 3, May-June 2002, 240-248.

Nevada Medicaid Demographics

This section provides an overview of the total MCO enrollment, gender/age bands, and racial/ethnic composition of the counties served by the Nevada Medicaid MCOs. Demographic data were supplied by the State of Nevada.

Table 2-1 presents the gender and age bands of Nevada Medicaid and SCHIP recipients in FY 2007–2008. The majority of members for both Medicaid and SCHIP were children between 3 and 14 years of age. Females 19 to 34 years of age were the largest proportion of adult Medicaid members.

Table 2-1––Nevada Medicaid and SCHIP Managed Care Demographics July 1, 2007–June 30, 2008

Gender/Age Band	Total Member Months	June 2008 Members
Medicaid		
Males and Females <1 Year of Age	125,979	11,055
Males and Females 1−2 Years of Age	122,149	11,332
Males and Females 3−14 Years of Age	447,614	40,312
Females 15−18 Years of Age	48,799	4,413
Males 15−18 Years of Age	38,099	3,479
Females 19−34 Years of Age	129,568	11,350
Males 19−34 Years of Age	19,762	1,720
Females 35+ Years of Age	46,718	4,002
Males 35+ Years of Age	13,958	1,220
Total Medicaid	**992,646**	**88,883**
SCHIP		
Males and Females <1 Year of Age	11,911	758
Males and Females 1−2 Years of Age	44,782	3,402
Males and Females 3−14 Years of Age	211,398	16,501
Females 15−18 Years of Age	17,026	1,329
Males 15−18 Years of Age	16,898	1,326
Total SCHIP	**302,015**	**23,316**
Total Medicaid and SCHIP	**1,294,661**	**112,199**

Table 2-2 presents the ethnic composition of Nevada MCO Medicaid recipients in June 2008.

Table 2-2––June 2008 Nevada MCO Medicaid Ethnic Composition		
Ethnicity	**Total Eligible Clark County**	**Total Eligible Washoe County**
Asian or Pacific Islander Non-Hispanic	2,198	208
Black Non-Hispanic	22,594	810
Hispanic	44	12
Am Indian/Alaskan Non-Hispanic	300	192
Am Indian/Alaskan & White	76	33
Asian and White	172	11
Black African Am and White	783	113
Am Indian/Alaskan & Black	331	47
Other Non-Hispanic	1,562	136
Asian/Pacific Islander Hispanic	274	20
Black Hispanic	325	9
Am Indian/Alaskan Hispanic	21	6
White Hispanic	28,394	4,130
White Non-Hispanic	19,154	6,008
Total	**76,228**	**11,735**

Table 2-3 presents the ethnic composition of SCHIP recipients in the Nevada Check Up program for June 2008.

Table 2-3––June 2008 Nevada MCO SCHIP (Nevada Check Up) Ethnic Composition		
Ethnicity	**Total Eligible Clark County**	**Total Eligible Washoe County**
Asian or Pacific Islander Non-Hispanic	497	60
Black Non-Hispanic	1,187	49
Hispanic	13,105	3,402
Am Indian/Alaskan Non-Hispanic	40	28
Other Non-Hispanic	950	129
White Non-Hispanic	3,008	824
Total	**18,787**	**4,492**

Table 2-4 presents the enrollment by MCO and county of Medicaid recipients for June 2008.

Table 2-4––June 2008 Nevada MCO Medicaid Recipients		
MCO	**Total Eligible Clark County**	**Total Eligible Washoe County**
Health Plan of Nevada	40,095	7,150
Anthem	36,885	4,741
Total	**76,980**	**11,891**

Table 2-5 presents the enrollment by MCO and county of SCHIP recipients in the Nevada Check Up program for June 2008.

Table 2-5––June 2008 Nevada MCO SCHIP (Nevada Check Up) Recipients		
MCO	**Total Eligible Clark County**	**Total Eligible Washoe County**
Health Plan of Nevada	12,611	2,447
Anthem	6,178	2,054
Total	**18,789**	**4,501**

Purpose of the EQR Technical Report

HSAG has served as the EQRO for DHCFP since 2000. The BBA requires that states contract with an EQRO to conduct an annual evaluation of their MCOs to determine each MCO's compliance with Quality Management Program (QMP) contractual standards. CMS regulates requirements and procedures for the EQRO.

Pursuant to the BBA, 42 CFR 438.364, each state must produce a detailed technical report on EQR results. As required, this report describes the manner in which the data from activities conducted in accordance with 42 CFR 438.358 were aggregated and analyzed and how conclusions were drawn as to the quality and timeliness of, and access to, care furnished to recipients of Medicaid and SCHIP, also known as Nevada Check Up, by the two contracted MCOs: **Anthem** and **HPN**. Information released in this technical report does not disclose the identity of any patient, in accordance with 438.350(f) and 438.364(a)(b).

The common goal of the managed care program is a successful partnership with quality health plans to provide care to recipients while focusing on continuous quality improvement. The current Nevada-enrolled recipient population encompasses the TANF and CHAP assistance groups as well as the SCHIP population. Traditionally, the Medicaid population is a high-risk, high-volume user of health care services.

The role of managed care is to ensure the accessibility and availability of appropriate health care, provide for continuity of care, and provide quality care to enrolled recipients. A major focus of managed care is health promotion and disease prevention. The enrolled recipient populations, which mainly consist of women and children, benefit from targeted, preventive health care services, the quality and availability of which are monitored and evaluated by DHCFP in conjunction with HSAG.

Scope of the Report

The FY 2007–2008 EQR Technical Report summarizes the mandatory, optional, and other EQR activities conducted by HSAG for the Nevada Medicaid MCOs, as described below.

This report includes the following for each activity conducted in accordance with 42 CFR 438.358:

- Activity objectives
- Technical methods of data collection and analysis
- Description of data obtained
- Conclusions drawn from the data
- The extent to which the State provided the necessary information to create this report while safeguarding the identity of patients

Mandatory EQR Activities

For each MCO the EQR must use information from the following activities:

- Validation of PIPs required by the State that were under way during the preceding 12 months to comply with requirements set forth in 438.240(b)(1).
- Validation of MCO performance measures reported (as required by the State) or MCO performance measures calculated by the State during the preceding 12 months to comply with requirements set forth in 438.240(b)(2).
- A review, conducted within the previous three-year period, to determine the MCO's compliance with standards (except with respect to standards under 438.240(b)(1).

Optional EQR Activities

The EQR may also use information derived during the preceding 12 months from the following optional activities:

- Validation of encounter data reported by an MCO.
- Administration or validation of consumer or provider surveys or quality care.
- Calculation of performance measures in addition to those reported by an MCO and validated by the EQRO.
- Conduct of PIPs in addition to those conducted by an MCO and validated by the EQRO.
- Conduct of studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time.
- Technical assistance. The EQRO may, at the State's direction, provide technical guidance to groups of MCOs to assist them in conducting activities related to the mandatory and optional activities that provide information for the EQR.

Of these optional activities, HSAG is contracted to conduct:

- Readiness review of information systems.
- Technical assistance to DHCFP and the MCOs.
- Readiness review of the ABD Care Management and Care Coordination Program.

State Quality Strategy

Nevada Medicaid developed a Nevada Medicaid and SCHIP Managed Care Quality Assessment and Performance Improvement Strategy (Strategy), pursuant to 42 CFR 438.200.

In 2008, CMS embarked upon a new goal in Medicaid quality, which includes a review of state quality strategies and EQR reports required of states with Medicaid managed care delivery systems (42 CFR Parts D and E). CMS made DQEHO responsible for working with states to provide feedback on these documents.

DHCFP's response to DQEHO on May 22, 2008, included the requested rationale and evidence, information about additional future revisions and methods to strengthen the State's Strategy, and new quality initiatives.

Other EQR Activities

HSAG conducted several activities on behalf of DHCFP during 2007–2008. The following is a brief description of these activities.

Aged, Blind and Disabled (ABD) Care Management and Care Coordination Program Readiness Review

HSAG conducted a review of **APS** regarding its readiness to provide services to the ABD Medicaid population as described in the Scope of Work (SOW) #1—Care Management and the SOW #2—Care Coordination for RFP 1629. The readiness review ensures that **APS** is prepared to fulfill all of the Medicaid program's requirements prior to enrolling eligible Medicaid recipients.

Fee-For-Service Program

HSAG administered a CAHPS survey for the FFS program. Three populations were surveyed: adult Medicaid, child Medicaid, and SCHIP. The objective of the CAHPS surveys was to effectively and efficiently obtain information on members' levels of satisfaction with their health care experiences.

HIFA Waiver

The HIFA waiver is a new Nevada program administered by **Anthem** and **HPN** to provide medically needed services for pregnant women who do not qualify for Medicaid. HSAG conducted a performance measure validation on the HIFA population for each MCO.

Organization of the Report

Section 1, Executive Summary, outlines the purpose of the EQR technical report, the role of HSAG, and a high-level description of EQR activities, conclusions, and recommendations.

Section 2, Background, provides contextual information about the purpose of the report and the scope of mandatory, optional, and other EQR activities. This section also presents demographic data on the enrolled recipient population.

Section 3, Description of EQR Activities, describes the plan-specific results and recommendations regarding EQR activities for **Anthem** and **HPN** and reviews the technical assistance provided to DHCFP and the MCOs by HSAG.

Section 4, Plan Comparisons and Recommendations, presents an overall assessment of the EQR activities performed for the Nevada Medicaid MCOs.

Section 5, Conclusions and Recommendations

3. Description of EQR Activities

The U.S. Department of Health and Human Services' final rule on external quality review of Medicaid MCOs and prepaid inpatient health plans (PIHPs), published on January 24, 2003, required that state Medicaid agencies use three of the nine protocols developed in response to the BBA quality review requirements. The protocols are:

- Monitoring Medicaid MCOs and PIHPs
- Validating performance measures
- Validating PIPs

The remaining six protocols are optional. States use the optional protocols whey they want information from these activities as part of the EQR and for enhanced federal financial participation in the costs of these activities. The protocols have been designed to be consistent with industry standards, accommodate continued evolution of quality assessment, and provide state Medicaid agencies with technical assistance.

HSAG conducted the following EQR activities for **Anthem**:

- Follow-up on the recommendations provided by HSAG resulting from the QAPI and information systems (IS) readiness review in preparation for **Anthem** accepting Nevada Medicaid enrollment.
- Validation of performance measures—HEDIS Compliance Audit
- Validation of PIPs

HSAG conducted the following EQR activities for **HPN**:

- QAPI evaluation—Corrective action follow-up on the QAPI evaluation results.
- Validation of performance measures—HEDIS Compliance Audit
- Validation of PIPs

For all activities, the State provided the necessary information to create reports while safeguarding the identity of patients.

For each activity, this section of the report presents:

- Objectives
- Technical methods of data collection and analysis
- For each MCO:
  - A description of data obtained
  - Conclusions drawn from the data
  - Strengths, weaknesses, and trend information
  - Recommendations

A review of technical assistance provided to DHCFP and the MCOs is presented at the conclusion of this section.

Quality Assessment and Performance Improvement (QAPI) Evaluation—FY 2007–2008

Objectives

According to 42 CFR 438.358, the State or its EQRO must conduct a review within a three-year period to determine the Medicaid MCOs' compliance with standards established by the State for access to care, structure and operations, and quality measurement and improvement. To meet this requirement, HSAG is scheduled to perform a comprehensive, on-site QAPI evaluation of the MCOs in SFY 2009.

The objective when evaluating contractual compliance with federal Medicaid managed care regulations was to identify any areas of noncompliance and assist the MCOs in developing corrective actions to achieve compliance with the contractual requirements.

Plan-Specific Findings—Anthem Blue Cross Blue Shield

Description of Data Obtained

In SFY 2007, HSAG conducted a QAPI and IS readiness review for **Anthem** to ensure that the health plan had established processes and functioning IS capabilities that would accommodate Nevada Medicaid enrollment. The review assessed processes and standards in the following areas:

- Capitation
- Claims processing
- Encounter data reconciliation
- Prior authorization
- 24-hour call center
- Provider relations
- Case management
- Member services
- Network adequacy

HSAG documented its findings in the readiness review tools. The readiness review assessed system standards, provided observations, identified risks and issues, and offered recommendations to ensure that information was timely, accurate, and complete in the areas identified above. HSAG provided specific recommendations that resulted in a CAP in all areas except 24-hour call center, provider relations, case management, and member services. **Anthem** corrected all recommendations prior to accepting Medicaid managed care enrollment.

Plan-Specific Findings—Health Plan of Nevada

Description of Data Obtained

HSAG conducted an annual comprehensive compliance review of **HPN** in SFY 2004 and 2007, assessing **HPN**'s compliance with contractual requirements. The table below provides a comparison of **HPN**'s scores for the QAPI and file reviews conducted in SFY 2004 and 2007.

HPN continues to achieve a high degree of compliance with the contract and BBA requirements as demonstrated in the scores for the QAPI reviews. Of the 18 standard areas reviewed, in SFY 2004, **HPN** achieved 100 percent compliance on 17 standards. In SFY 2007, HPN achieved 100 percent compliance on 16 standards. In the 2007 review, **HPN** demonstrated performance strengths and adherence to all requirements that were measured in the areas of quality improvement infrastructure, quality assessment, performance improvement, utilization management, access and availability, delegation, credentialing/recredentialing, and medical records. **HPN**'s performance declined slightly in the areas of Continuity of Care and Recipient Rights and Responsibilities for the SFY 2007 review. As a result of the SFY 2007 on-site compliance review, **HPN** implemented a corrective action plan and provided documentation to DHCFP substantiating the completion of the required corrective actions and compliance with the related contract requirements. Areas for continued quality improvement were: strengthening provider participation in the plan of care for members, revising the appeals and grievances policies to align with actual practice, continuing efforts toward improving member satisfaction, and HEDIS measure results.

In addition, **HPN** has demonstrated improved compliance with the standards for the file reviews. **HPN** improved its performance in the Delegation, Credentialing, Grievances, Appeals, Denials, and Provider Dispute file reviews. DHCFP added Case Management Stop Loss file reviews in SFY 2007.

Table 3-1 displays a comparison of HPN's QAPI Evaluation and files reviews for SFY 2004 and SFY 2007.

Table 3-1—Comparison of Scores for the QAPI Evaluation for HPN

Standard Number	Description of Standard	Standard Score for SFY 04	Health Plan of Nevada Rating	Standard Score for SFY 07	Health Plan of Nevada Rating
I	Written IQAP Description	100	★★★	100	★★★
II	Systematic Process of Quality Assessment and Improvement	100	★★★	100	★★★
III	Accountability to the Governing Body	100	★★★	100	★★★
IV	Active QA Committee	100	★★★	100	★★★
V	IQAP Supervision	100	★★★	100	★★★
VI	Adequate Resources	100	★★★	100	★★★
VII	Provider Participation In IQAP	100	★★★	100	★★★
VIII	Delegation of IQAP Activities	100	★★★	100	★★★
IX	Credentialing and Recredentialing	100	★★★	100	★★★
X	Recipient Rights and Responsibilities	100	★★★	92	★★★
XI	Standards for Availability and Accessibility	98	★★★	100	★★★
XII	Medical Record Standards	100	★★★	100	★★★
XIII	Utilization Review	100	★★★	100	★★★
XIV	Continuity-of-Care System	100	★★★	87	★★
XV	IQAP Documentation	100	★★★	100	★★★
XVI	Coordination of Quality Assurance Activity With Other Management Activity	100	★★★	100	★★★
XVII	Data Collection	100	★★★	100	★★★
XVIII	Dispute Resolution	100	★★★	100	★★★

Key: 90%–100% = ★★★ 80%–89% = ★★ 0%–79% = ★

Table 3-2—Summary of Scores for the File Reviews for HPN

Associated Standard #	Description of File Review	Score (% of Compliant Elements) –SFY 04	Score (% of Compliant Elements) for SFY 07
VIII	Delegation File Review	81	100
IX	Credentialing File Review	70	100
IX	Recredentialing File Review	*	100
X	Grievances File Review	74	100
X	Appeals File Review	89	98
XIII	Denials File Review	74	100
XIV	Continuity-of-Care File Review	100	85
XIV	Case Management Stop-Loss Review	N/A	85
XVIII	Provider Dispute File Review	65	100

As stated above, HSAG is scheduled to perform a comprehensive on-site QAPI evaluation of the MCOs in SFY 2009.

Validation of Performance Measures—HEDIS Compliance Audit—FY 2007–2008

At the request of DHCFP, HSAG validated the performance measures through the HEDIS compliance audits. The HEDIS compliance audits have focused on the ability of the MCOs to accurately process claims and encounter data, pharmacy data, laboratory data, enrollment (or membership) data, and provider data. As part of the HEDIS compliance audits, HSAG also explored the issue of data completeness of claims and encounter data to improve rates for the performance measures.

In 2006–2007, DHCFP contracted with an actuary to calculate incentive payments based on rates across all performance measures, along with disincentives for rates that did not show improvement. Using the concept of pay for performance, DHCFP linked data completeness to an incentive payment with a 20 percent direct pass-through to the MCOs' providers. The intent was to improve the quality and quantity of encounter data from providers, which, should help improve rates for the performance measures. The period of 2007–2008 marks the second year for this endeavor.

The following section provides summary information from the HEDIS Compliance Audit conducted by HSAG for **Anthem** and **HPN**. Further details can be found in the July 2008 HEDIS Compliance Audit Final Report of Findings for each MCO. Data on HEDIS performance can be found in the DHCFP QAPI Strategy Tool.

Objectives

The objectives of the HEDIS Compliance Audit were to assess the performance of the MCOs with respect to the *HEDIS 2008 Technical Specifications* and to review their performance on the HEDIS measures. The audits incorporated two main components:

- A detailed assessment of the health plan's IS capabilities for collecting, analyzing, and reporting HEDIS information.
- A review of the specific reporting methods used for HEDIS measures, including computer programming and query logic used to access and manipulate data and to calculate measures; databases and files used to store HEDIS information; medical record abstraction tools and abstraction procedures used; and any manual processes employed in 2008 HEDIS data production and reporting. The audit included any data collection and reporting processes supplied by vendors, contractors, or third parties, as well as the health plan's oversight of these outsourced functions.

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

Technical Methods of Data Collection and Analysis

HSAG performed a partial audit of Medicaid and SCHIP HEDIS reporting for the MCO and Nevada Check Up membership. Methods and information sources used by HSAG to conduct the audits included:

- Teleconferences with MCO personnel and vendor representatives as necessary.
- Detailed review of the MCOs' completed responses to the BAT.
- On-site meetings, including:
  - Staff interviews.
  - Live system and procedure documentation.
  - Documentation review and requests for additional information.
  - Primary HEDIS data source verification.
  - Programming logic review and inspection of dated job logs.
  - Computer database and file structure review.
  - Discussion and feedback sessions.
- Detailed evaluation of computer programming used to access administrative data sets, manipulate medical record review data, and calculate HEDIS measures.
- Detailed evaluation of encounter data completeness.
- Reabstraction of sample medical records selected by the auditors, with comparison of results to the MCO's review determinations for the same records, if the hybrid method was used.
- Requests for corrective actions and modifications to the MCO's HEDIS data collection and reporting processes and data samples, as necessary, and verification that actions were taken.
- Accuracy checks of the final HEDIS rates completed by the MCO.
- Interviews with a variety of individuals whose department or responsibilities played a role in the production of HEDIS data. Representatives of vendors that provided or processed HEDIS 2008 (and earlier historical) data may also have been interviewed and asked to provide documentation of their work.

Activities conducted prior to on-site meetings with representatives of the MCOs included written and e-mail correspondence with the MCOs explaining the scope of the audit, methods used, and time frames for major audit activities; a compilation of a standardized set of comprehensive working papers for the audit; a determination of the number of sites and locations for conducting on-site meetings, demonstrations, and interviews with critical personnel; the preparation of an on-site agenda; a review of source code, computer programming, and query language; and a detailed review of a select set of HEDIS measures required for reporting by DHCFP.

The IS capabilities assessment consisted of the auditor's findings on the MCOs' IS capabilities, compliance with each IS standard, and any impact on HEDIS reporting. This included facts on claims, membership and provider data, medical record review processes, data integration, data control, and measure calculation processes. The standards assessed were:

- IS 1.0 Sound Coding Methods for Medical Data
- IS 2.0 Data Capture, Transfer, and Entry—Medical and Service Data

- IS 3.0 Data Capture, Transfer, and Entry—Membership Data
- IS 4.0 Data Capture, Transfer, and Entry—Provider Data
- IS 5.0 Data Integration Required to Meet the Demands of Accurate Measure Reporting
- IS 6.0 Control Procedures That Support P4P Clinical Data Reporting Integrity

To validate the medical record review portion of the audit, NCQA policies and procedures require auditors to perform two steps. First, medical record review processes employed by the health plan are reviewed, which include staff qualifications, training, data collection instruments and tools, interrater reliability (IRR) testing, and the method used to combine medical record review data with administrative data. The second step is a reabstraction of selected medical records and a comparison of the audit team's results to the MCO's abstraction results for records used in the hybrid data source measures.

The analysis of the validation of performance measures involved tracking and reporting the rates for the nine HEDIS measures required for reporting by DHCFP. The audited measures (and the programs to which they apply) were:

Table 3-3––HEDIS Measures for 2008

Required Measure	Medicaid	Check Up	HIFA
Childhood Immunization Status (Combo 2 and Combo 3)	X	X	
Children's and Adolescents' Access to Primary Care Practitioners	X	X	
Well-Child Visits in the First 15 Months of Life	X	X	
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	X	X	
Adolescent Well-Care Visits	X	X	
Annual Dental Visit	X	X	
Comprehensive Diabetes Care	X	X	
Use of Appropriate Medications for People With Asthma*	X	X	
Mental Health Utilization—Percentage of Members Receiving Inpatient, Day/Night Care, and Ambulatory Services	X	X	
Follow-Up After Hospitalization for Mental Illness	X	X	
Weeks of Pregnancy at the Time of Enrollment	X		
Timeliness of Prenatal Care	X		X
Postpartum Care	X		X
Frequency of Ongoing Prenatal Care	X		X

* For the asthma measure, the Nevada Check Up (SCHIP) population will only be able to report the first two age groups (5–9 and 10–17) and will not be able to report the last age group (18–56) and the combined rate.

Plan-Specific Findings—Anthem Blue Cross Blue Shield

Description of Data Obtained

A detailed review of the 2008 performance reports submitted by **Anthem** determined that the reports were prepared according to the *HEDIS 2008 Technical Specifications* for all of the audited measures. Audits of the IS capabilities for accurate HEDIS reporting found that **Anthem** was compliant with the standards assessed as follows:

- The claims/encounter data system does not require a diagnosis code to process claims/ encounters. **Anthem** ran a query that found only three circumstances in which diagnosis codes were missing. The audit team determined that this issue had no impact on HEDIS reporting; however, the team recommended that **Anthem** implement a hard edit to require a diagnosis code to process all claims/encounters.
- The medical record review tool and training manual contained all the necessary data elements and supporting logic. The processes used to procure and abstract medical record data and to ensure IRR met standards. **Anthem** should implement a mechanism to monitor the data submission patterns of its capitated providers to further support data completeness.
- **Anthem** was determined to be fully compliant with all membership-related IS standards for the Medicaid, SCHIP, and HIFA product lines. The MCO is able to identify and track enrollment across each product line. Quality controls for loading and reconciling enrollment and eligibility files met standards.
- **Anthem** was determined to be fully compliant with all provider-related IS standards. The Diamond system captured all necessary provider-related data to report the State-required HEDIS measures.
- The source code review process required multiple submissions to address issues identified by the auditors. All issues related to source code were resolved prior to the final HEDIS measure calculation. However, **Anthem** should consider implementing a peer-led source code review process at the front end to identify any issues related to source code, which would reduce the incidence of source code errors and increase reporting efficiencies.
- **Anthem**'s BAT did not clearly indicate the processes for production of hybrid measures and medical record review specific to Nevada. In addition, several questions/sections were not completed appropriately. **Anthem** needs better communication and control of final BAT production. The MCO should consider implementing a final local review process of the BAT prior its submission to the auditors.

Conclusions Drawn From the Data

Medicaid Results

Table 3-4 displays the Medicaid HEDIS 2008 rates and the 2006 HEDIS 90th percentiles (measurable objectives) for **Anthem**. The MCO did not report on HEDIS measures for Nevada Medicaid prior to 2008, so trended results were not available.

Table 3-4—Medicaid HEDIS 2008 Rates for Anthem

HEDIS Measure	Medicaid 2008 HEDIS Results for Anthem	2006 HEDIS 90th Percentile
Childhood Immunization Rate—Combo 2	54.3	82.7
Childhood Immunization Rate—Combo 3	45.7	57.8
Children's Access to PCP (12–24 months)	90.4	98.2
Children's Access to PCP (25 months–6 years)	79.5	91.5
Children's Access to PCP (7–11 years)	NA	92.0
Children's Access to PCP (12–19 years)	NA	90.2
Well-Child Visits First 15 months (6 or more visits)	28.7	68.6
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	54.9	77.5
Adolescent Well Care	21.3	54.5
Annual Dental Visits—Combined Rate	42.0	52.9
Timeliness of Prenatal Care	75.9	91.5
Postpartum Care	49.3	71.0
Frequency of Ongoing Prenatal Care (<21% Visits)*	74.6	1.9
Frequency of Ongoing Prenatal Care (81–100% Visits)	6.0	79.9
Follow-up After Hospitalization for Mental Illness 7 Days	47.7	66.4
Follow-up After Hospitalization for Mental Illness 30 Days	68.2	85.1
Diabetes Care—HbA1c Testing	75.6	88.8
Diabetes Care—Poor HbA1c Control*	67.1	30.3
Diabetes Care—Good HbA1c Control	15.9	NA
Diabetes Care—Eye exams	36.6	68.1
Diabetes Care—LDL-C Screening	76.8	90.8
Diabetes Care—LDL-C Level <100	22.0	46.5
Diabetes Care—Blood Pressure <140/90	48.8	NA
Diabetes Care—Blood Pressure <130/80	26.8	NA
Diabetes Care—Monitoring Nephropathy	78.1	65.6
Use of Appropriate Medications for Asthma (5–9 Years)	NA	95.8
Use of Appropriate Medications for Asthma (10–17 Years)	NA	93.5
Use of Appropriate Medications for Asthma (18–56 Years)	NA	90.8
Use of Appropriate Medications for Asthma (Combined)	NA	92.5

*** Lower rates are better for this measure.**

In terms of quality, **Anthem** demonstrated a relatively good first-year performance. The rate for Diabetes Care—Monitoring Nephropathy exceeded the 90th percentile, while five measures were above the 50th percentile. **Anthem** did particularly well with Follow-up After Hospitalization for Mental Illness (7 Days and 30 Days), with both rates exceeding the 50th percentile. Six rates had fewer than 30 eligible members in the denominator and received an NA designation in accordance with HEDIS reporting.

In general, **Anthem**'s rates were at least comparable, albeit slightly lower, than the rates for **HPN**. However, **Anthem** had significantly lower rates for some measures. Well-Child Visits in the First 15 Months of Life and Adolescent Well-Care visits had rates below the 2006 national Medicaid 25th and 10th percentiles, respectively. The rates for Frequency of Ongoing Prenatal Care (both numerators) were well below the 10th percentile. These results may indicate issues with receiving all encounter data, lack of member compliance, and/or issues related to timeliness of, or access to, maternity care.

SCHIP Results

Table 3-5 displays the Nevada Check Up (SCHIP) HEDIS 2008 rates and the 2006 HEDIS 90th percentiles (measurable objectives) for **Anthem**. The MCO did not report on HEDIS measures for Nevada Check Up prior to 2008, so trended results were not available.

Table 3-5—Nevada Check Up HEDIS 2008 Rates for Anthem

HEDIS Measure	SCHIP 2008 HEDIS Results for Anthem	2006 HEDIS 90th Percentile
Childhood Immunization Rate—Combo 2	71.1	82.7
Childhood Immunization Rate—Combo 3	64.5	57.8
Children's Access to PCP (12–24 months)	98.7	98.2
Children's Access to PCP (25 months–6 years)	89.1	91.5
Children's Access to PCP (7–11 years)	NA*	92.0
Children's Access to PCP (12–19 years)	NA*	90.2
Well-Child Visits First 15 months (6 or more visits)	NA*	68.6
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	64.8	77.5
Adolescent Well Care	35.0	54.5
Annual Dental Visits—Combined Rate	56.9	52.9
Use of Appropriate Medications for Asthma (5–9 Years)	NA*	95.8
Use of Appropriate Medications for Asthma (10–17 Years)	NA*	93.5
Follow-up After Hospitalization for Mental Illness 7 Days	NA*	66.4
Follow-up After Hospitalization for Mental Illness 30 Days	NA*	85.1
*** The denominator had fewer than 30 eligible cases; therefore, the rate was reported as NA.**		

In terms of quality, access, and timeliness, **Anthem** demonstrated a strong first-year performance, with five out of seven rates above the 50th percentile, and three rates also above the 90th percentile.

Seven rates had fewer than 30 eligible members in the denominator and were given an NA designation in accordance with HEDIS reporting.

Plan-Specific Findings—Health Plan of Nevada

Description of Data Obtained

A detailed review of the 2008 performance reports submitted by **HPN** determined that the reports were prepared according to *HEDIS 2008 Technical Specifications* for all of the audited measures described above. Audits of the IS capabilities for accurate HEDIS reporting found that **HPN** was compliant with the standards assessed as follows:

- **HPN** was determined to be fully compliant with all membership-related IS standards for the Medicaid, SCHIP, and HIFA product lines. **HPN** was able to identify and track enrollment across each product line.
- **HPN** was determined to be fully compliant with all provider-related IS standards. The FACETs system captured all necessary provider-related data.
- The reviews of processes in place at **HPN** for performance of medical record review for all measures reported using the hybrid method determined that the **HPN**'s processes for IRR testing met HEDIS standards.
- **HPN** monitors provider submission patterns to ensure data completeness.
- **HPN** used an internally-built administrative database to supplement its HEDIS data. The process for maintaining this database was not well documented. Numerator events derived from this database that could not be verified were removed from the numerator; therefore, no bias to the rates resulted from the use of this database. However, the audit team recommended that **HPN** formally document each step used to collect and validate data within an internally-built administrative database to ensure data accuracy and validity.

Conclusions Drawn From the Data

Medicaid Results

Table 3-6 displays the Medicaid HEDIS rates for 2005 through 2008 and the 2006 HEDIS 90th percentiles (measurable objectives) for **HPN**. The MCO did not report Diabetes Care and Use of Appropriate Medications for Asthma prior to this year; therefore, the table presents the results for these measures as NA for 2005–2007. Appendix B also presents the trended results.

Table 3-6—Medicaid HEDIS Results for HPN						
HEDIS Measure	**2005**	**2006**	**2007**	**2008**	**2006 HEDIS 90th Percentile**	**Change Between 2005 and 2008**
Childhood Immunization Rate—Combo 2	55.0	50.1	56.7	59.6	82.7	+4.6
Childhood Immunization Rate—Combo 3	NA	20.4	43.8	50.1	57.8	+29.7
Children's Access to PCP (12–24 months)	90.4	92.2	93.2	94.1	98.2	+3.7
Children's Access to PCP (25 months–6 years)	74.9	78.9	82.4	82.4	91.5	+7.5
Children's Access to PCP (7–11 years)	81.6	75.3	80.5	79.5	92.0	-2.1
Children's Access to PCP (12–19 years)	76.0	71.9	73.9	75.7	90.2	-0.3
Well-Child Visits First 15 months (6 or more visits)	38.3	34.0	47.7	43.8	68.6	+5.5
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	43.8	56.0	64.0	62.5	77.5	+18.7
Adolescent Well Care	20.2	19.2	28.5	33.1	54.5	+12.9
Annual Dental Visits—Combined Rate	22.0	29.4	36.5	50.8	52.9	+28.8
Timeliness of Prenatal Care	63.5	73.5	84.4	71.8	91.5	+8.3
Postpartum Care	41.4	41.9	45.5	49.2	71.0	+7.8
Frequency of Ongoing Prenatal Care (<21% Visits)*	33.6	15.8	9.5	23.1	1.9	-10.5*
Frequency of Ongoing Prenatal Care (81-100% Visits)	49.4	60.8	65.7	55.2	79.9	+5.8
Follow-up After Hospitalization for Mental Illness 7 Days	46.7	42.6	32.3	35.7	66.4	-11.0
Follow-up After Hospitalization for Mental Illness 30 Days	53.3	59.3	50.8	68.6	85.1	+15.3
Diabetes Care—HbA1c Testing	NA	NA	NA	65.8	88.8	NA
Diabetes Care—Poor HbA1c Control*	NA	NA	NA	53.0	30.3	NA
Diabetes Care—Good HbA1c Control	NA	NA	NA	28.2	NA	NA
Diabetes Care—Eye exams	NA	NA	NA	47.5	68.1	NA
Diabetes Care—LDL-C Screening	NA	NA	NA	60.8	90.8	NA
Diabetes Care—LDL-C Level <100	NA	NA	NA	24.3	46.5	NA
Diabetes Care—Blood Pressure <140/90	NA	NA	NA	58.6	NA	NA
Diabetes Care—Blood Pressure <130/80	NA	NA	NA	28.2	NA	NA
Diabetes Care—Monitoring Nephropathy	NA	NA	NA	67.4	65.6	NA
Use of Appropriate Medications for Asthma (5–9 Years)	NA	NA	NA	90.2	95.8	NA
Use of Appropriate Medications for Asthma (10–17 Years)	NA	NA	NA	85.7	93.5	NA
Use of Appropriate Medications for Asthma (18–56 Years)	NA	NA	NA	79.4	90.8	NA
Use of Appropriate Medications for Asthma (Combined)	NA	NA	NA	86.8	92.5	NA
*** Lower rates are better for this measure.**						

Overall, rates for 13 out of 16 Medicaid HEDIS measures for **HPN** have improved since 2005. In terms of quality, **HPN** appeared to provide appropriate services and continued to improve the delivery of services to members. Two measures have improved by more than 20 percentage points, while an additional four measures improved by more than 10 percentage points. The rate for Diabetes Care—Monitoring Nephropathy exceeded the 90th percentile, while four measures were above the 50th percentile. Four additional measures were within 1 percentage point of the 50th percentile.

Although **HPN** has shown improvement with quality over time, there may be an issue with timeliness and/or access to care. Three measures, Children's Access to PCPs (7–11 Years and 12–19 Years) and Follow-up After Hospitalization for Mental Illness (7 Days), have declined since 2005. Last year's report mentioned these measures, all of which relate to access to care. **HPN**'s most significant one-year decline (from 2007 to 2008) was in Frequency of Ongoing Prenatal Care and Timeliness of Prenatal Care. Both of these measures relate to timeliness of, and access to, care and may indicate an issue with obtaining appointments in a timely manner, issues with network adequacy for maternity care, or member and/or provider non-compliance.

SCHIP Results

Table 3-7 displays the Nevada Check Up (SCHIP) HEDIS rates for 2005 through 2008 and the measurable objectives for **HPN**. The MCO did not report Use of Appropriate Medications for Asthma prior to this year; therefore, the table presents the results for these measures as NA for 2005–2007. Appendix B also presents the trended results.

Table 3-7—SCHIP HEDIS Results for HPN

HEDIS Measure	2005	2006	2007	2008	2006 HEDIS 90th Percentile	Change Between 2005 and 2008
Childhood Immunization Rate—Combo 2	70.1	62.3	70.8	73.7	82.7	+3.6
Childhood Immunization Rate—Combo 3	NA	25.7	56.0	65.2	57.8	+39.5
Children's Access to PCP (12–24 months)	98.5	96.0	98.7	97.9	98.2	-0.6
Children's Access to PCP (25 months–6 years)	91.5	90.4	93.1	92.3	91.5	+0.8
Children's Access to PCP (7–11 years)	94.2	92.6	92.4	91.6	92.0	-2.6
Children's Access to PCP (12–19 years)	88.0	87.5	88.5	85.3	90.2	-2.7
Well-Child Visits First 15 months (6 or more visits)	40.0	39.4	41.1	36.3	68.6	+28.6
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	59.4	57.9	76.2	78.4	77.5	+19.0
Adolescent Well Care	30.3	25.9	37.5	44.0	54.5	+13.7
Annual Dental Visits—Combined Rate	49.2	50.0	53.0	68.0	52.9	+18.8
Use of Appropriate Medications for Asthma (5–9 Years)	NA	NA	NA	98.5	95.8	NA
Use of Appropriate Medications for Asthma (10–17 Yrs.)	NA	NA	NA	88.3	93.5	NA
Follow-up After Hospitalization for Mental Illness 7 Days	NA*	NA*	NA*	29.4	66.4	NA*
Follow-up After Hospitalization for Mental Illness 30 Days	NA*	NA*	NA*	61.8	85.1	NA*

*** The denominator had fewer than 30 eligible cases; therefore, the rate was reported as NA.**

Overall, 7 out of 10 SCHIP HEDIS measures for **HPN** have improved since 2005. In terms of quality, as with Medicaid, **HPN** appeared to provide appropriate services and continued to improve the delivery of services to members. Two measures have improved by more than 20 percentage points, while an additional three measures improved by more than 10 percentage points. For HEDIS 2008, 5 of the 14 reported measures exceeded the 90th percentile, while 7 other measures were above the 50th percentile.

In comparison to Medicaid, the SCHIP rates were generally higher. However, rates for Medicaid and SCHIP had one similarity: the Children's Access to PCPs measures have shown small declines

since 2005. These small declines have not been significant, but they may indicate an issue with access to care, especially considering that both Medicaid and SCHIP had declining rates for measures related to access to care, including the maternity-related measures. Given this slight downward trend, HSAG recommends that **HPN** conduct a barrier analysis to determine if these are real issues or if the results reflect random fluctuation.

Validation of Performance Improvement Projects—FY 2007–2008

HSAG reviewed three PIPs submitted by **Anthem**: *Improving Childhood Immunization Rates*, *Improving Diabetes Screening and Control*, and *Lead Screening in Children.* Further details can be found in the State of Nevada DHCFP 2007–2008 PIP Validation Report, *Improving Childhood Immunization Rates* for Anthem Blue Cross Blue Shield Partnership Plan (June 2007 and June 2008); the State of Nevada DHCFP 2007–2008 PIP Validation Report, *Improving Diabetes Screening and Control* for Anthem Blue Cross Blue Shield Partnership Plan (June 2008); and the State of Nevada DHCFP 2007–2008 PIP Validation Report, *Lead Screening in Children* for Anthem Blue Cross Blue Shield Partnership Plan (June 2008).

HSAG reviewed three PIPs submitted by **HPN**: *Improving Childhood Immunization Rates for Children Two Years Old in Medicaid*, *Improving Diabetes Management*, and *Lead Screening in Children.* Further details can be found in the State of Nevada DHCFP 2007–2008 PIP Validation Report, *Improving Childhood Immunization Rates for Children Two Years Old in Medicaid* for Health Plan of Nevada (April 2007 and June 2008); the State of Nevada DHCFP 2007–2008 PIP Validation Report, *Improving Diabetes Management* for Health Plan of Nevada (April 2007 and June 2008); and the State of Nevada DHCFP 2007–2008 PIP Validation Report, *Lead Screening in Children* for Health Plan of Nevada (June 2008).

Objectives

The objectives of a PIP are to assess health care processes, implement process improvements, and improve outcomes of care. HSAG followed standardized procedures for validating each MCO's PIPs to assess the degree to which the MCOs designed, conducted, and reported their PIPs in a methodologically sound manner.

Technical Methods of Data Collection and Analysis

The PIP validation was based on *Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities* (U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, final protocol, Version 1.0, May 1, 2002). This document and its companion, *Conducting Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities* (U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, final protocol, Version 1.0, May 1, 2002), provide MCOs with guidelines for designing, implementing, and reporting on PIPs.

HSAG developed a PIP Summary Form to assist the Nevada MCOs in designing activities that flow logically through the BBA requirements for submission of a PIP. Projects are designed to conform to a process of 10 activities:

I. Select the study topic(s)
II. Define the study question(s)
III. Select the study indicator(s)
IV. Use a representative and generalizable study population
V. Use sound sampling techniques (if sampling is used)
VI. Reliably collect data
VII. Implement intervention and improvement strategies
VIII. Analyze data and interpret study results
IX. Plan for real improvement
X. Achieve sustained improvement

PIP validation is accomplished through analysis of the evaluation elements delineated in the PIP Validation Tool. The validation tool contains separate scoring areas for each of the 10 activities outlined above. Some of the evaluation elements are critical while others are somewhat less important, but are still central to an understanding of the details necessary to fully assess a PIP. The scoring categories for each element are *Met*, *Partially Met*, *Not Met*, or *Not Applicable (NA)*. All of the critical elements must receive a *Met* score to meet the standard. HSAG uses the scores to assess the overall proportion of *Met* elements for an overall PIP score. HSAG calculates the overall PIP percentage score by dividing the total number of *Met* evaluation elements by the sum of the evaluation elements *Met*, *Partially Met*, and *Not Met*. HSAG calculates the percentage score of critical elements *Met* by dividing the total number of critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

HSAG further identified any applicable *Points of Clarification* when the documentation for an evaluation element included the basic components to meet requirements for the evaluation element (as described in the narrative of the PIP), but enhanced documentation would demonstrate a stronger understanding of the CMS PIP Protocol.

The PIP results include a detailed description of the technical merit of each PIP. The data obtained allow the formulation of criterion-referenced assessments of the degree of success for each project, as well as norm-referenced (i.e., comparative) assessments across managed care plans.

Element and subelement scores, with their attendant comments, can be used to assess PIP results within and across MCOs. The State and the MCOs can see which evaluation elements scored well and which did not, along with the scoring rationale. This can help identify the activities needed to convert *Partially Met* or *Not Met* scores to *Met* scores. PIP findings supply the State and the MCOs with the information needed to assess the strengths and weaknesses of individual PIPs. In addition, they highlight areas in which the MCOs might need to enhance the skills of staff members who are involved in the implementation and the documentation of the PIPs.

The MCOs had an opportunity to resubmit a revised PIP Summary Form and additional information in response to any *Points of* Clarification or *Partially Met* or *Not Met* evaluation scores, regardless of whether the evaluation element was critical or noncritical. The resubmitted documents were due to HSAG within three weeks of the date of written notification. Once the re-review process had been completed, the PIP scores were considered final.

Plan-Specific Findings—Anthem Blue Cross Blue Shield

Improving Childhood Immunization Rates PIP

Description of Data Obtained

Using the PIP Validation Tool, HSAG assessed each component of **Anthem**'s *Improving Childhood Immunization Rates* PIP based on CMS protocol activities. **Anthem** had completed Activities I through VI for the 2007–2008 validation; consequently, HSAG did not assess Activities VII through X.

Conclusions Drawn From the Data

The following highlights the overall validation results for the **Anthem** *Improving Childhood Immunization Rates* PIP:

Table 3-8––PIP and Critical Element Scores

	Met	*Partially Met*	*Not Met*	*NA*
PIP Elements Evaluated	33	0	1	1
Critical Elements Evaluated	9	0	0	0

Strengths, Weaknesses, and Trend Information

The percentage score of evaluation elements *Met* was 97 percent in 2007–2008, compared with 100 percent in 2006–2007. The percentage score of critical elements *Met* was 100 percent in both years, resulting in a *Met* validation status in 2006–2007 and 2007–2008. Based on the validation of this PIP, HSAG's assessment determined high confidence in the reported results. This PIP continues to demonstrate strength in its study design and has a strong framework with which to move forward using *HEDIS 2008 Technical Specifications*.

During this period, the PIP reported no baseline results. The baseline period for this PIP was reported as February 2008 to June 2008.

Recommendations

For Activity I, "Clearly defined, answerable study question," the study question was a baseline question and continues to be appropriate for this stage of the PIP. However, as the study moves forward, the study question should be presented in an X/Y format (i.e., "Does doing X result in Y?") to meet CMS protocols.

For Activity VI, "Accurate/complete data collection," an overview of the study was not provided in the written instructions of the resubmitted documentation. This should be provided.

Improving Diabetes Screening and Control PIP

Description of Data Obtained

Using the PIP Validation Tool, HSAG assessed each component of **Anthem**'s *Improving Diabetes Screening and Control* PIP based on CMS protocol activities. **Anthem** had completed Activities I through VI for the 2007–2008 validation; consequently, HSAG did not assess Activities VII through X.

Conclusions Drawn From the Data

The following highlights the overall validation results for the **Anthem** *Improving Diabetes Screening and Control* PIP:

Table 3-9—PIP and Critical Element Scores

	Met	*Partially Met*	*Not Met*	*NA*
PIP Elements Evaluated	33	0	1	1
Critical Elements Evaluated	9	0	0	0

Strengths, Weaknesses, and Trend Information

The percentage score of evaluation elements *Met* was 97 percent in 2007–2008, compared with 100 percent in 2006–2007. The percentage score of critical elements *Met* was 100 percent in both years, resulting in a *Met* validation status in 2006–2007 and 2007–2008. Based on the validation of this PIP, HSAG's assessment determined high confidence in the reported results. This PIP continues to demonstrate strength in its study design and has a strong framework with which to move forward using *HEDIS 2008 Technical Specifications*.

During this period, the PIP reported no baseline results. The baseline period for this PIP was reported as February 2008 to June 2008.

Recommendations

For Activity II, "Clearly defined, answerable study question," the study question was a baseline question and continues to be appropriate for this stage of the PIP. However, as the study moves forward, the study question should be presented in an X/Y format (i.e., "Does doing X result in Y?") to meet CMS protocols.

For Activity VI, "Accurate/complete data collection," an overview of the study was not provided in the written instructions of the resubmitted documentation. This should be provided.

Lead Screening in Children PIP

Description of Data Obtained

Using the PIP Validation Tool, HSAG assessed each component of **Anthem**'s *Lead Screening in Children* PIP based on CMS protocol activities. **Anthem** had completed Activities I through IV for the 2007–2008 validation; consequently, HSAG did not assess Activities V through X.

Conclusions Drawn From the Data

The following highlights the overall validation results for the *Lead Screening in Children* PIP:

Table 3-10—PIP and Critical Element Scores

	Met	*Partially Met*	*Not Met*	*NA*
PIP Elements Evaluated	17	0	0	1
Critical Elements Evaluated	7	0	0	0

Strengths, Weaknesses, and Trend Information

The percentage score of evaluation elements *Met* and critical elements *Met* were both 100 percent, resulting in a *Met* validation status. Based on the validation of this PIP, HSAG's assessment determined high confidence in the reported results.

The two Medicaid MCOs in Nevada are collaborating on this PIP. The study topic, study question, study indicators, and study population were developed as part of the collaborative process. In Activity I, plan-specific information was provided by each health plan.

Recommendations

For Activity II, "Clearly defined, answerable study question," the HSAG PIP review team recommended that **Anthem** remove the following clause from the beginning of the study question: "Assuming the baseline lead screening rate does not meet national and regional goals...."

For Activity III, "Clearly defined study indicator(s)," if the Medicaid HEDIS Quality Compass benchmark was used for this study, that information should be included as the source of the benchmark.

For Activity IV, "Correctly identified study population," the year of the HEDIS technical specifications should be included in the study. **Anthem** should update this information annually if it changes.

Plan-Specific Findings—Health Plan of Nevada

Improving Immunization Rates for Children Two Years Old in Medicaid PIP

Description of Data Obtained

Using the PIP Validation Tool, HSAG assessed each component of **HPN**'s *Improving Immunization Rates for Children Two Years Old in Medicaid* PIP based on CMS protocol activities. **HPN** had completed Activities I through VIII for the 2007–2008 validation; consequently, HSAG did not assess Activities IX and X.

Conclusions Drawn from the Data

The following highlights the overall validation results for the **HPN** *Improving Immunization Rates for Children Two Years Old in Medicaid* PIP:

Table 3-11—PIP and Critical Element Scores

	Met	*Partially Met*	*Not Met*	*NA*
PIP Elements Evaluated	41	0	0	7
Critical Elements Evaluated	11	0	0	0

Strengths, Weaknesses, and Trend Information

The percentage scores of evaluation elements *Met* and critical elements *Met* were both 100 percent, resulting in a *Met* validation status in 2007–2008. **HPN** achieved the same results in 2006–2007 for its *Improving Immunization Rates for Children Two Years Old in Medicaid* PIP, when the plan completed Activities I through IV. Based on the validation of this PIP, HSAG's assessment determined high confidence in the reported results. This PIP continues to demonstrate strength in its study design and has a strong framework with which to move forward using *HEDIS 2008 Technical Specifications*.

Recommendations

For Activity V, "Valid sampling techniques (if sampling was used)," future submissions of the PIP should note that *HEDIS 2007 Technical Specifications* were used for the calculation of the sample population, margin of error, and confidence level. Further, **HPN** should include the most recent final NCQA-audited statement report summary with future submissions.

For Activity VI, "Accurate/complete data collection," future submissions of the PIP should report the estimated degree of administrative data completeness.

Improving Diabetes Management PIP

Description of Data Obtained

Using the PIP Validation Tool, HSAG assessed each component of **HPN**'s *Improving Diabetes Management* PIP based on CMS protocol activities. **HPN** completed all 10 activities during this validation cycle.

Conclusions Drawn from the Data

The following highlights the overall validation results for the **HPN** *Improving Diabetes Management* PIP:

Table 3-12—PIP and Critical Element Scores

	Met	*Partially Met*	*Not Met*	*NA*
PIP Elements Evaluated	45	0	0	8
Critical Elements Evaluated	9	0	0	2

Strengths, Weaknesses, and Trend Information

The percentage score of evaluation elements *Met* and the percentage score of critical elements *Met* were both 100 percent in 2007–2008, resulting in a *Met* validation status. Based on the validation of this PIP, HSAG's assessment determined high confidence in the reported results. This represents an improvement from 2006–2007, when the percentage score of evaluation elements *Met* was 95 percent and the percentage score of critical elements *Met* was 100 percent. In 2005–2006, **HPN** completed Activities I through VII and received scores of 100 percent for evaluation elements *Met* and critical elements *Met.*

HPN noted in the PIP submission that *HEDIS 2007 Technical Specifications* contained major changes, which restricted the trending of results for two of the three study indicators. For LDL-C screening, criteria were restricted to testing in the measurement year; previously, the prior year was included. For monitoring of diabetic nephropathy, **HPN** added the use of ACE inhibitors/ARBs to the numerator. **HPN** addressed these changes throughout the documentation. For this validation cycle, **HPN** completed a baseline with two remeasurements.

Table 3-13 provides the results for all three study indicators over the comparison periods of baseline, first remeasurement, and second remeasurement.

Table 3-13—HPN Diabetes Management Study Indicator Results

Study Indicator	Baseline 1/1/04–12/3/04	Remeasurement 1 1/1/05–12/31/05	Remeasurement 2 1/1/06–12/31/06
1. HbA1c Testing	50.45%	46.09%	63.82%
2. LDL-C Screening	47.75%	54.78%	60.53%*
3. Monitoring for Nephropathy	31.53%	37.39%	77.63%*

*These study indicators cannot be trended for the second remeasurement due to the changes in the *HEDIS 2007 Technical Specifications*.

HbA1c testing had a second remeasurement rate of 63.82 percent. The goal was 66.95 percent. The 2006 HEDIS Medicaid 90th percentile benchmark was reported at 95.1 percent. This was a statistically significant improvement from the first remeasurement, when the rate was 46.09 percent and the goal was 50.36 percent. **HPN**'s rate had declined to a statistically significant degree from baseline (50.45 percent) to the first remeasurement. Overall, the HbA1c indicator showed a statistically significant improvement over a three-year period.

LDL-C screening had a second remeasurement rate of 60.53 percent. The goal was 64.23 percent. The 2006 HEDIS Medicaid 90th percentile benchmark was reported as 97.5 percent.

Monitoring for diabetic nephropathy had a second remeasurement rate of 77.63 percent. The 2006 HEDIS Medicaid 90th percentile benchmark was reported as 77.1 percent. **HPN**'s goal for 2006 was to exceed the 90th percentile benchmark, and **HPN** reported that the new goal was to maintain the rate in the 90th percentile.

Recommendations

If DHCFP determines that the study should continue with the new 2007 HEDIS study measures for trending purposes, **HPN** should address the following *Points of Clarification*:

- For Activity VI, "Accurate/complete data collection," future submissions should report the estimated degree of data completeness.
- For Activity VIII, "Sufficient data analysis and interpretation," **HPN** should provide exact *p* values when submitting documentation to support statistical testing.

Lead Screening in Children PIP

Description of Data Obtained

Using the PIP Validation Tool, HSAG assessed each component of **HPN**'s *Lead Screening in Children* PIP based on CMS protocol activities. **HPN** had completed Activities I through IV for the 2007–2008 validation; consequently, HSAG did not assess Activities V through X.

Conclusions Drawn from the Data

The following highlights the overall validation results for the *Lead Screening in Children* PIP:

Table 3-14—PIP and Critical Element Scores

	Met	*Partially Met*	*Not Met*	*NA*
PIP Elements Evaluated	17	0	0	1
Critical Elements Evaluated	7	0	0	0

Strengths, Weaknesses, and Trend Information

The percentage score of evaluation elements *Met* and the percentage score of critical elements *Met* were both 100 percent, resulting in a *Met* validation status. Based on the validation of this PIP, HSAG's assessment determined high confidence in the reported results.

The two Medicaid MCOs in Nevada are collaborating on this PIP. The study topic, study question, study indicators, and study population were developed as part of the collaborative process. In Activity I, each health plan provided plan-specific information.

Recommendations

For Activity II, "Clearly defined, answerable study question," the HSAG PIP review team recommended that **HPN** remove the following clause from the beginning of the study question: "Assuming the baseline lead screening rate does not meet national and regional goals...."

For Activity IV, "Correctly identified study population," **HPN** noted that for Study Indicator 2, recipient race and ethnicity would be captured. In future submissions of the PIP, **HPN** should specify that capturing race and ethnicity is an optional component for the collaborative study and is not part of the formal submission.

Collaborative Lead Screening in Children PIP

DHCFP has recognized lead poisoning as a potential health threat to children enrolled in the Nevada Medicaid and Nevada Check Up programs. However, lead screening data are not readily available on these members, making it difficult to ascertain the extent of lead screening provided and the prevalence of lead poisoning in this population. In July 2007, DHCFP and its two contracted Medicaid MCOs began a collaborative PIP to determine the extent of lead screening of children 2 years of age enrolled in the Nevada Medicaid program.

The population identified for this study was determined using the HEDIS 2008 Lead Screening in Children (LSC) measure and included all children enrolled in Nevada Medicaid or Nevada Check Up who turned 24 months of age between January 1, 2007, and December 31, 2007. Children in the study population were continuously enrolled in either Anthem or HPN for at least 11 of the 12 months immediately preceding the date the child turned 24 months of age.

The final sample sizes were 597 cases for Nevada Medicaid and 487 cases for Nevada Check Up, totaling 1,084 children out of 2,158 eligible children in the population. The lead screening rates in the table below followed the *HEDIS 2008 Technical Specifications* that children have at least one lead screening by 24 months of age.

Table 3-15—Rates for Lead Screening in Children, Medicaid and SCHIP			
	Numerator	Denominator	Rate
NV Medicaid Results			
Anthem	17	186	9.1%
HPN	58	411	14.1%
Combined Total	75	597	12.6%
NV Check Up Results			
Anthem	11	76	14.5%
HPN	82	411	20.0%
Combined Total	93	487	19.1%

The results show that the Nevada Check Up rates were consistently higher (by 5 to 6 percentage points) than the Nevada Medicaid rates for both **Anthem** and **HPN**. Since this was a first-year HEDIS measure, national benchmarks were not yet available for comparisons.

The purpose of this baseline study was to determine the extent of lead screening of children 2 years of age enrolled in one of the contracted Medicaid MCOs. These results suggest that the rate of screening is not optimal at this time and both MCOs should continue efforts to improve lead screening in children.

Recommendations

HSAG recommends the following to assist the MCOs and DHCFP in designing interventions to improve childhood lead screening rates for children enrolled in Nevada Medicaid and Nevada Check Up:

- Efforts to improve lead testing rates should continue by disseminating current guidelines to the provider community, educating pregnant women and parents/caretakers of young children regarding lead testing requirements, and reminding the general public about the health risks and poor outcomes of children who experience lead poisoning. DHCFP and the MCOs should continue to work collaboratively with the Childhood Lead Poisoning Prevention Program (CLPPP) and other agencies to obtain and disseminate information about lead screening and lead poisoning.
- Both MCOs should employ strategies to target members within the age range of required lead testing, offering providers lists of members to notify for testing. This activity may lead to discussions of barriers to lead testing experienced by providers, especially if providers must send members to another facility for a blood lead test.
- The primary goal for all health care professionals providing pediatric care should be to target children for blood lead screening at 12 months of age. Since this is an ideal time to administer certain childhood immunizations, providers should be encouraged to complete immunizations and lead screening within the same visit.
- The lead screening PIP did not attempt to determine blood lead levels (BLLs) and follow-up activities. However, providers need to document the BLLs and follow-up activities for elevated BLLs in the medical record to ensure that children receive appropriate care. All BLLs, whether elevated or not, should be reported to the CLPPP. HSAG recommends that the MCOs consider capturing BLLs and follow-up activities in future studies.

Next Steps

This report provides a summary of the results to date of the collaborative lead screening PIP conducted by the MCOs. The MCOs are in the intervention phase of this PIP. The following is a brief summary of the next steps in the PIP process:

- The MCOs will develop and implement interventions to improve lead screening rates. The interventions and implementation process should be fully documented and based on barrier analyses conducted in response to the MCOs' PIP results.
- Following the intervention period, the MCOs will collect and report on lead screening rates using the same methodology to determine if the interventions were successful.
- The MCOs will complete the collaborative PIP, including complete documentation of interventions and a comparison of rates from the baseline study to the follow-up results.

CAHPS® Surveys—FY 2007–2008

The CAHPS surveys ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers, such as the communication skills of providers and the accessibility of services. **Anthem** and **HPN** were responsible for obtaining a CAHPS vendor to administer the CAHPS surveys on their behalf. DHCFP forwarded **Anthem**'s and **HPN**'s results to HSAG for analysis. HSAG administered the surveys on behalf of DHCFP for the **FFS** program.

Objectives

The overarching objective of the CAHPS surveys was to effectively and efficiently obtain information on patients' levels of satisfaction with their health care experiences.

Technical Methods of Data Collection and Analysis

For **Anthem**, **HPN**, and the **FFS** program, three populations were surveyed: adult Medicaid, child Medicaid, and SCHIP. As stated above, HSAG administered the CAHPS surveys to the **FFS** population, while DSS Research and the Myers Group administered the CAHPS surveys to **Anthem**'s and **HPN**'s populations, respectively.

The technical method of data collection was through the administration of the CAHPS 4.0 Adult Medicaid Survey to the adult population and the CAHPS 3.0 Child Medicaid Survey (without the children with chronic conditions measurement set) to the child population. For the **FFS** program, the surveys were administered in both English and Spanish. For **Anthem** and **HPN**, the surveys were administered only in English. All three programs/plans used a mixed methodology for data collection, which includes both a mail and telephone phase for data collection.

The survey questions were categorized into nine measures of satisfaction. These measures included four global ratings and five composite scores. The global ratings reflected patients' overall satisfaction with their personal doctor, specialist, health plan, and all health care. The composite scores were derived from sets of questions to address different aspects of care (i.e., getting needed care and how well doctors communicate). When a minimum of 100 responses for a measure was not achieved, the result of the measure was "Not Applicable" (NA).

For each of the four global ratings, the percentage of respondents who chose the top satisfaction ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. This percentage is referred to as a question summary rate (or top-box response). In addition to the question summary rate, a three-point mean was calculated. Response values of 0 to 6 were given a score of 1, response values of 7 and 8 were given a score of 2, and response values of 9 and 10 were given a score of 3. The three-point mean was the sum of the response scores (1, 2, or 3) divided by the total number of responses to the global rating question.

For each of the five composite scores, the percentage of respondents who chose a positive response was calculated. CAHPS composite question response choices in the adult Medicaid survey fell into one of the following two categories: 1) "Never," "Sometimes," "Usually," and "Always" or 2) "Definitely No," "Somewhat No," "Somewhat Yes," and "Definitely Yes." For the child Medicaid survey, response choices fell into one of the following two categories: 1) "Never," "Sometimes," "Usually," and "Always" or 2) "A Big Problem," "A Small Problem," and "Not a Problem."

A positive or top-box response for the composites was defined as a response of "Always," "Not a Problem," or "Definitely Yes." The percentage of top-box responses is referred to as a global proportion for the composite scores.

In addition to the global proportion, a three-point mean was calculated for each of the composite scores. Scoring was based on a three-point scale. Responses of "Always," "Not a Problem," and "Definitely Yes" were given a score of 3; responses of "Usually," "A Small Problem," or "Somewhat Yes" were given a score of 2; and all other responses were given a score of 1. The three-point mean is the average of the mean score for each question included in the composite.

Plan-Specific Findings––Anthem Blue Cross Blue Shield

Adult Medicaid

Table 3-16 displays **Anthem**'s 2008 adult Medicaid CAHPS top-box percentages and three-point means, along with NCQA's 2007 CAHPS national averages.

Table 3-16—Anthem Adult Medicaid CAHPS Results

	Top-Box Percentages	Three-Point Mean Scores	2007 NCQA CAHPS National Averages
Composite Measures			
Getting Needed Care	44.2%	2.142	47.3%
Getting Care Quickly	64.1%	2.482	54.0%
How Well Doctors Communicate	65.9%	2.535	66.8%
*Customer Service**	NA	NA	*
Shared Decision Making	NA	NA	58.4%
Global Ratings			
Rating of All Health Care	44.7%	2.274	46.6%
Rating of Personal Doctor	63.1%	2.480	60.5%
Rating of Specialist Seen Most Often	NA	NA	59.7%
Rating of Health Plan	48.2%	2.312	52.8%

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

* Due to changes in the *Customer Service* composite, a 2007 NCQA CAHPS national average was not calculated for this measure.

Anthem scored above the 2007 NCQA CAHPS national average for two measures*: Getting Care Quickly* and *Rating of Personal Doctor*. The rate for *Getting Care Quickly* was greater than the national average by more than 10 percentage points, representing an area of strength. Although the *Getting Needed Care*, *How Well Doctors Communicate*, *Rating of All Health Care*, and *Rating of Health Plan* measures all had rates less than the national average, these differences were not substantial, suggesting that these are not areas of major weakness. However, **Anthem** should continue to monitor these areas of care since they have an impact on members' satisfaction.

Child Medicaid

Table 3-17 displays **Anthem**'s 2008 child Medicaid CAHPS top-box percentages and three-point means, along with NCQA's 2007 CAHPS national averages.

Table 3-17—Anthem Child Medicaid CAHPS Results

	Top-Box Percentages	Three-Point Mean Scores	2007 NCQA CAHPS National Averages
Composite Measures			
Getting Needed Care	79.2%	2.681	80.3%
Getting Care Quickly	50.9%	2.232	50.9%
How Well Doctors Communicate	61.8%	2.464	66.3%
Courteous and Helpful Office Staff	65.7%	2.524	67.9%
Customer Service	NA	NA	73.6%
Global Ratings			
Rating of All Health Care	59.1%	2.469	64.0%
Rating of Personal Doctor	64.2%	2.556	64.6%
Rating of Specialist Seen Most Often	NA	NA	61.9%
Rating of Health Plan	61.1%	2.479	63.6%

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

Anthem scored at the 2007 NCQA CAHPS national averages for one measure: *Getting Care Quickly*. Although the *Getting Needed Care*, *How Well Doctors Communicate*, *Courteous and Helpful Office Staff*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan* measures all had rates less than the national average, these differences were not substantial, suggesting that these are not areas of major weakness. However, **Anthem** should continue to monitor these areas of care since they have an impact on members' satisfaction.

Child SCHIP

Table 3-18 displays **Anthem**'s 2008 child SCHIP CAHPS top-box percentages and three-point means, along with NCQA's 2007 CAHPS national averages.

Table 3-18—Anthem Child SCHIP CAHPS Results

	Top-Box Percentages	Three-Point Mean Scores	2007 NCQA CAHPS National Averages
Composite Measures			
Getting Needed Care	77.0%	2.697	80.3%
Getting Care Quickly	44.8%	2.186	50.9%
How Well Doctors Communicate	59.9%	2.437	66.3%
Courteous and Helpful Office Staff	60.2%	2.468	67.9%
Customer Service	74.0%	2.687	73.6%
Global Ratings			
Rating of All Health Care	64.2%	2.543	64.0%
Rating of Personal Doctor	62.9%	2.557	64.6%
Rating of Specialist Seen Most Often	65.8%	2.581	61.9%
Rating of Health Plan	72.5%	2.637	63.6%

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

Anthem scored above the 2007 NCQA CAHPS national averages for four measures: *Customer Service*, *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*. One of the measures exceeded the national average by more than 5 percentage points, *Rating of Health Plan* (by 8.9 percentage points). This level of performance suggests an area of strength for **Anthem**.

Rates for the *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Courteous and Helpful Office Staff*, and *Rating of Personal Doctor* measures were below the national average. For *Getting Care Quickly*, *How Well Doctors Communicate*, and *Courteous and Helpful Office Staff*, the differences were more than 5 percentage points, suggesting areas of weakness for **Anthem**. The MCO should target additional quality improvement strategies toward these areas of care.

Plan-Specific Findings––Health Plan of Nevada

Adult Medicaid

Table 3-19 displays **HPN**'s 2008 adult Medicaid CAHPS top-box percentages and three-point means, along with NCQA's 2007 CAHPS national averages.

Table 3-19—HPN Adult Medicaid CAHPS Results

	Top-Box Percentages	Three-Point Mean Scores	2007 NCQA CAHPS National Averages
Composite Measures			
Getting Needed Care	44.1%	2.172	47.3%
Getting Care Quickly	51.5%	2.268	54.0%
How Well Doctors Communicate	62.0%	2.461	66.8%
*Customer Service**	NA	NA	*
Shared Decision Making	NA	NA	58.4%
Global Ratings			
Rating of All Health Care	41.9%	2.153	46.6%
Rating of Personal Doctor	59.3%	2.396	60.5%
Rating of Specialist Seen Most Often	NA	NA	59.7%
Rating of Health Plan	44.7%	2.196	52.8%

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

* Due to changes in the *Customer Service* composite, a 2007 NCQA CAHPS national average was not calculated for this measure.

HPN did not score above the 2007 NCQA CAHPS national average for any of the measures.

The *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan* measures all had rates less than the national average. For *Rating of Health Plan*, the measure's rate was less than the national average by more than 5 percent points, suggesting an area of weakness. **HPN** should target additional quality improvement strategies toward this measure.

Child Medicaid

Table 3-20 displays **HPN**'s 2008 child Medicaid CAHPS top-box percentages and three-point means, along with NCQA's 2007 CAHPS national averages.

Table 3-20—HPN Child Medicaid CAHPS Results			
	Top-Box Percentages	**Three-Point Mean Scores**	**2007 NCQA CAHPS National Averages**
Composite Measures			
Getting Needed Care	67.0%	2.529	80.3%
Getting Care Quickly	49.9%	2.233	50.9%
How Well Doctors Communicate	65.9%	2.531	66.3%
Courteous and Helpful Office Staff	67.2%	2.519	67.9%
Customer Service	NA	NA	73.6%
Global Ratings			
Rating of All Health Care	58.0%	2.446	64.0%
Rating of Personal Doctor	62.7%	2.512	64.6%
Rating of Specialist Seen Most Often	NA	NA	61.9%
Rating of Health Plan	54.9%	2.377	63.6%
A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as Not Applicable (NA).			

HPN did not score above the 2007 NCQA CAHPS national average for any of the CAHPS measures.

The *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Courteous and Helpful Office Staff*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan* measures all had rates less than the national average. The *Getting Needed Care*, *Rating of All Health Care*, and *Rating of Health Plan* measures had rates less than the national average by more than 5 percentage points (13.3 percentage points, 6.0 percentage points, and 8.7 percentage points, respectively). These results suggest areas of weakness for **HPN**; therefore, the MCO should target additional quality improvement strategies toward these measures.

Child SCHIP

Table 3-21 displays **HPN**'s 2008 child SCHIP CAHPS top-box percentages and three-point means, along with NCQA's 2007 CAHPS national averages.

Table 3-21—HPN Child SCHIP CAHPS Results

	Top-Box Percentages	Three-Point Mean Scores	2007 NCQA CAHPS National Averages
Composite Measures			
Getting Needed Care	78.7%	2.728	80.3%
Getting Care Quickly	50.7%	2.248	50.9%
How Well Doctors Communicate	65.5%	2.540	66.3%
Courteous and Helpful Office Staff	65.2%	2.531	67.9%
Customer Service	NA	NA	73.6%
Global Ratings			
Rating of All Health Care	62.5%	2.500	64.0%
Rating of Personal Doctor	63.6%	2.512	64.6%
Rating of Specialist Seen Most Often	NA	NA	61.9%
Rating of Health Plan	73.3%	2.667	63.6%

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

HPN scored above the 2007 NCQA CAHPS national average for one measure, *Rating of Health Plan*. This measure's rate was greater than the national average by nearly 10 percentage points. This suggests an area of strength for **HPN**.

Although *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Courteous and Helpful Office Staff*, *Rating of All Health Care*, and *Rating of Personal Doctor* all scored below the national average, these differences were not substantial, suggesting that these are not areas of major weakness for **HPN**. However, **HPN** should continue to monitor these areas since they have an impact on members' satisfaction.

Program-Specific Findings––Fee-for-Service (FFS)

Adult Medicaid

Table 3-22 displays the **FFS** program's 2008 adult Medicaid CAHPS top-box percentages and three-point means, along with NCQA's 2007 CAHPS national averages.

Table 3-22—FFS Adult Medicaid CAHPS Results

	Top-Box Percentages	Three-Point Mean Scores	2007 NCQA CAHPS National Averages
Composite Measures			
Getting Needed Care	42.1%	2.113	47.3%
Getting Care Quickly	49.4%	2.265	54.0%
How Well Doctors Communicate	65.6%	2.546	66.8%
*Customer Service**	NA	NA	*
Shared Decision Making	58.8%	2.498	58.4%
Global Ratings			
Rating of All Health Care	38.9%	2.112	46.6%
Rating of Personal Doctor	57.9%	2.418	60.5%
Rating of Specialist Seen Most Often	54.9%	2.368	59.7%
Rating of Health Plan	41.9%	2.166	52.8%

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

* Due to changes in the *Customer Service* composite, a 2007 NCQA CAHPS national average was not calculated for this measure.

The **FFS** program scored above the 2007 NCQA CAHPS national average for one measure: *Shared Decision Making*.

The *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan* measures all had rates less than the national average. The *Getting Needed Care*, *Rating of All Health Care*, and *Rating of Health Plan* measures had rates less than the national averages by more than 5 percentage points (5.2 percentage points, 7.7 percentage points, and 10.9 percentage points, respectively). These results suggest areas of weakness for the **FFS** program, especially *Rating of Health Plan*. The **FFS** program should target additional quality improvement strategies toward these measures.

Child Medicaid

Table 3-23 displays the **FFS** program's 2008 child Medicaid CAHPS top-box percentages and three-point means, along with NCQA's 2007 CAHPS national averages.

Table 3-23—FFS Child Medicaid CAHPS Results

	Top-Box Percentages	Three-Point Mean Scores	2007 NCQA CAHPS National Averages
Composite Measures			
Getting Needed Care	63.7%	2.642	80.3%
Getting Care Quickly	58.2%	2.212	50.9%
How Well Doctors Communicate	62.6%	2.482	66.3%
Courteous and Helpful Office Staff	68.1%	2.576	67.9%
Customer Service	50.7%	2.250	73.6%
Global Ratings			
Rating of All Health Care	57.6%	2.437	64.0%
Rating of Personal Doctor	60.8%	2.501	64.6%
Rating of Specialist Seen Most Often	63.2%	2.509	61.9%
Rating of Health Plan	56.8%	2.401	63.6%

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

The **FFS** program scored above the 2007 NCQA CAHPS national average for three measures: *Getting Care Quickly*, *Courteous and Helpful Office Staff*, and *Rating of Specialist Seen Most Often*. The rate for the *Getting Care Quickly* measure was substantially higher (7.3 percentage points) than the national average. This rate suggests an area of strength for the **FFS** program.

The *Getting Needed Care*, *How Well Doctors Communicate*, *Customer Service*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan* measures all had rates less than the national average. The *Getting Needed Care*, *Customer Service*, *Rating of All Health Care*, and *Rating of Health Plan* measures had rates less than the national average by more than 5 percentage points, suggesting areas of weakness for the **FFS** program. The **FFS** program should target additional quality improvement strategies should toward these areas of care.

Child SCHIP

Table 3-24 displays the **FFS** program's 2008 child SCHIP CAHPS top-box percentages and three-point means, along with NCQA's 2007 CAHPS national averages.

Table 3-24—FFS Child SCHIP CAHPS Results

	Top-Box Percentages	Three-Point Mean Scores	2007 NCQA CAHPS National Averages
Composite Measures			
Getting Needed Care	70.7%	2.726	80.3%
Getting Care Quickly	56.1%	2.153	50.9%
How Well Doctors Communicate	56.8%	2.452	66.3%
Courteous and Helpful Office Staff	60.7%	2.517	67.9%
Customer Service	61.8%	2.456	73.6%
Global Ratings			
Rating of All Health Care	60.5%	2.516	64.0%
Rating of Personal Doctor	62.0%	2.535	64.6%
Rating of Specialist Seen Most Often	61.7%	2.509	61.9%
Rating of Health Plan	76.1%	2.694	63.6%

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

The **FFS** program scored above the 2007 NCQA CAHPS national average for two measures: *Getting Care Quickly*, and *Rating of Health Plan*. The *Rating of Health Plan* measure's rate was greater than the national rate by more than 10 percentage points, representing an area of strength the **FFS** program.

The *Getting Needed Care*, *How Well Doctors Communicate*, *Courteous and Helpful Office Staff*, *Customer Service*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often* measures scored below the national average. Rates for the *Getting Needed Care*, *How Well Doctors Communicate*, *Courteous and Helpful Office Staff*, and *Customer Service* measures were below the national average by more than 5 percentage points, suggesting areas of weakness for the **FFS** program. The **FFS** program should target additional quality improvement strategies toward these areas of care.

ABD Readiness Review

Objectives

HSAG conducted a review of **APS** to assess its readiness to provide services to the ABD Medicaid population as described in SOW #1—Care Management and SOW #2—Care Coordination of RFP 1629. The objective of the readiness review was to ensure that **APS** was prepared to fulfill all of the Medicaid program's requirements prior to enrolling eligible Medicaid recipients.

Technical Methods of Data Collection and Analysis

HSAG developed 2008 Readiness Review Tools for SOW #1—Care Management and SOW #2—Care Coordination. These tools listed the RFP requirements, corresponding documentation required and provided, readiness review findings, and approval status (yes or no). Some requirements were denoted as critical elements. HSAG made recommendations for improvement as appropriate.

Description of Data Obtained

The Care Management readiness review assessed the following areas:

- **APS** duties and responsibilities
- Enrollment and disenrollment
- Recipient services
- Network
- Provider outreach and education
- Confidentiality and medical records
- Care management duties
- Quality assurance standards
- Standards for internal quality assurance programs
- Operational requirements

The Care Coordination readiness review assessed the following areas:

- **APS** duties and responsibilities
- Cultural competence
- Enrollment and disenrollment requirements and limitations
- Network
- Provider outreach and education
- Confidentiality and medical records
- Care coordination duties

APS presented a Webcast to demonstrate its Care Management and Care Coordination systems.

Conclusions Drawn From the Data

In July 2008, HSAG completed the readiness reviews of the critical elements with the information that **APS** had sent to date. A majority of the critical areas were reviewed and approved. Some of the documentation had not been received in several of the critical areas. However, HSAG and DHCFP determined that the missing documentation should not prevent **APS** from contacting recipients. HSAG made recommendations for revisions to policies and procedures and processes when they did not meet the intent of the requirement, and **APS** is required to correct the identified deficiencies.

Nevada Quality Strategy and Work Plan

Nevada Medicaid developed a Nevada Medicaid and SCHIP Managed Care Quality Assessment and Performance Improvement Strategy (Strategy), pursuant to 42 CFR 438.200. The Strategy is in two parts: an overriding conceptual program and an annual Quality Strategy Work Plan (Work Plan).

The Nevada Medicaid and SCHIP Strategy incorporates policies, procedures, contract compliance, and input from the public, stakeholder providers, recipient advocates, and multiple Nevada State departments that hold an interest in improving access to care and clinical and service quality received by Medicaid and SCHIP recipients.

This Strategy includes improvement measurement and activities provided by other departments. These activities are integrated into a single Strategy, which applies throughout the Nevada Medicaid and SCHIP managed care service area. DHCFP oversees the Strategy to verify that the performance of quality improvement functions is timely, consistent, and effective.

The Strategy is designed so that services provided to recipients meet established standards for access to care, clinical quality of care, and quality of service. The Strategy is also designed so that opportunities to improve access to care, quality of care, and quality of service are identified and pursued. The Strategy is designed to identify, document, and review access, quality of care, and service issues and to verify that appropriate corrective actions are taken to address these issues.

The Strategy features:

- Assessment and improvement of quality of care and services through the use of monitors and indicators.
- Focused audits.
- Studies.
- Assessment of recipient satisfaction.
- Review of potential quality issues, recipient appeals, and grievances.
- Review of access to care through analysis of provider networks using contract and credentialing criteria by the MCO.
- Compliance with contractual operations and structures.

The Strategy is multidisciplinary with the collaboration of public health entities, identified stakeholders, and the public. Multifaceted outreach efforts are conducted to inform families of the availability of State-sponsored health care coverage for children under both Medicaid and Nevada's SCHIP, known as Nevada Check Up. The State's outreach efforts are supported by the Covering Kids and Families coalitions of Northern, Southern, and rural Nevada and by other community partners.

Stakeholders in the initial development of the State's Strategy were **NevadaCare, Inc.,** and **HPN**, both of which had Medicaid-enrolled recipients. Following the stakeholders meeting, the State provided public notice of the mandated federal regulations. Following the public notice, the Strategy was provided to CMS on June 30, 2003. The finalized Strategy became effective on July 1, 2003, with the execution of the new MCO contract. The Strategy is reviewed by the State monthly as a standing agenda item and during regularly scheduled MCO meetings and teleconferences pursuant to Section 2.1 of the current MCO contract. The State provides periodic updates to CMS regarding the status of the State's Strategy and provides CMS written revisions to the Strategy whenever significant revisions are made.

Since November 1, 2006, **Anthem** and **HPN** have been identified as stakeholders in the revision of the State's Strategy, both having Medicaid-enrolled recipients in each plan. The State conducts an annual review of the effectiveness of this strategy during the fourth quarter of each calendar year following receipt and review of the EQRO report and the annual managed care program reporting.

The 2006-2008 Quality Assessment and Performance Improvement Strategy (April 2008) includes the following sections:

I. Quality Strategy
II. Scope
III. Nevada Medicaid and SCHIP Managed Care Quality Mission
IV. Purposes of the Strategy
V. Goals and Objectives
VI. Functions and Activities
VII. Strategy Administration and Oversight
VIII. State Quality Department
IX. Summary

The 2006-2008 Quality Assessment and Performance Improvement Strategy Work Plan (April 2008) includes the following sections:

I. Purpose
II. Scope
III. Population Demographics and Top Ten Diagnoses
IV. Goals and Strategies
V. Confidentiality
VI. Oversight and Direction

In 2008 CMS embarked upon a new goal in Medicaid quality, which includes a review of state quality strategies and EQR reports required of states with Medicaid managed care delivery systems (42 CFR Parts D and E). CMS made DQEHO responsible for working with states to provide feedback on these documents.

DQEHO provided the CMS Response to Nevada's Quality Assessment & Improvement Strategy to DHCFP on April 25, 2008. This analysis of the quality strategy used two assessment tools: (1) the CMS Review List for State Quality Assessment & Improvement Strategies and (2) the "State Quality Strategy Toolkit for State Medicaid Agencies, October 2006, Components to Address in a Quality Strategy (Quality Assessment Tool). The review list was used to assess whether the Strategy met the minimum requirements set forth in the regulations. The quality assessment tool was used to address whether the State has put in place systems to support providers in their efforts to provide cost-efficient, quality care that goes beyond the minimum. The tool was also used to determine whether the system incorporates a mechanism that uses continuous feedback and review to help the provider continue to improve the quality of care provided.

DQEHO's analysis:

- Indicated that the State had complied with most of the mandatory regulatory requirements.
- Offered feedback and recommendations.
- Requested a response indicating the State's rationale and evidence to support its belief that it has met the regulatory requirements in 42 CFR 438.202 and 42 CFR 438.204 for access to care, structure and operations, quality measurement and improvement, and procedures for race, ethnicity, and primary language spoken.
- Invited the State to inform CMS about any new quality initiatives that might be useful to other states.

DHCFP's response to DQEHO on May 22, 2008, included the requested rationale and evidence, information about additional future revisions and methods to strengthen the State's Strategy, and new quality initiatives.

Conclusions and Recommendations

Based on DQEHO's feedback, DHCFP and the MCOs, stakeholders, strategic planning groups, and HSAG will work together to revise, implement, and strengthen the Strategy in the areas that did not meet the identified regulatory requirements or topics.

HSAG supports DQEHO's stated commitment to do the following:

- Strengthen the quality strategy by defining the performance measures and monitoring mechanisms currently in place to measure the member's attainment of timely, quality, and appropriate health care.
- Identify the results of the compliance audits as well as areas requiring targeted improvement through the revised Performance Tracking Tool described below and identify improvement opportunities through data in the EQR Technical Report.

- Enhance procedures for race, ethnicity, and primary language spoken through HSAG's evaluation and monitoring of the implementation and compliance with the cultural competency plan, including training of organizational staff and network providers.
- Expand the overview of the Strategy to include a comprehensive overview of the Nevada managed care program, including population description changes, program changes and expansions, and MCO contracting and turnover experience.

Performance Tracking Tool (PTT)

One of DHCFP's new quality initiatives is the creation of minimum standards for performance measures. In 2005, DHCFP and HSAG created a PTT for each MCO. The PTT was initially designed as a mechanism for the State and the MCOs to monitor and trend the results of each performance measure identified in the tool. The PTT was used to record baseline and remeasurement results for each performance measure and to identify how the plan is performing in comparison to national benchmarks and the calculated goals for the subsequent reporting period. The methodology used to calculate performance goals is based on the QISMC methodology.

Development

In 2005, a PTT was developed for each MCO. The development and use of the MCO-specific PTT, supported by frequent teleconference meetings, provided a structure and framework for DHCFP and the MCOs to work together to attain better health care outcomes for enrolled recipients.

Additionally, in an effort to continue to improve rates and sustain improvement across all performance measures, DHCFP contracted with an actuary to calculate incentive payments based on rates across all performance measures and disincentives for rates that do not show improvement. Beginning in 2007, the PTT was used to assist in the calculation of MCO incentive payments. The incentive payments will be based on the measured performance for a calendar year, as well as for continued improvement in performance from prior calendar years. This strategy is expected to alleviate complacency on performance goals.

To date, the implementation and evolution of the State's quality Strategy has been effective in targeting areas for performance improvement. The PTT has been instrumental in tracking and monitoring performance and eliciting the commitment of the MCOs to devote resources to primary care and disease management. Rates have shown some improvement for this year, and with the additional monetary incentives and added focused via the PTT, rates are expected to continue to improve.

Revisions

DHCFP, HSAG, and the MCOs were given the responsibility of updating and incorporating new data into the PTT. They have continued to make suggestions and provide enhancements to the PTT design and functionality. In 2008, an enhanced version of the PTT was provided to each MCO. The revised PTT is a living, functional tool that includes tracking and monitoring of all the activities the MCOs perform during the year. Some of the highlights to the PTT include:

- Key timeline dates for reporting requirements.
- Compliance monitoring activities, including areas for targeted improvement for the MCOs.
- A simplified process for entering rates for the various activities (e.g., HEDIS, CAHPS, PIPs).
- Links to automatically trend, graph, determine HEDIS percentile rankings, determine next goals, and calculate incentive payment qualification.
- Adding SCHIP and HIFA waiver reporting and simplifying the process for entering Medicaid, SCHIP, and HIFA waiver performance measure rates.
- Adding incentive measures and nonincentive measures.
- Adding benchmarks for performance measures.
- PIP summary tables to determine validation status and improvements on individual PIP quality indicators.
- A chi-square and *p* value calculator to facilitate the MCOs' ability to determine if changes are statistically significant.

The revised PTT has evolved into more than just a mechanism for monitoring and trending the results of performance measures. The latest revision in April 2008 facilitates tracking and monitoring of all rates and activities, quality improvement efforts, comparisons to benchmarks, setting and achieving goals, and internal and external reporting. This information will be used by the MCOs, DHCFP, and HSAG. Specifically, DHCFP will use the PTT to enhance reporting to CMS, the State legislature, and other departments, as well as interdepartmental reporting. DHCFP will also use the PTT to determine areas that need focused attention (e.g., DHCFP may use the PTT to develop areas that might be the topic of collaborative PIPs). The PTT may also be expanded to include the **FFS** program, facilitating comparisons between the MCOs and the **FFS** program.

Technical Assistance

The EQR may, at the State's direction, provide technical guidance to the MCOs to assist them in conducting activities related to the mandatory and optional activities that provide information for the EQR.

HSAG provided the following technical assistance to DHCFP:

- Guidance in strengthening the managed care contract language for race and ethnicity, fraud and abuse prevention, and case management and care coordination. HSAG provided information to DHCFP to strengthen the managed care program contract language to ensure that the MCOs comply with all applicable program integrity requirements, including those specified in 42 CFR 455 and 42 CFR 438 Subpart H. In addition, future revisions to the State quality strategy will include language that describes the oversight and monitoring of the Fraud and Abuse Prevention Program.
- Guidance in the evaluation and strengthening of the State quality strategy and work plan. HSAG provided guidance and technical assistance to DHCFP in the revisions of performance and program goals specifically related to cultural competency, HEDIS measures, and pay-for-performance measures.
- Review of the specifications for the pay-for-performance measures. HSAG assisted DHCFP in developing the incentive measures and the methodology for the nonincentive measures for the pay-for-performance program. HSAG provided DHCFP information on other pay-for-performance initiatives and conducted research on the return of investment (ROI) for the performance measures.
- Guidance in setting performance targets and goals for quality improvement. HSAG consulted with DHCFP to determine appropriate goals and performance levels using a hybrid QISMC methodology, then integrated these goals into the PTT.

HSAG provided the following technical assistance to MCOs:

- Guidance in the development and implementation of PIPs. HSAG provided technical assistance with general information and requirements to conduct PIPs. HSAG provided the PIP tool and instructions, allowing the MCOs to have a blueprint for conducting the PIP.
- Guidance in the development of a collaborative PIP. HSAG provided technical assistance with the selection of the study topic, the initial design of the collaborative PIP, and general information and requirements to conduct a successful collaborative PIP. HSAG held several conference calls with the MCOs and facilitated the collaboration and sharing of information between the two MCOs to ensure that both PIPs were conducted using the same methodology and that each MCO actively participated and contributed in the process.
- Provided resources to the MCOs on cultural competency. HSAG provided the Reducing Racial and Ethnic Disparaties, A Quality Improvement Initiative in Medicaid Managed Care Toolkit developed by the Centers for Health Care Strategies, Inc. The toolkit provides approaches and tools for addressing disparities as well as improving the quality of care.
- Guidance in the use and understanding of the PTT. HSAG developed the PTT with the MCOs in mind, then consulted with and received feedback from the MCOs on the functionality of the

PTT. This allowed HSAG to incorporate additional, specific information into the PTT that the MCOs wanted to utilize. Once the PTT was completed, HSAG conducted an on-site training demonstration of the PTT for the MCOs and DHCFP.

4. Plan Comparisons and Recommendations

This section of the report compares plan-specific findings and recommendations to provide an overall assessment of the quality, timeliness, and access to services available to Nevada Medicaid, Nevada Check Up, and HIFA recipients.

Quality Assurance Standards—Quality Assessment and Performance Improvement (QAPI) Evaluation—FY 2007–2008

This report does not present plan comparisons for the QAPI evaluation because **Anthem** was a new plan in the Nevada Medicaid program starting in SFY 2007. HSAG conducted a comprehensive review of **HPN**'s QAPI program in SFY 2005 and 2007. Section 3 presents a comparison of the results.

HSAG will conduct a comprehensive review of the MCO's QAPI in SFY 2009.

Validation of Performance Measures—HEDIS Compliance Audit—FY 2007–2008

Appendix B presents graphs showing trends in **HPN**'s performance from 2005 through 2008. Trending was not possible for **Anthem** because 2008 was the first year of full reporting for the HEDIS performance measures. In addition, 2008 was the first year for reporting HIFA results.

The 2008 Nevada Medicaid and Nevada Check Up HEDIS rates for the MCOs are shown in Table 4-1 and Table 4-2. Rates above the 2006 HEDIS 50th percentile are highlighted in yellow, and those above the 90th percentile are highlighted in green. Several HEDIS measures are relatively new (e.g., Comprehensive Diabetes Care—Good HbA1c Control), and therefore national percentiles are not yet available. The percentiles for these measures are designated as NA in the table.

The continuous enrollment requirement for specific HEDIS measures may result in fewer MCO-enrolled individuals who qualify in the eligible population. For example, several of the HEDIS measures require more than one year of enrollment in the MCO (e.g., Well-Child Visits in the First 15 Months of Life). Since **Anthem** was a new plan in the Nevada Medicaid program starting in 2006, many of their members did not have more than one year of continuous enrollment. In keeping with HEDIS methodology, the rate is reported as NA for HEDIS measures that had fewer than 30 eligible members in the denominator.

Medicaid Results

The Nevada Medicaid rates are calculated by adding the numerators and denominators for both MCOs. Overall, the Nevada Medicaid rates were above the 2006 HEDIS 50th percentile scores for five measures, and above the 90th percentile for one measure. The rates for the measures ranged

from a low of 14.5 percent for Frequency of Ongoing Prenatal Care (8–100 percent of visits), to a high of 92.7 percent for Children's Access to PCP (12–24 months).

Anthem reported four rates above the 50th percentiles, and one rate above the 90th percentile. Six rates were above **HPN**'s reported rate. **Anthem** reported six rates with fewer than 30 eligible members in the denominator. In accordance with HEDIS reporting, these rates were given an NA designation.

HPN had three rates above the 50th percentiles, and one rate above the 90th percentile. In addition, the rates for **HPN** were higher than **Anthem**'s reported rates for 16 of the 23 HEDIS measures reported by both MCOs. **HPN**'s rate for Postpartum Care (49.2 percent) was nearly identical to **Anthem**'s rate of 49.3 percent.

Overall, **HPN** performed better on measures related to children's needs (such as well-child visits), while **Anthem** performed higher on the diabetic testing measures (HbA1c Testing, LDL-C Screening, and Monitoring Nephropathy) and Follow-up After Hospitalization for Mental Illness.

Table 4-1—2008 HEDIS Results for Medicaid

HEDIS Measure	Anthem Medicaid	HPN Medicaid	Nevada Medicaid	2006 HEDIS Percentiles	
				50th	90th
Childhood Immunization Rate—Combo 2	54.3	59.6	58.0	72.4	82.7
Childhood Immunization Rate—Combo 3	45.7	50.1	48.7	42.3	57.8
Children's Access to PCP (12–24 months)	90.4	94.1	92.7	94.8	98.2
Children's Access to PCP (25 months–6 years)	79.5	82.4	81.2	85.4	91.5
Children's Access to PCP (7–11 years)	NA*	79.5	79.5	84.9	92.0
Children's Access to PCP (12–19 years)	NA*	75.7	75.7	83.4	90.2
Well Child Visits 1st 15 months (6 or more visits)	28.7	43.8	41.0	50.0	68.6
Well Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	54.9	62.5	58.6	64.8	77.5
Adolescent Well Care	21.3	33.1	27.1	39.4	54.5
Annual Dental Visits—Combined Rate	42.0	50.8	47.1	42.0	52.9
Timeliness of Prenatal Care	75.9	71.8	73.9	83.3	91.5
Postpartum Care	49.3	49.2	49.2	58.8	71.0
Frequency of Ongoing Prenatal Care (<21% Visits)**	74.6	23.1	65.7	9.4	1.9
Frequency of Ongoing Prenatal Care (81-100% Visits)	6.0	55.2	14.5	59.9	79.9
Diabetes Care - HbA1c Testing	75.6	65.8	68.8	77.4	88.8
Diabetes Care - Poor HbA1c Control**	67.1	53.0	57.4	45.2	30.3
Diabetes Care - Good HbA1c Control	15.9	28.2	24.3	NA***	NA***
Diabetes Care - Eye exams	36.6	47.5	44.1	50.8	68.1
Diabetes Care - LDL-C Screening	76.8	60.8	65.8	83.3	90.8
Diabetes Care - LDL-C Level <100	22.0	24.3	23.6	34.1	46.5
Diabetes Care - Blood Pressure <140/90	48.8	58.6	55.5	NA***	NA***
Diabetes Care - Blood Pressure <130/80	26.8	28.2	27.8	NA***	NA***

Table 4-1—2008 HEDIS Results for Medicaid					
Diabetes Care - Monitoring Nephropathy	78.1	67.4	70.7	49.3	65.6
Use of Appropriate Medications for Asthma (5 – 9 Years)	NA*	90.2	90.2	90.2	95.8
Use of Appropriate Medications for Asthma (10 – 17 Years)	NA*	85.7	85.7	87.4	93.5
Use of Appropriate Medications for Asthma (18 – 56 Years)	NA*	79.4	79.4	84.9	90.8
Use of Appropriate Medications for Asthma (Combined)	NA*	86.8	86.8	87.1	92.5
Follow-up After Hospitalization for Mental Illness – 7 Days	47.7	35.7	40.4	35.8	66.4
Follow-up After Hospitalization for Mental Illness – 30 Days	68.2	58.6	62.3	59.3	85.1

* There were less than 30 eligible cases in the denominator, and therefore, the rate is reported as NA.
** Lower rates are better for this measure.
*** These HEDIS measures were new, and National Medicaid Percentiles were not available for HEDIS 2006.

SCHIP Results

Table 4-2 shows the 2008 HEDIS rates for Nevada Check UP (SCHIP). Both MCOs showed strong performance with the performance measures; 12 out of 14 HEDIS measures had rates above the 2006 National Medicaid HEDIS 50th percentiles, with three of those rates also above the 90th percentiles. The rates for the measures ranged from a low of 33.3 percent for Follow-Up After Hospitalization for Mental Illness (7 Days), to a high of 98.5 percent for Use of Appropriate Medications for Asthma (5 - 9 Years).

Anthem demonstrated a strong first-year performance with five out of seven rates at or above the 50th percentiles, and three rates also above the 90th percentile. Seven rates had fewer than 30 eligible members in the denominator, and in accordance with HEDIS reporting, these rates were given an NA designation.

HPN had a remarkable 12 out of 14 rates above the 50th percentiles, with five of those rates also above the 90th percentile. In addition, the rates for **HPN** were higher than **Anthem**'s reported rates for every measure except Children's Access to PCP (12–24 months).

Table 4-2—2008 HEDIS Results for Check Up (SCHIP)					
HEDIS Measure	Anthem SCHIP	HPN SCHIP	Nevada SCHIP	2006 HEDIS Percentiles	
				50th	90th
Childhood Immunization Rate—Combo 2	71.1	73.7	73.3	72.4	82.7
Childhood Immunization Rate—Combo 3	64.5	65.2	65.1	42.3	57.8
Children's Access to PCP (12–24 months)	98.7	97.9	98.1	94.8	98.2
Children's Access to PCP (25 months–6 years)	89.1	92.3	91.3	85.4	91.5
Children's Access to PCP (7–11 years)	NA*	91.6	91.6	84.9	92.0
Children's Access to PCP (12–19 years)	NA*	85.3	85.3	83.4	90.2
Well Child Visits 1st 15 months (6 or more visits)	NA*	36.3	35.8	50.0	68.6
Well Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	64.8	78.4	71.4	64.8	77.5
Adolescent Well Care	35.0	44.0	39.4	39.4	54.5

Table 4-2—2008 HEDIS Results for Check Up (SCHIP)					
Annual Dental Visits—Combined Rate	56.9	68.0	64.6	42.0	52.9
Use of Appropriate Medications for Asthma (5 – 9 Years)	NA*	98.5	98.5	90.2	95.8
Use of Appropriate Medications for Asthma (10 – 17 Years)	NA*	88.3	88.3	87.4	93.5
Follow-up After Hospitalization for Mental Illness – 7 Days	NA*	29.4	33.3	35.8	66.4
Follow-up After Hospitalization for Mental Illness – 30 Days	NA*	61.8	66.7	59.3	85.1
* There were less than 30 eligible cases in the denominator, and therefore, the rate is reported as NA.					

HIFA Results

The 2008 HIFA rates for **Anthem** and **HPN** are shown in Table 4-3. This is the first year for reporting any measures for the HIFA program, and these rates should be viewed with caution. The rates for each MCO are presented separately for information purposes only, and should not be used for MCO comparisons or performance evaluation at this time. The total eligible cases for both MCOs combined was only 90 members, and **HPN** (N = 11) has fewer than 30 eligible members.

At the aggregate level, the HIFA total rates based on 90 cases are not too far different than the Nevada Medicaid rates for Frequency of Ongoing Prenatal Care. However, the first-year rates for Timeliness of Prenatal Care and Postpartum Care are both well below the Medicaid results and the benchmarks. These rates are likely to improve as more members become eligible for the program and the measures.

Table 4-3—2008 HEDIS Results for HIFA						
	HIFA Anthem	HIFA HPN	HIFA Total	Nevada Medicaid Results	2006 HEDIS Percentiles	
					50th	90th
Number of Eligible Members	**N = 79**	**N = 11**	**N = 90**	**N = 843**	**NA**	**NA**
Timeliness of Prenatal Care	25.3	36.4	26.7	73.9	83.3	91.5
Postpartum Care	22.8	18.2	22.2	49.2	58.8	71.0
Frequency of Ongoing Prenatal Care (<21% Visits)*	79.8	63.6	77.8	65.7	9.4	1.9
Frequency of Ongoing Prenatal Care (81-100% Visits)	3.8	27.3	6.7	14.5	59.9	79.9
* Lower rates are better for this measure.						

Comparison of HEDIS Measures

Overall, the Nevada Check Up (SCHIP) rates were higher than the Medicaid rates for every measure except Well-Child Visits in the First 15 Months of Life, and Follow-up After Hospitalization for Mental Illness—7 Days.

Anthem and **HPN** performed strongly in the area of Childhood Immunizations, Children's and Adolescent's Access to PCPs, and Annual Dental Visits. These measures demonstrate the MCOs appear to have relative strength in terms of access to care for children. However, there remains some concern with timeliness and access for maternity-related care. Timeliness of Prenatal Care

was below the national 50th percentile for both MCOs, and **HPN**'s rate effectively decreased from 84.4 percent last year to 71.8 percent for HEDIS 2008. Similar results were seen in Frequency of Ongoing Prenatal Care.

In terms of quality, the Nevada Check Up rates tend to be above the 50th percentiles, indicating at least average performance, and several measures are above the 90th percentiles. However, most of the Medicaid rates are at levels below the national 2006 HEDIS 50th percentiles. **Anthem**'s Medicaid rates were generally lower than **HPN**'s rates.

As displayed in Appendix B, an examination of overall trends reveals the following:

- Immunization rates have continued to improve each year for both Medicaid and SCHIP. For the first time, the SCHIP rate of 65.1 percent for Combo 3 exceeded the national 2006 Medicaid 90th percentile (57.8 percent).
- The area of Annual Dental Visits has continued to improve each year. The SCHIP rate of 64.6 percent exceeded the national 2006 Medicaid 90th percentile (52.9 percent).
- The rates for Well-Child Visits in the First 15 Months of Life declined this year, with SCHIP rates falling below the HEDIS 2005 levels. The rates for Well-Child Visits—3–6 Years also declined this year. This finding warrants some investigation since immunization rates and dental visit rates are on the increase, and this typically improves well-child visit rates.
- The rates for Frequency of Ongoing Prenatal Care and Timeliness of Prenatal Care both declined this year. For HEDIS 2007, only **HPN**'s rate was used for the overall Medicaid rate; **Anthem** did not report rates for HEDIS 2007. However, **HPN**'s rates also showed a significant decrease for these measures for HEDIS 2008.
- The rates for Children's Access to PCPs have shown a small improvement since 2005 for the two younger age groups, and equally small declines since 2005 for the two older age groups. The 12–19 year age group appears to be the most problematic in terms of access to PCPs.
- The rates for Follow-up After Hospitalization for Mental Illness (7 days and 30 days) have continued to improve each year. The most significant improvement has been in the 30-day follow-up, where the Medicaid rates have improved 19.3 percentage points since 2005.

Encounter Data Completeness

Table 4-4 provides an estimate of data completeness for the hybrid performance measures. These measures use administrative encounter data and supplement the results with medical record data. The rates in the table represent the percentage of the final HEDIS rate that was determined solely through administrative encounter data. A rate of 100 percent in the last two columns indicates that encounter data were complete for that HEDIS measure.

Table 4-4—Estimated Encounter Data Completeness for Medicaid Hybrid Measures

Performance Measures	Final HEDIS Rate		Percent from Encounter Data	
	Anthem	HPN	Anthem	HPN
Childhood Immunizations—Combo 2	54.3	59.6	0.0	23.3
Childhood Immunizations—Combo 3	45.7	50.1	0.0	24.3
Well-Child Visits 1st 15 months (6 or more visits)	28.7	43.8	24.1	85.6
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	54.9	62.5	91.6	96.9
Adolescent Well Care	21.3	33.1	82.6	85.3
Timeliness of Prenatal Care	75.9	71.8	25.9	40.7
Postpartum Care	49.3	49.2	28.6	40.6
Frequency of Ongoing Prenatal Care (81–100% Visits)	6.0	55.2	100	21.6
Diabetes Care—HbA1c Testing	75.6	65.8	67.7	91.6
Diabetes Care—Good HbA1c Control	15.9	28.2	0.0	84.3
Diabetes Care—Eye Exams	36.6	47.5	86.7	96.5
Diabetes Care—LDL-C Screening	76.8	60.8	66.7	89.1
Diabetes Care—LDL-C Level <100	22.0	24.3	0.0	88.6
Diabetes Care—Monitoring Nephropathy	78.1	67.4	95.3	95.1

Overall, the results demonstrate that **HPN** has a high volume of encounter data for most measures. **HPN** reported a higher final HEDIS rate than **Anthem** for 9 of the 14 measures presented in the table. In addition, the percentage of the rates that **HPN** captured in administrative encounter data was substantially higher than **Anthem**. The results indicate that **HPN** has very complete encounter data for well-child visits and comprehensive diabetes care, but continues to have some difficulty obtaining complete encounter data for childhood immunizations and maternity care. Childhood immunizations may be provided at locations other than the provider's office (e.g., health fairs, schools), making it difficult to collect this measure administratively. However, providers should be submitting maternity-related encounter data, and this should be an area of focus for **HPN**.

The encounter data for **Anthem** was generally less complete than **HPN**'s. Monitoring nephropathy for diabetes was the only measure for which **Anthem** had both a higher reported HEDIS rate and a higher encounter data completion rate than **HPN. Anthem** had commendable encounter data rates for Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life; Adolescent Well Care; and the general diabetes screening measures (i.e., HbA1c Testing, LDL-C Screening, and Eye Exams). **Anthem** did not use its encounter data to report on immunizations or the diabetes measure that required the use of lab values. **Anthem** should consider improving the capture of maternity-related encounter data, as well as lab data and results.

Validation of Performance Improvement Projects—FY 2007–2008

PIP validation involves the analysis of elements delineated in the PIP Validation Tool. PIP findings supply the State and the MCOs with the information needed to assess the strengths and weaknesses of individual PIPs. In addition, they highlight areas in which the MCOs might need to enhance the skills of staff members involved in the implementation and the documentation of the PIPs.

In addition to PIP findings, the report presents rates from the PIP indicators for comparison. This allows DHCFP and the MCOs to monitor progress toward achieving specific goals for the indicators (e.g., the 2006 HEDIS 90th percentile). The results also indicate whether the PIP is working to improve the rates. This piece of the analysis depends on how far along the PIP is in the process. Usually in the first year, an MCO has not completed all of the activities by the time of submission; therefore, no rates are available.

Improving Childhood Immunization Rates

Description of Data Obtained

Using the PIP Validation Tool, HSAG assessed each component of the *Improving Childhood Immunization Rates* PIP based on CMS protocol activities. **Anthem** completed Activities I through VI for the 2007–2008 validation, while **HPN** completed Activities I through VIII. Both MCOs were able to report HEDIS rates for the Childhood Immunization measure this year.

Conclusions Drawn from the Data

Table 4-5 displays the percentage scores for each MCO for all PIP elements *Met* and critical elements *Met*. Based on these results, both MCOs demonstrated strength in the design and implementation of their PIPs. Anthem received 97 percent for all PIP elements *Met*, while **HPN** scored 100 percent. **Anthem** did not provide an overview of the PIP study in the written instructions, resulting in a slightly lower score. Both MCOs scored 100 percent for critical elements *Met*.

Table 4-5—Comparison of PIP Elements for *Improving Childhood Immunization Rates*

	Anthem	HPN
Total PIP Elements *Met*	97%	100%
Total Critical Elements *Met*	100%	100%

Table 4-6 displays the HEDIS Childhood Immunization rates for **Anthem** and **HPN**. The Medicaid rates for **HPN** were 5.3 and 4.4 percentage points higher than **Anthem**'s rates for Combo 2 and Combo 3, respectively. While the rates for Combo 3 were above the 50th percentile for both MCOs, their Combo 2 rates were well below the 50th percentile. This was likely because Combo 3 was relatively new, so national rates were lower for this measure. Combo 2, however, was well-established, and neither MCO demonstrated strength in this area for Medicaid.

The SCHIP rates were very similar for both MCOs. In addition, **HPN**'s rate for Combo 2 was above the 50th percentile, and **Anthem**'s rate was merely 1.3 percentage points below the 50th percentile. Both MCOs exceeded the 90th percentile for Combo 3, demonstrating strong performance on a new measure.

Table 4-6—Childhood Immunization Rates for Medicaid and SCHIP, by MCO

HEDIS Measure (PIP Study Indicators)	Anthem	HPN	2006 HEDIS Percentiles	
			50th	90th
Medicaid				
Childhood Immunization Rate—Combo 2	54.3	59.6	72.4	82.7
Childhood Immunization Rate—Combo 3	45.7	50.1	42.3	57.8
SCHIP				
Childhood Immunization Rate—Combo 2	71.1	73.7	72.4	82.7
Childhood Immunization Rate—Combo 3	64.5	65.2	42.3	57.8

Based on the validation of this PIP, HSAG's assessment determined high confidence in the reported results. This PIP continues to demonstrate strength in its study design and a strong framework with which to move forward using the *HEDIS 2008 Technical Specifications*. The PIP results show that both MCOs are progressing toward their goals. However, the results also show that the Medicaid population requires a more concentrated effort to improve rates than the SCHIP population. HSAG recommends that both MCOs conduct a barrier analysis to determine more effective interventions to improve rates for the Medicaid population.

Improving Diabetes Screening and Control PIP

Description of Data Obtained

Using the PIP Validation Tool, HSAG assessed each component of the *Diabetes Screening and Control* PIP based on CMS protocol activities. **Anthem** had completed Activities I through VI for the 2007–2008 validation, while **HPN** completed Activities I through X. Both MCOs were able to report HEDIS rates for the diabetes measure this year.

Conclusions Drawn from the Data

Table 4-7 displays the percentage scores for each MCO for all PIP elements *Met* and critical elements *Met*. Both MCOs demonstrated strength in the design and implementation of their PIPs. **Anthem** received 97 percent for all PIP elements *Met*, while **HPN** scored 100 percent. Once again, **Anthem** did not provide an overview of the PIP study in the written instructions, resulting in a slightly lower score. Both MCOs scored 100 percent for critical elements *Met*.

Table 4-7—Comparison of PIP Elements for *Improving Diabetes Screening and Control*

	Anthem	HPN
Total PIP Elements *Met*	97%	100%
Total Critical Elements *Met*	100%	100%

Table 4-8 displays the 2008 Medicaid HEDIS rates of the three study indicators for **Anthem** and **HPN**. The study population does not include SCHIP due to the age criteria for the measure. The table shows that the Medicaid rates for Anthem were significantly higher than **HPN**'s rates for all three indicators. Rates for HbA1c Testing and LDL-C Screening were below the 50th percentile, although Anthem's rates for these indicators were fairly close to the 50th percentile. Both MCOs exceeded the 90th percentile for Monitoring Nephropathy. A change to the indicator in the HEDIS technical specifications may have impacted rates, but the performance demonstrated by both MCOs was still well above average for this indicator.

Table 4-8—Medicaid HEDIS 2008 Rates for Diabetes Care

HEDIS Measure (PIP Study Indicators)	Anthem HEDIS 2008	HPN HEDIS 2008	2006 HEDIS Percentiles	
			50th	90th
Diabetes Care—HbA1c Testing	75.6	65.8	77.4	88.8
Diabetes Care—LDL-C Screening	76.8	60.8	83.3	90.8
Diabetes Care—Monitoring Nephropathy	78.1	67.4	49.3	65.6

HSAG's assessment determined high confidence in the reported results. The PIP results showed that both MCOs are progressing towards their goals. **HPN** has completed Activity X (remeasurement) and has successfully demonstrated continued and sustained improvement. However, rates for the first two indicators were still below the 50th percentile for both MCOs. HSAG recommends that the MCOs either maintain this PIP another year or continue to monitor these indicators through HEDIS compliance audits.

Lead Screening in Children PIP

Description of Data Obtained

Using the PIP Validation Tool, HSAG assessed each component of the *Lead Screening in Children* PIP based on CMS protocol activities. This was a collaborative PIP, and both MCOs completed Activities I through IV for the 2007–2008 validation.

Conclusions Drawn from the Data

The following table highlights the overall validation results for the *Lead Screening in Children* PIP. Both MCOs demonstrated strength in conducting this collaborative PIP, scoring 100 percent for all elements. The validation status indicates high confidence in the PIP.

Table 4-9—Comparison of PIP Elements for *Lead Screening in Children*

	Anthem	HPN
Total PIP Elements *Met*	100%	100%
Total Critical Elements *Met*	100%	100%

Table 4-10 displays rates for the study indicator. Since this was a first-year HEDIS measure, national benchmarks were not available. **HPN**'s baseline rates were higher than **Anthem**'s baseline rates for both Medicaid and SCHIP. Similarly, the SCHIP rates were consistently higher than the Medicaid rates.

Table 4-10—Rates of Lead Screening in Children

	Anthem	HPN
Medicaid	9.1%	14.1%
SCHIP	14.5%	20.0%

These results suggest that the rate of screening is not optimal at this time and both MCOs should continue efforts to improve lead screening in children. As with childhood immunizations, the MCOs may need to focus more on the Medicaid population than the SCHIP population to improve lead testing rates.

CAHPS® Surveys

Adult Medicaid

Table 4-11 presents the 2008 adult Medicaid CAHPS results for **Anthem**, **HPN**, and the **FFS** program, as well as the 2007 NCQA national averages.

Table 4-11––2008 Adult Medicaid CAHPS Results

	Anthem	HPN	FFS	2007 NCQA CAHPS National Averages
Composite Measures				
Getting Needed Care	44.2%	44.1%	42.1%	47.3%
Getting Care Quickly	64.1%	51.5%	49.4%	54.0%
How Well Doctors Communicate	65.9%	62.0%	65.6%	66.8%
*Customer Service**	NA	NA	NA	*
Shared Decision Making	NA	NA	58.8%	58.4%
Global Ratings				
Rating of All Health Care	44.7%	41.9%	38.9%	46.6%
Rating of Personal Doctor	63.1%	59.3%	57.9%	60.5%
Rating of Specialist Seen Most Often	NA	NA	54.9%	59.7%
Rating of Health Plan	48.2%	44.7%	41.9%	52.8%

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

* Due to changes in the Customer Service composite, a 2007 NCQA CAHPS national average was not calculated for this measure.

Anthem outperformed **HPN** and the **FFS** program for all the comparable measures and showed particular strength for *Getting Care Quickly*, for which **Anthem**'s rate of 64.1 percent was substantially higher than **HPN**, the **FFS** program, and the NCQA national average.

The **FFS** program had the lowest rates among the three programs/plans for five of the six comparable measures: *Getting Needed Care*, *Getting Care Quickly*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*.

HPN had the lowest rate for the *How Well Doctors Communicate* measure.

Anthem, **HPN**, and the **FFS** program all scored below the 2007 NCQA national averages for four measures: *Getting Needed Care*, *How Well Doctors Communicate*, *Rating of All Health Care*, and *Rating of Health Plan*.

Child Medicaid

Table 4-12 presents the 2008 child Medicaid CAHPS results for **Anthem**, **HPN**, and the **FFS** program, as well as the 2007 NCQA national averages.

Table 4-12––2008 Child Medicaid CAHPS Results				
	Anthem	**HPN**	**FFS**	**2007 NCQA CAHPS National Averages**
Composite Measures				
Getting Needed Care	79.2%	67.0%	63.7%	80.3%
Getting Care Quickly	50.9%	49.9%	58.2%	50.9%
How Well Doctors Communicate	61.8%	65.9%	62.6%	66.3%
Courteous and Helpful Office Staff	65.7%	67.2%	68.1%	67.9%
Customer Service	NA	NA	50.7%	73.6%
Global Ratings				
Rating of All Health Care	59.1%	58.0%	57.6%	64.0%
Rating of Personal Doctor	64.2%	62.7%	60.8%	64.6%
Rating of Specialist Seen Most Often	NA	NA	63.2%	61.9%
Rating of Health Plan	61.1%	54.9%	56.8%	63.6%
A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as Not Applicable (NA).				

Anthem outperformed **HPN** and the **FFS** program on four of the measures: *Getting Needed Care*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*. However, **Anthem** had the lowest rates of the three programs/plans for two comparable measures: *How Well Doctors Communicate* and *Courteous and Helpful Office Staff*.

HPN outperformed **Anthem** and the **FFS** program on the *How Well Doctors Communicate* measure, but had the lowest rate for *Getting Care Quickly* and *Rating of Health Plan*.

The **FFS** program had the highest rates among the three programs/plans for the *Getting Care Quickly* and *Courteous and Helpful Office Staff* measures. The **FFS** program also had the lowest rates of the three programs/plans for three measures: *Getting Needed Care*, *Rating of All Health Care*, and *Rating of Personal Doctor*.

The **FFS** program was the only program to score above the 2007 NCQA national averages on any of these measures. The **FFS** program scored above the 2007 NCQA national averages for three measures: *Getting Care Quickly*, *Courteous and Helpful Office Staff*, and *Rating of Specialist Seen Most Often*. However, **Anthem** scored at the 2007 NCQA national average for one measure: *Getting Care Quickly*. **Anthem**, **HPN**, and the **FFS** program all scored below the 2007 NCQA national averages for five measures: *Getting Needed Care*, *How Well Doctors Communicate*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*.

Child SCHIP

Table 4-13 presents the 2008 child SCHIP CAHPS results for **Anthem**, **HPN**, and the **FFS** program, as well as the 2007 NCQA national averages.

Table 4-13––2008 Child SCHIP CAHPS Results				
	Anthem	HPN	FFS	2007 NCQA CAHPS National Averages
Composite Measures				
Getting Needed Care	77.0%	78.7%	70.7%	80.3%
Getting Care Quickly	44.8%	50.7%	56.1%	50.9%
How Well Doctors Communicate	59.9%	65.5%	56.8%	66.3%
Courteous and Helpful Office Staff	60.2%	65.2%	60.7%	67.9%
Customer Service	74.0%	NA	61.8%	73.6%
Global Ratings				
Rating of All Health Care	64.2%	62.5%	60.5%	64.0%
Rating of Personal Doctor	62.9%	63.6%	62.0%	64.6%
Rating of Specialist Seen Most Often	65.8%	NA	61.7%	61.9%
Rating of Health Plan	72.5%	73.3%	76.1%	63.6%
A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as Not Applicable (NA).				

Anthem outperformed **HPN** and the **FFS** program on one of the comparable measures: *Rating of All Health Care*. However, **Anthem** had the lowest rates for *Getting Care Quickly*, *Courteous and Helpful Office Staff*, and *Rating of Health Plan*

HPN outperformed **Anthem** and the **FFS** program for four measures: *Getting Needed Care*, *How Well Doctors Communicate*, *Courteous and Helpful Office Staff*, and *Rating of Personal Doctor*. **HPN** did not have the lowest rates on any of the measures.

The **FFS** program outperformed **Anthem** and **HPN** for the *Getting Care Quickly* and *Rating of Health Plan* measures. The **FFS** program had the lowest rates of the three programs/plans for four comparable measures: *Getting Needed Care*, *How Well Doctors Communicate*, *Rating of All Health Care*, and *Rating of Personal Doctor*.

Anthem, **HPN**, and the **FFS** program all scored substantially higher than the 2007 NCQA national average on one measure—*Rating of Health Plan*—by 8.9 percentage points, 9.7 percentage points, and 12.5 percentage points, respectively. However, all three programs/plans scored below the 2007 NCQA national averages for four measures: *Getting Needed Care*, *How Well Doctors Communicate*, *Courteous and Helpful Office Staff*, and *Rating of Personal Doctor*.

Statewide Conclusions and Recommendations

Quality Assessment and Performance Improvement Program Evaluation

HSAG is scheduled to perform a comprehensive QAPI on-site review of the MCOs in SFY 2008-2009.

Validation of Performance Measures

A detailed review of the 2008 HEDIS performance reports submitted by the two Nevada Medicaid MCOs determined that they prepared the reports according to *HEDIS 2008 Technical Specifications* for all of the audited measures. The MCOs were able to report on all selected performance measures.

Both MCOs showed strong performance on the HEDIS measures for Childhood Immunizations, Children's and Adolescents' Access to PCPs, and Annual Dental Visits. The MCOs' performance on these measures demonstrated their relative strength in terms of access to care for children.

Overall, the Nevada Check Up (SCHIP) rates were higher than the Medicaid rates for every comparable performance measure except Well-Child Visits in the First 15 Months of Life and Follow-up After Hospitalization for Mental Illness (7 Days). Medicaid and SCHIP programs in other states have shown similar differences. Further investigation may identify any differences in the populations that might provide guidance to ensure timely access to quality care for recipients in both programs.

Timeliness and access for maternity-related care is a statewide concern, as indicated by low performance results for both MCOs on Timeliness of Prenatal Care and Frequency of Ongoing Prenatal Care. These findings may indicate an issue with obtaining appointments in a timely manner, network adequacy for maternity care, obtaining all appropriate encounter data, or member compliance. Both MCOs should explore these issues and determine appropriate corrective action plans. DHCFP and the MCOs should consider implementing a collaborative PIP on maternity-related services.

Overall, the quality of services provided by both MCOs appears to be relatively good. The Nevada Check Up rates tended to be above the 50th percentile, indicating at least average performance, and rates for several measures were above the 90th percentiles. Medicaid rates are generally improving, although most rates remain below the national 2006 HEDIS 50th percentiles.

Performance Improvement Projects

Both **Anthem** and **HPN** achieved *Met* validation status for the two PIPs begun in 2006–2007 and continued in 2007–2008 on childhood immunization rates and diabetes. These results indicate progress in improving the care and services provided to recipients in these areas.

Both plans also achieved *Met* validation status for the collaborative *Lead Screening in Children* PIP initiated in 2007–2008. Recognizing that lead poisoning is a potential health threat to children enrolled in the Nevada Medicaid and Nevada Check Up programs, DHCFP and the two MCOs are conducting this collaborative PIP to determine the extent of lead screening of children 2 years of age enrolled in these programs.

Having achieved a *Met* validation status on all six PIPs indicates that the Nevada Medicaid MCOs are designing, conducting, and reporting PIPs in a methodologically sound manner based on the CMS protocols. However, the results of the *Lead Screening in Children* PIP indicate that the rate of screening is not optimal at this time and both MCOs should continue efforts to improve lead screening in children. The Nevada Check Up rates were consistently 5 to 6 percentage points higher than the Nevada Medicaid rates for both plans. HSAG made recommendations to assist the MCOs and DHCFP in designing interventions to improve screening rates. The next steps of the collaborative PIP will include complete documentation of interventions and a comparison of rates from baseline to the first remeasurement.

CAHPS

Anthem's CAHPS scores for the adult Medicaid population exceeded the 2007 NCQA CAHPS national average for only two measures: *Getting Care Quickly* and *Rating of Personal Doctor*. **HPN**'s adult CAHPS scores were at or below the national average. The **FFS** program exceeded the national average for one measure: *Shared Decision Making*.

The child Medicaid population's CAHPS scores were at or below the 2007 NCQA CAHPS national average for all measures for both **Anthem** and **HPN**. The **FFS** program exceeded the national average for three measures: *Getting Care Quickly, Courteous and Helpful Office Staff,* and *Rating of Specialist Seen Most Often*.

The SCHIP population's scores for *Rating of Health Plan* were substantially higher than the national average for **Anthem**, **HPN**, and the **FFS** program. Further, SCHIP scores were substantially higher than the child Medicaid scores on the *Rating of Health Plan* measure. All of the comparable composite measures were below the national average for both MCOs. For the **FFS** program all of the comparable composite measures were below the national average except *Getting Care Quickly*.

HSAG recommends that the two MCOs and the **FFS** program focus quality improvement initiatives on improving the following measures: *Getting Needed Care*, *How Well Doctors Communicate*, *Courteous and Helpful Office Staff*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*.

HSAG encourages **Anthem**, **HPN**, and the **FFS** program to implement quality improvement activities targeted at improving any additional measures that fell below the national average or where rates were substantially lower than other Nevada Medicaid providers.

Nevada Quality Strategy and Work Plan

Based on the DQEHO's feedback, DHCFP will obtain input from the MCOs, stakeholders, and strategic planning groups, then with technical assistance from HSAG will work to revise, strengthen, and implement the quality strategy in the areas that did not meet the identified regulatory requirements or topics.

Plan-Specific Conclusions and Recommendations

Anthem

Validation of Performance Measures

The audits of **Anthem**'s IS capabilities identified several potential issues, resulting in recommendations for the following corrective actions:

- **Anthem** should implement a hard edit requiring a diagnosis code to process all claims/encounters.
- **Anthem** should implement a mechanism to monitor the data submission patterns of its capitated providers to further support/improve encounter data completeness.
- **Anthem** should consider implementing a peer-led source code review process at the front end to identify any source code-related issues, which would reduce the incidence of source code errors and increase reporting efficiencies.
- **Anthem** did not clearly indicate within its BAT the processes for the production of hybrid measures and medical record review specific to Nevada. **Anthem** should consider implementing a final local review process of the BAT prior to its submission to auditors.

Anthem showed strong performance for Diabetes Care—Monitoring Nephropathy, which exceeded the 90th percentile. Five measures were above the 50th percentile, with particularly strong performance on Follow-up After Hospitalization for Mental Illness (7 Day and 30 Day).

For the Medicaid population, **Anthem** was below the national 10th percentile for Timeliness of Prenatal Care and Frequency of Ongoing Prenatal Care. Well-Child Visits in the First 15 Months of Life was below the 25th percentile and Adolescent Well-Care Visits was below the 10th percentile. These results suggest that **Anthem** should investigate issues with receiving all encounter data, lack of member compliance, and/or issues related to timeliness of or access to maternity care.

For the SCHIP population, five of **Anthem**'s seven reported rates were above the 50th percentile. Childhood Immunization Rate—Combo 3, Children's Access to PCP (12–24 months), and Annual Dental Visits—Combined Rate were above the 90th percentile. **Anthem** should consider ways to

bring Medicaid results on child and adolescent measures to the performance levels achieved for SCHIP recipients.

Performance Improvement Projects

Anthem received one *Not Met* score for noncritical elements on both its *Improving Childhood Immunization Rates* and *Improving Diabetes Screening and Control* PIPs. Nonetheless, the plan achieved a *Met* validation status on both PIPs and on the collaborative *Lead Screening in Children* PIP.

HSAG recommends that **Anthem** continue to focus on guidelines presented in the publication, *Conducting Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities* (U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, final protocol, Version 1.0, May 1, 2002). Further, **Anthem** should seek technical assistance, as needed, from HSAG.

CAHPS

For the Medicaid population, **Anthem** scored at or above the 2007 NCQA CAHPS national average for two adult measures, *Getting Care Quickly* and *Rating of Personal Doctor*, and one child measure, *Getting Care Quickly*. Although several of **Anthem**'s Medicaid adult and child rates were lower than the CAHPS national average, these differences were not substantial, suggesting that these are not areas of major weakness. However, **Anthem** should continue to monitor areas of care with ratings below the national average since they have an impact on member satisfaction.

For the SCHIP population, **Anthem** scored above the 2007 NCQA CAHPS national average for four measures: *Customer Service*, *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*. The *Rating of Health Plan* measure exceeded the national average by 8.9 percentage points, suggesting that this is an area of strength for **Anthem**.

However, the SCHIP results showed that rates for *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Courteous and Helpful Office Staff*, and *Rating of Personal Doctor* were below the national average. For *Getting Care Quickly*, *How Well Doctors Communicate*, and *Courteous and Helpful Office Staff*, the differences were greater than 5 percent, suggesting that these are areas of weakness for **Anthem**. For measures identified as weaknesses, Anthem should target additional quality improvement strategies toward these areas of care.

HPN

Validation of Performance Measures

The audits of **HPN**'s IS capabilities identified several potential issues, resulting in a recommendation for the following corrective action:

- **HPN** used an internally-built administrative database to supplement its HEDIS data. The health plan did not have a well-documented process for maintaining this database. **HPN** should

formally document each step used to collect and validate data within an internally-built administrative database to ensure data accuracy and validity.

Since 2005, **HPN** has improved 13 of 16 HEDIS measures for the Medicaid population. **HPN** appears to provide appropriate services and is continuing to show improvement in the delivery of services to recipients. The rate for Diabetes Care—Monitoring Nephropathy exceeded the 90th percentile. Four measures were above the 50th percentile and four additional measures were within 1 percentage point of the 50th percentile.

Similarly, **HPN** has improved 7 of 10 HEDIS measures for the SCHIP population since 2005. As with the Medicaid population, **HPN** appears to provide appropriate services and is continuing to show improvement in the delivery of services to recipients. Five HEDIS 2008 measures exceeded the 90th percentile and seven other measures exceeded the 50th percentile.

HPN should focus attention on improving timeliness of and access to care. In the Medicaid population, three measures have shown declines since 2005: Children's Access to PCPs (7–11 Years and 12–19 Years) and Follow-up After Hospitalization for Mental Illness (7 Days). The SCHIP population also showed a small decline since 2005 in the rates for Children's and Adolescents' Access to PCPs. Although these declines were not statistically significant, they were among similar declines in the Medicaid population, potentially indicating problems with access to care. **HPN** should conduct a barrier analysis to determine the nature and scope of any access issues.

HPN's rate for Timeliness of Prenatal Care was below the 50th percentile. **HPN**'s rate on this measure and on Frequency of Ongoing Prenatal Care decreased significantly for HEDIS 2008. These results may indicate an issue with obtaining appointments in a timely manner, issues with network adequacy for maternity care, or member and/or provider noncompliance.

Performance Improvement Projects

HPN achieved a *Met* validation status for its *Improving Immunization Rates for Children Two Years Old in Medicaid* and *Improving Diabetes Management* PIPs, as well as the collaborative *Lead Screening in Children* PIP. The percentage scores of all evaluation elements and critical elements *Met* were 100 percent for all three PIPs.

The results of the diabetes PIP indicate that **HPN** should continue its efforts to improve rates for providing services to members with diabetes. The second remeasurement for HbA1c testing showed a statistically significant improvement over a three-year period; however, the rate was below the goal and substantially below the 2006 HEDIS 90th percentile benchmark. The second remeasurement for LDL-C testing showed a rate below both the goal and the HEDIS benchmark. The rate for monitoring for diabetic nephropathy showed strong performance and exceeded the 2006 HEDIS 90th percentile benchmark. HSAG recommends that **HPN** consider ways to apply lessons learned from monitoring for nephropathy to HbA1c testing and LDL-C screening.

CAHPS

For the Medicaid population, **HPN** did not score above the 2007 NCQA CAHPS national average for any of the adult or child measures. The adult *Rating of Health Plan* rate was less than the

national average by more than 5 percentage points, suggesting an area of weakness. The child *Getting Needed Care*, *Rating of All Health Care*, and *Rating of Health Plan* measures had rates that were less than the national average by more than 5 percentage points (13.3 percentage points, 6.0 percentage points, and 8.7 percentage points, respectively). These results suggest areas of weakness for **HPN**. The health plan should target additional quality improvement strategies toward improving these adult and child measures.

For the SCHIP population, **HPN** scored above the 2007 NCQA CAHPS national average for one measure, *Rating of Health Plan*, which was greater than the national average by nearly 10 percentage points. This suggests an area of strength for **HPN**. Although *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Courteous and Helpful Office Staff*, *Rating of All Health Care*, and *Rating of Personal Doctor* all scored below the national average, these differences were not substantial, suggesting that these are not areas of major weakness for **HPN**. However, **HPN** should continue to monitor these areas since they have an impact on member satisfaction.

Appendix A. Performance Tracking Tool

In 2008, an enhanced version of the PTT was revised to facilitate tracking and monitoring of rates and activities, quality improvement efforts, comparisons to benchmarks, setting and achieving goals, and internal and external reporting. Some of the highlights to the PTT include:

- Key timeline dates for reporting requirements.
- Compliance monitoring activities, including areas for targeted improvement for the MCOs.
- A simplified process to enter rates for the various activities (e.g., HEDIS, CAHPS, PIPs).
- Links to automatically trend, graph, determine HEDIS percentile rankings, determine next goals, and calculate incentive payment qualification.
- PIP summary tables to determine validation status, and improvements on individual PIP quality indicators.
- A Chi-square and p-value calculator to facilitate the MCOs' ability to determine if changes are statistically significant.

In addition, DHCFP may use the PTT to enhance reporting to the State Legislature, CMS, and various interdepartmental reporting, and to determine areas that need focused attention (e.g., DHCFP may use the PTT to develop collaborative PIPs). The PTT may also be expanded to include the FFS program, facilitating comparisons between the Medicaid MCOs and the FFS program. A copy of the PTT follows this summary.

Appendix B. Trending Graphs

The following section displays graphs of Medicaid and SCHIP trends from 2005 through 2008 for specific HEDIS measures. The first set of graphs (i.e., graphs A-1 through A-15) shows trended overall results for Medicaid and SCHIP. Graphs A-16 through A-30 are specific to **HPN**, since **HPN** was the only participating MCO submitting HEDIS rates each year from 2005 through 2008. All of the graphs are compared to the HEDIS 2006 90th percentiles, which are the new measurable objectives for HEDIS 2008.

There were several changes to the Medicaid program for HEDIS 2007 and HEDIS 2008. For HEDIS 2007, **NevadaCare** no longer participated as a Medicaid MCO and **Anthem** was a new Nevada Medicaid MCO. Therefore, the results presented for HEDIS 2007 are based only on **HPN**'s rate. The HEDIS 2008 rates do include **Anthem**. Due to these two major changes, several of the measures had significant rate increases and decreases (e.g., Frequency of Ongoing Prenatal Care). In general, examination of the overall Medicaid and SCHIP trends reveals the following:

- SCHIP had higher rates than Medicaid for 9 out of 10 trended measures applicable to both populations.
- Immunization rates have continued to improve each year. For the first time, the SCHIP rate of 65.1 percent for Combo 3 exceeded the national 2006 Medicaid 90th percentile (57.8 percent).
- The rates for Well-Child Visits in the First 15 Months of Life declined this year, with SCHIP rates falling below the HEDIS 2005 levels. The rates for Well-Child Visits (3-6 Years) also declined this year.
- The area of Annual Dental Visits has continued to improve each year. The SCHIP rate of 64.6 percent exceeded the national 2006 Medicaid 90th percentile (52.9 percent).
- The rates for Frequency of Ongoing Prenatal Care, and Timeliness of Prenatal Care both declined this year. The decline is not as drastic as it appears in the graphs, since for HEDIS 2007, only HPN's rate was used for the overall Medicaid rate; Anthem did not report rates for HEDIS 2007. However, comparing Figures B-22 and B-23 shows that HPN's rates also decreased for these measures for HEDIS 2008.
- The rates for Children's Access to PCPs have shown a small improvement since 2005 for the two younger age groups, and equally small declines since 2005 for the two older age groups. The 12-19-year age group appears to be the most problematic in terms of access to PCPs.
- The rates for Follow-up After Hospitalization for Mental Illness (7 days and 30 days) have continued to improve each year. The most significant improvement has been in the 30-day follow-up, where the Medicaid rates have improved 19.3 percentage points since 2005.

Trends for HEDIS Measures

Figure B-1––Childhood Immunization Rate—Combo 2

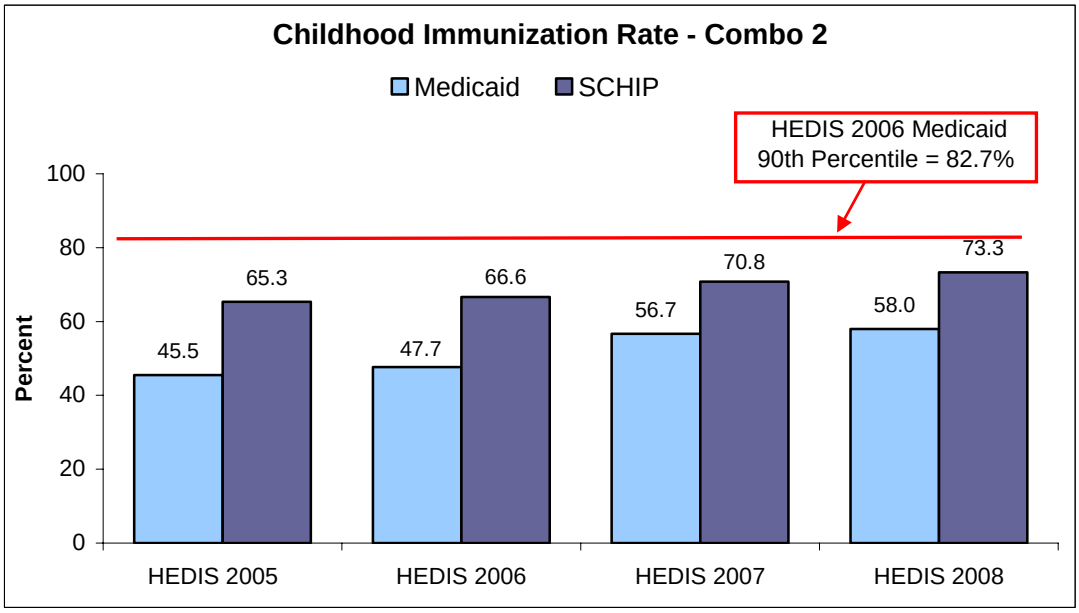


Figure B-2––Childhood Immunization Rate—Combo 3

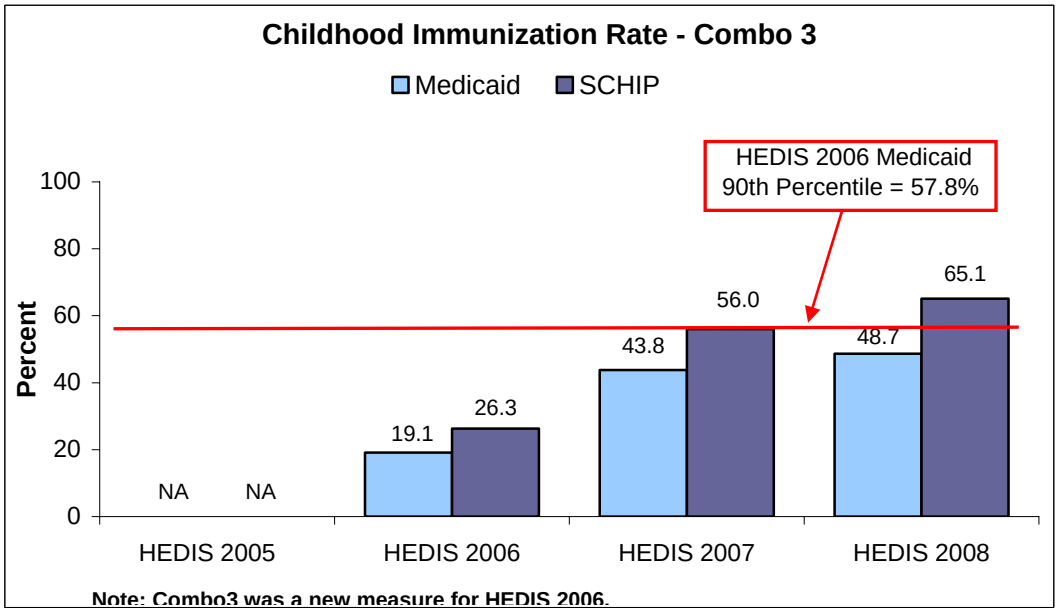


Figure B-3––Well-Child Visits in the First 15 Months of Life

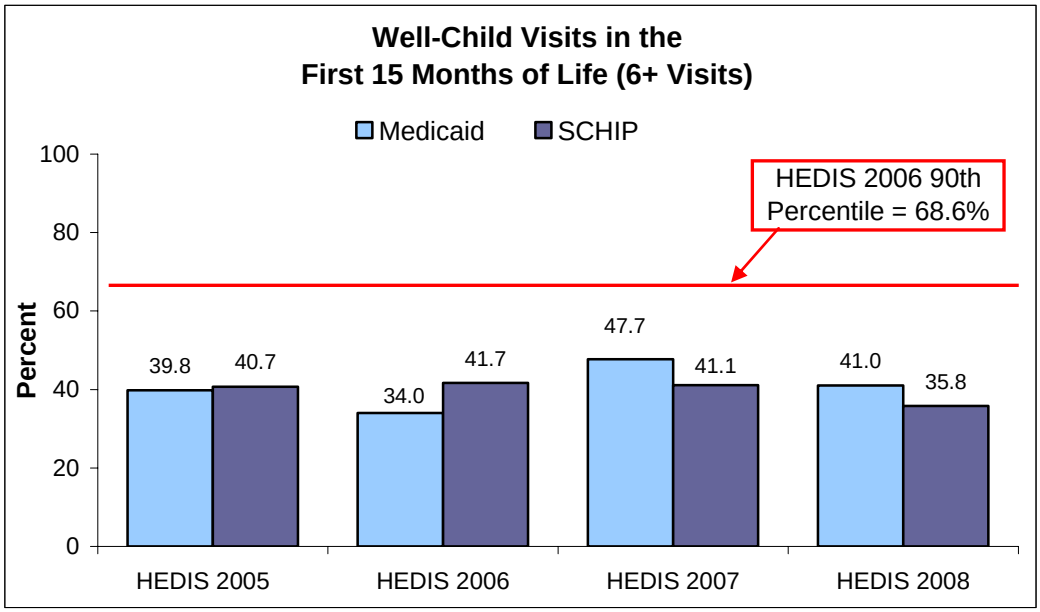


Figure B-4––Well-Child Visits 3-6 Years

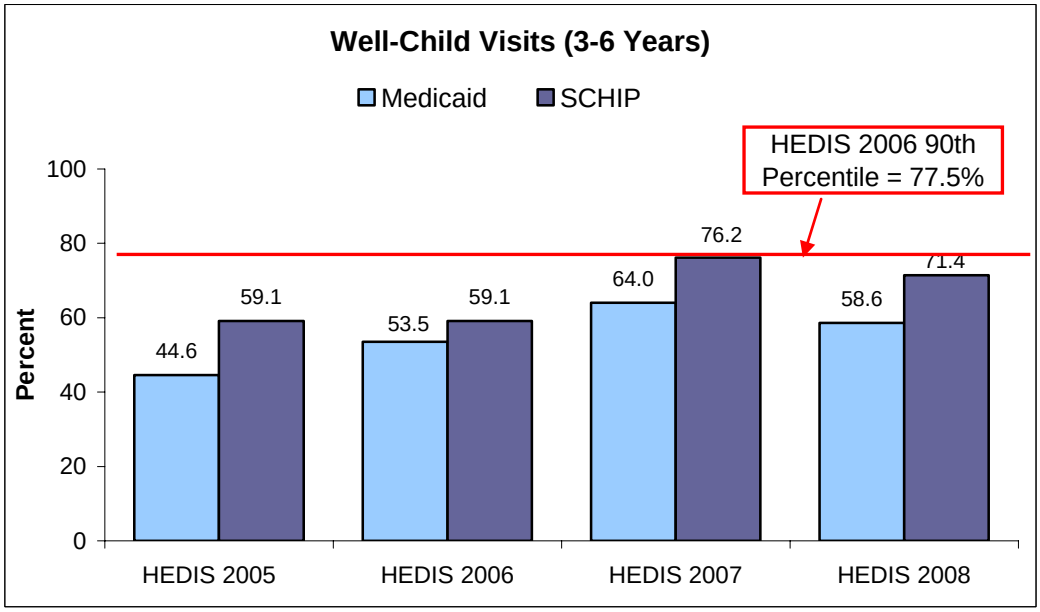


Figure B-5––Adolescent Well-Care Visits

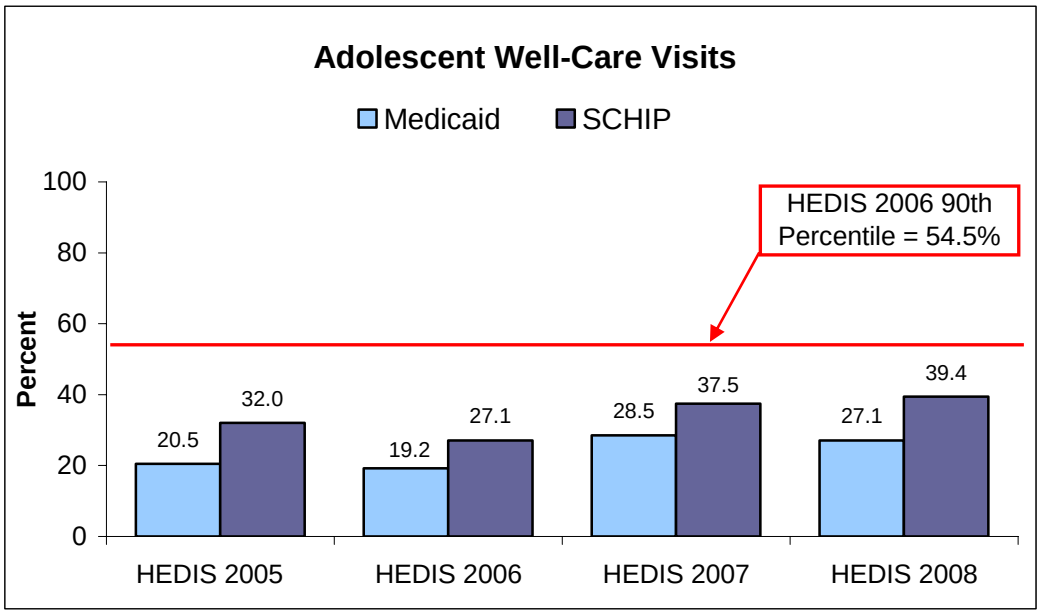


Figure B-6––Annual Dental Visits

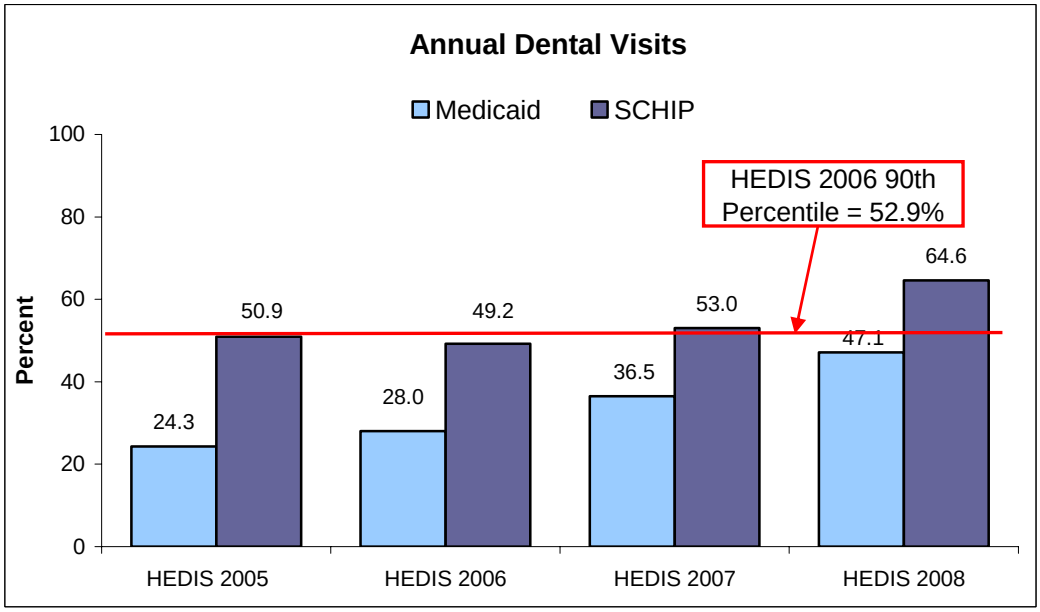


Figure B-7––Frequency of Ongoing Prenatal Care

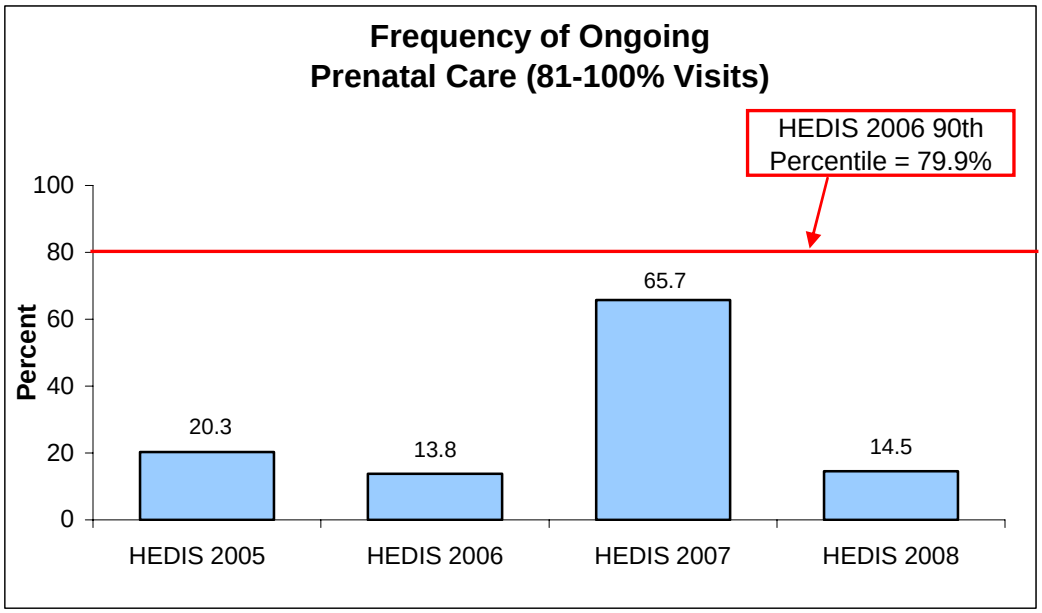


Figure B-8––Timeliness of Prenatal Care

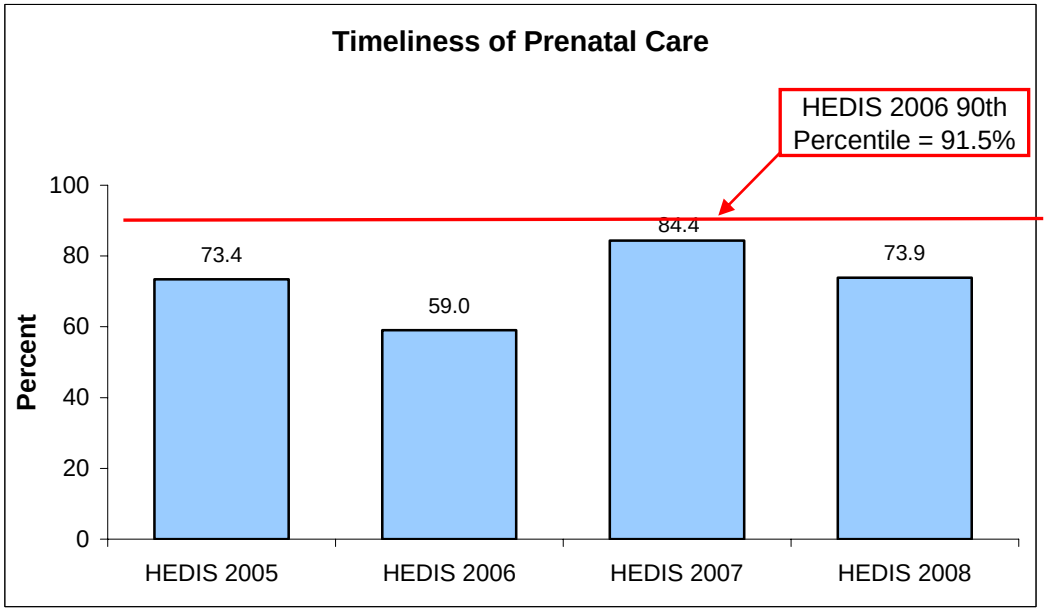


Figure B-9––Postpartum Care

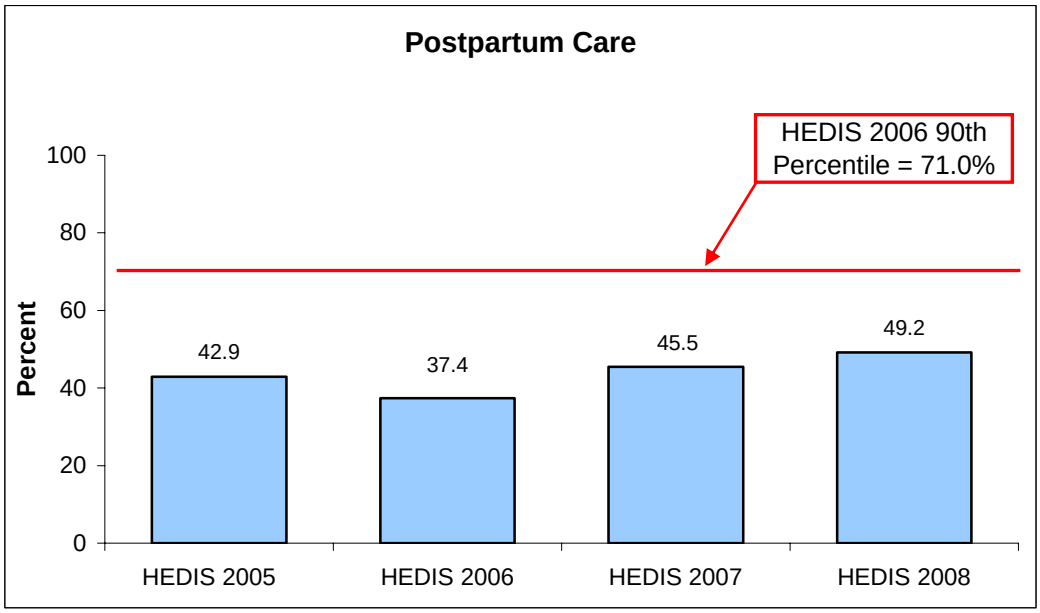


Figure B-10––Children's Access to PCPs, 12–24 Months

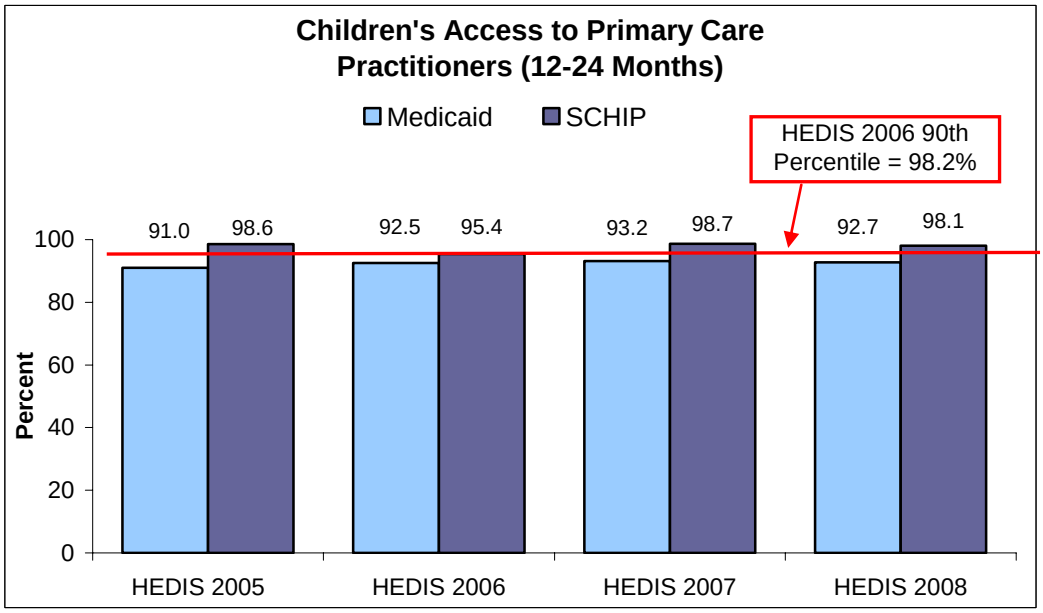


Figure B-11––Children's Access to PCPs, 25 Months to 6 Years

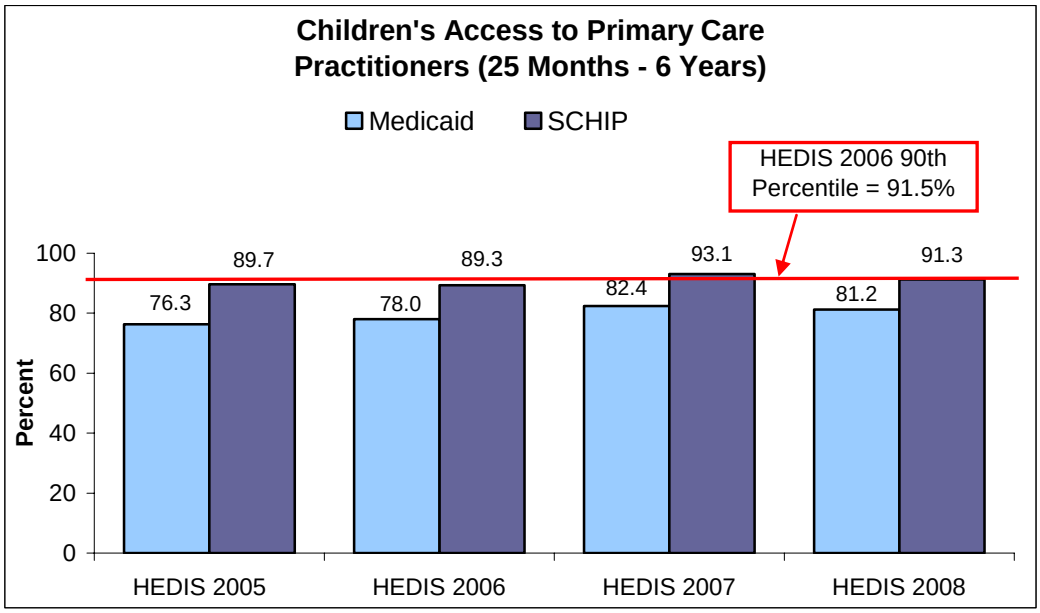


Figure B-12––Children's Access to PCPs, 7 to 11 Years

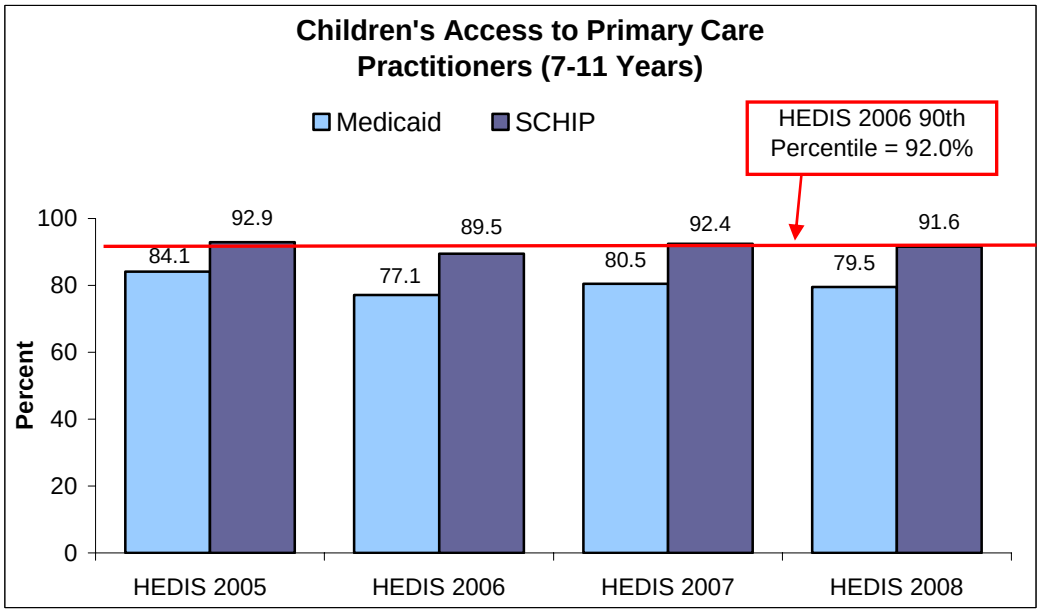


Figure B-13––Children's Access to PCPs, 12–19 Years

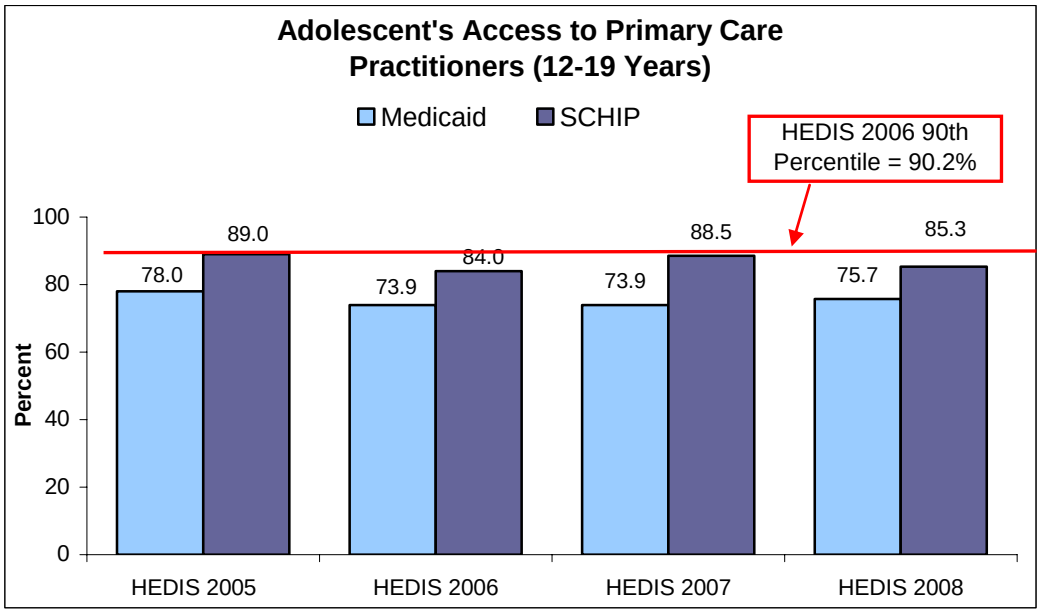


Figure B-14––Follow-up After Hospitalization for Mental Illness, 7 Days

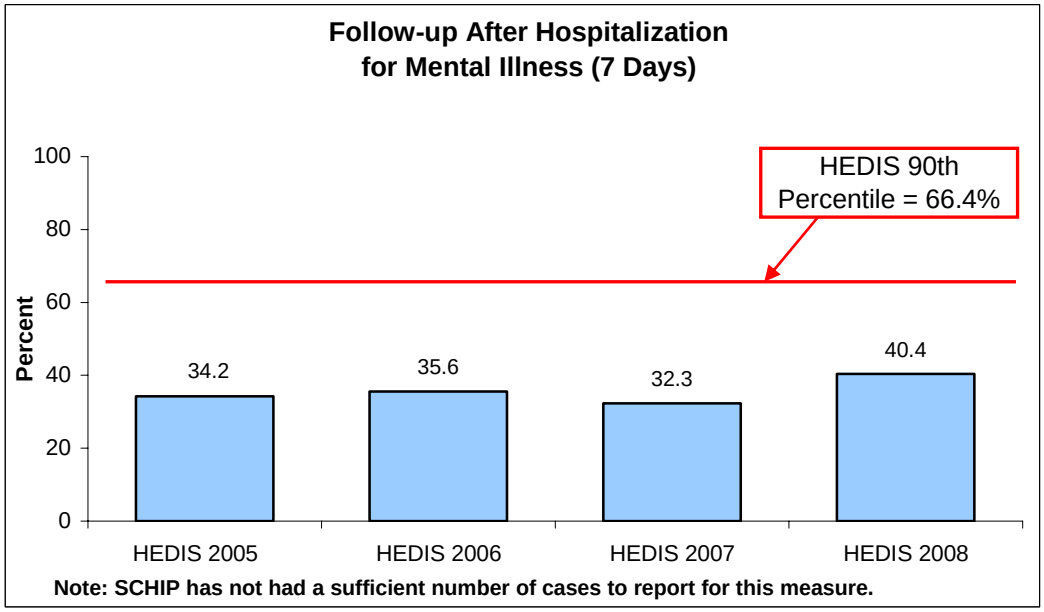
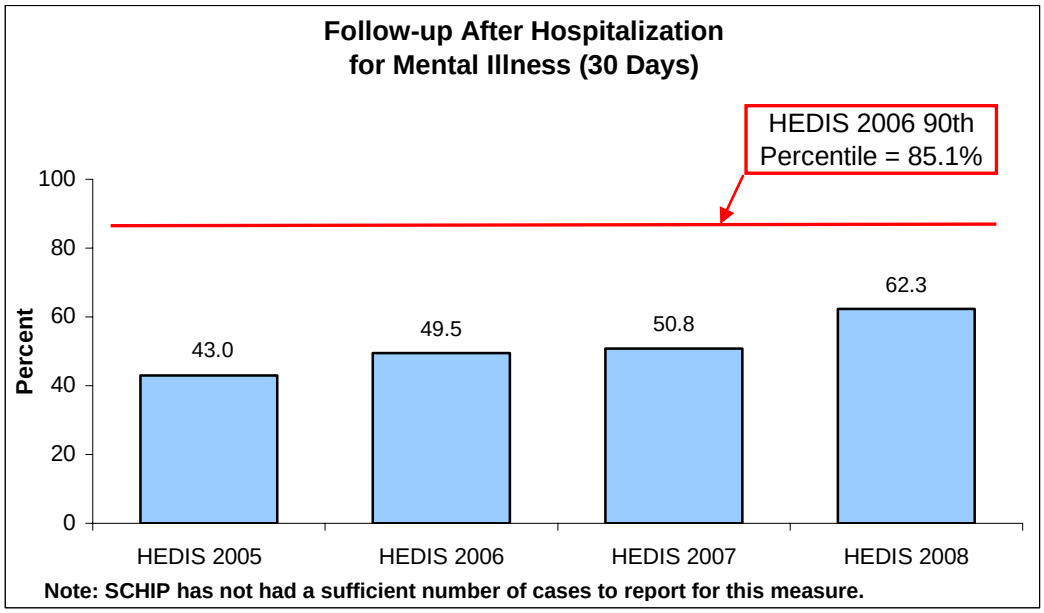


Figure B-15––Follow-up After Hospitalization for Mental Illness, 30 Days



Trends for HEDIS Measures for HPN

Figure B-16––Childhood Immunization Rate—Combo 2

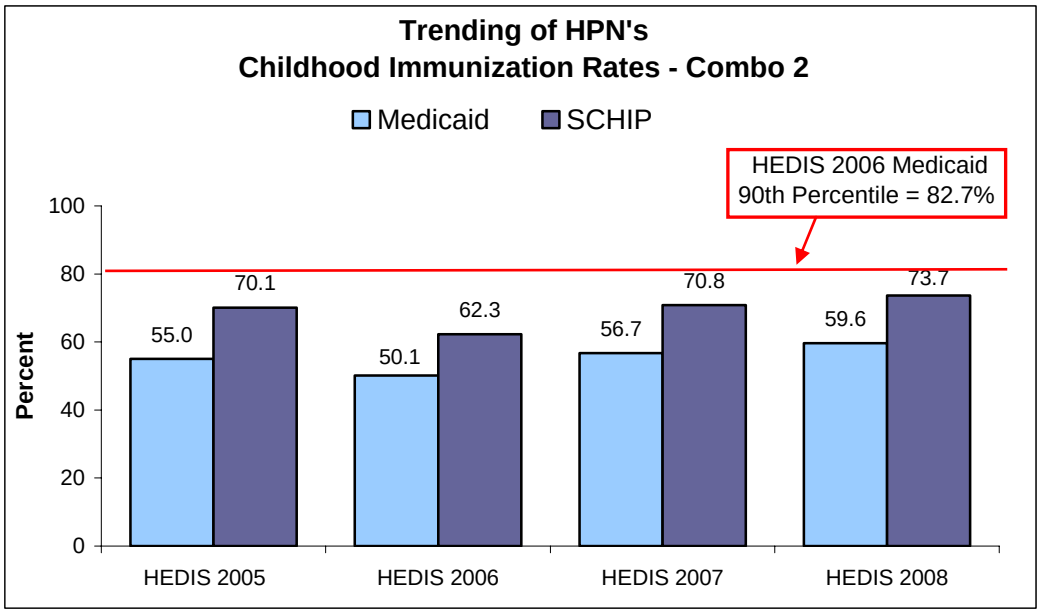


Figure B-17––Childhood Immunization Rate—Combo 3

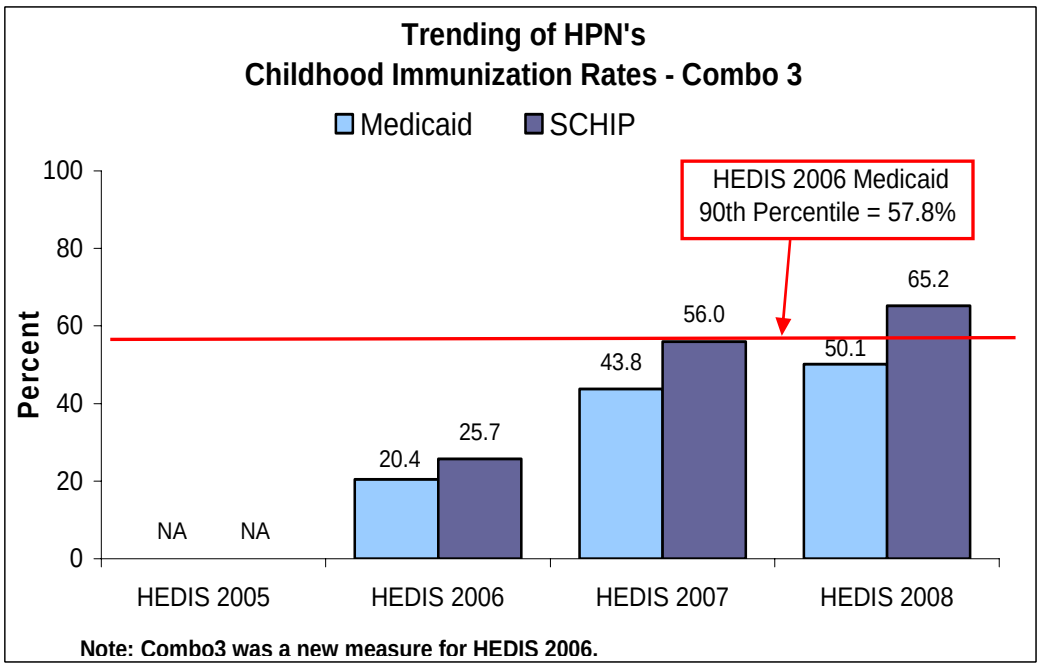


Figure B-18––Well-Child Visits in the First 15 Months of Life

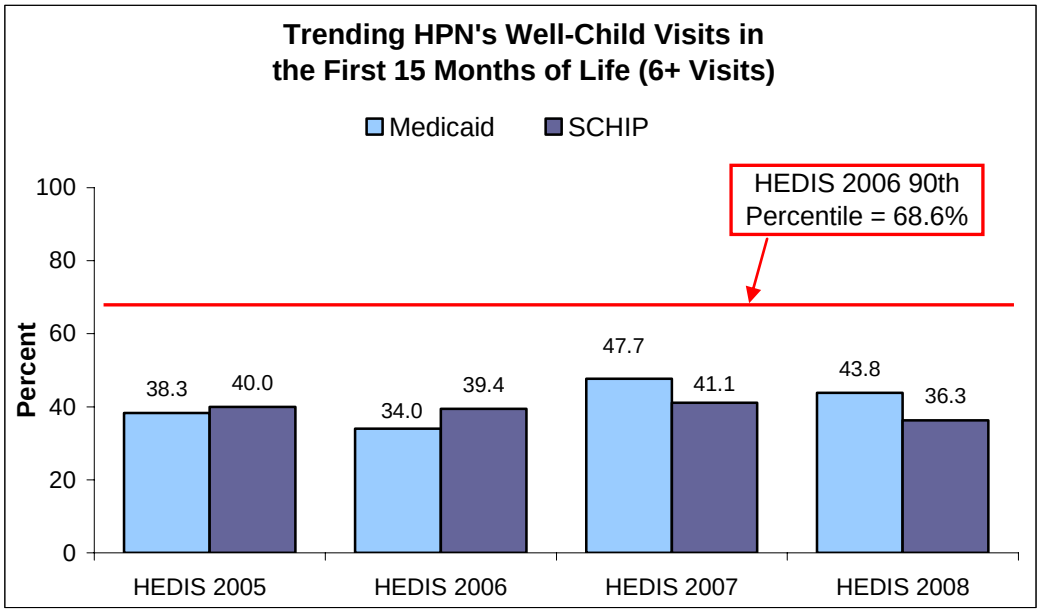


Figure B-19––Well-Child Visits 3-6 Years

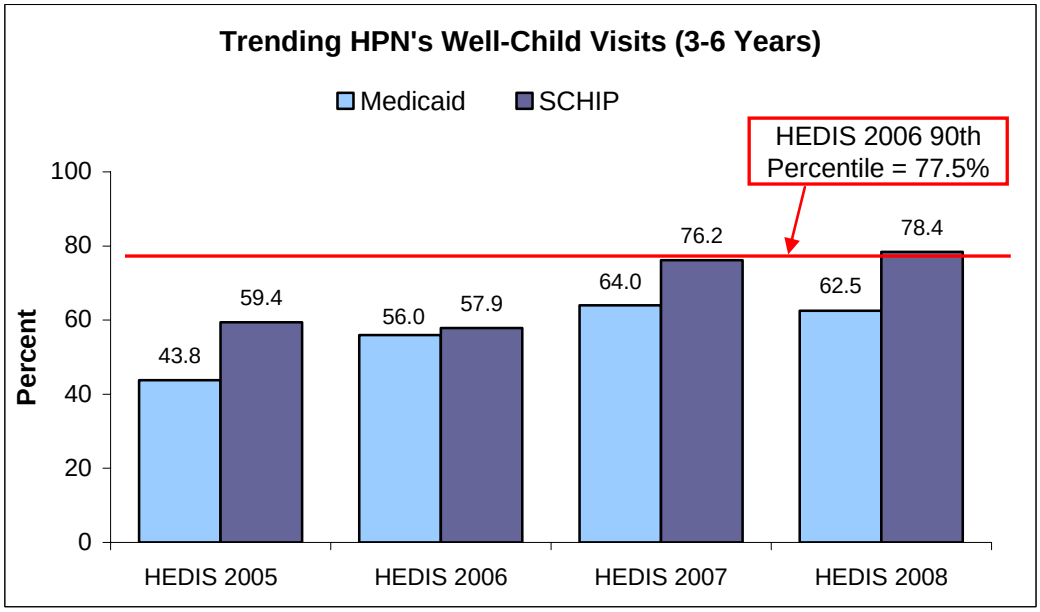


Figure B-20––Adolescent Well-Care Visits

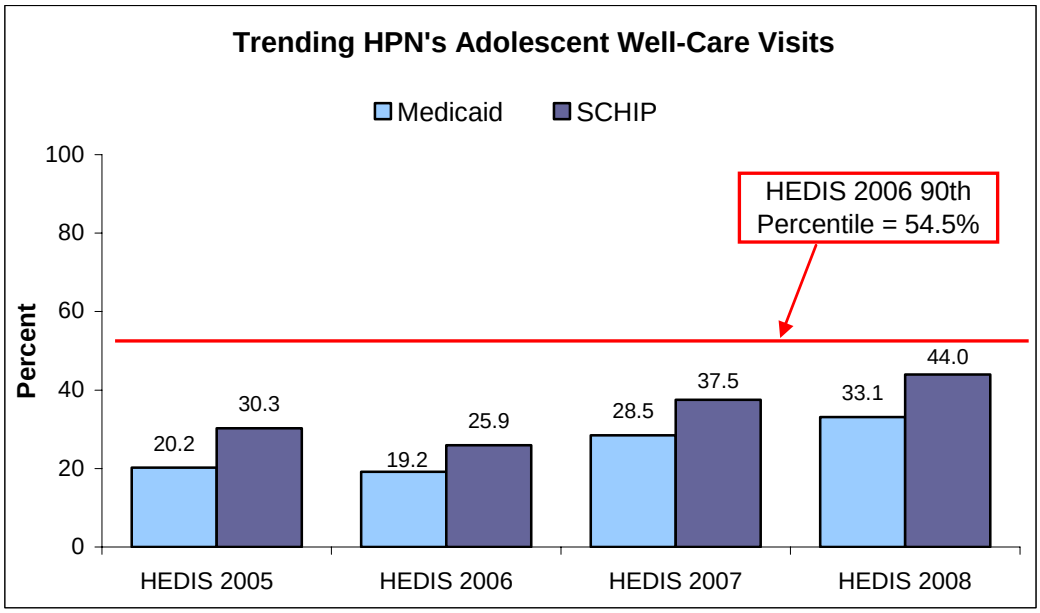


Figure B-21––Annual Dental Visits

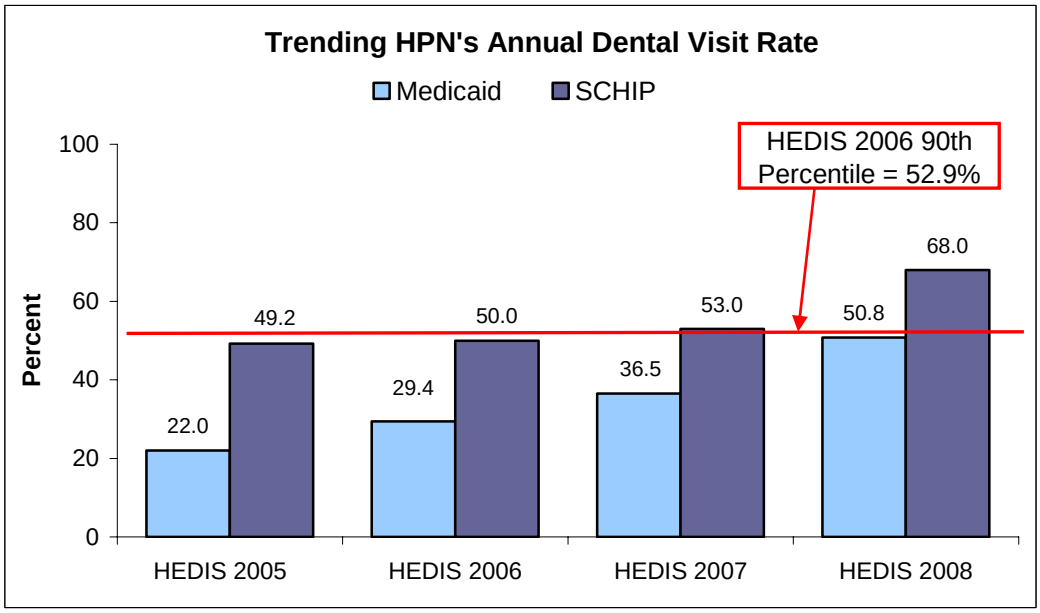


Figure B-22––Frequency of Ongoing Prenatal Care

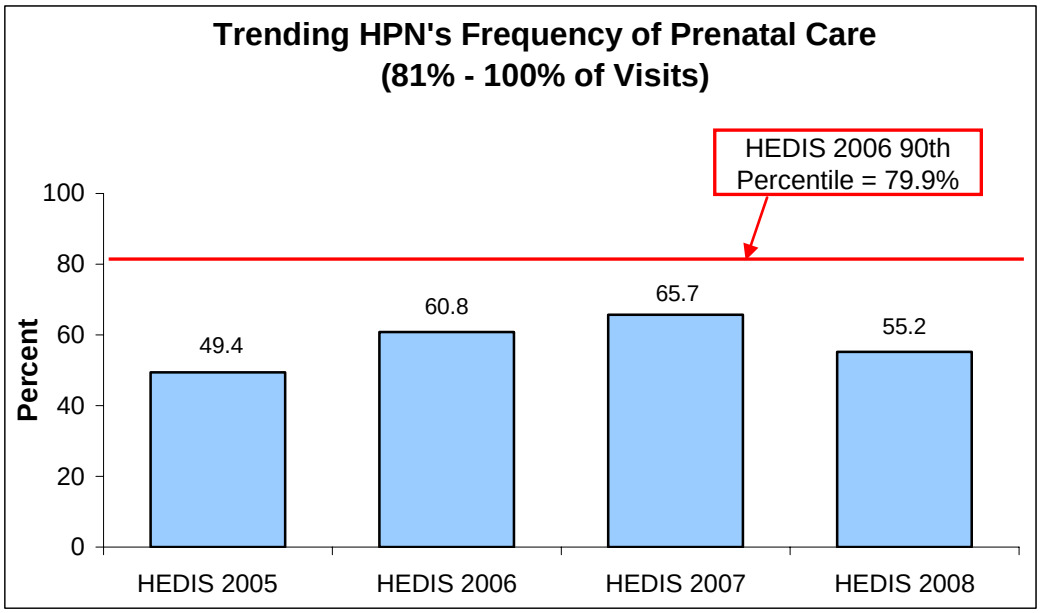


Figure B-23––Timeliness of Prenatal Care

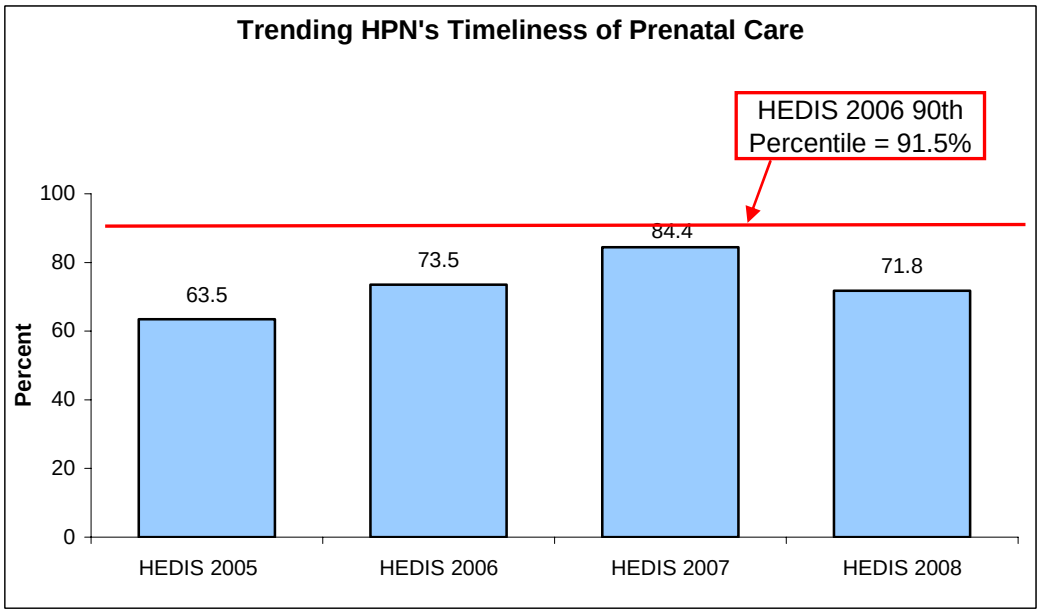


Figure B-24––Postpartum Care

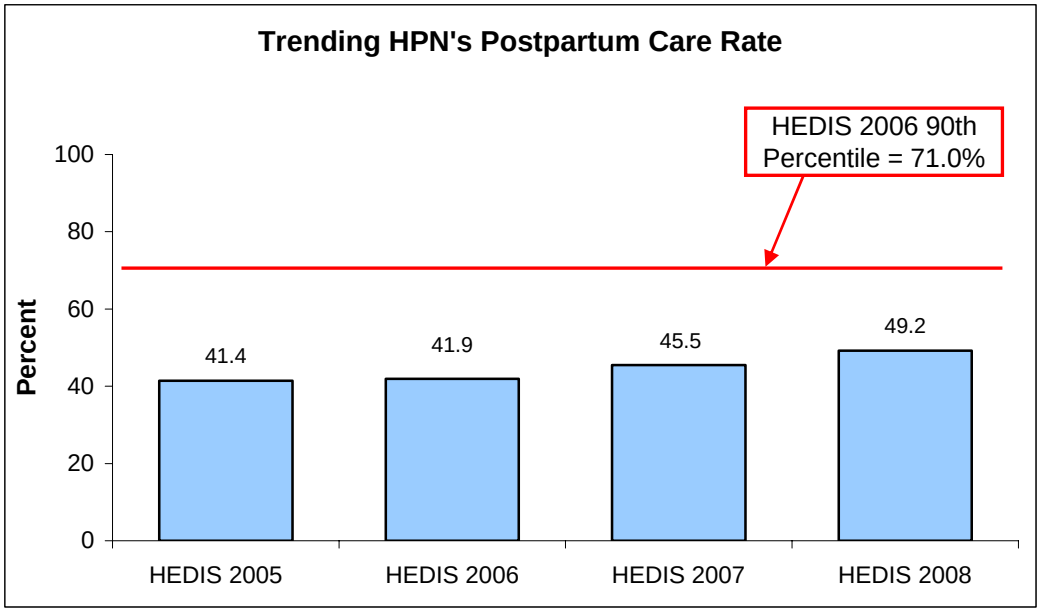


Figure B-25––Children's Access to PCPs, 12–24 Months

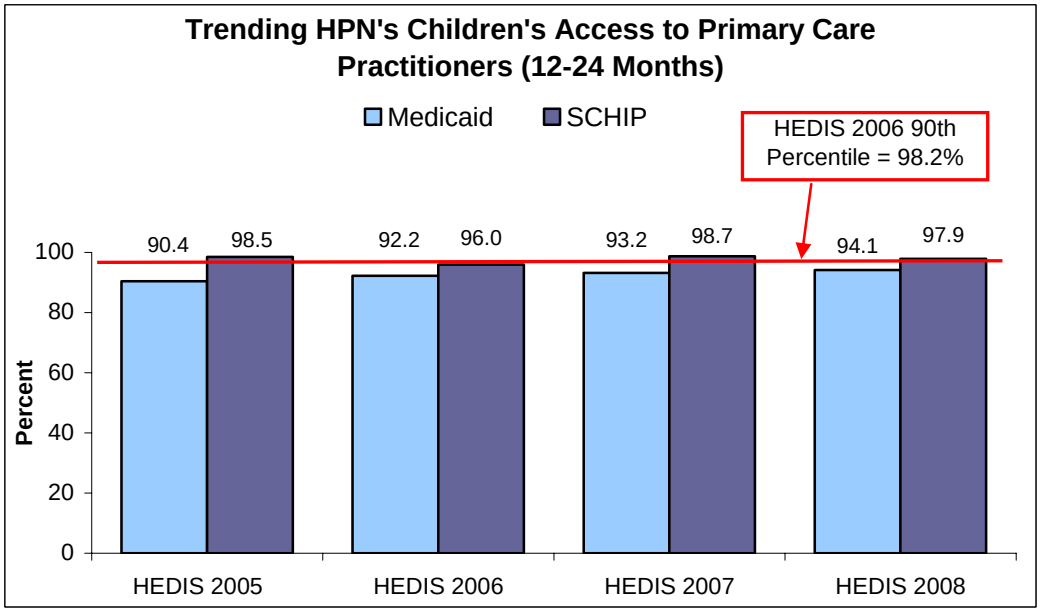


Figure B-26––Children's Access to PCPs, 25 Months to 6 Years

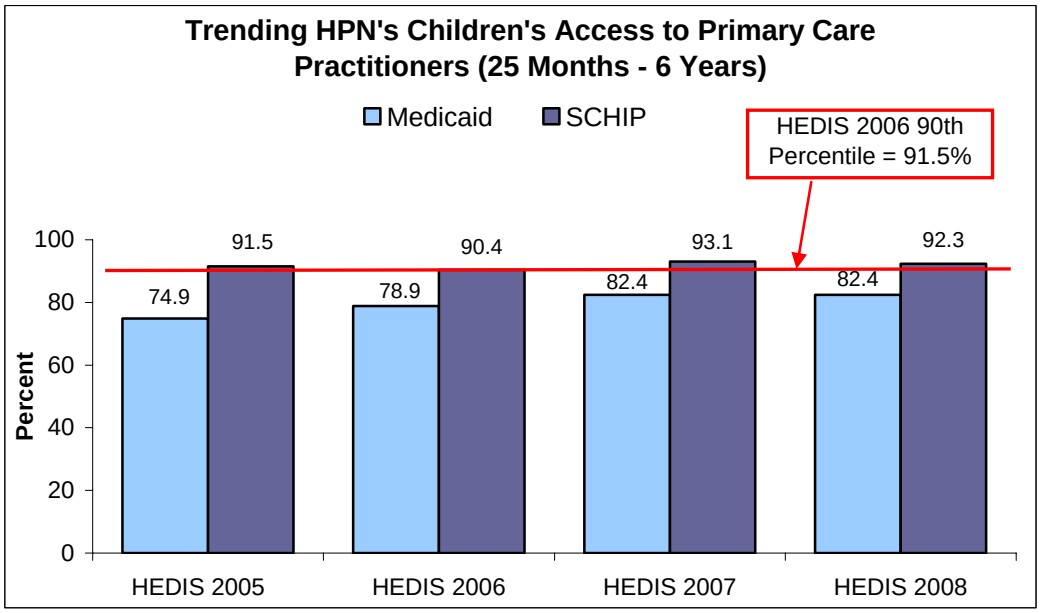


Figure B-27––Children's Access to PCPs, 7 to 11 Years

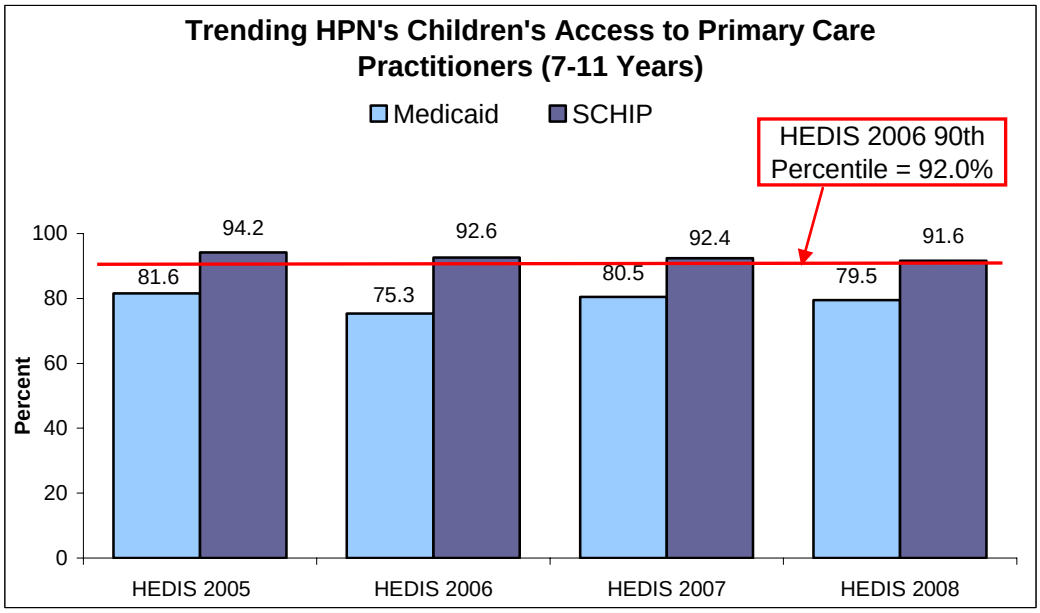


Figure B-28––Children's Access to PCPs, 12–19 Years

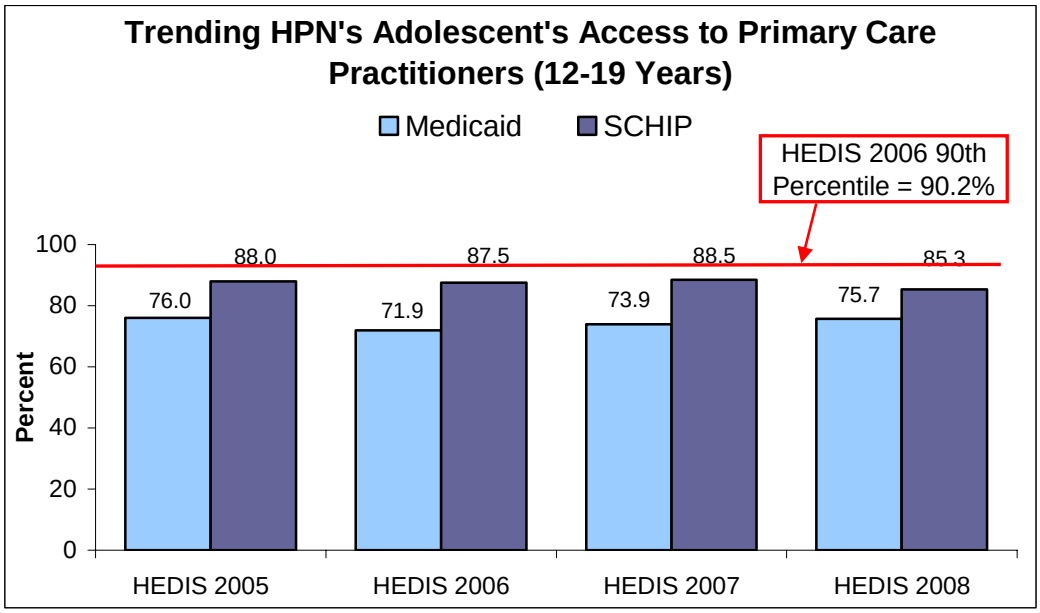


Figure B-29––Follow-up After Hospitalization for Mental Illness, 7 Days

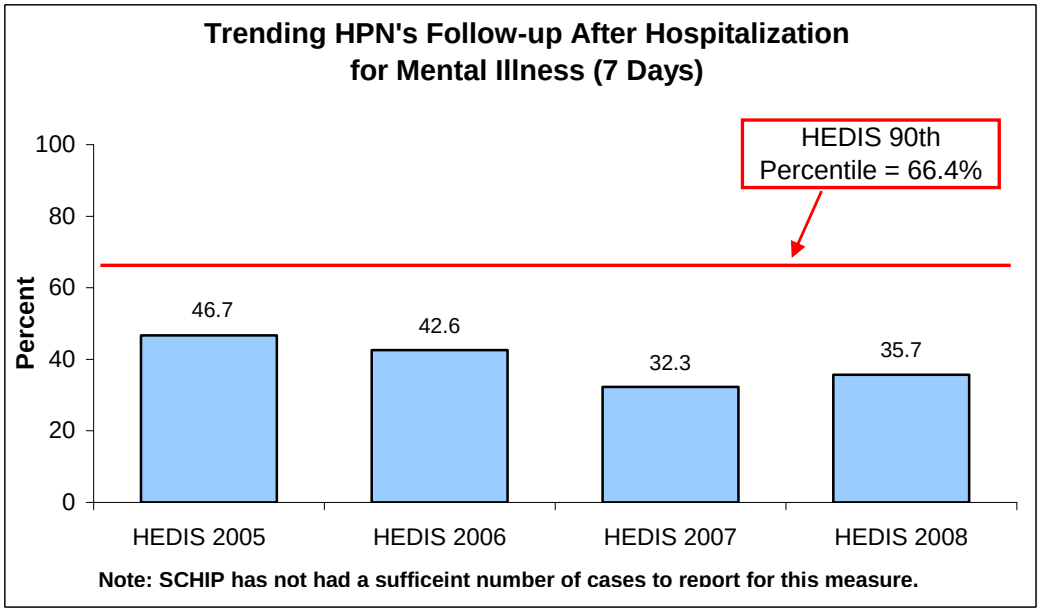
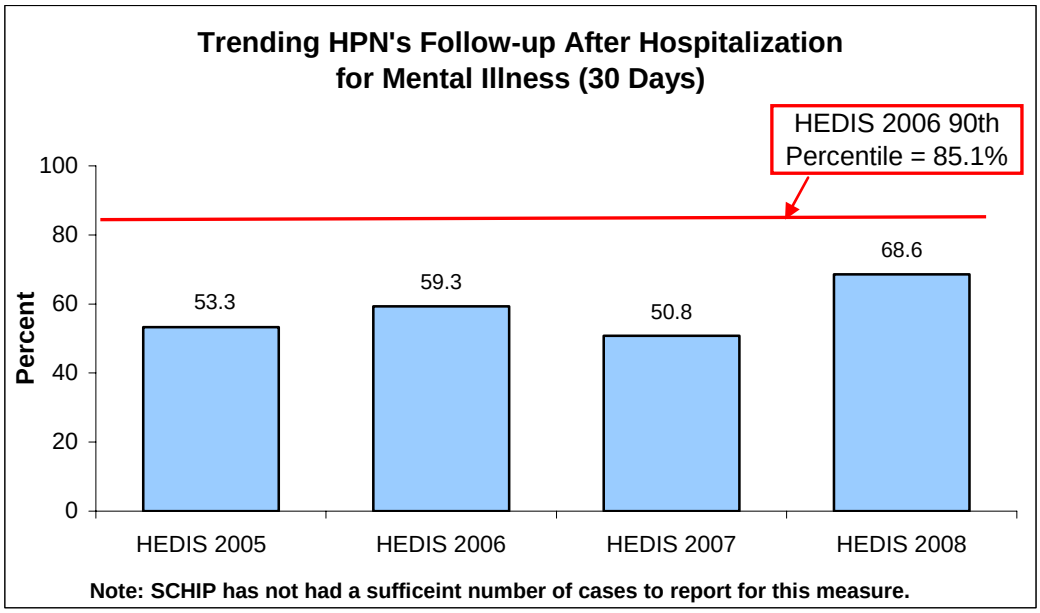


Figure B-30––Follow-up After Hospitalization for Mental Illness, 30 Days



Appendix C. Medicaid HEDIS 2006 Means and Percentiles

Medicaid HEDIS 2006 Means and Percentiles						
	Mean	P10	P25	P50	P75	P90*
Childhood Immunizations (Combo 2)	70.4	53.8	62.7	72.4	78.5	82.7
Childhood Immunizations (Combo 3)	42.5	25.1	33.8	42.3	49.8	57.8
Well-Child Visits in the First 15 Months of Life (0 visits)**	5.0	0.5	1.1	2.0	3.9	10.0
Well-Child Visits in the First 15 Months of Life (6+ visits)	48.6	22.4	41.6	50.0	59.2	68.6
Well-Child Visits (3-6 Years)	63.3	50.1	56.7	64.8	70.8	77.5
Adolescent Well Care Visits	40.6	28.0	32.8	39.4	47.9	54.5
Annual Dental Visit (Combined)	41.0	27.7	32.8	42.0	48.6	52.9
Children and adolescent's access to primary care practitioners (12-24) months	92.4	84.9	91.2	94.8	97.5	98.2
Children and adolescent's access to primary care practitioners (25 months-6 years)	82.8	71.6	79.9	85.4	88.6	91.5
Children and adolescent's access to primary care practitioners (7-11 years)	82.9	72.9	79.0	84.9	89.3	92.0
Children and adolescent's access to primary care practitioners (12-19 years)	80.5	69.2	76.2	83.4	87.7	90.2
Timeliness of Prenatal Care	79.1	61.1	74.2	83.3	88.1	91.5
Frequency of Ongoing Prenatal Care (<21%)**	16.7	1.9	4.6	9.4	20.1	44.7
Frequency of Ongoing Prenatal Care (81-100%)	55.8	24.2	44.4	59.9	71.7	79.9
Postpartum Care	57.0	41.8	49.7	58.8	65.9	71.0
Use of appropriate medications for people with asthma (5-9 years)	88.0	80.2	86.7	90.2	93.4	95.8
Use of appropriate medications for people with asthma (10-17 years)	85.6	75.3	83.3	87.4	91.1	93.5
Use of appropriate medications for people with asthma (18-56 years)	83.4	74.0	80.3	84.9	88.0	90.8
Use of appropriate medications for people with asthma (Total)	85.7	78.4	84.0	87.1	89.7	92.5
Comprehensive diabetes care (HbA1c Testing)	76.2	64.0	71.1	77.4	84.9	88.8
Comprehensive diabetes care (Poor HbA1c Control)**	49.1	30.3	37.3	45.2	60.1	74.3
Comprehensive diabetes care (Eye Exams)	48.6	25.5	35.2	50.8	61.5	68.1
Comprehensive diabetes care (LDL-C Screening)	80.5	66.3	76.2	83.3	88.1	90.8
Comprehensive diabetes care (LDL-C level <130)	51.3	26.5	43.7	53.8	61.8	69.2
Comprehensive diabetes care (LDL-C Level <100)	32.6	14.4	26.5	34.1	41.0	46.5
Comprehensive diabetes care (Monitoring Nephropathy)	48.8	30.2	39.5	49.3	59.7	65.6
Follow-up After Hospitalization for Mental Illness (7 Days)	39.2	10.0	23.2	35.8	55.4	66.4
Follow-up After Hospitalization for Mental Illness (30 Days)	56.8	23.8	43.0	59.3	73.0	85.1
Mental Health Utilization – Percent Any Services	7.0	0.6	2.9	6.1	10.6	14.3
Mental Health Utilization – Percent Inpatient Services	0.7	0.2	0.3	0.6	0.9	1.1
Mental Health Utilization – Percent Intermediate Services	0.1	0.0	0.0	0.0	0.0	0.2
Mental Health Utilization – Percent Ambulatory Services	6.9	0.1	2.8	6.2	10.3	14.5

* The Nevada Medicaid and Check-up goal (i.e., Measurable Objective) is the 90th percentile.
** A lower rate indicates better performance (i.e., a rate in the 10th percentile is better than a rate in the 90th percentile).

Appendix D. Medicaid HEDIS 2007 Means and Percentiles

Medicaid HEDIS 2007 Means and Percentiles						
	Mean	P10	P25	P50	P75	P90*
Childhood Immunizations (Combo 2)	73.4	58.7	68.3	75.2	80.1	84.8
Childhood Immunizations (Combo 3)	60.9	41.8	54.3	62.6	70.7	74.5
Well-Child Visits in the First 15 Months of Life (0 visits)**	3.8	0.4	0.7	1.4	2.9	6.8
Well-Child Visits in the First 15 Months of Life (6+ visits)	55.6	38.0	46.6	56.6	64.4	75.2
Well-Child Visits (3-6 Years)	66.8	55.7	62.7	67.5	74.9	79.9
Adolescent Well Care Visits	43.6	31.3	35.3	42.1	51.4	58.9
Annual Dental Visit (Combined)	42.5	27.9	36.5	42.8	50.6	57.3
Children and adolescent's access to primary care practitioners (12-24) months	94.1	90.2	93.0	95.8	97.4	98.0
Children and adolescent's access to primary care practitioners (25 months-6 years)	84.9	77.9	82.4	86.7	89.4	91.4
Children and adolescent's access to primary care practitioners (7-11 years)	85.9	77.0	83.4	87.2	90.5	93.3
Children and adolescent's access to primary care practitioners (12-19 years)	83.2	73.9	80.1	85.3	89.2	91.4
Timeliness of Prenatal Care	81.2	70.3	77.0	84.2	88.7	91.5
Frequency of Ongoing Prenatal Care (<21%)**	13.5	2.3	4.4	7.6	17.5	32.0
Frequency of Ongoing Prenatal Care (81-100%)	58.6	33.0	49.4	62.9	71.7	78.6
Postpartum Care	59.1	47.4	54.3	59.7	65.5	71.1
Use of appropriate medications for people with asthma (5-9 years)	89.6	83.1	88.6	91.7	94.6	96.3
Use of appropriate medications for people with asthma (10-17 years)	87.0	80.2	86.2	88.8	91.4	93.0
Use of appropriate medications for people with asthma (18-56 years)	84.7	76.4	82.6	85.4	88.2	90.9
Use of appropriate medications for people with asthma (Total)	87.1	81.5	85.6	88.4	90.3	92.0
Comprehensive diabetes care (HbA1c Testing)	78.0	67.6	74.4	79.3	84.3	89.1
Comprehensive diabetes care (Poor HbA1c Control)**	48.7	32.1	39.7	46.7	57.4	69.6
Comprehensive diabetes care (Good HbA1c Control)	30.2	14.9	24.4	31.3	36.6	40.9
Comprehensive diabetes care (Eye Exams)	51.4	30.6	42.1	53.6	62.7	68.3
Comprehensive diabetes care (LDL-C Screening)	71.1	58.7	66.9	72.8	77.9	81.0
Comprehensive diabetes care (LDL-C Level <100)	30.6	15.2	24.1	31.3	37.2	44.1
Comprehensive diabetes care (BP <130/80)	30.4	19.2	25.1	30.6	35.5	41.4
Comprehensive diabetes care (BP <140/90)	57.3	41.1	50.6	60.1	65.5	69.3
Comprehensive diabetes care (Monitoring Nephropathy)	74.6	60.3	68.6	76.6	81.8	85.5
Follow-up After Hospitalization for Mental Illness (7 Days)	39.1	11.4	26.0	35.8	58.0	66.2
Follow-up After Hospitalization for Mental Illness (30 Days)	57.7	17.1	48.2	57.3	75.9	79.8
Mental Health Utilization – Percent Any Services	9.1	2.5	3.5	8.4	13.4	17
Mental Health Utilization – Percent Inpatient Services	0.7	0.3	0.5	0.7	0.9	1.1
Mental Health Utilization – Percent Intermediate Services	0.1	0	0	0	0.1	0.2
Mental Health Utilization – Percent Ambulatory Services	8.9	2.4	3.8	8.3	13.2	15.7

* The Nevada Medicaid and Check-up goal (i.e., Measurable Objective) is the 90th percentile.
** A lower rate indicates better performance (i.e., a rate in the 10th percentile is better than a rate in the 90th percentile).